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 FISHERS HOSPITAL (15-0181) 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	113, 290	37, 116	-4, 817	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2. 00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing bed - SNF	0	0	0		0	5. 00
6.00 Swing bed - NF	0				0	6. 00
12. 00 CMHC I	0		0		0	12.00
200. 00 Total	0	113, 290	37, 116	-4, 817	0	200. 00
The characteristic constraint with the few ways for the first state of the few ways and the few ways for the	Alex and the left of	E +l-	1		!!!	

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.

HOSPI 7	TAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	ATA	Provi de	r CCN: 1		Peri od:		Workshe	et S-2	
							From 07/01, To 06/30,	/2016 /2017	Part I Date/Ti	me Prem	pared:
									11/20/2		
	1.00 Hospital and Hospital Health Care Co		. 00	,	3. 00			4. 00			
1.00	Street: 13861 OLIO RD	PO Box:									1. 00
2.00	City: FISHERS	State:	IN Zi	p Code	: 46037	Count	y: HAMILTON				2. 00
		Component N		CCN	CBSA	Provi der		1 2	nt Syst		
			NL	umber	Number	Туре	Certi fi ed	V ,	0, or		
		1.00		2. 00	3. 00	4.00	5. 00	6.00			
	Hospital and Hospital-Based Componen				0.00	11.00	0.00	1 0.00	1 7. 00	0.00	
3.00	Hospi tal	ST. VINCENT FISH	IERS 15	50181	26900	1	05/13/2013	N	Р	0	3. 00
4. 00	Subpravi dan I DE	HOSPI TAL									4. 00
5.00	Subprovi der - I PF Subprovi der - I RF										5. 00
6.00	Subprovider - (Other)										6. 00
7.00	Swing Beds - SNF										7. 00
8.00	Swing Beds - NF										8. 00
9. 00 10. 00	Hospi tal -Based SNF Hospi tal -Based NF										9. 00 10. 00
11. 00	Hospi tal -Based OLTC										11. 00
12.00	Hospi tal -Based HHA										12.00
13.00	, ,										13.00
14. 00 15. 00	Hospi tal -Based Hospi ce Hospi tal -Based Health Clinic - RHC										14. 00 15. 00
16. 00	Hospital-Based Health Clinic - FQHC										16. 00
17. 00	Hospi tal -Based (CMHC) I			İ							17. 00
	Renal Dialysis										18. 00
19. 00	Other						From		To		19. 00
							1.00		To 2. 0		
20. 00	Cost Reporting Period (mm/dd/yyyy)						07/01/2		06/30/		20. 00
21. 00	Type of Control (see instructions)						111				21.00
00.00	Inpatient PPS Information				1.						00.00
22. 00	Does this facility qualify and is it share hospital adjustment, in accord						Y		N		22. 00
	for yes or "N" for no. Is this facil						e				
	amendment hospital?) In column 2, en	ter "Y" for yes	or "N" for	no.	. ,						
22. 01	Did this hospital receive interim un						N		N		22. 01
	period? Enter in column 1, "Y" for y reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)		G								
22. 02	Is this a newly merged hospital that						N		N		22. 02
	determined at cost report settlement or "N" for no, for the portion of th						2				
	in column 2, "Y" for yes or "N" for						n				
	or after October 1.										
22. 03	Did this hospital receive a geograph of the OMB standards for delineating						T N		N		22. 03
	in column 1. "Y" for yes or "N" for	no for the porti	on of the c	ost ren	ortina r	peri od					
	prior to October 1. Enter in column	2, "Y" for yes o	r "N" for n	o for t	he porti	on of the	9				
	cost reporting period occurring on o										
	hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,			untea i	n accord	ance witr	ו				
23. 00	Which method is used to determine Me			/or 25	below? I	n column		3	N		23. 00
	1, enter 1 if date of admission, 2 i										
	method of identifying the days in the used in the prior cost reporting per	is cost reporting	g period di	fferent	from th	ne method					
	used III the piror cost reporting per	iour ili corulliir.	In-State	In-St		ut-of		Medi cai	id 0	ther	
			Medi cai d	Medi c		State		HMO day		li cai d	
			paid days	eligi			ledi cai d		d	lays	
				unpa day:		d days e	el i gi bl e unpai d				
			1.00	2. 0		3. 00	4. 00	5. 00	6	. 00	
24. 00	If this provider is an IPPS hospital	, enter the	62		13	0	5		517		24. 00
	in-state Medicaid paid days in colum										
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in										
25. 00	If this provider is an IRF, enter th Medicaid paid days in column 1, the		0	1	0	0	0		0		25. 00
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column	3, out-of-state									
	Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid day	S III CUI UIIIN 5.	I	I	I	I	I		I	ı	

Health Financial Systems CT VIIV	YENT FLC	LIEDE LIGEDI TAL			n 1 i o	u of For	m CMC (DEED 10
Health Financial Systems ST. VINC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		HERS HOSPITAL Provider CC		Peri od:		u of For Workshe		
				From 07/01, To 06/30,		Part I Date/Ti	me Pre	pared:
				Urban/Rui		11/20/2	2017 2:	
				1. 00		2.0		
26.00 Enter your standard geographic classification (not wo cost reporting period. Enter "1" for urban or "2" for			inning of the	e	1			26. 00
27.00 Enter your standard geographic classification (not w	age) st	atus at the end			1			27. 00
reporting period. Enter in column 1, "1" for urban center the effective date of the geographic reclassif			pl i cabl e,					
35.00 If this is a sole community hospital (SCH), enter the			CH status in		0			35. 00
effect in the cost reporting period.				Begi nni	ng:	Endi	ng:	
2/ 00 Fatar and inches beginning and and inches of COU.		C	2/ 5	1.00		2. (00	27, 00
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		Subscript Tine	36 FOI HUIIDEI					36. 00
37.00 If this is a Medicare dependent hospital (MDH), entering is in effect in the cost reporting period.	er the n	umber of period	ls MDH status		0			37. 00
37.01 Is this hospital a former MDH that is eligible for t				N				37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)	for yes	or "N" for no.	(see					
38.00 If line 37 is 1, enter the beginning and ending date								38. 00
greater than 1, subscript this line for the number of enter subsequent dates.	r perio	as in excess of	one and					
				Y/N 1. 00		Y/ 2. (
39.00 Does this facility qualify for the inpatient hospita						2. C		39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage re								
CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	or "N"	for no. (see i	nstructions)					
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo				_ N		N		40. 00
no in column 2, for discharges on or after October 1					\ \/	VVIII	VIV	
					1. 00	XVIII 2. 00	XI X 3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payme	nt for	di sproporti opat	e share in a	cordance	l N	l N	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	nital?	Enter "V for ve	es or "N" for	no	N	N	l N	47. 00
48.00 Is the facility electing full federal capital paymen					N	N N	N	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	noried .	during which ro	sidonts in a	annovod				57. 00
57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for								37.00
is "Y" did residents start training in the first mor 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	I, if a	ppl i cabl e.						
58.00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	burseme comple	nt for physicia te Wkst. D-5.	ıns' servi ces	as				58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If ye	s, comp	lete Wkst. D-2,			N			59.00
60.00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"		1 9			N			60.00
	Y/N	IME	Direct GME	IME		Di rect	GME	
(1 00 hid your book tol. rook) at ETE state water 100	1.00	2. 00	3. 00	4.00		5. ((1.00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N				0.00	1	0.00	61. 00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care		0.00	0. (nn				61. 01
FTEs from the hospital's 3 most recent cost reports		0.00	0.	50				01.01
ending and submitted before March 23, 2010. (see instructions)								
61.02 Enter the current year total unweighted primary care	:	0.00	0. (od				61. 02
FTE count (excluding OB/GYN, general surgery FTEs, 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. (20				61. 03
and/or general surgery residents, which is used for		0.00	0.1	50				01.03
determining compliance with the 75% test. (see instructions)								
61.04 Enter the number of unweighted primary care/or		0.00	0. (od				61. 04
surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).								
61.05 Enter the difference between the baseline primary		0.00	0. (od				61. 05
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line								
61.04 minus line 61.03). (see instructions)								

lealth Financial Systems HOSPLTAL AND HOSPLTAL HEALTH CARE COMPLE			Provi der CC	N: 15_0191 De	In Lie	u of Form CMS-2 Worksheet S-2	
NOSPITAL AND NOSPITAL HEALTH CARE COMPLE	A IDENTIFICATION DA	IA	Provider CC		om 07/01/2016	Part I Date/Time Pre 11/20/2017 2:3	pared:
		Y/N	IME	Direct GME	IME	Direct GME	рііі
(1 0/ Fatar the amount of ACA SEFO2 amount		1.00	2. 00	3. 00	4. 00	5. 00	(1.0)
61.06 Enter the amount of ACA §5503 awar used for cap relief and/or FTEs the care or general surgery. (see inst	nat are nonprimary		0.00	0.00			61. 06
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
// 10 06 the ETF- in line // 0Fi 6			1. 00	2. 00	3.00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify specialty, if any, and the number for each new program. (see instruction column 1, the program name, enter program code, enter in column 3, the unweighted count and enter in column 4. TE unweighted count. 61.20 Of the FTEs in line 61.05, specify	of FTE residents ctions) Enter in in column 2, the che IME FTE umn 4, direct GME				0. 00		61. 10
program specialty, if any, and the residents for each expanded progra instructions) Enter in column 1, t enter in column 2, the program coc 3, the IME FTE unweighted count ar 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	01. 20
						1. 00	
ACA Provisions Affecting the Healt 52.00 Enter the number of FTE residents					od for which	0.00	62. 00
your hospital received HRSA PCRE f 62.01 Enter the number of FTE residents	funding (see instruc that rotated from a	cti ons) a Teachi	ng Health Cent	er (THC) into			62. 0
during in this cost reporting peri Teaching Hospitals that Claim Resi				s)			
63.00 Has your facility trained resident "Y" for yes or "N" for no in colum					eriod? Enter	N	63. 00
	,			Unwei ghted FTEs Nonprovi der	Unwei ghted 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 Jul				his base year	is your cost r	eporting	
64.00 Enter in column 1, if line 63 is y in the base year period, the number resident FTEs attributable to rota settings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column 1	ves, or your faciliter of unweighted nor ations occurring in number of unweighted hospital. Enter in	y trair n-primar all nor I non-pr n columr	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	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(5.00 5.1	1.00		2.00	3. 00	4.00	5.00	, = ·
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				0. 00	0.00	0.000000	. GS. UL

In Lieu of Form CMS-2552-10 Health Financial Systems ST. VINCENT FISHERS HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0181 Peri od: Worksheet S-2 From 07/01/2016 Part I Date/Time Prepared: 06/30/2017 11/20/2017 2:33 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in 2)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 0.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Ratio (col. 3/ Program Name Program Code Unwei ghted Unwei ahted FTEs FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2 00 3.00 4.00 5 00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4. the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 Ν Enter "Y" for yes or "N" for no. If line 70 yes. Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 Ν subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Provi ders 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 \$413.40(f)(i)(i)? Enter "Y" for yes and "N" for no.
Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" Ν 87.00 for yes or "N" for no. ٧/ XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν 90.00 yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Ν 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 92.00 N Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93 00 N N 93 00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N 94.00 Ν applicable column.

Health Financial Systems ST. VINCENT FIST HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		eriod: com 07/01/2	2016 F	orksheet Part I	CMS-2552-10 t S-2 e Prepared:
		10				17 2: 33 pm
			V 1.00	_	XIX	
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye			1. 00 0. 00 N		2. 00 0. 00 N	
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the ap	plicable column	n.	0.00	\perp	0.00	97. 00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (C			N			105. 00
106.00 f this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions) 107.00 f this facility qualifies as a CAH, is it eligible for cos	t reimbursement	t for I&R	N N			106. 00 107. 00
training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	. 25 and the pr	rogram is cost				
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00		Respi rat 4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109. 00
					1. 00	
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for		N	110. 00
				1. 00	2. 00 3	3.00
Miscellaneous Cost Reporting Information				1.00	2.00 .	3.00
115.00 s this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide	. If column 2 i nt for long ter	is "E", enter i rm care (includ	n column les	N		0 115.00
Pub.15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu			N" for	N Y		116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence po	licy? Enter 1 i	f the policy i	s	1		118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses		Insuran	nce
		1. 00	2. 00		3. 00	
118.01 List amounts of malpractice premiums and paid losses:		0		0	10	7, 268 118. 01
			1. 00		2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.	center other 1 dule listing co	than the ost centers	N			118. 02
119.00D0 NOT USE THIS LINE 120.00ls this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme	n column 1, "Y' ualifies for th	' for yes or ne Outpatient	N		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost impl	·	•	Y			121. 00
patients? Enter "Y" for yes or "N" for no.		<u> </u>				
122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.			Y		5. 00	122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f	or ves and "N"	for no lf	N			125, 00
yes, enter certification date(s) (mm/dd/yyyy) below.	•					
126.00 f this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column	2.					126. 00
127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column		cation date				127. 00
128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi	cation date				128. 00
129.00 If this is a Medicare certified lung transplant center, ent		cation date in				129. 00
column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare certified pancreas transplant center,		ti fi cati on				130. 00
date in column 1 and termination date, if applicable, in co 131.00 of this is a Medicare certified intestinal transplant cente		ertification				131. 00
date in column 1 and termination date, if applicable, in co 132.00 f this is a Medicare certified islet transplant center, en	lumn 2.					132. 00
in column 1 and termination date, if applicable, in column		Cation uate				132.00

lealth Financial Systems	ST. VINCENT FIS	HERS HOSPITAL			In Lie	u of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX		Provi der CCI	N: 15-0181	Peri od:		Worksheet S	
					7/01/2016 6/30/2017	Part Date/Time Pi	renared:
				1.0		11/20/2017	
					1 00	2.00	
133.00 If this is a Medicare certified ot	her transplant center en	ter the certifi	cation date		1. 00	2.00	133. 00
in column 1 and termination date,			catron date				133.00
134.00 If this is an organ procurement or	ganization (OPO), enter t		n column 1				134. 00
and termination date, if applicable ALL Providers	e, in column 2.						
140.00 Are there any related organization	or home office costs as	defined in CMS	Pub. 15-1,		Υ	15H046	140. 00
chapter 10? Enter "Y" for yes or "	N" for no in column 1. If	yes, and home	office cost	s			
are claimed, enter in column 2 the			i ons)				
1.00 If this facility is part of a chai	2.0			namo ano	3.00	of the	
home office and enter the home off				maile and	a auui ess	or the	
141.00 Name: ST. VINCENT HEALTH	Contractor's Name: WF			tor's Nu	mber: 8101		141. 00
142.00 Street: 10330 N. MERIDIAN STREET	PO Box:						142. 00
143.00 City: INDIANAPOLIS	State: IN	<u> </u>	Zi p Cod	e:	4629	90	143. 00
						1 00	
144.00 Are provider based physicians' cos	ts included in Worksheet	Δ?				1. 00 Y	144. 00
144. Oomie provider based priysrerans eos	ts meruded in worksheet	Α;				,	177.00
					1. 00	2.00	
145.00 If costs for renal services are cl					N	N	145. 00
inpatient services only? Enter "Y"							
no, does the dialysis facility inc period? Enter "Y" for yes or "N"		for this cost	reporting				
period? Effer it for yes of N 146.00Has the cost allocation methodolog		usly filed cost	renort?		N		146. 00
Enter "Y" for yes or "N" for no in				f	14		140.0
yes, enter the approval date (mm/d		<u> </u>					
47 00 Wee there a shange in the statisti	and banks? Entar "V" for	uso on "N" for	no.			1.00 N	147. 00
147.00 Was there a change in the statisti 148.00 Was there a change in the order of						N N	148. 00
149.00 Was there a change to the simplifi		-		r no.		N N	149. 00
<u> </u>	<u> </u>	Part A	Part B		itle V	Title XIX	
		1.00	2. 00		3. 00	4. 00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or " 155.00 Hospi tal	iv for no for each compon	N N	N	(3ee 42	V CFR 9413	N N	155. 00
156. 00 Subprovi der – TPF		N N	N		N	N N	156. 00
157. 00 Subprovi der – IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N		N N	N N	160. 00 161. 00
161. 00 CWINC			IN		IV	IV	161.00
						1.00	
Multicampus							
165.00 Is this hospital part of a Multica	mpus hospital that has on	e or more campu	ses in diff	erent CB	SSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Namo	County	Stato 7	in Codo	CDSA	FTE/Campus	
	Name 0	County 1.00	2. 00	<u>i p Code</u> 3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each		1.00	2.00	0.00	7. 00		00 166. 00
campus enter the name in column							
O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
cordinar o (see riisti detrons)					1		
						1.00	
Health Information Technology (HIT) incentive in the Americ	an Recovery and	Rei nvestme	ent Act			-
67.00 Is this provider a meaningful user	under §1886(n)? Enter "	Y" for yes or "I	N" for no.			Y	167. 0
168.00 If this provider is a CAH (line 10			16/ IS "Y"), enter	tne		0168.00
	ı ı assets (see HistruCtio	113)					168. 0
reasonable cost incurred for the H	ot a meaningful user doe	s this provider	gualify fo	r a nard	ISNI D		
reasonable cost incurred for the H 168.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?					isni p		100.0
68.01 If this provider is a CAH and is n	Enter "Y" for yes or "N" ser (line 167 is "Y") and	for no. (see i	nstructi ons)	·	0.	25169. 0

Health Financial Systems	In Lieu of Form CMS-2552-1				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Peri od: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Pre 11/20/2017 2:	pared:	
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	09/01/2016	12/31/2016	170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this prov	rider have any days for indi	viduals enrolled in	N	C	171. 00
section 1876 Medicare cost plans i					
"Y" for yes and "N" for no in colu	n				
1876 Medicare days in column 2. (s	see instructions)				

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0181	Peri od: From 07/01/2016	Worksheet S-2 Part II	2
				To 06/30/2017	Date/Time Pro 11/20/2017 2:	epared : 33 pr
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ente	1.00 er all dates in t	2. 00 the	
	mm/dd/yyyy format.		<u>'</u>			
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	instructions Y/N) Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	N			3.
	Trefutronships. (See That detrons)		Y/N	Туре	Date	
	Financial Data and Deports		1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, lable in	Y	A		4.
00	Are the cost report total expenses and total revenues differed those on the filed financial statements? If yes, submit recommends		Y			5.
	those on the fired financial statements: If yes, submit feet	SHOTTI ATTOIL.		Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	•	ne provider i	s N		6.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		d during the	N N		7. 8.
00	Are costs claimed for Interns and Residents in an approved (cal education	N	1	9.
. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		the current	N		10.
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11.
					1. 00	
00	Bad Debts	ann i material	ti ono		V	12
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 13.
. 00	If line 12 is yes, were patient deductibles and/or co-payment Bed Complement	nts waived? If	yes, see in:	structi ons.	N	14.
. 00	Did total beds available change from the prior cost reporting				N	15.
		Y/N	Tt A Date	Par Y/N	t B Date	
		1.00	2.00	3.00	4. 00	
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Υ	10/11/2017	Y	10/11/2017	16.
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17.
00	either column 1 or 3 is yes, enter the paid-through date 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	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19

HOSPI T	FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	CN: 15-0181	Period: From 07/01/2016 To 06/30/2017	Worksheet S Part II Date/Time P 11/20/2017	repared:		
		Descri	pti on	Y/N	Y/N	2. 33 piii		
		(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: beserve the other day astments.	Y/N	Date	Y/N	Date			
24 22	Turn vi	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	PT CHILDRENS H	OSPI TALS)					
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions				22, 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost		23. 00		
24. 00	Were new leases and/or amendments to existing leases entere lf yes, see instructions	ed into during	this cost re	eporting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	? If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	f yes, see		26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	ges, submit		27. 00		
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	ntered into dur	ing the cost	t reporting		28. 00		
29. 00								
30. 00	treated as a funded depreciation account? If yes, see instructions 00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see							
31. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	s, see		31.00		
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvi ces furni she	d through co	ontractual		32.00		
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If		33.00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	ased physicians?		34.00		
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			
	Home Office Costs			1. 00	2. 00			
	Were home office costs claimed on the cost report?			Y		36.00		
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?	? Y		37. 00		
38. 00				e N		38.00		
39. 00				s, N		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.		40. 00					
		1.	00	2.	00			
	Cost Report Preparer Contact Information			2.				
		JI LL		HI LL		41.00		
41. 00				1		II.		
41. 00 42. 00	respectively. Enter the employer/company name of the cost report preparer.	ST. VINCENT HE	ALTH			42.00		

Heal th	Financial Systems ST. VINCENT	FIS	SHERS HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provi der CCN: 1		Peri od: From 07/01/2016		
					To 06/30/2017	Date/Time Pre 11/20/2017 2:	
			3. 00				
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position		REIMBURSEMENT MANA	GER			41. 00
	held by the cost report preparer in columns 1, 2, and 3	3,					
	respecti vel y.						
42. 00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cos	st					43.00
	report preparer in columns 1 and 2, respectively.						

Provider CCN: 15-0181

| Peri od: | Worksheet S-3 | From 07/01/2016 | Part | To 06/30/2017 | Date/Time Prepared:

					T	o 06/30/2017	Date/Time Prep 11/20/2017 2:	
							I/P Days / 0/P	33 PIII
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	35p31.0111	Line Number		0. 2000	Avai I abl e	57 II 1 1 1 5 G1 5		
		1.00		2.00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		46	16, 790	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			46	16, 790	0.00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		0	0	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00		0	0	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	0	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13.00
14. 00	Total (see instructions)			46	16, 790	0. 00	0	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	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					_	24. 10
25. 00	CMHC - CMHC	99. 00					0	25. 00
26. 00	RURAL HEALTH CLINIC						_	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			46				27. 00
28. 00	Observation Bed Days						0	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)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions)							33. 00
33.00	LTCH non-covered days		l	ı				33.00

| Peri od: | Worksheet S-3 | From 07/01/2016 | Part | To 06/30/2017 | Date/Time Prepared: | Provider CCN: 15-0181

				1	0 06/30/2017	11/20/2017 2:	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	у р
	Component	Title XVIII	Title XIX	Total All	Total Interns		
		4 00	7.00	Pati ents	& Residents	Payrol I	
1. 00	Hearital Adulta & Dada (aslumna E. / 7 and	6. 00	7.00	8.00	9. 00	10.00	1. 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	5/1	40	2, 376			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	160	517				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	571	40	2, 376			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	0	0				8. 00
9.00	CORONARY CARE UNIT	0	0	0			9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		40	,			13.00
14. 00	Total (see instructions)	571	80			210. 20	1
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - I RF						17. 00 18. 00
18. 00 19. 00	SUBPROVIDER 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	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC	O	0	0	0.00	0.00	ł
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	210. 20	27. 00
28.00	Observation Bed Days		0	712			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			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
00.00	outpatient days (see instructions)						00.00
33.00	LTCH non-covered days	O			l	l	33. 00

| Period: | Worksheet S-3 | From 07/01/2016 | Part | To 06/30/2017 | Date/Time Prepared: Provider CCN: 15-0181

				To	06/30/2017	Date/Time Prep 11/20/2017 2:3	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
1.00		11. 00	12. 00	13.00	14. 00	15.00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		C	224	17	1, 277	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			63	220		2. 00
3.00	HMO I PF Subprovi der				0		3. 00
4. 00 5. 00	HMO IRF Subprovider				0		4. 00 5. 00
6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						11. 00 12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	C	224	17	1, 277	14. 00
15. 00	CAH visits						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 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	0. 00					24. 10 25. 00
26. 00	RURAL HEALTH CLINIC	0.00					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) Employee discount days - IRF						30. 00 31. 00
31. 00 32. 00	Labor & delivery days (see instructions)						31.00
32. 00	Total ancillary labor & delivery room						32. 00
	outpatient days (see instructions)						-
33. 00	LTCH non-covered days						33. 00

| Peri od: | Worksheet S-3 | From 07/01/2016 | Part II | To 06/30/2017 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0181

					Т	o 06/30/2017	Date/Time Pre 11/20/2017 2:	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	DO PIII
		Line Number	Reported	on of Salaries (from	Sal ari es (col. 2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col . 4	COI . 3)	
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	15, 495, 218	80, 956	15, 576, 174	437, 316. 41	35. 62	1.00
	instructions)		_	_	_			
2. 00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2. 00
3.00	Non-physician anesthetist Part		0	0	О	0.00	0. 00	3. 00
4.00	B Physician-Part A -		302, 352	0	302, 352	1, 830. 21	165. 20	4. 00
4.00	Administrative		302, 332		302, 332	1,030.21	103. 20	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 812, 220	0	·	0. 00 9, 600. 00		4. 01 5. 00
5.00	Physician-Part B		012, 220	0	012, 220	9, 800. 00	04.01	3.00
6.00	Non-physician-Part B for		450	0	450	6. 00	75. 00	6. 00
	hospital-based RHC and FQHC services							
7.00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0.00	0.00	7. 01
7.01	residents (in an approved		0			0.00	0.00	7.01
8. 00	programs) Home office and/or related		3, 241, 382	0	3, 241, 382	120, 259. 67	26. 95	8. 00
0.00	organi zati on personnel		3, 241, 302		3, 241, 302	120, 237. 07	20. 73	0.00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 2, 075	0	·		l .	
10.00	instructions)		2,075	0	2,075	242. 40	0. 50	10.00
11 00	OTHER WAGES & RELATED COSTS		FO 0F1	٥	FO 0F1	1 010 00	F0.00	11 00
11. 00	Contract Labor: Direct Patient Care		50, 951	0	50, 951	1, 019. 00	50. 00	11. 00
12. 00	Contract Labor: Top Level		0	0	0	0.00	0. 00	12. 00
	management and other management and administrative							
	servi ces							
13. 00	Contract Labor: Physician-Part A - Administrative		1, 133, 533	0	1, 133, 533	9, 120. 00	124. 29	13. 00
14. 00	Home office and/or related		0	0	0	0.00	0. 00	14. 00
	orgainzation salaries and wage-related costs							
14. 01	Home office salaries		3, 666, 300	0	3, 666, 300	120, 546. 00	30. 41	14. 01
14. 02	Related organization salaries		0	0	0	0.00		14. 02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15. 00
16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		3, 441, 408	0	3, 441, 408			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
	(see instructions)		_	,				
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		71, 185 0	0	71, 185			19. 00 20. 00
	A		J					
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		302, 352	0	302, 352			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		212, 305	0	212, 305			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	approved program)		U	0				25. 00
25. 50	Home office wage-related		942, 693	0	942, 693			25. 50
25. 51	Related orgainzation wage-related		0	0	"			25. 51
25. 52	Home office: Physician Part A		0	0	0			25. 52
	- Administrative - wage-related							
25. 53	Home office & Contract		0	0	0			25. 53
	Physicians Part A - Teaching - wage-related							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	143, 898 3, 180, 810			· ·		26. 00 27. 00
∠1. UU	mami in strative a delitial	ა. 00	3, 100, 610	0	J 3, 100, 610	103, 470. 87	1 30.74	1 21.00

| Peri od: | Worksheet S-3 | From 07/01/2016 | Part II | To 06/30/2017 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0181

					10	06/30/201/	11/20/2017 2:3	
		Worksheet A	Amount	Recl assi fi cati	Adjusted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries			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	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	172, 367	0	172, 367	9, 608. 00	17. 94	30. 00
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00	0. 00	31.00
32.00	Housekeepi ng	9. 00	0	0	0	0.00	0. 00	32.00
33.00	Housekeeping under contract		500, 002	0	500, 002	21, 808. 12	22. 93	33.00
	(see instructions)							
34.00	Di etary	10. 00	0	0	0	0.00	0. 00	34.00
35.00	Di etary under contract (see		71, 787	0	71, 787	2, 821. 53	25. 44	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	0	0	0.00	0. 00	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	675, 202	0	675, 202	15, 777. 94	42. 79	38.00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0. 00	39.00
40.00	Pharmacy	15. 00	739, 244	0	739, 244	16, 981. 04	43. 53	40.00
41.00	Medical Records & Medical	16. 00	362, 418	0	362, 418	14, 846. 40	24. 41	41.00
	Records Library							
42.00	Social Service	17. 00	100, 486	0	100, 486	2, 516. 05	39. 94	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

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

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 15-0181 Peri od: From 07/01/2016 To 06/30/2017 11/20/2017 2:33 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 2.00 4.00 5.00 6.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 13, 753, 238 80, 956 13, 834, 194 344, 039. 76 40. 21 1.00 instructions) 2.00 Excluded area salaries (see 2,075 2,075 242.40 2.00 8. 56 instructions) 3.00 Subtotal salaries (line 1 13, 751, 163 80, 956 13, 832, 119 343, 797. 36 40. 23 3.00 minus line 2) 4.00 Subtotal other wages & related 4, 850, 784 4, 850, 784 130, 685. 00 37. 12 4.00

C

80, 956

80, 956

4, 686, 453

23, 369, 356

7, 767, 453

0.00

474, 482. 36

201, 388. 01

33. 88

49 25

38.57

5.00

6.00

7.00

4, 686, 453

23, 288, 400

7, 686, 497

costs (see inst.)

(see inst.)

instructions)

5.00

6.00

7.00

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

Health Financial Systems	ST. VINCENT FISHERS HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0181	Peri od: Worksheet S-3 From 07/01/2016 Part IV

	From 07/01/2016 To 06/30/2017		
		Amount	,
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	284, 547	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	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)	1, 829, 140	8. 00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	19, 226	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12, 874	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-116	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	70, 486	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	3, 407	14.00
15. 00	'Workers' Compensation Insurance	115, 602	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	1, 116, 332	
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	0	19. 00
20. 00	State or Federal Unemployment Taxes	12, 986	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22.00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	13, 824	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3, 478, 308	24.00
	Part B - Other than Core Related Cost		
25. 00		0	25. 00

Health Financial Systems	ST. VINCENT FISHERS HOSPITAL		In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der C	CN: 15-0181 Peri od:	Worksheet S-3
			01/2016 Part V 30/2017 Date/Time Prepared:

		1	o 06/30/2017	Date/lime Prep 11/20/2017 2:3	
	Cost Center Description		Contract Labor		эо рііі
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		50, 951	3, 478, 308	1.00
2.00	Hospi tal		50, 951	3, 478, 308	2.00
3.00	Subprovi der - I PF				3.00
4.00	Subprovi der - I RF				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
8.00	Hospi tal -Based SNF				8.00
9.00	Hospi tal -Based NF				9.00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA				11.00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC		0	0	16.00
17. 00	Renal Dialysis		0	0	17.00
18. 00	Other		0	0	18.00

Heal th	Financial Systems ST. VINCENT FISHERS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
		rovider CCN: 15-018		od:	Worksheet S-10		
			From To	07/01/2016 06/30/2017	Date/Time Pre	narod:	
			10	00/30/201/	11/20/2017 2:		
					1. 00		
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 202 co	lumn 8)		0. 232129	1. 00	
0.00	Medicaid (see instructions for each line)				0.000.405	0.00	
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				2, 092, 185 N	2. 00 3. 00	
4.00	If line 3 is yes, does line 2 include all DSH or supplemental pa	avments from Medica	i d?		IN	4. 00	
5. 00	If line 4 is no, then enter DSH or supplemental payments from Me	,			0	5. 00	
6.00	Medi cai d charges				23, 234, 936	6.00	
7.00	Medicaid cost (line 1 times line 6)				5, 393, 502		
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 minus sum of	lines 2	and 5; if	3, 301, 317	8. 00	
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	each line)					
9. 00	Net revenue from stand-alone CHIP	cacii i i iic)			0	9. 00	
10.00	Stand-alone CHIP charges				0	10. 00	
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0		
12.00	Difference between net revenue and costs for stand-alone CHIP (I	ine 11 minus line	9; if < :	zero then	0	12.00	
	<pre>enter zero) Other state or local government indigent care program (see instr</pre>	custions for each I	inol				
13. 00	Net revenue from state or local indigent care program (Not inclu				0	13. 00	
14. 00	Charges for patients covered under state or local indigent care			ines 6 or	Ö	14. 00	
	10)						
15. 00	State or local indigent care program cost (line 1 times line 14)				0		
16. 00	6.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)					16. 00	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local i	ndi gent	care progran	ıs (see		
	instructions for each line)		3	. 3	·		
17. 00	Private grants, donations, or endowment income restricted to fur	9			0	17. 00 18. 00	
18. 00 19. 00							
17.00	8, 12 and 16)	margent care prog	raiis (su	01 111103	3, 301, 317	19. 00	
	Uninsured Insured Total (co						
		pati en		pati ents	+ col . 2)		
	Uncompensated Care (see instructions for each line)	1.00		2. 00	3. 00		
20. 00	Charity care charges and uninsured discounts for the entire faci	lity 3,55	0, 332	2, 915, 371	6, 465, 703	20. 00	
	(see instructions)		,				
21. 00	Cost of patients approved for charity care and uninsured discour	nts (see 82	4, 135	2, 915, 371	3, 739, 506	21. 00	
22. 00	instructions) Payments received from patients for amounts previously written of	off as 2	6, 694	127, 216	153, 910	22. 00	
00.00	charity care			0 700 455	0 505 504	00.00	
23. 00	Cost of charity care (line 21 minus line 22)	19	7, 441	2, 788, 155	3, 585, 596	23.00	
					1. 00		
24. 00	Does the amount in line 20 column 2 include charges for patient		th of st	ay limit	N	24.00	
25. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the		gram's L	ength of	0	25. 00	
04.00	stay limit				4 7/4 0/0	0/ 00	
26. 00	Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex				1, 761, 842		
27. 00 27. 01	Medicare allowable bad debts for the entire hospital complex (se	,			44, 700 68, 770		
28. 00	Non-Medicare bad debt expense (line 26 minus line 27.01)	o matructions)			1, 693, 072	28. 00	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see instructi	ons)		417, 081		
	Cost of uncompensated care (line 23 column 3 plus line 29)				4, 002, 677		
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus lir	ne 30)			7, 303, 994	31. 00	

Heal th	Financial Systems	ST. VINCENT FISH	ERS HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co		Period: From 07/01/2016 To 06/30/2017	Worksheet A Date/Time Pre	narod:
					10 00/30/201/	11/20/2017 2:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	
	·			+ 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			
1.00	00100 CAP REL COSTS-BLDG & FIXT		6, 095, 259			-,,	1
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 699, 131	1, 699, 13	0	1, 699, 131	
3.00	00300 OTHER CAP REL COSTS	140.000	0 704 447	0.000.04	0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	143, 898	2, 784, 447			2, 928, 345	
5.00	00500 ADMINISTRATIVE & GENERAL	3, 180, 810	4, 680, 292			7, 861, 102	
7.00	00700 OPERATION OF PLANT	172, 367	2, 359, 127			2, 531, 494	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	127, 898			127, 898	1
9.00	00900 HOUSEKEEPI NG	0	579, 725			579, 725	1
10.00	01000 DI ETARY	0	742, 409			96, 275	1
11. 00 13. 00	01100 CAFETERI A	475 202	127 504		0.07.0.	646, 134	1
14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	675, 202	126, 584 155, 255			801, 786 155, 255	1
15. 00	01500 PHARMACY	739, 244	137, 640			876, 884	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	362, 418	159, 799			522, 217	
17. 00	01700 SOCIAL SERVICE	100, 486	12, 485			112, 971	
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100, 460	12, 400	112, 71	1 0	112, 7/1	17.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 050, 363	687, 360	2, 737, 72	3 487, 955	3, 225, 678	30.00
31. 00	03100 I NTENSI VE CARE UNI T	2,030,303	007, 300	2, 737, 72.	1 407, 733	3, 223, 070	
32. 00	03200 CORONARY CARE UNIT		0			0	1
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0			Ö	
43. 00	04300 NURSERY		0		385, 729	385, 729	
10.00	ANCI LLARY SERVI CE COST CENTERS	1 9			000,727	000, 727	10.00
50. 00	05000 OPERATING ROOM	1, 441, 645	1, 301, 841	2, 743, 48	6 0	2, 743, 486	50.00
51. 00	05100 RECOVERY ROOM	0	0	_, ,		0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 955, 453	2, 149, 955	4, 105, 40	-873, 684	3, 231, 724	
53.00	05300 ANESTHESI OLOGY	0	0	, , , , , ,	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	873, 188	257, 709	1, 130, 89	7 0	1, 130, 897	54.00
54.01	03630 ULTRA SOUND	168, 557	14, 322	182, 87	9 0	182, 879	54. 01
56.00	05600 RADI OI SOTOPE	0	0		o	0	56.00
56. 01	05601 ONCOLOGY	212, 872	55, 024	267, 89	6 0	267, 896	56. 01
57.00	05700 CT SCAN	337, 757	106, 540	444, 29	7 0	444, 297	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	160, 104	47, 449	207, 55	3 0	207, 553	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	
60.00	06000 LABORATORY	0	1, 156, 180	1, 156, 18	0	1, 156, 180	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	(0	0	
65. 00	06500 RESPI RATORY THERAPY	335, 219	55, 603			390, 822	
66. 00	06600 PHYSI CAL THERAPY	886, 230	106, 468			992, 698	
67. 00	06700 OCCUPATI ONAL THERAPY	5, 748	798			6, 546	1
68.00	06800 SPEECH PATHOLOGY	98, 583	87, 756			186, 339	
	06900 ELECTROCARDI OLOGY	136, 635	30, 129			166, 764	
	07000 ELECTROENCEPHALOGRAPHY	0	(10 (0)		0	(10 (0)	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	610, 686			610, 686	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	657, 866			657, 866	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 814, 485			1, 814, 485	
74. 00 75. 00	07400 RENAL DIALYSIS	0	0			0	
75.00	O7500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	J U	0	1	J	0	75. 00
91. 00	09100 EMERGENCY	1, 456, 364	344, 483	1, 800, 84	7 0	1, 800, 847	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 430, 304	344, 403	1, 800, 84	/	1, 600, 647	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						/2.00
99. 00	09900 CMHC	O	0		0	0	99. 00
,,,,,,	SPECIAL PURPOSE COST CENTERS				<u> </u>	J	1 /// 00
118.00		15, 493, 143	29, 144, 705	44, 637, 84	8 0	44, 637, 848	118.00
2. 30	NONREI MBURSABLE COST CENTERS		,,	, 22. , 0		, ,	1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 350	3, 350	0 0	3, 350	190. 00
	19100 RESEARCH	O	0	1	0 0	0	191.00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 030	1, 398, 240	1, 399, 270	o	1, 399, 270	
193.00	19300 NONPALD WORKERS	o	0		lo lc	0	193. 00
	07950 COMMUNITY EDUCATION	1, 045	79				194. 00
	07951 MARKETI NG	0	304, 968			304, 968	
200.00	TOTAL (SUM OF LINES 118-199)	15, 495, 218	30, 851, 342	46, 346, 560	0	46, 346, 560	200.00

Provi der CCN: 15-0181

Peri od: Worksheet A From 07/01/2016 Date/Time Prepared:

Cost Center Description	33 pm
SEMERAL SERVICE COST CENTERS	
1.00	
2.00 002000 CAP REL COSTS-MYBLE EQUIP 0 1,699,131 31 00 00300 OTHER CAP REL COSTS 0 0 0 0 0 0 0 0 0	1. 00
3.00 00300 OTHER CAP REL COSTS	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 151, 248 3,079, 593	3. 00
5.00 00500 ADMIN ISTRATIVE & GENERAL -2, 101, 749 5, 759, 353 0.00 00500 DEADLY OF PLANT -5, 868 2, 127, 898 0.00 00500 LAUNDRY & LINEN SERVICE 0 0.579, 725 0.00 01000 DETARY -1, 225 95, 050 0.00 0.00 0.00 DETARY -1, 255 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	4. 00
7. 00 00700 00FERATI ON OF PLANT -5.86	5. 00
8.00 OOBDO LAUMRY & LINEN SERVICE 0 127, 898 0 0 0000 HOUSEKEPING 0 0 7579, 725 0 0 0 0 0 0 0 0 0	7. 00
9.00 00900 HOUSEKEEPI NG	8. 00
10.00 01000 01ETARY -1, 225 95, 050	9. 00
13.00 01300 NURSI NG ADMINI STRATI ON -1.61 801, 625 151, 563 15.00 01500 PHARMACY -3, 692 151, 563 15.00 01500 PHARMACY -3, 091 873, 793 873, 793 16.00 01600 MEDI CAL. RECORDS & LI BRARY -1.95 522, 022 17.00 17.00 17.00 17.00 17.00 50C1 AL SERVI CE -4, 760 108, 211 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 1	10.00
14.00	11. 00
15. 00 01500 PARRIMACY -3,091 873,793 16. 00 01500 MEDI CAL RECORDS & LI BRARY -195 522, 022 17. 00 01700 SOCI AL SERVI CE	13. 00
16.00	14. 00
17.00 01700 SOCI AL SERVICE NPATI ENT ROUTINE SERVICE COST CENTERS 1,939,884	15. 00
INPATI ENT ROUTINE SERVICE COST CENTERS 1, 939, 884 33.00 03000 ADULTS & PEDI ATRI CS -1, 285, 794 1, 939, 884 32.00 03100 INTENSI VE CARE UNIT 0 0 0 0 0 0 0 0 0 0	16. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03200 CORONARY CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 385. 593 ANCILLARY SERVICE COST CENTERS	17. 00
331.00 03100 INTENSI VE CARE UNI T	l
32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 0 0 0 0	30.00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 0 0 0 43. 00 04300 NURSERY -136 385, 593	31.00
43.00 0.4300 NURSERY	32.00
ANCILLARY SERVICE COST CENTERS -6, 911 2, 736, 575	34. 00 43. 00
50. 00 05000 0FERATI NG ROOM -6, 911 2, 736, 575	43.00
51. 00	50. 00
52. 00	51.00
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C -18, 648 1, 112, 249 54. 01 03630 ULTRA SOUND 0 182, 879 0 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0	52. 00
54. 01 03630 ULTRA SOUND 56. 00 05600 RADI OI SOTOPE 0 0 0 56. 01 05601 ONCOLOGY 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 RESPI RATORY THERAPY 67. 00 06500 RESPI RATORY THERAPY 68. 00 06600 PHYSI CAL THERAPY 69. 00 06700 OCCUPATI ONAL THERAPY 69. 00 06900 SPEECH PATHOLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 07500 ASC (NON-DI STI NCT PART) 77. 00 07500 ASC (NON-DI STI NCT PART) 78. 00 07500 ASC (NON-DI STI NCT PART) 79. 00 07500 ASC (NON-DI STI NCT PART)	53. 00
54. 01 03630 ULTRA SOUND 56. 00 05600 RADI OI SOTOPE 0 0 0 56. 01 05601 ONCOLOGY 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06500 RESPI RATORY THERAPY 68. 00 06600 PHYSI CAL THERAPY 69. 00 06900 CUPATI ONAL THERAPY 69. 00 06900 SPEECH PATHOLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART) 75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 07500 ASC (NON-DI STI NCT PART) 77. 00 07500 ASC (NON-DI STI NCT PART) 78. 00 07500 ASC (NON-DI STI NCT PART)	54.00
56. 01 05601 0NCOLOGY 05700 CT SCAN -30, 999 413, 298 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 207, 553 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54. 01
57. 00 05700 CT SCAN -30, 999 413, 298 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 207, 553 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 60. 00 06000 LABORATORY 0 1, 156, 180 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 390, 822 66. 00 06500 RESPI RATORY THERAPY -460 992, 238 67. 00 06600 PHYSI CAL THERAPY 0 6, 546 68. 00 06800 SPEECH PATHOLOGY -165 186, 174 69. 00 06900 ELECTROCARDI OLOGY 0 166, 764 70. 00 07000 ELECTROCARDI OLOGY 0 166, 764 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 610, 686 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 1, 814, 485 74. 00 07400 RENAL DI ALYSI S 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0	56. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 207, 553 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 60. 00 06000 LABORATORY 0 1, 156, 180 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 65. 00 06500 RESPI RATORY THERAPY 0 390, 822 66. 00 06600 PHYSI CAL THERAPY -460 992, 238 67. 00 06700 OCCUPATI ONAL THERAPY 0 6, 546 68. 00 O6800 SPEECH PATHOLOGY -165 186, 174 69. 00 06900 ELECTROCARDI OLOGY 0 166, 764 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 610, 686 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 1, 814, 485 74. 00 <td>56. 01</td>	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 60. 00 06000 LABORATORY 0 1, 156, 180 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 65. 00 06500 RESPI RATORY THERAPY 0 390, 822 66. 00 06600 PHYSI CAL THERAPY -460 992, 238 67. 00 06700 OCCUPATI ONAL THERAPY 0 6, 546 68. 00 06800 SPEECH PATHOLOGY -165 186, 174 69. 00 06900 ELECTROCARDI OLOGY 0 166, 764 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 657, 866 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 657, 866 74. 00 07400 RENAL DI ALYSI S 0 0 75. 00 07500 ASC (NON-DI STI NCT	57. 00
60. 00	58. 00
62. 00	59. 00
63. 00	60.00
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0	62.00
65. 00	63.00
66. 00	64.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 6, 546 68. 00 06800 SPEECH PATHOLOGY -165 186, 174 69. 00 06900 ELECTROCARDI OLOGY 0 166, 764 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 610, 686 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 657, 866 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 1, 814, 485 74. 00 07400 RENAL DI ALYSI S 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0 0	65. 00 66. 00
68. 00	67.00
69. 00 06900 ELECTROCARDI OLOGY 0 166, 764 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0	68. 00
70. 00	69. 00
71. 00	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 657, 866 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485 1, 814, 485	71. 00
74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 0	72. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0	73. 00
	74. 00
OUTPATIENT SERVICE COST CENTERS	75. 00
	l
91. 00 09100 EMERGENCY -3, 247 1, 797, 600	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	92. 00
OTHER REIMBURSABLE COST CENTERS	
99. 00 O9900 CMHC O O	99. 00
SPECIAL PURPOSE COST CENTERS	110 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) -4, 601, 579 40, 036, 269 NONREI MBURSABLE COST CENTERS	118. 00
	100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 3,350 191.00 19100 RESEARCH 0 0	190. 00 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 399, 270	191.00
193. 00 19300 NONPALD WORKERS 0 0	193. 00
194. 00 07950 COMMUNITY EDUCATION 0 1, 124	194. 00
194. 01 07951 MARKETI NG 227, 172 532, 140	194. 00
200. 00 TOTAL (SUM OF LINES 118-199) -4, 374, 407 41, 972, 153	200. 00

Heal th	Financial Systems		ST. VINCENT FIS	SHERS HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider 0	CCN: 15-0181	Period: From 07/01/2016 To 06/30/2017	Worksheet A- Date/Time Pr 11/20/2017 2	epared:
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5.00				
	A - GENERAL SALARY ACCRUAL							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	80, 956	0				1. 00
	TOTALS		80, 956	0				
	B - CAFETERIA RECLASS							
1.00	CAFETERI A	11. 00	0	646, 134				1. 00
	TOTALS		0	646, 134				
	C - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	400, 477	87, 478				1. 00
2.00	NURSERY	43.00	305, 389	80, 340				2. 00
	TOTALS		705, 866	167, 818				
500.00	Grand Total: Increases		786, 822	813, 952				500.00
		•	•					•

TOTALS 0 80, 956 B - CAFETERI A RECLASS	Heal th	Financial Systems	9	ST. VINCENT FI	SHERS HOSPITAL		In Lie	u of Form CMS-	2552-10
To 06/30/2017 Date/Time Prepared: 11/20/2017 2: 33 pm	RECLASS	SIFICATIONS			Provi der (Worksheet A-6	5
Cost Center								Date/Time Pro 11/20/2017 2:	epared: _33_pm
6. 00 7. 00 8. 00 9. 00 10. 00 A - GENERAL SALARY ACCRUAL 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 80, 956 0 1. 0 TOTALS 0 80, 956 B - CAFETERIA RECLASS			Decreases						
A - GENERAL SALARY ACCRUAL 1. 00		Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref			
1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 80, 956 0 1. 0 TOTALS 0 80, 956 B - CAFETERIA RECLASS		6. 00	7. 00	8. 00	9. 00	10.00			
TOTALS 0 80, 956 B - CAFETERI A RECLASS		A - GENERAL SALARY ACCRUAL							
B - CAFETERIA RECLASS	1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	80, 956		0		1. 00
		TOTALS	T		80, 956		7		
1. 00 DI ETARY 10. 00 0 646, 134 0 1. 0		B - CAFETERIA RECLASS							
	1.00	DI ETARY	10.00	0	646, 134		0		1. 00
TOTALS 0 646, 134		TOTALS			646, 134				

705, 866

705, 866 705, 866 167, 818

167, 818 894, 908 0

0

1. 00

2.00

500.00

52. 00 <u>0. 00</u>

TOTALS
C - NURSERY RECLASS
DELIVERY ROOM & LABOR ROOM

TOTALS

500.00 Grand Total: Decreases

1.00

2.00

ST. VINCENT FISHERS HOSPITAL

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0181

				7	o 06/30/2017	Date/Time Prep 11/20/2017 2:3	
				Acqui si ti ons			эо рііі
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	8, 112, 032	2, 759, 288		2, 759, 288		1.00
2.00	Land Improvements	9, 017	13, 159		13, 159		2.00
3.00	Buildings and Fixtures	43, 627, 925	1, 177, 405	(1, 177, 405	0	3.00
4.00	Building Improvements	853, 804	0	(0	0	4.00
5.00	Fixed Equipment	1, 897, 164	0	(0	0	5.00
6.00	Movable Equipment	15, 007, 816	1, 655, 840	(1, 655, 840	127, 583	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	69, 507, 758	5, 605, 692	(5, 605, 692	127, 583	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	69, 507, 758	5, 605, 692	(5, 605, 692	127, 583	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART I ANALYGIC OF QUANCES IN CARLTAL ACCET	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		0				4 00
1.00	Land	10, 871, 320	0				1. 00
2.00	Land Improvements	22, 176	0				2. 00
3.00	Buildings and Fixtures	44, 805, 330	0				3. 00
4.00	Building Improvements	853, 804	0				4. 00
5.00	Fi xed Equipment	1, 897, 164	0				5. 00
6.00	Movable Equipment	16, 536, 073	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	74, 985, 867	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	74, 985, 867	0			l	10. 00

Heal th	Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lieu of Form CMS-2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0181	Peri od:	Worksheet A-7	
					From 07/01/2016 To 06/30/2017		pared.
						11/20/2017 2:	
			SL	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	40.00	44.00		instructions)	
		9.00	10.00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORL		· · · · · · · · · · · · · · · · · · ·			1	
1.00	CAP REL COSTS-BLDG & FLXT	1, 685, 279	4, 368, 955		0 39, 241	1, 784	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 455, 930	240, 713		0 2, 167	321	2.00
3.00	Total (sum of lines 1-2)	3, 141, 209	4, 609, 668		0 41, 408	2, 105	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	,				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	6, 095, 259				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 699, 131				2. 00
3.00	Total (sum of lines 1-2)	0	7, 794, 390	1			3. 00
2.00		1 9	.,,,,,	1			1 2:00

Heal th	Financial Systems	ST. VINCENT FIS	SHERS HOSPITAL		In Lieu of Form CMS-2552-10		
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 15-0181		Peri od: Worksheet A-7 From 07/01/2016 Part III To 06/30/2017 Date/Time Pre 11/20/2017 2:		pared:
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	•
Cost Center Description		Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	DART III DECONOLILATION OF CARLTAL COCTO	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	6, 076, 791	1 0	6, 076, 79	1 0. 782193	0	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1, 692, 120	1	1, 692, 12			2.00
3. 00	Total (sum of lines 1-2)	7, 768, 911		7, 768, 91			3. 00
0.00	Total (Sam of Times 1 2)	ALLOCATION OF OTHER CAPITAL				F CAPITAL	0.00
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONCILIATION OF CARLTAL COCTE O	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1		0 1, 666, 811	4, 368, 955	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	0	1		0 1, 455, 930		2.00
3.00	Total (sum of lines 1-2)		1		0 3, 122, 741	·	3.00
3.00	Total (Suil of Titles 1 2)		·	JMMARY OF CAPI		4,007,000	3. 00
			0.		.,,,_		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS O	11.00	12.00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS	39, 241	1, 78	4 0	6, 076, 791	1. 00
2.00	CAP REL COSTS-BUBB & TTXT		1			1, 699, 131	2.00
3.00	Total (sum of lines 1-2)	0	1			7, 775, 922	
0.00	1.013. (04 01 111103 1 2)	1	11, 400	2,10	٥,	1,110,722	0.00

Health Financial Systems ST. VINCENT FISHERS HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0181 Peri od: Worksheet A-8 From 07/01/2016 06/30/2017 Date/Time Prepared: 11/20/2017 2:33 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 -2 444 070 10.00 Provider-based physician A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 -982, 136 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -158, 000 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others Sale of medical and surgical 16.00 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than В -923 PHARMACY 15.00 17.00 pati ents -195 MEDICAL RECORDS & LIBRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts Nursing school (tuition, fees, 19.00 19 00 0 00 books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21.00 0 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 0 00 22 00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 23.00 A - 8 - 365.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 66.00 24.00 Adjustment for physical A-8-3 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 O 26.00 1.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 Physicians' assistant 29. 00 29 00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of

OADULTS & PEDIATRICS

-30, 733 ADMINISTRATIVE & GENERAL

OSPEECH PATHOLOGY

30.00

68 00

0.00

5 00

30.99

31.00

32.00

0 33 00

30. 99

31.00

limitation (chapter 14)

Adjustment for speech

instructions)

33.00 MISC INCOME - A&G

Hospice (non-distinct) (see

pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for

Depreciation and Interest

A - 8 - 3

В

From 07/01/2016
To 06/30/2017 Date/Time Prepared:

						11/20/2017 2:	33 pm
	Expense Classification on Worksheet A						
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	0001 0011101 D0001 1 p 11 011	1.00	2. 00	3.00	4. 00	5. 00	
33. 01	MISC INCOME - RENTAL INCOME -	В		CAP REL COSTS-BLDG & FIXT	1.00	9	33. 01
00.01	BLDG		10, 100	ON REE GOOTS BEBG & TTXT	1.00	ĺ	00.01
33. 02	MISC INCOME - AUDIOLOGY	В	-165	SPEECH PATHOLOGY	68. 00	9	33. 02
33. 03	MISC INCOME - REHAB	В		PHYSI CAL THERAPY	66.00	ń	33. 03
33. 04	MISC INCOME - DIAG RAD	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 04
33. 04	MISC INCOME - DIETARY	В		DI ETARY	10.00	0	33. 05
	INVENTORY DONATIONS MADE -	A A	, .	CENTRAL SERVICES & SUPPLY		0	33. 06
33. 06	CENTRAL S	A	-3, 092	CENTRAL SERVICES & SUPPLY	14. 00	U	33.00
33. 07	INVENTORY DONATIONS MADE -	A	/ E70	ODEDATI NO DOOM	50.00	0	33. 07
33.07		A	-0, 570	OPERATING ROOM	50.00	U	33.07
22.00	SURGERY		7.5	ADMINISTRATIVE & CENEDAL	F 00		22.00
33. 08	INVENTORY DONATIONS MADE - MAT	A	-/5	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
00.00	MGMT		200	COOLAL CERVILOE	47.00		00.00
33. 09	DONATIONS MADE - SOC SVC	В		SOCIAL SERVICE	17. 00	0	33. 09
33. 10	ENTERTAL NMENT - ADMIN	A	·	ADMI NI STRATI VE & GENERAL	5. 00	0	33. 10
33. 11	ENTERTALNMENT - NURS ADMIN	A		NURSING ADMINISTRATION	13. 00	0	33. 11
33. 12	ENTERTAL NMENT - PHARMACY	A		PHARMACY	15. 00	0	33. 12
33. 13	ENTERTAL NMENT - MED SURG	A		ADULTS & PEDIATRICS	30.00	0	33. 13
33. 14	ENTERTALNMENT - SURGERY	A		OPERATING ROOM	50.00	0	33. 14
33. 15	ENTERTAI NMENT - LDRP	A		DELIVERY ROOM & LABOR ROOM	52.00	0	33. 15
33. 16	ENTERTALNMENT - ED	A	-497	EMERGENCY	91.00	0	33. 16
33. 17	CORP SPONSORHSIP - A&G	A	-13, 915	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	COPR SPONSORSHIP - ED	A	-1, 500	EMERGENCY	91.00	0	33. 18
33. 19	MARKETING - ROUTINE	A	-169	ADULTS & PEDIATRICS	30.00	0	33. 19
33. 20	MARKETING - L&D	A	-1, 105	DELIVERY ROOM & LABOR ROOM	52.00	0	33. 20
33. 21	MARKETING - NURSERY	A	-136	NURSERY	43.00	0	33. 21
33. 22	MARKETING - REHAB	A	-210	PHYSI CAL THERAPY	66.00	0	33. 22
33. 23	PROMOTIONAL ITEMS	A	-238	ADULTS & PEDIATRICS	30.00	0	33. 23
33. 24	CHARITABLE COSTS - HOSPICE	l A	-180	ADMINISTRATIVE & GENERAL	5. 00	0	33. 24
	MEMORI AL						
33. 25	CHARITABLE OTHER COSTS - A&G	l A	-925	ADMINISTRATIVE & GENERAL	5.00	0	33. 25
33. 26	CHARI TABLE OTHER COSTS - PHARM	1		PHARMACY	15. 00	0	33. 26
33. 27	CHARI TABLE OTHER COSTS - SOC	A		SOCI AL SERVI CE	17. 00	0	33. 27
55. 27	SVC	'`	1, 701		17.00		00.27
33. 28	LOBBYING EXPENSE	A	-724	ADMINISTRATIVE & GENERAL	5. 00	0	33. 28
33. 29	MEDICALD PROVIDER TAX	A		ADMINISTRATIVE & GENERAL	5. 00	-	33. 29
33. 30	INCENTIVE ADJUSTMENT - SALARY	A		ADMINISTRATIVE & GENERAL	5. 00	Ö	33. 30
33. 31	INCENTIVE ADJUSTMENT - SALAKT	Ä	·	ADMINISTRATIVE & GENERAL	5.00	0	33. 31
JJ. J I	BENEFITS	^	-7,011	ADMINISTRATIVE & GENERAL	3.00		JJ. J1
50. 00	TOTAL (sum of lines 1 thru 49)		-4, 374, 407				50. 00
30.00	(Transfer to Worksheet A,		-4, 3/4, 40/				30.00
	column 6, line 200.)						
	Tool Williams, Title 200.)	1		L			

⁽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.

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

Provider CCN: 15-0181 | Period: From 07/01/2016 To 06/30/2017 | Date/Time Prepare

011.02	300.0			To 06/30/2017	Date/Time Pre	
	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 O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		I			
1.00	0.00	l .	ST. VINCENT HEALTH HOME OFFI		0	1. 00
2.00			ST. VINCENT HEALTH HOME OFFI			2. 00
3.00		l .	ST. VINCENT HEALTH HOME OFFI	227, 172	0	3. 00
3. 01	0.00	l .		0	0	3. 01
3.02			ST. VINCENT HEALTH CHARGEBAC			3. 02
3.03			ST. VINCENT HEALTH CHARGEBAC	,		3. 03
3.04		l .	ST. VINCENT HEALTH CHARGEBAC		97, 807	3. 04
3.05	15. 00	PHARMACY	ST. VINCENT HEALTH CHARGEBAC	-6, 056	-6, 056	3. 05
3.06			ST. VINCENT HEALTH CHARGEBAC	522, 216	522, 216	3. 06
3.07	30.00	ADULTS & PEDIATRICS	ST. VINCENT HEALTH CHARGEBAC	1, 286, 149	1, 286, 149	3. 07
3.08	50.00	OPERATING ROOM	ST. VINCENT HEALTH CHARGEBAC	700	700	3. 08
3.09	52. 00	DELIVERY ROOM & LABOR ROOM	ST. VINCENT HEALTH CHARGEBAG	133	133	3. 09
3.10	54. 00	RADI OLOGY-DI AGNOSTI C	ST. VINCENT HEALTH CHARGEBAG	74, 052	74, 052	3. 10
3. 11	56. 01	ONCOLOGY	ST. VINCENT HEALTH CHARGEBAG	275	275	3. 11
3. 12	66.00	PHYSI CAL THERAPY	ST VINCENT HEALTH CHARGEBACK	85, 365	85, 365	3. 12
3. 13	68. 00	SPEECH PATHOLOGY	ST VINCENT HEALTH CHARGEBACK	27, 780	27, 780	3. 13
3.14	91.00	EMERGENCY	ST VINCENT HEALTH CHARGEBACK	1, 025	1, 025	3. 14
3. 15	192. 00	PHYSICIANS' PRIVATE OFFICES	ST VINCENT HEALTH CHARGEBACK	1, 382, 498	1, 382, 498	3. 15
3. 16	0.00			0	0	3. 16
3. 17	4. 00	EMPLOYEE BENEFITS DEPARTMENT	ST VINCENT HEALTH SELF INS	1, 595, 007	1, 648, 931	3. 17
3. 18	7. 00	OPERATION OF PLANT	TRI MDEX	805, 572	811, 440	3. 18
4.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	470, 350	265, 178	4. 00
5.00	TOTALS (sum of lines 1-4).			10, 757, 885	11, 740, 021	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership				
1. 00	2.00	3.00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6.00	В	ST. VINCENT HEA	100.00 ST. VINCEN	IT HEA 100. 0	6. 00
7.00	В	ASCENSION HEALT	100. 00 ASCENSI ON	HEALT 100. 0	7. 00
8.00	A	TRI MEDX	O. OO TRI MEDX	0.0	8.00
9.00			0. 00	0.0	9.00
10.00			0. 00	0.0	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

			10 00/30/2017 Bate/11me Prep. 11/20/2017 2: 3:	areu. 3 nm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	0	0		1. 00
2.00	-1, 354, 688			2. 00
3.00	227, 172	0		3. 00
3. 01	0	0		3. 01
3. 02	0	0		3. 02
3. 03	0	0		3. 03
3.04	0	0		3. 04
3. 05	0	0		3. 05
3.06	0	0		3.06
3. 07	0	0		3. 07
3.08	0	0		3. 08
3.09	0	0		3. 09
3. 10 3. 11	0	0		3. 10 3. 11
3. 12	0	0		3. 12
3. 13	0	0		3. 13
3. 14	0	0		3. 14
3. 15	0	0		3. 15
3. 16	0	0		3. 16
3. 17	-53, 924	0		3. 17
3. 18	-5, 868			3. 18
4.00	205, 172			4. 00
5.00	-982, 136			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						
Type of Business						
6. 00						
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

Termbursement under tritle AVIII.							
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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0181

					-	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	30.00	ADULTS & PEDIATRICS	1, 285, 192	1, 285, 192			0	
2.00	50.00	OPERATING ROOM	257, 250	0	257, 250	246, 400	8, 664	2. 00
3.00	52. 00	DELIVERY ROOM & LABOR ROOM	1, 901, 144	1, 108, 031	793, 113	237, 100	8, 364	
4.00	54.00	RADI OLOGY-DI AGNOSTI C	18, 598	18, 598	0	0	0	4. 00
5.00	57. 00	CT SCAN	30, 999	30, 999	0	0	0	5. 00
6.00	5. 00	ADMINISTRATIVE & GENERAL	78, 840	0	78, 840	211, 500	8, 760	6. 00
7.00	91.00	EMERGENCY	1, 250	1, 250	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	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			3, 573, 273		1, 129, 203			200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
		0.00			Educati on	12	44.00	
4 00	1.00	2.00	8. 00	9. 00	12. 00	13.00	14.00	4 00
1.00		ADULTS & PEDIATRICS	0	_	-	1	0	1
2.00		OPERATING ROOM	1, 026, 351	•	0	0	0	2.00
3.00		DELIVERY ROOM & LABOR ROOM	953, 416		0	0	0	
4.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	4. 00
5. 00 6. 00		CT SCAN	890, 740	1	0	0	0	
7. 00		ADMINISTRATIVE & GENERAL EMERGENCY	890, 740	44, 537	0	0	0	6. 00 7. 00
7. 00 8. 00	0.00				0	0	0	8.00
9. 00	0.00				0	0	0	
10. 00	0.00				0	0	0	10.00
200.00	0.00		2, 870, 507	143, 526	0	0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSt. A LITIC #	I denti fi er	Component	Limit	Di sal I owance	Auj us tilicit		
		racittifici	Share of col.		Di Sai i Owanice			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00	30.00	ADULTS & PEDIATRICS	0	_	_	1, 285, 192		1. 00
2.00	50.00	OPERATING ROOM	0	1, 026, 351	0	0		2. 00
3.00		DELIVERY ROOM & LABOR ROOM	0	953, 416	0	1, 108, 031		3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	0	18, 598		4. 00
5.00		CT SCAN	0	0	0	30, 999		5. 00
6.00		ADMINISTRATIVE & GENERAL	0	890, 740	0	0		6. 00
7. 00		EMERGENCY	0	0	0	1, 250		7. 00
8.00	0.00		0	0	0	0		8. 00
9.00	0. 00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0		10.00
200.00	l		0	2, 870, 507	0	2, 444, 070		200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 ST. VINCENT FISHERS HOSPITAL Provider CCN: 15-0181

COST CENTER DESCRIPTION						10	06/30/2017	Date/Time Pre 11/20/2017 2:	
PRINCE P					CAPI TAL REI	ATED COSTS		11/20/2017 2.	JJ PIII
PRINCE P									
All Local Start Coll Department Department Coll Department Departme			Cost Center Description		BLDG & FIXT	MVBLE EQUIP		Subtotal	
1.00									
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43. 00 04300 NURSERY 60. 05 50. 04 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50. 05 50.				0	0	0	0		
ANCILLARY SERVICE COST CENTERS				0	0	0	0	-	
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51.00 05100 DEJOUPEY ROOM \$ LABOR ROOM 2,122,466 540,394 151,099 256,934 3,070,893 52.00 05200 DEJLYEPEY ROOM \$ LABOR ROOM 2,122,466 540,394 151,099 256,934 3,070,893 52.00 05300 05300 ANESTHESIOLOGY 0 0 0 0 0 0 0 0 0	50 00			2 736 575	604 649	169 066	296 424	3 806 714	50.00
52 OD 05200 DELIVERY ROOM & LABOR ROOM 2, 122, 466 540, 394 151, 099 256, 934 3, 070, 893 52, 00 53.00 05300 ARSTHESI LOGY 0 0 0 0 0 0 0 0 53, 00 54. 00 05400 RADIDLOGY-DIAGNOSTI C 1, 112, 249 281, 180 78, 621 179, 541 1, 651, 591 54, 00 56. 00 05500 LADIDLOGY-DIAGNOSTI C 182, 879 25, 541 1, 01, 151, 591 54, 00 56. 00 05500 CADIDLOGY-DIAGNOSTI C 182, 879 25, 541 1, 01, 151, 591 54, 00 56. 00 05500 CADIDLOS/OFDE 182, 879 267, 896 117, 211 32, 273 43, 770 461, 656 66, 01 57. 00 05700 CT SCAN 41, 450 413, 298 64, 227 17, 958 69, 448 564, 931 57, 00 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 207, 553 39, 926 11, 164 32, 90 291, 503 58, 00 60. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 207, 553 39, 926 11, 164 32, 90 291, 503 58, 00 60. 00 06800 LABORATORY 30, 800 30, 900 30, 900 30, 900 60. 00 06800 LABORATORY 30, 900 30, 900 30, 900 60. 00 06800 MAGNETI C RESONANCE RED BLOOD CELLS 30, 900 30, 900 30, 900 60. 00 06800 MAGNETI C RESONANCE IMAGING (MRI) 30, 900 30, 900 60. 00 06800 MAGNETI C RESONANCE IMAGING (MRI) 30, 900 30, 900 60. 00 06800 MAGNETI C RESONANCE IMAGING (MRI) 207, 553 30, 926 11, 164 32, 900 30, 900 60. 00 06800 MAGNETI C RESONANCE IMAGING (MRI) 207, 553 30, 926 11, 164 32, 900 20, 900 60. 00 06800 MAGNETI C RESONANCE IMAGING (MRI) 207, 553 30, 926 11, 164 32, 900 20, 900 60. 00 06800 MAGNETI C RESONANCE IMAGING (MRI) 207, 553 30, 926 11, 164 60. 00 06800 MAGNETI C RESONANCE IMAGING (MRI) 207, 500 20, 900 20, 900 60. 00 06800 MAGNETI C RESONANCE IMAGING (MRI) 207, 500 60. 00 06800 MAGNETI C RESONANCE IMAGING (MRI) 207, 500 60. 00 06800 MAGNETI C RESONANCE IMAGING (MRI) 207, 500 60. 00 06900 DELECTRANCE MAGNETI C RESONANCE IMAGING (MRI) 207, 500 60. 00 06900 DELECTRANCE MAGNETI C RESONA				2, 730, 373		0			
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				1	0 06/30/201/	11/20/2017 2:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
	OFNEDAL CEDIMOS OCCI OFNITEDO	5. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			T			1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	7, 096, 166					5.00
7. 00	00700 OPERATION OF PLANT	7, 070, 100	4, 315, 179				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	26, 023	1, 010, 177	153, 921			8.00
9. 00	00900 HOUSEKEEPI NG	135, 947	63, 679		871, 274		9. 00
10.00	01000 DI ETARY	26, 635	25, 822		5, 292	188, 654	1
11. 00	01100 CAFETERI A	148, 278	173, 290		35, 513	0	1
13.00	01300 NURSING ADMINISTRATION	196, 435	17, 985		3, 686	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	38, 802	28, 187	0	5, 776	0	14. 00
15.00	01500 PHARMACY	222, 767	49, 732	2 0	10, 192	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	123, 254	6, 642	2 0	1, 361	0	16. 00
17.00	01700 SOCIAL SERVICE	27, 392	4, 144	0	849	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	731, 621	829, 604	35, 182	170, 014	121, 154	1
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	1
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	1
43. 00	04300 NURSERY	108, 548	61, 288	2, 927	12, 560	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	774, 534	557, 223	1		0	
51.00	05100 RECOVERY ROOM	(24 022	400.007	0		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	624, 832	498, 007	23, 789	102, 058	67, 500 0	1
53. 00 54. 00	05400 RADI OLOGY - O5400 RADI OLOGY - O5400 RADI OLOGY - O1400 RADI OLOGY - O1400 RADI OLOGY - O1400 RADI OLOGY	336, 048	259, 125	15, 572	53. 103	0	1
54. 00	03630 ULTRA SOUND	50, 912	23, 538			0	
56. 00	05600 RADI OI SOTOPE	30, 712	23, 330	0, 234	4, 624	0	
56. 01	05601 ONCOLOGY	93, 931	108, 018	1	22, 136	0	1
57. 00	05700 CT SCAN	114, 946	59, 189	1		0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	59, 324	36, 794	1	7, 540	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0,,02,	00,77	0	0	0	
60.00	06000 LABORATORY	251, 323	56, 905	o o	11, 662	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	o o	0	0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	O	0	0	o	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	o	0	0	o	0	1
65.00	06500 RESPIRATORY THERAPY	96, 869	11, 769	0	2, 412	0	65. 00
66.00	06600 PHYSI CAL THERAPY	309, 780	250, 651	0	51, 367	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 150	2, 046	0	419	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	53, 916	42, 160	0	8, 640	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	63, 252	83, 550	0	17, 122	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	124, 256	0	0	0	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	133, 855	0	0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	369, 191	0	0	0	0	
74.00		0	0	0	0	0	
/5.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
01 00	OUTPATIENT SERVICE COST CENTERS	F40.0/3	404 405	JE 440	02.004		01 00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	540, 963	404, 495	35, 469	82, 894	0	
92. 00	OTHER REIMBURSABLE COST CENTERS						92. 00
00 00	09900 CMHC	0	0	0	ol	0	99. 00
99.00	SPECIAL PURPOSE COST CENTERS	l o		<u> </u>	l ol	0	99.00
118. 00		6, 515, 346	3, 653, 843	153, 921	735, 744	188, 654	118 00
110.00	NONREI MBURSABLE COST CENTERS	0,313,340	3, 033, 043	133, 721	755, 744	100, 054	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	682	0	0	ol	0	190. 00
	19100 RESEARCH	0	0	o o			191. 00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	471, 592	661, 336				192. 00
	19300 NONPALD WORKERS	0	0	ol o	0		193. 00
	07950 COMMUNITY EDUCATION	272	O	Ö	o		194. 00
	I 07951 MARKETI NG	108, 274	O	0	o		194. 01
200.00		1		1			200.00
201.00		o	0	0	ol	0	201.00
202.00		7, 096, 166	4, 315, 179	153, 921	871, 274	188, 654	202.00
		·			·		

Provider CCN: 15-0181

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2016 | Part |
| To 06/30/2017 | Date/Time Prepared: | 11/20/2017 2:33 pm

				00/30/2017	11/20/2017 2:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						4 00
1.00 00100 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 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY	1 005 022					10.00
11. 00 01100 CAFETERI A	1, 085, 832	1 224 714				11.00
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	53, 178	1, 236, 714	242 444			13. 00 14. 00
15. 00 01500 PHARMACY	57, 233	16, 281	263, 466 2, 097	1, 453, 148		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	50, 037	10, 201	2,097	1, 433, 146	787, 057	16. 00
17. 00 01700 SOCIAL SERVICE	8, 480	0	24	0	787,037	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0, 400	<u> </u>	24	<u> </u>		17.00
30. 00 03000 ADULTS & PEDI ATRI CS	192, 236	297, 444	7, 429	ol	48, 568	30. 00
31. 00 03100 NTENSI VE CARE UNI T	172, 230	277, 444	0	Ö	40, 300	31. 00
32. 00 03200 CORONARY CARE UNIT	Ö	0	0	Ö	0	32. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	ol	Ö	0	ol	0	34. 00
43. 00 04300 NURSERY	32, 457	50, 416	3, 079	ol	18, 957	43. 00
ANCI LLARY SERVI CE COST CENTERS		227	2, 21.1	-1		
50. 00 05000 OPERATING ROOM	134, 426	208, 627	78, 167	0	204, 914	50. 00
51.00 05100 RECOVERY ROOM	o	0	0	o	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	103, 667	160, 905	2, 912	0	48, 143	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	91, 925	142, 715	8, 593	0	35, 273	54.00
54. 01 03630 ULTRA SOUND	12, 808	19, 875	69	0	14, 120	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56.00
56. 01 05601 ONCOLOGY	21, 756	0	1, 206	0	5, 411	56. 01
57.00 05700 CT SCAN	32, 828	50, 978	5, 268	0	25, 945	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	13, 809	21, 447	3, 356	0	12, 699	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY	0	0	3	0	59, 027	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	이	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	34, 297	53, 223	2, 768	0	8, 315	65. 00
66. 00 06600 PHYSI CAL THERAPY	84, 611	0	1, 031	0	21, 613	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	465	0	28	0	185	67. 00
68. 00 06800 SPEECH PATHOLOGY	13, 809	(17(8, 262	0	2, 375	68. 00
69. 00 06900 ELECTROCARDI OLOGY	13, 276	6, 176	1, 653	U	15, 144	69. 00
70.00 O7000 ELECTROENCEPHALOGRAPHY 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0 50 177	U O	14 754	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	59, 177 66, 384	0	16, 754 21, 484	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	00, 384	1, 453, 148	51, 231	
74. 00 07400 RENAL DI ALYSI S	o	0	0	1, 433, 140	0 0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	ő	Ö	0	ő	0	75. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	3	<u> </u>		70.00
91. 00 09100 EMERGENCY	134, 426	208, 627	11, 421	ol	176, 899	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	- ,		,			92.00
OTHER REIMBURSABLE COST CENTERS						
99. 00 09900 CMHC	0	0	0	0	0	99. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 085, 724	1, 236, 714	262, 927	1, 453, 148	787, 057	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	539	0		192.00
193. 00 19300 NONPALD WORKERS	109	0	0	0		193. 00 194. 00
194. 00 07950 COMMUNI TY EDUCATI ON 194. 01 07951 MARKETI NG	108	O	0	O ₁		194. 00 194. 01
200.00 Cross Foot Adjustments	٩	٩	٥	٩	Ü	200. 00
201.00 Negative Cost Centers		0	^		0	200.00
202.00 TOTAL (sum lines 118-201)	1, 085, 832	1, 236, 714	263, 466	1, 453, 148	787, 057	
	., 500, 502	., 200, , 17	200, 100	., 100, 140	, 5, , 55,	

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0181 Peri od: Worksheet B From 07/01/2016 Part I Date/Time Prepared: 06/30/2017 11/20/2017 2:33 pm Cost Center Description SOCIAL SERVICE Total Subtotal Intern & 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 175, 515 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 112, 709 30.00 6.141.697 0 6, 141, 697 0 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 C 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34.00 04300 NURSERY 62, 806 0 43.00 886, 523 886, 523 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 5, 910, 044 5, 910, 044 0 51.00 05100 RECOVERY ROOM 51.00 0000000000000000000000000 05200 DELIVERY ROOM & LABOR ROOM 0 4, 702, 706 4, 702, 706 52 00 52 00 0 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 593, 945 0 2, 593, 945 54.00 54.00 03630 ULTRA SOUND 0 54.01 382, 599 382, 599 54.01 05600 RADI 01 SOTOPE 0 56.00 56.00 56.01 05601 ONCOLOGY 714, 108 0 714, 108 56.01 05700 CT SCAN 57.00 866, 215 866, 215 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 446, 532 0 446, 532 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 06000 LABORATORY 1, 614, 113 60.00 1,614,113 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 C 0 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 685, 742 685, 742 65.00 06600 PHYSI CAL THERAPY 2, 241, 546 2, 241, 546 66.00 66.00 06700 OCCUPATIONAL THERAPY 15, 862 0 15, 862 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 394, 147 394, 147 68.00 69.00 06900 ELECTROCARDI OLOGY 511, 042 511, 042 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 810, 873 810, 873 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 879, 589 879, 589 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 688, 055 3, 688, 055 73.00 0 07400 RENAL DIALYSIS 74 00 74 00 75.00 07500 ASC (NON-DISTINCT PART) 75.00 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 0 91.00 91.00 4, 253, 893 4, 253, 893 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 09900 CMHC 0 0 0 0 99.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 118.00 175, 515 37, 739, 231 0 37, 739, 231 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 4, 032 190.00 4,032 191. 00 19100 RESEARCH 0 0 191 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 3, 586, 757 3, 586, 757 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193.00 1, 719 194. 00 07950 COMMUNITY EDUCATION 0 1.719 0 194.00 194. 01 07951 MARKETI NG 0 194 01 0 640, 414 640, 414 0 200.00 Cross Foot Adjustments 200.00 C 0 0 201.00 Negative Cost Centers 201. 00 41, 972, 153 0 41, 972, 153 202.00 TOTAL (sum lines 118-201) 175, 515 202.00

| Peri od: | Worksheet B | From 07/01/2016 | Part II | To 06/30/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0181

				To	06/30/2017	Date/Time Pre 11/20/2017 2:	
			CAPI TAL REI	LATED COSTS		11/20/2017 2.	33 pili
	Cook Cooker Doored at the	D:+1	DIDC & FLVT	MANDLE FOLLID	C	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	802, 304	60, 076 533, 590		76, 874	76, 874 15, 926	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	002, 304	800, 674		1, 485, 091 1, 024, 550	863	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0		0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	69, 099	19, 321	88, 420	0	9. 00
10.00	01000 DI ETARY	0	28, 020	1	35, 855	0	10.00
11.00	01100 CAFETERI A	0	188, 039		240, 617	0	11. 00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	19, 516 30, 586	1	24, 973 39, 138	3, 381 0	13. 00 14. 00
15. 00	01500 PHARMACY	0	53, 964	1	69, 053	3, 702	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	7, 207	2, 015	9, 222	1, 815	16. 00
17. 00	01700 SOCIAL SERVICE	0	4, 497	1, 257	5, 754	503	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	900, 214	251, 709	1, 151, 923	12, 274	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	900, 214		1, 151, 423	12, 2/4	31. 00
32. 00	03200 CORONARY CARE UNIT	0	Ö	Ö	Ō	0	32. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
43. 00	04300 NURSERY	0	66, 504	18, 595	85, 099	1, 529	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		604, 649	169, 066	773, 715	7, 220	50. 00
51. 00	05100 RECOVERY ROOM	0	004, 047		773, 713	7, 220	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	540, 394	151, 099	691, 493	6, 258	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	281, 180	1	359, 801	4, 373	54.00
54. 01 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	25, 541 0		32, 682 0	844 0	54. 01 56. 00
56. 01	05601 ONCOLOGY	0	117, 211	_	149, 984	1, 066	56. 01
57.00	05700 CT SCAN	0	64, 227		82, 185	1, 691	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	39, 926		51, 090	802	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	0	70.013	0	59. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	61, 748 0	17, 265 0	79, 013 0	0	60. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	12, 770		16, 341	1, 679	65. 00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	271, 984	1	348, 033	4, 438	66. 00 67. 00
67. 00 68. 00	06800 SPEECH PATHOLOGY	0	2, 220 45, 749		2, 841 58, 541	29 494	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	90, 661	1	116, 011	684	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
74. 00		0	0		0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS	1					
	09100 EMERGENCY	0	438, 922	122, 727	561, 649	7, 293	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92. 00
99. 00	09900 CMHC	0	0	0	0	0	99. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	,	802, 304	5, 359, 168	1, 498, 476	7, 659, 948	76, 864	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		0	0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00 191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	717, 623	T .	918, 278		192. 00
193.00	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
	07950 COMMUNITY EDUCATION	0	0	0	0		194. 00
194. 01 200. 00	1 07951 MARKETING Cross Foot Adjustments	0	0	9	0		194. 01 200. 00
200.00	, ,		n	0	0		200. 00
202.00		802, 304	6, 076, 791	1, 699, 131	8, 578, 226		
	•			,	'		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0181

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 2:33 pm

						11/20/2017 2:	
	Cost Center Description		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	7.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 501, 017					5. 00
7.00	00700 OPERATION OF PLANT	154, 321	1, 179, 734				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	5, 505	0	5, 505			8. 00
9. 00	00900 HOUSEKEEPI NG	28, 756	17, 409				9. 00
10. 00	01000 DI ETARY	5, 634	7, 060			49, 367	
11. 00	01100 CAFETERI A	31, 365	47, 376		-,	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	41, 551	4, 917		570	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 208	7, 706		893	0	14.00
15.00	01500 PHARMACY	47, 121	13, 596		1, 576	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	26, 071	1, 816		210	0	16.00
17. 00	01700 SOCIAL SERVICE	5, 794	1, 133	0	131	0	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	154 757	227 007	1 250	27, 205	21 704	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	154, 757	226, 807	1, 258		31, 704 0	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	0		0	0	32.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0		0	0	34.00
43. 00	04300 NURSERY	22, 961	16, 756	· · · · · ·	1, 942	0	43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	22, 701	10, 730	103	1, 742		43.00
50. 00	05000 OPERATING ROOM	163, 826	152, 340	1, 117	17, 656	0	50.00
51. 00	05100 RECOVERY ROOM	0	102, 010	1, 11,		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	132, 168	136, 151	851	15, 780	17, 663	1
53. 00	05300 ANESTHESI OLOGY	0	0	0		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	71, 083	70, 843	557	8, 210	0	54.00
54. 01	03630 ULTRA SOUND	10, 769	6, 435	223		0	54. 01
56.00	05600 RADI OI SOTOPE	0	0			0	56. 00
56. 01	05601 ONCOLOGY	19, 869	29, 531	0	3, 423	0	56. 01
57.00	05700 CT SCAN	24, 314	16, 182	0	1, 875	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	12, 549	10, 059	0	1, 166	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	53, 161	15, 557	0	1, 803	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	20, 490	3, 217			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	65, 527	68, 526		7, 942	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	455	559		65	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	11, 405	11, 526		.,	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	13, 379	22, 842	1	2, 647	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	26, 283	0	0	0	0	71.00
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	28, 314 78, 094	0		0	0	72. 00 73. 00
		78, 094	0		0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0		0	0	
75.00	OUTPATIENT SERVICE COST CENTERS	ı o	0		U U	<u>U</u>	75.00
91. 00	09100 EMERGENCY	114, 428	110, 586	1, 269	12, 817	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	114, 420	110, 300	1,207	12,017	O	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
99. 00		0	0	0	0	0	99. 00
	SPECIAL PURPOSE COST CENTERS	-1	-	-	-1		
118.00		1, 378, 158	998, 930	5, 505	113, 755	49, 367	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	144	0	0	0	0	190. 00
191.00	19100 RESEARCH	O	0	0	0	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	99, 754	180, 804	0	20, 955	0	192. 00
	19300 NONPALD WORKERS	0	0	0	O		193. 00
	07950 COMMUNITY EDUCATION	58	0	0	0		194. 00
	07951 MARKETI NG	22, 903	0	0	0	0	194. 01
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	1, 501, 017	1, 179, 734	5, 505	134, 710	49, 367	J202. 00

Provider CCN: 15-0181

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2016 | Part II | To 06/30/2017 | Date/Time Prepared: |

				10	06/30/201/	Date/IIme Pre 11/20/2017 2:	pared: 33 pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	JU 2011
	·		ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11 00	12.00	SUPPLY	15.00	LI BRARY	
	GENERAL SERVICE COST CENTERS	11.00	13. 00	14. 00	15. 00	16. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERIA	324, 849					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	15, 909	91, 301	55, 945			13. 00 14. 00
15. 00	01500 PHARMACY	17, 122	1, 202	445	153, 817		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	14, 970		0	0	54, 104	1
17. 00	01700 SOCIAL SERVICE	2, 537	0	5	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	57, 513	21, 960	1, 577	0	3, 341	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00 34. 00
34. 00 43. 00	03400 SURGICAL INTENSIVE CARE UNIT	9, 710	3, 722	654	ol Ol	1, 304	43.00
43.00	ANCILLARY SERVICE COST CENTERS	9,710	3, 722	034	- υ _լ	1, 304	43.00
50. 00	05000 OPERATI NG ROOM	40, 216	15, 402	16, 598	0	14, 060	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	31, 014	11, 879	618	0	3, 312	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	27, 501	10, 536	1, 825	0	2, 426	
54. 01	03630 ULTRA SOUND	3, 832	1, 467	15	0	971	54. 01
56. 00 56. 01	05600 RADI OI SOTOPE 05601 ONCOLOGY	6, 509	_	0 256	0	0 372	56. 00 56. 01
57. 00	05700 CT SCAN	9, 821	3, 763	1, 119	0	1, 785	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 131	1, 583	713	o	874	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	o	1	0	4, 060	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	10, 261	3, 929 0	588 219	O O	572 1, 487	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	25, 313 139	1	6	0	1, 467	1
68. 00	06800 SPEECH PATHOLOGY	4, 131		1, 754	0	163	
69. 00	06900 ELECTROCARDI OLOGY	3, 972		351	Ö	1, 042	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	О	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	12, 566	0	1, 152	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	14, 096	0	1, 478	
73. 00		0		0	153, 817	3, 524	
74.00	07400 RENAL DIALYSIS	0	I "	0	O O	0	
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	U U	U	<u> </u>	0	75. 00
91. 00		40, 216	15, 402	2, 425	ol	12, 168	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,210	10, 102	2, 120	J	.2, .00	92. 00
	OTHER REIMBURSABLE COST CENTERS	·	'	<u>'</u>			
99. 00		0	0	0	0	0	99. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		324, 817	91, 301	55, 831	153, 817	54, 104	118. 00
400.04	NONREI MBURSABLE COST CENTERS				ما		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	O O		190. 00 191. 00
191.00	D 19100 RESEARCH D 19200 PHYSICIANS'PRIVATE OFFICES		-	114	0		191.00
	19300 NONPALD WORKERS			0	0		192.00
	07950 COMMUNITY EDUCATION	32		ő	ol		194. 00
	1 07951 MARKETI NG	0	o	Ö	o		194. 01
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	324, 849	91, 301	55, 945	153, 817	54, 104	202. 00

Heal th	Financial Systems	ST. VINCENT FISH	ERS HOSPITAL		In Lie	eu of Form CMS-:	2552-10
ALLOCA	ITION OF CAPITAL RELATED COSTS		Provi der Co	F	eriod: rom 07/01/2016 o 06/30/2017	Worksheet B Part II Date/Time Pre 11/20/2017 2:	pared: 33 pm
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17. 00	24. 00	25. 00	26. 00		
1. 00 2. 00 4. 00 5. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1. 00 2. 00 4. 00 5. 00
7. 00 8. 00 9. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						7. 00 8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON						11. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15.00
17. 00	01700 SOCIAL SERVICE	15, 857					16. 00 17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	10, 183	1, 699, 582	0			30.00
32. 00	03200 CORONARY CARE UNIT	0	0	0			32.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	-		34. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	5, 674	149, 456	0	149, 456		43. 00
50.00	05000 OPERATING ROOM	0	1, 202, 150	0	1, 202, 150		50.00
51.00	05100 RECOVERY ROOM	0	0	0			51.00
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	0	1, 047, 187 0	0			52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	557, 155	0	557, 155		54. 00
54. 01 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	57, 984	0			54. 01 56. 00
56. 00	05601 0NCOLOGY	0	211, 010				56. 00
57. 00	05700 CT SCAN	0	142, 735			1	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	82, 967	0	,		58. 00 59. 00
60.00	06000 LABORATORY	0	153, 5 9 5	1	_		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0			62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0			63. 00 64. 00
65.00	06500 RESPIRATORY THERAPY	o	57, 450				65. 00
66.00	06600 PHYSI CAL THERAPY	0	521, 485			1	66.00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	4, 107 89, 350		4, 107 89, 350	1	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	161, 384			1	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40, 001	0	0 40, 001		70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	43, 888	1	43, 888		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	235, 435	1		i e	73.00
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	1	_	1	74. 00 75. 00
	OUTPATIENT SERVICE COST CENTERS	ı o		,	J		73.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	878, 253	0			91. 00 92. 00
99. 00	09900 CMHC	0	0	0	0		99. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	15, 857	7, 335, 174	0	7, 335, 174		118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	144				190. 00
	19100 RESEARCH	0	1 210 010	0			191. 00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS		1, 219, 910 0	0			192. 00 193. 00
194.00	07950 COMMUNITY EDUCATION	O	95	0	95		194. 00
194. 01 200. 00	O7951 MARKETING Cross Foot Adjustments	0	22, 903	0	22, 903		194. 01 200. 00
200.00		0	0	0	0		200.00
202.00		15, 857	8, 578, 226	0	8, 578, 226		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0181 Peri od: Worksheet B-1 From 07/01/2016 06/30/2017 Date/Time Prepared: 11/20/2017 2:33 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 210 801 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 210, 801 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2,084 2, 084 15, 351, 320 4.00 00500 ADMINISTRATIVE & GENERAL 3, 180, 810 -7, 096, 166 34, 875, 987 5 00 18 510 18, 510 5 00 7.00 00700 OPERATION OF PLANT 27, 775 27, 775 172, 367 3, 585, 617 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 127, 898 8.00 0 00900 HOUSEKEEPI NG 2, 397 2, 397 0 668, 145 9.00 9.00 01000 DI ETARY 0 972 972 130, 905 10 00 10.00 11.00 01100 CAFETERI A 6,523 6, 523 728, 751 11.00 01300 NURSING ADMINISTRATION 13.00 677 677 675, 202 965, 430 13.00 0 01400 CENTRAL SERVICES & SUPPLY 190, 701 14.00 1.061 1.061 14.00 1,872 739, 244 15.00 01500 PHARMACY 1,872 1, 094, 846 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 250 250 362, 418 605, 763 16.00 01700 SOCIAL SERVICE 17.00 156 156 100, 486 134, 626 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31, 228 31, 228 2, 450, 840 0 3, 595, 736 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 32.00 03200 CORONARY CARE UNIT 0 C 0 0 0 32.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 0 34.00 04300 NURSERY 43.00 2, 307 2, 307 305, 389 533, 485 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 975 20, 975 3, 806, 714 50.00 1, 441, 645 05100 RECOVERY ROOM 0 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 18, 746 18, 746 1, 249, 587 0 3, 070, 893 52.00 05300 ANESTHESI OLOGY 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9,754 9, 754 873, 188 1, 651, 591 54.00 54.01 03630 ULTRA SOUND 886 886 168, 557 250, 219 54.01 05600 RADI OI SOTOPE 56.00 56.00 56.01 05601 ONCOLOGY 4,066 4,066 212, 872 0 461, 650 56.01 05700 CT SCAN 337.757 57 00 2,228 2.228 564, 931 57 00 1, 385 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 385 160, 104 291, 563 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 59.00 06000 LABORATORY 1, 235, 193 60.00 2.142 2.142 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0 C Λ 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 C 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 0 06500 RESPIRATORY THERAPY 65 00 443 443 335 219 476, 089 65 00 06600 PHYSI CAL THERAPY 66.00 9, 435 9, 435 886, 230 1, 522, 493 66.00 67.00 06700 OCCUPATIONAL THERAPY 77 77 5, 748 10, 569 67.00 68.00 06800 SPEECH PATHOLOGY 1,587 1,587 98, 583 0 264, 985 68.00 06900 ELECTROCARDI OLOGY 310, 869 69 00 69 00 3.145 3, 145 136, 635 70.00 07000 ELECTROENCEPHALOGRAPHY C 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 610, 686 71.00 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 657, 866 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 Ω 1, 814, 485 73 00 74.00 07400 RENAL DIALYSIS 0 C 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 15, 226 15, 226 2, 658, 699 09100 EMERGENCY 1, 456, 364 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09900 CMHC 99.00 0 0 0 0 99.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 185, 907 185, 907 32, 021, 398 118. 00 118.00 15, 349, 245 -7, 096, 166 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 350 190, 00 191. 00 19100 RESEARCH 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 24, 894 24, 894 1,030 2, 317, 760 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193, 00 194. 00 07950 COMMUNITY EDUCATION 1,045 1, 339 194, 00 0 194. 01 07951 MARKETI NG 0 532, 140 194. 01 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 6, 076, 791 1, 699, 131 3, 156, 467 7, 096, 166 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 28. 827145 8.060356 0.205615 0. 203469 203. 00 1, 501, 017 204. 00 204 00 Cost to be allocated (per Wkst. B, 76.874 Part II)

Health Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				From 07/01/2016 To 06/30/2017		
	CAPITAL REL	LATED COSTS				
Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2.00	4. 00	5A	5. 00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 00500	8	0. 043039	205. 00

In Lieu of Form CMS-2552-10 Health Financial Systems ST. VINCENT FISHERS HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0181 Peri od: Worksheet B-1 From 07/01/2016 06/30/2017 Date/Time Prepared: 11/20/2017 2:33 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A (SQUARE FEET) (MEALS SERVED) (MEALS SERVED) PLANT LINEN SERVICE (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 162, 432 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 188, 571 8.00 00900 HOUSEKEEPI NG 9.00 2.397 4, 292 160, 035 9.00 10.00 01000 DI ETARY 972 972 9, 251 10.00 01100 CAFETERI A 6, 523 322, 166 11.00 6.523 11.00 01300 NURSING ADMINISTRATION 15, 778 13.00 13.00 677 C 677 0 14.00 01400 CENTRAL SERVICES & SUPPLY 1,061 C 1,061 0 0 14.00 15.00 01500 PHARMACY 1,872 1,872 16, 981 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 250 250 14.846 16.00 01700 SOCIAL SERVICE 17.00 156 156 2, 516 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 5, 941 30.00 03000 ADULTS & PEDIATRICS 31, 228 43, 102 31, 228 57, 037 30.00 03100 INTENSIVE CARE UNIT 31 00 31 00 C 0 32.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 34.00 0 43.00 04300 NURSERY 2, 307 3,586 2, 307 0 9, 630 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 975 38, 279 20, 975 0 39,884 50.00 51.00 05100 RECOVERY ROOM 51.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 18 746 29, 144 3, 310 30, 758 18.746 52 00 05300 ANESTHESI OLOGY 53.00 0 0 53.00 \cap 05400 RADI OLOGY-DI AGNOSTI C 9,754 19,077 9, 754 0 27, 274 54.00 54.00 0 54.01 03630 ULTRA SOUND 886 7,637 886 3,800 54.01 05600 RADI OI SOTOPE 56.00 0 56.00 0 56.01 05601 ONCOLOGY 4,066 4,066 6, 455 56.01 05700 CT SCAN 2, 228 9, 740 57.00 2.228 0 0 0 0 0 0 0 0 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 4, 097 58.00 1, 385 1, 385 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 0 60.00 06000 LABORATORY 2, 142 2, 142 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 63.00 0 06400 I NTRAVENOUS THERAPY 64.00 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 443 10, 176 443 65.00 66.00 06600 PHYSI CAL THERAPY 9, 435 9, 435 25, 104 66.00 06700 OCCUPATIONAL THERAPY 67.00 77 138 67.00 77 06800 SPEECH PATHOLOGY 68.00 1.587 1.587 4, 097 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 145 3, 145 0 0 0 3, 939 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 o 07400 RENAL DIALYSIS 0 0 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 15, 226 43, 454 15, 226 0 39, 884 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 0 0 99.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 118.00 137, 538 188, 571 135, 141 9, 251 322, 134 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 191. 00 19100 RESEARCH 0 0 191.00 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 24,894 C 24, 894 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 COMMUNITY EDUCATION 0 0 32 194. 00 0 194. 01 07951 MARKETI NG 0 0 0 194 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 4, 315, 179 153, 921 871, 274 188, 654 1, 085, 832 202. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 26. 566065 0.816250 5.444272 20. 392822 3. 370412 203. 00 Cost to be allocated (per Wkst. B, 324, 849 204. 00 204.00 1, 179, 734 5, 505 134, 710 49, 367 Part II)

7. 262941

0.029193

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11)

Unit cost multiplier (Wkst. B, Part

205.00

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Control Cont	COST AL	LUCATION - STATISTICAL BASIS		Provider CC	F	rom 07/01/2016	Date/Time Pre	pared:
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118.00 SUBTOTALS (SUM OF LINES 1-117) 11,014 2,605,612 1,506,484 162,578,840 3,700 180.00 190.00 190.00 191.00 191.00 RESEARCH 0 0 0 0 0 0 0 0 0 0 0 191.00 192.00 192.00 192.00 192.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00			0	0	(0	0	99. 00
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	205. 00	1	8. 289541	0. 021427	0. 102103	0. 000333	4. 285676	205. 00
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Health Financial Systems	ST. VINCENT FISHERS HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0181	Peri od: Worksheet C

From 07/01/2016 To 06/30/2017 Part I Date/Time Prepared: 11/20/2017 2:33 pm Title XVIII Hospi tal PPS Costs Therapy Limit Cost Center Description Total Cost Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 6, 141, 697 6, 141, 697 6, 141, 697 03100 INTENSIVE CARE UNIT 0 31.00 03200 CORONARY CARE UNIT 0 0 0 32.00 O 32.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 34.00 0 43.00 04300 NURSERY 886, 523 886, 523 886, 523 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 5, 910, 044 5, 910, 044 5, 910, 044 50.00 05100 RECOVERY ROOM 0 51 00 Λ 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 4, 702, 706 4, 702, 706 4, 702, 706 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 593, 945 2, 593, 945 2, 593, 945 54.00 54.00 54.01 03630 ULTRA SOUND 382, 599 382, 599 382, 599 54.01 56.00 05600 RADI OI SOTOPE 0 56.00 05601 ONCOLOGY 56.01 714, 108 714, 108 0 714, 108 56.01 05700 CT SCAN 57 00 866 215 866 215 866, 215 57 00 |05800|MAGNETIC RESONANCE IMAGING (MRI) 58.00 446, 532 446, 532 446, 532 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 C 0 60.00 06000 LABORATORY 1, 614, 113 1, 614, 113 1, 614, 113 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 0 0 0 62 00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 685, 742 685, 742 65 00 06500 RESPIRATORY THERAPY 685.742 65 00 66.00 06600 PHYSI CAL THERAPY 2, 241, 546 2, 241, 546 2, 241, 546 66.00 67.00 06700 OCCUPATIONAL THERAPY 15, 862 15, 862 15, 862 67.00 68.00 06800 SPEECH PATHOLOGY 394, 147 394, 147 0 394, 147 68.00 06900 ELECTROCARDI OLOGY 69 00 511, 042 511, 042 511, 042 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 810, 873 810, 873 810, 873 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 879, 589 879, 589 879, 589 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 688, 055 3, 688, 055 3, 688, 055 73 00 74.00 07400 RENAL DIALYSIS 0 74.00 C 07500 ASC (NON-DISTINCT PART) 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 4, 253, 893 4, 253, 893 4, 253, 893 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 416, 090 1, 416, 090 1, 416, 090 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 99.00 Ol 39, 155, 321 39, 155, 321 39, 155, 321 200. 00 200.00 Subtotal (see instructions) 0 0 201.00 Less Observation Beds 1, 416, 090 1, 416, 090 1, 416, 090 201. 00 202.00 Total (see instructions) 37, 739, 231 37, 739, 231 37, 739, 231 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0181 Peri od: Worksheet C From 07/01/2016 Part I Date/Time Prepared: 06/30/2017 11/20/2017 2:33 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 7, 573, 749 7, 573, 749 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 03200 CORONARY CARE UNIT 0 0 32.00 32.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04300 NURSERY 43.00 3, 916, 022 3, 916, 022 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 4, 970, 412 37, 355, 814 42, 326, 226 0 139631 0.000000 50.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 9, 624, 966 319, 870 9, 944, 836 0.472879 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 236, 385 7, 049, 847 7, 286, 232 0.356006 0.000000 54.00 03630 ULTRA SOUND 2, 821, 269 2, 916, 839 0.000000 54.01 95, 570 0.131169 54.01 56.00 05600 RADI OI SOTOPE 0.000000 0.000000 56.00 56. 01 05601 ONCOLOGY 4.550 1, 117, 680 0.638920 0.000000 1, 113, 130 56.01 57.00 05700 CT SCAN 331, 993 5, 027, 492 5, 359, 485 0.161623 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 22,049 2, 601, 173 2, 623, 222 0.170223 0.000000 58 00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 06000 LABORATORY 12, 193, 091 0.000000 60.00 3, 207, 628 8, 985, 463 0.132379 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0.000000 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0.000000 0.000000 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 493, 431 1, 224, 115 1, 717, 546 0.399257 0.000000 65.00 06600 PHYSI CAL THERAPY 159 061 4, 305, 609 4 464 670 0.502063 0 000000 66 00 66 00 06700 OCCUPATIONAL THERAPY 67.00 29, 949 8, 199 38, 148 0.415802 0.000000 67.00 06800 SPEECH PATHOLOGY 9, 386 481, 298 490, 684 0.803260 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 130,079 2, 998, 216 3, 128, 295 0.163361 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 890, 863 2, 569, 914 3, 460, 777 0.234304 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4, 437, 934 1,028,675 3, 409, 259 0.198198 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 2, 537, 678 8.045.005 10, 582, 683 0 348499 0 000000 73 00 07400 RENAL DIALYSIS 74.00 \cap 0.000000 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 75.00 0 OUTPATIENT SERVICE COST CENTERS 91 00 34, 686, 631 0.000000 91 00 09100 EMERGENCY 1, 855, 173 36, 541, 804 0 116412 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 103, 961 0.575900 92.00 354, 956 2, 458, 917 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 99.00

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Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	ST. VINCENT FISHERS	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	F	Provider CCN: 15-0181	From 07/01/2016	
			From 07/01/2016	Part I Date/Time Prepa

Title XVIII Hospital PPS Inpatient Ratio 11.00 Ratio R
NPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 ADULTS & PEDIATRICS 31.00 31.00 31.00 31.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00
11.00 1.00 1.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30.00 ADULTS & PEDI ATRI CS 31.00 31.00 INTENSI VE CARE UNI T 31.00 32.00 03200 CORONARY CARE UNI T 32.00 34.00 03400 SURGI CAL INTENSI VE CARE UNI T 34.00 43.00 NURSERY 43.00 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.139631 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 51.00
30. 00 31. 00 31. 00 31. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 33. 00 34. 00 34. 00 34. 00 34. 00 34. 00 34. 00 34. 00 34. 00 35. 00 36. 00 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30
31. 00 03100 INTENSI VE CARE UNI T 31. 00 32. 00 03200 CORONARY CARE UNI T 32. 00 34. 00 03400 SURGI CAL I INTENSI VE CARE UNI T 34. 00 04300 NURSERY 43. 00 ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 139631 51. 00 05100 RECOVERY ROOM 0. 000000 51. 00 05100 RECOVERY ROOM 0. 000000 51. 00 05100 RECOVERY ROOM 0. 000000 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05
32. 00 03200 CORONARY CARE UNIT 32. 00 34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 34. 00 43. 00 43. 00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0. 139631 50. 00 51. 00 05100 RECOVERY ROOM 0. 0000000 51. 00 05100 RECOVERY ROOM 0. 0000000 51. 00 05100 RECOVERY ROOM 0. 0000000 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 0
34. 00
43. 00 04300 NURSERY
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 0. 139631 50. 00 51. 00
50. 00 05000 OPERATI NG ROOM 0. 139631 50. 00 51. 00 05100 RECOVERY ROOM 0. 000000 51. 00
51. 00 05100 RECOVERY ROOM 0.000000 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 472879 52. 00 53. 00 05300 ANESTHESI OLOGY 0. 000000 53. 00
56. 00 05600 RADI 0I SOTOPE 0. 000000 56. 01 05601 0NCOLOGY 56. 01
57. 00 05700 CT SCAN 0. 161623 57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 170223 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 59. 00
60. 00 06000 LABORATORY 0. 132379 60. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 000000 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63. 00
63. 00 06300 BLOOD STORTING, PROCESSTING & TRAINS. 0. 000000 63. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY
66. 00 06600 PHYSI CAL THERAPY 0. 502063 66. 00
67. 00 06700 0CCUPATI ONAL THERAPY
68. 00 06800 SPEECH PATHOLOGY 0. 803260 68. 00
69. 00 06900 ELECTROCARDI OLOGY
70. 00 07000 ELECTROENCEPHALOGRAPHY
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 234304 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 198198 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 348499 73. 00
74. 00 07400 RENAL DI ALYSI S 0. 000000 74. 00
75. 00 07500 ASC (NON-DI STI NCT PART)
OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY 0. 116412 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 575900 92. 00
OTHER REIMBURSABLE COST CENTERS
99. 00 09900 CMHC 99. 00
200.00 Subtotal (see instructions)
201.00 Less Observation Beds 201.00
202.00 Total (see instructions) 202.00

Health Financial Systems	ST. VINCENT FISHERS HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0181	Peri od: Worksheet C

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC		Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Pre	pared:
					Date/Time Pre 11/20/2017 2:	33 pm
		Ti tl	e XIX	Hospi tal	Cost	
	T	- 1 1 1 1 1	T 1 1 0 1	Costs	T 1 1 0 1	
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	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	6, 141, 697		6, 141, 69	07	6, 141, 697	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0, , 0		0, , 0 .	0 0	0, , 0, ,	31.00
32. 00 03200 CORONARY CARE UNIT	0			0	0	32.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	o			o o	0	34. 00
43. 00 04300 NURSERY	886, 523		886, 52	23 0	886, 523	43.00
ANCILLARY SERVICE COST CENTERS	·				· · · · · · · · · · · · · · · · · · ·	
50. 00 05000 OPERATING ROOM	5, 910, 044		5, 910, 04	4 0	5, 910, 044	50.00
51.00 05100 RECOVERY ROOM	0			0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 702, 706		4, 702, 70	06	4, 702, 706	52. 00
53. 00 05300 ANESTHESI OLOGY	0			0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 593, 945		2, 593, 94	5 0	2, 593, 945	54.00
54. 01 03630 ULTRA SOUND	382, 599		382, 59	9 0	382, 599	54. 01
56. 00 05600 RADI 0I SOTOPE	0			0 0	0	56. 00
56. 01 05601 0NCOLOGY	714, 108		714, 10	0 8	714, 108	56. 01
57.00 05700 CT SCAN	866, 215		866, 21		866, 215	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	446, 532		446, 53	0	446, 532	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
60. 00 06000 LABORATORY	1, 614, 113		1, 614, 11	3 0	1, 614, 113	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0			0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	685, 742	0	685, 74		685, 742	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 241, 546	0	2, 241, 54		2, 241, 546	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	15, 862	0	15, 86		15, 862	67. 00
68. 00 06800 SPEECH PATHOLOGY	394, 147	0	394, 14		394, 147	68. 00
69. 00 06900 ELECTROCARDI OLOGY	511, 042		511, 04		511, 042	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	040.070		040.0	0	0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	810, 873		810, 87		810, 873	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	879, 589		879, 58		879, 589	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	3, 688, 055		3, 688, 05		3, 688, 055 0	73.00
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0			0	0	74. 00 75. 00
OUTPATIENT SERVICE COST CENTERS	U			0 0	0	75.00
91. 00 09100 EMERGENCY	4, 253, 893		4, 253, 89	0	4, 253, 893	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 416, 090		1, 416, 09		1, 416, 090	91.00
OTHER REIMBURSABLE COST CENTERS	1,410,090		1, 410, 09	·U	1, 410, 090	72.00
99. 00 09900 CMHC	0			0	0	99.00
200.00 Subtotal (see instructions)	39, 155, 321	0	39, 155, 32	<u> </u>	39, 155, 321	
201.00 Less Observation Beds	1, 416, 090	0	1, 416, 09		1, 416, 090	
202.00 Total (see instructions)	37, 739, 231	0				
	0.,,0,,201	ı	0.,.0,,20	9	0.,.0.,201	,_ ,_ ,

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0181 Peri od: Worksheet C From 07/01/2016 Part I Date/Time Prepared: 06/30/2017 11/20/2017 2:33 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 7, 573, 749 7, 573, 749 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 03200 CORONARY CARE UNIT 0 0 32.00 32.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04300 NURSERY 43.00 3, 916, 022 3, 916, 022 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 4, 970, 412 37, 355, 814 42, 326, 226 0 139631 0.000000 50.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 9, 624, 966 319, 870 9, 944, 836 0.472879 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 236, 385 7, 049, 847 7, 286, 232 0.356006 0.000000 54.00 03630 ULTRA SOUND 2, 821, 269 0.000000 54.01 95, 570 2, 916, 839 0.131169 54.01 56.00 05600 RADI OI SOTOPE 0.000000 0.000000 56.00 56. 01 05601 ONCOLOGY 4.550 1, 117, 680 0.638920 0.000000 1, 113, 130 56.01 57.00 05700 CT SCAN 331, 993 5, 027, 492 5, 359, 485 0.161623 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 22,049 2, 601, 173 2, 623, 222 0.170223 0.000000 58 00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 06000 LABORATORY 12, 193, 091 0.000000 60.00 3, 207, 628 8, 985, 463 0.132379 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0.000000 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0.000000 0.000000 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 493, 431 1, 224, 115 1, 717, 546 0.399257 0.000000 65.00 06600 PHYSI CAL THERAPY 159 061 4, 305, 609 4 464 670 0.502063 0 000000 66 00 66 00 06700 OCCUPATIONAL THERAPY 67.00 29.949 8, 199 38, 148 0.415802 0.000000 67.00 06800 SPEECH PATHOLOGY 9, 386 481, 298 490, 684 0.803260 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 130,079 2, 998, 216 3, 128, 295 0.163361 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 890, 863 2, 569, 914 3, 460, 777 0.234304 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4, 437, 934 1,028,675 3, 409, 259 0.198198 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 2, 537, 678 8.045.005 10, 582, 683 0 348499 0 000000 73 00 07400 RENAL DIALYSIS 74.00 \cap 0.000000 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 75.00 0 OUTPATIENT SERVICE COST CENTERS 91 00 34, 686, 631 0.000000 91 00 09100 EMERGENCY 1, 855, 173 36, 541, 804 0 116412 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 103, 961 0.575900 92.00 354, 956 2, 458, 917 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 99.00

37, 472, 575

37, 472, 575

125, 106, 265

125, 106, 265

162, 578, 840

162, 578, 840

200. 00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	ST. VINCENT FISHER	RS HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0181	From 07/01/2016	Worksheet C Part I Date/Time Prepared:

			10 06/30/201/	11/20/2017 2:33 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
, , , , , , , , , , , , , , , , , , ,	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30. 0
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34. 0
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0. 000000			50. 00
51.00 05100 RECOVERY ROOM	0. 000000			51. 0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 0
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 0
54. 01 03630 ULTRA SOUND	0. 000000			54. 0
56. 00 05600 RADI 0I SOTOPE	0. 000000			56. 0
56. 01 05601 0NCOLOGY	0. 000000			56. 0
57. 00 05700 CT SCAN	0. 000000			57. 0
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. 0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 0
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 0
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 0
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 0
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 0
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 0
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 0
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1			71. 0
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72. 0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 0
74. 00 07400 RENAL DIALYSIS	0. 000000			74. 0
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 0
OUTPATIENT SERVICE COST CENTERS	0.000000			01.0
91. 00 09100 EMERGENCY	0.000000			91. 0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 000000			92. 0
99. 00 09900 CMHC				99. 0
200.00 Subtotal (see instructions)				200. 0
201.00 Less Observation Beds				200. 0
202.00 Total (see instructions)				201. 0
202.00 TOTAL (SEE THSTINCTIONS)	1 1			J202. U

Heal th	Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPIT	TAL COSTS	Provi der C		Period: From 07/01/2016 Fo 06/30/2017		pared: 33 pm
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capi tal Related Cost (col. 1 - col.		Per Diem (col. 3 / col. 4)	
		26)		2)			
		1.00	2.00	3, 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30.00	ADULTS & PEDI ATRI CS	1, 699, 582	0	1, 699, 582	2 3, 088	550. 38	30.00
31. 00	INTENSIVE CARE UNIT	0			0	0.00	
32.00	CORONARY CARE UNIT	0			0	0.00	32. 00
34.00	SURGICAL INTENSIVE CARE UNIT	0			0	0.00	34. 00
43.00	NURSERY	149, 456		149, 450	1, 324	112. 88	43.00
200.00	Total (lines 30-199)	1, 849, 038		1, 849, 038	4, 412		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						
30.00	ADULTS & PEDIATRICS	571	314, 267				30. 00
31. 00	INTENSIVE CARE UNIT	0	0)			31. 00
32. 00	CORONARY CARE UNIT	0	0	1			32. 00
	SURGICAL INTENSIVE CARE UNIT	0	0	1			34. 00
	NURSERY	0	0				43. 00
200.00	Total (lines 30-199)	571	314, 267	1			200. 00

Health Financial Systems	ST. VINCENT FISHE	RS HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT A	NCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0181	Peri od:	Worksheet D

Health Financial Systems	ST. VINCENT FIS	SHERS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	ITAL COSTS	Provider C		Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Pre 11/20/2017 2:	pared: 33 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		T			Г	
50. 00 05000 OPERATI NG ROOM	1, 202, 150	42, 326, 226			30, 744	
51. 00 05100 RECOVERY ROOM	0	0	0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 047, 187	9, 944, 836			l	
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	557, 155		•		10, 229	
54. 01 03630 ULTRA SOUND	57, 984				•	
56. 00 05600 RADI OI SOTOPE	0	1	0.00000		0	56. 00
56. 01 05601 0NCOLOGY	211, 010				0	56. 01
57. 00 05700 CT SCAN	142, 735					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	82, 967	2, 623, 222			210	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	
60. 00 06000 LABORATORY	153, 595	12, 193, 091	II.		10, 967	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000		0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	57, 450					
66. 00 06600 PHYSI CAL THERAPY	521, 485				11, 033	
67. 00 06700 OCCUPATI ONAL THERAPY	4, 107				0	67. 00
68. 00 06800 SPEECH PATHOLOGY	89, 350					
69. 00 06900 ELECTROCARDI OLOGY	161, 384	3, 128, 295			5, 534	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					3, 757	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	43, 888					
73.00 07300 DRUGS CHARGED TO PATIENTS	235, 435	10, 582, 683			12, 798	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0.0000		0	
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0	0	75. 00
OUTPATIENT SERVICE COST CENTERS	_					
91. 00 09100 EMERGENCY	878, 253					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						
200.00 Total (lines 50-199)	5, 878, 008	151, 089, 069	ol .	4, 605, 180	140, 067	lann nn

Health Financial Systems	ST. VINCENT FIS	HERS HOSPI	TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS				Period: From 07/01/2016 To 06/30/2017	Date/Time Pre 11/20/2017 2:	
				XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Hea Cost		All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00		3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00		0.00		0.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNIT	0		0		0 0	0	30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	0		0		0	0	32.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0		0		0	0	34.00
43. 00 04300 NURSERY	0		o		0	0	43.00
200.00 Total (lines 30-199)	0		0		0	0	200.00
Cost Center Description	Total Patient Days	5 ÷ col.		Inpatient Program Days	Pass-Through Cost (col. 7 x col. 8)		
	6. 00	7. 00		8. 00	9. 00		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY	3, 088 0 0 0 1, 324		0. 00 0. 00 0. 00 0. 00 0. 00	57	0 0 0 0 0 0 0 0		30. 00 31. 00 32. 00 34. 00 43. 00
200.00 Total (lines 30-199)	4, 412		I	57	1 0	ĺ	200. 00

| Peri od: | Worksheet D | Part IV | To | 06/30/2017 | Date/Time Prepared: | THROUGH COSTS

					10 00/30/2017	11/20/2017 2:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician Nu	ursing School	Allied Healt	h All Other	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						
50.00	05000 OPERATI NG ROOM	0	0		0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
54. 01	03630 ULTRA SOUND	0	0		0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
56. 01	05601 ONCOLOGY	0	0		0	0	56. 01
57.00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59. 00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						1
91. 00	09100 EMERGENCY	0	0		0 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92. 00
200.00	Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems	ST. VINCENT FISHER	RS HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0181	Peri od:	Worksheet D
TURQUEU COSTS			From 07/01/2016	Part IV

THROUGH COSTS To 06/30/2017 Date/Time Prepared: 11/20/2017 2:33 pm Title XVIII Hospi tal PPS I npati ent Cost Center Description Total Total Charges Ratio of Cost Outpati ent (from Wkst. C, to Charges Outpati ent Ratio of Cost Program Cost (sum of (col. 5 ÷ col to Charges Part I, col. Charges 7) col. 2, 3 and 8) $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 0.000000 1, 082, 473 50.00 42, 326, 226 0 51.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 9, 944, 836 0.000000 0.000000 52.00 0000000000000000000000000 7,090 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0.000000 54.00 7, 286, 232 133, 772 54.00 54.01 03630 ULTRA SOUND 2, 916, 839 0.000000 0.000000 10, 446 54.01 56.00 05600 RADI OI SOTOPE 0.000000 0.000000 56.00 05601 ONCOLOGY 0.000000 0.000000 56 01 1, 117, 680 0 56 01 5, 359, 485 0.000000 148, 750 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 2, 623, 222 0.000000 0.000000 6, 650 58.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 0.000000 0 59.00 12, 193, 091 870, 591 06000 LABORATORY 0.000000 0.000000 60 00 60 00 |06200|WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 0.000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0.000000 63.00 0 63.00 06400 INTRAVENOUS THERAPY 64 00 0.000000 0.000000 64 00 0 65.00 06500 RESPIRATORY THERAPY 1, 717, 546 0.000000 0.000000 162, 443 65.00 06600 PHYSI CAL THERAPY 4, 464, 670 0.000000 0.000000 94, 459 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 38, 148 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 490, 684 0.000000 0.000000 4,005 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 3, 128, 295 0.000000 0.000000 107, 269 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 460, 777 0.000000 0.000000 325, 051 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 4, 437, 934 0.000000 0.000000 181, 218 72 00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 10, 582, 683 0.000000 0.000000 575, 254 73.00 07400 RENAL DIALYSIS 0 0.000000 0.000000 74.00 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0.000000 0 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 36, 541, 804 0.000000 0.000000 745, 003 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 150, 706 92. 00 2, 458, 917 0.000000 0.000000 200.00 Total (lines 50-199) 151, 089, 069 4, 605, 180 200. 00

Heal th Financial Systems ST. VINCENT FISHERS HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0181 | Period: From 07/01/2016 | Part IV |
Through COSTS | Provider CCN: 15-0181 | To 06/30/2017 | Date/Time Prepared:

11/20/2017 2:33 pm Title XVIII Hospi tal PPS I npati ent Outpati ent Outpati ent Cost Center Description Program Program Program Pass-Through Pass-Through Charges Costs (col. Costs (col. x col. 10) x col. 12) 13.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 00 4, 040, 567 0 50.00 51. 00 | 05100 | RECOVERY ROOM 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 00000000000000000000000000 3,045 53. 00 | 05300 | ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 926, 386 54.00 54.01 03630 ULTRA SOUND 428, 414 54.01 56.00 05600 RADI 0I S0T0PE 0 56.00 0 56. 01 05601 ONCOLOGY 379, 510 56.01 0 05700 CT SCAN 57.00 894, 007 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 442, 780 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 06000 LABORATORY 1, 580, 950 0 60 00 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS C 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 06400 INTRAVENOUS THERAPY 0 0 0 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 76, 694 65.00 66.00 06600 PHYSI CAL THERAPY 23, 053 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 06800 SPEECH PATHOLOGY 46, 092 68 00 0 68 00 69.00 06900 ELECTROCARDI OLOGY 712, 816 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 453, 752 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 204, 479 72.00 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 515, 159 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 3, 991, 958 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 684, 342 92.00

0

16, 404, 004

0

200.00

200.00

Total (lines 50-199)

Health Financial Systems	ST. VINCENT FISHE	RS HOSPITAL	In Lie	u of Form CMS-2552-10
ADDODTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Drovi don CCN: 15 0191	Pori od:	Workshoot D

Health Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider Co		Period: From 07/01/2016 To 06/30/2017		pared:
		Title	: XVIII	Hospi tal	PPS	00 piii
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.			
	1.00	2.00	(see inst.)	(see inst.)	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3. 00	4. 00	5.00	
50. 00 05000 OPERATING ROOM	0. 139631	4, 040, 567	I	0 0	564, 188	50.00
51. 00 05100 RECOVERY ROOM	0. 000000			0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 472879			0 0	1, 440	52.00
53. 00 05300 ANESTHESI OLOGY	0. 472877			0 0	0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 356006			0 0	329, 799	54.00
54. 01 03630 ULTRA SOUND	0. 131169			0 0	56, 195	54. 01
56. 00 05600 RADI OI SOTOPE	0. 000000			0 0	0 0	56.00
56. 01 05601 0NCOLOGY	0. 638920			0 0	242, 477	56. 01
57. 00 05700 CT SCAN	0. 161623			o o	144, 492	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 170223			0 0	75, 371	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000		1	0 0	0	59. 00
60. 00 06000 LABORATORY	0. 132379	1, 580, 950		0 0	209, 285	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 399257	76, 694		0 0	30, 621	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 502063			0	11, 574	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 415802		1	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 803260		•	0	37, 024	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 163361	712, 816	1	0	116, 446	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	l e	1	0	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 234304			2 0	106, 316	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 198198		•	0	40, 527	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 348499		1	0 4, 090		
74. 00 07400 RENAL DIALYSIS	0. 000000			0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY	0. 116412	3, 991, 958	I	0 130	464, 712	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 110412			0 0	394, 113	
200.00 Subtotal (see instructions)	0. 373900	16, 404, 004		9		
201.00 Less PBP Clinic Lab. Services-Program		10, 404, 004		0 4,220		201.00
Only Charges				5		201.00
202.00 Net Charges (line 200 +/- line 201)		16, 404, 004	15	2 4, 220	3, 352, 611	202. 00

Health Financial Systems	ST. VINCENT FISHER	ST. VINCENT FISHERS HOSPITAL			
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0181	Peri od: From 07/01/2016	Worksheet D Part V	

06/30/2017 Date/Time Prepared: To 11/20/2017 2:33 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 0 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54. 01 03630 ULTRA SOUND 54.01 0 05600 RADI OI SOTOPE 56.00 56.00 56. 01 05601 ONCOLOGY 0 56.01 05700 CT SCAN 0 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58 00 58 00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 60.00 06000 LABORATORY 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 Ol 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 425 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 0 91.00 09100 EMERGENCY 15 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 200.00 Subtotal (see instructions) 36 1,440 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 Only Charges 202.00 Net Charges (line 200 +/- line 201) 36 202. 00 1,440

Health Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS		CCN: 15-0181	Peri od: From 07/01/2016 To 06/30/2017	Date/Time Pre 11/20/2017 2:	
			le XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Co		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	(0 0	0	
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	0)		0	0	0 00
34. 00 03200 CORONARY CARE UNIT	0)		0	0	
43. 00 04300 NURSERY	0)		0	0	
200.00 Total (lines 30-199)	0			0		200. 00
Cost Center Description	Total Patient	Per Diem (col	Inpati ent	Inpatient		200.00
oost denter bescription	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 088		-	40 0		30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0.00	-	0 0		31. 00
32. 00 03200 CORONARY CARE UNIT	0	0.00	1	0		32. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0.00	- 1	0		34. 00
43. 00 04300 NURSERY	1, 324			40 0		43. 00
200.00 Total (lines 30-199)	4, 412		1	30 0		200. 00

Health Financial Systems	ST. VINCENT FISHE	RS HOSPITAL	In L	ieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCLITARY SERVICE OTHER PASS	Provider CCN: 15-0181	Peri od:	Worksheet D

From 07/01/2016 | Part IV
To 06/30/2017 | Date/Time Prepared: THROUGH COSTS 11/20/2017 2:33 pm Title XIX Hospi tal Cost Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost Anestheti st Medi cal (sum of col 1 Cost Education Cost through col. 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 0 0 05100 RECOVERY ROOM 51.00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 0 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 03630 ULTRA SOUND 0 54.01 0 54.01 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 56. 01 05601 ONCOLOGY 0 56.01 0 57.00 57.00 05700 CT SCAN 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 60.00 06000 LABORATORY 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 INTRAVENOUS THERAPY 0 64.00 64.00 0 06500 RESPIRATORY THERAPY 0 65.00 65 00 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 0 0 69.00 69 00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 71.00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 Ω 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 74.00 07500 ASC (NON-DISTINCT PART)
OUTPATIENT SERVICE COST CENTERS 0 75.00 0 75.00 91.00 91.00 09100 EMERGENCY 0 0 0

0

0 92.00 0 200.00

0

0

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50-199)

200.00

Health Financial Systems	ST. VINCENT FISHER	RS HOSPITAL	In Lie	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0181	Peri od:	Worksheet D
THROUGH COSTS			From 07/01/2016	Part IV

THROUGH COSTS To 06/30/2017 Date/Time Prepared: 11/20/2017 2:33 pm Title XIX Hospi tal Cost I npati ent Cost Center Description Total Total Charges Ratio of Cost Outpati ent (from Wkst. C, to Charges Program Outpati ent Ratio of Cost Cost (sum of (col. 5 ÷ col to Charges Part I, col. Charges 7) col. 2, 3 and 8) $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 0.000000 50.00 42, 326, 226 246, 087 0 51.00 05100 RECOVERY ROOM 0.000000 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 9, 944, 836 0.000000 0.000000 52.00 000000000000 2, 317, 639 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 0 13, 019 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0.000000 54.00 7, 286, 232 54.00 54.01 03630 ULTRA SOUND 2, 916, 839 0.000000 0.000000 9, 321 54.01 56.00 05600 RADI OI SOTOPE 0.000000 0.000000 56.00 05601 ONCOLOGY 0.000000 56 01 1, 117, 680 0.000000 0 56 01 5, 359, 485 57.00 05700 CT SCAN 0.000000 0.000000 17, 574 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 2, 623, 222 0.000000 0.000000 2,068 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 0 59.00 12, 193, 091 06000 LABORATORY 0.000000 371, 666 60 00 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0.000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 00000000000 0.000000 0.000000 63.00 0 63.00 06400 INTRAVENOUS THERAPY 64 00 0.000000 0.000000 64 00 0 65.00 06500 RESPIRATORY THERAPY 1, 717, 546 0.000000 0.000000 51, 789 65.00 06600 PHYSI CAL THERAPY 4, 464, 670 0.000000 0.000000 11, 085 66.00 66.00 06700 OCCUPATIONAL THERAPY 1, 900 67.00 38, 148 0.000000 0.000000 67.00 490, 684 940 06800 SPEECH PATHOLOGY 0.000000 0.000000 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 3, 128, 295 0.000000 0.000000 6,582 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 460, 777 0.000000 0.000000 106, 798 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 4, 437, 934 0.000000 0.000000 72 00 16, 521 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 10, 582, 683 0.000000 0.000000 280, 979 73.00 07400 RENAL DIALYSIS 0 0.000000 0.000000 74.00 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0.000000 0 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 36, 541, 804 0.000000 0.000000 154, 621 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 2, 458, 917 0.000000 0.000000 0 92.00 3, 608, 589 200. 00 200.00 Total (lines 50-199) 151, 089, 069

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0181 From 07/01/2016 Part IV

TO 06/30/2017 Date/Time Prepared:

111100011 00010				То	06/30/2017	Date/Time Pr 11/20/2017 2	
		Ti t	le XIX		Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent				
	Program	Program	Program				
	Pass-Through	Charges	Pass-Throug	h			
	Costs (col. 8		Costs (col.				
	x col. 10)		x col. 12)				
	11. 00	12.00	13.00				
ANCI LLARY SERVI CE COST CENTERS	1		1				
50.00 05000 OPERATING ROOM	0	(0			50.00
51.00 05100 RECOVERY ROOM	0	(0			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	(0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(0			54. 00
54.01 03630 ULTRA SOUND	0	(0			54. 01
56. 00 05600 RADI 0I SOTOPE	0	(0			56. 00
56. 01 05601 0NCOLOGY	0	(0			56. 01
57. 00 05700 CT SCAN	0	(0			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (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
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(0			63. 00
64.00 06400 I NTRAVENOUS THERAPY	0	(0			64. 00
65. 00 06500 RESPIRATORY THERAPY	0	(0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	(0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	(0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	(0			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	(0			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	(0			73. 00
74.00 07400 RENAL DIALYSIS	0	(0			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	(0			75. 00
OUTPATIENT SERVICE COST CENTERS							
91. 00 09100 EMERGENCY	0	(이	0			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(이	0			92. 00
200.00 Total (lines 50-199)	0	(0			200. 00

Health Financial Systems	ST. VINCENT FISHER	RS HOSPITAL	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF MEDICAL	OTHER HEALTH CERVICES AND MASSINE COST	D: -I CON 1E 0101	D =! = -I	Wasaliaka a B

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0181 From 07/01/2016 To 06/30/2017 Part V Date/Time Prepared: 11/20/2017 2:33 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services 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. 139631 5, 034, 878 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 472879 0 54, 593 52 00 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.356006 708, 576 0 54.00 54.01 03630 ULTRA SOUND 0.131169 0 401, 548 0 54 01 05600 RADI OI SOTOPE 56.00 0.000000 0 56.00 56.01 05601 ONCOLOGY 0.638920 61, 190 0 56.01 57.00 05700 CT SCAN 0. 161623 549, 320 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 0 170223 283, 082 58 00 0 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 06000 LABORATORY 0. 132379 1, 384, 404 0 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.000000 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 64.00 06500 RESPIRATORY THERAPY 0. 399257 159, 031 65.00 65.00 06600 PHYSI CAL THERAPY 0.502063 0 887, 599 66.00 0 66, 00 06700 OCCUPATIONAL THERAPY 67.00 0.415802 0 730 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.803260 140, 807 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0.163361 356, 049 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 809, 643 71.00 0. 234304 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 198198 0 125, 250 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.348499 895, 967 73.00 07400 RENAL DIALYSIS 0 74.00 0.000000 0 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0. 116412 0 6, 713, 906 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 0.575900 0 294, 253 Λl 200.00 Subtotal (see instructions) 18, 860, 826 0 200. 00 o 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 0 202.00 18, 860, 826

Health Financial Systems	ST. VINCENT FISHER	S HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0181	Peri od:	Worksheet D

From 07/01/2016 | Part V To 06/30/2017 | Date/Time Prepared: 11/20/2017 2:33 pm Titl<u>e XIX</u> Hospi tal Cost Costs Cost Center Description Cost Cost Reimbursed 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 703, 025 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 25 816 52 00 0 53.00 05300 ANESTHESI OLOGY 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 252, 257 54.00 54. 01 03630 ULTRA SOUND 52, 671 0 54.01 05600 RADI OI SOTOPE 0 56.00 56.00 56. 01 05601 ONCOLOGY 39, 096 0 56.01 05700 CT SCAN 0 57.00 88, 783 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 58 00 48.187 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 60.00 06000 LABORATORY 183, 266 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 63, 494 65.00 66.00 06600 PHYSI CAL THERAPY 445, 631 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 304 67.00 68.00 06800 SPEECH PATHOLOGY 113, 105 68.00 06900 ELECTROCARDI OLOGY 69.00 58, 165 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 189, 703 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 24,824 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 312, 244 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 0 91.00 09100 EMERGENCY 781, 579 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 169, 460 92.00 0 200.00 Subtotal (see instructions) 3, 551, 610 0 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 Only Charges 202.00 Net Charges (line 200 +/- line 201) 3, 551, 610 202. 00 0

Health Financial Systems	ST. VINCENT FISHER	RS HOSPITAL	In Lie	u of Form CMS-2552	2-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0181	Peri od: From 07/01/2016	Worksheet D-1	
				Date/Time Prepare 11/20/2017 2:33 p	
		Title XVIII	Hospi tal	PPS	

		Title XVIII	Hospi tal	11/20/2017 2: PPS	33 pm
	Cost Center Description	II tie XVIII	nospi tai	FF3	
	DART I ALL PROVIDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		3, 088	1. 00
2.00	Inpatient days (including private room days, excluding swing-	ped and newborn days)		3, 088	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		2, 376	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	r 31 of the cost	2, 3, 0	5. 00	
	reporting period	3 .			
6.00	Total swing-bed SNF type inpatient days (including private room	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	" days) thi dagii becember	31 01 the cost		7.00
8.00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	- +b - D (ldi		F74	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	571	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
.2.00	through December 31 of the cost reporting period	t sin y (this during privat	o room dayo)		12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	din (excidening swring bed	uays)	Ö	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions		ing popied (line	6, 141, 697	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	er 31 of the cost report	ing period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
04.00	x line 18)	04 6 11			04.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	1 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
0, 00	x line 20)				
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 6, 141, 697	26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(Title 21 milles Title 20)		0, 141, 077	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	Line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir		tions)	0. 00 0. 00	34.00
35. 00 36. 00	, , , , , , , , , , , , , , , , , , ,				35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 6, 141, 697	37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 988. 89	38. 00
39. 00	Program general inpatient routine service cost per dreim (see	•		1, 135, 656	39. 00
40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 135, 656	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	ST. VINCENT FISHE	Provider CCN:		eri od:	worksheet D-1	
					rom 07/01/2016 o 06/30/2017		
			Title XV		Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costlr		verage Per m (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	0	0	0. 00	0	0	42.
3. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	S 0	0	0.00	0	0	43.
1. 00	CORONARY CARE UNIT	0	o	0.00			
5. 00	BURN INTENSIVE CARE UNIT		٩	0.00			45.
. 00	SURGICAL INTENSIVE CARE UNIT	0	O	0. 00	0	0	
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1. 00	
. 00	Program inpatient ancillary service cost (V	Vkst. D-3, col. 3,	line 200)			963, 009	48
. 00	Total Program inpatient costs (sum of lines					2, 098, 665	49
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program in	npatient routine se	ervices (from Wk	st. D, sum	of Parts I and	314, 267	50
. 00	<pre>III) Pass through costs applicable to Program ir</pre>	npatient ancillary	services (from	Wkst D su	m of Parts II	140, 067	51
	and IV)	patront anortrally	00. 1. 000 (0		01 14110 11	1.0,007	"
. 00	Total Program excludable cost (sum of lines					454, 334	
. 00	Total Program inpatient operating cost excl		ited, non-physic	ian anesthe	tist, and	1, 644, 331	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
00	Program di scharges					0	54
00	Target amount per discharge					0.00	55
	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient opera	nting cost and targ	get amount (line	56 minus I	ine 53)	0	
00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	cenorting period er	nding 1006 unda	ted and com	nounded by the	0.00	
00	market basket	eportring perrod er	idi iig 1770, upda	ted and com	pounded by the	0.00	3,
00	Lesser of lines 53/54 or 55 from prior year					0.00	60
. 00	If line 53/54 is less than the lower of lin					0	61
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		(lines 54 x 60)	, or 1% of	the target		
. 00	Relief payment (see instructions)	: IIIStructions)				0	62
	Allowable Inpatient cost plus incentive pay	ment (see instruct	i ons)			Ō	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine co	sts through Decemb	er 31 of the co	st reportin	g period (See	0	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after December	31 of the cost	reporting	period (See	0	65
00	instructions) (title XVIII only)	Joes area December	or or the cost	reporting	perrou (occ	Ĭ	"
00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 64	l plus line 65)(title XVIII	only). For	0	66
00	CAH (see instructions))				, ,
. 00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through t	recember 31 of t	ne cost rep	orting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after Dec	cember 31 of the	cost repor	ting period	0	68
	(line 13 x line 20)						
00	Total title V or XIX swing-bed NF inpatient					0	69
00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci						70
00	Adjusted general inpatient routine service			(71
00	Program routine service cost (line 9 x line	2 71)					72
00	Medically necessary private room cost appli			35)			73
00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient	•	,	choot P Da	rt II column		74
00	26, line 45)	. Toutine service (JOSES (TI OIII WOLK	зпеет в, га	rt II, Corumii		'`
00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76
00	Program capital -related costs (line 9 x lin	,					77
00	Inpatient routine service cost (line 74 mir Aggregate charges to beneficiaries for exce	,	wider records)				78
00	Total Program routine service costs for con			ine 78 minu	s line 79)		80
	Inpatient routine service cost per diem lin				/		81
00	Inpatient routine service cost limitation ((line 9 x line 81)					82
00	Reasonable inpatient routine service costs						83
. 00	Program inpatient ancillary services (see i Utilization review - physician compensation		:)				84
. 00	Total Program inpatient operating costs (su	•	•				86
	PART IV - COMPUTATION OF OBSERVATION BED PA]
						740	1 0-
. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per	•				712 1, 988. 89	

Health Financial Systems	ST. VINCENT FIS	HERS 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 2:	
		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	1, 699, 582	6, 141, 697	0. 27672	1, 416, 090	391, 872	90.00
91.00 Nursing School cost	0	6, 141, 697	0.00000	0 1, 416, 090	0	91.00
92.00 Allied health cost	0	6, 141, 697	0.00000	0 1, 416, 090	0	92.00
93.00 All other Medical Education	0	6, 141, 697	0. 00000	1, 416, 090	0	93. 00

Health Financial Systems	ST. VINCENT FISHE	RS HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0181	Peri od: From 07/01/2016	Worksheet D-1	
				Date/Time Pre	
				11/20/2017 2:	33 pm
		Title XIX	Hospi tal	Cost	

1. On Impart ent days (including pri vate room days, excluding saing-bed and newborn days) 2. On Private room days (excluding saing-bed and observation bed days). If you have only private room days, so all on or complete this line. 2. Seel-private room days (excluding saing-bed and observation bed days). If you have only private room days, so all on or complete this line. 3. Seel-private room days (excluding saing-bed and observation bed days). If you have only private room days. 4. On or complete this line. 3. Seel-private room days (excluding saing-bed and observation bed days). 5. On or complete this line. 5. On or complete this line. 5. On or complete this line is saing-bed saing-bed saing-bed saing-bed saing-bed saing-bed says (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 5. On or complete the private inpatient days (including private room days) after December 31 of the cost reporting period the private room days and private room days and private room days and private room days are room days. 5. On or complete the days including private room days applicable to the Program (excluding saing-bed and newborn days). 5. On or complete the days including private room days applicable to the Program (excluding private room days). 5. On or complete the days applicable to the Program (excluding private room days). 5. On or complete the days applicable to the Program (excluding private room days). 5. On or complete the days applicable to the Program (excluding private room days). 5. On or complete the days applicable to the Program (excluding private room days). 5. On or complete the days applicable to the Program (excluding private room days). 5. On or complete the days applicable to the Program (excluding private room days). 5. On or complete the days applicable to the Program (excluding private room days). 5. On or complete the days applicable to the Program (excluding private room days). 5. On or complete the days applicable to the Program (e				10 00/00/201/	11/20/2017 2:	33 pm
PART I - ALL PROVIDER COMPONENTS 100		Cook Cooker Doorwinking	Title XIX	Hospi tal	Cost	
NAME		Cost Center Description			1 00	
MATERIT EAVS		PART I - ALL PROVIDER COMPONENTS			1.00	
1		I NPATI ENT DAYS				1
2. 3.00 private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4. 00 Somi-private room days (excluding swing-bed and observation bed days) through December 31 of the cost	1.00				3, 088	1.00
do not complete this I line. Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ine) 7.00 7.00 7.00 8.00 1.01 8.00 1.01 8.00 1.02 8.00 1.03 8.00 1.04 8.00 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.0	2.00		3 /		3, 088	2. 00
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	39. 00	, , , , , , , , , , , , , , , , , , , ,	•		79, 556	39. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 79,556 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41. 00	Iotal Program general inpatient routine service cost (line 39	+ line 40)		79, 556	41. 00

Heal th	Financial Systems	ST. VINCENT FISH	ERS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0181	Peri od: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Pre 11/20/2017 2:	pared:
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	2000 20000 20000 4 0000	Inpatient Cost				(col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1. 00 886, 523	2. 00 1, 324	3.00	4. 00 58 40	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	000, 323	1, 324	007.	30 40	20, 703	1 42.00
43.00	INTENSIVE CARE UNIT	0	0				
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0.	00 0	0	44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.	00 0	0	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description					1.00	47. 00
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ine)		1, 361, 655 1, 467, 994	1
	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,	m of Parts I and	0	1
50.00	Pass through costs applicable to Program inp.		•				
51.00	Pass through costs applicable to Program inp. and IV)	,	services (fr	om wkst. D,	Sum OF PARTS II	0	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu- medical education costs (line 49 minus line	ding capital rel	ated, non-phy	sician anest	hetist, and	0	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55.00	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re market basket	porting period e	endi ng 1996, u	pdated and c	ompounded by the	0.00	
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line					0.00	1
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
62.00	Relief payment (see instructions)	,	stions)			0	
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST					_	
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	Ü		•		0	
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)			·		0	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	64 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 o	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	ity/ICF/IID rout	ine service c	ost (line 37)		70. 00 71. 00
72.00	Program routine service cost (line 9 x line		ne 70 ÷ 11ne	2)			72.00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26. line 45)				Part II, column		74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from pr					79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation	(line 78 mi	nus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per dreim frim						82.00
83.00	Reasonable inpatient routine service costs (s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation	,	ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					712	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 988. 89	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 416, 090	89. 00

Health Financial Systems	ST. VINCENT FIS	HERS 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 Pre 11/20/2017 2:	pared: 33 pm_
		Titl	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	1, 699, 582	6, 141, 697	0. 27672	8 1, 416, 090	391, 872	90. 00
91.00 Nursing School cost	0	6, 141, 697	0.00000	0 1, 416, 090	0	91. 00
92.00 Allied health cost	0	6, 141, 697	0.00000	0 1, 416, 090	0	92.00
93.00 All other Medical Education	0	6, 141, 697	0. 00000	1, 416, 090	0	93. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 07/01/2016 To 06/30/2017	Date/Time Prepared:	
			10 00/30/2017	11/20/2017 2:	
	Ti tl e	xVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INDATI ENT. DOUTING CERVI OF COCT. CENTERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	1 420 000		1
10.00 03000 ADULTS & PEDIATRICS 11.00 03100 INTENSIVE CARE UNIT			1, 439, 080		30.0
12. 00 03100 INTENSIVE CARE UNIT			0		31. 0 32. 0
14.00 03400 SURGICAL INTENSIVE CARE UNIT			0		34. (
14. 00 03400 SURGI CAL TIVIENSI VE CARE UNIT			0		43. (
ANCI LLARY SERVI CE COST CENTERS					43. (
io. 00 05000 OPERATING ROOM		0. 13963	1, 082, 473	151, 147	50. (
1. 00 05100 RECOVERY ROOM		0. 00000		0	51. (
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 47287		3, 353	
33. 00 05300 ANESTHESI OLOGY		0. 00000		0	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 35600		47, 624	1
4. 01 03630 ULTRA SOUND		0. 13116		1, 370	
66. 00 05600 RADI OI SOTOPE		0.00000	0 0	0	56.0
66. 01 05601 0NCOLOGY		0. 63892	0 0	0	56. (
77. 00 05700 CT SCAN		0. 16162	3 148, 750	24, 041	57. (
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 17022		1, 132	58. (
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	0	0	59. (
0. 00 06000 LABORATORY		0. 13237		115, 248	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	62. (
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		0	63.0
4. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64. (
5. 00 06500 RESPI RATORY THERAPY		0. 39925		64, 857	
66. 00 06600 PHYSI CAL THERAPY		0. 50206		47, 424	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 41580		0	
98. 00 06800 SPEECH PATHOLOGY		0. 80326		3, 217	68. (
99. 00 06900 ELECTROCARDI OLOGY		0. 16336		17, 524	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		7/ 1/1	70. (
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23430		76, 161	
12.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 19819		35, 917	72. (
		0. 34849 0. 00000		200, 475 0	
4.00 07400 RENAL DIALYSIS '5.00 07500 ASC (NON-DISTINCT PART)		0.00000		0	74. 0 75. 0
OUTPATIENT SERVICE COST CENTERS		0.00000	<u>U</u>	0	1 /5.0
11. 00 09100 FMFRGENCY		0. 11641	2 745, 003	86. 727	١

0. 116412

0. 575900

745, 003 150, 706

4, 605, 180

4, 605, 180

86, 727

86, 792

963, 009 200. 00

91.00

92.00

201. 00 202. 00

91.00

200.00

201.00

202.00

09100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

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

Health Financial Systems CT WINCENT FIGURE	THE MACHITAL	lo li c	ou of Form CMC (DEE2 10
Health Financial Systems ST. VINCENT FISH INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0181	Peri od: From 07/01/2016 To 06/30/2017	w of Form CMS-2552-10 Worksheet D-3 Date/Time Prepared: 11/20/2017 2:33 pm	
	Title XIX	Hospi tal	Cost	оо р
Cost Center Description	Ratio of Cos		Inpatient	
	To Charges	Program Charges	Program Costs (col. 1 x col.	
			2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		547, 467		30. 00
31.00 03100 INTENSIVE CARE UNIT		0		31. 00
32. 00 03200 CORONARY CARE UNIT		0		32. 00
34.00 O3400 SURGICAL INTENSIVE CARE UNIT		0		34. 00
43. 00 04300 NURSERY		217, 550		43. 00
ANCILLARY SERVICE COST CENTERS			T	
50.00 05000 OPERATING ROOM	0. 1396			
51. 00 05100 RECOVERY ROOM	0.0000		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 4728			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 0000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 3560			
54. 01 03630 ULTRA SOUND	0. 1311			
56. 00 05600 RADI OI SOTOPE	0.0000		0	56. 00
56. 01 05601 0NCOLOGY	0. 6389		0	56. 01
57. 00 05700 CT SCAN	0. 1616			
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	0. 1702			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.0000		0	59.00
60. 00 06000 LABORATORY	0. 1323			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.0000		0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.0000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0.0000		0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 3992			65. 00
66. 00 06600 PHYSI CAL THERAPY	0.5020			
67. 00 06700 OCCUPATI ONAL THERAPY	0. 4158			
68. 00 06800 SPEECH PATHOLOGY	0.8032			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 1633			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.0000			

106, 798

16, 521

280, 979

154, 621

3, 608, 589

3, 608, 589

25, 023

3, 274

97, 921

18, 000

0 75.00

1, 361, 655 200. 00

71.00

72.00

73.00

0 74.00

91.00

0 92.00

201. 00

202. 00

0. 234304

0.198198

0.348499

0.000000

0.000000

0. 116412

0. 575900

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

72.00 07200 IMPL. DEV. CHARGED TO PATIENTS

07500 ASC (NON-DISTINCT PART)

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

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

73. 00 07300 DRUGS CHARGED TO PATIENTS

07400 RENAL DIALYSIS

09100 EMERGENCY

74.00

75.00

91.00

200.00

201.00

202.00

Health Financial Systems	ST. VINCENT FISHERS HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 1	15-0181

Biger A				To 06/30/2017	Date/Time Prep 11/20/2017 2:	
PART A - INPATENT HOSPITAL SERVICES WINDER IPPS			Title XVIII	Hospi tal		
PART A - INPATENT HOSPITAL SERVICES WINDER IPPS						
1.00 BRC Amounts other than outlier Payments 0 1.00		DADT A LANDATI ENT HOCOLITAL CEDIM OFC HADED LDDC			1. 00	
1.00 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 347,509 1.01 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 1.45,848 1.02 DRG amounts other than outlier payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for federal specific operating payment for Model 4 BPCI (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI (see instructions) 0.00 2.01 DRG for federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model 4 BPCI (see instructions) 0.00 0.00 DRG federal specific operating payment for Model	1 00				0	1 00
1.15 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05 1.05		DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (see		•
1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03	1. 02	DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (see	1, 145, 848	1. 02
1.04 October 1 (see instructions) 1.04 October 1 (see instructions) 1.05 October 1 (see instructions) 1.2 33 2.00 October 1 (see instructions) 1.2 33 2.00 October 1 (see instructions) 1.2 33 2.00 October 1 3.00 October 1 3.00 October 1 3.00 October 2	1. 03	DRG for federal specific operating payment for Model 4 BPCI fo	0	1. 03		
2.00 Outlier payments for discharges. (see instructions) 12,33 2.00 2.01 Outlier reconciliation amount 0 2.01 2.00 Outlier payment for discharges for Model 4 BPCI (see instructions) 0 2.02 3.00 Managed Cares Similated Payments 4.05 3.00 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 4.00 5.00 Total Cares (Model as Education Ag Justiment) 6.00 6.00 Flectmut for all legathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(i)(8)(2) 0.00 7.00 8.01 Adjustment (increase or decrease) to the FE count for all lapathic and osteopathic programs for the cost report straddle SJUly 1, 2011 the see instructions. 0.00 8.00 8.02 The amount of increase if the hospital was awarded FE cap slots under section 5503 of the ACA. If the cost report straddle SJUly 1, 2011, see instructions. 0.00 0.00 8.01 9.00 Sum of I lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 0.00	1. 04	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	on or after	0	1. 04
2. 02 0utilier payment for discharges for Model 4 BPCI (see instructions) 0 2. 02 4. 00 Bed days available divided by number of days in the cost reporting period (see instructions) 4. 05 5. 00 Fee Count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 0. 00 5. 00 6. 00 FEE count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap or before 12/31/1996 (see instructions) 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 7. 00 0. 00 0. 00 7. 00 0. 00 7. 00 0. 00 7. 00 0. 00 7. 00 0. 00 0. 00 7. 00 0. 00 7. 00 0. 00 0. 00 7. 00 0. 00 7. 00 0. 00 7. 00 0. 00 7. 00 0. 00 7. 00 0. 00 7. 00 0. 00 7. 00 0. 00 0		Outlier payments for discharges. (see instructions)				1
Managed Car's Simulated Payments					- 1	
Bed days available divided by number of days in the cost reporting period (see instructions) 44.05 4.00		, ,	ons)			1
Indirect Medical Education Adjustment		, ,	rting period (see instru	ctions)	- 1	1
FIE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/66 (see instructions) FIE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for mere programs in accordance with 42 CFR 413.79(c) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR 5412.105(f)(1)(iv)(B)(1) MMA Section 503 reduction amount to the IME cap as specified under 42 CFR 5412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FIE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). But memount of increases if the hospital was awarded FIE cap slots under section 5503 of the ACA. If the amount of increase if the hospital was awarded FIE cap slots under section 5503 of the ACA. If the amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital under section 5506 of ACA (see instructions). But the amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital under section 5506 of ACA (see instructions). But of Ilines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 1)	00		tring period (eee riietra	1	111 00	
FIE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	5.00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5. 00
7.00	6.00	FTE count for allopathic and osteopathic programs which meet	the criteria for an add-	on to the cap	0. 00	6. 00
ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(T)(1)(iv)(B)(2)	7. 00		under 42 CFR §412.105(f)	(1)(iv)(B)(1)	0.00	7. 00
Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.79(c).2(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		ACA Section 5503 reduction amount to the IME cap as specified	under 42 CFR §412.105(f)			1
1998), and 67 FR 50009 (August 1, 2002).	8.00	Adjustment (increase or decrease) to the FTE count for allopa	thic and osteopathic pro		0. 00	8. 00
8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report stradile suly 1, 2011, see instructions.						
8.02 The amount of increase if the 'nospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9.00 Sum of Iines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.0	8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If				8. 01
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 11.00 12.00 Current year all owable FTE (see instructions) 0.00 12.00 13.00 13.00 13.00 14.00 10.01 14.00 10.01 14.00 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.	8. 02					8. 02
10.00 FTE count for all opathic and osteopathic programs in the current year from your records 1.00 10.00 11.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 13.00 13.00 14.00 15.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15	9. 00	, , ,				9. 00
11. 00 FTE count for residents in dental and podiatric programs. 0. 00 11. 00 12. 00 12. 00 13. 00 10. 10. 10. 10. 10. 10. 10. 10. 10. 10.	10.00		ont year from your recor	de	0.00	10.00
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 10.00 13.00 10.00 10.00 10.00 10.00 13.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00			erit year from your record	us		1
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 ended on or after September 30, 1997, 0.00 14.00 otherwise enter zero. 0.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 17.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 10.00 19.00 10.00 19.00 10.00 19.00 10.00 10.00 19.00 10.00 10.00 10.00 19.00 10.00 10.00 19.00 10.00 10.00 19.00 10.00 19.00 10.00 19.00 10.00 19.00 19.00 10.00 10.00 19.00 19.00 10.00 10.00 19.00 19.00 10.00 10.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00						1
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15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 0.00 18.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	14. 00	,	ar ended on or after Sep	tember 30, 1997,	0. 00	14. 00
16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 IME payment adjustment (see instructions) 0.000000 21.00 22.01 IME payment adjustment - Managed Care (see instructions) 0.000000 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.000000 22.01 23.00 IME payment adjustment Count Over Cap (see instructions) 0.00 23.00 24.01 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 lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.	15.00				0.00	15 00
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19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 20.00 21.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 1ME payment adjustment (see instructions) 0.22.00 1ME payment adjustment (see instructions) 0.22.01 1ME payment adjustment - Managed Care (see instructions) 0.000000 22.01 1ME payment adjustment - Managed Care (see instructions) 0.000 22.01 1ME payment adjustment - Managed Care (see instructions) 0.000 23.00 (f) (1) (iv) (C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 IME payment adjustment factor, (see instructions) 0.000 24.00 25.00 1ME payments adjustment factor, (see instructions) 0.000000 26.00 27.00 1ME payments adjustment factor, (see instructions) 0.000000 27.00 28.00 1ME add-on adjustment amount (see instructions) 0.000000 27.00 28.00 1ME add-on adjustment amount - Managed Care (see instructions) 0.000000 28.00 29.00 0.00000 29.00 0.00000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 29.00 0.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.000000 20.0000000 20.000000 20.000000 20.0000000 20.0000000000		, , , , , , , , , , , , , , , , , , , ,	sui e			1
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22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 10.587 32.00 31.00 Allowable disproportionate share percentage (see instructions) 30.01 Allowable disproportionate share percentage (see instructions) 30.02 IME payment adjustment amount (see instructions) 30.03 Allowable disproportionate share percentage (see instructions) 30.04 Allowable disproportionate share percentage (see instructions) 30.05 Imediate Medical adjustment days (see instructions) 30.06 Allowable disproportionate share percentage (see instructions)						
IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 (f)(1)(iv)(C)		· · · · · · · · · · · · · · · · · · ·			0	22. 00
Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 (f)(1)(iv)(C). 1ME FTE Resident Count Over Cap (see instructions) 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 1ME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Sum of lines 30 and 31	22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
(f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 30.00 Allowable disproportionate share percentage (see instructions)		Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of the MMA			
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.00	23. 00	la a a a a a a a a a	ent cap slots under 42 S	ec. 412.105	0. 00	23. 00
instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 30.00 Allowable disproportionate share percentage (see instructions)	24.00				0. 00	24. 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 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 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 Disproportionate Share Adjustment 0 29. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.57 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 14. 30 31. 00 32. 00 Sum of lines 30 and 31 15. 87 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 3. 07 33. 00	25. 00		ower of line 23 or line	24 (see	0. 00	25. 00
28. 00 IME add-on adjustment amount (see instructions) 0 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 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) 0 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1. 57 31. 00 Percentage of Medicaid patient days (see instructions) 14. 30 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 3. 07	26. 00				0. 000000	26. 00
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 30. 00 Allowable disproportionate share percentage (see instructions) 30. 00 Sum of lines 30 and 31 30. 00 Allowable disproportionate share percentage (see instructions) 30. 00 Sum of lines 30 and 31 30. 00 Sum of lines 30 and 31	27.00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00
29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1. 57 31. 00 Percentage of Medicaid patient days (see instructions) 14. 30 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 3. 00	28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 30. 00 29. 01 10. 57 30. 00 11. 57 30. 00 12. 00 31. 00 13. 00 32. 00 14. 30 31. 00 32. 00 33. 00	28. 01	IME add-on adjustment amount - Managed Care (see instructions))		0	28. 01
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Instructions 30.00 Inst	29. 00	Total IME payment (sum of lines 22 and 28)			0	29. 00
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions)	29. 01		1)		0	29. 01
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of Lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 14.30 31.00 15.87 32.00 33.00	30. 00	_ ' ' '	atient days (see instruc	tions)	1. 57	30.00
32.00 Sum of lines 30 and 31 15.87 32.00 33.00 Allowable disproportionate share percentage (see instructions) 3.00 33.00			J (2.2.2	<i>'</i>		1
33.00 Allowable disproportionate share percentage (see instructions) 3.07 33.00						1
34.00 Disproportionate share adjustment (see instructions) 11,463 34.00		Allowable disproportionate share percentage (see instructions))			1
	34. 00	Disproportionate share adjustment (see instructions)			11, 463	34.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0181	Period: From 07/01/2016 To 06/30/2017		pare
				11/20/2017 2:	
		Title XVIII	Hospi tal	PPS	
			1. 00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment				
5. 00	Total uncompensated care amount (see instructions)			5, 977, 483, 147	
5. 01	Factor 3 (see instructions)		0. 000016747		35.
5. 02	Hospital uncompensated care payment (If line 34 is zero, en instructions)	nter zero on this line) (s	ee 107, 284	100, 105	35.
5. 03	Pro rata share of the hospital uncompensated care payment a	amount (see instructions)	26, 968	74, 873	35.
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35		101, 841		36.
	Additional payment for high percentage of ESRD beneficiary		<u> </u>	1	
0. 00	Total Medicare discharges on Worksheet S-3, Part I excludin 652, 682, 683, 684 and 685 (see instructions)	ng discharges for MS-DRGs	276	1	40
	032, 002, 003, 004 and 003 (see Tristractions)		Before 1/1	On/After 1/1	
			1. 00	1. 01	
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	, 683, 684 an 685. (see	0	0	41.
. 01	Total ESRD Medicare covered and paid discharges excluding Nan 685. (see instructions)	MS-DRGs 652, 682, 683, 68-	4 0	0	41
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00		42
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)	682, 683, 684 an 685. (see	9 0)	43
1. 00	Ratio of average length of stay to one week (line 43 divide	ed by line 41 divided by 7	0. 000000		44
	days)				
. 00	Average weekly cost for dialysis treatments (see instruction		0.00	0.00	
. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	41.01)	1, 619, 074	1	46 47
. 00	Hospital specific payments (to be completed by SCH and MDH,	. small rural hospitals	1, 019, 074		48
	only. (see instructions)				
				Amount 1.00	
0. 00	Total payment for inpatient operating costs (see instruction	ons)		1, 619, 074	49
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I)	130, 768	50
. 00	Exception payment for inpatient program capital (Wkst. L, I			0	51
. 00	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	Title 49 see Histructions)			52 53
. 00	Special add-on payments for new technologies			0	54
. 01	Islet isolation add-on payment			0	54
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	55
. 00	Cost of physicians' services in a teaching hospital (see in	•		0	56
. 00	Routine service other pass through costs (from Wkst. D. Pt.		through 35).	0	57 58
. 00	Ancillary service other pass through costs from Wkst. D, P. Total (sum of amounts on lines 49 through 58)	t. TV, Cor. IT Title 200)		1, 749, 842	
. 00	Primary payer payments			0	60
. 00		nus line 60)		1, 749, 842	61
. 00				249, 872	
	Coinsurance billed to program beneficiaries				63
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			11, 668 7, 584	
	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		541	66
. 00		,		1, 507, 554	
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			0	68
. 00 . 00 . 00 . 00	Credits received from manufacturers for replaced devices for		ns)	0	69
. 00 . 00 . 00 . 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96	6).(For SCH see instruction		1 0	70
. 00 . 00 . 00 . 00 . 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	6).(For SCH see instruction		^	
6. 00 6. 00 6. 00 6. 00 6. 00 6. 50	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT	6).(For SCH see instruction		0	
6. 00 6. 00 7. 00 8. 00 9. 00 9. 00 9. 50 9. 88	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 0	70
5. 00 5. 00 7. 00 8. 00 9. 00 9. 00 9. 50 9. 88 9. 89	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment	nstructions)		0	70 70 70 70
5. 00 5. 00 7. 00 8. 00 9. 00 9. 50 9. 88 9. 90 9. 91	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	nstructions)		0 0 0 0	70 70 70 70
5. 00 6. 00 7. 00 3. 00 9. 00 9. 00 9. 50 9. 88 9. 89 9. 90 9. 91 9. 92	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	nstructions)		0 0 0 0	70 70 70 70 70
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 88 0. 89 0. 90 0. 91 0. 92	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	nstructions)		0 0 0 0	70 70 70 70 70 70

Heal th	Financial Systems ST. VINCENT FISHER	RS HOSPITAL		In lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0181		Peri od: From 07/01/2016 To 06/30/2017	Worksheet E Part A	
	Title XVIII Hospital					
			FFY	' (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n 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 i			0	0	70. 97
	the corresponding federal year for the period ending on or af	ter 10/1)				
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				0	70. 99
	71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)				1, 514, 035	71. 00
71. 01	Sequestration adjustment (see instructions)				30, 281	71. 01
72.00	Interim payments				1, 370, 464	72. 00
73.00	Tentative settlement (for contractor use only)	use only)			0	73. 00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72,				113, 290	74.00
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			4, 123, 640	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructi ons)			0	
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92.00	Operating outlier reconciliation adjustment amount (see instr				0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc				0	93. 00
94.00	The rate used to calculate the time value of money (see instr	uctions)			0.00	
95.00	Time value of money for operating expenses (see instructions)				0	95. 00
96.00	Time value of money for capital related expenses (see instruc	tions)			0	96. 00
				Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00

0.0000

0.0000000000 101.00

0 102. 00

0. 0000 103. 00 0 104. 00

HVBP Adjustment for HSP Bonus Payment

101.00 HVBP adjustment factor (see instructions)
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)
HRR Adjustment for HSP Bonus Payment

103.00 HRR adjustment factor (see instructions)
104.00 HRR adjustment amount for HSP bonus payment (see instructions)

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 2: 33 pm Provider CCN: 15-0181

						0 00/30/201/	11/20/2017 2:	
		W/C E Dowt A	Amounto (from		XVIII	Hospi tal	Total (Col 2	
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od 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	(0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	347, 569	0	347, 569		347, 569	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier	1. 02	1, 145, 848	0		1, 145, 848	1, 145, 848	1. 02
	payments for discharges occurring on or after October 1							
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 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	12, 353	0	4, 395	7, 957	12, 352	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	(0	0	3. 00
4. 00	Managed care simulated payments	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	22. 01	0	0	(0	0	6. 01
	managed care (see instructions)			11 400 6 11				
7. 00	Indirect Medical Education Adju	27.00	0. 000000	0.000000	0.00000	0. 000000		l 7. 00
	(see instructions)			0.000000				
8. 00	IME adjustment (see instructions)	28. 00	0	0	(0	0	
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	(0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	(0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	(O	0	9. 01
	Di sproporti onate Share Adjustmo	ent						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0307	0. 0307	0. 0307	0. 0307		10. 00
11. 00	Di sproporti onate share adjustment (see instructions)	34. 00	11, 463	0	2, 668	8, 795	11, 463	11. 00
11. 01	Uncompensated care payments	36. 00	101, 841	0	(77, 824	77, 824	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	RD beneficiary o	di scharges 0	(0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	1, 619, 074	0	354, 632		1, 619, 074	
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	0	(0	0	14. 00
15. 00	Total payment for inpatient operating costs (see	49. 00	1, 619, 074	0	354, 632	1, 264, 442	1, 619, 074	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	130, 768	0	31, 970	98, 798	130, 768	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	(0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from	68. 00	0	0	(o	0	17. 01 17. 02
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see	93. 00	0	0	(0	0	18. 00
	instructions)							

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LOW VOLUME	CALCULATION EXHIBIT 4			Provider CO	<u> </u>	Period: From 07/01/2016 To 06/30/2017	Date/Time Pre 11/20/2017 2:	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
19. 00 SUBT	OTAL			0	386, 602	1, 363, 240	1, 749, 842	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00 Capi	tal DRG other than outlier	1. 00	120, 668	0	27, 87	1 92, 797	120, 668	20.00
20. 01 Mode	el 4 BPCI Capital DRG other	1. 01	ol	0		0	0	20. 01
	outlier							
21. 00 Capi	tal DRG outlier payments	2. 00	10, 100	0	4, 09	6, 001	10, 100	21.00
	l 4 BPCI Capital DRG	2. 01	l ol	0		0	0	21. 01
	ier payments							
	rect medical education	5. 00	0. 0000	0.0000	0. 000	0.0000		22. 00
	entage (see instructions)							
	rect medical education	6. 00	l ol	0		0	0	23. 00
	stment (see instructions)						_	
	wable disproportionate	10.00	0. 0000	0.0000	0. 000	0.0000		24.00
	e percentage (see							
	ructions)							
	proporti onate share	11, 00	ol	0		0	0	25. 00
	stment (see instructions)		آ ا	_			_	
	I prospective capital	12. 00	130, 768	0	31, 97	98, 798	130, 768	26, 00
	ents (see instructions)	.=	,		.,	15,		
	(222 1122 222 2122)	W/S E, Part A	(Amounts to E.					
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00 Low	volume adjustment factor				0, 23500	0. 227321		27. 00
	volume adjustment	70. 96			90, 85		90, 851	
	insfer amount to Wkst. E,	70.70			, , , , ,		,0,001	20.00
	A, line)							
	volume adjustment	70. 97				309, 893	309, 893	29.00
	insfer amount to Wkst. E,							
	A, line)							
	sfer low volume		Υ					100.00
	stments to Wkst. E, Pt. A.		.					30.00
1 2 4 7		1	ı		1	1	ı	1

HU3P1 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IION EXHIBIT 5	Provider CC	F	From 07/01/2016 To 06/30/2017		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Peri od on after 10/01	Total (cols. 2 and 3)	
		A, TITIE	A)	10/01	arter 10/01	and 5)	
		0	1.00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	347, 569	347, 569		347, 569	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	1, 145, 848		1, 145, 848	1, 145, 848	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0	C)	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see linstructions)	2.00	12, 353	4, 395	7, 957	12, 352	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	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)	22. 01	0	(0	0	6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t	he MMA			
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	1	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	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
	Disproportionate Share Adjustment					Г	
10. 00	Allowable disproportionate share percentage	33. 00	0. 0307	0. 0307	0. 0307		10.00
11. 00	(see instructions) Disproportionate share adjustment (see	34.00	11, 463	2, 668	8, 795	11, 463	11. 00
11. 01	instructions) Uncompensated care payments	36. 00	101, 841	26, 968	74, 873	101, 841	11. 01
11.01	Additional payment for high percentage of ESF			20, 700	74,073	101,041	11.01
12. 00	Total ESRD additional payment (see instructions)	46.00	0	(0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47. 00 48. 00	1, 619, 074 0	381, 600 (1, 237, 474 0 0	1, 619, 074 0	13. 00 14. 00
15. 00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	1, 619, 074	381, 600	1, 237, 474	1, 619, 074	15. 00
16. 00	Payment for inpatient program capital	50.00	130, 768	31, 970	98, 798	130, 768	16. 00
17. 00	Special add-on payments for new technologies	54.00	0]	0	0	1
17. 01 17. 02	Net organ acquisition cost	68. 00		(0		17. 01
18. 00	replaced devices for applicable MS-DRGs	93. 00					
	amount (see instructions) SUBTOTAL	73.00		413, 570			
17.00	JOUDITOTAL	I	I I	413,5/0	1, 336, 272	1, /49, 842	19.00

Health Financial Systems	ST. VINCENT FISHERS	HOSPI TAL	In Lieu	of Form CMS-2552-10
HOODITAL ACCULINED CONDITION (HAC)	DEDUCTION ON ON ATION EVILIBLE E	1 1 001 45 0404	D . 1	W 1 1 1 5

Heal th	Financial Systems	ST. VINCENT FIS	HERS HOSPITAL		In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider Co	F	Period: From 07/01/2016 Fo 06/30/2017	Date/Time Pre 11/20/2017 2:	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	120, 668	27, 87	92, 797	120, 668	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
	Capital DRG outlier payments	2. 00	10, 100	4, 099	6, 001	10, 100	21.00
	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	21. 01
	Indirect medical education percentage (see	5. 00	0.0000	0.0000	0.0000	_	22. 00
22.00	instructions)	0.00	0.0000	0.000	0.000		
23. 00	Indirect medical education adjustment (see	6.00	0		0	0	23. 00
20.00	instructions)	0.00		`		Ĭ	20.00
24. 00	Allowable disproportionate share percentage	10.00	0. 0000	0. 0000	0. 0000		24. 00
21.00	(see instructions)	10.00	0.0000	0.0000	0.0000		21.00
25. 00	Di sproporti onate share adjustment (see	11. 00	0		0	0	25. 00
20.00	instructions)	11.00		`		Ĭ	20.00
26. 00	Total prospective capital payments (see	12. 00	130, 768	31, 970	98, 798	130, 768	26. 00
20.00	instructions)	12.00	100, 700]	70, 770	100,700	20.00
	That dott only	Wkst. E, Pt.	(Amt. from				
		A. line	Wkst. E, Pt.				
		,	A)				
		0	1. 00	2.00	3. 00	4. 00	
27. 00					0.00		27. 00
	Low volume adjustment prior to October 1	70. 96	0	1		0	
	Low volume adjustment on or after October 1	70. 97	0	`	1	Ŏ	1
30.00	HVBP payment adjustment (see instructions)	70. 93	6, 481	5, 082	1, 399	_	
30. 00	HVBP payment adjustment for HSP bonus	70. 90	0, 401	3,002	1, 377	0, 401	30. 00
30.01	payment (see instructions)	70. 90	0			1	30.01
31. 00	HRR adjustment (see instructions)	70. 94	^				31.00
	HRR adjustment for HSP bonus payment (see	70. 94	0				31.00
31.01	instructions)	70. 91	0			1	31.01
	THISTI UCTI OHS)					(Amt. to Wkst.	
						E, Pt. A)	
		0	1. 00	2.00	3. 00	4.00	
32 00	HAC Reduction Program adjustment (see	70, 99	1.00	2.00			32. 00
32.00	instructions)	10. 77					32.00
100 00	Transfer HAC Reduction Program adjustment to		N				100.00
100.00	Wkst. E, Pt. A.		I V				1.50.00
	WKSt. E, It. M.	1	I	I	I	I	I

Health Financial Systems	ST. VINCENT FISHE	RS HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0181	Peri od: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/20/2017 2:33 pm

MARIE MEDICAL AND DIFFE HEALTH SERVICES 1.00				To 06/30/2017	Date/Time Prep 11/20/2017 2:	
PART 8 - MEDICAL AND OTHER HEALTH SERVICES 1,100 Medical and other services (as fear instructions) 3,1,476 1,00 Medical and other services (reinbursed under OPPS (see instructions) 3,25,211 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00			Title XVIII	Hospi tal		
PART 8 - MEDICAL AND OTHER HEALTH SERVICES 1,100 Medical and other services (as fear instructions) 3,1,476 1,00 Medical and other services (reinbursed under OPPS (see instructions) 3,25,211 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00					1.00	
Medical and other services (see instructions) 1,476 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00		DADT R _ MEDICAL AND OTHER HEALTH SERVICES			1.00	
Medical and other services releabursed under OPPS (see instructions) 3, 352, 411 2, 00 2, 415, 13 3.00 PMS payments 2, 415, 13 3.00 PMS payments 2, 415, 13 3.00 PMS payments 3, 400 0.011 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.00 5.00 0.00 5.00 0.00 5.00 0.000 5.00 0.00 5.00 0.00 5.00 0.00 5.00 0.00 5.00 0.00 5.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000 0.00 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.00	1. 00				1. 476	1.00
0.00		,	tions)			•
Inter the fospital specific payment to cost ratio (see Instructions) 0.000 5.00 6.00 1.00 5.00 6.00 1.00 5.00 6.00 1.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00	3.00	PPS payments	•		2, 617, 511	3. 00
Line 2 times line 5 0 6.00	4.00	Outlier payment (see instructions)			28, 462	4. 00
2.00 Sum of Fine 3 plus line 4 divided by line 6 0.00 7.00 8.00 Transit foral corridor payment (see instructions) 0.10 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		, , , , , , , , , , , , , , , , , , , ,	ctions)		0. 000	1
					-	1
9.00 Ancillary service other pass through costs from West. D. Pt. IV, col. 13, line 200 0 9.00		, , , , , , , , , , , , , , , , , , , ,				1
0.00 Organ acquisitions 1.476 1.00 Total cost (sum of lines 1 and 10) (see instructions) 1.476 1.00 Total cost (sum of lines 1 and 10) (see instructions) 2.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00			IV ool 12 line 200		-	1
1.00 Total cost (sum or lines 1 and 10) (see instructions) 1.476 1.00			rv, cor. 13, 11ne 200		-	1
Computation of LESSER OF COST OR CHARGES Reasonable charges Reasonable charges Reasonable charges Ancil lary service charges (from West. D-4, Pt. III., col. 4, line 69) 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.00 0. 13.					-	ı
Reasonable charges 4, 377 12.00 Ancil lary service charges 4, 377 12.00 Ancil lary service charges 4, 377 12.00 Ancil lary service charges (from Wist. D-4, Pt. III, col. 4, line 69) 0 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00	11.00				1, 170	11.00
13.00 Organ acquistion charges (from West. D-4, Pt. III., col. 4, line 69)		Reasonabl e charges				
14. 00 Total reasonable charges (sum of lines 12 and 13)					4, 372	12. 00
Customary charges			ne 69)			1
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 not be considered to the construction 0 16.00 not be considered to the construction 0 16.00 not be considered to the construction 0 17.00 not of line 15 to line 16 (not to exceed 1.000000) 0.0000000 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00	14. 00				4, 372	14. 00
16.00 Aniounits that would have been realized from patients Iable for payment for services on a chargebasis National Control National National Control	15 00					1 - 00
had such payment been made in accordance with 42 CFR \$413.13(e)					-	
17.00	16.00			ii a ciiai yebasi s	ا ا	10.00
18. 00 Total customary charges (see instructions)	17. 00				0.000000	17.00
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 2,896 19.00						1
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00 1,476 21.00 22.00 22.00 23.00 20.00 20.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00			y if line 18 exceeds li	ne 11) (see		ł
Instructions		instructions)				
21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 0.21.00	20. 00		y if line 11 exceeds li	ne 18) (see	0	20. 00
22.00 Interns and residents (see Instructions) 0 22.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00	21 00	1	o i notrupti ono)		1 474	21 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 2.00 23.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.0		, ,	e instructions)			1
24.00		1	cuctions)		-	
COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 25.00		, , , , , , , , , , , , , , , , , , , ,	4611 0113)		- 1	
25.00 Deductibles and coinsurance (For CAH, see instructions) Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) S57,806 26.00	2 00					
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see Instructions) 0 28.00	25.00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
Instructions Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 2.089, 643 30.00 31.00 Primary payer payments 2.11 31.00 32.00 Subtotal (line 30 minus line 31) 2.089, 422 32.00 32.00 Subtotal (line 30 minus line 31) 2.089, 422 32.00 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 Allowable bad debts (see instructions) 57.102 34.00 Allowable bad debts (see instructions) 37.116 35.00 Allowable bad debts (see instructions) 37.116 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 33.00 Subtotal (see instructions) 34.719 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.116 38.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 39.00 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 MS (2000 EVENTAL ELEMATED DEPRECIATION 0 39.90 MS (2000 EVENTAL ELEMATED DEPRECIATION 0 39.00 39.90 MS (2000 EVENTAL ELEMATED DEPRECIATION 0 39.00 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39	26.00	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH, see instructions)		557, 806	26. 00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) Carbon Car	27. 00	'	olus the sum of lines 22	and 23] (see	2, 089, 643	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.00 Subtotal (sum of lines 27 through 29) 30.00 31.00 Primary payer payments 2.089, 643 30.00 31.00 Primary payer payments 2.089, 643 30.00 32.00 All Owable (line 30 minus line 31) 2.089, 422 32.00 All Owable bad debts (see instructions) 57, 102 34.00 34.00 All owable bad debts (see instructions) 57, 102 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 37, 116 35.00 37.00 38.00 All owable bad debts (see instructions) 37.00 38.00 All owable bad debts for dual eligible beneficiaries (see instructions) 37.00 38.00 MSP-LCC reconciliation amount from PS&R 2126, 538 38.00 MSP-LCC reconciliation amount from PS&R 2126, 538 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.90 39.99 39.90 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00	00.00	1	50)			00.00
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93.00 Time Value of Money (see instructions) 0 93.00						ı
	94.00	Total (sum of lines 91 and 93)			ا O	94. 00

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der C		Period: From 07/01/2016 To 06/30/2017		pared:
		Title	e XVIII	Hospi tal	PPS	
		Inpatien	nt 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, 370, 46	4	2, 046, 891	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02	THE SOUTHERT OF THE VIDER		l .	o	Ö	
3. 03				o	0	3. 03
3.04				o	0	3. 04
3.05				0	0	3. 05
	Provider to Program	1		_1		
3. 50 3. 51 3. 52 3. 53	ADJUSTMENTS TO PROGRAM			0 0 0 0	0 0	3. 51
3. 54				o	l o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 370, 46	4	2, 046, 891	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
F 01	Program to Provider	I				F 01
5. 01 5. 02	TENTATI VE TO PROVI DER		1	0	0	
5. 02				0	0	
0.00	Provider to Program			<u> </u>		0.00
5.50	TENTATIVE TO PROGRAM			0	0	5. 50
5. 51				0	0	
5. 52				0	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		113, 29	o	37, 116	6. 01
6. 02	SETTLEMENT TO PROGRAM		1	Ö	0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 483, 75	4	2, 084, 007	
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00	N 60 1		0	1. 00	2. 00	0.05
o nn	Name of Contractor	1		1	I .	2 nn

8.00 Name of Contractor

Heal th	Financial Systems ST. VINCENT FISHE	RS HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0181	Peri od: From 07/01/2016 To 06/30/2017		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		2 14	1, 277	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	1-12		571	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			160	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	1-12		2, 376	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			162, 578, 840	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20		6, 465, 703	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			162, 251	8. 00
9.00	Sequestration adjustment amount (see instructions)			3, 245	9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		159, 006	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			163, 823	30.00
31.00	Other Adjustment (specify)			0	31.00
22 00	Balance due provider (line 0 (an line 10) minus line 20 and l	ing 21) (and instruction	· -)	4 017	22 00

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

163, 823 30. 00 0 31. 00 -4, 817 32. 00

Health Financial Systems	ST.	VINCENT FISHER	S HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provi der C	CCN: 15-0181	From 07/01/2016	Worksheet E-3 Part VII Date/Time Prepared:

			To 06/30/2017	Date/Time Pre 11/20/2017 2:	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient hospital/SNF/NF services		1, 467, 994		1. 00
2.00	Medical and other services			3, 551, 610	2. 00
3. 00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 467, 994	3, 551, 610	4.00
5.00	Inpatient primary payer payments		0	0	5.00
6.00	Outpatient primary payer payments		1 447 004	0 2 FF1 (10	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		1, 467, 994	3, 551, 610	7. 00
	Reasonable Charges				
8. 00	Routi ne servi ce charges		527, 761		8. 00
9. 00	Ancillary service charges		3, 608, 589	18, 860, 826	9. 00
10. 00	Organ acquisition charges, net of revenue		0,000,007	10,000,020	10.00
11. 00	Incentive from target amount computation		o		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		4, 136, 350	18, 860, 826	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for p		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)	0 000000	0.00000	45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16.00	Total customary charges (see instructions)	if line 14 exceeds	4, 136, 350	18, 860, 826	16. 00 17. 00
17.00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	IT TITLE TO exceeds	2, 668, 356	15, 309, 216	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	TI TITLE I EXCECUS TITLE		· ·	10.00
19. 00	Interns and Residents (see instructions)		o	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)	O	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16))	1, 467, 994	3, 551, 610	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid	ers.		
	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0	0	25. 00
26. 00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	26. 00 27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)			0	28. 00
	Titles V or XIX (sum of lines 21 and 27)		1, 467, 994	3, 551, 610	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1, 10,, ,, 1	0,001,010	27.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 467, 994	3, 551, 610	31. 00
32.00	Deducti bl es		o	0	32. 00
33.00	Coinsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0		35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	1, 467, 994	3, 551, 610	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		1, 467, 994	3, 551, 610	
39. 00	Direct graduate medical education payments (from Wkst. E-4)		1 4/7 004	2 554 742	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		1, 467, 994	3, 551, 610	
41. 00	Interim payments		1, 467, 994	3, 551, 610 0	1
42. 00 43. 00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance	a with CMS Pub 15.2	0	0	42. 00 43. 00
43.00	chapter 1, §115.2	WI CH GWG FUD 19-2,	١	U	45.00
	1 · · · · · · · · · · · · · · · · · · ·		1		'

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: 15-0181

Peri od: Worksheet G From 07/01/2016 To 06/30/2017 Date/Time Prepared: 11/20/2017 2:33 pm

Unit y)					11/20/2017 2:	33 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	1, 400	0	0	0	1. 00
2.00	Temporary investments	0	0	0		
3.00	Notes receivable	0	0	0	0	
4.00	Accounts recei vable	16, 721, 029		0	0	
5.00	Other receivable	94, 613		0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-8, 591, 283		0	0	
7.00	Inventory	932, 002	0	0	0	
8. 00 9. 00	Prepaid expenses Other current assets	8, 544, 332	0	0	0	
10. 00	Due from other funds	0, 344, 332	0	0	0	
11. 00	Total current assets (sum of lines 1-10)	17, 702, 093		0	l	
11.00	FI XED ASSETS	17,702,073	,	<u> </u>		11.00
12. 00	Land	10, 871, 320	0	0	0	12. 00
13. 00	Land improvements	22, 176		0	l	
14.00	Accumulated depreciation	-4, 636	0	0	0	14. 00
15.00	Bui I di ngs	43, 432, 830	0	0	0	15. 00
16. 00	Accumulated depreciation	-6, 191, 479	0	0	0	16. 00
17. 00	Leasehold improvements	853, 803	0	0	0	
18. 00	Accumulated depreciation	-727, 635	1	0	0	
19. 00	Fi xed equipment	3, 269, 663	1	0	0	1
20.00	Accumulated depreciation	-2, 017, 152	1	0	0	
21. 00	Automobiles and trucks	0	0	0	0	
22. 00	Accumulated depreciation	14 524 073	0	0	0	
23. 00 24. 00	Maj or movable equipment	16, 536, 073 -10, 875, 791		0	0	
25. 00	Accumulated depreciation Minor equipment depreciable	-10, 6/3, /91		0	0	
26. 00	Accumulated depreciation		0	0	0	
27. 00	HIT designated Assets			0	Ö	
28. 00	Accumul ated depreciation	0	o o	0	Ö	
29. 00	Mi nor equi pment-nondepreci abl e	0	o o	0	l	
30.00	Total fixed assets (sum of lines 12-29)	55, 169, 172	2 0	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	5, 575	0	0	1	
32. 00	Deposits on Leases	0	0	0	1	
33. 00	Due from owners/officers	0	0	0	0	
34. 00	Other assets	988, 154		_	0	1
35. 00	Total other assets (sum of lines 31-34)	993, 729		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	73, 864, 994	. 0	0	0	36. 00
37. 00	Accounts payable	1, 499, 535	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 410, 511	1	0	1	
39. 00	Payrol Laxes payable	1,410,311		0	0	
40. 00	Notes and Loans payable (short term)			0	Ö	
41. 00	Deferred income	0	Ö	0	Ō	
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6, 984, 623	0	0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	9, 894, 669	0	0	0	45. 00
	LONG TERM LIABILITIES	1				
46. 00	Mortgage payable	0	0	0	1	
47. 00	Notes payable	0	0	0	1	
48. 00	Unsecured Loans	0	0	_		1
49. 00	Other long term liabilities	865, 545		0	1	
50.00	Total long term liabilities (sum of lines 46 thru 49)	865, 545 10, 760, 214			1	
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	10, 760, 214	. 0	U	0	51.00
52. 00	General fund balance	63, 104, 780	1			52.00
53. 00	Specific purpose fund	03, 104, 780	0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,		1		ő	
	repl acement, and expansi on		1			
59. 00	Total fund balances (sum of lines 52 thru 58)	63, 104, 780	0	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	73, 864, 994	0	0	0	60.00
	[59]		1			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10
Worksheet G-1 Peri od: From 07/01/2016 Provider CCN: 15-0181

					To 06/30/		Date/Time Pr 11/20/2017 2	epa 2: 3:	ared: 3 pm_
		General	Fund	Speci al	Purpose Fund		Endowment Fun	ıd	
		1.00	2.00	3.00	4. 00		5. 00		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) OTHER ADJUSTMENTS TO FUND BALANCE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) OTHER ADJUSTMENTS TO FUND BALANCE	0 0 0 0 0 0 0 0	68, 464, 797 25, 030, 143 93, 494, 940 0 93, 494, 940		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0		0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 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)	0 0 0 0	30, 390, 160 63, 104, 780		0 0 0	0		0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant						
1. 00	Fund balances at beginning of period	6.00	7. 00	8. 00	0				1. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) OTHER ADJUSTMENTS TO FUND BALANCE	0	0 0 0 0 0		0				2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) OTHER ADJUSTMENTS TO FUND BALANCE Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0	0 0 0 0 0		0 0 0				10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
50	sheet (line 11 minus line 18)				-				

Health Financial Systems ST STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0181

		Т	o 06/30/2017	Date/Time Pre 11/20/2017 2:	
	Cost Center Description	I npati ent	Outpati ent	Total	DO PIII
		1.00	2. 00	3.00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	11, 491, 323		11, 491, 323	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	NURSI NG FACILITY				8. 00
9.00	OTHER LONG TERM CARE	44 404 000		44 404 000	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	11, 491, 323		11, 491, 323	10. 00
11 00	Intensive Care Type Inpatient Hospital Services			0	11 00
11. 00 12. 00	INTENSIVE CARE UNIT			0	11. 00 12. 00
13. 00	BURN INTENSIVE CARE UNIT			U	13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT			0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)			Ü	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines			0	16. 00
10.00	11-15)			O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	11, 491, 323		11, 491, 323	17. 00
18. 00	Ancillary services	23, 772, 676		112, 088, 351	18. 00
19. 00	Outpati ent servi ces	2, 208, 577		38, 999, 169	19. 00
20.00	RURAL HEALTH CLINIC	0	I	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	o	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC		0	0	24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27. 00	PHYSI CI AN PRI VATE OFFI CES	C	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	37, 472, 576	125, 106, 267	162, 578, 843	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES	1			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		46, 346, 560		29. 00
30.00	ADD (SPECIFY)	C			30.00
31.00		0			31.00
32. 00 33. 00					32. 00 33. 00
34. 00					34.00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)	0	Ĭ		37. 00
38. 00	52500. (0. 20.1.)	i			38. 00
39. 00		1			39. 00
40. 00					40.00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)		o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		46, 346, 560		43.00
	to Wkst. G-3, line 4)				

	Financial Systems ST. VINCENT FISHER			u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0181	Peri od: From 07/01/2016	Worksheet G-3	
			To 06/30/2017	Date/Time Pre 11/20/2017 2:	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	e 28)		162, 578, 843	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	•		97, 293, 812	1
3.00	Net patient revenues (line 1 minus line 2)			65, 285, 031	ı
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		46, 346, 560	
5.00	Net income from service to patients (line 3 minus line 4)	•		18, 938, 471	•
	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	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
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			158, 000	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			923	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			823, 165	1
23. 00	Governmental appropriations			0	1 20.00
24. 00	GAIN ON SALE/DISPOSAL PPE			0	24. 00
24. 01	MI SCELLANEOUS I NCOME			5, 039, 420	1
24. 02	EHR/HIT INCENTIVE REVENUE			80, 800	ı
24. 03	OTHER (SPECIFY)			0	24. 03
24 04				Λ	24 04

6, 102, 308 25. 00 25, 040, 779 26. 00

10, 636 27. 00 10, 636 28. 00 25, 030, 143 29. 00

24.04

24.04

27. 00 DONATIONS

25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25)

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)

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0181	Peri od:	Worksheet L	
			From 07/01/2016 To 06/30/2017		narodi
			To 06/30/2017	Date/Time Pre 11/20/2017 2:	
		Title XVIII	Hospi tal	PPS	
				4 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			120, 668	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			10, 100	2.00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost r	reporting period (see inst	tructions)	7. 81	3.00
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	ne sum of lines 1 and 1.0 $^{\circ}$	1, columns 1 and	0	6. 00
7 00	1.01) (see instructions)			0.00	7 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (worksheet i	=, part A line	0.00	7. 00
8. 00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	8.00
9. 00	Sum of lines 7 and 8	461.66)		0.00	
10.00	Allowable disproportionate share percentage (see instruction	ns)		0.00	
11.00	Disproportionate share adjustment (see instructions)			0	11.00
12.00	Total prospective capital payments (see instructions)			130, 768	12. 00
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	,		0	3.00
4.00	Applicable exception percentage (see instructions)			0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinar	ry circumstances (line 2 x	k line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9. 00	Current year capital payments (from Part I, line 12, as appl	•		0	
10.00	Current year comparison of capital minimum payment level to			0	10.00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11. 00
12. 00	Net comparison of capital minimum payment level to capital p	navments (line 10 nlus lin	ne 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, enter			0	
14. 00	Carryover of accumulated capital minimum payment level over			0	1
	(if line 12 is negative enter the amount on this line)	, ,	5 451.34	ū	

15.00 0 16.00 0 17.00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)