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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT ANDERSON (15-0088) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 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.

[]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)				
	Officer	or	Admi ni strator	of Provider(s)
Title				
Date				

			Title XVIII				
	Cost Center Description		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	932, 590	274, 065	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	-35, 204	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	897, 386	274, 065	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

Health Financial Systems ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0088 Peri od: Worksheet S-2 From 07/01/2017 Part I Date/Time Prepared: 06/30/2018 11/26/2018 2:01 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2015 JACKSON STREET 1.00 PO Box: 1.00 State: IN Zip Code: 46016 2.00 City: ANDERSON County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed Number Number T, 0, or N) Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal ST. VINCENT ANDERSON 150088 26900 07/01/1966 Ν 0 3.00 1 Subprovider - IPF 4.00 4.00 Subprovi der - IRF 5.00 BENNETT REHAB CENTER 15T088 26900 5 06/01/1989 N Р 0 5 00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital-Based (CMHC) I 17.00 18. 00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 07/01/2017 06/30/2018 20.00 Cost Reporting Period (mm/dd/yyyy) 20 00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting Υ 22.01 Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2, or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method

	used in the prior cost reporting period? In column 2	2, enter "Y	' for yes d	r "N" for r	no.			
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	el i gi bl e	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00	If this provider is an IPPS hospital, enter the	1, 119	196	5	18	6, 837	12	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25.00	If this provider is an IRF, enter the in-state	49	0	0	0	212		25. 00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPL			ANDERSON Provider C	F	Period: From 07/01/2017 To 06/30/2018	u of Form CMS- Worksheet S-2 Part I Date/Time Pre)
			Y/N	I ME	Direct GME	I ME	11/26/2018 2: Direct GME	
			1 00	2.00	2.00	4.00	F 00	_
	Enter the base line FTE count for and/or general surgery residents, determining compliance with the 7 instructions)	which is used for	1.00	2. 00	3. 00	4.00	5.00	61. 03
51. 04	Enter the number of unweighted pr surgery allopathic and/or osteopa current cost reporting period.(se	thic FTEs in the						61. 04
61. 05	Enter the difference between the and/or general surgery FTEs and t primary care and/or general surge	baseline primary the current year's try FTE counts (line						61. 05
	61.04 minus line 61.03). (see ins Enter the amount of ACA §5503 awa used for cap relief and/or FTEs t care or general surgery. (see ins	rd that is being hat are nonprimary						61. 06
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61. 10	Of the FTEs in line 61.05, specif			1. 00	2. 00	3.00	4.00	61. 10
61. 20	specialty, if any, and the number for each new program. (see instruction of the program code. Enter in column 1, the program name. Enter program code. Enter in column 3, unweighted count. Enter in column FTE unweighted count. Of the FTEs in line 61.05, specific program specialty, if any, and the residents for each expanded progrinstructions) Enter in column 1, Enter in column 2, the program code, the limit of the lim	ctions) Enter in circ column 2, the the IME FTE 4, the direct GME by each expanded the number of FTE am. (see the program name. The column Enter in column 4,				0. 00	0. 00	61. 20
							1. 00	
	ACA Provisions Affecting the Heal Enter the number of FTE residents					iod for which	0.00	62.00
52. 01	your hospital received HRSA PCRE Enter the number of FTE residents during in this cost reporting per	funding (see instructs that rotated from a riod of HRSA THC prog	tions) ı Teachi ıram. (s	ng Health Cen see instructio	ter (THC) into			62. 01
	Teaching Hospitals that Claim Res Has your facility trained resider "Y" for yes or "N" for no in colu	its in nonprovider se	ttings	during this c			N	63. 00
					Unwei ghted FTEs Nonprovi der Si te 1.00	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
	Section 5504 of the ACA Base Year						3.00 reporting	
	period that begins on or after Ju Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facilit er of unweighted nor ations occurring in number of unweighted ur hospital. Enter ir	y trair i-primar all nor I non-pr i columr	ned residents ry care aprovider rimary care n 3 the ratio	0.0	0.00	0. 000000	64.00
	pr (cordinir r drvided by (cordinir)	Program Name		ogram Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	/

1.00

Unweighted FTEs Nonprovider Site

3. 00

2.00

Unweighted FTEs in Hospital

4.00

Ratio (col. 3/ (col. 3 + col. 4))

5.00

Health Financial Systems ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0088 Period: From 07/01/2017 Part I

HUSPI I	AL AND HOSPITAL HEALTH CARE COMPL	LEX IDENIIFICATION DA	IA Provider Co		eriod: rom 07/01/2017 o 06/30/2018	Date/Time Pre	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3. 00	4. 00	5. 00	
65. 00	Enter in column 1, if line 63 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	65. 00
	4)). (see instructions)			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2. 00	3. 00	
	Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	or cost report	ing periods	
	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident B the ratio of	0.00	0.00	0. 000000	66. 00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	3.00	4.00	5. 00 0. 000000	67. 00
	(555511 4511 6113)						
	Innationt Doughistria Facility	DC			1. 0	0 2.00 3.00	
70. 00	Inpatient Psychiatric Facility P Is this facility an Inpatient Ps		PF), or does it conta	ain an IPF subn	rovi der? N		70.00
	Enter "Y" for yes or "N" for no If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indice instructions) Inpatient Rehabilitation Facilit	the facility have an efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	n approved GME teachi 1004? Enter "Y" for yo lity train residents (D)? Enter "Y" for yo	ng program in t es or "N" for n in a new teach es or "N" for n	he most o. (see i ng o.	0	71. 00
75. 00	Is this facility an Inpatient Re		(IRF), or does it co	ontain an IRF	Y		75. 00
76. 00	subprovider? Enter "Y" for yes If line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. the facility have an ing on or before Nove train residents in a r "Y" for yes or "N"	n approved GME teachin ember 15, 2004? Enter new teaching program for no. Column 3: If	ng program in t "Y" for yes or in accordance column 2 is Y,	he most N "N" for with 42	N O	76. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-0088	Peri od: From 07/01/2017 To 06/30/2018	Worksheet S-Part I Date/Time Pro 11/26/2018 2	epared:
			1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes ar 81.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no.		ng period? Enter	N N	80.00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE 86.00 Did this facility establish a new Other subprovider (excluded useful) §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	85. 00 86. 00
18413.40(1)(1)(1)? Effet if for yes and in for inc. 187.00 Is this hospital an extended neoplastic disease care hospital of 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	n	N	87. 00	
Tidou(d)(T)(b)(vi): Enter 1 Tor yes or N Tor no.		V 1.00	XI X 2. 00	
Title V and XIX Services 00.00 Does this facility have title V and/or XIX inpatient hospital s	convices? Enter "V" for	· N	Y	90.00
yes or "N" for no in the applicable column.				
11.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applica-		N	N	91.00
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual	certification)? (see		N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicable 3.00 Does this facility operate an ICF/IID facility for purposes of		. N	N	93.00
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and	!"N" for no in the	N	N	94.00
applicable column.		0.00	0.00	95. 00
5.00 If line 94 is "Y", enter the reduction percentage in the applic 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or		N N	N N	96. 0
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the applic	cable column.	0. 00	0.00	97. 0
18.00 Does title V or XIX follow Medicare (title XVIII) for the interstepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.		N	Y	98. 0
28.01 Does title V or XIX follow Medicare (title XVIII) for the report, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title			Y	98. 0
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "		N	Y	98. 0
for title V, and in column 2 for title XIX. 18.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes of the content of the c			N	98. 03
for title V, and in column 2 for title XIX. 18.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reioutpatient services cost? Enter "Y" for yes or "N" for no in co		N nd	N	98. 04
in column 2 for title XIX. 18.05 Does title V or XIX follow Medicare (title XVIII) and add back 18.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu			Y	98. 05
column 2 for title XIX. 18.06 Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.		N	Υ	98. 00
Rural Providers 05.00 Does this hospital qualify as a CAH?		N		105. 00
06.00 If this facility qualifies as a CAH, has it elected the all-inc	clusive method of payme	1		106. 0
for outpatient services? (see instructions) 07.00 f this facility qualifies as a CAH, is it eligible for cost retraining programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25	(see instructions) If			107. 0
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 Is this a rural hospital qualifying for an exception to the CRN CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	1 3			108. 0
	Physical Occupation		Respi ratory	
09.00 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.	1.00 2.00 N N	3. 00 N	4. 00 N	109. 00
	'	•	1 00	
10.00 Did this hospital participate in the Rural Community Hospital [Demonstration project (S410Δ	1. 00 N	110. 0

	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 1		eriod: rom 07/01/ o 06/30/	2017 2018	Workshe Part I Date/Ti 11/26/2	me Pr	epared:
			1. 00		2.0	00	1
1.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	st reporting perion lumn 1 is Y, ente ticipating in colo	od? Enter r the umn 2.	N				111. 0
				1. 00	2.00	3. 00	
Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 6.00 Is this facility classified as a referral center? Enter "Y"	If column 2 is "t for long term cas) based on the deformation for yes or "N" for	E", enter i are (includ efinition i r no.	n column des n CMS	N N		0	115. 0
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence pol		,		Y 1			117. 0
claim-made. Enter 2 if the policy is occurrence.							110.0
		Premiums	Losses	5	Insur	ance	
		1. 00	2.00		3. C	00	-
8.01 List amounts of malpractice premiums and paid losses:		728, 087	7	0			0 118. 0
8.02 Are malpractice premiums and paid losses reported in a cost			1. 00 N		2.0	00	118.0
Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 10.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendmen	Harmless provision column 1, "Y" for alifies for the 0	on in ACA r yes or utpatient	N		N		119. (120. (
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla	ntable devices ch	arged to	Y				121. (
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Y		5. C	00	122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" fo	r yes and "N" for	no. If	N				125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2		tion date					126.
27.00 f this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2	er the certificat						127.
8.00 f this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2							128.
(9.00) If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2. (0.00) If this is a Medicare certified pancreas transplant center,							129. 130.
date in column 1 and termination date, if applicable, in column 1.00 f this is a Medicare certified intestinal transplant center	umn 2.						131.
date in column 1 and termination date, if applicable, in col 2.00 If this is a Medicare certified islet transplant center, ent	er the certificat	on date					132.
in column 1 and termination date, if applicable, in column 2 3.00 f this is a Medicare certified other transplant center, ent	er the certificat	on date					133.
in column 1 and termination date, if applicable, in column 2 44.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.		olumn 1					134.
All Providers		45 :	I				١.
!O.OO∣Are there any related organization or home office costs as d	etined in CMS Pub	15-1.	Υ		1540	146	140. (

Health Financial Systems ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0088 Peri od: Worksheet S-2 From 07/01/2017 Part I 06/30/2018 Date/Time Prepared: То 11/26/2018 2:01 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: ST VINCENT HEALTH Contractor's Name: WPS Contractor's Number: 08101 141 00 142.00 Street: 250 WEST 96TH STREET , SUITE PO Box: 142.00 2058 I NDI ANAPOLI S 143.00 Ci ty: State: ΙN Zip Code: 46260 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155.00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY Ν Ν Ν Ν 160.00 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. Ν 165.00 FTE/Campus Zip Code Name County **CBSA** State Ω 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 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)			
	'		
		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment	Act		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167. 00
168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), reasonable cost incurred for the HIT assets (see instructions)	enter the		168. 00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	a hardshi p		168. 01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "transition factor. (see instructions)	9. 9	9169. 00	
	Begi nni ng	Endi ng	
	1. 00	2.00	
170 00 February 1 and 2 the FUD having invaded and and the fear the granding	10/01/2016	12/31/2016	170. 00
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	107 017 2010		
	10/01/2010		
	1. 00	2.00	

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		eri od:	Worksheet S-2	2
				rom 07/01/2017 o 06/30/2018		epare
				1	11/26/2018 2:	
				Y/N	Date	
	Constal Instruction. Enter V for all VEC recommence. Enter N	l for all NO sa	onences Enter	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	i for all NO re	esponses. Enter	all dates in	tne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
OC	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1
	reporting period? If yes, enter the date of the change in o					
			Y/N	Date	V/I	
	II		1.00	2. 00	3. 00	+
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum		N			2
	voluntary or "I" for involuntary.	III 3, V 101				
00	Is the provider involved in business transactions, including	na management	Y			1 3
,,	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)					\perp
			Y/N	Type	Date	
	Fire and Development		1.00	2. 00	3. 00	
	Financial Data and Reports	ified Dublie	Y	Ι Δ	1	+
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f		Y	Α		4
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.	irrabic iii				
00	Are the cost report total expenses and total revenues diffe	erent from	N			
	those on the filed financial statements? If yes, submit red					
				Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		1
	the legal operator of the program?					١.
00	Are costs claimed for Allied Health Programs? If "Y" see in			Y		
00	Were nursing school and/or allied health programs approved	and/or renewed	a during the	N		8
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduate medic	al education	N		
,0	program in the current cost report? If yes, see instruction		ai caacation			
00	Was an approved Intern and Resident GME program initiated of		he current	N		10
	cost reporting period? If yes, see instructions.					
00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		1
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	D-1 D-1				1.00	
00	Bad Debts	and I material	lana		T v	۱.
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			t roporting	Y	1:
00	period? If yes, submit copy.	officy change c	iui i iig tiii s cos	t reporting	IN IN	'`
00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	ves see inst	ructions	N	14
00	Bed Complement	mar ved. 11	yes, see mat	r de tr ons.	1	Η.
00	Did total beds available change from the prior cost reporti	ng period? If	yes, see instr	uctions.	N	7 15
		Par	t A	Par	rt B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data	, , , .	10.000.000		10 (05 (55)	١.
00	Was the cost report prepared using the PS&R Report only?	Y	10/09/2018	Υ	10/09/2018	16
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)		1			
00	Was the cost report prepared using the PS&R Report for	N	1	N		17
50	totals and the provider's records for allocation? If	IN IN		IN		'
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)		1			
00	If line 16 or 17 is yes, were adjustments made to PS&R	N	1	N		18
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this		1			
	1					
	cost report? If yes, see instructions.					
00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19
00		N		N		19

SPI T	Financial Systems ST. VINCENT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CO	CN: 15-0088	Peri od:	u of Form CMS- Worksheet S-2	
				From 07/01/2017 To 06/30/2018	Part II Date/Time Pre	
		Descri	nti on	Y/N	11/26/2018 2: Y/N	T D
		(•	1.00	3. 00	
. 00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	PT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, see				N	22
00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost	N	23
00	Were new leases and/or amendments to existing leases entered If yes, see instructions	d into during	this cost re	porting period?	N	24
00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25
00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? I	f yes, see	N	26
00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit	N	27
	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporting	N	28
00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or b		S		N	29
	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur	uctions .		,	N	30
00	instructions. Has debt been recalled before scheduled maturity without is:	,	,		N	31
	instructions. Purchased Services	Sudfice of fiew	ucbt: 11 yes	, 300]
	Have changes or new agreements occurred in patient care servarrangements with suppliers of services? If yes, see instru		d through co	ntractual	N	32
00	If line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.		g to competi	tive bidding? If	N	33
	Provi der-Based Physi ci ans					
	Are services furnished at the provider facility under an arm If yes, see instructions.	rangement with	provi der-ba	sed physicians?	Υ	34
00	If line 34 is yes, were there new agreements or amended exist physicians during the cost reporting period? If yes, see instance.		ts with the	provi der-based	N	35
	period of and during the cost reporting period: 11 yes, see the	21. 4011 0113.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs			V		١,,
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pro	epared by the	home office?	Y		36
	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home offi					38
00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			, N		39
00	see instructions. If line 36 is yes, did the provider render services to the H	home office?	If yes, see	N		40
	instructions.		-			
		1.	00	2.	00	
	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	KATHY		ZAMBOS		41
55	held by the cost report preparer in columns 1, 2, and 3, respectively.	w				'
00	Enter the employer/company name of the cost report	ST VINCENT HEA	LTH			42
	preparer.					43

Health Financial Systems	ST. VINCENT	ANDERSON		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT C	UESTI ONNAI RE	Provi der CC		Peri od:	Worksheet S-2	
				From 07/01/2017 To 06/30/2018	Part II Date/Time Pre	narod:
				10 00/30/2016	11/26/2018 2:	
		3.0	0			
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the ti		LEAD ANALYST				41. 00
held by the cost report preparer in column	s 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the cos	t report					42. 00
preparer.						
43.00 Enter the telephone number and email addre						43. 00
report preparer in columns 1 and 2, respec	ti vel y.					

Health Financial Systems ST. V Provider CCN: 15-0088

				Τ̈́	o 06/30/2018	Date/Time Pre 11/26/2018 2:	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	120	43, 800	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 I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF		120	42 000	0.00	0	1
7.00	Total Adults and Peds. (exclude observation		120	43, 800	0.00	ĺ	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	21	7, 665	0.00	0	8.00
9. 00	CORONARY CARE UNIT	31.00	21	7,003	0.00	ĺ	9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43. 00				0	1
14. 00	Total (see instructions)	10.00	141	51, 465	0.00		14. 00
15. 00	CAH visits			0., .00	0.00	0	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - IRF	41. 00	13	4, 745		0	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						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	
27. 00	Total (sum of lines 14-26)		154				27. 00
28. 00	Observation Bed Days					0	
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	C			32.00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions)						22 00
33.00	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01
33. UT	TETOTI SI LE TIEUTI AI MAYS AND UI SCHAI GES			1		i	J 33. UT

Provider CCN: 15-0088

						11/26/2018 2:	01 pm
		I/P Days	o/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 588	936	19, 274			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)	4, 442	6, 253				2. 00
3.00	HMO IPF Subprovider	4, 442	0, 203				3.00
4. 00	HMO IRF Subprovider	371	212				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	212	C	1		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	Ĭ	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	5, 588	936	19, 274			7. 00
7.00	beds) (see instructions)	0,000	700	17, 27 1			7.00
8.00	INTENSIVE CARE UNIT	4, 352	125	6, 285	i		8. 00
9.00	CORONARY CARE UNIT	·					9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		861	1, 052			13. 00
14.00	Total (see instructions)	9, 940	1, 922	26, 611	0.00	725. 20	14. 00
15.00	CAH visits	0	0	C)		15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	1, 419	49	2, 620	0.00	13. 09	
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
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)	0	0	0			24. 00
25. 00	CMHC - CMHC	ı o	ď	C			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)	Ĭ	Ĭ	Č	0.00	l	
28. 00	Observation Bed Days		o	1, 105		700.27	28. 00
29. 00	Ambul ance Trips	o	٦	.,			29. 00
30.00	Employee discount days (see instruction)			267	•		30.00
31. 00	Employee discount days - IRF		İ	16			31. 00
32.00	Labor & delivery days (see instructions)	o	12	128	1		32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

				10	06/30/2018	Date/IIme Pre 11/26/2018 2:0	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	40.00	40.00	11.00	Pati ents	
1 00	Illerai tel Adulte a Dede (celumne 5 / 7 and	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 Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	1, 918	171	5, 154	1. 00
2.00	HMO and other (see instructions)			865	1, 501		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	0. 00	0	1, 918	171	5, 154	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0. 00	0	117	40	214	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 25. 00	HOSPICE (non-distinct part)						24. 10 25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 00
27. 00	Total (sum of lines 14-26)	0.00					20. 23
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29.00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. U I	outpatient days (see instructions)						JZ. U1
33. 00		}		o			33. 00
	LTCH site neutral days and discharges			l o			33. 01
	1	1		١ - ١	'		

| Period: | Worksheet S-3 | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0088

Instructions Company						T	o 06/30/2018		
No. Physician and for No. No					on of Salaries	Sal ari es	Related to	Average Hourly Wage (col. 4 ÷	J1 pili
### SAMABLE SA					`	`		col. 5)	
MAMELS 1.00 Total salaries (see 200.00 50,735,696 0 50,735,696 1,536,086 6 33.03 1 1 1 1 1 1 1 1 1		DART II WACE DATA	1. 00	2. 00	3.00	4.00	5. 00	6. 00	
Description									
2.00 Non-physic clan anesthetist Part 0 0 0 0 0 0 0 0 0	1.00		200. 00	50, 735, 696	0	50, 735, 696	1, 536, 008. 65	33. 03	1. 00
4.00 Physical an Part A - Teaching	2. 00			0	О	0	0.00	0.00	2. 00
Administrative A - Teaching Physicians - Part B - Paylocians - Part B - Teaching Physicians - Part B - Paylocians - Paylocians - Paylocians - Part B - Paylocians - Part B - Paylocians - Part B - Paylocians - Paylocians - Paylocians - Paylocians - Paylocians - Part B - Paylocians - Paylocia	3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
Physicians - Part A - Teaching 0	4. 00			520, 357	0	520, 357	3, 718. 72	139. 93	4. 00
Non-physician-Part B for hopst fall-hased RRIC and FDK SerVices SerVice		Physicians - Part A - Teaching		0 3, 108, 511					4. 01 5. 00
Services	6. 00	Non-physician-Part B for		0	0	0	0.00	0. 00	6. 00
7.01 Contracted interns and residents (in an approved programs) 8.00 Home office and/or related 2,791,942	7. 00	services Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
Book Contract Co	7. 01	Contracted interns and		0	О	О	0.00	0. 00	7. 01
9.00 SNF 44.00 0 0 0 0 0 0 0 0 0	8.00	programs) Home office and/or related		2, 791, 942	0	2, 791, 942	72, 752. 56	38. 38	8. 00
Instructions OTHER WAGES & RELATED COSTS 1,590,922 0		SNF	44. 00	0	О	1		1	9. 00
11. 00 Contract Labor: Direct Patient 1,590,922 0 1,590,922 22,844.85 69.64 11. 00 Care	10. 00	instructions)		6, 588, 322	1, 257, 099	7, 845, 421	189, 431. 28	41. 42	10. 00
12. 00 Contract labor: Top level management and other management and other management and other management and administrative services	11. 00	Contract Labor: Direct Patient		1, 590, 922	0	1, 590, 922	22, 844. 85	69. 64	11. 00
management and administrative services	12. 00	Contract Labor: Top Level		0	О	0	0. 00	0. 00	12. 00
A - Administrative		management and administrative services							
organization sallaries and wage-related costs 14, 01 Home office sallaries 10, 078, 448 0 10, 078, 448 227, 868. 84 44, 23 14, 10 14, 10 14, 10 15, 10 15, 10 15, 10 16, 10		A - Administrative				, , , , , , , , , , , , , , , , , , , ,			
14. 01 Home office salaries 10,078,448 0 10,078,448 227,868,84 44.23 14.01 14. 02 Related organization salaries 0 0 0 0 0 0 0 15. 00 Home office: Physician Part A 0 0 0 0 0 0 0 16. 00 Home office: OSTS	14.00	organization salaries and		0	0	0	0.00	0.00	14.00
15.00 Home office: Physician Part A		Home office salaries		10, 078, 448	0				
Admin strative Home office and Contract Ho				0	0				
WAGE-RELATED COSTS Wage-related costs (core) (see instructions) 17.00 Wage-related costs (core) (see instructions) 17.00 19,021,139 17.00 18.00 Wage-related costs (other) (see instructions) 18.00 Wage-related costs (other) (see instructions) 18.00 18.0		- Administrative Home office and Contract		0	0	0			
Instructions Wage-related costs (other) (see instructions) 18.00 (see instructions) 18.00 (see instructions) 19.00 Excluded areas 2,775,087 0 2,775,087 19.00 20.00 Non-physic ian anesthetist Part 0 0 0 0 0 0 0 0 0									
18.00 Wage-related costs (other) (see instructions) 18.00 (see instructions) 19.00 Excluded areas 2,775,087 0 2,775,087 19.00 20.00 Non-physician anesthetist Part 0 0 0 0 0 0 0 0 0	17. 00	1. 9		19, 021, 139	0	19, 021, 139			17. 00
19. 00 Excluded areas	18. 00	Wage-related costs (other)		0	0	0			18. 00
B		Excluded areas		2, 775, 087 0	0	2, 775, 087 0			19. 00 20. 00
Administrative Administrative Physician Part A - Teaching 0 0 0 0 22.01	21. 00	Non-physician anesthetist Part B		0	О	0			21. 00
23. 00		Admi ni strati ve		117, 085	0	117, 085			22. 00
24. 00 Wage-related costs (RHC/FQHC) 25. 00 Interns & residents (in an approved program) 25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A - Administrative - wage-related (core) 25. 53 Home office & Contract Physicians Part A - Teaching - wage-related (core) 26. 00 Employee Benefits Department 27. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				699 <i>44</i> 5	0	0 699 445			22. 01 23. 00
approved program) Home office wage-related (core) 25. 50 Related organization wage-related (core) Home office: Physician Part A - Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) 25. 52 DVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 2, 903, 150 0 0 2, 903, 150 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 159, 862 0 159, 862 14, 923. 89 10. 71 26. 00	24.00	Wage-related costs (RHC/FQHC)		0,7,443	0	0			24. 00
(core) Related organization wage-related (core) 25. 52 Home office: Physician Part A - Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 4. 00 159, 862 0 159, 862 14, 923. 89 10. 71 26. 00		approved program)		2 903 150	0	_			
wage-related (core)		(core)		2, 703, 130					
- Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department		wage-related (core)		0	0	0			25. 51
Physicians Part A - Teaching -		- Administrative - wage-related (core)		Š					
OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4. 00 159, 862 0 159, 862 14, 923. 89 10. 71 26. 00	25. 53	Physicians Part A - Teaching -		0	0	0			25. 53
	a	OVERHEAD COSTS - DIRECT SALARIE							

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0088

Peri od: Worksheet S-3 From 07/01/2017 Part II To 06/30/2018 Date/Ti me Prepared:

11/26/2018 2:01 pm Wkst. A Line Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (from Wkst. Salaries in col . 5) $(col.2 \pm col.$ col. 4 A-6) 3) 6.00 1.00 5.00 2.00 4.00 3.00 28.00 Administrative & General under 694, 097 694, 097 13, 956. 76 49. 73 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 29.00 0.00 Operation of Plant 25, 834. 28 30.00 7. 00 474.076 0 474, 076 18. 35 30.00 31.00 0.00 0.00 Laundry & Linen Service 8.00 0 31.00 32.00 Housekeepi ng 9.00 0.00 0.00 32.00 33.00 Housekeeping under contract 2, 038, 006 2, 038, 006 85, 431. 00 23.86 33.00 (see instructions) 0.00 34.00 34.00 10.00 0.00 Di etary 35.00 Di etary under contract (see 474, 178 474, 178 18, 006. 00 26. 33 35. 00 instructions) 36.00 Cafeteri a 11.00 0.00 0.00 36.00 0. 00 Maintenance of Personnel 37.00 12.00 37.00 0 0 0.00 38.00 Nursing Administration 13.00 2, 246, 424 0 2, 246, 424 32, 507. 77 69. 10 38.00 39.00 Central Services and Supply 14.00 481, 864 481, 864 23, 467. 13 20. 53 39.00 71, 177. 52 Pharmacy 37. 40 40.00 15.00 2, 818, 464 -156, 677 2, 661, 787 40.00 Medical Records & Medical 41.00 16.00 0 0.00 0.00 41.00 Records Library Social Service 0 42.00 17.00 0 0 0.00 0.00 42.00 0.00 43.00 43.00 Other General Service 18.00 0 0.00

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

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0088 Peri od: From 07/01/2017 To 06/30/2018 11/26/2018 2:01 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 . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 48, 041, 524 48, 041, 524 1, 562, 803. 45 30. 74 1.00 instructions) 2.00 Excluded area salaries (see 6, 588, 322 1, 257, 099 7, 845, 421 189, 431. 28 2.00 41. 42 instructions) 3.00 Subtotal salaries (line 1 41, 453, 202 -1, 257, 099 40, 196, 103 1, 373, 372. 17 29. 27 3.00 minus line 2) 4.00 Subtotal other wages & related 15, 896, 703 15, 896, 703 285, 451. 99 55.69 4.00 costs (see inst.) Subtotal wage-related costs 5.00 22, 041, 374 Ω 22, 041, 374 0.00 54.83 5.00

-1, 257, 099

-156, 677

78, 134, 180

14, 723, 345

1, 658, 824. 16

462, 817. 03

79, 391, 279

14, 880, 022

6.00

7.00

47 10

31.81

(see inst.)

instructions)

6.00

7.00

Total (sum of lines 3 thru 5)

Total overhead cost (see

Health Financial Systems	ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0088	Period: Worksheet S-3 From 07/01/2017 Part IV

	To 06/30/2018	Date/Time Prep 11/26/2018 2:0	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 144, 915	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)	5, 408, 903	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	424, 023	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	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)	6, 323, 526	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	1, 984, 680	9. 00
10.00	Dental, Hearing and Vision Plan	39, 570	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	39, 230	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	-1, 399	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	191, 770	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	103, 551	14. 00
15. 00	'Workers' Compensation Insurance	228, 259	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		
17. 00	FICA-Employers Portion Only	3, 266, 988	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	33, 803	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	109, 858	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	20, 297, 677	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	ST.	. VIN	ICENT A	NDERSON			In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST				Provi der	CCN:	15-0088	Peri od: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part V Date/Time Pre 11/26/2018 2:	pared:
Cost Center Description							Contract Labor	Benefit Cost	
							1. 00	2. 00	
PART V - Contract Labor and Benefit Cost									
Hospital and Hospital-Based Component Identifi	catio	on:							

PART V - Contract Labor and Benefit Cost				11/20/2010 2.	O I PIII
PART V - Contract Labor and Benefit Cost Hospital and Hospital -Based Component Identification: 1.00 Total facility's contract labor and benefit cost 1,590,922 20,297,677 1.00 2.00 Hospital 1,590,922 20,297,677 2.00 3.00 Subprovi der - IPF 0 0 0 4.00 4.00 5.00 Subprovi der - (Other) 0 0 0 5.00 6.00 Swing Beds - SNF 0 0 0 6.00 6.00 Swing Beds - NF 0 0 0 6.00 8.00 Hospital -Based SNF 0 0 0 7.00 8.00 Hospital -Based NF 9.00 Hospital -Based NF 9.00 11.00 Hospital -Based HIA 10.00 12.00 Separately Certified ASC 12.00 13.00 Hospital -Based Hospice 13.00 14.00 Hospital -Based Health Clinic RHC 15.00 15.00 Hospital -Based Health Clinic FOHC 15.00 Renal Dialysis 17.00 17.00 Renal Dialysis 17.00		Cost Center Description	Contract Labor	Benefit Cost	
Hospital and Hospital - Based Component I dentification: Total facility's contract labor and benefit cost 1,590,922 20,297,677 1.00 2.00			1. 00	2. 00	
1.00		PART V - Contract Labor and Benefit Cost			
2.00 Hospi tal		Hospital and Hospital-Based Component Identification:			
3.00 Subprovi der - I PF 4.00 Subprovi der - I RF 5.00 Subprovi der - (Other) 6.00 Swi ng Beds - SNF 7.00 Swi ng Beds - NF 8.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 Hospi tal -Based HHA 12.00 Separatel y Certi fied ASC 13.00 Hospi tal -Based Hospi ce 14.00 Hospi tal -Based Heal th Clinic RHC 15.00 Hospi tal -Based Heal th Clinic FOHC 16.00 Hospi tal -Based -CMHC 17.00 Renal Dialysis	1.00	Total facility's contract labor and benefit cost	1, 590, 922	20, 297, 677	1.00
4. 00 Subprovi der - IRF	2.00	Hospi tal	1, 590, 922	20, 297, 677	2. 00
5.00 Subprovider - (Other) 6.00 Swing Beds - SNF 0 0 0 6.00 7.00 Swing Beds - NF 0 0 0 7.00 8.00 Hospi tal -Based SNF 9.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 Separatel y Certified ASC 13.00 Hospi tal -Based Heal th Clinic RHC 15.00 Hospi tal -Based Heal th Clinic FOHC 16.00 Hospi tal -Based Heal th Clinic FOHC 17.00 Renal Dialysis	3.00	Subprovi der - I PF			3. 00
6.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 Hospi tal -Based HHA 11.00 Hospi tal -Based HHA 12.00 Separatel y Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 Hospi tal -Based Heal th Clinic RHC 15.00 Hospi tal -Based Heal th Clinic FOHC 16.00 Hospi tal -Based-CMHC 17.00 Renal Dialysis	4.00	Subprovi der - I RF	0	0	4.00
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 Separatel y Certified ASC 12. 00 13. 00 Hospi tal -Based Hospi ce 14. 00 Hospi tal -Based Heal th Clinic RHC 13. 00 15. 00 Hospi tal -Based Heal th Clinic FOHC 15. 00 16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	5.00	Subprovi der - (0ther)	0	0	5. 00
8.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 11.00 Separatel y Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 Hospi tal -Based Heal th Clinic RHC 15.00 Hospi tal -Based Heal th Clinic FOHC 16.00 Hospi tal -Based-CMHC 17.00 Renal Dialysis	6.00	Swi ng Beds - SNF	0	0	6. 00
9. 00 Hospi tal -Based NF 10. 00 Hospi tal -Based OLTC 11. 00 Hospi tal -Based HHA 11. 00 12. 00 Separatel y Certi fi ed ASC 13. 00 Hospi tal -Based Hospi ce 14. 00 Hospi tal -Based Heal th Clinic RHC 15. 00 Hospi tal -Based Heal th Clinic FOHC 16. 00 Hospi tal -Based-CMHC 17. 00 Renal Dialysis	7.00	Swing Beds - NF	0	0	7. 00
10. 00 Hospi tal -Based OLTC 10. 00 11. 00 Hospi tal -Based HHA 11. 00 12. 00 Separatel y Certi fied ASC 12. 00 13. 00 Hospi tal -Based Hospi ce 13. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 14. 00 15. 00 Hospi tal -Based Heal th Clinic FQHC 15. 00 16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	8.00	Hospi tal -Based SNF			8. 00
11. 00 Hospi tal -Based HHA 11. 00 12. 00 Separatel y Certi fi ed ASC 12. 00 13. 00 Hospi tal -Based Hospi ce 13. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 14. 00 15. 00 Hospi tal -Based Heal th Clinic FQHC 15. 00 16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	9.00	Hospi tal -Based NF			9. 00
12.00 Separately Certified ASC 12.00 13.00 Hospital - Based Hospice 13.00 14.00 Hospital - Based Health Clinic RHC 14.00 15.00 Hospital - Based Health Clinic FOHC 15.00 16.00 Hospital - Based - CMHC 16.00 17.00 Renal Dialysis 17.00	10.00	Hospi tal -Based OLTC			10.00
13. 00 Hospi tal - Based Hospi ce 13. 00 14. 00 Hospi tal - Based Heal th Clinic RHC 14. 00 15. 00 Hospi tal - Based Heal th Clinic FQHC 15. 00 16. 00 Hospi tal - Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	11. 00	Hospi tal -Based HHA			11. 00
14. 00 Hospital -Based Health Clinic RHC 14. 00 15. 00 Hospital -Based Health Clinic FOHC 15. 00 16. 00 Hospital -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	12.00	Separately Certified ASC			12.00
15. 00 Hospital -Based Health Clinic FQHC 15. 00 16. 00 Hospital -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	13.00	Hospi tal -Based Hospi ce			13.00
16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 Renal Dialysis 17. 00	14.00	Hospital-Based Health Clinic RHC			14.00
17. 00 Renal Dialysis 17. 00	15. 00	Hospital-Based Health Clinic FQHC			15. 00
	16.00	Hospi tal -Based-CMHC			16. 00
18.00 Other 0 0 18.00	17.00	Renal Dialysis			17. 00
	18. 00	0ther	0	0	18. 00

Heal th	Financial Systems ST. VINCENT AND	DERSON		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	N: 15-0088	Peri od:	Worksheet S-10	0
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2:	
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by lir	ne 202 column	1 8)	0. 241262	1.00
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid		23, 461, 475	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?		N 23, 131, 173	3. 00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen	tal payments	s from Medica	ni d?		4. 00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicaio	t		0	5. 00
6.00	Medicaid charges				139, 242, 282	
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	(line 7 minu	ıs sum of lir	nes 2 and 5 if	33, 593, 871 10, 132, 396	7. 00 8. 00
0.00	<pre>< zero then enter zero)</pre>	(TTTIC 7 IIITTIC	33 34III 01 111	ics 2 and 5, 11	10, 132, 370	0.00
	Children's Health Insurance Program (CHIP) (see instructions for	or each line	e)			
9.00	Net revenue from stand-alone CHIP				0	
10.00	Stand-allone CHIP charges				0	10.00
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(line 11 mir	nus line 9· i	f < zero then	0	12.00
12.00	enter zero)	(11116 11 11111	ius i i iic 7, i	1 \ Zero then		12.00
	Other state or local government indigent care program (see ins					
13.00	Net revenue from state or local indigent care program (Not incl				0	
14. 00	Charges for patients covered under state or local indigent card 10)	e program (r	not included	in lines 6 or	0	14. 00
15. 00	State or local indigent care program cost (line 1 times line 1	4)			0	15. 00
16.00	Difference between net revenue and costs for state or local in		program (lin	ne 15 minus line	0	16. 00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	IP and state	e/Local Indio	gent care program	ns (see	
17. 00	Private grants, donations, or endowment income restricted to fi	undi ng chari	ty care		0	17. 00
18.00	Government grants, appropriations or transfers for support of				0	18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	l indigent o	care programs	s (sum of lines	10, 132, 396	19. 00
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
			1. 00	2. 00	3. 00	
20.00	Uncompensated Care (see instructions for each line)	-:::	17 110 0	7 515 000	24 (24 14(20.00
20. 00	Charity care charges and uninsured discounts for the entire far (see instructions)	Cility	17, 118, 3	7, 515, 802	24, 634, 146	20.00
21. 00	Cost of patients approved for charity care and uninsured disco	unts (see	4, 130, 00	7, 515, 802	11, 645, 808	21. 00
	instructions)					
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00
23 00	charity care Cost of charity care (line 21 minus line 22)		4, 130, 00	7, 515, 802	11, 645, 808	23 00
20.00	cost of chartty care (fine 21 minus fine 22)		1, 100, 0	7,010,002	11,010,000	20.00
					1. 00	
24. 00	Does the amount on line 20 column 2, include charges for patien		ond a Length	of stay limit	N	24. 00
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the stay limit		care program	n's length of	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see in:	structions)			4, 138, 470	26. 00
27. 00	Medicare reimbursable bad debts for the entire hospital complet	,	ructions)		684, 482	
27. 01	Medicare allowable bad debts for the entire hospital complex (see instruct	tions)		1, 053, 050	1
28. 00	Non-Medicare bad debt expense (see instructions)				3, 085, 420	1
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex Cost of uncompensated care (line 23 column 3 plus line 29)	pense (see i	nstructions)	1	1, 112, 963 12, 758, 771	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus I)	i ne 30)			22, 891, 167	
200	1.111. Implication and anomythological control (1116-17) plus 1					,

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	ST. VINCENT F FXPFNSFS	ANDERSON Provi der CO	CN: 15-0088	In Lie Period:	u of Form CMS- Worksheet A	2552-10
11202710		- E/ E.1.020		1	From 07/01/2017 To 06/30/2018		
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FLXT		2, 996, 717	2, 996, 71	138, 569	3, 135, 286	1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MAB	450.040	0		o	0	1. 01
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	159, 862 5, 493, 051	12, 518, 923 42, 816, 208			12, 678, 785 48, 099, 619	4. 00 5. 00
7.00	00700 OPERATION OF PLANT	474, 076	5, 152, 569	5, 626, 64	5 0	5, 626, 645	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	465, 004 2, 424, 576			465, 004 2, 424, 576	
10.00	01000 DI ETARY	0	2, 944, 630			907, 381	
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	422 445	2 490 09	2, 037, 249	2, 037, 249 2, 680, 089	
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 246, 424 481, 864	433, 665 192, 779			2, 680, 089 674, 643	
15. 00	01500 PHARMACY	2, 818, 464	898, 426			3, 560, 213	1
16. 00 23. 00	01600 MEDICAL RECORDS & LIBRARY 02300 ALLIED HEALTH-EMS	0 151, 466	10, 879 14, 846			10, 879 113, 751	1
23. 01	02301 ALLIED HEALTH-RAD TECH	67, 706	30, 145			216, 197	23. 01
23. 02	02303 ALLI ED HEALTH-PHARM RESI DENTS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	94, 725	18, 228	112, 95	3 156, 677	269, 630	23. 02
30. 00	03000 ADULTS & PEDIATRICS	11, 427, 560	1, 478, 223	12, 905, 78	3 -1, 419, 028	11, 486, 755	30.00
31.00	03100 I NTENSI VE CARE UNI T	3, 432, 730	1, 287, 345			4, 720, 075	
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	905, 856 0	228, 024 0		0 350, 625	1, 133, 880 350, 625	
	ANCILLARY SERVICE COST CENTERS						
50. 00 52. 00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	1, 207, 394 1, 497, 651	17, 412, 009 337, 798			17, 556, 091 1, 128, 857	1
53. 00	05300 ANESTHESI OLOGY	0	0		1, 216, 350	1, 216, 350	1
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03440 MAMMOGRAPHY	1, 839, 867 192, 847	1, 093, 235 270, 079			2, 814, 756 462, 926	
54. 01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	305, 648	675, 794			981, 442	
54. 03	03630 ULTRA SOUND	379, 355	129, 566			508, 921	
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	900, 269 515, 191	1, 633, 705 181, 759			2, 533, 974 696, 950	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	249, 012	520, 590	769, 60:	2 0	769, 602	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	974, 232 48, 044	319, 116 6, 719, 007			1, 293, 348 6, 767, 051	
65. 00	06500 RESPI RATORY THERAPY	1, 082, 613	177, 826	1, 260, 43	55, 433	1, 315, 872	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 736, 476	610, 322	3, 346, 79	3 -1, 212, 024 0 889, 241	2, 134, 774 889, 241	1
68. 00	06800 SPEECH PATHOLOGY	0	0		322, 783	322, 783	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	117, 967	47, 036			165, 003	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	346, 475 0	226, 649 3, 280, 817			573, 124 3, 143, 417	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	4, 668, 949			4, 668, 949	
	07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY	781, 370	20, 868, 280 245, 213			20, 868, 280 1, 026, 583	
	OUTPATIENT SERVICE COST CENTERS		,				
90. 00 90. 01	09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER	0 1, 094, 265	0 554, 369		0 4 633, 544	0 2, 282, 178	
90. 02	04950 DIABETIC EDUCATION	0	0	1,040,03	0 0 0	2, 202, 170	1
90. 03 91. 00	09002 MS CLINIC 09100 EMERGENCY	43, 430 3, 301, 237	4, 813 1, 615, 911			48, 243 4, 969, 709	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 301, 237	1,015, 711	4, 717, 140	52, 501	4, 707, 707	92.00
112 00	SPECIAL PURPOSE COST CENTERS		0	1		0	113. 00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	45, 367, 127	135, 504, 030		0	179, 729, 706	
100.00	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH	0 64, 837	0 59, 507	124, 34	0 4 0	0 124, 344	190. 00 191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	3, 162, 501	900, 731	4, 063, 23	2 0	4, 063, 232	192. 00
	07950 FOUNDATI ON 07951 CHI LDRENS CLI NI C	133, 017 254, 091	114, 320 107, 020			247, 337 361, 111	
	07952 PSS ADMINISTRATION	21, 925	1, 682				194. 02
	07953 SEXUAL ASSULT PROGRAM 07954 ASPR BIOTERRORISM GRANT	106, 656	11, 506			118, 162	
	07955 HEALTHY FAMILIES	320, 299	12, 644 131, 840			452, 139	194. 04 194. 05
194.06	07956 DME-HOME CARE	1, 177, 705	3, 252, 894	4, 430, 59	9 0	4, 430, 599	194. 06
	07957 MARKETING 07958 CORPORATE COMMUNICATIONS	0	0		0 0		194. 07 194. 08
194. 09	07959 MOB	o	355			355	194. 09
	07960 ASC 07961 MAB	0	2, 126 0		6 0 0 0		194. 10 194. 11
	07963 ADOLESCENT RESIDENTIAL SERVICES	127, 538	9, 231			1, 278, 220	

Health Financial Systems	ST. VINCENT	ANDERSON		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Peri od:	Worksheet A	
				From 07/01/2017 Fo 06/30/2018	Date/Time Pre 11/26/2018 2:	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	
194. 13 07962 I DLE SPACE	0	0	(0	0	194. 13
200.00 TOTAL (SUM OF LINES 118 through 199)	50, 735, 696	140, 107, 886	190, 843, 582	2 0	190, 843, 582	200. 00

 Health Financial
 Systems
 ST. VIN

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-0088 Peri od: Worksheet A From 07/01/2017 To 06/30/2018 Date/Time Prepared:

				10 06/3	0/2018 Date/lime Prepard 11/26/2018 2:01	
	Cost Center Description	Adjustments	Net Expenses	,	1	
			For Allocation			
CEA	NERAL SERVICE COST CENTERS	6. 00	7. 00			
	100 CAP REL COSTS-BLDG & FLXT	2, 146, 677	5, 281, 963		1	1. 00
	101 CAP REL COSTS-BLDG & FIXT-MAB	0	0	I		1. 01
4.00 004	400 EMPLOYEE BENEFITS DEPARTMENT	35, 059	12, 713, 844	I	4	4. 00
1	500 ADMINISTRATIVE & GENERAL	-6, 935, 430	41, 164, 189	I		5. 00
1	700 OPERATION OF PLANT	-6, 087	5, 620, 558	I		7. 00
1	BOO LAUNDRY & LINEN SERVICE ROO HOUSEKEEPING	-399 0	464, 605 2, 424, 576	I		8. 00 9. 00
	000 DI ETARY	-688, 916	218, 465			0. 00
	100 CAFETERI A	0	2, 037, 249	I		1. 00
	BOO NURSING ADMINISTRATION	-80, 200	2, 599, 889			3. 00
14. 00 014	400 CENTRAL SERVICES & SUPPLY	0	674, 643	I	14	4. 00
1	500 PHARMACY	-21, 800	3, 538, 413	I		5. 00
1	600 MEDICAL RECORDS & LIBRARY	-10, 879	112 224	I		6. 00
1	300 ALLIED HEALTH-EMS 301 ALLIED HEALTH-RAD TECH	-515 -13, 850	113, 236 202, 347	I		3. 00 3. 01
1	303 ALLIED HEALTH-PHARM RESIDENTS	- 13, 630	269, 630			3. 02
	PATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	2077 000			J. 02
	000 ADULTS & PEDIATRICS	-3, 015, 214	8, 471, 541		30	0. 00
1	100 INTENSIVE CARE UNIT	-131	4, 719, 944	1		1. 00
1	100 SUBPROVI DER - I RF	-261	1, 133, 619	I		1.00
	300 NURSERY	0	350, 625		43	3. 00
	CILLARY SERVICE COST CENTERS DOO OPERATING ROOM	-725, 828	16, 830, 263		50	0. 00
1	200 DELIVERY ROOM & LABOR ROOM	-5, 361	1, 123, 496			2. 00
53. 00 053	BOO ANESTHESI OLOGY	o	1, 216, 350		53	3. 00
	400 RADI OLOGY-DI AGNOSTI C	-3, 029	2, 811, 727	I		4. 00
	440 MAMMOGRAPHY	0	462, 926	1		4. 01
	450 NUCLEAR MEDICINE - DIAGNOSTIC	0	981, 442	l		4. 02
1	630 ULTRA SOUND	-5, 531	503, 390			4. 03
1	500 RADI OLOGY-THERAPEUTI C 700 CT SCAN	-759 -376	2, 533, 215 696, 574		•	5. 00 7. 00
	BOO MAGNETIC RESONANCE IMAGING (MRI)	-6, 228	763, 374			8. 00
	900 CARDI AC CATHETERI ZATI ON	-376	1, 292, 972			9. 00
	DOO LABORATORY	0	6, 767, 051	I		0. 00
65. 00 065	500 RESPI RATORY THERAPY	-24, 204	1, 291, 668	I	65	5. 00
	600 PHYSI CAL THERAPY	-17, 993	2, 116, 781	1		6. 00
1	700 OCCUPATI ONAL THERAPY	0	889, 241	1		7. 00
1	BOO SPEECH PATHOLOGY	0	322, 783	I		8. 00
1	900 ELECTROCARDI OLOGY DOO ELECTROENCEPHALOGRAPHY	-840 -29, 000	164, 163 544, 124	1		9. 00 0. 00
1	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-27,000	3, 143, 417			1. 00
1	200 IMPL. DEV. CHARGED TO PATIENTS	o	4, 668, 949	I		2. 00
	BOO DRUGS CHARGED TO PATIENTS	o	20, 868, 280		73	3. 00
	190 CHEMOTHERAPY	0	1, 026, 583	1	76	6. 00
	FPATIENT SERVICE COST CENTERS					
	DOO CLINIC DO1 ANDERSON OUTPATIENT CENTER	0 -150, 655	0 2, 131, 523			0. 00 0. 01
	950 DIABETIC EDUCATION	- 150, 655	2, 131, 523			0. 01
1	002 MS CLINIC	l ől	48, 243			0. 03
	100 EMERGENCY	-1, 145, 928	3, 823, 781		91	1. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART)			<u>I</u>	92	2. 00
	ECIAL PURPOSE COST CENTERS	ا ما			115	
113.00 113	300 INTEREST EXPENSE	0 -10, 708, 054	0 169, 021, 652		•	3.00
	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	- 10, 706, 034	109, 021, 032		110	8. 00
	DOO GIFT, FLOWER, COFFEE SHOP, & CANTEEN	ol	0		190	0. 00
	100 RESEARCH	Ö	124, 344			1. 00
192. 00 192	200 PHYSICIANS' PRIVATE OFFICES	o	4, 063, 232			2. 00
	950 FOUNDATION	0	247, 337			4. 00
	951 CHI LDRENS CLI NI C	0	361, 111	l		4. 01
1	952 PSS ADMINISTRATION	0	23, 607	I		4. 02
	953 SEXUAL ASSULT PROGRAM 954 ASPR BIOTERRORISM GRANT	0	118, 162 12, 644			4. 03 4. 04
	955 HEALTHY FAMILIES	0	12, 644 452, 139			4. 04 4. 05
	956 DME-HOME CARE	o	4, 430, 599			4. 06
	957 MARKETI NG	873, 156	873, 156			4. 07
	958 CORPORATE COMMUNICATIONS	0	0		194	4. 08
194. 09 079	959 MOB	o	355			4. 09
194. 10 079		0	2, 126			4. 10
194. 11 079		0	1 270 220			4. 11
	963 ADOLESCENT RESIDENTIAL SERVICES 962 IDLE SPACE	0	1, 278, 220			4. 12 4. 13
200. 00	TOTAL (SUM OF LINES 118 through 199)	-9, 834, 898	181, 008, 684		•	0. 00
200.00	(00 0. 220 110 till odgir 177)	7,001,070	, ,		1200	

Health Financial Systems RECLASSIFICATIONS ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 Provider CCN: 15-0088

Peri od: Worksheet A-6 From 07/01/2017 To 06/30/2018 Date/Time Prepared:

					ate/IIMe Prepared 1/26/2018 2:01 pm
		Increases			
	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3. 00	4. 00	5. 00	
	B - INSURANCE EXPENSE RECLASS				
00	CAP REL COSTS-BLDG & FIXT	1. 00	0	145, 164	1.
00		0.00	0	0	2.
	TOTALS		0	145, 164	
	C - INTEREST EXPENSE RECLASS				
00	ADMI NI STRATI VE & GENERAL		0	<u>6, 5</u> 95	1.
	TOTALS		0	6, 595	
	D - CAFETERIA/DIETARY RECLASS				
00	CAFETERI A	11. 00	0	<u>2, 037, 2</u> 49	1.
	TOTALS		0	2, 037, 249	
	E - LABOR DELIVERY RECLASS				
00	ADULTS & PEDIATRICS	30. 00	290, 454	65, 513	1.
00	NURSERY	43. 00	286, 096	6 <u>4, 5</u> 29	2.
	TOTALS		576, 550	130, 042	
	H - PT_OT_ST RECLASS				
00	OCCUPATI ONAL THERAPY	67.00	727, 079	162, 162	1.
00	SPEECH PATHOLOGY	68.00	263, 920	58, 863	2.
	TOTALS		990, 999	221, 025	
	J - ADOLESCENT RESIDENTIAL SE	RVI CES			
00	ADOLESCENT RESIDENTIAL	194. 12	1, 034, 637	106, 814	1.
	SERVI CES				
	TOTALS		1, 034, 637	106, 814	
	K - AH-PHARMACY RESIDENCY REC	LASS			
00	ALLIED HEALTH-PHARM	23. 02	156, 677	0	1.
	RESI DENTS				
	TOTALS		156, 677	0	
	M - RAD TECH RECLASS				
00	ALLIED HEALTH-RAD TECH	23. 01	118, 346	0	1.
	TOTALS	- $ +$	118, 346	-	
	O - ANESTHESI OLOGY RECLASS			·	
00	ANESTHESI OLOGY	53.00	0	1, 216, 350	1.
00		0.00	o	О	2.
	TOTALS			1, 216, 350	
	P - AND CTR OP RECLASS	•	•		
00	ANDERSON OUTPATIENT CENTER	90. 01	576, 027	57, 517	1.
	TOTALS		576, 027	57, 517	
	Q - PHYSICIAN RECLASS				
00	OPERATING ROOM	50.00	0	15, 638	1.
00	RESPIRATORY THERAPY	65.00	ol	55, 433	2.
	TOTALS			71, 071	-
	R - SECURITY OFFICERS TO ED				
00	EMERGENCY	91.00	52, 561	0	1.
-	TOTALS	— — — ' †	52, 561	0	
0 00	Grand Total: Increases		3, 505, 797	3, 991, 827	500.

Health Financial Systems RECLASSIFICATIONS ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 Provider CCN: 15-0088

Peri od: Worksheet A-6 From 07/01/2017 To 06/30/2018 Date/Time Prepared:

						0 00/30/2010	11/26/2018 2: 01 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	B - INSURANCE EXPENSE RECLASS						
. 00	ADMINISTRATIVE & GENERAL	5. 00	0	145, 164			1. 0
2. 00		0.00	•	0			2. 0
	TOTALS		0	145, 164			
	C - INTEREST EXPENSE RECLASS						
. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	<u>6, 5</u> 95			1.0
	TOTALS		0	6, 595			
	D - CAFETERIA/DIETARY RECLASS						
. 00	DI ETARY	1000	0	<u>2, 037, 2</u> 49			1. 0
	TOTALS		0	2, 037, 249)		
	E - LABOR DELIVERY RECLASS						
. 00	DELIVERY ROOM & LABOR ROOM	52.00	576, 550	130, 042	0		1.0
. 00		0.00	0	0			2. 0
	TOTALS		576, 550	130, 042	2		
	H - PT_OT_ST RECLASS						
. 00	PHYSI CAL THERAPY	66. 00	990, 999	221, 025	0		1. 0
. 00		0.00	0	0	00		2. 0
	TOTALS		990, 999	221, 025	5		
	J - ADOLESCENT RESIDENTIAL SE	RVI CES					
. 00	ADULTS & PEDIATRICS	30.00	1, 034, 637	106, 814	0		1. 0
	TOTALS		1, 034, 637	106, 814			
	K - AH-PHARMACY RESIDENCY REC	LASS					
. 00	PHARMACY	15. 00	156, 677	0	0		1.0
	TOTALS		156, 677	0			
	M - RAD TECH RECLASS						
. 00	RADI OLOGY-DI AGNOSTI C	54. 00	118, 346	0	0		1.0
	TOTALS		118, 346	0			
	O - ANESTHESIOLOGY RECLASS						
. 00	OPERATING ROOM	50.00	0	1, 078, 950	0		1.0
. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	137, 400	0		2. 0
	PATI ENTS						
	TOTALS		0	1, 216, 350			
	P - AND CTR OP RECLASS						
. 00	ADULTS & PEDIATRICS	30.00	576, 027	57, 517	0		1.0
	TOTALS		576, 027	57, 517			
	Q - PHYSICIAN RECLASS		·				
. 00	ADMINISTRATIVE & GENERAL	5. 00	0	15, 638	0		1.0
. 00	ADMINISTRATIVE & GENERAL	5. 00	o	55, 433			2. 0
	TOTALS	— — [—] †	 	71, 071			
	R - SECURITY OFFICERS TO ED	<u>'</u>					
. 00	ALLI ED HEALTH-EMS	23. 00	52, 561	0	0		1.0
	TOTALS	 _	52, 561				
00.00	Grand Total: Decreases		3, 505, 797	3, 991, 827	,		500. 0

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS ST. VINCENT ANDERSON

Provider CCN: 15-0088

					To 06/30/2018	Date/Time Pre	
				Acqui si ti ons		11/26/2018 2:	OI pm
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	rui chases	Donation	Total	Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	0.00	1. 00	0.00	
1.00	Land	5, 292, 602	0		0 0	0	1. 00
2.00	Land Improvements	1, 539, 559	o		0 0	0	2. 00
3.00	Buildings and Fixtures	65, 433, 115	1, 765, 664		0 1, 765, 664	6, 789	3. 00
4.00	Building Improvements	0	О		0 0	0	4. 00
5.00	Fi xed Equipment	31, 415, 641	o		0 0	0	5. 00
6.00	Movable Equipment	50, 470, 085	4, 025, 383		0 4, 025, 383	516, 957	6. 00
7.00	HIT designated Assets	0	0		0 0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	154, 151, 002	5, 791, 047		0 5, 791, 047	523, 746	8. 00
9.00	Reconciling Items	0	0		0 0	0	9. 00
10. 00	Total (line 8 minus line 9)	154, 151, 002	5, 791, 047		0 5, 791, 047	523, 746	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		al				
1.00	Land	5, 292, 602	0				1. 00
2.00	Land Improvements	1, 539, 559	0				2. 00
3.00	Buildings and Fixtures	67, 191, 990	0				3. 00
4.00	Building Improvements	01 445 (44	0				4.00
5.00	Fi xed Equi pment	31, 415, 641	0				5. 00
6.00	Movable Equipment	53, 978, 511	0				6. 00
7.00	HIT designated Assets	150 410 202	U				7. 00
8.00	Subtotal (sum of lines 1-7)	159, 418, 303	0				8. 00 9. 00
9. 00 10. 00	Reconciling Items Total (line 8 minus line 9)	159, 418, 303	0				10.00
10.00	Tiotal (Title o milius Title 9)	109, 418, 303	υĮ				10.00

Health Financial Systems	ST. VI NCENT	ANDERSON		In Lieu of Form CMS-25		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0088	Peri od:	Worksheet A-7	
				From 07/01/2017		
				To 06/30/2018	Date/Time Pre 11/26/2018 2:	parea:
·		SI	JMMARY OF CAP	Ι ΤΔΙ	11/20/2010 2.	I
		30	DIVINIANT OF CAL	IIAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	.,			,	instructions)	
	9. 00	10.00	11.00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	2, 996, 717	0		0 0	0	1.00
1.01 CAP REL COSTS-BLDG & FLXT-MAB	0	0		0 0	0	1. 01
3.00 Total (sum of lines 1-2)	2, 996, 717	0		0 0	0	3. 00
	SUMMARY 0	F CAPITAL				
Cost Center Description		Total (1) (sum				
	Capi tal -Relate					
	d Costs (see	through 14)				
	instructions)					
	14. 00	15.00	L			
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	· ·				
1.00 CAP REL COSTS-BLDG & FLXT	0	2, 996, 717				1. 00
1. 01 CAP REL COSTS-BLDG & FIXT-MAB	0	0 00 717				1. 01

0 0 0

2, 996, 717

1.00 1. 01 3. 00

3.00 Total (sum of lines 1-2)

Health Financial Systems	ST. VI NCENT	ANDERSON		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 07/01/2017 To 06/30/2018		pared:
	COMPUTATION OF RATIOS ALLOCATION OF OTHER CA					
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)		Insurance	
DART III DECONCLILATION OF CARLTAL COCTS OF	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MAB Total (sum of lines 1-2)	159, 418, 303 0 159, 418, 303	0	159, 418, 30	0. 000000 1. 000000		1. 00 1. 01 3. 00
Cost Center Description		Other Capi tal -Relate d Costs	through 7)	·	Lease	
DART III DECONOLILIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MAB 3.00 Total (sum of lines 1-2)	0 0 0	0 0		0 2, 550, 808 0 0 0 0 2, 550, 808	0 0	1. 00 1. 01 3. 00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see instructions)	,	Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11. 00	12.00	13.00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT 1.01 CAP REL COSTS-BLDG & FIXT-MAB 3.00 Total (sum of lines 1-2)	2, 585, 991 0 2, 585, 991	0		0 0 0	5, 281, 963 0 5, 281, 963	1. 00 1. 01 3. 00

Health Financial Systems ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0088 Peri od: Worksheet A-8 From 07/01/2017 06/30/2018 Date/Time Prepared: 11/26/2018 2:01 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL -482, 562 CAP REL COSTS-BLDG & FLXT 1. 00 1.00 11 Α COSTS-BLDG & FIXT (chapter 2) 1.01 Investment income - CAP REL OCAP REL COSTS-BLDG & 1.01 1.01 COSTS-BLDG & FIXT-MAB (chapter FIXT-MAB 2) 2.00 Investment income - CAP REL 0 *** Cost Center Deleted *** 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) -6, 042 ADMI NI STRATI VE & GENERAL 3.00 Investment income - other Α 5 00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) 6.00 Rental of provider space by 6.00 0.00 suppliers (chapter 8) 7.00 Tel ephone services (pay -18, 035 ADMINISTRATIVE & GENERAL 5.00 7.00 Α stations excluded) (chapter 21) -6, 087 OPERATION OF PLANT 8.00 8.00 Tel evi si on and radio servi ce 7.00 Α 0 (chapter 21) 9 00 Parking lot (chapter 21) 0.00 9 00 Provider-based physician -5, 190, 757 10.00 A-8-2 10.00 adj ustment Sale of scrap, waste, etc. (chapter 23) 11.00 11.00 0 0.00 12.00 Related organization A-8-1 8 065 040 12 00 transactions (chapter 10) 13 00 Laundry and linen service В -399 LAUNDRY & LINEN SERVICE 8.00 13.00 -629, 465 DI ETARY 14.00 Cafeteria-employees and guests В 10.00 14.00 15 00 Rental of quarters to employee 0 00 15.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents Sale of drugs to other than -21, 695 PHARMACY 17.00 17.00 В 15.00 ol pati ents -10, 879 MEDI CAL RECORDS & LI BRARY 18.00 Sale of medical records and B 16.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) -59, 451 DI ETARY 20 00 Vending machines 10 00 20 00 В 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) 0 *** Cost Center Deleted *** 25.00 25.00 Utilization review -114.00 physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 26.00 COSTS-BLDG & FLXT

OCAP REL COSTS-BLDG &

O OCCUPATIONAL THERAPY

OADULTS & PEDIATRICS

0 *** Cost Center Deleted ***

0 *** Cost Center Deleted ***

FLXT-MAB

1.01

2.00

19.00

0.00

67.00

30.00

26.01

27.00

28.00

29.00

30.00

30.99

26.01

27.00

28.00

29.00

30.00

Depreciation - CAP REL

COSTS-BLDG & FLXT-MAB

Depreciation - CAP REL

Physicians' assistant

Non-physician Anesthetist

Adjustment for occupational

therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see A-8-3

COSTS-MVBLE EQUIP

instructions)

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0088 Peri od: Worksheet A-8 From 07/01/2017 06/30/2018 Date/Time Prepared: 11/26/2018 2:01 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code (2) Cost Center Description Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4. 00 5.00 31.00 Adjustment for speech OSPEECH PATHOLOGY 31. 00 A-8-3 68.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest 33.00 OTHER MI SCELLANEOUS REVENUE -4,807 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.00 В -124, 309 ADMI NI STRATI VE & GENERAL OTHER MI SCELLANEOUS REVENUE 33.01 R 5.00 0 33.01 33.02 OTHER MI SCELLANEOUS REVENUE В -105 PHARMACY 15.00 33.02 OTHER ADJUSTMENTS (SPECIFY) 33.03 0.00 33.03 (3)OTHER MI SCELLANEOUS REVENUE -13, 850 ALLI ED HEALTH-RAD TECH 33.04 В 23.01 33.04 0 OTHER MI SCELLANEOUS REVENUE -7, 371 OPERATING ROOM ol 33.05 В 50.00 33.05 OTHER MI SCELLANEOUS REVENUE В -2, 278 RADI OLOGY-DI AGNOSTI C 54.00 33.06 33.06 -261 SUBPROVI DER - I RF 33 07 OTHER MI SCELLANEOUS REVENUE В 41.00 33.07 OTHER MI SCELLANEOUS REVENUE 33.08 -560 RADI OLOGY-THERAPEUTI C 55.00 0 33.08 В OTHER MI SCELLANEOUS REVENUE 33.09 В -6. 228 MAGNETIC RESONANCE I MAGING 58.00 33.09 (MRI) OTHER MI SCELLANEOUS REVENUE -71 ANDERSON OUTPATIENT CENTER 33. 10 В 90.01 33.10 33.11 OTHER MI SCELLANEOUS REVENUE В -6, 126 RESPIRATORY THERAPY 65.00 33.11 -17, 993 PHYSI CAL THERAPY OTHER MI SCELLANEOUS REVENUE 33.12 В 66.00 33.12 33. 13 OTHER MI SCELLANEOUS REVENUE В -2, 489 EMERGENCY 91.00 33.13 -435, 367 CAP REL COSTS-BLDG & FIXT 33.14 LEASE INCOME В 1.00 33.14 OTHER ADJUSTMENTS (SPECIFY) 33 15 0 00 33 15 36.00 OTHER ADJUSTMENTS (SPECIFY) 0 0.00 36.00 36, 01 OTHER ADJUSTMENTS (SPECIFY) 0.00 36.01 OTHER ADJUSTMENTS (SPECIFY) 36.02 0 00 36 02 36.03 OTHER ADJUSTMENTS (SPECIFY) 0.00 36.03 OTHER ADJUSTMENTS (SPECIFY) 36.04 0.00 36.04 OTHER ADJUSTMENTS (SPECIFY) 36, 05 0.00 36, 05 OTHER ADJUSTMENTS (SPECIFY) 36.06 0.00 36.06 PHYSICIAN RECRUITMENT EXPENSE -45, 278 ADMINI STRATI VE & GENERAL 36.07 5.00 36.07 PHYSICIAN RECRUITMENT EXPENSE -8. 178 ADULTS & PEDIATRICS 36.08 30.00 0 36.08 Α PHYSICIAN RECRUITMENT EXPENSE -5, 531 ULTRA SOUND 36.09 Α 54.03 36.09 36. 10 OTHER ADJUSTMENTS (SPECIFY) 0.00 36.10 Α 36 11 PROVIDER TAX EXPENSE Α -10, 803, 658 ADMI NI STRATI VE & GENERAL 5.00 0 36. 11 MARKETING EXPENSE -144 RADI OLOGY-THERAPEUTI C 36. 12 55.00 0 36, 12 Α -515 ALLI ED HEALTH-EMS 36. 13 MARKETING EXPENSE Α 23.00 36.13 MARKETING EXPENSE -41, 122 ADMINI STRATI VE & GENERAL 36.14 5.00 36.14 36. 15 MARKETING EXPENSE -865 DELIVERY ROOM & LABOR ROOM 52.00 36. 15 Α CHARITABLE CONTRIBUTIONS -1, 435 ADMI NI STRATI VE & GENERAL 36, 16 Α 5.00 36, 16 36. 17 CHARITABLE CONTRIBUTIONS Α -80, 200 NURSING ADMINISTRATION 13.00 36.17 36, 18 CORPORATE SPONSORSHIPS Α -90, 793 ADMINI STRATI VE & GENERAL 5.00 36. 18 COMMUNITY BENEFIT -55 RADI OLOGY-THERAPEUTI C 36, 19 Α 55.00 36, 19 36. 20 COMMUNITY BENEFIT Α -52, 940 ADMINISTRATIVE & GENERAL 5.00 ol 36.20 INCENTIVE PAY OFFSET 269, 425 ADMINISTRATIVE & GENERAL 36.21 5.00 36.21 39, 866 EMPLOYEE BENEFITS DEPARTMENT INCENTIVE PAY OFFSET 36. 22 36. 22 4.00 Α -1. 686 ADMINISTRATIVE & GENERAL 36, 23 LATE FEES AND PENALTIES Α 5.00 0 36, 23 36. 24 LOBBYING EXPENSE Α -2, 195 ADMI NI STRATI VE & GENERAL 5.00 36. 24 36. 25 DEPRECIATION AHA LIFE Α -10,542 CAP REL COSTS-BLDG & FIXT 1.00 36, 25 ADJUSTMENT 36, 26 PROMOTIONAL ITEMS Α -840 ELECTROCARDI OLOGY 69.00 0 36, 26 36.27 PROMOTIONAL ITEMS -8, 630 ADMI NI STRATI VE & GENERAL Α 5.00 36, 27 36. 28 PROMOTIONAL ITEMS -1, 037 ADULTS & PEDIATRICS 30.00 36. 28 Α -131 INTENSIVE CARE UNIT 36, 29 PROMOTIONAL ITEMS Α 31.00 36.29 36, 30 PROMOTIONAL ITEMS -4, 496 DELIVERY ROOM & LABOR ROOM 52.00 ol 36, 30 Α 36.31 PROMOTIONAL ITEMS Α -751 RADI OLOGY-DI AGNOSTI C 54.00 36.31 PROMOTIONAL ITEMS -376 CT SCAN 57.00 36.32 Α 36.32 36, 33 PROMOTIONAL ITEMS -376 CARDIAC CATHETERIZATION 59.00 0 36, 33 Α PROMOTIONAL ITEMS -268RESPIRATORY THERAPY 36.34 Α 65.00 0 36.34 36.35 OTHER ADJUSTMENTS (SPECIFY) 0.00 36.35 (3)

Health Financial Systems		ST. VINCENT	ANDERSON	In Li€	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Peri od:	Worksheet A-8		
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2:	pared: 01 pm_
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4. 00	5. 00	
50.00 TOTAL (sum of lines 1 thru 49)		-9, 834, 898				50. 00
(Transfer to Worksheet A,						
column 6, line 200.)						

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

- A. Costs if cost, including applicable overhead, can be determined.

 B. Amount Received if cost cannot be determined.

 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

 Note: See instructions for column 5 referencing to Worksheet A-7.

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

0.00

0.00

0.00

TOTALS (sum of lines 1-4).

Transfer column 6, line 5 to Worksheet A-8, column 2,

Provider CCN: 15-0088

Worksheet A-8-1

0

0

0

34, 231, 650

C

42, 296, 690

4 23

4.24

4.25

5.00

From 07/01/2017 06/30/2018 Date/Time Prepared: 11/26/2018 2:01 pm Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 3.00 4.00 5.00 1.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00 5. OO ADMINISTRATIVE & GENERAL HOME OFFICE COSTS 35, 824, 900 31, 708, 164 2.00 194. 07 MARKETI NG HOME OFFICE COSTS 3.00 873, 156 4.00 4. 00 EMPLOYEE BENEFITS DEPARTMENT SVH CHARGEBACK 1, 420, 134 1, 420, 134

1.00 2.00 3.00 4.00 4.01 5. 00 ADMINISTRATIVE & GENERAL SVH CHARGEBACK 306, 720 306, 720 4.01 15. 00 PHARMACY 4 02 SVH CHARGEBACK -10, 925 -10 925 4 02 23. 01 ALLI ED HEALTH-RAD TECH 4.03 SVH CHARGEBACK 24, 181 24, 181 4.03 4.04 30.00 ADULTS & PEDIATRICS SVH CHARGEBACK 455 455 4.04 4.05 52. OODELIVERY ROOM & LABOR ROOM SVH CHARGEBACK 350 350 4 05 54. 00 RADI OLOGY-DI AGNOSTI C 4.06 SVH CHARGEBACK 84, 819 84, 819 4.06 4.07 55. 00 RADI OLOGY-THERAPEUTI C SVH CHARGEBACK 6.192 6, 192 4.07 59. 00 CARDI AC CATHETERI ZATI ON 4.08 SVH CHARGEBACK 114,000 114,000 4.08 65. 00 RESPIRATORY THERAPY SVH CHARGEBACK 4 09 900 900 4 09 4.10 91. 00 EMERGENCY SVH CHARGEBACK 350 350 4. 10 194.06 DME-HOME CARE SVH CHARGEBACK 43, 013 4.11 43,013 1.00 CAP REL COSTS-BLDG & FIXT HOME OFFICE COST 3, 075, 148 4.12 4.12 5. 00 ADMINISTRATIVE & GENERAL 4.13 HOME OFFICE COST 533, 297 533, 297 4 13 4.14 0.00 4.14 0 0.00 4.15 0 4.15 0.00 0 4.16 C 4. 16 0.00 0 4.17 C 4. 17 0.00 4.18 4.18 0 4.19 0.00 0 4.19 0 4.20 0.00 0 4.20 4 21 0.00 4 21 4.22 0.00 0 0 4.22

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

1100 1101	The Book posted to Heritanoet A, octamino i ana, or 2, the amount arrowable chock a borrior octamin i or this parti							
				Related Organization(s) and/	or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
	•		Ownershi p		Ownershi p			
	1. 00	2. 00	3.00	4. 00	5. 00			
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:					

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

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

	Comorre under the control					
6. 00	G	ST VINCENT HEAL	100.00	ST VINCENT HEAL	100.00	6. 00
7.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	7. 00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9. 00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	FI NANCI AL				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.
- Corporation, partnership, or other organization has financial interest in provider.
- 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

4.23

4.24

4.25

5.00

line 12

			To 06/30/2018	Date/Time Prepared: 11/26/2018 2:01 pm
	Net	Wkst. A-7 Ref.		1172072010 2. 01 piii
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
	A. COSTS INCUR	RED AND ADJUSTME	NTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR (CLAI MED
	HOME OFFICE CO	STS:		
1.00	0			1.00
2.00	4, 116, 736			2. 00
3.00	873, 156	0		3.00
4.00	0	0		4. 00
4.01	0	0		4. 01
4.02	0	0		4. 02
4.03	0	0		4. 03
4.04	0	0		4. 04
4.05	0	0		4. 05
4.06	0	0		4. 06
4.07	0	0		4. 07
4.08	0	0		4. 08
4.09	0	0		4. 09
4. 10	0	0		4. 10
4. 11	0	1		4. 11
4. 12	3, 075, 148	11		4. 12
4. 13	0	0		4. 13
4. 14	0	0		4. 14
4. 15	0	0		4. 15
4. 16	0	0		4. 16
4. 17	0	0		4. 17
4. 18	0	-		4. 18
4. 19	0	1		4. 19
4. 20	0	0		4. 20
4. 21	0	0		4. 21
4. 22	0	0		4. 22
4. 23	0	0		4. 23
4.24	0	0		4. 24
4. 25	0	1		4. 25
5.00	8, 065, 040			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.

 	The second of th	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELATE	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	HOME OFFICE	6.00
7.00	SYSTEM OFFICE	7.00
8.00		8.00
9.00		9.00
10. 00 100. 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.
- $\hbox{B. Corporation, partnership, or other organization has financial interest in provider.}\\$
- 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.

Provider CCN: 15-0088

					1	To 06/30/2018	Date/Time Pre 11/26/2018 2:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	•		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	160, 955		55, 879	211, 500	349	1. 00
2.00		ADULTS & PEDIATRICS	3, 005, 999			0	0	
3.00		INTENSIVE CARE UNIT	371, 597		371, 597	211, 500		
4.00		OPERATING ROOM	3, 555, 374	0	3, 555, 374	246, 400	23, 948	4. 00
5.00		RESPI RATORY THERAPY	55, 433		55, 433	211, 500	370	
6.00		ELECTROENCEPHALOGRAPHY	129, 000		100, 000	211, 500	8, 760	
7.00		ANDERSON OUTPATIENT CENTER	150, 584		0	0	0	
8.00		EMERGENCY	1, 153, 000	1, 084, 361	68, 639	21, 500	925	8. 00
9.00	0. 00		0	0	0	0	0	7.00
10.00	0. 00		0	0	0	0	0	10. 00
200.00			8, 581, 942		4, 206, 922		43, 112	
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	0.00	0.00	0.00	Educati on	12	11.00	
1. 00	1.00	2. 00 ADMINISTRATIVE & GENERAL	8. 00 35, 487	9. 00 1, 774	12. 00	13.00	14.00	1, 00
2.00		ADULTS & PEDIATRICS	35, 487	1, 7/4	0	-	0	
3.00		INTENSIVE CARE UNIT	890, 740	_	0	0	0	
4. 00		OPERATING ROOM	2, 836, 917	141, 846	0	0	0	0.00
5.00		RESPIRATORY THERAPY	37, 623		0	0) 0	5. 00
6.00		ELECTROENCEPHALOGRAPHY	890, 740		0	0	0	
7. 00		ANDERSON OUTPATIENT CENTER	090, 740	44, 337	0	0	0	
8.00		EMERGENCY	9, 561	478	0	0	0	
9. 00	0.00		7, 301	470	0	0	0	
10. 00	0.00				0	0	0	
200.00	0.00		4, 701, 068	235, 053	0	0	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	MKSt. A LITTO #	I denti fi er	Component	Limit	Di sal I owance	riaj astilierre		
		1 40.11.11.01	Share of col.		B. Gai i Gilando			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	5. 00	ADMINISTRATIVE & GENERAL	0	35, 487	20, 392	125, 468		1. 00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	3, 005, 999		2. 00
3.00	31. 00	INTENSIVE CARE UNIT	0	890, 740	0	0		3. 00
4.00	50.00	OPERATING ROOM	0	2, 836, 917	718, 457	718, 457		4. 00
5.00	65. 00	RESPI RATORY THERAPY	0	37, 623	17, 810	17, 810		5. 00
6.00	70.00	ELECTROENCEPHALOGRAPHY	0	890, 740	0	29, 000		6. 00
7.00	90. 01	ANDERSON OUTPATIENT CENTER	0	0	0	150, 584		7. 00
8.00	91. 00	EMERGENCY	0	9, 561	59, 078	1, 143, 439		8. 00
9.00	0.00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0		10. 00
200.00			0	4, 701, 068	815, 737	5, 190, 757		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0088 Peri od: Worksheet B From 07/01/2017 Part I 06/30/2018 Date/Time Prepared: 11/26/2018 2:01 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT BLDG & **EMPLOYEE** Subtotal for Cost FIXT-MAB **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 1. 01 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 5, 281, 963 00100 CAP REL COSTS-BLDG & FLXT 5, 281, 963 1 00 1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB 0 1.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12, 713, 844 69, 790 0 12, 783, 634 4.00 00500 ADMINISTRATIVE & GENERAL 0 1, 388, 435 43, 029, 475 5 00 41 164 189 476, 851 5 00 0 7.00 00700 OPERATION OF PLANT 5, 620, 558 627, 712 119, 828 6, 368, 098 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 464, 605 88, 628 553, 233 8.00 9.00 00900 HOUSEKEEPI NG 2, 424, 576 112, 341 0 o 2, 536, 917 9.00 01000 DI ETARY 10.00 0 218, 465 72, 582 0 291, 047 10 00 11.00 01100 CAFETERI A 2,037,249 240, 841 2, 278, 090 11.00 01300 NURSING ADMINISTRATION 2, 599, 889 0 567, 811 3, 222, 694 13.00 54, 994 13.00 01400 CENTRAL SERVICES & SUPPLY 674, 643 178, 584 121, 797 975, 024 14.00 0 14.00 0 01500 PHARMACY 672, 799 4, 264, 348 15.00 3, 538, 413 53, 136 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 58, 710 0 58, 710 16.00 02300 ALLIED HEALTH-EMS 113, 236 24, 999 23.00 1, 464 139, 699 23.00 02301 ALLIED HEALTH-RAD TECH 1, 239 0 250, 613 23.01 202.347 47,027 23.01 23.02 02303 ALLIED HEALTH-PHARM RESIDENTS 269, 630 1, 126 0 63, 545 334, 301 23 02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 471, 541 745, 366 0 2, 554, 737 11, 771, 644 30.00 03100 INTENSIVE CARE UNIT 4, 719, 944 31.00 165, 072 0 867.664 5, 752, 680 31.00 04100 SUBPROVI DER - I RF 0 41.00 1, 133, 619 112,600 228, 966 1, 475, 185 41.00 04300 NURSERY 350, 625 0 72, 314 505, 610 43.00 82, 671 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 16, 830, 263 540, 447 305, 183 17, 675, 893 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1, 123, 496 230, 211 232, 819 1, 586, 526 52.00 05300 ANESTHESI OLOGY 53.00 1, 216, 350 0 1, 216, 350 53.00 3, 407, 633 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 811, 727 160, 771 0 435, 135 54.00 03440 MAMMOGRAPHY 0 54.01 462, 926 48, 744 511, 670 54.01 1, 071, 388 03450 NUCLEAR MEDICINE - DIAGNOSTIC 981, 442 77, 256 54.02 12,690 54.02 0 54.03 03630 ULTRA SOUND 503, 390 95, 887 599, 277 54.03 05500 RADI OLOGY-THERAPEUTI C 2, 533, 215 0 227.554 2, 760, 769 55 00 55 00 57.00 05700 CT SCAN 696, 574 6, 204 130, 221 832, 999 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 11, 294 0 58.00 763, 374 62, 941 837, 609 58.00 05900 CARDIAC CATHETERIZATION 1, 292, 972 0 246, 249 59.00 96, 408 1, 635, 629 59.00 06000 LABORATORY 0 6, 920, 441 6, 767, 051 141, 246 60.00 12, 144 60.00 65.00 06500 RESPIRATORY THERAPY 1, 291, 668 80, 374 0 273, 643 1, 645, 685 65.00 66.00 06600 PHYSI CAL THERAPY 2, 116, 781 113, 895 441, 190 2, 671, 866 66.00 06700 OCCUPATIONAL THERAPY 0 183. 778 1, 120, 457 67 00 889 241 47, 438 67 00 06800 SPEECH PATHOLOGY 0 68.00 322, 783 17, 217 66, 709 406, 709 68.00 69.00 06900 ELECTROCARDI OLOGY 164, 163 29, 818 193, 981 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 544, 124 131, 112 0 87, 576 762, 812 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 3 143 417 3. 143. 417 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4,668,949 0 4, 668, 949 72.00 07300 DRUGS CHARGED TO PATIENTS 20, 868, 280 0 20, 868, 280 73.00 C 73.00 76, 00 03190 CHEMOTHERAPY 1,026,583 0 0 197, 501 1, 224, 084 76, 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 ANDERSON OUTPATIENT CENTER 0 90.01 2, 131, 523 39, 410 422, 186 2, 593, 119 90.01 04950 DIABETIC EDUCATION 0 90.02 90.02 0 09002 MS CLINIC 24, 367 0 10, 977 90.03 48.243 83.587 90.03 91.00 09100 EMERGENCY 3, 823, 781 253, 407 0 847, 713 4, 924, 901 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 169, 021, 652 5, 050, 198 0 167, 171, 399 118. 00 118.00 11, 165, 146 NONREI MBURSABLE COST CENTERS 21, 191 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 21, 191 0 191. 00 19100 RESEARCH 124, 344 0 16, 388 140, 732 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 799, 360 4, 883, 187 192. 00 4, 063, 232 20, 595 0 194. 00 07950 FOUNDATI ON 0 33, 622 288, 120 194. 00 247, 337 7, 161 194. 01 07951 CHI LDRENS CLI NI C 0 361, 111 64, 225 425, 336 194. 01 194. 02 07952 PSS ADMINISTRATION 23,607 5, 542 35, 376 194. 02 6, 227 0 194.03 07953 SEXUAL ASSULT PROGRAM 118, 162 C 26, 959 145, 121 194. 03 194. 04 07954 ASPR BI OTERRORI SM GRANT 0 12, 644 194. 04 12,644 194.05 07955 HEALTHY FAMILIES 452, 139 113, 625 80.959 646, 723 194. 05 194.06 07956 DME-HOME CARE 4, 430, 599 2, 477 0 297, 679 4, 730, 755 194. 06 194. 07 07957 MARKETI NG 0 873, 156 194. 07 873, 156 0 28, 454 194. 08 194. 08 07958 CORPORATE COMMUNICATIONS 0 28, 454 194. 09 07959 MOB 355 0 355 194. 09

Health Financial Systems	ST. VINCENT ANDERSON			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0088			Peri od: From 07/01/2017 To 06/30/2018	rom 07/01/2017 Part I	
		CAPITAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT-MAB	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	1. 01	4. 00	4A	
194. 10 07960 ASC 194. 11 07961 MAB	2, 126 0	0		0 0		194. 10 194. 11
194.12 07963 ADOLESCENT RESIDENTIAL SERVICES 194.13 07962 IDLE SPACE 200.00 Cross Foot Adjustments Negative Cost Centers	1, 278, 220 0	0		0 293, 754 0 0	0 0 0	194. 13 200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	181, 008, 684	5, 281, 963		0 12, 783, 634	181, 008, 684	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2017 Part I
To 06/30/2018 Date/Time Prepared:
11/26/2018 2:01 pm

						11/26/2018 2:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MAB						1. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	40,000,475					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	43, 029, 475	0.254.021				5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 985, 923 172, 528	8, 354, 021 180, 250				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	791, 150	228, 479		3, 556, 546		9.00
10.00	01000 DI ETARY	90, 764	147, 617		14, 318	543, 746	
11. 00	01100 CAFETERI A	710, 434	489, 819		47, 397	0	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 005, 013	111, 846		23, 315	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	304, 066	363, 202		37, 029	0	14. 00
15. 00	01500 PHARMACY	1, 329, 858	108, 068	0	15, 086	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	18, 309	119, 403		8, 229	0	16. 00
23. 00	02300 ALLIED HEALTH-EMS	43, 566	2, 977	1	0	0	23. 00
23. 01	02301 ALLIED HEALTH-RAD TECH	78, 155	2, 519		0	0	23. 01
23. 02	02303 ALLIED HEALTH-PHARM RESIDENTS INPATIENT ROUTINE SERVICE COST CENTERS	104, 253	2, 290	0	l ol	0	23. 02
30. 00	03000 ADULTS & PEDIATRICS	3, 671, 046	1, 515, 923	270, 204	1, 429, 324	438, 861	30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 794, 002	335, 722			32, 919	
41. 00	04100 SUBPROVI DER - I RF	460, 044	229, 005	1		49, 320	
43.00	04300 NURSERY	157, 677	168, 136	8, 961	34, 067	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 512, 316	1, 099, 157			0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	494, 766	468, 201	1	109, 661	0	52. 00
53. 00	05300 ANESTHESI OLOGY	379, 325	0	1	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C 03440 MAMMOGRAPHY	1, 062, 687	326, 974			0	54.00
54. 01 54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	159, 567 334, 118	25, 809	1, 020 637	13, 714 13, 714	0	54. 01 54. 02
54. 02	03630 ULTRA SOUND	186, 888	25, 609	1		0	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	860, 960	0	14, 941	13, 714	19, 082	
57. 00	05700 CT SCAN	259, 775	12, 618			0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	261, 213	22, 969			0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	510, 079	196, 074	0	21, 943	0	59. 00
60.00	06000 LABORATORY	2, 158, 174	287, 264		104, 230	0	60.00
65. 00	06500 RESPI RATORY THERAPY	513, 215	163, 464		-,	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	833, 235	231, 639			0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	349, 420	96, 480			0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	126, 834	35, 015		5, 815	0	68. 00 69. 00
70.00	07000 ELECTROCARDI GLOGT	60, 494 237, 887	266, 654	331	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	980, 290	200, 034		o o	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 456, 035	0	o o	o	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	6, 507, 845	O	0	o	0	73. 00
76.00	03190 CHEMOTHERAPY	381, 737	0	17, 610	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0				
90. 01		808, 677	80, 152	2 0	38, 401		
	04950 DI ABETI C EDUCATI ON	0 0 7	40.557	0	0	0	
90. 03 91. 00	09002 MS CLINIC 09100 EMERGENCY	26, 067 1, 535, 855	49, 557 515, 376	1	4, 114 355, 479	0 3, 564	90. 03 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 555, 655	313, 370	143, 200	333, 477	3, 304	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
113.00	11300 NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	38, 714, 247	7, 882, 659	905, 589	3, 457, 693	543, 746	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6, 609	43, 099	0	0		190. 00
	19100 RESEARCH	43, 888	0	0	0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 522, 846	41, 885				192. 00
	0/07950 FOUNDATI ON 07951 CHI LDRENS CLI NI C	89, 852	14, 565	422	4, 114		194. 00 194. 01
	207951 CHI EDRENS CETNI C	132, 643 11, 032	12, 664		52, 115		194. 01
	3 O7953 SEXUAL ASSULT PROGRAM	45, 257	12, 004		0		194. 02
	107954 ASPR BIOTERRORISM GRANT	3, 943	0		o o		194. 04
	07955 HEALTHY FAMILIES	201, 684	231, 089	ol o	6, 857		194. 05
	07956 DME-HOME CARE	1, 475, 310	5, 038		0		194. 06
	7 07957 MARKETI NG	272, 298	0	0	o	0	194. 07
	07958 CORPORATE COMMUNICATIONS	8, 874	57, 870	0	4, 114		194. 08
	07959 MOB	111	0	0	9, 874		194. 09
	07960 ASC	663	0	0	5, 486		194. 10
	07961 MAB	0	0	0	0		194. 11
	207963 ADOLESCENT RESIDENTIAL SERVICES 307962 IDLE SPACE	500, 218	65, 152	0	0		194. 12 194. 13
200. 00		"	Ü	,	ا ۱	0	200. 00
200.00	or 033 1001 Auj ustilients	<u> </u>		I	<u> </u>		1200.00

Health Fina	ancial Systems	ST. VINCENT	ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOCA	ATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0088	Peri od:	Worksheet B	
						Part I	
					To 06/30/2018		
						11/26/2018 2:	01 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7. 00	8.00	9. 00	10.00	
201.00	Negative Cost Centers	0	0		0 0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	43, 029, 475	8, 354, 021	906, 01	1 3, 556, 546	543, 746	202. 00

			l C	00/30/2018	Date/lime Pre 11/26/2018 2:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS BLDG & FLXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 01 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	2 525 740					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	3, 525, 740 99, 510	4, 462, 378				11. 00 13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	71, 981	4, 402, 370	1, 759, 378			14. 00
15. 00 01500 PHARMACY	218, 325	o	27, 418	5, 963, 103		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	204, 651	16. 00
23. 00 02300 ALLI ED HEALTH-EMS	17, 735	0	96	0	0	23. 00
23. 01 02301 ALLI ED HEALTH-RAD TECH 23. 02 02303 ALLI ED HEALTH-PHARM RESI DENTS	18, 655 21, 312	0	0	O O	0	23. 01 23. 02
I NPATIENT ROUTINE SERVICE COST CENTERS	21, 312	<u> </u>	<u> </u>	<u></u>	0	25.02
30. 00 03000 ADULTS & PEDI ATRI CS	996, 266	2, 133, 946	44, 204	0	12, 252	30. 00
31.00 03100 INTENSIVE CARE UNIT	326, 230	698, 765	49, 586	0	5, 352	31. 00
41. 00 04100 SUBPROVI DER - RF	83, 566	178, 993	4, 596	0	1, 083	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	27, 704	59, 340	2, 659	0	518	43. 00
50. 00 05000 0PERATING ROOM	53, 414	253, 740	1, 314, 612	ol	33, 148	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	89, 197	191, 055	8, 561	0	1, 143	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	3, 173	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	203, 261	0	48, 371	0	6, 255	54.00
54. 01 03440 MAMMOGRAPHY 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	19, 505 23, 287	0	11, 768 36, 480	0	1, 296 4, 396	54. 01 54. 02
54. 03 03630 ULTRA SOUND	29, 023	0	14	o	2, 898	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	88, 228	Ö	39, 606	Ö	9, 530	55. 00
57. 00 05700 CT SCAN	45, 473	o	0	o	4, 713	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	19, 576	0	540	0	1, 025	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	86, 461	185, 195	35, 903	0	6, 929 22, 446	59. 00 60. 00
65. 00 06500 RESPI RATORY THERAPY	4, 310 109, 555	0	1, 135 19, 128	0	4, 141	65. 00
66. 00 06600 PHYSI CAL THERAPY	95, 068	o	13, 161	o	3, 057	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	68, 745	О	5, 482	О	1, 104	67. 00
68. 00 06800 SPEECH PATHOLOGY	24, 953	0	1, 990	0	401	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	13, 490	0	344 797	0	316	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 226 0	0	797	0	1, 596 5, 354	70.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	o	0	o	5, 453	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	О	0	5, 957, 769	37, 893	73. 00
76. 00 03190 CHEMOTHERAPY	91, 203	0	23, 999	0	2, 857	76. 00
90. 00 09000 CLINIC	0	ol	0	ol	0	90.00
90. 01 09000 CEINIC 90. 01 09001 ANDERSON OUTPATIENT CENTER	101, 077	0	216	0	1, 560	
90. 02 04950 DIABETIC EDUCATION	0	o	0	o	0	90. 02
90. 03 09002 MS CLINIC	3, 626	О	510	0	95	90. 03
91. 00 09100 EMERGENCY	355, 446	761, 344	67, 282	0	24, 667	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 418, 408	4, 462, 378	1, 758, 458	5, 957, 769	204, 651	
NONREI MBURSABLE COST CENTERS		., ,	, ,			
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	6, 619	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 FOUNDATI ON	19, 459 12, 794	0	600	698		192. 00 194. 00
194. 01 07951 CHI LDRENS CLI NI C	12, 7,74	0	320	4, 636		194. 00
194. 02 07952 PSS ADMINISTRATION	11, 266	Ö	0	0		194. 02
194.03 07953 SEXUAL ASSULT PROGRAM	1, 209	o	0	o		194. 03
194. 04 07954 ASPR BI OTERRORI SM GRANT	0	0	0	0		194. 04
194. 05 07955 HEALTHY FAMILIES	55, 985	0	0	0		194. 05 194. 06
194. 06 07956 DME-HOME CARE 194. 07 07957 MARKETI NG	0	0	0	0		194. 06
194. 08 07958 CORPORATE COMMUNI CATI ONS	o	ol O	0	ol		194. 07
194. 09 07959 MOB	o	o	O	o	0	194. 09
194. 10 07960 ASC	0	o	0	o		194. 10
194. 11 07961 MAB	0	0	0	0		194. 11
194. 12 07963 ADOLESCENT RESI DENTI AL SERVI CES 194. 13 07962 I DLE SPACE	0	0	0	0		194. 12 194. 13
	١	<u> </u>	٥١	<u> </u>	0	1.71.10

Health Fina	ncial Systems	ST. VINCENT	ANDERSON		In Lie	u of Form CMS-2552-10	
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provider Co		Peri od: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/26/2018 2:01 pm	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	

						11/26/2018 2:	01 pm
	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	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	3, 525, 740	4, 462, 378	1, 759, 378	5, 963, 103	204, 651	202. 00

			10	06/30/2018	Date/lime Pre 11/26/2018 2:	
Cost Center Description	ALLI ED	ALLI ED	ALLI ED	Subtotal	Intern &	
	HEALTH-EMS	HEALTH-RAD	HEALTH-PHARM		Residents Cost	
		TECH	RESI DENTS		& Post Stepdown	
					Adjustments	
	23. 00	23. 01	23. 02	24.00	25. 00	
GENERAL SERVICE COST CENTERS	T T					
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 01 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A						11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY						15. 00 16. 00
23. 00 02300 ALLIED HEALTH-EMS	204, 073					23. 00
23. 01 02301 ALLI ED HEALTH-RAD TECH	2017070	349, 942				23. 01
23. 02 02303 ALLI ED HEALTH-PHARM RESI DENTS		2,	462, 156			23. 02
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	0	22, 283, 670	0	30. 00
31. 00 03100 INTENSIVE CARE UNIT	0	0	0	9, 403, 702	0	31. 00
41. 00 04100 SUBPROVI DER - RF	0	0	0	2, 699, 738	0	41.00
43. 00 04300 NURSERY	0	0	0	964, 672	0	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 OPERATING ROOM	O	0	0	26, 621, 559	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	2, 971, 107	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	Ö	1, 598, 848	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	72, 696	0	5, 253, 278	0	54. 00
54. 01 03440 MAMMOGRAPHY	0	15, 067	0	733, 607	0	54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	51, 086	0	1, 560, 915	0	54. 02
54. 03 03630 ULTRA SOUND	0	33, 680	0	852, 834	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	110, 735	0	3, 917, 565	0	55. 00
57. 00 05700 CT SCAN	0	54, 769	0	1, 262, 402	0	57.00
58.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON	0	11, 909	0	1, 179, 290 2, 678, 213	0	58. 00 59. 00
60. 00 06000 LABORATORY	0	0	0	9, 498, 000	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	Ö	Ö	2, 460, 674	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	3, 898, 756	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	1, 662, 439	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0	602, 787	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	268, 956	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	1, 281, 972	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4, 129, 061	0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	462, 156	6, 130, 437 33, 833, 943	0	72. 00 73. 00
76. 00 03190 CHEMOTHERAPY	0	0	402, 130	1. 741. 490	0	76.00
OUTPATIENT SERVICE COST CENTERS		-,	-,	.,,		
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	0	0	0	3, 623, 202	0	90. 01
90. 02 04950 DI ABETI C EDUCATI ON	0	0	0	0	0	90. 02
90. 03 09002 MS CLINIC	0	0	0	167, 556	0	90. 03
91. 00 09100 EMERGENCY	204, 073	0	O	8, 891, 275	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS					U	92. 00
113. 00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	204, 073	349, 942	462, 156	162, 171, 948	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	70, 899	0	190. 00
191. 00 19100 RESEARCH	0	0	0	191, 239		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	6, 484, 968		192. 00
194. 00 07950 FOUNDATION	0	0	0	409, 445		194. 00
194. 01 07951 CHI LDRENS CLI NI C 194. 02 07952 PSS ADMI NI STRATI ON	0	0	0	615, 472 70, 338		194. 01 194. 02
194.03 07953 SEXUAL ASSULT PROGRAM	0	0	0	191, 587		194. 02
194. 04 07954 ASPR BIOTERRORISM GRANT		0	0	16, 587		194. 03
194. 05 07955 HEALTHY FAMILIES		n	0	1, 142, 338		194. 05
194. 06 07956 DME-HOME CARE	o	O	0	6, 211, 103		194. 06
194. 07 07957 MARKETI NG	0	0	0	1, 145, 454		194. 07
194. 08 07958 CORPORATE COMMUNICATIONS	0	O	0	99, 312		194. 08
194. 09 07959 MOB	0	0	0	10, 340		194. 09
194. 10 07960 ASC	0	0	0	8, 275		194. 10
194. 11 07961 MAB	0	0	0	0	0	194. 11

Health Financial Systems	ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0088	Peri od: Worksheet B From 07/01/2017 Part I To 06/30/2018 Date/Time Prepared:

				1	0 00/30/2016	Date/Tille Fie	
						11/26/2018 2:	01 pm_
Cost Center	Description	ALLI ED	ALLI ED	ALLI ED	Subtotal	Intern &	
		HEALTH-EMS	HEALTH-RAD	HEALTH-PHARM		Residents Cost	
			TECH	RESI DENTS		& Post	
						Stepdown	
						Adjustments	
		23. 00	23. 01	23. 02	24.00	25. 00	
194. 12 07963 ADOLESCENT F	RESIDENTIAL SERVICES	0	0	C	2, 169, 379	0	194. 12
194. 13 07962 I DLE SPACE		0	0	C	0	0	194. 13
200.00 Cross Foot A	djustments	0	0	C	0	0	200. 00
201.00 Negative Cos	st Centers	0	0	C	0	0	201. 00
202 00 TOTAL (SUM I	ines 118 through 201)	204 073	349 942	462 156	181 008 684	0	202 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2017 | Part |
| To 06/30/2018 | Date/Time Prepared: | 11/26/2018 2:01 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0088

		11/26/2018 bate/frille Pre	
Cost Center Description	Total		
	26. 00		
GENERAL SERVICE COST CENTERS			1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.01 00101 CAP REL COSTS-BLDG & FLXT-MAB			1. 00 1. 01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL			5. 00
7.00 00700 OPERATION OF PLANT			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00 00900 HOUSEKEEPI NG			9. 00
10. 00 01000 DI ETARY			10.00
11. 00 01100 CAFETERI A			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON			13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY			14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY			16. 00
23. 00 02300 ALLI ED HEALTH-EMS			23. 00
23. 01 02301 ALLI ED HEALTH-RAD TECH			23. 01
23. 02 02303 ALLIED HEALTH-PHARM RESIDENTS			23. 02
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS	22, 283, 670		30. 00
31. 00 03100 INTENSIVE CARE UNIT	9, 403, 702		31. 00
41. 00 04100 SUBPROVI DER - RF	2, 699, 738		41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	964, 672		43. 00
50. 00 O5000 OPERATING ROOM	26, 621, 559		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 971, 107		52. 00
53. 00 05300 ANESTHESI OLOGY	1, 598, 848		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 253, 278		54. 00
54. 01 03440 MAMMOGRAPHY	733, 607		54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 560, 915		54. 02
54. 03 03630 ULTRA SOUND	852, 834		54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 917, 565		55. 00
57. 00 05700 CT SCAN	1, 262, 402		57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)	1, 179, 290		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	2, 678, 213 9, 498, 000		59. 00 60. 00
65. 00 06500 RESPIRATORY THERAPY	2, 460, 674		65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 898, 756		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 662, 439		67. 00
68. 00 06800 SPEECH PATHOLOGY	602, 787		68. 00
69. 00 06900 ELECTROCARDI OLOGY	268, 956		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 281, 972		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 129, 061		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	6, 130, 437		72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS 76.00 O3190 CHEMOTHERAPY	33, 833, 943		73. 00 76. 00
76. 00 03190 CHEMOTHERAPY OUTPATIENT SERVICE COST CENTERS	1, 741, 490		76.00
90. 00 09000 CLINIC	O		90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	3, 623, 202		90. 01
90. 02 04950 DIABETIC EDUCATION	0		90. 02
90. 03 09002 MS CLINIC	167, 556		90. 03
91. 00 09100 EMERGENCY	8, 891, 275		91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
SPECIAL PURPOSE COST CENTERS	1		4
113. 00 11300 INTEREST EXPENSE	1/0 171 0/0		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	162, 171, 948		118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	70, 899		190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	191, 239		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	6, 484, 968		192. 00
194. 00 07950 FOUNDATION	409, 445		194. 00
194. 01 07951 CHI LDRENS CLI NI C	615, 472		194. 01
194.02 07952 PSS ADMINISTRATION	70, 338		194. 02
194.03 07953 SEXUAL ASSULT PROGRAM	191, 587		194. 03
194.04 07954 ASPR BIOTERRORISM GRANT	16, 587		194. 04
194. 05 07955 HEALTHY FAMILIES	1, 142, 338		194. 05
194. 06 07956 DME-HOME CARE	6, 211, 103		194. 06
194. 07 07957 MARKETI NG	1, 145, 454		194. 07
194. 08 07958 CORPORATE COMMUNICATIONS	99, 312		194. 08
194. 09 07959 MOB 194. 10 07960 ASC	10, 340 8, 275		194. 09 194. 10
194. 11 07960 ASC 194. 11 07961 MAB	8, 2/5		194. 10
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	2, 169, 379		194. 11
194. 13 07962 I DLE SPACE	0		194. 13
200.00 Cross Foot Adjustments	o		200.00
201.00 Negative Cost Centers	0		201. 00
			_

Health Financial Systems	ST. VINCENT	ANDERSON	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0088	Peri od:	Worksheet B
			From 07/01/2017	
				Date/Time Prepared:
				11/26/2018 2:01 pm
Cost Center Description	Total			
	26. 00			
202.00 TOTAL (sum lines 118 through 201)	181, 008, 684			202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0088

							11/26/2018 2:	01 pm
				CAPI TAL REI	LATED COSTS			
		Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	BLDG & FIXT-MAB	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Related Costs 0	1. 00	1. 01	2A	4. 00	
		AL SERVICE COST CENTERS		1.00	1.01	271	1. 00	
1. 00 1. 01 4. 00 5. 00 7. 00	00101 00400 00500 00700	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MAB EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT	0 3, 075, 148 0	69, 790 476, 851 627, 712	0	3, 551, 999 627, 712	69, 790 7, 580 654	5. 00 7. 00
8. 00 9. 00 10. 00	00900 01000	LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY	0 0	88, 628 112, 341 72, 582	0	112, 341 72, 582	0 0 0	9. 00 10. 00
11. 00 13. 00 14. 00	01300 01400	CAFETERIA NURSI NG ADMINI STRATI ON CENTRAL SERVI CES & SUPPLY	0 0	240, 841 54, 994 178, 584	0	54, 994 178, 584	0 3, 100 665	13. 00 14. 00
15. 00 16. 00 23. 00	01600 02300	PHARMACY MEDICAL RECORDS & LIBRARY ALLIED HEALTH-EMS	0	53, 136 58, 710 1, 464	0	1, 464	3, 673 0 136	16. 00 23. 00
23. 01 23. 02	02303 I NPAT	ALLIED HEALTH-RAD TECH ALLIED HEALTH-PHARM RESIDENTS IENT ROUTINE SERVICE COST CENTERS	0	1, 239 1, 126	0	1, 126	257 347	23. 02
30. 00 31. 00 41. 00	03100 04100	ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVI DER - IRF	0 0	745, 366 165, 072 112, 600	0	165, 072 112, 600	13, 946 4, 737 1, 250	31. 00 41. 00
43. 00 50. 00	ANCI L 05000	NURSERY LARY SERVICE COST CENTERS OPERATING ROOM	0	82, 671 540, 447			395 1, 666	
52. 00 53. 00 54. 00	05300 05400	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY RADIOLOGY-DI AGNOSTI C	0 0	230, 211 0 160, 771	0	0 160, 771	1, 271 0 2, 376	54. 00
54. 01 54. 02 54. 03 55. 00	03450 03630	MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC	0	12, 690 0	0 0	12, 690	266 422 524 1, 242	54. 02 54. 03
57. 00 58. 00 59. 00	05700 05800	CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0 0	6, 204 11, 294 96, 408	0	11, 294	711 344 1, 344	57. 00 58. 00
60. 00 65. 00 66. 00	06500 06600	LABORATORY RESPI RATORY THERAPY PHYSI CAL THERAPY	0 0 0	141, 246 80, 374 113, 895	0	80, 374	66 1, 494 2, 409	65. 00 66. 00
67. 00 68. 00 69. 00	06800 06900	OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY	0 0	47, 438 17, 217 0	0	17, 217 0	1, 003 364 163	68. 00 69. 00
	07100 07200	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0 0	131, 112 0 0 0	0	0	478 0 0	71. 00 72. 00
76. 00	03190 0UTPA	CHEMOTHERAPY TIENT SERVICE COST CENTERS	0	0	0		0 1, 078	76. 00
90. 00 90. 01 90. 02	09001 04950	CLINIC ANDERSON OUTPATIENT CENTER DIABETIC EDUCATION	0	0 39, 410 0	0	0	0 2, 305 0	90. 01 90. 02
90. 03 91. 00 92. 00	09100 09200	MS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS	0	24, 367 253, 407		24, 367 253, 407 0	4, 628	
113. 00 118. 00	11300	INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	3, 075, 148	5, 050, 198	0	8, 125, 346	60, 954	113. 00 118. 00
191.00	19000 19100	GIFT, FLOWER, COFFEE SHOP, & CANTEEN RESEARCH	0	21, 191 0	0	0	89	190. 00 191. 00
194. 00 194. 01	07950 1 07951	PHYSICIANS' PRIVATE OFFICES FOUNDATION CHILDRENS CLINIC	0	20, 595 7, 161 0	0	20, 595 7, 161 0	184 351	192. 00 194. 00 194. 01
194. 03 194. 04	3 07953 4 07954	PSS ADMINISTRATION SEXUAL ASSULT PROGRAM ASPR BIOTERRORISM GRANT	0	6, 227 0 0	0	6, 227 0 0	147 0	194. 02 194. 03 194. 04
194. 06 194. 07	07956 07957	HEALTHY FAMILIES DME-HOME CARE MARKETING	0	113, 625 2, 477 0	0	113, 625 2, 477 0	1, 625 0	194. 05 194. 06 194. 07
194. 09	07958 9 07959 0 07960		0 0	28, 454 0 0	0		0	194. 08 194. 09 194. 10

Health Financial Systems	ST. VINCENT	ANDERSON		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS	Provi d		CN: 15-0088	Peri od:	Worksheet B		
				From 07/01/2017 To 06/30/2018		pared:	
					11/26/2018 2:		
		CAPI TAL REL	LATED COSTS				
Cost Center Description	Directly	BLDG & FLXT	BLDG &	Subtotal	EMPLOYEE		
Cost Center Description	Assigned New	שבטט מ דואו	FIXT-MAB	Subtotal	BENEFITS		
	Capi tal		117(1 1117(2)		DEPARTMENT		
	Related Costs						
	0	1.00	1. 01	2A	4. 00		
194. 11 07961 MAB	0	0		0 0	0	194. 11	
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	32, 035		0 32, 035	1, 604	194. 12	
194. 13 07962 I DLE SPACE	0	0		0 0	0	194. 13	
200.00 Cross Foot Adjustments				0		200. 00	
201.00 Negative Cost Centers		0		0	0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	3, 075, 148	5, 281, 963		0 8, 357, 111	69, 790	202. 00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared: |

				0 06/30/2018	Date/lime Pre 11/26/2018 2:	
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS			1			
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB						1. 00 1. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			•			4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	3, 559, 579					5. 00
7.00 00700 OPERATION OF PLANT	164, 284	792, 650	l .			7. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	14, 272 65, 447	17, 103 21, 679	1			8. 00 9. 00
10. 00 01000 DI ETARY	7, 508	14, 006	l .		94, 899	10.00
11. 00 01100 CAFETERI A	58, 770	46, 475	l .		0	11. 00
13.00 01300 NURSING ADMINISTRATION	83, 139	10, 612	1	1, 308	0	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	25, 154	34, 462	1		0	14. 00 15. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	110, 012 1, 515	10, 254 11, 329	1	462	0	16.00
23. 00 02300 ALLI ED HEALTH-EMS	3, 604	282	1	0	0	23. 00
23. 01 02301 ALLIED HEALTH-RAD TECH	6, 465	239	1	0	0	23. 01
23. 02 02303 ALLIED HEALTH-PHARM RESIDENTS INPATIENT ROUTINE SERVICE COST CENTERS	8, 624	217	0	0	0	23. 02
30. 00 03000 ADULTS & PEDIATRICS	303, 685	143, 836	35, 787	80, 159	76, 594	30.00
31. 00 03100 INTENSIVE CARE UNIT	148, 408	31, 854			5, 745	31. 00
41. 00 04100 SUBPROVI DER - RF	38, 057	21, 729			8, 608	41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	13, 044	15, 953	1, 187	1, 911	0	43. 00
50. 00 05000 OPERATING ROOM	456, 003	104, 291	21, 671	28, 921	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	40, 929	44, 424	1		0	52. 00
53. 00 05300 ANESTHESI OLOGY	31, 379	0		_	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03440 MAMMOGRAPHY	87, 910	31, 024	624 135		0	54. 00 54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	13, 200 27, 640	2, 449	l .		0	54.01
54. 03 03630 ULTRA SOUND	15, 460	0			0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	71, 222	0	1, 979		3, 330	
57. 00 05700 CT SCAN	21, 490	1, 197	1		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	21, 609 42, 196	2, 179 18, 604	l		0	58. 00 59. 00
60. 00 06000 LABORATORY	178, 534	27, 256	l .		0	60.00
65. 00 06500 RESPI RATORY THERAPY	42, 455	15, 510	1		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	68, 929	21, 978	1		0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	28, 906 10, 492	9, 154 3, 322	1		0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	5, 004	0, 322	44		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	19, 679	25, 301	0	0	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	120, 450 538, 350	0	1	_	0	72. 00 73. 00
76. 00 03190 CHEMOTHERAPY	31, 579	0	_		0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	7 (05				90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER 90. 02 04950 DI ABETI C EDUCATION	66, 897 0	7, 605 0		2, 154 0	0	90. 01 90. 02
90. 03 09002 MS CLINIC	2, 156	4, 702	_	231	0	90. 03
91. 00 09100 EMERGENCY	127, 053	48, 900	18, 979	19, 937	622	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T)					92. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through	117) 3, 202, 604	747, 926	119, 947	193, 921	94, 899	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTE		4, 089	1	_		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 631 125, 976	0 3, 974	1			191. 00 192. 00
194. 00 07950 FOUNDATION	7, 433	1, 382			0	194. 00
194. 01 07951 CHI LDRENS CLI NI C	10, 973	0	56	2, 923		194. 01
194. 02 07952 PSS ADMINISTRATION	913	1, 202	0	0		194. 02
194. 03 07953 SEXUAL ASSULT PROGRAM 194. 04 07954 ASPR BIOTERRORISM GRANT	3, 744 326	0	0	0		194. 03 194. 04
194. 05 07955 HEALTHY FAMILIES	16, 684	21, 926		385		194. 05
194.06 07956 DME-HOME CARE	122, 044	478		0	0	194. 06
194. 07 07957 MARKETI NG	22, 526	_ 0	0			194. 07
194. 08 07958 CORPORATE COMMUNICATIONS 194. 09 07959 MOB	734	5, 491	0	231		194. 08 194. 09
194. 10 07960 ASC	55	0	0	554 308		194. 09
194. 11 07961 MAB	0	0	Ö	0	0	194. 11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	41, 380	6, 182	0	0		194. 12
194.13 07962 IDLE SPACE 200.00 Cross Foot Adjustments	0	0	0	0	0	194. 13 200. 00
200. 00 OF 033 FOOT AUJ USTINETITS			<u> </u>	<u> </u>		1200.00

Health Fina	ancial Systems	ST. VI NCENT	ANDERSON		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-0088 F	Peri od:	Worksheet B	
					rom 07/01/2017	Part II	
				1	o 06/30/2018		
						11/26/2018 2:	01 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
201.00	Negative Cost Centers	0	0	C	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	3, 559, 579	792, 650	120, 003	199, 467	94, 899	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared: |

			10	00/30/2016	Date/lime Pre 11/26/2018 2:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11.00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	111.00	10.00	111.00	10.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 CAP REL COSTS-BLDG & FLXT-MAB						1. 01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00 00700 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	348, 744					11.00
13. 00 01300 NURSING ADMINISTRATION	9, 843	162, 996				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	7, 120	0	249, 132			14. 00
15. 00 01500 PHARMACY	21, 595	0	3, 882	203, 398		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	72, 016	16.00
23. 00 02300 ALLI ED HEALTH-EMS 23. 01 02301 ALLI ED HEALTH-RAD TECH	1, 754	0	14 0	0	0	23. 00 23. 01
23. 02 02303 ALLI ED HEALTH-PHARM RESI DENTS	1, 845 2, 108	0	0	0	0	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 100	<u> </u>	<u> </u>	<u> </u>	0	25.02
30. 00 03000 ADULTS & PEDI ATRI CS	98, 546	77, 946	6, 259	0	4, 312	30. 00
31.00 03100 INTENSIVE CARE UNIT	32, 269	25, 524	7, 022	o	1, 884	31. 00
41. 00 04100 SUBPROVI DER - I RF	8, 266	6, 538	651	0	381	41. 00
43. 00 04300 NURSERY	2, 740	2, 167	377	0	182	43. 00
ANCILLARY SERVICE COST CENTERS	F 202	0.240	10/ 150	ما	11 //7	FO 00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 283 8, 823	9, 268 6, 979	186, 150 1, 212	0	11, 667 402	50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0, 023	0, 9/9	1, 212	0	1, 117	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	20, 105	o	6, 850	ő	2, 202	54.00
54. 01 03440 MAMMOGRAPHY	1, 929	0	1, 666	Ö	456	54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	2, 303	0	5, 166	0	1, 547	54. 02
54. 03 03630 ULTRA SOUND	2, 871	0	2	0	1, 020	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	8, 727	0	5, 608	0	3, 354	55. 00
57. 00 05700 CT SCAN	4, 498	0	0	0	1, 659	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	1, 936	0 4 74E	77 5 094	0	361	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	8, 552 426	6, 765 0	5, 084 161	0	2, 439 7, 900	59. 00 60. 00
65. 00 06500 RESPIRATORY THERAPY	10, 837	0	2, 709	o	1, 458	65. 00
66. 00 06600 PHYSI CAL THERAPY	9, 404	o	1, 864	o	1, 076	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	6, 800	О	776	o	389	67. 00
68. 00 06800 SPEECH PATHOLOGY	2, 468	0	282	0	141	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 334	0	49	0	111	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 209	0	113	0	562	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	U O	1, 884 1, 919	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	203, 216	13, 323	73.00
76. 00 03190 CHEMOTHERAPY	9, 021	ő	3, 398	0	1, 006	76. 00
OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,		.,.	-,	,	
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 09001 ANDERSON OUTPATIENT CENTER	9, 998	0	31	0	549	90. 01
90. 02 04950 DI ABETI C EDUCATI ON	0	0	0	0	0	90. 02
90. 03 09002 MS CLINIC 91. 00 09100 EMERGENCY	359 35, 158	27 900	72 9, 527	0	33 8, 682	90. 03 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	33, 136	27, 809	9, 327	٩	0,002	91.00
SPECIAL PURPOSE COST CENTERS						72.00
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	338, 127	162, 996	249, 002	203, 216	72, 016	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	655	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 FOUNDATI ON	1, 925	0	85 0	24		192. 00 194. 00
194. 00 07950 FOUNDATION 194. 01 07951 CHI LDRENS CLI NI C	1, 265 0	0	45	158		194. 00
194. 02 07952 PSS ADMINI STRATI ON	1, 114	0	0	0		194. 02
194. 03 07953 SEXUAL ASSULT PROGRAM	120	o	0	Ö		194. 03
194. 04 07954 ASPR BIOTERRORISM GRANT	0	o	0	o	0	194. 04
194.05 07955 HEALTHY FAMILIES	5, 538	0	0	0	0	194. 05
194. 06 07956 DME-HOME CARE	0	0	0	0		194. 06
194. 07 07957 MARKETI NG	0	0	0	0		194. 07
194. 08 07958 CORPORATE COMMUNICATIONS 194. 09 07959 MOB		0	0	0		194. 08 194. 09
194. 10 07959 MOB 194. 10 07960 ASC		0	0	0		194. 09
194. 11 07961 MAB		n	0	ol Ol		194. 10
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	Ö	o	Ö	ő		194. 12
194. 13 07962 I DLE SPACE	o	o	0	o		194. 13
	'	·	·	<u> </u>		

Health Financial Systems	ST. VINCENT	ANDERSON		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		From 07/01/2017	Worksheet B Part II Date/Time Pre 11/26/2018 2:	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	

13.00

0 162, 996 14.00

0 249, 132 15.00

0 203, 398 16.00

200. 00 0 201. 00 72, 016 202. 00

11.00

0 348, 744

200. 00 201. 00 202. 00

Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0088

			T	06/30/2018	Date/Time Pre 11/26/2018 2:	
Cost Center Description	ALLI ED	ALLI ED	ALLI ED	Subtotal	Intern &	OT PIII
	HEALTH-EMS	HEALTH-RAD TECH	HEALTH-PHARM RESI DENTS		Residents Cost & Post	
					Stepdown	
	23. 00	23. 01	23. 02	24. 00	Adjustments 25.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.01 00101 CAP REL COSTS-BLDG & FLXT-MAB						1. 00 1. 01
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 & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13.00 01300 NURSING ADMINISTRATION						13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY						14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY						15. 00 16. 00
23. 00 02300 ALLI ED HEALTH-EMS	7, 254					23. 00
23.01 02301 ALLIED HEALTH-RAD TECH		10, 045				23. 01
23. 02 02303 ALLI ED HEALTH-PHARM RESI DENTS			12, 422			23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS				1, 586, 436	0	30. 00
31. 00 03100 INTENSIVE CARE UNIT				455, 249	Ö	31. 00
41. 00 04100 SUBPROVI DER - I RF				213, 332	0	41. 00
43. 00 04300 NURSERY				120, 627	0	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 OPERATI NG ROOM				1, 365, 367	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM				343, 315	Ö	52. 00
53. 00 05300 ANESTHESI OLOGY				32, 496	0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C				318, 631	0	54.00
54. 01 03440 MAMMOGRAPHY 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC				18, 421 53, 070	0 0	54. 01 54. 02
54. 03 03630 ULTRA SOUND				20, 017	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C				96, 231	0	55. 00
57. 00 05700 CT SCAN				42, 654	0	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON				39, 991 182, 623	0	58. 00 59. 00
60. 00 06000 LABORATORY				361, 435	ő	60.00
65. 00 06500 RESPI RATORY THERAPY				155, 145	0	65. 00
66. 00 06600 PHYSI CAL THERAPY				223, 334	0	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY				95, 991 34, 754	0 0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY				6, 705	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY				178, 454	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				82, 978	0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS				122, 369 754, 889	0	72. 00 73. 00
76. 00 03190 CHEMOTHERAPY				48, 414	_	l
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C				0	0	90.00
90.01 09001 ANDERSON OUTPATIENT CENTER 90.02 04950 DIABETIC EDUCATION				128, 949	0 0	90. 01 90. 02
90. 03 09002 MS CLINIC				31, 980	0	90.02
91. 00 09100 EMERGENCY				554, 702	_	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE	T		1			113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	7, 668, 559	0	118. 00
NONREI MBURSABLE COST CENTERS		·	_	.,,		
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN				25, 827		190. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES				4, 375 157, 857		191. 00 192. 00
194. 00 07950 FOUNDATION				17, 656		194. 00
194. 01 07951 CHI LDRENS CLI NI C				14, 506		194. 01
194. 02 07952 PSS ADMINISTRATION				9, 486		194. 02
194.03 07953 SEXUAL ASSULT PROGRAM 194.04 07954 ASPR BIOTERRORISM GRANT				4, 011 326		194. 03 194. 04
194.05 07955 HEALTHY FAMILIES				326 158, 600		194. 04
194. 06 07956 DME-HOME CARE				126, 624		194. 06
194. 07 07957 MARKETI NG				22, 526		194. 07
194. 08 07958 CORPORATE COMMUNI CATLONS 194. 09 07959 MOB				34, 910 563		194. 08 194. 09
194. 10 07960 ASC				363		194. 09
194. 11 07961 MAB			1	0		194. 11

Health Financial Systems	ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Peri od: Worksheet B From 07/01/2017 Part II To 06/30/2018 Date/Time Prepared:

				'	0 00/30/2010		
						11/26/2018 2:0	01 pm_
Cost Center Descript	i on	ALLI ED	ALLI ED	ALLI ED	Subtotal	Intern &	
		HEALTH-EMS	HEALTH-RAD	HEALTH-PHARM		Residents Cost	
			TECH	RESI DENTS		& Post	
						Stepdown	
						Adjustments	
		23. 00	23. 01	23. 02	24.00	25.00	
194. 12 07963 ADOLESCENT RESIDENTI	AL SERVICES				81, 201	0	194. 12
194. 13 07962 I DLE SPACE					0	0	194. 13
200.00 Cross Foot Adjustmen	ts	7, 254	10, 045	12, 422	29, 721	0	200. 00
201.00 Negative Cost Center	s	o	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118	through 201)	7. 254	10. 045	12, 422	8. 357. 111	0	202.00

| Peri od: | Worksheet B | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0088

		To 06/30/2018 Date/Time Pre 11/26/2018 2:	
Cost Center Description	Total	11/20/2018 2.	O I DIII
	26. 00		
GENERAL SERVICE COST CENTERS			4 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB			1. 00 1. 01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL			5.00
7.00 OO700 OPERATION OF PLANT			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00 00900 HOUSEKEEPI NG			9. 00
10. 00 01000 DI ETARY			10.00
11. 00 01100 CAFETERI A			11.00
13. 00 O1300 NURSI NG ADMINI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY			13. 00 14. 00
15. 00 01500 PHARMACY			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY			16. 00
23. 00 02300 ALLI ED HEALTH-EMS			23. 00
23. 01 02301 ALLIED HEALTH-RAD TECH			23. 01
23. 02 02303 ALLIED HEALTH-PHARM RESIDENTS			23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 504 404		
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T	1, 586, 436 455, 249		30. 00 31. 00
31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVI DER - I RF	213, 332		41.00
43. 00 04300 NURSERY	120, 627		43.00
ANCILLARY SERVICE COST CENTERS	.==, ==,		1
50. 00 05000 OPERATI NG ROOM	1, 365, 367		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	343, 315		52. 00
53. 00 05300 ANESTHESI OLOGY	32, 496		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	318, 631		54.00
54. 01 03440 MAMMOGRAPHY 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	18, 421 53, 070		54. 01 54. 02
54. 03 03630 ULTRA SOUND	20, 017		54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	96, 231		55. 00
57. 00 05700 CT SCAN	42, 654		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	39, 991		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	182, 623		59. 00
60. 00 06000 LABORATORY	361, 435		60.00
65. 00 06500 RESPI RATORY THERAPY	155, 145		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	223, 334 95, 991		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	34, 754		68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 705		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	178, 454		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	82, 978		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	122, 369		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03190 CHEMOTHERAPY	754, 889 48, 414		73. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	40, 414		76.00
90. 00 09000 CLINIC	0		90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	128, 949		90. 01
90. 02 04950 DIABETIC EDUCATION	0		90. 02
90. 03 09002 MS CLI NI C	31, 980		90. 03
91. 00 09100 EMERGENCY	554, 702		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS			92.00
113. 00 11300 NTEREST EXPENSE			113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 668, 559		118. 00
NONREI MBURSABLE COST CENTERS			1
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	25, 827		190. 00
191. 00 19100 RESEARCH	4, 375		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	157, 857		192. 00
194. 00 07950 FOUNDATI ON 194. 01 07951 CHI LDRENS CLI NI C	17, 656 14, 506		194. 00 194. 01
194. 02 07952 PSS ADMINISTRATION	9, 486		194. 01
194. 03 07953 SEXUAL ASSULT PROGRAM	4, 011		194. 03
194. 04 07954 ASPR BIOTERRORISM GRANT	326		194. 04
194. 05 07955 HEALTHY FAMILIES	158, 600		194. 05
194. 06 07956 DME-HOME CARE	126, 624		194. 06
194. 07 07957 MARKETI NG	22, 526		194. 07
194. 08 07958 CORPORATE COMMUNI CATI ONS 194. 09 07959 MOB	34, 910 563		194. 08 194. 09
194. 09 07959 MOB 194. 10 07960 ASC	363		194. 09
194. 11 07961 MAB	0		194. 10
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	81, 201		194. 12
194. 13 07962 I DLE SPACE	0		194. 13
200.00 Cross Foot Adjustments	29, 721		200. 00
201.00 Negative Cost Centers	0		201. 00

Health Financial Systems	ST. VINCENT	ANDERSON	In Li e	eu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-00		Worksheet B
			From 07/01/2017	Part II
			To 06/30/2018	Date/Time Prepared:
				11/26/2018 2:01 pm
Cost Center Description	Total		· .	
	26.00			
202.00 TOTAL (sum lines 118 through 201)	8, 357, 111			202. 00

	ALLOCATION - STATISTICAL BASIS	31. VINCENT	Provi der CO	CN: 15-0088 F	Peri od:	Worksheet B-1	
				Į.	From 07/01/2017 Fo 06/30/2018	Dato/Timo Pro	narod:
						11/26/2018 2:	01 pm
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FLXT	BLDG &	EMPLOYEE	Reconciliation	ADMINISTRATIVE	
	COST CENTER DESCRIPTION	(SQUARE FEET)	FIXT-MAB	BENEFITS	neconcili i ati on	& GENERAL	
			(SQUARE FEET)	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	1. 01	SALARI ES) 4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	469, 090	_				1. 00
1. 01 4. 00	00101 CAP REL COSTS-BLDG & FIXT-MAB 00400 EMPLOYEE BENEFITS DEPARTMENT	0 6, 198	0	50, 575, 83 ⁴	1		1. 01 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	42, 349	0	5, 493, 05		137, 979, 209	1
7. 00	00700 OPERATION OF PLANT	55, 747	0	474, 076			1
8.00	00800 LAUNDRY & LINEN SERVICE	7, 871	0				
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	9, 977	0		0 0		1
11. 00	01100 CAFETERI A	6, 446 21, 389	0				
	01300 NURSI NG ADMI NI STRATI ON	4, 884	Ö	2, 246, 424		1	
14. 00		15, 860	0	481, 864			
	01500 PHARMACY	4, 719	0	2, 661, 787		.,,	1
16. 00 23. 00		5, 214 130	0	98, 905			
23. 00		110	0				
	02303 ALLIED HEALTH-PHARM RESIDENTS	100	0	251, 402			
	INPATIENT ROUTINE SERVICE COST CENTERS	1	_		-T -		
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	66, 196 14, 660	0				1
41. 00	I I	10, 000	0				
43. 00		7, 342	Ö				•
	ANCILLARY SERVICE COST CENTERS]
50.00		47, 997	0				•
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	20, 445	0	921, 10			
	05400 RADI OLOGY-DI AGNOSTI C	14, 278	Ö	1, 721, 52 ²			
54. 01	03440 MAMMOGRAPHY	0	0	192, 847			54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 127	0	305, 648			1
54. 03 55. 00		0	0	379, 355 900, 269			1
57. 00	I I	551	0	1		, , , , , ,	
58. 00		1, 003	0	249, 012	2 0	837, 609	58. 00
59. 00		8, 562	0				
60. 00 65. 00	1	12, 544 7, 138	0	48, 044 1, 082, 613			
66. 00	+ +	10, 115	0	1, 745, 47			1
67. 00		4, 213	0	727, 079		1, 120, 457	67. 00
68. 00		1, 529	0	263, 920		· ·	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0 11, 644	0	117, 967 346, 475		193, 981 762, 812	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	340, 473		3, 143, 417	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	4, 668, 949	
73. 00	I I	0	0	(0		
76. 00	03190 CHEMOTHERAPY	0	0	781, 370	0 0	1, 224, 084	76. 00
90 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0		0	0	90.00
90. 01	09001 ANDERSON OUTPATIENT CENTER	3, 500	Ö	1, 670, 292	2 0	2, 593, 119	1
90. 02	04950 DIABETIC EDUCATION	0	0	(0	0	70.02
90. 03		2, 164	0	43, 430		83, 587	
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	22, 505	U	3, 353, 798	0	4, 924, 901	91.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
	11300 INTEREST EXPENSE						113. 00
118.00	3 /	448, 507	0	44, 172, 628	-43, 029, 475	124, 141, 924	118. 00
100 0	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1, 882	0			21 101	190. 00
	19100 RESEARCH	0	0	64, 83		140, 732	1
	19200 PHYSICIANS' PRIVATE OFFICES	1, 829	0	3, 162, 50		4, 883, 187	1
	07950 FOUNDATI ON	636	0	133, 017		288, 120	
	1 07951 CHI LDRENS CLI NI C	0	0	254, 091		425, 336	1
	2 07952 PSS ADMINISTRATION 3 07953 SEXUAL ASSULT PROGRAM	553	0	21, 925 106, 656		145, 121	194. 02 194. 03
	4 07954 ASPR BIOTERRORI SM GRANT	l ő	o	(194. 04
	07955 HEALTHY FAMILIES	10, 091	0	320, 299		646, 723	1
194.00	6 07956 DME-HOME CARE 7 07957 MARKETING	220	0	1, 177, 705		4, 730, 755	1
	7 07957 MARKETING B 07958 CORPORATE COMMUNICATIONS	2, 527	0		0	873, 156 28, 454	194. 07
	9 07959 MOB	0	0				194. 09
	·	'	'				

Health Financial Systems	ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0088	Period: Worksheet B-1

CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET) BLDG & FIXT-MAB (SQUARE FEET) FIXT-MAB (SQUARE FEET) DEPARTMENT (GROSS SALARIES) 1.00 1.01 4.00 5A 5.00 194.11 07961 MAB 0 0 0 0 0 1.01 1.01 1.02 1.02 1.00 1.01 1.00 1.					, T	06/30/2018	Date/Time Pre 11/26/2018 2:	
CSQUARE FEET FIXT-MAB			CAPITAL REL	LATED COSTS				
CSQUARE FEET FIXT-MAB		Cost Contor Description	DIDC 0 FLVT	DI DC 0	EMDLOVEE	Doconci Li ati on	ADMINISTRATIVE	
CACCUM. COST CACCUM. CACCUM. COST CACCUM.		cost center bescription				Reconciliation		
CGROSS SALARI ES)			(SQUARE TEET)					
SALARI ES)				(300/11/2 1221)			(1000)	
194. 10 07960 ASC 0 0 0 0 2, 126 194. 10 194. 11 07961 MAB 0 0 0 0 0 194. 11 194. 12 07963 ADOLESCENT RESI DENTI AL SERVI CES 2, 845 0 1, 162, 175 0 1, 604, 009 194. 12								
194. 11 07961 MAB 0 0 0 0 194. 11 194. 12 07963 ADOLESCENT RESI DENTI AL SERVI CES 2, 845 0 1, 162, 175 0 1, 604, 009 194. 12			1.00	1. 01	4. 00	5A		
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES 2, 845 0 1, 162, 175 0 1, 604, 009 194. 12			0	0	0	0		
	194. 11 07961	MAB	0	0	0	0	0	194. 11
194. 13 07962 I DLE SPACE 0 0 0 0 194. 13	194. 12 07963	ADOLESCENT RESIDENTIAL SERVICES	2, 845	0	1, 162, 175	0	1, 604, 009	194. 12
	194. 13 07962	I DLE SPACE	0	0	0	0	0	194. 13
200.00 Cross Foot Adjustments 200.00	-							
201.00 Negative Cost Centers	201. 00	Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, 5, 281, 963 0 12, 783, 634 43, 029, 475 202.00	202. 00		5, 281, 963	0	12, 783, 634		43, 029, 475	202. 00
		1						
203.00 Unit cost multiplier (Wkst. B, Part I) 11.260020 0.000000 0.252762 0.311855 203.00			11. 260020	0. 000000			l	1
204.00 Cost to be allocated (per Wkst. B, 69,790 3,559,579 204.00	204. 00				69, 790		3, 559, 579	204. 00
Part II)		,						
205.00 Unit cost multiplier (Wkst. B, Part 0.001380 0.025798 205.00	205. 00				0. 001380		0. 025798	205. 00
	201 20	1 /						00/ 00
206.00 NAHE adjustment amount to be allocated 206.00	206.00							206. 00
(per Wkst. B-2)	007.00							007.00
207.00 NAHE unit cost multiplier (Wkst. D,	207.00							207.00
Parts III and IV)		rants iii and iv)		I	l	l	l	I

Health Financial Systems ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0088 Peri od: Worksheet B-1 From 07/01/2017 06/30/2018 Date/Time Prepared: 11/26/2018 2:01 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (HOURS OF (MEALS SERVED) (TOTAL HOURS) PLANT (SQUARE FEET) (POUNDS OF SERVICE) 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 1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB 1. 01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 364, 796 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 7.871 1,038,715 8.00 00900 HOUSEKEEPI NG 9, 977 9.00 64,832 9.00 88, 022 10.00 01000 DI ETARY 6, 446 0 261 10.00 11.00 01100 CAFETERI A 21, 389 864 1, 149, 457 11.00 01300 NURSING ADMINISTRATION 13.00 4 884 425 0 32.442 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15,860 9, 259 675 0 23, 467 14.00 15.00 01500 PHARMACY 4,719 275 0 71, 178 15.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 5, 214 0 16.00 150 0 02300 ALLIED HEALTH-EMS 5, 782 23.00 130 C 0 23.00 23.01 02301 ALLIED HEALTH-RAD TECH 110 C 0 6,082 23.01 02303 ALLIED HEALTH-PHARM RESIDENTS 23.02 100 0 6, 948 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 66, 196 309, 781 26,055 71, 043 324, 802 30.00 31.00 03100 INTENSIVE CARE UNIT 14,660 147, 517 5, 100 5, 329 106, 357 31.00 04100 SUBPROVIDER - IRF 41.00 10,000 45, 467 3, 250 7, 984 27, 244 41.00 43.00 04300 NURSERY 7,342 10, 273 621 9,032 43 00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 47, 997 187, 580 9, 400 17, 414 50.00 1, 999 25, 219 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 20, 445 29, 080 52.00 05300 ANESTHESI OLOGY 0 53.00 C 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 14, 278 5, 405 2, 200 0 66, 267 54.00 03440 MAMMOGRAPHY 0 54.01 1, 169 250 6, 359 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 54 02 730 250 7 592 54 02 1, 127 03630 ULTRA SOUND 54.03 1, 208 0 9, 462 54.03 05500 RADI OLOGY-THERAPEUTI C 17, 129 250 3, 089 28, 764 55.00 55.00 0 57.00 05700 CT SCAN 551 59, 680 0 14,825 57.00 \cap 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,003 6, 382 12, 307 250 0 58 00 05900 CARDIAC CATHETERIZATION 59.00 8,562 400 0 28, 188 59.00 C 06000 LABORATORY 12, 544 0 60.00 1,900 1, 405 60.00 35, 717 65.00 06500 RESPIRATORY THERAPY 7, 138 100 0 0 0 0 0 65.00 06600 PHYSI CAL THERAPY 30, 994 14,010 66.00 10, 115 702 66.00 67.00 06700 OCCUPATIONAL THERAPY 4, 213 5, 425 292 22, 412 67.00 68 00 06800 SPEECH PATHOLOGY 1,529 1, 227 106 8, 135 68.00 06900 ELECTROCARDI OLOGY 4.398 69.00 69.00 380 0 C 07000 ELECTROENCEPHALOGRAPHY 0 70.00 11,644 r 3, 986 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 Ω 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 73.00 03190 CHEMOTHERAPY 76.00 0 20, 189 0 0 29, 734 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 0 09001 ANDERSON OUTPATIENT CENTER 3,500 0 32, 953 90.01 C 700 90.01 90.02 04950 DIABETIC EDUCATION 0 90.02 C 0 09002 MS CLINIC 90.03 2, 164 75 0 1, 182 90.03 09100 EMERGENCY 577 91.00 22,505 164, 276 6, 480 115, 882 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS

113. 00 11300 INTEREST_EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	344, 213	1, 038, 231	63, 030	88, 022	1, 114, 465 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1, 882	0	0	0	0 190. 00
191. 00 19100 RESEARCH	0	0	0	0	2, 158 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 829	0	297	0	6, 344 192. 00
194. 00 07950 FOUNDATI ON	636	0	75	0	4, 171 194. 00
194. 01 07951 CHI LDRENS CLI NI C	0	484	950	0	0 194. 01
194. 02 07952 PSS ADMINISTRATION	553	0	0	0	3, 673 194. 02
194.03 07953 SEXUAL ASSULT PROGRAM	0	0	0	0	394 194. 03
194.04 07954 ASPR BIOTERRORISM GRANT	0	0	0	0	0 194. 04
194.05 07955 HEALTHY FAMILIES	10, 091	0	125	0	18, 252 194. 05
194.06 07956 DME-HOME CARE	220	0	0	0	0 194. 06
194. 07 07957 MARKETI NG	0	0	0	0	0 194. 07
194.08 07958 CORPORATE COMMUNICATIONS	2, 527	0	75	0	0 194. 08
194. 09 07959 MOB	0	0	180	0	0 194. 09
194. 10 07960 ASC	0	0	100	0	0 194. 10
194. 11 07961 MAB	0	0	0	0	0 194. 11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	2, 845	0	0	o	0 194. 12

Heal th F	inancial Systems	ST. VINCENT	ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CCN: 15-0088 Period: Wo From 07/01/2017		Worksheet B-1		
					To 06/30/2018		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(TOTAL HOURS)	
		(SQUARE FEET)	(POUNDS OF	SERVI CE)			
			LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 13 0	7962 I DLE SPACE	0	0		0	0	194. 13
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	8, 354, 021	906, 011	3, 556, 54	6 543, 746	3, 525, 740	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	22. 900528	0. 872242	54. 85787	9 6. 177387	3. 067309	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	792, 650	120, 003	199, 46	7 94, 899	348, 744	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	2. 172858	0. 115530	3. 07667	5 1. 078128	0. 303399	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Heal th Financial Systems	ST. VINCENT		N 45 0000 D		u of Form CMS-:	
COST ALLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 07/01/2017 o 06/30/2018	Worksheet B-1 Date/Time Pre	
Cost Contan Decemintion	MUDCLNC	CENTRAL			11/26/2018 2:	
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDICAL RECORDS &	ALLIED HEALTH-EMS	
	(DI RECT NURS.	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	(ASSI GNED TIME)	
	HRS.)	REQUIS.)		CHARGES)	IIME)	
OFNEDAL CERVICE COCT CENTERS	13. 00	14. 00	15. 00	16. 00	23. 00	
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 O0101 CAP REL COSTS-BLDG & FIXT-MAB						1. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00
11. 00 01100 CAFETERI A						11. 00
13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY	679, 206 0	11, 395, 857				13. 00 14. 00
15. 00 01500 PHARMACY	Ö	177, 591	20, 667, 710			15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY 23. 00 02300 ALLIED HEALTH-EMS	0	0 624	0	672, 181, 251	100	16. 00 23. 00
23. 01 02300 ALLIED HEALTH-EMS	0	024	0	0	100	23. 00
23. 02 02303 ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0		23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	324, 802	286, 317	0	40, 303, 284	0	30.00
31.00 03100 INTENSIVE CARE UNIT	106, 357	321, 181	Ö	17, 605, 436	0	
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	27, 244	29, 766	0	3, 562, 253 1, 705, 543	0	
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	9, 032	17, 223	0	1, 705, 543	0	43. 00
50. 00 05000 OPERATI NG ROOM	38, 621	8, 515, 021	0	109, 038, 445	0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	29, 080	55, 451	0	3, 760, 693 10, 436, 535	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	313, 311	Ö	20, 576, 206	0	1
54. 01 03440 MAMMOGRAPHY	0	76, 221	0	4, 264, 526	0	
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.03 03630 ULTRA SOUND		236, 287 93	0	14, 459, 758 9, 532, 887	0	54. 02 54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	256, 538	0	31, 349, 981	0	55. 00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1 3, 500	0	15, 502, 061 3, 370, 849	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	28, 188	232, 548	Ö	22, 793, 226	0	1
60. 00 06000 LABORATORY	0	7, 351	0	73, 835, 413	0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	123, 894 85, 247	0	13, 621, 900 10, 055, 925	0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	35, 509	0	3, 631, 742	0	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	12, 889 2, 229	0	1, 318, 276 1, 039, 782	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	5, 161	o	5, 249, 802	0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	17, 610, 454	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0 20, 649, 222	17, 937, 057 123, 635, 708	0	
76. 00 03190 CHEMOTHERAPY	0	155, 446	0	9, 397, 448	0	1
90.00 OUTPATIENT SERVICE COST CENTERS 90.00 O9000 CLINIC		0	0	ol	0	90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	o	1, 400	Ö	5, 130, 705	0	
90. 02 04950 DIABETIC EDUCATION 90. 03 09002 MS CLINIC	0	3 306	0	0 312, 343	0	
91. 00 09100 EMERGENCY	115, 882	3, 306 435, 798	0	81, 143, 013		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE				I] 113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	679, 206	11, 389, 903	20, 649, 222	672, 181, 251	100	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN				ما	0	1100.00
191. 00 19100 RESEARCH	0	0	0	o		190. 00 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	3, 884	2, 420	0		192. 00
194. 00 07950 FOUNDATI ON 194. 01 07951 CHI LDRENS CLI NI C	0	0 2, 070	0 16, 068	0		194. 00 194. 01
194. 02 07952 PSS ADMINISTRATION	o	2, 3, 3	0	ő	0	194. 02
194. 03 07953 SEXUAL ASSULT PROGRAM	0	0	0	0		194. 03
194.04 07954 ASPR BIOTERRORISM GRANT 194.05 07955 HEALTHY FAMILIES		0	0	0		194. 04 194. 05
194.06 07956 DME-HOME CARE	o	ō	Ō	o	0	194. 06
194. 07 07957 MARKETI NG 194. 08 07958 CORPORATE COMMUNI CATI ONS	0	0	0	0		194. 07 194. 08
194. 09 07959 MOB		0	0	o	0	194. 09
194. 10 07960 ASC 194. 11 07961 MAB	0	0	0	0		194. 10 194. 11
174. 11 U/7U1 WAU	1 0	υĮ	υ	·	0	174. II

Health Fina	ncial Systems	ST. VINCENT	ANDERSON		In lie	eu of Form CMS-	2552-10
	TION - STATISTICAL BASIS	OT. VINOLIVI		CN: 15-0088	Peri od: From 07/01/2017	Worksheet B-1	
					To 06/30/2018	Date/Time Pre 11/26/2018 2:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	ALLI ED	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	HEALTH-EMS	
			SUPPLY	REQUIS.)	LI BRARY	(ASSI GNED	
		(DI RECT NURS.	(COSTED		(GROSS	TIME)	
		HRS.)	REQUIS.)		CHARGES)		
		13.00	14.00	15.00	16. 00	23. 00	
194. 12 07963	ADOLESCENT RESIDENTIAL SERVICES	0	0		0 0	0	194. 12
194. 13 07962	IDLE SPACE	0	0		0 0	0	194. 13
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	4, 462, 378	1, 759, 378	5, 963, 10	204, 651	204, 073	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 569992	0. 154388	0. 28852	0. 000304	2,040.730000	203.00
204. 00	Cost to be allocated (per Wkst. B,	162, 996	249, 132	203, 39	72, 016	7, 254	204. 00

0. 239980

0.021862

0.009841

72. 540000 205. 00

0. 000000 207. 00

0 206. 00

0.000107

205.00

206.00

207.00

Part II)

Parts III and IV)

11)

Unit cost multiplier (Wkst. B, Part

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D,

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 | Period: | Worksheet B-1 | From 07/01/2017 | To 06/30/2018 | Date/Time Prepared: 11/26/2018 2: 01 pm Provider CCN: 15-0088

			11/26/2018 2	
Cost Center Description	ALLI ED	ALLI ED		
	HEALTH-RAD TECH	HEALTH-PHARM RESI DENTS		
	(ASSI GNED	(ASSI GNED		
	TIME)	TIME)		
CENEDAL SERVICE COST CENTERS	23. 01	23. 02		
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT				1.00
1. 01 O0101 CAP REL COSTS-BLDG & FIXT-MAB				1. 01
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 10. 00 01000 DI ETARY				9. 00
11. 00 01100 CAFETERI A				11. 00
13.00 01300 NURSING ADMINISTRATION				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00 01500 PHARMACY				15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY 23. 00 02300 ALLIED HEALTH-EMS				16. 00 23. 00
23. 01 02300 ALLIED HEALTH-EMS	99, 056, 268			23. 00
23. 02 02303 ALLI ED HEALTH-PHARM RESI DENTS	77, 030, 200	100		23. 02
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	0	0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	O		31. 00
41. 00 04100 SUBPROVI DER - 1 RF	0	0		41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0		43. 00
50. 00 05000 OPERATING ROOM	0	O		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o		52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	20, 576, 206	O		54. 00
54. 01 03440 MAMMOGRAPHY	4, 264, 526	0		54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54. 03 03630 ULTRA SOUND	14, 459, 758 9, 532, 887	0		54. 02 54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	31, 349, 981	ol		55. 00
57. 00 05700 CT SCAN	15, 502, 061	o		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 370, 849	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0		60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	ol		67. 00
68.00 06800 SPEECH PATHOLOGY	0	o		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	O		70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENTS	0	0		71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0 100		72. 00 73. 00
76. 00 03190 CHEMOTHERAPY	0	o		76.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0	0		90. 00
90. 01 09001 ANDERSON OUTPATIENT CENTER	0	0		90. 01
90. 02 04950 DIABETIC EDUCATION 90. 03 09002 MS CLINIC	0	O		90. 02 90. 03
91. 00 09100 EMERGENCY	0	ol		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	J	S		92. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 I NTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	99, 056, 268	100		118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190. 00
190.00 19000 GTFT, FLOWER, COFFEE SHOP, & CANTEEN	0	ol Ol		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	o		192. 00
194. 00 07950 FOUNDATI ON	0	0		194. 00
194. 01 07951 CHI LDRENS CLI NI C	0	0		194. 01
194. 02 07952 PSS ADMI NI STRATI ON	0	0		194. 02
194. 03 07953 SEXUAL ASSULT PROGRAM 194. 04 07954 ASPR BI OTERRORI SM GRANT	0	O O		194. 03 194. 04
194.05 07955 HEALTHY FAMILIES	0	0		194. 04
194. 06 07956 DME-HOME CARE	o	ol		194. 06
194. 07 07957 MARKETI NG	o	o		194. 07
194. 08 07958 CORPORATE COMMUNICATIONS	0	0		194. 08
194. 09 07959 MOB	0	0		194. 09
194. 10 07960 ASC	0	0		194. 10
194. 11 07961 MAB	0	0		194. 11

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088
Period: From 07/01/2017
To 06/30/2018 Date/Time Prepared:

				10 06/3	0/2018 Date/Time Prepared: 11/26/2018 2:01 pm
	Cost Center Description	ALLI ED HEALTH-RAD TECH (ASSI GNED TI ME)	ALLI ED HEALTH-PHARM RESI DENTS (ASSI GNED TI ME)	· ·) 117 267 2610 2. OT pill
104 13	07963 ADOLESCENT RESIDENTIAL SERVICES	23. 01	23. 02		194. 12
	07962 I DLE SPACE	0	0		194. 12
200.00					200. 00
201.00	1 1				201. 00
202.00	9	349, 942	462, 156		202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 003533	4, 621. 560000		203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)	10, 045	12, 422		204. 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000101	124. 220000		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0		206. 00
207. 00	1 1 1	0. 000000	0. 000000		207. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0088 Peri od: Worksheet C From 07/01/2017 Part I Date/Time Prepared: 06/30/2018 11/26/2018 2:01 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit 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 22, 283, 670 22, 283, 670 0 22, 283, 670 03100 INTENSIVE CARE UNIT 9, 403, 702 9, 403, 702 0 9, 403, 702 31.00 31.00 04100 SUBPROVI DER - I RF 2, 699, 738 o 41.00 2, 699, 738 2, 699, 738 41.00 04300 NURSERY 43.00 43.00 964, 672 964, 672 964, 672 ANCILLARY SERVICE COST CENTERS 26, 621, 559 50.00 05000 OPERATING ROOM 26, 621, 559 718, 457 27, 340, 016 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 971, 107 2, 971, 107 2, 971, 107 52.00 1, 598, 848 53 00 05300 ANESTHESI OLOGY 1, 598, 848 1, 598, 848 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 253, 278 5, 253, 278 0 5, 253, 278 54.00 54.01 03440 MAMMOGRAPHY 733, 607 733, 607 0 733, 607 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 1, 560, 915 1, 560, 915 0 1, 560, 915 54.02 54.02 03630 ULTRA SOUND 54.03 852, 834 852, 834 852, 834 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 3, 917, 565 3, 917, 565 3, 917, 565 55.00 05700 CT SCAN 57.00 1, 262, 402 1, 262, 402 0 1, 262, 402 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 179, 290 1, 179, 290 1, 179, 290 58 00 58 00 59.00 05900 CARDIAC CATHETERIZATION 2, 678, 213 2, 678, 213 2, 678, 213 59.00 06000 LABORATORY 9, 498, 000 9, 498, 000 0 9, 498, 000 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 2, 460, 674 2, 460, 674 17, 810 2, 478, 484 65.00 06600 PHYSI CAL THERAPY 3, 898, 756 3, 898, 756 Ω 3, 898, 756 66 00 0 66 00 67.00 06700 OCCUPATIONAL THERAPY 1,662,439 0 1, 662, 439 0 1, 662, 439 67.00 0 68.00 06800 SPEECH PATHOLOGY 602, 787 602, 787 602, 787 68.00 69 00 06900 ELECTROCARDI OLOGY 268.956 268, 956 268, 956 69 00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 281, 972 1, 281, 972 1, 281, 972 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 129, 061 4, 129, 061 0 4, 129, 061 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 6, 130, 437 6, 130, 437 6, 130, 437 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 33 833 943 33 833 943 33, 833, 943 73 00 03190 CHEMOTHERAPY 76.00 1, 741, 490 1, 741, 490 1, 741, 490 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09001 ANDERSON OUTPATIENT CENTER 0 3, 623, 202 3, 623, 202 3, 623, 202 90 01 90.01 90.02 04950 DIABETIC EDUCATION 0 0 90.02 09002 MS CLINIC 90.03 167, 556 167, 556 167, 556 90.03 8, 891, 275 8, 891, 275 91.00 09100 EMERGENCY 59, 078 8, 950, 353 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 208, 273 92.00 1, 208, 273 1, 208, 273 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 163, 380, 221 163, 380, 221 164, 175, 566 200. 00 200.00 Subtotal (see instructions) 0 795, 345 1, 208, 273 201. 00 201.00 Less Observation Beds 1, 208, 273 1, 208, 273

162, 171, 948

162, 171, 948

795, 345

162, 967, 293 202. 00

202.00

Total (see instructions)

	Titialici ai Systellis	31. VINCLIVI	ANDERSON		THI LIFE	u or rorm cws	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider CO		Peri od: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Pre 11/26/2018 2:	pared: 01 pm
			Title	XVIII	Hospi tal	PPS	<u> </u>
			Charges	,,,,,,,	noop: tui		
	Cost Center Description	Inpati ent	Outpati ent	Total (col	Cost or Other	TEFRA	
	oost outtor boson per on	Impatrent	outputtent	+ col . 7)	Ratio	Inpati ent	
				' 001. //	nati o	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1			1.00		
30.00	03000 ADULTS & PEDIATRICS	37, 004, 635		37, 004, 63	5		30.00
31. 00	03100 INTENSIVE CARE UNIT	17, 605, 436		17, 605, 43			31. 00
41. 00	04100 SUBPROVI DER - I RF	3, 562, 253		3, 562, 25			41. 00
43. 00	04300 NURSERY	1, 705, 543		1, 705, 54			43. 00
10.00	ANCILLARY SERVICE COST CENTERS	177007010		1,700,01	<u> </u>		1
50.00	05000 OPERATING ROOM	25, 352, 056	83, 686, 389	109, 038, 44	5 0. 244148	0. 000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 033, 499	727, 194	3, 760, 69		0. 000000	
53. 00	05300 ANESTHESI OLOGY	2, 095, 430	8, 341, 105	10, 436, 53		0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 588, 415	13, 987, 791	20, 576, 20		0. 000000	
54. 01	03440 MAMMOGRAPHY	993	4, 263, 533	4, 264, 52		0. 000000	1
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 153, 810	13, 305, 948	14, 459, 75		0. 000000	1
54. 03	03630 ULTRA SOUND	1, 459, 234	8, 073, 653	9, 532, 88		0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 280, 028	30, 069, 953	31, 349, 98		0. 000000	1
57. 00	05700 CT SCAN	3, 448, 243	12, 053, 818	15, 502, 06		0. 000000	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	707, 550	2, 663, 299	3, 370, 84		0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	6, 065, 199	16, 728, 027	22, 793, 22		0. 000000	1
60. 00	06000 LABORATORY	27, 090, 795	46, 744, 618	73, 835, 41		0. 000000	1
65. 00	06500 RESPIRATORY THERAPY	11, 794, 693	1, 827, 207	13, 621, 90		0. 000000	
66. 00	06600 PHYSI CAL THERAPY	2, 860, 554	7, 195, 371	10, 055, 92		0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 109, 134	1, 522, 608	3, 631, 74		0. 000000	
68. 00	06800 SPEECH PATHOLOGY	589, 652	728, 624	1, 318, 27		0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	11, 628	1, 028, 154	1, 039, 78		0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	380, 567	4, 869, 235	5, 249, 80		0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 926, 707	8, 683, 747	17, 610, 45		0. 000000	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 656, 986	9, 280, 071	17, 910, 43		0. 000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	24, 709, 228	98, 926, 480			0. 000000	
76. 00							1
76.00	03190 CHEMOTHERAPY OUTPATI ENT SERVI CE COST CENTERS	124, 612	9, 272, 836	9, 397, 44	8 0. 185315	0. 000000	76. 00
90. 00	09000 CLINIC	l ol	0		0. 000000	0. 000000	90.00
90.00	09000 CETNIC	1	•				1
		1, 277	5, 129, 428	5, 130, 70		0.000000	1
90. 02 90. 03	04950 DI ABETI C EDUCATI ON 09002 MS CLINIC	2 520	309, 815	212 24	0.000000	0. 000000 0. 000000	
		2, 528		312, 34			
91.00	09100 EMERGENCY	15, 242, 677	65, 900, 336			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	471, 608	2, 827, 041	3, 298, 64	0. 366293	0. 000000	92. 00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE	214 024 070	4EO 144 001	(70 101 05	1		113. 00
200.00		214, 034, 970	458, 146, 281	672, 181, 25			200.00
201.00		214 024 070	4EO 144 001	(70 101 05	1		201. 00
202.00	Total (see instructions)	214, 034, 970	458, 146, 281	672, 181, 25	¹ 1		202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0088 | Period: From 07/01/2017 | Part | Part | Period: From 07/01/2017 | Period: From 07/01/2017 | Part | Period: From 07/01/2017 |

06/30/2018 Date/Time Prepared: 11/26/2018 2:01 pm Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 250737 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 790042 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0. 153197 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 255308 54.00 03440 MAMMOGRAPHY 0. 172025 54 01 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 0. 107949 54.02 54. 03 03630 ULTRA SOUND 0.089462 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 124962 55.00 57. 00 05700 CT SCAN 0. 081434 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.349850 58.00 05900 CARDI AC CATHETERI ZATI ON 0. 117500 59.00 59.00 60.00 06000 LABORATORY 0.128637 60.00 06500 RESPIRATORY THERAPY 65.00 0. 181948 65.00 66.00 06600 PHYSI CAL THERAPY 0. 387707 66.00 06700 OCCUPATIONAL THERAPY 0. 457753 67.00 67.00 06800 SPEECH PATHOLOGY 0.457254 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 258666 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 244194 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 234466 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0.341775 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 273658 73.00 03190 CHEMOTHERAPY 0. 185315 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 09001 ANDERSON OUTPATIENT CENTER 90.01 0.706180 90.01 04950 DIABETIC EDUCATION 0.000000 90. 02 90.02 09002 MS CLINIC 90.03 0.536449 90 03 09100 EMERGENCY 91.00 0.110303 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 366293 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 Less Observation Beds 201.00 201. 00 202.00 Total (see instructions) 202. 00

Hearth Financial Systems	SI. VINCENI	ANDERSON		in Lie	u of Form CMS	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Pre 11/26/2018 2:	
		Ti +I	e XIX	Hospi tal	Cost	O I PIII
		11 (1	e xix	Costs	0031	
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	Part I, col.					
	26)	0.00	2.22			
LABORT SUT BOUTLAND OFFICE COOT OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	00.000.470				00 000 170	
30. 00 03000 ADULTS & PEDI ATRI CS	22, 283, 670		22, 283, 67		22, 283, 670	
31. 00 03100 INTENSIVE CARE UNIT	9, 403, 702		9, 403, 70		9, 403, 702	
41. 00 04100 SUBPROVI DER - RF	2, 699, 738		2, 699, 73		2, 699, 738	
43. 00 04300 NURSERY	964, 672		964, 67	2 0	964, 672	43. 00
ANCILLARY SERVICE COST CENTERS		T	r	1		
50. 00 05000 OPERATI NG ROOM	26, 621, 559		26, 621, 55		27, 340, 016	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 971, 107		2, 971, 10		2, 971, 107	1
53. 00 05300 ANESTHESI OLOGY	1, 598, 848		1, 598, 84		1, 598, 848	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 253, 278		5, 253, 27		5, 253, 278	
54. 01 03440 MAMMOGRAPHY	733, 607		733, 60		733, 607	54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 560, 915		1, 560, 91		1, 560, 915	
54. 03 03630 ULTRA SOUND	852, 834		852, 83	4 0	852, 834	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 917, 565		3, 917, 56	5 0	3, 917, 565	55. 00
57. 00 05700 CT SCAN	1, 262, 402		1, 262, 40	2 0	1, 262, 402	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 179, 290		1, 179, 29	0	1, 179, 290	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 678, 213		2, 678, 21	3 0	2, 678, 213	59. 00
60. 00 06000 LABORATORY	9, 498, 000		9, 498, 00	0	9, 498, 000	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 460, 674	0	2, 460, 67	4 17, 810	2, 478, 484	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 898, 756	0	3, 898, 75	6 0	3, 898, 756	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 662, 439	0	1, 662, 43	9 0	1, 662, 439	67. 00
68. 00 06800 SPEECH PATHOLOGY	602, 787	0	602, 78	7 0	602, 787	68. 00
69. 00 06900 ELECTROCARDI OLOGY	268, 956		268, 95	6 0	268, 956	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 281, 972		1, 281, 97		1, 281, 972	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 129, 061		4, 129, 06		4, 129, 061	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 130, 437		6, 130, 43		6, 130, 437	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	33, 833, 943		33, 833, 94		33, 833, 943	1
76. 00 03190 CHEMOTHERAPY	1, 741, 490		1, 741, 49		1, 741, 490	1
OUTPATIENT SERVICE COST CENTERS	, , , , , ,					1
90. 00 09000 CLINIC	0			0 0	0	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	3, 623, 202		3, 623, 20	-	3, 623, 202	
90. 02 04950 DI ABETI C EDUCATION	0,020,202			0	0,020,202	90. 02
90. 03 09002 MS CLINIC	167, 556		167, 55	-	167, 556	1
91. 00 09100 EMERGENCY	8, 891, 275		8, 891, 27		8, 950, 353	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 208, 273		1, 208, 27		1, 208, 273	1
SPECIAL PURPOSE COST CENTERS	1,200,273		1, 200, 27	~	1, 200, 273	1 /2.00
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	163, 380, 221	0	163, 380, 22	1 795, 345	164, 175, 566	
201.00 Less Observation Beds	1, 208, 273	١	1, 208, 27		1, 208, 273	
202.00 Total (see instructions)	162, 171, 948	0				
202.00 10tal (300 1113ti dott 0113)	102, 171, 740	١	102, 171, 74	7,75, 545	102, 701, 273	1202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Heal th Fi	inancial Systems	ST. VINCENT	ANDERSON		In Lie	u of Form CMS-	<u> 2552-10</u>
Title XIX	COMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-0088	Peri od:		
NPAT I ENT ROUTINE SERVICE COST CENTERS 1						From 07/01/2017		
Title XIX						To 06/30/2018	Date/Time Pre	pared:
Cost Center Description								01 pm_
INPATIENT ROUTINE SERVICE COST CENTERS					e XIX	Hospi tal	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS 6.00				Charges				
INPATI ENT ROUTINE SERVICE COST CENTERS 37,004,635 37,004,635 37,004,635 31,00 30300 ADULTS & PEDIATRICS 37,004,635 37,004,635 37,004,635 31,00 3100 INTERSI VE CARE UNI T 17,005,436 17,605,436 31,00 31,00 3100 INTERSI VE CARE UNI T 17,005,436 17,605,436 31,00 31,00 3100 UNIFERSI VE CARE UNI T 17,005,436 17,605,436 31,00 31,00 31,00 UNIFERSI VE CARE UNI T 17,005,433 1,705,543 1,705,543 41,00 31,00		Cost Center Description	Inpati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
NPATIENT ROUTINE SERVICE COST CENTERS 37, 004, 635 37, 004, 635 37, 004, 635 31, 004,					+ col. 7)	Ratio	Inpati ent	
INPATIENT ROUTINE SERVICE COST CENTERS 37, 004, 635 37, 004, 635 37, 004, 635 30, 00 3100 03100 INTERSI VE CARE LINIT 17, 605, 436 17, 605, 436 31, 00 4100 04100 SUBPROVI DER - I RF 3, 562, 253 411, 00 4300 NURSERY 1, 705, 543 17, 705, 543 41, 00 4300 NURSERY 1, 705, 543 41, 705, 543 41, 705, 543 41, 705, 703, 705, 705, 705, 705, 705, 705, 705, 705							Ratio	
30.00			6. 00	7.00	8. 00	9. 00	10.00	
31.00	1.1	NPATIENT ROUTINE SERVICE COST CENTERS						
41 00 04100 SUBPROVIDER - IRF 3,562,253 3,562,253 41,00 43.00 04300 NIRSERY 1,705,543 1,705,543 43.00 04300 NIRSERY 1,705,543 1,705,543 43.00 04300 NIRSERY 1,705,543 1,	30.00 03	3000 ADULTS & PEDIATRICS	37, 004, 635		37, 004, 63	35		30.00
41.00 04100 SUBPROVIDER - IRF 3,562,253 1,705,543 1,705,543 1,705,543 43.00 04300 NURSERY 1,705,543 1,705,543 1,705,543 43.00 04300 NURSERY 1,705,543	31. 00 03	3100 INTENSIVE CARE UNIT	17, 605, 436		17, 605, 43	36		31.00
A3. 00 O4300 NURSERY 1, 705, 543 1, 705, 543 43. 00								41.00
ANCIL LARY SERVI CE COST CENTERS Service								1
50.00 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000			177007010		1770070			1 .0.00
S2.00 DS200 DELIVERY ROOM & LABOR ROOM 3, 033, 499 727, 194 3, 760, 693 0, 790042 0, 000000 52, 00			25 352 056	83 686 389	109 038 44	0 244148	0.000000	50.00
S3 00 05300 ABSTHESI OLOGY 2, 095, 430 8, 341, 105 10, 436, 535 0, 153197 0, 000000 54, 00 54 00 05400 RADIOLOGY-DI AGNOSTI C 6, 588, 415 13, 987, 791 20, 576, 206 0, 255308 0, 000000 54, 00 54 01 03440 MAMMOGRAPHY 993 4, 264, 526 1, 72025 0, 000000 54, 00 54 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 1, 153, 810 13, 305, 948 14, 459, 758 0, 107949 0, 000000 54, 00 55 03 05300 LTRA SOUND 1, 459, 234 8, 735, 653 9, 522, 887 0, 089462 0, 000000 54, 00 55 00 05500 RADI OLOGY-THERAPEUTI C 1, 280, 028 30, 069, 953 31, 349, 981 0, 124962 0, 000000 55, 00 57 00 05700 CT SCAN 3, 448, 243 12, 053, 818 15, 502, 061 0, 081434 0, 000000 57, 00 58 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 707, 550 2, 663, 299 3, 370, 849 0, 349850 0, 000000 58, 00 59 00 05900 CARDIA C CATHETERI ZATI ON 6, 065, 199 16, 728, 027 22, 793, 226 0, 117500 0, 000000 59, 00 65 00 05600 MEDIA C CATHETERI ZATI ON 6, 065, 199 16, 728, 027 22, 793, 226 0, 117500 0, 000000 65, 00 66 00 06600 PARSI CAL THERAPY 11, 794, 693 1, 827, 207 13, 621, 900 0, 180641 0, 000000 65, 00 66 00 06600 PARSI CAL THERAPY 2, 860, 554 7, 195, 371 0, 055, 925 0, 387707 0, 000000 66, 00 67 00 06000 CALDRATORY 2, 109, 134 1, 522, 608 3, 631, 742 0, 457753 0, 000000 67, 00 68 00 06900 ELECTROCARDI LOLOGY 11, 628 1, 222, 608 3, 631, 742 0, 457753 0, 000000 67, 00 69 00 06900 ELECTROCARDI LOLOGY 11, 628 1, 228, 608 1, 318, 276 0, 457254 0, 000000 71, 00 70 00 07000 ELECTROCARDI LOLOGY 11, 628 1, 228, 608 1, 318, 276 0, 457254 0, 000000 70, 00 71 00 07100 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 8, 266, 707 8, 683, 747 17, 610, 454 0, 234466 0, 000000 70, 00 71 00 07000 ELECTROCARDIA LOGY 1, 24, 612 9, 272, 836 9, 397, 448 0, 185315 0, 000000 90, 00 72 00 0			1					1
54. 00 05400 RADI OLOGY - DI AGNOSTI C 6, 588, 415 13, 987, 791 20, 576, 206 0. 255308 0. 000000 54. 00								1
54. 02 03450 03440 MAMMOGRAPHY 993 4, 263, 533 4, 264, 526 0. 172025 0. 000000 54. 02 54. 02 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 1, 153, 810 13, 305, 948 14, 459, 758 0. 107949 0. 000000 54. 02 54. 03 03630 ULTRA SOUND 1, 459, 234 8, 073, 653 9, 532, 887 0. 089462 0. 000000 54. 03 55. 00 05500 RADI OLOGY-THERAPEUTI C 1, 280, 028 30, 069, 953 31, 349, 981 0. 124962 0. 000000 55. 00 57. 00 055700 CT SCAN 3, 448, 243 12, 503, 818 15, 502, 061 0. 081434 0. 000000 57. 00 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 707, 550 2, 663, 299 3, 370, 849 0. 349850 0. 000000 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 6, 065, 199 16, 728, 027 22, 793, 226 0. 117500 0. 000000 59. 00 65. 00 06000 LABORATORY 27, 090, 795 46, 744, 618 73, 835, 413 0. 128637 0. 000000 60. 00 65. 00 06000 LABORATORY 11, 794, 693 1, 827, 207 13, 621, 900 0. 180641 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 806, 554 7, 195, 371 10, 055, 925 0. 387707 0. 000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 2, 109, 134 1, 522, 608 3, 631, 742 0. 457753 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 589, 6552 728, 624 1, 318, 276 0. 457754 0. 000000 69. 00 69. 00 06900 LELETROCRAPI LOGY 380, 657 4, 869, 235 5, 249, 802 0. 244194 0. 000000 70. 00 69. 00 07000 LELETROCRAPI LOGY 380, 656, 986 9, 280, 071 17, 937, 057 0. 341775 0. 000000 69. 00 69. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 8, 656, 986 9, 280, 071 17, 937, 057 0. 341775 0. 000000 70. 00 69. 00 07000 LABORASON OUTPATI ENT CENTER 1, 277 5, 129, 428 5, 130, 705 0. 706180 0. 000000 90. 00 69. 00 09000 LABORASON OUTPATI ENT CENTER 1, 277 5, 129, 428 5, 130, 705 0. 706180 0. 000000 90. 00 69. 00 09000 LABORASON OUTPATI ENT CENTER 1, 277 5, 129, 428 5, 130, 705 0. 70								
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54. 03 03630 IUTRA SOUND 1, 459, 234 8, 073, 653 9, 532, 887 0. 089462 0. 000000 54. 03 55. 00 05500 RADI OLOGY-THERAPEUTI C 1, 280, 028 30, 069, 953 31, 349, 981 0. 124962 0. 000000 55. 00 05700 CT SCAN 3, 448, 243 12, 053, 818 15, 502, 061 0. 081434 0. 000000 57. 00 05700 CRT SCAN 0. 08000 CARDIA C CATHETERI ZATI ON 0. 60, 65, 199 10, 707, 55. 00 0. 0800 LABORATORY 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 000000 0. 00000			1 I					
55. 00 05500 RADI OLOGY-THERAPEUTI C		1						1
57. 00 05700 CT SCAN 3,448,243 12,053,818 15,502,061 0.081434 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 707,550 2,663,299 3,370,849 0.349850 0.000000 59.00 0.000000 59.00 0.000000 59.00 0.000000 59.00 0.000000 59.00 0.000000 59.00 0.000000 59.00 0.000000 59.00 0.000000 59.00 0.000000 59.00 0.000000 59.00 0.000000 59.00 0.0000000 0.0000000 0.0000000 0.00000000								
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 707, 550 2, 663, 299 3, 370, 849 0. 349850 0. 000000 58. 00 05900 CARDIAC CATHETERIZATION 6, 665, 199 16, 728, 027 22, 793, 226 0. 117500 0. 000000 59. 00 0. 000000 CABDIAC CATHETERIZATION 6, 665, 199 16, 728, 027 22, 793, 226 0. 117500 0. 000000 60. 00 0. 000000 CABDIAC CATHETERIZATION 6, 665, 199 16, 728, 027 22, 793, 226 0. 117500 0. 000000 60. 00 0. 000000 60. 00 0. 000000 60. 00 0. 000000 60. 00 0. 000000 60. 00 0. 000000 60. 00 0. 000000 60. 00 0. 000000 60. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 0000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 0000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 0000000 65. 00 0. 0000000 65. 00 0. 0000000 65. 00 0. 0000000 65. 00 0. 0000000 65. 00		1	1 ' ' 1					1
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66. 00 06600 PHYSI CAL THERAPY 2, 860, 554 7, 195, 371 10, 055, 925 0.387707 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 2, 109, 134 1, 522, 608 3, 631, 742 0.457753 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 589, 652 728, 624 1, 318, 276 0.457254 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 11, 628 1, 028, 154 1, 039, 782 0.258666 0.000000 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 380, 567 4, 869, 235 5, 249, 802 0.244194 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 656, 986 9, 280, 071 17, 937, 057 0.341775 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 24, 709, 228 98, 926, 480 123, 635, 708 0.273658 0.000000 73. 00 76. 00 03190 CHEMOTHERAPY 124, 612 9, 272, 836 9, 397, 448 0.185315 0.000000 76. 00 79. 01 09001 ANDERSON OUTPATI ENT CENTER 1, 277 5, 129, 428 5, 130, 705 0.706180 0.000000 90. 01 90. 02 04950 DI ABETI C EDUCATI ON 0 0 0 0.000000 0.000000 90. 02 90. 03 09002 MS CLI NI C 2, 528 309, 815 312, 343 0.536449 0.000000 91. 00 09000 SERVATI ON BEDS (NON-DISTINCT PART) 471, 608 2, 827, 041 3, 298, 649 0.366293 0.000000 92. 00 Subtotal (see instructions) 214, 034, 970 458, 146, 281 672, 181, 251 200. 00 201. 00 Less Observation Beds 214, 034, 970 458, 146, 281 672, 181, 251 200. 00 201. 00 0000000000000000000000000000000		1						1
67. 00 06700 OCCUPATI ONAL THERAPY 2, 109, 134 1, 522, 608 3, 631, 742 0. 457753 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 589, 652 728, 624 1, 318, 276 0. 457254 0. 000000 68. 00 06900 ELECTROCARDI OLOGY 11, 628 1, 028, 154 1, 039, 782 0. 258666 0. 000000 69. 00 07000 ELECTROCARDI OLOGY 11, 628 1, 028, 154 1, 039, 782 0. 258666 0. 000000 70. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 926, 707 8, 683, 747 17, 610, 454 0. 234466 0. 000000 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 656, 986 9, 280, 071 17, 937, 057 0. 341775 0. 000000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 24, 709, 228 98, 926, 480 123, 635, 708 0. 273658 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 24, 709, 228 98, 926, 480 123, 635, 708 0. 273658 0. 000000 73. 00 07300 CHEMOTHERAPY 124, 612 9, 272, 836 9, 397, 448 0. 185315 0. 000000 74. 00 00000 00000 00000 000000 000000 0000		1	11, 794, 693	1, 827, 207				1
68. 00 06800 SPEECH PATHOLOGY 589, 652 728, 624 1, 318, 276 0. 457254 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 11, 628 1, 028, 154 1, 039, 782 0. 258666 0. 000000 69. 00 70. 00 7000 ELECTROENCEPHALOGRAPHY 380, 567 4, 869, 235 5, 249, 802 0. 244194 0. 000000 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 8, 656, 986 9, 280, 071 17, 610, 454 0. 234466 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 656, 986 9, 280, 071 17, 937, 057 0. 341775 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 24, 709, 228 98, 926, 480 123, 635, 708 0. 273658 0. 000000 73. 00 03190 CHEMOTHERAPY 124, 612 9, 272, 836 9, 397, 448 0. 185315 0. 000000 76. 00 00000 CLI NI C 0 0 0 0. 000000 0. 000000 90. 01 09001 ANDERSON OUTPATIENT CENTER 1, 277 5, 129, 428 5, 130, 705 0. 706180 0. 000000 90. 01 09001 ANDERSON OUTPATIENT CENTER 1, 277 5, 129, 428 5, 130, 705 0. 706180 0. 0000000 90. 01 09001 MBETI C EDUCATION 0 0 0 0. 0000000 0. 000000 90. 01 09000 MB CLI NI C 2, 528 309, 815 312, 343 0. 536449 0. 000000 91. 00 09000 MBERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 91. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 91. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 92. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 92. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 92. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 92. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 92. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 92. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 92. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 92. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 92. 00 09000 DEMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 92. 00 09000 DEMERGENCY 15			2, 860, 554					1
69. 00	67. 00 06	6700 OCCUPATI ONAL THERAPY	2, 109, 134	1, 522, 608	3, 631, 74	0. 457753	0. 000000	67. 00
70. 00	68. 00 06	6800 SPEECH PATHOLOGY	589, 652	728, 624	1, 318, 27	0. 457254	0.000000	68. 00
71. 00	69.00 06	6900 ELECTROCARDI OLOGY	11, 628	1, 028, 154	1, 039, 78	0. 258666	0.000000	69. 00
72. 00	70.00 07	7000 ELECTROENCEPHALOGRAPHY	380, 567	4, 869, 235	5, 249, 80	0. 244194	0.000000	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 24, 709, 228 98, 926, 480 123, 635, 708 0. 273658 0. 000000 73. 00 76. 00 0. 01900 0. 000000 0. 00000000	71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 926, 707	8, 683, 747	17, 610, 45	0. 234466	0. 000000	71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 24, 709, 228 98, 926, 480 123, 635, 708 0. 273658 0. 000000 73. 00 76. 00 0. 01900 0. 000000 0. 00000000	72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	8, 656, 986	9, 280, 071	17, 937, 05	0. 341775	0. 000000	72. 00
90. 00 07000 07000 07000 07000 070000 07000000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 07000000 0700000 0700000 0700000 0700000 0700000 070000000 070000000 070000000 070000000 070000000 0700000000	73.00 07	7300 DRUGS CHARGED TO PATIENTS	24, 709, 228	98, 926, 480	123, 635, 70	0. 273658	0. 000000	73. 00
90. 00 07000 07000 07000 07000 070000 07000000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 07000000 0700000 0700000 0700000 0700000 0700000 070000000 070000000 070000000 070000000 070000000 0700000000	76, 00 03	3190 CHEMOTHERAPY	124, 612	9, 272, 836	9, 397, 44	0. 185315	0. 000000	76. 00
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0			.,		, , , , ,			
90. 01			0	0	ı	0 000000	0.000000	90.00
90. 02								
90. 03 09002 MS CLINIC 2,528 309,815 312,343 0.536449 0.000000 90.03 91.00 92.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 471,608 2,827,041 3,298,649 0.366293 0.000000 92.00			0	0, 127, 120	1			1
91. 00 09100 EMERGENCY 15, 242, 677 65, 900, 336 81, 143, 013 0. 109575 0. 000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 471, 608 2, 827, 041 3, 298, 649 0. 366293 0. 000000 92. 00 92. 00 92. 00 92. 00 93. 00 93. 00 94. 00 9			2 528	300 815	312 3/			
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 471,608 2,827,041 3,298,649 0.366293 0.000000 92. 00			1					1
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 214,034,970 458,146,281 672,181,251 200.00 201.00 Less Observation Beds 201.00								
113.00			471,000	2, 027, 041	3, 290, 02	19 0. 300293	0.000000	92.00
200.00 Subtotal (see instructions) 214,034,970 458,146,281 672,181,251 200.00 201.00 Less Observation Beds 201.00					I			112 00
201.00 Less Observation Beds 201.00	1	1	214 024 070	4EO 147 001	(72 101 2	-1		1
	1	,	214, 034, 970	458, 146, 281	0/2, 181, 25	21		1
202. 00 Total (see Histructions) 214, 034, 970 458, 146, 281 672, 181, 251			214 024 070	4EO 144 001	(72 101 2	-1		
	202.00	Trotal (See Tristructions)	214, 034, 970	458, 146, 281	0/2, 181, 25	2 1	I	12U2. UU

Health Financial Systems ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0088 | Period: From 07/01/2017 | Part I Date/Time Prepared:

			To 06/30/2018	Date/Time Prepared: 11/26/2018 2:01 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 INTENSI VE CARE UNI T				31. 00
41. 00 04100 SUBPROVI DER - RF				41.00
43. 00 04300 NURSERY				43. 00
ANCI LLARY SERVI CE COST CENTERS 50.00 OPERATI NG ROOM	0.000000			F0.00
50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000 0. 000000			50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000			53. 00 54. 00
54. 01 03440 MAMMOGRAPHY	0. 000000			54. 00
54. 01 03440 MANINOGRAPHY 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54. 03 03630 ULTRA SOUND	0. 000000			54. 02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000			55. 00
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00 03190 CHEMOTHERAPY	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	0. 000000			90. 01
90. 02 04950 DI ABETI C EDUCATI ON	0. 000000			90. 02
90. 03 09002 MS CLINIC	0. 000000			90. 03
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	ST. VINCENT	ANDERSON		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 07/01/2017 To 06/30/2018		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 586, 436	0	1, 586, 43	6 20, 379	77. 85	30. 00
31.00 INTENSIVE CARE UNIT	455, 249		455, 24	9 6, 285	72. 43	31.00
41. 00 SUBPROVI DER - I RF	213, 332	0	213, 33	2, 620	81. 42	41.00
43. 00 NURSERY	120, 627		120, 62	7 1, 052	114. 66	43.00
200.00 Total (lines 30 through 199)	2, 375, 644		2, 375, 64	4 30, 336		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 & PEDI ATRI CS	5, 588	435, 026				30. 00
31.00 INTENSIVE CARE UNIT	4, 352	315, 215	5			31. 00
41. 00 SUBPROVI DER - I RF	1, 419	115, 535	5			41.00
43. 00 NURSERY	0		1			43.00
200.00 Total (lines 30 through 199)	11, 359	865, 776				200. 00

Health Financial Systems ST. VINCENT	ANDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provi der CCN: 15-0088	Peri od: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/26/2018 2:01 pm
	Title XVIII	Hospi tal	PPS

APPORT	TOWNENT OF INFATTENT ANGILLARY SERVICE CAPITA	AL 00313	Provider C		From 07/01/2017 To 06/30/2018	Part II Date/Time Pre 11/26/2018 2:	
				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		T			
	05000 OPERATING ROOM	1, 365, 367	109, 038, 445	1			
52.00	05200 DELIVERY ROOM & LABOR ROOM	343, 315	3, 760, 693				
53.00	05300 ANESTHESI OLOGY	32, 496		1	· ·		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	318, 631	20, 576, 206	1			
54. 01	03440 MAMMOGRAPHY	18, 421	4, 264, 526			1	54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	53, 070		1	· ·		54. 02
54. 03	03630 ULTRA SOUND	20, 017	9, 532, 887				
55. 00	05500 RADI OLOGY-THERAPEUTI C	96, 231	31, 349, 981	1	· ·		
57. 00	05700 CT SCAN	42, 654					
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	39, 991	3, 370, 849	1	· ·		
59. 00	05900 CARDI AC CATHETERI ZATI ON	182, 623	22, 793, 226				
60.00	06000 LABORATORY	361, 435	73, 835, 413	0. 00489	5 11, 674, 794	57, 148	60. 00
65.00	06500 RESPI RATORY THERAPY	155, 145	13, 621, 900	0. 01138	9 5, 561, 671	63, 342	65. 00
66.00	06600 PHYSI CAL THERAPY	223, 334	10, 055, 925	0. 02220	9 872, 645	19, 381	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	95, 991	3, 631, 742	0. 02643	1 526, 334	13, 912	67. 00
68.00	06800 SPEECH PATHOLOGY	34, 754	1, 318, 276	0. 02636	3 187, 959	4, 955	68. 00
69. 00	06900 ELECTROCARDI OLOGY	6, 705	1, 039, 782	0.00644	3, 101	20	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	178, 454	5, 249, 802			7, 168	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	82, 978	17, 610, 454	0. 00471	2 3, 695, 742	17, 414	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	122, 369	17, 937, 057	0. 00682	2 4, 445, 682	30, 328	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	754, 889	123, 635, 708	0.00610	6 10, 832, 793	66, 145	73. 00
76.00	03190 CHEMOTHERAPY	48, 414	9, 397, 448	0. 00515	2 14, 222	73	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0	0	0.00000	0	0	90. 00
90. 01	09001 ANDERSON OUTPATIENT CENTER	128, 949	5, 130, 705	0. 02513	3 0	0	90. 01
90. 02	04950 DIABETIC EDUCATION	o	0	0. 00000	0 0	0	90. 02
90. 03	09002 MS CLINIC	31, 980	312, 343	0. 10238	7 0	0	90. 03
91.00	09100 EMERGENCY	554, 702	81, 143, 013	0. 00683	6 5, 646, 714	38, 601	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	86, 021	3, 298, 649	0. 02607	8 170, 988	4, 459	92. 00
200.00	Total (lines 50 through 199)	5, 378, 936	612, 303, 384	.[64, 048, 487	539, 022	200. 00

Health Financial Systems	ST. VINCENT	ANDERSON		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 07/01/2017		
				To 06/30/2018	Date/Time Pre	pared:
		Ti +L	e XVIII	Hospi tal	11/26/2018 2: PPS	UI pm
Cost Center Description	Murcing School	Nursing School		Allied Health	All Other	
cost center bescription	Post-Stepdown		Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	<u> </u>	2.00	3.00	
30, 00 03000 ADULTS & PEDIATRICS		1			0	30.00
31. 00 03100 NTENSI VE CARE UNI T					0	
41. 00 04100 SUBPROVI DER - RF					0	41.00
43. 00 04100 30BPROVIDER - TRF				0		
200.00 Total (lines 30 through 199)				0	1	200.00
	Cui na Dod	Total Costs	Total Dotions	Per Diem (col.	Inpati ent	200.00
Cost Center Description	Swing-Bed					
	Adjustment Amount (see	(sum of cols. 1 through 3,	Days	5 ÷ col. 6)	Program Days	
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
30. 00 03000 ADULTS & PEDIATRICS			20, 37	9 0.00	5, 588	30.00
31. 00 03100 NTENSI VE CARE UNI T		1	6, 28			
	C	,	2, 62			
43. 00 04300 NURSERY			1, 05			1 .0.00
200.00 Total (lines 30 through 199)		C	30, 33	6	11, 359	200. 00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8) 9.00					
INDATI ENT DOUTINE CEDVICE COCT CENTEDO	9.00					

30. 00 31. 00

41. 00 43. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY Total (lines 30 through 199)

Health Financial Systems	ST. VINCENT ANDER	RSON	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Pro			Worksheet D
		l c	From 07/01/2017	Dor+ IV

THROUGH COSTS From 07/01/2017 | Part IV To 06/30/2018 | Date/Time Prepared: 11/26/2018 2:01 pm Title XVIII Hospi tal PPS Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Anesthetist Post-Stepdown Post-Stepdown Cost Adjustments Adjustments 1.00 2.00 3. 00 2A 3A ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 52.00 0 05300 ANESTHESI OLOGY 53.00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 72, 696 54.00 03440 MAMMOGRAPHY 0 0 15, 067 54.01 54. 01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 0 51,086 54.02 54.02 0 54.03 03630 ULTRA SOUND 33, 680 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 110, 735 55.00 05700 CT SCAN 0 54, 769 57.00 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 11, 909 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 60.00 06000 LABORATORY 60.00 OI 06500 RESPIRATORY THERAPY 0 65.00 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0 68.00 0 06900 ELECTROCARDI OLOGY 69.00 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 462, 156 73.00 03190 CHEMOTHERAPY 76.00 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 n 90.00 0 0 0 0 0 0 09001 ANDERSON OUTPATIENT CENTER 0 90.01 90.01 0 90.02 04950 DIABETIC EDUCATION 0 0 90.02 0 09002 MS CLINIC 0 0 90.03 0 90.03 0 91. 00 09100 EMERGENCY 0 91.00 204, 073 92.00 |09200 OBSERVATION BEDS (NON-DISTINCT PART)

0

0

o

Ω 92.00

1, 016, 171 200. 00

Total (lines 50 through 199)

200.00

Health Financial Systems	ST. VINCENT A	NDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0088	Peri od:	Worksheet D
THROUGH COSTS			From 07/01/2017	Part IV

THROUG	H COSTS				To 06/30/2018		
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			T			
	05000 OPERATING ROOM	0	0	(109, 038, 445	0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(3, 760, 693	0. 000000	
	05300 ANESTHESI OLOGY	0	0	(10, 436, 535	0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	0	72, 696			0. 003533	
	03440 MAMMOGRAPHY	0	15, 067			0. 003533	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	51, 086				
	03630 ULTRA SOUND	0	33, 680			0. 003533	
	05500 RADI OLOGY-THERAPEUTI C	0	110, 735			0. 003532	
57.00	05700 CT SCAN	0	54, 769	54, 769	15, 502, 061	0. 003533	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	11, 909	11, 909	3, 370, 849	0. 003533	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(22, 793, 226	0.000000	59. 00
60.00	06000 LABORATORY	0	0	(73, 835, 413	0. 000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	(13, 621, 900	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(10, 055, 925	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(3, 631, 742	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	(1, 318, 276	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(1, 039, 782	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(5, 249, 802	0.000000	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(17, 610, 454	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(17, 937, 057	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	462, 156	462, 156	123, 635, 708	0. 003738	73. 00
76.00	03190 CHEMOTHERAPY	0	0	(9, 397, 448	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(0	0.000000	90.00
90. 01	09001 ANDERSON OUTPATIENT CENTER	0	0	(5, 130, 705	0.000000	90. 01
90. 02	04950 DIABETIC EDUCATION	0	0	(0	0.000000	90. 02
90. 03	09002 MS CLINIC	0	0	(312, 343	0. 000000	90. 03
91.00	09100 EMERGENCY	0	204, 073	204, 073	81, 143, 013	0. 002515	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(3, 298, 649	0. 000000	92. 00
200.00	Total (lines 50 through 199)	0	1, 016, 171	1, 016, 171	612, 303, 384		200. 00

Health Financial Syste	ems	ST. VINCENT	ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPAT	TIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der Co	CN: 15-0088	Peri od:	Worksheet D	
THROUGH COSTS					From 07/01/2017	Part IV	
					To 06/30/2018	Date/Time Pre	oared:
						11/26/2018 2:	01 pm
			Title	: XVIII	Hospi tal	PPS	
Cost Cent	er Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	

Cost Center Description				Title	XVIII	Hospi tal	PPS	
Charges		Cost Center Description		I npati ent	Inpati ent	Outpati ent	Outpati ent	
Cost Col 6 + Col 7			Ratio of Cost	Program		Program		
NOTITION				Charges		Charges		
NCT LLARY SERVICE COST CENTERS			(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
ANCILLARY SERVICE COST CENTERS			- '					
50.00			9. 00	10.00	11. 00	12. 00	13. 00	
52.00 05200 DELLVERY ROOM & LABOR ROOM 0.000000 119, 227 0 3, 699 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 798, 415 0 1, 928, 870 0 53.00 54.01 03440 MAMMOGRAPHY 0.003533 1, 932, 691 6, 828 3, 801, 708 13, 431 54.00 54.01 03450 NULERA MEDI CINE - DI AGNOSTI C 0.003533 476, 542 1, 684 5, 027, 018 17, 760 54.02 54.02 03450 NULERA MEDI CINE - DI AGNOSTI C 0.003533 476, 542 1, 684 5, 027, 018 17, 760 54.02 55.00 03500 RADI OLOGY-THERAPEUTI C 0.003533 868, 834 3, 070 1, 726, 906 6, 101 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 0.003532 532, 593 1, 881 12, 810, 762 45, 248 55.00 57.00 05700 CT SCAN 0.003533 321, 875 1, 137 779, 090 2, 753 58.00 58.00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 0.003533 321, 875 1, 137 779, 090 2, 753 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.0000000 11, 674, 794 0 7, 935, 455 0 60.00 60.00 06000 LABORATORY 0.000000 11, 674, 794 0 7, 935, 455 0 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 11, 674, 794 0 7, 935, 455 0 60.00 66.00 06600 RESPI RATORY THERAPY 0.000000 526, 334 0 16, 960 0 67.00 67.00 06900 CLECTROCARDI OLOGY 0.000000 3, 101 0 649, 221 0 65.00 68.00 06800 SPEECH PATHOLOGY 0.000000 3, 101 0 642, 104 0 69.00 69.00 07000 ELECTROCARDI OLOGY 0.000000 3, 101 0 642, 104 0 69.00 67.00 07000 ELECTROCARDI OLOGY 0.000000 3, 101 0 642, 104 0 69.00 67.00 07000 CLINI C 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 67.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0								
53.00 05300 AMESTHESI OLOGY 0.000000 978, 415 0 1, 928, 870 0 53.00			ł				_	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.03533 1,932,691 6,828 3,801,708 13,431 54.00 54. 01 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0.03533 476,542 1,684 5,027,018 17,760 54.02 54. 03 03630 NUCLRA SOUND 0.003533 868,834 3,070 1,726,906 6,101 54.03 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.003533 1,881 12,810,762 45,248 55.00 57. 00 05700 CT SCAN 0.003533 1,399,956 4,946 3,332,312 11,773 57.00 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0.003533 321,875 1,137 779,090 2,753 58.00 60. 00 06500 CARDI AC CATHETERI ZATI ON 0.000000 11,674,794 0 7,935,455 0 60.00 65. 00 06500 RESPI RATORY THERAPY 0.000000 15,614,714 0 649,221 0 65.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 872,645 0 28,201 0	52. 00 0	5200 DELIVERY ROOM & LABOR ROOM	0. 000000	119, 227	0	3, 699	0	52. 00
54. 01 03440 MAMMOGRAPHY 0. 003533 0 0 0 0 0 54. 01	53.00 0	5300 ANESTHESI OLOGY	0. 000000	978, 415	0	1, 928, 870	0	53.00
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.003533 476, 542 1, 684 5, 027, 018 17, 760 54. 02 54. 03 03630 ULTRA SOUND 0.003533 868, 834 3, 070 1, 726, 906 6, 101 54. 03 55. 00 05500 RADIO LOGY-THERAPEUTIC 0.003532 532, 593 1, 881 12, 810, 762 45, 248 55. 00 57. 00 05700 CT SCAN 0.003533 1, 399, 956 4, 946 3, 332, 312 11, 773 57. 00 58. 00 05800 MAGNETTI C RESONANCE I MAGI NG (MRI) 0.003533 321, 875 1, 137 779, 090 2, 753 58. 00 69. 00 05900 CARDIAC CATHETERI ZATI ON 0.000000 2, 361, 096 0 4, 665, 698 0 59. 00 60. 00 06500 RESPIRATORY THERAPY 0.000000 11, 674, 794 0 7, 935, 455 0 60. 00 65. 00 06600 RESPIRATORY THERAPY 0.000000 872, 645 0 28, 201 0 66. 00	54.00 0	5400 RADI OLOGY-DI AGNOSTI C	0. 003533	1, 932, 691	6, 828	3, 801, 708	13, 431	54. 00
54. 03 03630 ULTRA SOUND 0.003533 868, 834 3,070 1,726,906 6,101 54.03 55. 00 05500 RODIOLOGY-THERAPEUTIC 0.003532 532,593 1,881 12,810,762 45,248 55.00 57. 00 05700 CT SCAN 0.003533 1,399,956 4,946 3,332,312 11,773 57.00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.003533 321,875 1,137 779,090 2,753 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 2,361,096 0 4,665,698 0 59.00 60. 00 06500 LABORATORY 0.000000 11,674,794 0 7,935,455 0 60.00 65. 00 06500 PRISTI RATORY THERAPY 0.000000 5,561,671 0 649,221 0 65.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 872,645 0 28,201 0 66.00 67. 00 06700 OCCUPA	54. 01 0	3440 MAMMOGRAPHY	0. 003533	0	0	0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C 0.003532 D.003532 532, 593 D.003533 1, 881 D.0046 12, 810, 762 D.0045 45, 248 D.0045 55. 00 D.003533 1, 399, 956 D.0046 4, 946 D.0046 3, 332, 312 D.0046 11, 773 D.0046 3, 332, 312 D.0046 11, 773 D.0046 0.003533 D.0046 0.003533 D.0046 0.000000 D.0046 0.000000 D.0046	54. 02 0	3450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 003533	476, 542	1, 684	5, 027, 018	17, 760	54. 02
57. 00 05700 CT SCAN 0.003533 1,399,956 4,946 3,332,312 11,773 57.00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.003533 321,875 1,137 779,090 2,753 58.00 60. 00 06900 CARDIAC CATHETERIZATION 0.000000 2,361,096 0 4,665,698 0 59.00 60. 00 06000 LABORATORY 0.000000 11,674,794 0 7,935,455 0 60.00 65. 00 06500 RESPI RATORY THERAPY 0.000000 5,561,671 0 649,221 0 65.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 872,645 0 28,201 0 66.00 67. 00 06700 OCCUPATIONAL THERAPY 0.000000 526,334 0 16,960 0 67.00 68. 00 06800 SPEECH PATHOLOGY 0.000000 3,01 0 642,104 0 69.00 69. 00 O09000 ELECTROCARDIOLOGY	54.03 0	3630 ULTRA SOUND	0. 003533	868, 834	3, 070	1, 726, 906	6, 101	54. 03
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.003533 321,875 1,137 779,090 2,753 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 2,361,096 0 4,665,698 0 59.00 60. 00 06000 LABORATORY 0.000000 11,674,794 0 7,935,455 0 60.00 65. 00 06500 RESPI RATORY THERAPY 0.000000 5,561,671 0 649,221 0 65.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 872,645 0 28,201 0 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 526,334 0 16,960 0 67.00 68. 00 06800 SPEECH PATHOLOGY 0.000000 3,101 0 642,104 0 69.00 70. 00 06900 ELECTROCARDI OLOGY 0.000000 3,101 0 642,104 0 69.00 71. 00 07000 BELECTROCARDI OLOGY	55.00 0	5500 RADI OLOGY-THERAPEUTI C	0. 003532	532, 593	1, 881	12, 810, 762	45, 248	55. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 2,361,096 0 4,665,698 0 59.00 60. 00 06000 LABORATORY 0.000000 11,674,794 0 7,935,455 0 60.00 65. 00 06500 RESPI RATORY THERAPY 0.000000 15,561,671 0 649,221 0 65.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 872,645 0 28,201 0 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 526,334 0 16,960 0 67.00 68. 00 06800 SPECH PATHOLOGY 0.000000 187,959 0 222,728 0 68.00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 3,101 0 642,104 0 69.00 70. 00 07000 ELECTROCARDI OLOGY 0.000000 3,695,742 0 2,624,561 0 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.	57.00 0	5700 CT SCAN	0. 003533	1, 399, 956	4, 946	3, 332, 312	11, 773	57.00
60. 00	58. 00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 003533	321, 875	1, 137	779, 090	2, 753	58. 00
65. 00 06500 RESPIRATORY THERAPY 0.000000 5,561,671 0 649,221 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 872,645 0 28,201 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 526,334 0 16,960 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 187,959 0 222,728 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 3,101 0 642,104 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 210,855 0 1,611,420 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 3,695,742 0 2,624,561 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 4,445,682 0 2,350,321 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.003738 10,832,793 40,493 46,277,078 172,984 73. 00 76. 00 03190 CHEMOTHERAPY 0.000000 14,222 0 1,641,596 0 76. 00 79. 01 09001 ANDERSON OUTPATI ENT CENTER 0.000000 0 0 0 0 0 90. 01 09001 ANDERSON OUTPATI ENT CENTER 0.000000 0 0 0 0 0 90. 02 04950 DI ABETI C EDUCATI ON 0.000000 0 0 0 0 0 90. 03 09002 MS CLINIC 0.000000 0 0 0 0 0 90. 04 09100 EMERGENCY 0.000001 0.000000 0 0 0 90. 05 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 170,988 0 1,183,152 0 92.00 90. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 0 1,183,152 0 92.00 90. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 0 0 0 90. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 0 0 0 90. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 0 0 0 90. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 0 0 0 90. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0.0000000 0 0 0 0 0 90. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 0 0 0 0 90. 00	59.00 0	5900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 361, 096	0	4, 665, 698	0	59. 00
66. 00 06600 PHYSI CAL THERAPY 0.000000 872, 645 0 28, 201 0 66. 00 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 526, 334 0 16, 960 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 187, 959 0 222, 728 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 3, 101 0 642, 104 0 69. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 210, 855 0 1, 611, 420 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 3, 695, 742 0 2, 624, 561 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 4, 445, 682 0 2, 350, 321 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.003738 10, 832, 793 40, 493 46, 277, 078 172, 984 73. 00 03190 CHEMOTHERAPY 0.000000 14, 222 0 1, 641, 596 0 76. 00 000000 000000 000000 0000000	60.00 0	6000 LABORATORY	0. 000000	11, 674, 794	0	7, 935, 455	0	60.00
67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 526, 334 0 16, 960 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 187, 959 0 222, 728 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 3, 101 0 642, 104 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 210, 855 0 1, 611, 420 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 3, 695, 742 0 2, 624, 561 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 4, 445, 682 0 2, 350, 321 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.003738 10, 832, 793 40, 493 46, 277, 078 172, 984 73. 00 76. 00 03190 CHEMOTHERAPY 0.000000 14, 222 0 1, 641, 596 0 76. 00 0UTPATI ENT SERVI CE COST CENTERS 0.000000 0 0 0 0 0 90. 01 09001 ANDERSON OUTPATI ENT CENTER 0.000000 0 0 437, 141 0 90. 01 90. 02 04950 0 ASETI C EDUCATI ON 0.000000 0 0 0 0 0 90. 03 09002 MS CLI NI C 0.000000 0 0 0 0 0 90. 03 09002 MS CLI NI C 0.000000 0 0 0 0 0 91. 00 09100 EMERGENCY 0.002515 5, 646, 714 14, 201 15, 396, 766 38, 723 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 170, 988 0 1, 183, 152 0 92. 00 00 00 00 00 00 00 00	65.00 0	6500 RESPI RATORY THERAPY	0. 000000	5, 561, 671	0	649, 221	0	65.00
68. 00 06800 SPEECH PATHOLOGY 0.000000 187, 959 0 222, 728 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 3, 101 0 642, 104 0 69. 00 70	66.00 0	6600 PHYSI CAL THERAPY	0. 000000	872, 645	0	28, 201	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 3, 101 0 642, 104 0 69. 00 70. 00	67.00 0	6700 OCCUPATIONAL THERAPY	0. 000000	526, 334	0	16, 960	0	67. 00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 3, 101 0 642, 104 0 69. 00 70. 00	68.00 0	6800 SPEECH PATHOLOGY	0. 000000	187, 959	0	222, 728	0	68. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 3,695,742 0 2,624,561 0 71.00 72.00 72.00 72.00 73.00	69.00 0	6900 ELECTROCARDI OLOGY	0. 000000			642, 104	0	69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 4, 445, 682 0 2, 350, 321 0 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.003738 10, 832, 793 40, 493 46, 277, 078 172, 984 73. 00 76. 00 03190 CHEMOTHERAPY 0.000000 14, 222 0 1, 641, 596 0 76. 00 00 0 0 0 0 0 0 0	70.00 0	7000 ELECTROENCEPHALOGRAPHY	0. 000000	210, 855	0	1, 611, 420	0	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.003738 10,832,793 40,493 46,277,078 172,984 73.00 03190 CHEMOTHERAPY 0.000000 14,222 0 1,641,596 0 76.00 0 0 0 0 0 0 0 0 0	71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 695, 742	0	2, 624, 561	0	71. 00
76. 00 03190 CHEMOTHERAPY 0. 000000 14, 222 0 1, 641, 596 0 76. 00 017PATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0. 000000 0 0 0 0 0 0 90. 00 90. 01	72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 445, 682	0	2, 350, 321	0	72. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.000000 0 0 0 0 90.00 90. 01 09001 ANDERSON OUTPATIENT CENTER 0.000000 0 0 437, 141 0 90.01 90. 02 04950 DI ABETI C EDUCATION 0.000000 0 0 0 0 90.02 90. 03 09002 MS CLINIC 0.000000 0 0 0 0 90.03 91. 00 09100 EMERGENCY 0.002515 5,646,714 14,201 15,396,766 38,723 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 170,988 0 1,183,152 0 92.00	73.00 0	7300 DRUGS CHARGED TO PATIENTS	0. 003738	10, 832, 793	40, 493	46, 277, 078	172, 984	73. 00
90. 00 09000 CLINIC 0.000000 0 0 0 0 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02 90. 03 90. 02 90. 03 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 0 170, 988 0 1, 183, 152 0 92. 00 90. 0	76.00 0	3190 CHEMOTHERAPY	0. 000000	14, 222	0	1, 641, 596	0	76. 00
90. 01 09001 ANDERSON OUTPATIENT CENTER 0.000000 0 0 437, 141 0 90. 01 90. 02 90. 03 09002 MS CLINIC 0.000000 0 0.000000 0 0 0	0	UTPATIENT SERVICE COST CENTERS						
90. 02 04950 DI ABETI C EDUCATI ON 0.000000 0 0 0 90. 02 90. 03 90902 MS CLI NI C 0.000000 0 0 0 0 90. 03 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 170, 988 0 1, 183, 152 0 92. 00 92. 00 08500	90.00 0	9000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 02 04950 DI ABETI C EDUCATION 0.000000 0 0 0 90. 02 90. 03 90002 MS CLINI C 0.000000 0 0 0 0 90. 03 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 170, 988 0 1, 183, 152 0 92. 00 92. 00 00 00 00 00 00 00 00	90. 01 0	9001 ANDERSON OUTPATIENT CENTER	0. 000000	0	0	437, 141	0	90. 01
91. 00 09100 EMERGENCY 0. 002515 5, 646, 714 14, 201 15, 396, 766 38, 723 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 170, 988 0 1, 183, 152 0 92. 00	90. 02 0	4950 DIABETIC EDUCATION	0. 000000	0	0	0	0	90. 02
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 170, 988 0 1, 183, 152 0 92. 00	90. 03 0	9002 MS CLINIC	0. 000000	0	0	0	0	90. 03
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 170,988 0 1,183,152 0 92.00	91.00 0	9100 EMERGENCY	0. 002515	5, 646, 714	14, 201	15, 396, 766	38, 723	91.00
	92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000					92.00
200.00 10tal (11163 30 till ough 177) 04, 040, 407 74, 240 137, 177, 344 300, 773 200.00	200. 00	Total (lines 50 through 199)		64, 048, 487	74, 240	139, 779, 344		200. 00

APPORTI ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0088 Provider CCN: 15-0088 Provider CN: 15-008
Title XVIII Hospital PPS Cost Charges Cost Cost Charges Charges Charges Charges Charges Cost Charges Ch
Title XVIII Hospital PPS Cost Center Description Cost to Charge Ratio From Worksheet C, Part I , col . 9 PPS Reimbursed Services (See inst.) Subject To Ded. & Coins. (See inst.) Subject To Ded. & Coins. (See inst.) Ded. & Co
Title XVIII
Cost Center Description
Ratio From Worksheet C, Part I, col. 9 Services (see inst.) Services Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coi
Worksheet C, Part I, col. 9
Part I, col. 9
Ded. & Coi ns. See i nst. Ded. & Coi ns. See i nst. See i nst. Ded. & Coi ns. Ded. & Coi ns. See i nst. Ded. & Coi ns. Ded. & Ded. & Coi ns. Ded. & Ded. & Ded. & Ded. Ded. & Coi ns. Ded. & Ded. & Ded. & Ded. Ded. & Ded. & Ded. Ded. & Coi ns. Ded. & Ded. & Ded. & Ded. Ded. Ded. & Ded. Ded. Ded. & Ded. Ded. Ded. & Ded.
NACILLARY SERVICE COST CENTERS
1.00 2.00 3.00 4.00 5.00
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI NG ROOM 0. 244148 24,686,577 0 0. 6,027,178 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 790042 3,699 0 0 2,922 52. 00 53. 00 05300 ANESTHESI OLOGY 0. 153197 1,928,870 0 0 295,497 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 255308 3,801,708 0 0 970,606 54. 00 54. 01 03440 MAMMOGRAPHY 0. 172025 0 0 0 54. 01 54. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 0. 107949 5,027,018 0 0 542,662 54. 02 54. 03 03630 ULTRA SOUND 0. 089462 1,726,906 0 0 154,492 54. 03 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 124962 12,810,762 0 0 154,492 55. 03 57. 00 05700 CT SCAN 0. 081434 3,32,312
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 790042 3, 699 0 0 2, 922 Deciding 52. 00 53. 00 Deciding 05300 ANESTHESI OLOGY 0. 153197 1, 928, 870 0 0 295, 497 Deciding 53. 00 54. 01 Deciding 05400 RADI OLOGY-DI AGNOSTI C 0. 255308 Deciding 3, 801, 708 Deciding 0 0 970, 606 Deciding 54. 01 Deciding 54. 01 Deciding 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 0. 107949 Deciding 5, 027, 018 Deciding 0 0 54. 01 Deciding 54. 02 Deciding 55. 02 Deciding 0 0 54. 02 Deciding 54. 02 Deciding 55. 02 Deciding 0 0 54. 02 Deciding 54. 02 Deciding 0 0 54. 02 Deciding 0 0 154. 492 Deciding 0 0 154. 492 Deciding 0 0 154. 492 Deciding </td
53. 00 05300 ANESTHESI OLOGY 0. 153197 1, 928, 870 0 0 295, 497 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 255308 3, 801, 708 0 0 970, 606 54. 00 54. 01 03440 MAMMOGRAPHY 0. 172025 0 0 0 54. 01 54. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 0. 107949 5, 027, 018 0 0 0 54. 02 54. 03 03630 ULTRA SOUND 0. 089462 1, 726, 906 0 0 154, 492 54. 03 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 124962 12, 810, 762 0 0 1, 600, 858 55. 00 57. 00 05700 CT SCAN 0. 081434 3, 332, 312 0 0 271, 363 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 349850 779, 090 0 0 272, 565 58. 00 59. 00 05900 CARDI AC CATHETRI ZATI ON
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 255308 3, 801, 708 0 0 970, 606 54. 00 54. 01 03440 MAMMOGRAPHY 0. 172025 0 0 0 54. 01 54. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 0. 107949 5, 027, 018 0 0 542, 662 54. 02 54. 03 03630 ULTRA SOUND 0. 089462 1, 726, 906 0 0 154, 492 54. 03 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 124962 12, 810, 762 0 0 1, 600, 858 55. 00 57. 00 05700 CT SCAN 0. 081434 3, 332, 312 0 0 271, 363 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 349850 779, 090 0 0 272, 565 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 117500 4, 665, 698 0 0 548, 220 59. 00 60. 00 06500 RESPI RATORY THERA
54. 01 03440 MAMMOGRAPHY 0. 172025 0 0 0 54. 01 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0. 107949 5, 027, 018 0 0 542, 662 54. 02 54. 03 03630 ULTRA SOUND 0. 089462 1, 726, 906 0 0 154, 492 54. 03 55. 00 05500 RADIOLOGY-THERAPEUTIC 0. 124962 12, 810, 762 0 0 1, 600, 858 55. 00 57. 00 05700 CT SCAN 0. 081434 3, 332, 312 0 0 271, 363 57. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 349850 779, 090 0 0 272, 565 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 117500 4, 665, 698 0 0 548, 220 59. 00 60. 00 06600 RESPI RATORY THERAPY 0. 180641 649, 221 0 0 117, 276 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 387707 28, 201 0 0 7, 763 67. 00
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0. 107949 5, 027, 018 0 0 542, 662 54. 02 54. 03 03630 ULTRA SOUND 0. 089462 1, 726, 906 0 0 154, 492 54. 03 55. 00 05500 RADI OLOGY-THERAPEUTIC 0. 124962 12, 810, 762 0 0 1, 600, 858 55. 00 57. 00 05700 CT SCAN 0. 081434 3, 332, 312 0 0 271, 363 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 349850 779, 090 0 0 272, 565 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 117500 4, 665, 698 0 0 548, 220 59. 00 60. 00 06000 LABORATORY 0. 128637 7, 935, 455 0 0 1, 020, 793 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 180641 649, 221 0 0 117, 276 65. 00 66. 00 06500
54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 124962 12, 810, 762 0 0 1, 600, 858 55. 00 57. 00 05700 CT SCAN 0. 081434 3, 332, 312 0 0 271, 363 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 349850 779, 090 0 0 272, 565 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 117500 4, 665, 698 0 0 548, 220 59. 00 60. 00 06000 LABORATORY 0. 128637 7, 935, 455 0 0 1, 020, 793 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 180641 649, 221 0 0 117, 276 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 387707 28, 201 0 0 10, 934 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 457753 16, 960 0 0 7, 763 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 457254 222, 728 0 0 101, 843 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 258666 642, 104 0 0 393, 499 70. 00 70. 00 07100 MEDI CAL S
57. 00 05700 CT SCAN 0.081434 3,332,312 0 0 271,363 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.349850 779,090 0 0 272,565 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.117500 4,665,698 0 0 548,220 59. 00 60. 00 06000 LABORATORY 0.128637 7,935,455 0 0 1,020,793 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.180641 649,221 0 0 117,276 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.387707 28,201 0 0 10,934 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.457753 16,960 0 0 7,763 67. 00 68. 00 0800 SPEECH PATHOLOGY 0.457754 222,728 0 0 101,843 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.258666 642,104 0 0 166,090 69. 00 70. 00<
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 349850 779, 090 0 0 272, 565 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 117500 4, 665, 698 0 0 548, 220 59. 00 60. 00 06000 LABORATORY 0. 128637 7, 935, 455 0 0 1, 020, 793 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 180641 649, 221 0 0 117, 276 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 387707 28, 201 0 0 10, 934 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 457753 16, 960 0 0 7, 763 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 457254 222, 728 0 0 101, 843 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 258666 642, 104 0 0 166, 090 69. 00 70. 00 07100 MEDI CAL
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 117500 4, 665, 698 0 0 548, 220 59. 00 60. 00 06000 LABORATORY 0. 128637 7, 935, 455 0 0 1, 020, 793 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 180641 649, 221 0 0 117, 276 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 387707 28, 201 0 0 10, 934 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 457753 16, 960 0 0 7, 763 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 457254 222, 728 0 0 101, 843 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 258666 642, 104 0 0 166, 090 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 244194 1, 611, 420 0 0 393, 499 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 234466 2, 624, 561 0 0 615, 370 71. 00
60. 00 06000 LABORATORY 0. 128637 7, 935, 455 0 0 1,020, 793 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 180641 649, 221 0 0 0 117, 276 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 387707 28, 201 0 0 10, 934 66. 00 67. 00 0CCUPATI ONAL THERAPY 0. 457753 16, 960 0 0 7, 763 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 457754 222, 728 0 0 101, 843 68. 00 6900 ELECTROCARDI OLOGY 0. 258666 642, 104 0 0 166, 900 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 244194 1, 611, 420 0 0 393, 499 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 234466 2, 624, 561 0 0 0 615, 370 71. 00
65. 00 06500 RESPIRATORY THERAPY 0. 180641 649, 221 0 0 1117, 276 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 387707 28, 201 0 0 10, 934 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 457753 16, 960 0 0 7, 763 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 457754 222, 728 0 0 101, 843 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 258666 642, 104 0 0 166, 090 69. 00 70. 00 07000 ELECTROCACPHALOGRAPHY 0. 244194 1, 611, 420 0 0 393, 499 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 234466 2, 624, 561 0 0 0 615, 370 71. 00
66. 00 06600 PHYSI CAL THERAPY 0. 387707 28, 201 0 0 10, 934 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 457753 16, 960 0 0 7, 763 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 457254 222, 728 0 0 101, 843 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 258666 642, 104 0 0 166, 090 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 244194 1, 611, 420 0 0 393, 499 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 234466 2, 624, 561 0 0 615, 370 71. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 457753 16, 960 0 0 7, 763 67. 00 68. 00 06800 SPECH PATHOLOGY 0. 457254 222, 728 0 0 0101, 843 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 258666 642, 104 0 0 06900 616, 090 69. 00 07000 ELECTROENCEPHALOGRAPHY 0. 244194 1, 611, 420 0 0 393, 499 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 234466 2, 624, 561 0 0 615, 370 71. 00 07100
68. 00 06800 SPEECH PATHOLOGY 0. 457254 222, 728 0 0 101, 843 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 258666 642, 104 0 0 166, 090 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 244194 1, 611, 420 0 0 393, 499 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 234466 2, 624, 561 0 0 615, 370 71. 0
69. 00 06900 ELECTROCARDI OLOGY 0. 258666 642, 104 0 0 166, 090 69. 00 07000 ELECTROENCEPHALOGRAPHY 0. 244194 1, 611, 420 0 0 393, 499 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 234466 2, 624, 561 0 0 615, 370 71. 00 07100
70. 00 07000 ELECTROENCEPHALOGRAPHY
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 234466 2, 624, 561 0 0 615, 370 71. 00
72.00 07200 1MPL. DEV. CHARGED TO PATTENTS 0.341775 2,350,321 0 0 803,281 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 273658 46, 277, 078 0 25, 322 12, 664, 093 73. 00
75. 00 07300 DR0GS CHARGED TO PATTENTS 0. 273036 46, 277, 078 0 25, 322 12, 664, 093 75. 00 76. 00 03190 CHEMOTHERAPY 0. 185315 1, 641, 596 0 0 304, 212 76. 00
0. 00 190] CHEMOTHERAPT 0. 163313 1, 641, 390 0 0 304, 212 76. 00 OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC 0. 000000 0 0 0 90. 00
90. 01 09001 ANDERSON OUTPATIENT CENTER
90. 02 04950 DI ABETI C EDUCATI ON
90. 03 09002 MS CLINI C
91. 00 09100 EMERGENCY 0. 109575 15, 396, 766 0 0 1, 687, 101 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 366293 1, 183, 152 0 0 433, 380 92. 00
200. 00 Subtotal (see instructions) 139, 779, 344 0 25, 322 29, 320, 698 200. 00
201.00 Less PBP Clinic Lab. Services-Program 0 23, 322 27, 320, 676 200.00
Only Charges
202. 00 Net Charges (Line 200 - Line 201) 139, 779, 344 0 25, 322 29, 320, 698 202. 00

Health Financial Systems	ST. VINCENT AN	IDERSON	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0088	Peri od: From 07/01/2017	Worksheet D Part V

				From 07/01/2017 To 06/30/2018	Part V Date/Time Prepare 11/26/2018 2:01 p	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLULARY OFRIVERS COOT OFFITTERS	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				. 00
53. 00 05300 ANESTHESI OLOGY	0	0				. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				. 00
54. 01 03440 MAMMOGRAPHY	0	0				. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0				. 02
54. 03 03630 ULTRA SOUND	0	0				. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				. 00
57. 00 05700 CT SCAN	0	0				. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0			•	. 00
†	0	0				. 00 . 00
†	0	0			•	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0				. 00 . 00
68. 00 06800 SPEECH PATHOLOGY	0	0				. 00
69. 00 06900 SFEECH FATHOLOGY	0	0				. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0				. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0				. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0			l l	. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	6, 930				. 00
76. 00 03190 CHEMOTHERAPY	0					. 00
OUTPATIENT SERVICE COST CENTERS					, 0.	. 00
90. 00 09000 CLI NI C	0	0			90.	. 00
90. 01 09001 ANDERSON OUTPATIENT CENTER	0	0			•	. 01
90. 02 04950 DI ABETI C EDUCATI ON	0	0			90.	. 02
90. 03 09002 MS CLINIC	0	0			90.	. 03
91. 00 09100 EMERGENCY	0	0			91.	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.	. 00
200.00 Subtotal (see instructions)	0	6, 930			200.	. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201.	. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	6, 930			202.	. 00

		o .				6.5	
	Financial Systems IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	ST. VINCENT		CCN: 15-0088	Peri od:	eu of Form CMS-: Worksheet D	2552-10
APPURT	TONWENT OF INPATIENT ANGILLARY SERVICE CAPITA	AL CUSTS		t CCN: 15-T088	From 07/01/2017 To 06/30/2018	Part II	pared: 01 pm
			Ti	tle XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal		es Ratio of Cos		Capital Costs	
		Related Cost				(column 3 x	
		(from Wkst. B,	Part I, col	. (col . 1 ÷ co	I. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 365, 367				1	
	05200 DELIVERY ROOM & LABOR ROOM	343, 315				1	
	05300 ANESTHESI OLOGY	32, 496					
	05400 RADI OLOGY-DI AGNOSTI C	318, 631					1
	03440 MAMMOGRAPHY	18, 421					
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	53, 070				ή	
	03630 ULTRA SOUND	20, 017				1	54. 03
	05500 RADI OLOGY-THERAPEUTI C	96, 231				ή	
	05700 CT SCAN	42, 654				1	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	39, 991					
	05900 CARDI AC CATHETERI ZATI ON	182, 623					
	06000 LABORATORY	361, 435					
	06500 RESPI RATORY THERAPY	155, 145					1
	06600 PHYSI CAL THERAPY	223, 334					
	06700 OCCUPATI ONAL THERAPY	95, 991					
	06800 SPEECH PATHOLOGY	34, 754					
	06900 ELECTROCARDI OLOGY	6, 705				1	
	07000 ELECTROENCEPHALOGRAPHY	178, 454					70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	82, 978				1	
	07200 I MPL. DEV. CHARGED TO PATIENTS	122, 369					
	07300 DRUGS CHARGED TO PATIENTS	754, 889					
	03190 CHEMOTHERAPY OUTPATIENT SERVICE COST CENTERS	48, 414	9, 397,	0. 0051	52 0) 0	76. 00
	09000 CLINIC	0	1	0 0.0000	00 0	0	90.00
	09001 ANDERSON OUTPATIENT CENTER	128, 949					
	04950 DIABETIC EDUCATION	120, 949		0.0000			
	09002 MS CLINIC	31, 980					1
	09100 EMERGENCY	554, 702					
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	554, 702					
200.00		5, 292, 915			2, 657, 126	1	200. 00
200.00		J, Z7Z, 713	1 012, 303,	,o ₋₁	2,007,120	1 43, 470	1200.00

Health Financial Systems	ST. VINCENT AN	IDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0088 Component CCN: 15-T088	Peri od: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/26/2018 2:01 pm
-		Title XVIII	Subprovi der -	PPS

			Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	cost center bescription	Anesthetist	Post-Stepdown	Indi Siring Scribbi	Post-Stepdown	Airred Hearth	
		Cost	Adjustments		Adjustments		
		1, 00	2A	2, 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	11.00					
50.00	05000 OPERATI NG ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	72, 696	54.00
54. 01	03440 MAMMOGRAPHY	0	0	0	0	15, 067	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	51, 086	54. 02
54.03	03630 ULTRA SOUND	0	0	0	0	33, 680	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	110, 735	55. 00
57.00	05700 CT SCAN	0	0	0	0	54, 769	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	11, 909	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
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
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	462, 156	73. 00
76.00	03190 CHEMOTHERAPY	0	0	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0	0	0	90.00
	09001 ANDERSON OUTPATIENT CENTER	0	0	0	0	0	90. 01
	04950 DI ABETI C EDUCATI ON	0	0	0	0	0	90. 02
	09002 MS CLINIC	0	0	0	0	0	90. 03
	09100 EMERGENCY	0	0	0	0	204, 073	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92. 00
200.00	Total (lines 50 through 199)	0	0	0	0	1, 016, 171	200. 00

	OT				5.5	
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	ST. VINCENT	S Provider C	CN: 15-0088	In Lie Period: From 07/01/2017 To 06/30/2018		pared:
		Ti tl e	e XVIII	Subprovi der - I RF	PPS	<u> </u>
Cost Center Description	All Other Medical Education Cost	4)	Cost (sum of col. 2, 3 an 4)	Total Charges (from Wkst. C, Part I, col. d 8)	(col. 5 ÷ col. 7)	
ANOLLI ADV. CEDVI CE. COCT. CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1 0	0	ı	0 100 000 445	0.000000	F0 00
50. 00 05000 OPERATI NG ROOM	0	0	1	0 109, 038, 445		
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0	0		0 3, 760, 693		
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0 72, 696	1	0 10, 436, 535		
54. 00 03400 RADI OLOGY - DI AGNOSTI C 54. 01 03440 MAMMOGRAPHY	0	15, 067			1	
54. 01 03440 MAMMOGRAPHY 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	51, 086				
54. 03 03630 ULTRA SOUND	0	33, 680				
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	110, 735				
57. 00 05700 CT SCAN	0	54, 769				
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	11, 909				1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	11, 909	1	0 22, 793, 226		
60. 00 06000 LABORATORY	0	0	1	0 73, 835, 413		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 13, 621, 900		1
66. 00 06600 PHYSI CAL THERAPY	0	0		0 10, 055, 925		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 631, 742		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 1, 318, 276		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 1, 039, 782		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 249, 802		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 17, 610, 454	l .	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 17, 937, 057		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	462, 156	462, 15			
76. 00 03190 CHEMOTHERAPY	0			0 9, 397, 448		1
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0.000000	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	0	0		0 5, 130, 705	0.000000	90. 01
90. 02 04950 DIABETIC EDUCATION	0	0	1	0 0	0.000000	90. 02
90. 03 09002 MS CLINIC	0	0)	0 312, 343	0.000000	90. 03
91. 00 09100 EMERGENCY	0	204, 073	204, 07			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)	0 3, 298, 649		92. 00
200.00 Total (lines 50 through 199)	0	1, 016, 171	1, 016, 17	612, 303, 384		200. 00

Health Financial Systems	ST VINCENT	ANDEDSON		In Lio	u of Form CMS	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER' THROUGH COSTS	ST. VINCENT A	Provi der CO	CN: 15-0088 CCN: 15-T088	Period: From 07/01/2017 To 06/30/2018	wof Form CMS-2 Worksheet D Part IV Date/Time Pre 11/26/2018 2:	pared:
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) 9.00	Inpati ent Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10) 11.00		Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00	
ANCILLARY SERVICE COST CENTERS	7. 00	10.00	11.00	12.00	10.00	
50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03440 MAMMOGRAPHY 54. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 54. 03 03630 ULTRA SOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05500 CARDI AC CATHETERI ZATI ON 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07300 DRUGS CHARGED TO PATI ENTS 73. 00 03190 CHEMOTHERAPY	0. 000000 0. 000000 0. 000000 0. 003533 0. 003533 0. 003533 0. 003533 0. 003533 0. 003533 0. 000000	20, 459 0 884 61, 732 0 0 9, 887 0 20, 400 6, 650 8, 682 356, 058 262, 737 607, 197 644, 410 141, 699 5, 825 134 71, 505 1, 465 437, 402	1, 63	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	0.000000			<u> </u>	0	1 , 0. 00
90. 00 09000 CLINIC 90. 01 09001 ANDERSON OUTPATIENT CENTER 90. 02 04950 DIABETIC EDUCATION 90. 03 09002 MS CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200. 00 Total (lines 50 through 199)	0. 000000 0. 000000 0. 000000 0. 000000 0. 002515 0. 000000	0 0 0 0 0 0 2, 657, 126		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 33 0	0 0 0 0 0 0	90. 01 90. 02 90. 03 91. 00

Health Financial Systems	ST. VINCENT	ANDERSON		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Pre 11/26/2018 2:	
		Ti tl	e XIX	Hospi tal	Cost	от рііі
			Charges	поортта	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
'	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_					
50.00 05000 OPERATING ROOM	0. 244148		, ,		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 790042				0	
53. 00 05300 ANESTHESI OLOGY	0. 153197			0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 255308		0,0.0,0.		0	
54. 01 03440 MAMMOGRAPHY	0. 172025		359, 76		0	1
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 107949		1, 362, 55	3 0	0	1 0 02
54. 03 03630 ULTRA SOUND	0. 089462		2, 219, 94	8 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 124962		3, 576, 16		0	
57. 00 05700 CT SCAN	0. 081434	0	2, 824, 99	9 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 349850	0	436, 29		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 117500	0	_, _,		0	
60. 00 06000 LABORATORY	0. 128637	0	10, 686, 46	4 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 180641	0	309, 46	2 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 387707	0	1, 199, 58	0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 457753	0	510, 15	2 0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 457254	0	185, 09	1 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 258666	0	51, 44		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 244194	0	930, 85		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 234466	0	1, 323, 35		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 341775		.,		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 273658				0	
76. 00 03190 CHEMOTHERAPY	0. 185315	0	1, 077, 58	4 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000		1	0 0	0	
90.01 09001 ANDERSON OUTPATIENT CENTER	0. 706180		1, 303, 80	6 0	0	
90. 02 04950 DIABETIC EDUCATION	0. 000000			0 0	0	
90. 03 09002 MS CLINIC	0. 536449				0	
91. 00 09100 EMERGENCY	0. 109575				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 366293	0	494, 62		0	
200.00 Subtotal (see instructions)		0	90, 535, 70	2 0	0	
201.00 Less PBP Clinic Lab. Services-Program				이		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	90, 535, 70	2 0	0	202. 00

Health Financial Systems	ST. VINCENT	ANDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0088	Peri od:	Worksheet D

From 07/01/2017 | Part V To 06/30/2018 | Date/Time Prepared: 11/26/2018 2:01 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 4, 023, 878 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 386, 902 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 982, 122 54.00 54.01 03440 MAMMOGRAPHY 61, 889 54.01 0 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 147.086 54.02 198, 601 0 54.03 03630 ULTRA SOUND 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 446, 884 0 55.00 05700 CT SCAN 230, 051 0 57.00 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 58 00 152, 639 59.00 05900 CARDIAC CATHETERIZATION 267, 228 59.00 60.00 06000 LABORATORY 1, 374, 675 0 60.00 65.00 06500 RESPIRATORY THERAPY 55, 902 65.00 0 465, 086 66.00 06600 PHYSI CAL THERAPY 66.00 67.00 06700 OCCUPATIONAL THERAPY 233, 524 0 67.00 68.00 06800 SPEECH PATHOLOGY 84,634 68.00 69.00 06900 ELECTROCARDI OLOGY 13, 306 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 227, 310 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 310, 283 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 604, 464 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 920, 097 0 73.00 73.00 03190 CHEMOTHERAPY 199, 692 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 90.01 09001 ANDERSON OUTPATIENT CENTER 920, 722 0 90.01 04950 DIABETIC EDUCATION 0 90.02 90.02 90.03 09002 MS CLINIC 19, 989 0 90.03 09100 EMERGENCY 0 91.00 2, 861, 546 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 181.179 0 92.00 200.00 Subtotal (see instructions) 17, 369, 689 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 17, 369, 689 0 202. 00

Health Financial Systems	ST. VINCENT ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0088	Peri od: From 07/01/2017	Worksheet D-1
		To 06/30/2018	Date/Time Prepared: 11/26/2018 2:01 pm
	Title XVIII	Hospi tal	PPS

Title XVIII Blospital PPS				10 06/30/2018	11/26/2018 2:	
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Non-Title Mark 1 Mark		Cost Center Description				
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32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 283, 670) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 32.00 32.00 33.00 34.00 35.00 36.00 37.00 37.00 37.00 48.00 49.00 40.00 40.00						30.00
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34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 283, 670) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 22, 283, 670) 37.00 Average per diem private room cost differential (line 22, 283, 670) 38.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00						
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 283, 670 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Average per diem private room cost differential (line 22, 283, 670 37.00 27 minus line 36) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 283, 670 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 22, 283, 670 22, 283, 670 37.00						
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 283, 670 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 37.00 40.00						
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,093.46 39.00 Program general inpatient routine service cost (line 9 x line 38) 6,110,254 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,093.46 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 6,110,254 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					. ===, =.0	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,093.46 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 6,110,254 39.00 40.00		PART II - HOSPITÁL AND SUBPROVIDERS ONLY		·		
39.00 Program general inpatient routine service cost (line 9 x line 38) 6,110,254 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 6,110,254 39.00 40.00						
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, , , , , , , , , , , , , , , , , , , ,	•			
41. 00 Total Frogram general impatrent routine service cost (Tine 39 + Tine 40) 6, 110, 254 41. 00						
	41.00	Tiotal Trogram general impatrent routine service cost (ITHE 39	+ 11116 40)	I	0, 110, 254	1 41.00

COMPLIT	Financial Systems	ST. VINCENT	ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der C	CN: 15-0088	Peri od: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Pre 11/26/2018 2:	pared:
	Cost Contar Decement on	Total	_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl		col . 2)	÷	Program Cost (col. 3 x col. 4)	
42.00	NUIDCEDY (+i+lo // 0 VIV only)	1.00	2.00	3.00	4. 00 00 0	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	<u> </u>		η <u></u> Ο.	00 0	0	42.00
44. 00 45. 00 46. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	9, 403, 702	6, 285	1, 496.	21 4, 352	6, 511, 506	44. 00 45. 00 46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
40.00	Decree in the contract of the	-+ D 21 2	11 200)			1.00	40.00
	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS			ons)		13, 518, 774 26, 140, 534	
50. 00	Pass through costs applicable to Program inpa	atient routine :	services (from	n Wkst. D, su	m of Parts I and	750, 241	50.00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	y services (fr	rom Wkst. D,	sum of Parts II	613, 262	51. 00
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclumedical education costs (line 49 minus line!	ding capital re	ated, non-phy	/sician anest	hetist, and	1, 363, 503 24, 777, 031	1
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55.00
	Target amount (line 54 x line 55)				==>	0	
57. 00 58. 00	Difference between adjusted inpatient operations, payment (see instructions)	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
59. 00							59. 00
	0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60. 00 61. 00
62. 00	amount (line 56), otherwise enter zero (see instructions) 2.00 Relief payment (see instructions)						62.00
	Allowable Inpatient cost plus incentive payments	ent (see instru	ctions)			-	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cosinstructions) (title XVIII only)	ts through Dece	mber 31 of the	cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the d	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line	64 plus line 6	55)(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 d	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 Do	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 NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ty/ICF/IID rou	tine service d	cost (line 37)		70.00
	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71. 00
	Medically necessary private room cost applications		(line 14 x li	ne 35)			73.00
74. 00	Total Program general inpatient routine serv	ce costs (line	72 + line 73))	5		74. 00
75. 00 76. 00	Capital-related cost allocated to inpatient (26, line 45) Per diem capital-related costs (line 75 ÷ line 75)		costs (from V	Vorksheet B,	Part II, column		75. 00 76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	1e)			78. 00 79. 00
	Total Program routine service costs for compa				nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limit	tati on		,	/		81.00
	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		>)				83.00
85. 00	Utilization review - physician compensation		ns)				85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					1, 105	87. 00
	Adjusted general inpatient routine cost per		line 2)			1, 093. 46	
	Observation bed cost (line 87 x line 88) (see						89. 00

Health Financial Systems	ST. VI NCENT	ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2:0	oared: O1 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 586, 436	22, 283, 670	0. 07119	1, 208, 273	86, 021	90.00
91.00 Nursing School cost	0	22, 283, 670	0.00000	1, 208, 273	0	91.00
92.00 Allied health cost	0	22, 283, 670	0.00000	1, 208, 273	0	92.00
93.00 All other Medical Education	0	22, 283, 670	0.00000	1, 208, 273	0	93. 00

Health Financial Systems	ST. VINCENT ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0088	Peri od: From 07/01/2017	Worksheet D-1
	Component CCN: 15-T088	To 06/30/2018	Date/Time Prepared: 11/26/2018 2:01 pm
	Title XVIII	Subprovi der -	PPS

		litle XVIII	I RF	PPS	
	Cost Center Description		110	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 620	1. 00
2.00	Inpatient days (including private room days, excluding swing-			2, 620	2.00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 620	4. 00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember	or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
0.00	reporting period		1 -6 +1	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	ii days) arter beceiliber 3	i or the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 419	9. 00
10.00	newborn days)	-1 (:1)		0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructions)		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, en				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	X only (including privat	e room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period 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	Medicald rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period 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 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing pariod (line	2, 699, 738	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost report	ing period (fine	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 21 of the cost reporti	ng poriod (line	0	24. 00
24.00	7 x line 19)	1 31 01 the cost reporti	ng perrod (Trile	O	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
26 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 699, 738	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	0	28. 00 29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x li		(10113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 699, 738	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 030. 43	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			1, 462, 180 0	
	Total Program general inpatient routine service cost (line 39	,		1, 462, 180	
	, , , , , , , , , , , , , , , , , , , ,	,	'		

COMPUI	ATION OF INPATIENT OPERATING COST		Provi der CC	N: 15-0088	Peri od:	Worksheet D-1	2552-1
			Component C		From 07/01/2017 To 06/30/2018		pared:
			Title	XVIII	Subprovi der - I RF	PPS	or hiii
	Cost Center Description	Total Inpatient Cost Ir	Total patient Days			Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0.			42. 00
43. 00	Intensive Care Type Inpatient Hospital Units	l ol	ol	0.	00 0	0	43. 00
44. 00	CORONARY CARE UNIT		U _I	U.	00	U	44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	1						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			>		854, 218	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(Se	e instruction	ns)		2, 316, 398	49.00
50. 00	Pass through costs applicable to Program inc	patient routine se	ervices (from	Wkst. D, su	m of Parts I and	115, 535	50.00
							l
51. 00	Pass through costs applicable to Program inpland IV)	oatient ancillary	services (fro	om Wkst. D,	sum of Parts II	45, 473	51.00
52. 00	Total Program excludable cost (sum of lines					161, 008	52. 00
53. 00	Total Program inpatient operating cost exclu		ited, non-phys	sician anest	hetist, and	2, 155, 390	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54. 00	Program di scharges					0	54.00
55. 00							55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tare	not amount (Li	no 56 minus	Lino 52)	0	
58. 00	Bonus payment (see instructions)	ing cost and targ	get amount (11	ne so illi nus	111le 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period er	ndi ng 1996, up	odated and c	ompounded by the	0. 00	59. 0
40 00	market basket 10 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						
60. 00 61. 00	If line 53/54 is less than the lower of line					0. 00 0	1
	which operating costs (line 53) are less that	in expected costs					
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63.00		ment (see instruct	i ons)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Decemb	er 31 of the	cost report	ing period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after December	31 of the co	ost reportin	g period (See	0	65.00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	l plus line 6	5)(title XVI	II only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through [December 31 of	the cost r	eporting period	0	67.00
	(line 12 x line 19)					_	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ne costs after Dec	cember 31 of 1	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of)		70.00
72. 00			10 70 11110 2	-/			72.00
73.00	Medically necessary private room cost applic	•	•	ne 35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	,		nrksheet R	Part II column		74. 00 75. 00
73.00	26, line 45)	Toutine service of	.0313 (110m w	or Karleet B,	rait II, corumii		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 78. 00
79. 00			ovi der records	s)			79.00
30.00			st limitation	(line 78 mi	nus line 79)		80.00
31. 00 32. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
32.00	Reasonable inpatient routine service costs (83.00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85.00	Utilization review - physician compensation						85. 00
50. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86.00
07.00	Total observation bed days (see instructions					0	87. 0
37. 00 38. 00	Adjusted general inpatient routine cost per						88.00

Health Financial Systems	ST. VINCENT	ANDERSON		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2:	
		Title	XVIII	Subprovi der -	PPS	
	1			IRF		
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	213, 332	2, 699, 738	0. 07902	0	0	90. 00
91.00 Nursing School cost	0	2, 699, 738	0.00000	0	0	91. 00
92.00 Allied health cost	0	2, 699, 738	0.00000	0	0	92.00
93.00 All other Medical Education	0	2, 699, 738	0. 00000	0 0	0	93. 00

Health Financial Systems	ST. VINCENT ANDERSO	N	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi	ider CCN: 15-0088	Peri od:	Worksheet D-3

Health Financial Systems S	T. VINCENT ANDERSON		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
			From 07/01/2017		
			To 06/30/2018	Date/Time Pre 11/26/2018 2:	pared:
	Title	xVIII	Hospi tal	PPS	or pili
Cost Center Description		Ratio of Cost		Inpati ent	
oost ochter bescriptron		To Charges	Program	Program Costs	
		10 onar ges		(col. 1 x col.	
			onal ges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			8, 126, 178		30.00
31.00 03100 INTENSIVE CARE UNIT			10, 399, 444		31. 00
41. 00 04100 SUBPROVI DER - 1 RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 25073	7 11, 213, 758	2, 811, 704	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 79004:	2 119, 227	94, 194	52.00
53. 00 05300 ANESTHESI OLOGY		0. 15319	7 978, 415	149, 890	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 25530	1, 932, 691	493, 431	54.00
54. 01 03440 MAMMOGRAPHY		0. 17202	5 0	0	54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 10794	9 476, 542	51, 442	54. 02
54. 03 03630 ULTRA SOUND		0. 08946	2 868, 834	77, 728	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12496	2 532, 593	66, 554	55. 00
57. 00 05700 CT SCAN		0. 08143	4 1, 399, 956	114, 004	57.00
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)		0. 349850	321, 875	112, 608	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 11750	2, 361, 096	277, 429	59. 00
60. 00 06000 LABORATORY		0. 12863	7 11, 674, 794	1, 501, 810	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 18194	5, 561, 671	1, 011, 935	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 38770	7 872, 645	338, 331	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 45775	3 526, 334	240, 931	67.00
68.00 06800 SPEECH PATHOLOGY		0. 45725	4 187, 959	85, 945	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 25866	6 3, 101	802	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 24419		51, 490	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23446	6 3, 695, 742	866, 526	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 34177	5 4, 445, 682	1, 519, 423	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27365	10, 832, 793	2, 964, 480	73. 00
76. 00 03190 CHEMOTHERAPY		0. 18531	5 14, 222	2, 636	76. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 000000		0	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER		0. 706180	0 0	0	90. 01
90. 02 04950 DIABETIC EDUCATION		0. 000000	0 0	0	90. 02
90. 03 09002 MS CLINIC		0. 53644		0	90. 03
91. 00 09100 EMERGENCY		0. 11030	5, 646, 714	622, 849	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 366293	170, 988	62, 632	92. 00
200.00 Total (sum of lines 50 through 94 and 96 th	rough 98)		64, 048, 487	13, 518, 774	200. 00
201.00 Less PBP Clinic Laboratory Services-Program	only charges (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			64, 048, 487		202. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO		Peri od:	Worksheet D-3	,
	Component (CCN: 15-T088	From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2:	
	Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	<u> </u>	Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.
1.00 03100 INTENSIVE CARE UNIT			0		31.
1.00 04100 SUBPROVI DER - I RF			1, 920, 104		41
3. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM		0. 25073		5, 130	
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 79004		ľ	
3. 00 05300 ANESTHESI OLOGY		0. 15319		135	
4. 00 05400 RADI OLOGY-DI AGNOSTI C 4. 01 03440 MAMMOGRAPHY		0. 25530		1	1
4.01 03440 MAMMOGRAPHY 4.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 17202 0. 10794		0 0	
4. 03 03630 ULTRA SOUND		0. 08946		885	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12496		000	55
7. 00 05700 CT SCAN		0. 08143			
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 34985			
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 11750	8, 682	1, 020	59
D. 00 06000 LABORATORY		0. 12863	356, 058		
5. 00 06500 RESPI RATORY THERAPY		0. 18194			
6. 00 06600 PHYSI CAL THERAPY		0. 38770		235, 415	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 45775		l	
3. 00 06800 SPEECH PATHOLOGY		0. 45725		l	
9. 00 06900 ELECTROCARDI OLOGY		0. 25866	· ·	1	
0.00 07000 ELECTROENCEPHALOGRAPHY		0. 24419		l	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2.00 07200 MPL. DEV. CHARGED TO PATIENTS		0. 2344 <i>6</i> 0. 34177	· ·		
3. 00 07300 DRUGS CHARGED TO PATTENTS		0. 27365	· ·	119, 699	1
5. 00 03190 CHEMOTHERAPY		0. 18531			
OUTPATIENT SERVICE COST CENTERS		55501			1
0. 00 09000 CLI NI C		0.00000	00 0	0	90
0. 01 09001 ANDERSON OUTPATIENT CENTER		0. 70618		l e	
O. O2 O4950 DIABETIC EDUCATION		0. 00000	00	0	90
0. 03 09002 MS CLINIC		0. 53644		0	1
1. 00 09100 EMERGENCY		0. 11030			
22 OO OO2OOOORSERVATION REDS (NON_DISTINCT PART)		0.36630)3 U	Ι	ıl as

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 Net charges (line 200 minus line 201)

0. 110303 0. 366293

2, 657, 126

201. 00 202. 00

0 92.00 854, 218 200.00

Health Financial Systems ST. VINCENT A	NDERSON		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 1		Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Pre	nared:
		'	0 00/30/2018	11/26/2018 2:	
	Title XI	X	Hospi tal	Cost	
Cost Center Description	Rati	o of Cost	Inpati ent	Inpati ent	
	To	Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			12, 536, 917		30. 00
31. 00 03100 I NTENSI VE CARE UNI T			3, 837, 952		31.00
41. 00 04100 SUBPROVI DER - RF			0		41.00
43. 00 04300 NURSERY			1, 085, 433		43. 00
ANCI LLARY SERVI CE COST CENTERS		0.044446	4 405 470	4 007 5/0	F0 00
50. 00 05000 OPERATI NG ROOM		0. 244148		1, 097, 562	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 790042		1, 886, 154	52.00
53. 00 05300 ANESTHESI OLOGY		0. 153197	1	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 255308		299, 284	54.00
54. 01 03440 MAMMOGRAPHY		0. 172025		0	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 107949		23, 145	54. 02
54. 03 03630 ULTRA SOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 089462		26, 772	54. 03 55. 00
		0. 124962		26, 642	55.00
		0. 081434		53, 719	
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 349850 0. 117500		57, 158 130, 364	59.00
60. 00 06000 LABORATORY		0. 117500		767, 146	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 120037		373, 376	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 180841		45, 301	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 367707		90, 054	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 457753		19, 076	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 457254		19, 076	69.00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 236000		39, 884	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 234466		311, 316	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATTENTS		0. 234400		224, 934	71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS		0. 273658		1, 448, 217	73.00
75. 00 07300 DR003 CHARGED TO FATTENTS 76. 00 03190 CHEMOTHERAPY		0. 273036		1, 446, 217	76.00
OUTPATIENT SERVICE COST CENTERS		0. 100010	0, 303	1, 370	70.00
90. 00 09000 CLINIC		0.000000	0	0	90. 00
90. 01 09001 ANDERSON OUTPATIENT CENTER		0. 706180		749	90. 01
90. 02 04950 DI ABETI C EDUCATI ON		0. 000000		0	90. 02
90. 03 09002 MS CLINIC		0. 536449		0	90. 02
91. 00 09100 EMERGENCY		0. 109575		453, 272	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 366293		455, 272	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		5. 500270	30, 687, 920	7, 375, 701	
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		00,007,720		201. 00
202.00 Net charges (line 200 minus line 201)	(30, 687, 920		202. 00
[1.57 Sharges (1116 200 millias 1116 201)	1		30, 337, 720		_52.00

	Financial Systems	ST. VINCENT ANDERSON			u of Form CMS-2	
INPATIE	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0088	Peri od:	Worksheet D-3	
		Component	CCN: 15-T088	From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2:	
		Ti tl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description		Ratio of Cos	•	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
	03000 ADULTS & PEDIATRICS			0		30.00
	03100 NTENSI VE CARE UNI T			0		31.00
	04100 SUBPROVI DER – I RF			387, 275		41. 00
	04300 NURSERY			007,270		43. 00
	NCILLARY SERVICE COST CENTERS					10.00
	05000 OPERATING ROOM		0. 24414	1, 434	350	50.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM		0. 79004		0	52.00
53.00	05300 ANESTHESI OLOGY		0. 15319	97 0	0	53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C		0. 25530	08 6, 988	1, 784	54.00
54.01	03440 MAMMOGRAPHY		0. 17202	25 0	0	54. 01
1	03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 10794	49 0	0	54. 02
	03630 ULTRA SOUND		0. 08946		0	
	05500 RADI OLOGY-THERAPEUTI C		0. 12490		0	55. 00
	05700 CT SCAN		0. 08143		415	
	D5800 MAGNETIC RESONANCE IMAGING (MRI)		0. 34985		332	
	05900 CARDI AC CATHETERI ZATI ON		0. 11750		0	
	06000 LABORATORY		0. 12863		7, 213	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0. 1806 0. 38770		4, 588	1
	06700 OCCUPATIONAL THERAPY		0. 36770		46, 752 52, 346	1
	06800 SPEECH PATHOLOGY		0. 4577		10, 826	
	06900 ELECTROCARDI OLOGY		0. 4572		10, 620	1
	07000 ELECTROENCEPHALOGRAPHY		0. 24419		1, 208	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23440			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3417		0	1
	07300 DRUGS CHARGED TO PATIENTS		0. 2736		18, 203	
	03190 CHEMOTHERAPY		0. 1853 ²		0	76. 00
O	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		0. 00000	00	0	90.00
	09001 ANDERSON OUTPATIENT CENTER		0. 70618		0	
	04950 DI ABETI C EDUCATI ON		0. 00000		0	1 ,0.02
	09002 MS CLINIC		0. 53644		0	70.00
01 00 0	00100 EMEDCENCY		0 1005	75I A	Λ .	01 00

0. 109575

0. 366293

91.00

201. 00 202. 00

0

0 92.00 145, 998 200.00

91. 00 09100 EMERGENCY

201.00 202.00

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART)
200. 00 | Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

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

Health Financial Systems	ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088	Peri od: Worksheet E From 07/01/2017 Part A Date/Time Prepared: Da

			10 06/30/2018	11/26/2018 2:	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri instructions)	ng prior to October 1 (see	0 4, 235, 591	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurriinstructions)	ng on or after October	1 (see	12, 579, 866	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or discharges occurring	orior to October	0	1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			1, 191, 608	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
3. 00	Managed Care Simulated Payments	0113)		0	3. 00
4. 00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	rting period (see instru	ctions)	137. 97	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet to for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified a ACA § 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopar affiliated programs in accordance with 42 CFR 413.75(b), 413.	thic and osteopathic pro	grams for	0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slo			0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slo	-		0. 00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line			0. 00	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the curre	•		0. 00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.			0.00	11. 00
12.00	Current year allowable FTE (see instructions)			0.00	12. 00
	Total allowable FTE count for the prior year.				13. 00
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	0. 00	14. 00
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				16.00
17.00	Adjustment for residents displaced by program or hospital clos	sure		0.00	17. 00
18.00	Adjusted rolling average FTE count			0.00	18. 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	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21. 00
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	C II MMA		0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside	ent cap slots under 42 C	FR 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C). 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 linstructions)	ower of line 23 or line	24 (see	0.00	ı
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
	IME payments adjustment factor. (see instructions)			0. 000000	ł
	IME add-on adjustment amount (see instructions)			0.000000	28. 00
	IME add-on adjustment amount (see Firstructions)	0	•		
	, , ,	-	28. 01		
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0)	0			
20 00	Disproportionate Share Adjustment Percentage of SSL recipient nations days to Medicare Part A nations days (see instructions)				
30.00					30.00
	Percentage of Medicaid patient days (see instructions)			30. 32	
	Sum of lines 30 and 31			35. 94	1
	Allowable disproportionate share percentage (see instructions))		18. 87	1
34.00	Disproportionate share adjustment (see instructions)		I	793, 269	J 34. UU

	Financial Systems ST. VINCENT			eu of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Pre 11/26/2018 2:0	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)		5, 977, 483, 147		
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, en instructions)	nter zero on this line) (se	0. 000194704 ee 1, 163, 840		35. 01 35. 02
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 35		293, 352 1, 677, 417		35. 03 36. 00
10.00	Additional payment for high percentage of ESRD beneficiary				40.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excludin 652, 682, 683, 684 and 685 (see instructions)	ng discharges for MS-DRGs	0		40. 00
	1002/ 002/ 000/ 00 · d.id 000 (000 · iii c.i doci oiio)		Before 1/1	On/After 1/1	
41 00	Total FCDD Madi core di cohorgeo evaludi na MC DDCo (F2 (02	402 404 on 40E 4000	1. 00	1. 01	41.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (See	0	0	41. 00
41. 01	Total ESRD Medicare covered and paid discharges excluding N an 685. (see instructions)		0	0	41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00 e 0	l I	42. 00 43. 00
44. 00	<pre>instructions) Ratio of average length of stay to one week (line 43 divide days)</pre>	ed by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instruction	•	0.00	0.00	
46. 00 47. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	41. 01)	20, 477, 751		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	20, 477, 751		48. 00
	only. (see instructions)	· · · · · · · · · · · · · · · · · · ·			
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction			20, 477, 751	49. 00
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L, P			1, 513, 187 0	50. 00 51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4,			0	52.00
53.00	Nursing and Allied Health Managed Care payment			34, 831	53.00
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			0	54. 00 54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	e 69)		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see in	ntructions)		0	56. 00
57. 00 58. 00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt		hrough 35).	0 74, 240	57. 00 58. 00
59. 00	Total (sum of amounts on lines 49 through 58)	IV, Cor. II IIIle 200)		22, 100, 009	
60.00	Primary payer payments			184	60.00
61.00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		22, 099, 825	
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			1, 876, 688 110, 145	1
64. 00	Allowable bad debts (see instructions)			273, 188	•
65. 00	Adjusted reimbursable bad debts (see instructions)			177, 572	•
66.00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		143, 796	1
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	or applicable to MS-DRGs (s	see instructions)	20, 290, 564	67. 00 68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96			Ö	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70. 50 70. 87	Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration		ınstructions)	0	70. 50 70. 87
70. 87	SCH or MDH volume decrease adjustment (contractor use only)			0	70.87
70. 89	Pioneer ACO demonstration payment adjustment amount (see in	nstructions)			70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 91 70. 92
70. 92	HVBP payment adjustment amount (see instructions)			-3, 619	
70 04	HRR adjustment amount (see instructions)		-113, 514	70. 94	
70. 94	Recovery of accelerated depreciation				70. 9

Health Financial Systems	ST. VINCENT ANDERSO	ON		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Prov	/ider CC	CN: 15-0088	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Pre	pared:
		Title	: XVIII	Hospi tal	11/26/2018 2: PPS	
			FFY		Amount	

CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96) TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96) TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96) TO Departing outlier amount from Wkst. E. Pt. A, line 2 (see instructions) 0,000 0,					To 06/30/2018	Date/Time Pre	
FIY (yyyy)			Ti +La	> V// I I	Hospi tal		UT PIII
1.00			11 11 6				
10				- '''			
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Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0088

						0 00/ 30/ 2010	11/26/2018 2:	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1, 00	1.00	2.00	3.00		0.00	1.00
1.00	payments	1.00	ı .	J			· ·	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	4, 235, 591	0	4, 235, 591		4, 235, 591	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	12, 579, 866	0		12, 579, 866	12, 579, 866	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4	1. 03	0	0	C		0	1. 03
1. 04	BPCI occurring prior to October 1 DRG for Federal specific operating payment for Model 4	1. 04	0	0		0	0	1. 04
2. 00	BPCI occurring on or after October 1 Outlier payments for	2. 00	1, 191, 608	0	304, 039	887, 570	1, 191, 609	2. 00
2.00	discharges (see instructions)	2.00	1, 191, 000	O	304, 039	007, 370	1, 191, 609	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	C	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			<u> </u>	0	4. 00
	Indirect Medical Education Adju					,		
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	C	0	0	6. 00
6. 01	instructions) IME payment adjustment for managed care (see	22. 01	0	0	C	0	0	6. 01
	instructions) Indirect Medical Education Adju	ustment for the	Add-on for Se	ction 422 of t	he MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0.000000	0. 000000		7. 00
8.00	(see instructions) IME adjustment (see instructions)	28. 00	0	0	C	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	0	C	0	0	8. 01
9. 00	<pre>instructions) Total IME payment (sum of lines 6 and 8)</pre>	29. 00	0	0	C	O	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	C	0	0	9. 01
	8. 01)							l
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1887	0. 1887	0. 1887	0. 1887		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34.00	793, 269	0	199, 814	593, 455	793, 269	11. 00
11. 01	Uncompensated care payments	36.00	1, 677, 417	0	321, 525	870, 488	1, 192, 013	11. 01
10.00	Additional payment for high per		RD beneficiary				^	12.00
12. 00	Total ESRD additional payment (see instructions)	46. 00		0	C	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	20, 477, 751 0	0	5, 060, 969 (15, 416, 782 0	20, 477, 751 0	1
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)		05.1-				0	
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	20, 477, 751	0	5, 060, 969	15, 416, 782	20, 477, 751	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	1, 513, 187	0	379, 398	1, 133, 789	1, 513, 187	16. 00
17. 00	if applicable) Special add-on payments for new technologies	54.00	0	0	C	o	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced	68. 00	0	0	C	0	0	17. 01 17. 02
	devices for applicable MS-DRGs							

near tii	Financiai systems		SI. VINCENI	ANDERSON		III LI E	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provi der Co		Period: From 07/01/2017	Worksheet E Part A Exhibi	t 4
						o 06/30/2018		pared:
				Title	XVIII	Hospi tal	PPS	<u> </u>
	·	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)	
	T	0	1.00	2. 00	3. 00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	C	0	0	18. 00
19.00	SUBTOTAL			0	5, 440, 367	16, 550, 571	21, 990, 938	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	1, 367, 776	0	343, 021	1, 024, 755	1, 367, 776	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	C	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	42, 144	0	10, 479	31, 665	42, 144	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 0000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	C	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0755	0. 0755	0. 0755	0. 0755		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	103, 267	0	25, 898	77, 369	103, 267	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 513, 187	0	379, 398	1, 133, 789	1, 513, 187	26. 00
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 000000	0. 000000	_	27. 00
28. 00	Low volume adjustment	70. 96			(0	28. 00
	(transfer amount to Wkst. E, Pt. A, line)							
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Peri od on	Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)			·	
		0	1.00	2.00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1.00					1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	4, 235, 591	4, 235, 591		4, 235, 591	1. 01
	discharges occurring prior to October 1						
1.02	DRG amounts other than outlier payments for	1. 02	12, 579, 866		12, 579, 866	12, 579, 866	1. 02
	discharges occurring on or after October 1						
1.03	DRG for Federal specific operating payment	1.03	0	0		0	1.03
	for Model 4 BPCI occurring prior to October						
	1						
1.04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2.00	1, 191, 608	304, 039	887, 570	1, 191, 609	2.00
	instructions)						
2.01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
	BPCI						
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
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5.00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0.000000	0.000000		7.00
	instructions)						
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
	care (see instructions)						
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	29. 01	0	0	0	0	9. 01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 1887	0. 1887	0. 1887		10.00
	(see instructions)						
11. 00	Disproportionate share adjustment (see	34. 00	793, 269	199, 814	593, 455	793, 269	11. 00
	instructions)						
11. 01	Uncompensated care payments	36. 00	1, 677, 417	293, 352	1, 384, 065	1, 677, 417	11. 01
	Additional payment for high percentage of ESR						
12. 00	Total ESRD additional payment (see	46. 00	0	0	0	0	12.00
	instructions)						
13. 00	Subtotal (see instructions)	47. 00	20, 477, 751	5, 032, 796	15, 444, 955	20, 477, 751	13.00
14.00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14.00
	and MDH, small rural hospitals only.) (see						
	instructions)						
15. 00	Total payment for inpatient operating costs	49. 00	20, 477, 751	5, 032, 796	15, 444, 955	20, 477, 751	15. 00
	(see instructions)						
16. 00	Payment for inpatient program capital (from	50. 00	1, 513, 187	379, 398	1, 133, 789	1, 513, 187	16. 00
	Wkst. L, Pt. I, if applicable)						
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	17. 00
17. 01	Net organ acquisition cost						17. 01
17. 02	Credits received from manufacturers for	68. 00	0	0	0	0	17. 02
	replaced devices for applicable MS-DRGs						
18. 00	Capital outlier reconciliation adjustment	93. 00	0	0	0	0	18. 00
	amount (see instructions)						
19. 00	SUBTOTAL			5, 412, 194	16, 578, 744	21, 990, 938	19. 00

Heal th	Financial Systems	ST. VINCENT	T ANDERSON		In Lie	eu of Form CMS-2	2552-10
HOSPI T	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 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	1, 367, 776	343, 02	1, 024, 755	1, 367, 776	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	42, 144	10, 47	9 31, 665	42, 144	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0755	0. 075	0. 0755		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	103, 267	25, 89	77, 369	103, 267	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	1, 513, 187	379, 39	1, 133, 789	1, 513, 187	26. 00
	•	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1.00	2.00	3. 00	4. 00	
27.00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-3, 619	21, 89	-25, 516	-3, 619	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-113, 514	242, 49	-356, 010	-113, 514	31. 00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31. 01
	•					(Amt to Wkst	

0

70. 99

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

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

0 32.00

100. 00

3. 00

2.00

1.00

Ν

Health Financial Systems	ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0088	Peri od: Worksheet E From 07/01/2017 Part B Date/Time Prepared: 11/24/2018 2:01 pm

			10 06/30/2018	11/26/2018 2:0	
		Title XVIII	Hospi tal	PPS	от рііі
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1	Medical and other services (see instructions)			6, 930	
1	Medical and other services reimbursed under OPPS (see instruct	tions)		29, 011, 925	
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			24, 844, 169 197, 741	
4. 00	Outlier reconciliation amount (see instructions)			197, 741	l l
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	1
6.00	Line 2 times line 5	o : . o ,		0	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		308, 773	9. 0
1	Organ acquisitions			0	
	Total cost (sum of lines 1 and 10) (see instructions)			6, 930	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable charges			25 222	12.00
	Ancillary service charges	ina (0)		25, 322	1
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii Total reasonable charges (sum of lines 12 and 13)	THE 69)		25, 322	
	Customary charges			25, 322	14.00
	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15. 00
	Amounts that would have been realized from patients liable for			Ö	
	had such payment been made in accordance with 42 CFR §413.13(e		3 -]	
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)			25, 322	ı
19. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 18 exceeds li	ne 11) (see	18, 392	19. 0
00.00	instructions)		40) (00.0
20. 00	Excess of reasonable cost over customary charges (complete onlinetructions)	IY IT IINE II exceeds II	ne 18) (see	0	20. 0
21. 00	instructions) Lesser of cost or charges (see instructions)			6, 930	21. 0
1	Interns and residents (see instructions)			0, 730	
1	Cost of physicians' services in a teaching hospital (see instr	ructions)		Ö	23. 0
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		25, 350, 683	ı
ĺ	COMPUTATION OF REIMBURSEMENT SETTLEMENT]
1	Deductibles and coinsurance (for CAH, see instructions)			0	
	Deductibles and Coinsurance relating to amount on line 24 (for			4, 904, 138	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	plus the sum of lines 22	and 23] (see	20, 453, 475	27.0
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	ino 50)		0	28. 0
	ESRD direct medical education costs (from Wkst. E-4, line 36)	The 30)		0	29. 0
1	Subtotal (sum of lines 27 through 29)			20, 453, 475	ı
1	Primary payer payments			5, 131	1
	Subtotal (line 30 minus line 31)			20, 448, 344	32. 0
[ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			778, 574	
1	Adjusted reimbursable bad debts (see instructions)			506, 073	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		451, 073	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			20, 954, 417 -250	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			-230	1
1	Pioneer ACO demonstration payment adjustment (see instructions	5)		o o	39. 5
1	Demonstration payment adjustment amount before sequestration	2,		0	1
1	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	Ö	1
	RECOVERY OF ACCELERATED DEPRECIATION		,	0	1
40.00	Subtotal (see instructions)			20, 954, 667	40.0
40. 01	Sequestration adjustment (see instructions)			419, 093	40.0
40. 02	Demonstration payment adjustment amount after sequestration			0	40.0
1	Interim payments			20, 261, 509	
1	Tentative settlement (for contractors use only)			0	
1	Balance due provider/program (see instructions)	040 5 . 45 0		274, 065	
44. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	cnapter 1,	0	44.0
ļ	§115. 2 TO BE COMPLETED BY CONTRACTOR				1
				0	90.0
	Original outlier amount (see instructions)			. 0	
90.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			n	91 r
90. 00 91. 00	Outlier reconciliation adjustment amount (see instructions)			0.00	1
90. 00 91. 00 92. 00	· · · · · · · · · · · · · · · · · · ·			0 0. 00 0	92. 0

Health Financial Systems S ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0088

					11/26/2018 2:0	01 pm
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		18, 837, 37	2	20, 261, 509	1. 00
2.00	Interim payments payable on individual bills, either			o	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3.04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		18, 837, 37	2	20, 261, 509	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 02	TENTATIVE TO PROVIDER			0		5. 02
5. 02				o		5. 02
5.05	Provider to Program			<u> </u>	0	5.05
5. 50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 51	TENTALI VE TO TROUM			o		5. 51
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
5. 77	5. 50-5. 98)				Ĭ	3. 77
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 00	the cost report. (1)					5. 50
6. 01	SETTLEMENT TO PROVIDER		932, 59	ol	274, 065	6. 01
6. 02	SETTLEMENT TO PROGRAM			o	0	6. 02
7. 00	Total Medicare program liability (see instructions)		19, 769, 96	~	20, 535, 574	7. 00
	(300 1101 401 310)		, , , , , , ,	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•			•		

Provider CCN: 15-0088 Component CCN: 15-T088 Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		2, 209, 667 C		0	1. 00 2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 02	ABSOLIMENTS TO TROVIDER		C		l ol	3. 02
3. 03			C		l ol	3. 03
3. 04			C		o o	3. 04
3. 05			C		0	3. 05
0.00	Provider to Program			1	, and the second	0.00
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C)	O	3. 51
3.52			C)	ol	3. 52
3.53			C)	ol	3. 53
3.54			C)	ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	ol	3. 99
	3. 50-3. 98)					
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		2, 209, 667		0	4. 00
	appropri ate)					
	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
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			C		0	5. 02
5. 03			C		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		C		0	5. 50
5. 50 5. 51	TENTATIVE TO PROGRAM					5. 50
5. 51						5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		C)	o	6. 01
6.02	SETTLEMENT TO PROGRAM		35, 204		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 174, 463		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems ST. VINCENT A	NDERSON	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0088	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Pre 11/26/2018 2:	epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1. 00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
22.00	Polones due provider (line 0 (er line 10) minus line 20 and l	ina 21) (aaa imatmustian)		22.00

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

30. 00 31. 00 32. 00

Health Financial Systems	ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088	Peri od: Worksheet E-3
	Component CCN: 15-T088	From 07/01/2017 Part III To 06/30/2018 Date/Time Prepared:
	Component Con. 15-1000	11/26/2018 2: 01 pm
	Title XVIII	Subprovi der - PPS

		litle XVIII	Subprovi der - I RF	PPS	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1. 00	
1.00	Net Federal PPS Payment (see instructions)			2, 113, 756	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0278	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			81, 802	3. 00
4.00	Outlier Payments			32, 761	4. 00
5.00	Unweighted intern and resident FTE count in the most recent co	ost reporting period en	ding on or prior	0. 00	5. 00
5. 01	to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident FTE count program or hospital closure, that would not be counted without CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)			0. 00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in 1	the new program growth p	eriod of a "new	0. 00	7. 00
8. 00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within 1 teaching program" (see instructions)	the new program growth p	eriod of a "new	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjust	tment (see instructions)		0.00	9. 00
10.00	Average Daily Census (see instructions)	,		7. 178082	10.00
11. 00	Teaching Adjustment Factor (see instructions)			0.000000	11. 00
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			2, 228, 319	13. 00
14.00	Nursing and Allied Health Managed Care payments (see instructi	on)		0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	16. 00
17. 00	Subtotal (see instructions)			2, 228, 319	
18. 00	Primary payer payments			0	18. 00
19. 00	Subtotal (line 17 less line 18).			2, 228, 319	
20.00	Deductibles			10, 624	
21. 00	Subtotal (line 19 minus line 20)			2, 217, 695	
22. 00 23. 00				1, 675 2, 216, 020	
24. 00	Subtotal (line 21 minus line 22) Allowable bad debts (exclude bad debts for professional service	cos) (soo instructions)		1, 288	
25. 00	Adjusted reimbursable bad debts (see instructions)	Les) (see Histi uctions)		837	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	suctions)		1, 288	
27. 00	Subtotal (sum of lines 23 and 25)	uctions)		2, 216, 857	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 49)		2, 210, 037	28. 00
29. 00	Other pass through costs (see instructions)	110 47)		1, 983	
30.00	Outlier payments reconciliation			0	30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration	-,		0	31. 99
32. 00	Total amount payable to the provider (see instructions)			2, 218, 840	32. 00
32. 01	Sequestration adjustment (see instructions)			44, 377	
32. 02	Demonstration payment adjustment amount after sequestration			0	
33.00	Interim payments			2, 209, 667	33. 00
34.00	Tentative settlement (for contractor use only)			0	34. 00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02	2, 33, and 34)		-35, 204	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	13, 105	36. 00
	TO BE COMPLETED BY CONTRACTOR				
50.00				32, 761	50.00
	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52. 00				0.00	52. 00
53. 00	Time Value of Money (see instructions)			0	53. 00

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

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

Provider CCN: 15-0088

Peri od: Worksheet G From 07/01/2017 To 06/30/2018 Date/Time Prepared: 11/26/2018 2: 01 pm

oni y)					11/26/2018 2:	01 pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS		2.00	0.00	00	
1.00	Cash on hand in banks	28, 062	1	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	70, 542, 818	0	0	0	3. 00 4. 00
5.00	Other receivable	70, 342, 616	0	0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-43, 688, 311	l o	o	0	6. 00
7.00	Inventory	3, 155, 561	0	0	0	7. 00
8.00	Prepai d expenses	330, 229		0	0	8. 00
9.00	Other current assets	3, 494, 719		0	0	9.00
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	33, 863, 078	0	0	0	10. 00 11. 00
11.00	FIXED ASSETS	33, 603, 076	0	<u>U</u>	0	11.00
12. 00	Land	5, 292, 602	0	0	0	12. 00
13.00	Land improvements	1, 539, 559	0	o	0	13. 00
14. 00	Accumulated depreciation	0	0	0	0	14. 00
15. 00	Buildings	101, 222, 568	1	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements		0	0	0	16. 00 17. 00
18. 00	Accumulated depreciation		0	o	0	18. 00
19. 00	Fi xed equipment	O	Ō	Ō	0	19. 00
20.00	Accumulated depreciation	0	0	o	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	C 422 024	0	0	0	22. 00
23. 00 24. 00	Major movable equipment Accumulated depreciation	53, 423, 826 -109, 644, 032	1	0	0	23. 00 24. 00
25. 00	Mi nor equipment depreciable	107, 044, 032	0	o	0	25. 00
26. 00	Accumulated depreciation	O	Ō	Ō	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Minor equipment-nondepreciable	E1 024 E22	0	0	0	29. 00 30. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	51, 834, 523	0	0	0	30.00
31. 00	Investments	С	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	255, 028		0	0	34. 00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	255, 028 85, 952, 629		0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	05, 752, 027	1 0	<u>U</u>	0	30.00
37. 00	Accounts payable	8, 034, 128	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	4, 587, 623		O	0	38. 00
39. 00	Payroll taxes payable	490, 463		0	0	39. 00
40.00	Notes and Loans payable (short term)	205, 578	0	0	0	40.00
41. 00 42. 00	Deferred income Accelerated payments		0	U U	ا	41. 00 42. 00
43. 00	Due to other funds		0	o	0	
44. 00	Other current liabilities	23, 322, 582	0	o	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	36, 640, 374	0	0	0	45. 00
47.00	LONG TERM LIABILITIES	1 44 404 770	1 0	ما		1,, 00
46. 00 47. 00	Mortgage payable Notes payable	14, 424, 778	0	0	0	46. 00 47. 00
48. 00	Unsecured Loans		0	0	0	48. 00
49. 00	Other long term liabilities	637, 780		o	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15, 062, 558	0	0	0	50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	51, 702, 932	0	0	0	51. 00
F2 00	CAPI TAL ACCOUNTS	24 240 (07				F2 00
52. 00 53. 00	General fund balance Specific purpose fund	34, 249, 697	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			Ō		55. 00
56.00	Governing body created - endowment fund balance			O		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	34, 249, 697	0	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	85, 952, 629		ő	0	60.00
	59)				 	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES ST. VINCENT ANDERSON

| Peri od: | Worksheet G-1 | To 06/30/2010 | From 07/01/2017 | Worksheet G-1 | To 06/30/2010 | From 07/01/2017 | To 06/30/2010 | From 07/01/2017 | From 07/0 Provi der CCN: 15-0088

					To	06/30/2018	Date/Time Pro 11/26/2018 2:	par 01	ed: pm
		General	Fund	Speci al	Pui	rpose Fund	Endowment Fund		
		1.00	2. 00	3.00		4. 00	5. 00		
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		27, 735, 537 10, 343, 505			0			1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		38, 079, 042			0			2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	О	00, 077, 012		0	0	c		1. 00
5.00		0			0		C		5. 00
6.00		0			0		C	1 -	5. 00
7. 00 8. 00					0		C I		7. 00 3. 00
9. 00					0			1 -	9. 00
10.00	Total additions (sum of line 4-9)		0			0			0. 00
11. 00	Subtotal (line 3 plus line 10)	_	38, 079, 042		_	0	l		1.00
12. 00 13. 00	Deductions (debit adjustments) (specify) MISCELLANEOUS	3, 829, 345			0				2. 00 3. 00
14. 00	WII SCLLLANEOUS	3, 624, 343			0				1. 00
15. 00		Ö			0		Ċ		5. 00
16. 00		0			0		C		5. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)	0	3, 829, 345		0	0	C	1	7. 00 3. 00
19. 00	Fund balance at end of period per balance		34, 249, 697			0	l .		9. 00
	sheet (line 11 minus line 18)							' '	
		Endowment Fund	PI ant	Fund					
		6.00	7. 00	8.00					
1. 00	Fund balances at beginning of period	0			0				1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				_				2. 00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0				3. 00 1. 00
5. 00	(Spectry)		0						5. 00
6.00			0						5. 00
7.00			0						7. 00
8. 00 9. 00			0						3. 00 9. 00
10. 00	Total additions (sum of line 4-9)	o	J		0). 00
11. 00	Subtotal (line 3 plus line 10)	0			0				1.00
12.00	Deductions (debit adjustments) (specify)		0						2. 00
13. 00 14. 00	MI SCELLANEOUS		0						3. 00 1. 00
15. 00			0						i. 00 5. 00
16. 00			0						5. 00
17. 00			0						7. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0				3. 00 9. 00
19.00	sheet (line 11 minus line 18)				U			19	7. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0088

			To 06/30/2018	Date/Time Pre 11/26/2018 2:	
	Cost Center Description	Inpatient	Outpati ent	Total	O I PIII
		1.00	2, 00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				1
1.00	Hospi tal	39, 012, 6	70	39, 012, 670	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	3, 577, 7	81	3, 577, 781	3. 00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	42, 590, 4	51	42, 590, 451	10.00
	Intensive Care Type Inpatient Hospital Services	, , , , , , ,			
11. 00	INTENSIVE CARE UNIT	17, 798, 7	46	17, 798, 746	11. 00
12.00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of line	es 17, 798, 7	46	17, 798, 746	•
	11-15)	,,			
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	60, 389, 1	97	60, 389, 197	17. 00
18. 00	Ancillary services	153, 644, 4			18. 00
19. 00	Outpatient services	133,311,	0 70, 276, 109		19.00
20. 00	RURAL HEALTH CLINIC		0 0		20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		o o	l .	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	PHYSI CI AN REVENUE		0 2, 714, 736	2, 714, 736	
27. 01	DME/HOME HEALTH		0 8, 756, 179		27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to V	lkst. 214, 033, 6			
	G-3, line 1)		,,		
	PART II - OPERATING EXPENSES	· · · · · · · · · · · · · · · · · · ·	<u>'</u>	'	
29.00	Operating expenses (per Wkst. A, column 3, line 200)		190, 843, 582		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32. 00
33.00			0		33. 00
34.00			0		34.00
35.00			0		35. 00
36.00	Total additions (sum of lines 30-35)		C		36.00
37.00	DEDUCT (SPECIFY)		0		37. 00
38.00			0		38. 00
39. 00			0		39. 00
40.00			0		40. 00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		C		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tr	ansfer	190, 843, 582		43. 00
	to Wkst. G-3, line 4)				

Health Financial Systems	ST. VINCENT ANDERSON	In Lie	eu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0088	Peri od: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/26/2018 2:01 pm
			1172072010 2.0

1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 2.00 Less contractual allowances and discounts on patients' accounts 3.00 Net patient revenues (line 1 minus line 2) 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	1. 00 683, 614, 885 487, 153, 216 196, 461, 669 190, 843, 582 5, 618, 087	1. 00 2. 00 3. 00 4. 00
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 2.00 Less contractual allowances and discounts on patients' accounts 3.00 Net patient revenues (line 1 minus line 2)	1. 00 683, 614, 885 487, 153, 216 196, 461, 669 190, 843, 582 5, 618, 087	1. 00 2. 00 3. 00 4. 00
2.00 Less contractual allowances and discounts on patients' accounts 3.00 Net patient revenues (line 1 minus line 2)	683, 614, 885 487, 153, 216 196, 461, 669 190, 843, 582 5, 618, 087	2. 00 3. 00 4. 00
2.00 Less contractual allowances and discounts on patients' accounts 3.00 Net patient revenues (line 1 minus line 2)	683, 614, 885 487, 153, 216 196, 461, 669 190, 843, 582 5, 618, 087	2. 00 3. 00 4. 00
2.00 Less contractual allowances and discounts on patients' accounts 3.00 Net patient revenues (line 1 minus line 2)	487, 153, 216 196, 461, 669 190, 843, 582 5, 618, 087	2. 00 3. 00 4. 00
3.00 Net patient revenues (line 1 minus line 2)	196, 461, 669 190, 843, 582 5, 618, 087	3. 00 4. 00
	190, 843, 582 5, 618, 087	4. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43)	5, 618, 087	
	0	
5.00 Net income from service to patients (line 3 minus line 4)		5. 00
OTHER I NCOME		
6.00 Contributions, donations, bequests, etc		6. 00
7.00 Income from investments	425	7. 00
8.00 Revenues from telephone and other miscellaneous communication services	10, 122	8. 00
9.00 Revenue from television and radio service	0	9. 00
10.00 Purchase di scounts		10. 00
11.00 Rebates and refunds of expenses		11. 00
12.00 Parking Lot receipts		12.00
13.00 Revenue from Laundry and Linen service	399	13.00
14.00 Revenue from meals sold to employees and guests	629, 465	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 than patients	l	16. 00
17.00 Revenue from sale of drugs to other than patients		17. 00
18.00 Revenue from sale of medical records and abstracts		18. 00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)		19. 00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00 Rental of vending machines		21. 00
22.00 Rental of hospital space	549, 859	22. 00
23.00 Governmental appropriations	0	23. 00
24.00 LAB SERVICE REVENUE	20	24.00
24.01 SHARED SERVICE REVENUE	2, 240, 066	24. 01
24. 02 DME	153, 801	24. 02
24. 03 GRANTS REVENUE	482, 010	24. 03
24. 04 OTHER MI SCELLANEOUS REVENUE	191, 695	24. 04
24. 05 CHILD CARE REVENUE	410	24. 05
24.06 STATE PROGRAM REVENUE	42, 500	24. 06
24.07 CONTRACT SERVICE REVENUE	54, 670	24. 07
24.08 LAUNDRY REVENUE	· · · · · · · · · · · · · · · · · · ·	24. 08
24.09 RESEARCH REVENUE		24. 09
24.10 ASSETS RELEASED FROM RESTRICTED FUND		24. 10
24.11 GAIN ON DISPOSAL OF ASSET		24. 11
25.00 Total other income (sum of lines 6-24)	4, 746, 255	25. 00
26.00 Total (line 5 plus line 25)	10, 364, 342	26. 00
27. 00 EHR		27. 00
27. 01 RESTRUCTURI NG EXPENSE		27. 01
27.02 FUND RAISING ACTIVITIES	l	27. 02
27. 03 OTHER EXPENSES		27. 03
28.00 Total other expenses (sum of line 27 and subscripts)		28. 00
29.00 Net income (or loss) for the period (line 26 minus line 28)	10, 343, 505	29. 00

Health Financial Systems ST. VINCENT A CALCULATION OF CAPITAL PAYMENT		NT ANDERSON Provider CCN: 15-0088	Peri od: From 07/01/2017	worksheet L	
					narad:
			To 06/30/2018	Date/Time Pre 11/26/2018 2:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
1. 00	Capital DRG other than outlier			1, 367, 776	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2. 00	Capital DRG outlier payments			42, 144	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			71. 11	
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			0	
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			5. 62	7.00
8. 00	Percentage of Medicaid patient days to total days (see instructions)			30. 32	8. 00
9. 00	Sum of lines 7 and 8			35. 94	
10. 00	5 (7. 55	
11. 00	Disproportionate share adjustment (see instructions)			103, 267	
12. 00	Total prospective capital payments (see instructions)			1, 513, 187	12. 0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions	s)		0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1.00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1 0	1 1 0
1.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums	tanasa (asa inatruatiana)		0	
2. 00 3. 00	Net program inpatient capital costs for extraordinary circums	tances (see firstructions)		0	
3. 00 4. 00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6. 00	Percentage adjustment for extraordinary circumstances (see	e instructions)		0.00	
7. 00	Adjustment to capital minimum payment level for extraordin	*	(line 6)	0.00	1
8. 00	Capital minimum payment level (line 5 plus line 7)	iary erreamstances (Trie 2)	(11116 0)	Ö	
9. 00	Current year capital payments (from Part I, line 12, as as	oplicable)		l o	
	Current year comparison of capital minimum payment level		less line 9)	0	
	Carryover of accumulated capital minimum payment level over	er capital payment (from pri	or year	0	11.00
10. 00	Worksheet L. Part III. line 14)		00 11)	0	12.00
10. 00 11. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	payments (line 10 plus lin			
10. 00 11. 00 12. 00 13. 00	Net comparison of capital minimum payment level to capital			l 0	13.00
10. 00 11. 00 12. 00 13. 00		nter the amount on this line	e)	0	
10. 00 11. 00 12. 00 13. 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en	nter the amount on this line	e)	_	
10. 00 11. 00 12. 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level over	nter the amount on this line er capital payment for the f	e)	_	14. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	nter the amount on this line er capital payment for the f instructions)	e)	0	14. 00 15. 00 16. 00