Haal the Financial Quatana	ST. VINCENT RANDOL				u of Form CMS-:	2552 10
Health Financial Systems         S           This report is required by law (42 USC 1395g; 42 CF payments made since the beginning of the cost report	R 413.20(b)). Fai	lure to repo		t in all interim		0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO AND SETTLEMENT SUMMARY	ORT CERTIFICATION	Provider CO	CN: 15-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Pre 11/28/2018 5:	
PART I - COST REPORT STATUS						
Provider 1. [X] Electronically filed cost repuse only 2. [Manually submitted cost repo				Date: 11/28/2	2018 Time: 5	5:05 pm
3. [ 0] If this is an amended report 4. [ F] Medicare Utilization. Enter	enter the number	of times the " for low.	e provider r	esubmitted this c	ost report	
use only (1) As Submitted 7. Contr (2) Settled without Audit 8. [N]	Received: Tactor No. Initial Report for Final Report for	or this Provi this Provide	11.0 der CCN 12.		or Code: olumn 1 is 4: E nes reopened =	
[PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA CERTIFICATION BY CHIEF FINANCIAL OFFICER OF I HEREBY CERTIFY that I have read the above electronically filed or manually submitted Expenses prepared by ST. VINCENT RANDOLPH H 07/01/2017 and ending 06/30/2018 and to the correct, complete and prepared from the boo instructions, except as noted. I further of provision of health care services, and that compliance with such laws and regulations.	DER FEDERAL LAW. DR INDIRECTLY OF A Y RESULT. R ADMINISTRATOR OF e certification st cost report and t HOSPITAL (15-1307 e best of my knowl poks and records of certify that I am t the services ide certification star	FURTHERMORE, KICKBACK OF PROVIDER(S) tatement and the Balance S I) for the c edge and be edge and be familiar with entified in the tement. I cent gally binding	IF SERVICES WERE OTHERN that I have Sheet and St cost reporti ief, this r er in accord th the laws this cost re rtify that I g equivalent	S IDENTIFIED IN T WISE ILLEGAL, CRI examined the acc atement of Revenu ng period beginni eport and stateme ance with applica and regulations r port were provide intend my electr	HIS REPORT WERE WINAL, CIVIL AN ompanying e and ng nt are true, ble egarding the d in onic ignature.	Ξ
		Title Date				
		<b>T</b> ! !!				
Cost Center Description	Title V	Title Part A	XVIII Part B	ніт	Title XIX	
COST CENTER DESCRIPTION	1.00	2.00	3.00	4,00	5.00	

		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	89, 219	157, 009	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	23, 305	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	112, 524	157, 009	0	0	200.00

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

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX (		NT RANDOLPI		TAL	15 1201	l Peri od:	n Lieu	<u>of</u> For Workshe		
HUSPI I	AL AND HUSPITAL HEALTH CARE COMPLEX I	IDENTIFICATION DA	IA	Provia	er con:	15-1301	From 07/01, To 06/30,		Part I Date/Ti 11/28/2	me Pre	pared:
	1.00		00		3.00			4.00	1172072		
1 00	Hospital and Hospital Health Care Co										1 00
	Street: 473 GREENVILLE AVE. City: WINCHESTER	PO Box: State: I	N Zi	p Code	e: 47934	Coun	ty: RANDOLPH	1			1.00 2.00
		Component Na		CCN	CBSA	Provi dei		Payme	nt Syst		
			Nu	umber	Number	Туре	Certi fi ed		0, or		
		1.00		2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00	XIX 8.00	
	Hospital and Hospital-Based Componen			00	0.00	1.00	0.00	1 0.00	17.00	1 0.00	
3.00	Hospi tal	ST. VINCENT RAND	OLPH 15	51301	99915	1	01/01/2000	N	0	0	3.00
4.00	Subprovider - IPF	HOSPI TAL									4.00
	Subprovider - IRF										5.00
	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF	ST. VINCENT RAND	OLPH 15	5Z301	99915		09/01/1999	N	0	N	7.00
8.00	Swing Beds - NF	SWING DEDS									8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospi tal -Based NF										10.00
11. 00 12. 00	Hospital-Based OLTC Hospital-Based HHA										11.00 12.00
13.00	Separately Certified ASC										13.00
	Hospi tal -Based Hospi ce										14.00
15. 00 16. 00	Hospital-Based Health Clinic - RHC										15.00 16.00
17.00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other							<u> </u>			19.00
							From: 1.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2		06/30/		20.00
21.00	Type of Control (see instructions)						1				21.00
22.00	Inpatient PPS Information Does this facility qualify and is it	currently receiv	/ing navmen	ts for	di spro	portionate	e N		N		22.00
22.00	share hospital adjustment, in accord										22.00
	for yes or "N" for no. Is this facil				2.106(c)	) (2) (Pi ckl	e				
	amendment hospital?) In column 2, en Did this hospital receive interim un				s cost i	reporting	N		N		22. 01
22.01	period? Enter in column 1, "Y" for y										22.01
	reporting period occurring prior to										
	for no for the portion of the cost r (see instructions)	eporting period c	occurring o	n or a	fter Oc	tober 1.					
22. 02	Is this a newly merged hospital that	requires final ι	uncompensat	ed car	e paymei	nts to be	N		N		22.02
	determined at cost report settlement						s				
	or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for						'n				
	or after October 1.	no, for the porti	on or the	cost i	eportri	g period c					
22.03	Did this hospital receive a geograph								N		22.03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column						ie				
	cost reporting period occurring on o	r after October 1	I. (see ins	tructi	ons) Do	es this					
	hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,			unted	in acco	rdance wit	'n				
23.00	Which method is used to determine Me			/or 25	bel ow?	In columr	1	2	N		23.00
	1, enter 1 if date of admission, 2 i										
	method of identifying the days in th used in the prior cost reporting per										
			In-State	In-St		Out-of		Aedi ca		ther	
			Medicaid paid days	Medio   eligi		State ledi cai d	State   H Medicaid	HMO dag	·	li cai d lays	
				unpa			eligible			idy5	
				day	/s		unpai d				
24.00	If this provider is an IPPS hospital	onter the	1.00	2.0	00	3.00	4.00	5.00	0	b. 00	24.00
24.00	in-state Medicaid paid days in colum		0		0	0	0		0	0	24.00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in	column 6.									
25.00	If this provider is an IRF, enter th		0		0	0	0		0		25.00
	Medicaid paid days in column 1, the Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column	3, out-of-state									
	Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid day	5 TH COLUMN D.		I	I	I	I		I		I

OSPI T	Financial Systems ST. VINCE AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		DOLPH HOSPITAL Provider CC	F	Period: rom 07/01/201 o 06/30/201	7 Part I 8 Date/1	neet S-2	pared:
				L	Urban/Rural	S Date o	f Geogr	
6. 00	Enter your standard geographic classification (not wa	ge) st	atus at the bec	ginning of the	1.00	2	. 00	26.00
7. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	ge) st "2" f	atus at the end or rural. If ap	d of the cost oplicable,		2		27.00
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0		35.00
					Begi nni ng: 1. 00		li ng: . 00	-
6. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number	1.00			36.0
	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.				N	0		37.0
7.01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)				N			37.0
8. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.							38.0
					Y/N 1.00		/N .00	-
9.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (i eage r	i)? Enter in co equirements in	olumn 1 "Y" accordance	N		N	39.00
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	er 1.	Enter "Y" for y		Ν		N	40.00
	no in column 2, for discharges on or after October 1.	(see	Instructions)			V XVII 00 2.00	_	
5 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for	di sproporti opat	to sharo in ac	cordanco	N N	N	45.0
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption	for extraordina	ary circumstan	ces	N N	N	46.0
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment					N N N N	N	47.0
6. 00	Teaching Hospitals Is this a hospital involved in training residents in					N		56. 0
7.00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes o h of t ", com	r "N" for no ir his cost report plete Worksheet	n column 1. lf ting period?	column 1 Enter "Y"	N		57.0
3. 00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	urseme	nt for physicia	ans' services	as	N		58. C
9.00	Are costs claimed on line 100 of Worksheet A? If yes	, comp	lete Wkst. D-2,		Worksheet A		 Through	59. C
				NAHE 413.85 Y/N	Line #	Qual i f	i cati on on Code	
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (			1.00 N	2.00	3.	00	60. C
	The second secon	Y/N	IME	Direct GME	IME	Dire	ct GME	
1 00		1.00	2.00	3.00	4.00		.00	11.
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.		0.00	61.0
I. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61.0
. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of							61. (
1. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for							61.0

Health Financial Systems ST. VINCE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider C	CN: 15-1301	Peri od:	wof Form CMS- Worksheet S-2	
				From 07/01/2017 To 06/30/2018		
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
<ul> <li>61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).</li> <li>61.05 Enter the difference between the baseline primary</li> </ul>						61. 0
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being						61.0
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
care or general surgery. (see first detroits)	Pro	ogram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.2
					1.00	
ACA Provisions Affecting the Health Resources and Ser				at and form which	0.00	(2.0
22.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct)	tions)				0.00	62.0
22.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	gram. (s	see instructio		o your hospital	0.00	62.0
53.00 Has your facility trained residents in nonprovider se	ettings	during this c			N	63.0
"Y" for yes or "N" for no in column 1. If yes, comple	ete line	es 64 through (	Unweighted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor	•	0	nnis base yea	i is your cost r	eporting	
4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	y train priman all nor non-pr column	ned residents ry care nprovider rimary care n 3 the ratio	0.0	0. 00	0. 000000	64.0
of (column 1 divided by (column 1 + column 2)). (see Program Name		ogram Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			Si te			
1.00		2.00	3.00	4.00	5.00	

SPITAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION DA	ATA Provider		eriod: ^om 07/01/20′		neet S-2	
					18 Date/	Time Pre	
	Program Name	Program Code	Unweighted	Unweighted		<u>/2018_4:</u> (col3/	
	r r ogr am riamo		FTEs	FTEs in		3 + col.	
			Nonprovi der	Hospi tal	4	))	
	1.00	0.00	Site	4.00			-
00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00		. 00 0. 000000	65 (
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3							
divided by (column 3 + column 4)). (see instructions)					Datio	(col 1/	
			Unweighted FTEs	Unweighted FTEs in		(col. 1/ 1 + col.	
			Nonprovi der	Hospital		2))	
			Si te				
	V FTF D		1.00	2.00		. 00	
Section 5504 of the ACA Current beginning on or after July 1, 2		n Nonprovider Settir	ngsEffective fo	or cost repor	ting per	ods	
FTEs attributable to rotations of	occurring in all nonp	rovider settings.	0.00	0.	00	0.000000	66.
	occurring in all nonp unweighted non-prima tal. Enter in column	rovider settings. ry care resident 3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col.	(col. 3/ 3 + col.	66. (
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in:	rovider settings. ry care resident 3 the ratio of structions)	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 5	(col. 3/ 3 + col.	
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi	Deccurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in: Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital 4.00	Ratio (col. 5	(col. 3/ 3 + col. }))	
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospir (column 1 divided by (column 2 divided by 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 3 divided by (column 3 + column 4)</li> </ul>	Deccurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in: Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00 0.	Ratio (col	(col . 3/ 3 + col . 1)) 0.000000	-
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospin (column 1 divided by (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)</li> </ul>	Deccurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00 0.	Ratio (col. 5	(col . 3/ 3 + col . 1)) 0.000000	-
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospir (column 1 divided by (column 2 divided 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)</li> </ul>	poccurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospital 4.00 0.	Ratio (col	(col . 3/ 3 + col . 1)) 0.000000	67.1
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospir (column 1 divided by (column 100Enter 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 3 divided by (column 3 + column 4)). (see instructions)00Inpatient Psychiatric Facility Enter "Y" for yes or "N" for me Enter "Y"	PPS sychiatric Facility (	<pre>ivovider settings. ry care resident 3 the ratio of structions) Program Code 2.00 IPF), or does it cor</pre>	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 0. 0.	Ratio (col	(col. 3/ 3 + col. ))) 0.000000	67.0
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospir (column 1 divided by (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 3 divided by (column 3 + column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</li> <li>Inpatient Psychiatric Facility</li> <li>Is this facility an Inpatient Psenter "Y" for yes or "N" for no 1f line 70 is yes: Column 1: Divide Column 3: If column 2 is Y, ind (see instructions)</li> </ul>	PPS sychiatric Facility have an before November 15, 22 olumn 2: Did this fac FR 412. 424 (d)(1)(iii) icate which program ye	IPF), or does it cor n approved GME teach 00/2°. Enter "Y" for 10/20? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs i n Hospi tal 4.00 0. 1. 1. vrovi der? he most i. (see i ng i.	Ratio (col	(col . 3/ 3 + col . 1)) 0.000000	67.
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospir (column 1 divided by (column 2, the program code. 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)</li> <li>Inpatient Psychiatric Facility 00 Is this facility an Inpatient Psenter "Y" for yes or "N" for m 00 If line 70 is yes: Column 1: Div recent cost report filed on or 1 42 CFR 412. 424(d)(1)(iii)(c)) Cd program in accordance with 42 Ci column 3: If column 2 is Y, ind</li> </ul>	PPS Sychiatric Facility ( d the facility have an before November 15, 22 column 2: Did this fac. FR 412.424 (d)(1)(iii icate which program ye ty PPS	IPF), or does it cor n approved GME teach 00/2 Enter "Y" for ear began during thi	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs i n Hospi tal 4.00 0. 1. rrovi der? he most i ng io. j peri od.	Ratio (col	(col. 3/ 3 + col. ))) 0.000000	

Heal th	Financial Systems ST. VINCENT RAND	OLPH HOSPITAL		In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-1301	Period:	Worksheet S-2	2
				From 07/01/2017 To 06/30/2018	Part I Date/Time Pre	
					11/28/2018 4	:47 pm
					1.00	-
	Long Term Care Hospital PPS					
	Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part of			a poriod? Entor	N	80.00
61.00	"Y" for yes and "N" for no.		cost reportin	ig periou? Enter	IN	01.00
	TEFRA Provi ders				1	
	Is this a new hospital under 42 CFR Section 413.40(f)(1)(i)				N	85.00
86.00	Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ea unit) under	42 CFR Secti	ON		86.00
87.00	Is this hospital an extended neoplastic disease care hospita	al classified (	under section	1	N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N/	VIV	
				V 1.00	XI X 2.00	-
	Title V and XIX Services			1.00	2.00	
90.00	Does this facility have title V and/or XIX inpatient hospita	al services? E	nter "Y" for	N	Y	90.00
01 00	yes or "N" for no in the applicable column.	the cost report	t olthor in	N	Y	91.00
91.00	Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the appl			IN IN	T	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (du	ual certificat			N	92.00
02.00	instructions) Enter "Y" for yes or "N" for no in the applica		d VIVO Enton	N	N	02.00
93.00	Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	or title v and	u XIX? Enter	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
05 00	applicable column.		_	0.00	0.00	05.00
	If line 94 is "Y", enter the reduction percentage in the app Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0.00 N	95.00 96.00
70.00	applicable column.					/0.00
	If line 96 is "Y", enter the reduction percentage in the app			0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" i			N	Y	98.00
	column 1 for title V, and in column 2 for title XIX.	I yes of N				
98.01	Does title V or XIX follow Medicare (title XVIII) for the re				Y	98. 01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti	tle V, and in	column 2 for			
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the ca	alculation of (	observation	N	Y	98.02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o					
00 02	for title V, and in column 2 for title XIX.	tical access b		N	N	00.02
90.03	Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for ye				IN	98.03
	for title V, and in column 2 for title XIX.					
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH			N	N	98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.		title v, and			
98.05	Does title V or XIX follow Medicare (title XVIII) and add ba	ack the RCE di	sallowance on	N N	Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in (	column 1 for t	itle V, and i	n		
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed fo	r Wkst. D.	N	Y	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column					
	column 2 for title XIX.					-
105.00	Rural Providers Does this hospital qualify as a CAH?			Y		105.00
	If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of paymen			106.00
107.00	for outpatient services? (see instructions)		+ <i>f</i> 10D	N		107.00
107.00	If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in column			N		107.00
	yes, the GME elimination is not made on Wkst. B, Pt. I, col.			t		
100.00	reimbursed. If yes complete Wkst. D-2, Pt. II.	CDNA fee cobe	dul of Coo 41	N		108.00
108.00	Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRINA LEE SCHE	dulle? See 42	2 N		108.00
		Physi cal	Occupati ona	I Speech	Respi ratory	
100.00	If this happital qualifier as a CAU and the second	1.00	2.00	3.00	4.00	100.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	N	N	N	N	109.00
	for yes or "N" for no for each therapy.					
					1.00	_
110 00	Did this hospital participate in the Rural Community Hospita	al Demonstratio	on project (8	410A	1.00 N	110.00
	Demonstration)for the current cost reporting period? Enter '	'Y" for yes or	"N" for no.	lf yes,		
	complete Worksheet E, Part A, lines 200 through 218, and Worksheet E	rksheet E-2, I	ines 200 thro	ough 215, as		1
	appl i cabl e.				1	1

eal th Financial Systems ST. VINCENT RANDOLPH H OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pro	vider CCN: 15-1301	Period: From 07/0 To 06/3	1/2017 0/2018	Workshe Part I Date/Ti 11/28/2	me Pre	epared:
		1. (	)()	2. (	)()	1
11.00 If this facility qualifies as a CAH, did it participate in the Fro Health Integration Project (FCHIP) demonstration for this cost rep "Y" for yes or "N" for no in column 1. If the response to column 1 integration prong of the FCHIP demo in which this CAH is participa Enter all that apply: "A" for Ambulance services; "B" for addition for tele-health services.	orting period? Ente is Y, enter the ting in column 2.	n N				111.00
			1.00	) 2.00	3.00	
<ul> <li>Miscellaneous Cost Reporting Information</li> <li>15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for is yes, enter the method used (A, B, or E only) in column 2. If co 3 either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) bas Pub. 15-1, chapter 22, §2208.1.</li> <li>16.00 Is this facility classified as a referral center? Enter "Y" for yes 17.00 Is this facility legally-required to carry malpractice insurance?</li> </ul>	lumn 2 is "E", ente long term care (inc ed on the definitions s or "N" for no.	r in columr ludes n in CMS			0	115. 00 116. 00 117. 00
no. 18.00 s the malpractice insurance a claims-made or occurrence policy? E	nter 1 if the polic	y is	2			118.00
claim-made. Enter 2 if the policy is occurrence.	Premiums	Loss	ses	Insur	ance	
10.01 ist security of estimation reactions and said losses	1.00	2. (		3. (		110.01
18.01 List amounts of malpractice premiums and paid losses:	85,	197	0		Ĺ	0 118. 01
18.02 Are malpractice premiums and paid losses reported in a cost center	athen then the	1. ( N		2.0	00	118.02
Administrative and General? If yes, submit supporting schedule li and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harml §3121 and applicable amendments? (see instructions) Enter in colum "N" for no. Is this a rural hospital with < 100 beds that qualifie Hold Harmless provision in ACA §3121 and applicable amendments? (s Enter in column 2, "Y" for yes or "N" for no.	ess provision in AC n 1, "Y" for yes or s for the Outpatier			Ν		119. 00 120. 00
21.00 Did this facility incur and report costs for high cost implantable patients? Enter "Y" for yes or "N" for no.	devices charged to	Y				121.00
22.00 Does the cost report contain healthcare related taxes as defined i Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y the Worksheet A line number where these taxes are included.				5.0	00	122.00
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes	and "N" for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter th	e certification dat	e				126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.	certification date					127. 0
28.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.						128. 0
29.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.		in				129.00
30.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter						130. 0
date in column 1 and termination date, if applicable, in column 2. 32.00 f this is a Medicare certified islet transplant center, enter the						132. 00
in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, enter the						133. 00
in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (OPO), enter the OPO	number in column 1					134. 00
and termination date, if applicable, in column 2. All Providers	in CMS Dub 15 1					140.0
40.00 Are there any related organization or home office costs as defined chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, a		Y				140. 00

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLE			PH HOSPITAL	CN: 15-1301			u of Form CMS Worksheet S-	
						06/30/2018	Part I Date/Time Pr 11/28/2018 4	
1.00		2.00				3.00	11/20/2010 1	
If this facility is part of a cha home office and enter the home of					e name ar	nd address	of the	
41.00Name: ST. VINCENT HEALTH	Contractor's N	Name: WPS		Contra	actor's N	umber: 0810	1	141. 0
42.00 Street: 250 WEST 96TH ST SUITE 215				7. 0		44.04	•	142.0
43.00 City: INDIANAPOLIS	State:	IN		Zip Co	ode:	4626	0	143.0
							1.00	-
44.00 Are provider based physicians' co	sts included in Work	ksheet A?					Y	144.0
						1.00	0.00	_
45.00 If costs for renal services are c	laimod on Wkst A	ino 74 /	are the cost	s for		1.00	2.00	145.0
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog	" for yes or "N" for clude Medicare utili for no in column 2.	r no in co zation fo	olumn 1. lfo or this cost	column 1 i reporting		N		145.0
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o			-2, chapter 4	40, §4020)	lf			
							1.00	_
47.00Was there a change in the statist	ical basis? Enter "\	(" for you	s or "N" for	no			1.00 N	147.0
48.00 Was there a change in the order of		5					N	147.0
9.00Was there a change to the simplif					for no.		Ν	149. 0
			Part A	Part		Title V	Title XIX	_
			1.00	2.00		3.00	4.00	_
Does this facility contain a prov or charges? Enter "Y" for yes or								
55. 00 Hospi tal		component	N	N	<u>D. (300</u>	N	N	155. 0
6.00 Subprovider - IPF			Ν	N		Ν	N	156. 0
57.00 Subprovider - IRF			Ν	N		N	N	157.0
58. 00 SUBPROVI DER 59. 00 SNF			Ν	l N		N	N	158. C
50.00 HOME HEALTH AGENCY			N	N N		N	N	160. C
51.00 CMHC				N		Ν	N	161.0
							1.00	_
Multicampus							1.00	-
65.00 Is this hospital part of a Multica	ampus hospital that	has one o	or more campu	uses in di	fferent C	BSAs?	N	165. C
Enter "Y" for yes or "N" for no.	N		0		7' 0 1	00004		_
	Name 0		County 1.00	State 2.00	Zip Code 3.00	e CBSA 4.00	FTE/Campus 5.00	-
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in								)0 166. C
column 5 (see instructions)								
	T) inconting is di	Amore:	Decoversi	d Doi	mont A-		1.00	_
llool the Information Technology (11)	i) incentive in the						N	167.0
Health Information Technology (HI	r under §1886(n)? F					er the		0168.0
57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10	05 is "Y") and is a	meani ngfu		8 107 15				1
57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 58.01 If this provider is a CAH and is	D5 is "Y") and is a HIT assets (see inst not a meaningful use	meaningfu tructions) er, does f	) this provider	r qualify		dshi p	Y	168. 0
57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 58.01 If this provider is a CAH and is exception under §413.70(a)(6)(i) 59.00 If this provider is a meaningful of	05 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "\	meaningfu tructions) er, does f or "N" fo	) this providen or no. (see i	r qualify instructio	ns)			168. 0 00169. 0
57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 58.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	05 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "\	meaningfu tructions) er, does f or "N" fo	) this providen or no. (see i	r qualify instructio	ns) is "N"),	enter the eginning	0. C Endi ng	
<ul> <li>57.00 Is this provider a meaningful use</li> <li>58.00 If this provider is a CAH (line 16 reasonable cost incurred for the line seception under §413.70(a) (6) (ii)</li> <li>59.00 If this provider is a meaningful transition factor. (see instruction for the line seception under §413.70(a) (6) (ii)</li> <li>59.00 If this provider is a meaningful transition factor. (see instruction factor)</li> <li>70.00 Enter in columns 1 and 2 the EHR 10 for the factor.</li> </ul>	D5 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons)	meaningfu tructions) er, does f or "N" fo (") and is	) this provider or no. (see i s not a CAH	r qualify instructio (line 105	ns) is "N"),	enter the	0. 0	00169.0
<ul> <li>57.00 Is this provider a meaningful use</li> <li>58.00 If this provider is a CAH (line 10 reasonable cost incurred for the lister of the lister of</li></ul>	D5 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons)	meaningfu tructions) er, does f or "N" fo (") and is	) this provider or no. (see i s not a CAH	r qualify instructio (line 105	ns) is "N"),	enter the eginning	0. C Endi ng	
<ul> <li>67.00 Is this provider a meaningful use</li> <li>68.00 If this provider is a CAH (line 16 reasonable cost incurred for the line 16 reasonable cost incurred for the line exception under §413.70(a) (6) (ii)</li> <li>69.00 If this provider is a meaningful transition factor. (see instruction 170.00 Enter in columns 1 and 2 the EHR 10 to 10 t</li></ul>	D5 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons) beginning date and e	meaningfu tructions) er, does f or "N" fo (") and is	) this provider or no. (see i s not a CAH te for the re	r qualify instructio (line 105 eporting	ns) is "N"),	enter the eginning	0. 0 Endi ng 2. 00 2. 00	00169.0

)SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1301	Period: From 07/01/2017 To 06/30/2018		epared
				Y/N	Date	. 47 pm
				1, 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lforall NO re	esponses. Ente			
	Provider Organization and Operation			••		
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			) Date	V/I	1. (
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2. (
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug ler or its of the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4. (
00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec	conciliation.		)/ /N		_
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	-
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	5 N		6.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		l during the	N N		7. 8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	Ν		9.
0. 00	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.			N		10.
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11.
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 13.
I. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structions.	Ν	14.
. 00	Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	tructions.	N	15.
			rt A		tВ	
		Y/N	Date	Y/N	Date	
	DCVD Data	1.00	2.00	3.00	4.00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	10/10/2018	Y	10/10/2018	16.
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		Ν		17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		Ν		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19.

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In lieu of Form CMS\_2552\_10

IEEE/TAL_AND_INDERFIAL IFALTICARE BETAINDESTIENT OURSTIENT ALL         Provider CDL: 15-13D         Period 2017         Description         Period 2017         Benchmerts S-2 From 07/07/0710           20.00         Filter 16 or 17 is yes, were adjustments made to PSR Period 401 for 0104r7 Describe the other adjustments         0         1.00         3.00         4.00           21.00         Nes the cost report preserved only using the provider's         N         0         1.00         3.00         4.00           22.00         Nes the cost report preserved only using the provider's         N         0         1.00         3.00         4.00           22.00         Nes the cost report preserved only using the provider's         N         0         1.00         2.00           22.00         Nes the cost report preserved only using the provider's         N         1.00         2.00           22.00         Nes the cost report preserved only using the provider's         N         2.00         1.00         2.00           22.00         Nes the cost report preserved only using the provider's on preserved to using the cost report preserved not preserved to using the preserved to using the preserved to using the cost report preserved not preserved not using the preserved not preserved not preserved not using the preserved not preserved not preserved not using the preserved not preserve	Health Financial Systems ST. VINCENT RA	NDOLPH HOSPITAL		In Lie	u of Form CM	S-2552-10
Description         Y/N         Y/N         Y/N           20.00         11 into 16 or 17 is yee, were adjustent's made to PS&R         N         N         20.00         3.00         4.00         3.00         4.00         21.00           20.01         Was the cost report prepared only using the provider's         N         N         21.00         3.00         4.00         21.00           21.01         Was the cost report prepared only using the provider's         N         N         21.00         3.00         4.00           22.00         Nast the cost report prepared only using the provider's         N         N         21.00           22.00         Nast the cost report prepared only using the provider's         N         N         21.00           22.00         Nast the cost report ing period?         N         22.00         N         22.00           22.00         Nast the cost report ing period?         N         23.00         N         23.00           22.00         Nast the cost report ing period?         N         23.00         N         23.00           23.00         Nast the cost report ing period?         F yes, see         N         25.00         N         25.00           24.00         Dere cost isst ing let bear cost istor ing period?		Provider C	CN: 15-1301	From 07/01/2017	Part II Date/Time P	repared:
0         1.00         3.00         20.00           0.00         1F Fine 16 or 17 is yes, were adjustments made to PSR         N         N         20.00           21.00         Was the cost report prepared only using the provider's         N         1.00         21.00         8.00         4.00         21.00           21.00         Was the cost report prepared only using the provider's         N         1.00         21.00         8.00         4.00         21.00           21.00         Was the cost report prepared only using the provider's         N         1.00         21.00         8.00         4.00         21.00           21.00         Mass the cost report of the Wad care purpows? If yes, see instructions         N         22.00         N <t< td=""><td></td><td>Descri</td><td>ntion</td><td>V/N</td><td></td><td>4:4/pm</td></t<>		Descri	ntion	V/N		4:4/pm
20.00     [IF   Inc 16 or 17 is yes, were adjustments mude to FS48     N     N     N     20.00       21.00     Report data for Other? Describe the other adjustments:     V/N     Date     V/N     Date     V/N     Date       21.00     Report data for Other? Describe the other adjustments:     N     N     2.00     3.00     4.00     21.00       21.00     Russ the cost report prepared enty using the provider's     N     N     N     22.00       21.00     Russ tasks the cost report prepared enty using the provider's     N     N     N     22.00       22.01     Russ assits been relifed for Medicare purposes? If yes, see instructions     N     22.00       22.02     Russ assits been relifed for Medicare purposes? If yes, see instructions     N     22.00       23.00     Hore heases and/or amendments to odisting leases entered into during this cost reporting period?     N     24.00       24.00     Beer neases subjuct to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see     N     25.00       25.00     Beer neases subjuct to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see     N     26.00       26.00     Beer nease is subjuct to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see     N     26.00       27.00     Bas the provider's capitalization policy changed during the cost report						
V/R         Date         V/N         Date         V/N         Date           21.00         Records? If Yes, see Instructions.         N         2.00         3.00         4.00         2.00         3.00         4.00         2.00         N         2.00         Not charastic subject to see. set for charastic subject of the during the cost reporting period? If yes, see         N         2.00         Not for charastic subject to see. 2314 of DEFRA acquired during the cost reporting period? If yes, subject not charastic subject to see. 2314 of DEFRA acquired during the cost reporting period? If yes, see         N         2.00         Not for been nec capitalized leases entered into during the cost reporting period? If yes, see instructions.         N         2.00         Not for been nec capitalized lease for for during the cost reporting period? If yes, see instructions.         N			-			20.00
21.00       Was the cost report prepared only using the provider's       N       N       21.00         Precords 21 Fyes, see instructions.       1.00       1.00       1.00       1.00         Completed By cost RetMBURSED AND TERA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)       1.00       1.00       1.00         20.00       Have changes occurred in the Medicare purposes? If yes, see instructions       N       22.00         20.01       Have changes occurred in the Medicare purposes? If yes, see instructions       N       23.00         20.02       Have there been new capitalized leases entered into during the cost reporting period? If yes, see       N       24.00         20.03       Have there been new capitalized leases entered into during the cost reporting period? If yes, see       N       26.00         20.04       Mare assets sable et to Sec 2314 of DEFRA acquired during the cost reporting period? If yes, see       N       27.00         20.01       Have there been new capitalization policy changed during the cost reporting period? If yes, see       N       28.00         20.02       Have the provider have a funded depreciation account and/or bond funds (beb Service Reserve fund)       N       29.00         20.01       His provider have a funded depreciation account and/or bond funds (beb Service Reserve fund)       N       29.00         20.00       Hes the provider have a funded de		Y/N	Date	Y/N	Date	
Incomparison         Incomparison           COMPLETED BY COST RELIMBURSED AND TERA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)         Incomparison           Capital Related Cost         N         22.00           20.00         Have charges on cord FLF in the Medicare purposes? If yes, see instructions         N         22.00           21.00         Have charges on cord FLF in the Medicare purposes? If yes, see instructions         N         22.00           22.00         Have charges on cord FLF in the Medicare purposes? If yes, see instructions         N         22.00           22.01         Wave charges on cord FLF in the Medicare purposes? If yes, see instructions         N         22.00           23.00         Have charges on cord FLF in the Medicare purposes? If yes, see instructions         N         22.00           20.01         Wave new leaves and/or mandments to existing leatboard mediating the cost reporting period? If yes, see N         26.00           20.02         Next the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)         N         27.00           20.01         Next the arges on repaired appresents or letters of credit entered into during the cost reporting period? If yes, see         N         30.00           20.01         Next the arge appresents or letters of credit entered into during the cost reporting period? If yes, see         N         30.00 <t< td=""><td></td><td></td><td>2.00</td><td></td><td>4.00</td><td></td></t<>			2.00		4.00	
Commentation         Commentation<		N		N		21.00
Commentation         Commentation<					1.00	
22.00       Have assets been relifed for Medicare purposes? If yes, see instructions       N       22.00         23.00       Have changes occurred in the Medicare depreciation expense due to apprisials made during the cost reporting period?       N       23.00         23.00       Have changes occurred in the Medicare depreciation expense due to apprisials made during the cost reporting period?       N       23.00         23.00       Have there been new capitalized leases entered into during the cost reporting period? If yes, see       N       24.00         25.00       Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see       N       25.00         26.00       Were new leans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.       N       28.00         20.00       Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)       N       29.00         20.00       Have there repeared prior to its subschedied maturity without issuance of new debt? If yes, see       N       30.00         31.00       Have during the entrop of the repeared into account? If yes, see instructions.       N       32.00         32.00       Have changes occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.       N       32.00         32.00       Have changes or n		CEPT CHILDRENS H	OSPI TALS)			
23.00       Have changes occurred in the Medicare depreciation expense due to appraisals nade during the cost reporting period?       N       23.00         24.00       Were new leases and/or mendments to existing leases entered into during this cost reporting period?       N       24.00         25.00       Have there been new capitalized leases entered into during the cost reporting period? If yes, see       N       25.00         26.00       Were new leases subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see       N       26.00         27.00       Was the provider's capitalization policy changed during the cost reporting period? If yes, subnit       N       27.00         28.00       Were new leans, mortgage agreements or letters of credit entered into during the cost reporting period?       N       28.00         29.00       Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)       N       29.00         30.00       Has existing debt been replaced prior to its scheduled maturity without issuance of new debt? If yes, see       N       31.00         31.00       Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers or services? If yes, see instructions.       N       32.00         32.00       If ine 34 is yes, were ther new agreements or amended existing agreements with the provider-based physici ans?       Y       34.00		ee instructions			N	22 00
24.00       We're new'iseases and/or amendments to existing leases entered into during this cost reporting period?       N       24.00         25.00       Have there been new capitalized leases entered into during the cost reporting period? If yes, see       N       25.00         26.00       Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see       N       26.00         27.00       Has the provider's capitalization policy changed during the cost reporting period? If yes, submit       N       27.00         28.00       Were new lears, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.       N       28.00         29.00       Dd the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)       N       29.00         20.01       Has the provider have a funded depreciation account? If yes, see instructions.       N       30.00         31.00       Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see       N       31.00         32.00       If rike 32 is yes, were ther engulation of Secure 42 is 2 applied pertaining to competitive bidding? If N       33.00         33.00       If like 32 is yes, were there new agreements of a manded existing agreements with provider-based physicians?       Y         34.00       If fike 32 is yes, were there new agreements or amended existing agreements with the provider-	23.00 Have changes occurred in the Medicare depreciation expens		als made duri	ng the cost		
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27.00       Has the provider's capitalization policy changed during the cost reporting period? If yes, submit       N       27.00         20.00       Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.       N       28.00         20.00       Home new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.       N       29.00         20.00       Home provider have a funded depreciation account? If yes, see instructions.       N       29.00         20.00       Has the provider have a funded depreciation account? If yes, see instructions.       N       30.00         20.00       Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see       N       30.00         31.00       Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see       N       31.00         32.00       Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.       N       32.00         33.00       If line 32 is yes, were the requirements or amended existing agreements with the provider-based Physicians?       Y       34.00         40.0       Are services furnished       N       35.00       physicians during the cost report?       Y       34.00         50.00		the cost reporti	ng period? If	fyes, see	N	26.00
28.00         Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.         28.00           29.00         Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)         N         29.00           30.00         Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see         N         30.00           31.00         Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see         N         31.00           31.00         Instructions.         Purchased Services         N         32.00           32.00         Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see         N         33.00           33.00         If inter 32 is yes, were the requi rements of Sec. 2135.2 applied pertaining to competitive bidding? If N         33.00           33.00         If yes, see instructions.         YN         Date           44.00         Are services furnished at the provider facility under an arrangement with provider-based physicians?         Y         34.00           35.00         If yes, see instructions.         YN         Date         37.00           9/* yes, see instructions.         YN         Date         37.00         37.00           16         In a 34 is yes, were there new agreements or am		N	27.00			
28.00       Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting       N       28.00         29.00       Treated as a funded depreciation account and/or bond funds (Debt Service Reserve Fund)       N       29.00         30.00       Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see       N       30.00         31.00       Has existing debt been recalled before scheduled maturity without issuance of new debt? If yes, see       N       30.00         32.00       Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.       N       32.00         33.00       If line 32 is yes, were there requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N       33.00         40.00       Reservices Thursished at the provider facility under an arrangement with provider-based physicians?       Y       34.00         34.00       If yes, see instructions.       Y       Date       1.00       2.00         55.00       If yes, see instructions.       Y       34.00       35.00         77.00       If yes, see instructions.       Y       34.00       35.00         78.00       If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians?       Y       34.00		•				_
29.00       Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)       N       29.00         30.00       Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see       N       30.00         31.00       Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see       N       30.00         31.00       Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see       N       31.00         32.00       Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.       N       32.00         33.00       If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N       33.00         34.00       Are services furnished at the provider facility under an arrangement with provider-based physicians?       Y         35.00       If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N       35.00         36.00       Were home office costs       1.00       2.00         36.00       If line 36 is yes, has a home office cost statement been prepared by the home office?       Y       36.00         37.00       If line 36 is yes, due thin column 2.th fiscal year end of the home office?       Y       36.00         38.00 <td< td=""><td>28.00 Were new Loans, mortgage agreements or letters of credit</td><td>entered into dur</td><td>ing the cost</td><td>reporti ng</td><td>N</td><td>28.00</td></td<>	28.00 Were new Loans, mortgage agreements or letters of credit	entered into dur	ing the cost	reporti ng	N	28.00
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31.00       Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see       N       31.00         31.00       Instructions.       N       31.00         Purchased Services       N       31.00         32.00       Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.       N       32.00         33.00       If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N       33.00         34.00       Are services furnished at the provider facility under an arrangement with provider-based physicians?       Y       34.00         35.00       If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N       35.00         physicians during the cost reporting period? If yes, see instructions.       Y/N       Date         0       If yes, see instructions.       Y/N       Date         10.00       2.00       1       10.00       2.00         40.00       If line 36 is yes, has a home office cost statement been prepared by the home office?       Y       36.00         31.00       If line 36 is yes, due the provider render services to other chain components? If yes, see instructions.       39.00         00       If line 36 is yes, duid the provider render services to the home offic	30.00 Has existing debt been replaced prior to its scheduled ma		debt? If yes,	see	N	30.00
Purchased Services         32.00       Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.       N       32.00         33.00       If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.       N       33.00         34.00       Are services furnished at the provider facility under an arrangement with provider-based physicians?       Y       34.00         35.00       If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.       Y/N       Date         Mome Office Costs       1.00       2.00       36.00         If line 36 is yes, has a home office cost statement been prepared by the home office?       Y       J         If yes, see instructions.       38.00       38.00       38.00         37.00       If line 36 is yes, has a home office cost statement been prepared by the home office?       Y       J         38.00       If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.       38.00         39.00       If line 36 is yes, did the provider render services to the home office?       Y       J         39.00       If line 36 is yes, did the provider render services to other chain components? If yes, see instructions		issuance of new	debt? If yes,	see	N	31.00
arrangements with suppliers of services? If yes, see instructions.       33.00         33.00       If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N       33.00         arrangements with supplicians.       34.00       Are services furnished at the provider facility under an arrangement with provider-based physicians?       Y       34.00         34.00       Are services furnished at the provider facility under an arrangement with provider-based physicians?       Y       34.00         35.00       If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N       35.00         by bysicians during the cost reporting period? If yes, see instructions.       Y/N       Date         0       Are services the yes, were there new agreements or amended existing agreements with the provider-based N       35.00         0       If line 36 is yes, were there new agreements or amended existing agreements with the provider-based N       35.00         36.00       Were home office Costs       Y       36.00         37.00       If line 36 is yes, as a home office cost statement been prepared by the home office?       Y       36.00         38.00       If line 36 is yes, did the provider render services to other chain components? If yes, N       38.00       39.00         9.00       If line 36 is yes, did the provider render services to the home office?       If yes, see						-
33.00       If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N       33.00         34.00       Are services furnished at the provider facility under an arrangement with provider-based physicians?       Y       34.00         35.00       If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N       35.00         35.00       If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N       35.00         36.00       Were home office Costs       Y/N       Date         1.00       2.00       2.00         37.00       If line 36 is yes, has a home office cost statement been prepared by the home office?       Y       36.00         38.00       If line 36 is yes, was the fiscal year end of the home office.       Y       37.00         39.00       If line 36 is yes, did the provider render services to other chain components? If yes, see Instructions.       39.00         39.00       If line 36 is yes, did the provider render services to the home office? If yes, see N       40.00         11 line 36 is yes, did the provider render services to the home office? If yes, see N       40.00         12 content the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.       JILL       HILL       41.00         42.00       Enter the employer/comp			ed through cor	ntractual	N	32.00
Provider-Based Physicians       34.00         Are services furnished at the provider facility under an arrangement with provider-based physicians?       Y         35.00       If line 34 is yes, were there new agreements or amended existing agreements with the provider-based       N         35.00       If line 34 is yes, were there new agreements or amended existing agreements with the provider-based       N       35.00         9       Home Office Costs       Y/N       Date       1.00       2.00         1       1.00       2.00       11       1.00       2.00         1       1       1.00       2.00       0       1.00       2.00         36.00       Were home office costs claimed on the cost report?       Y       36.00       37.00       1f line 36 is yes, has a home office cost statement been prepared by the home office?       Y       37.00         38.00       If line 36 is yes, was the fiscal year end of the home office.       N       38.00       38.00         39.00       If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.       80.00       10       100       2.00         40.00       If line 36 is yes, did the provider render services to the home office? If yes, see N       40.00       40.00         1.00       2.00       2.00       2.00       2.0	33.00 If line 32 is yes, were the requirements of Sec. 2135.2 a		ng to competit	ive bidding? If	Ν	33.00
1f yes, see instructions.       1f line 34 is yes, were there new agreements or amended existing agreements with the provider-based       N       35.00         1f line 34 is yes, were there new agreements or amended existing agreements with the provider-based       N       35.00         1       1.00       2.00         1       00       2.00         36.00       Were home office costs       Y       36.00         36.00       Were home office costs claimed on the cost report?       Y       36.00         37.00       If line 36 is yes, has a home office cost statement been prepared by the home office?       Y       37.00         1f line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.       N       38.00         39.00       If line 36 is yes, did the provider render services to other chain components? If yes, N       39.00       39.00         40.00       Instructions.       40.00       2.00       40.00         1       1.00       2.00       2.00       40.00         1       1.00       2.00       40.00       40.00         1       1.00       2.00       2.00       40.00         1       1.00       2.00       40.00       40.00         1						
35.00       If Îine 34 is yes, were there new agreements or amended existing agreements with the provider-based       N       35.00         physicians during the cost reporting period? If yes, see instructions.       Y/N       Date         1.00       2.00         Home Office Costs       1.00       2.00         36.00       Were home office costs claimed on the cost report?       Y       36.00         37.00       If line 36 is yes, has a home office cost statement been prepared by the home office?       Y       37.00         1f yes, see instructions.       If line 36 is yes, was the fiscal year end of the home office.       N       38.00         39.00       If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.       N       39.00         40.00       If line 36 is yes, did the provider render services to the home office? If yes, see       N       40.00         1.00       2.00       2.00       40.00       40.00         Instructions.       1.00       2.00       40.00       40.00         Instructions	34.00 Are services furnished at the provider facility under an	arrangement with	provi der-bas	sed physi ci ans?	Y	34.00
Home Office Costs         Y/N         Date           36.00         Were home office costs claimed on the cost report?         Y         36.00         37.00         If line 36 is yes, has a home office cost statement been prepared by the home office?         Y         36.00         37.00         If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.         N         38.00         38.00         If line 36 is yes, did the provider render services to other chain components? If yes, N         39.00         39.00         If line 36 is yes, did the provider render services to the home office? If yes, see         N         40.00           10.00         2.00         10.00         2.00         40.00         10.00         2.00           40.00         If line 36 is yes, did the provider render services to the home office? If yes, see         N         40.00         40.00           If line 36 is yes, did the provider render services to the home office? If yes, see         N         40.00         40.00           If line 36 is yes, did the provider render services to the home office? If yes, see         N         40.00         40.00           If line 36 is yes, did the provider render services to the home office? If yes, see         N         40.00         40.00           If line 36 is yes, cost report preparer in columns 1, 2, and 3, respectively.         ST VIN	35.00 If line 34 is yes, were there new agreements or amended e		its with the p	provi der-based	N	35.00
Home Office Costs         36.00       Were home office costs claimed on the cost report?       Y       36.00         37.00       If line 36 is yes, has a home office cost statement been prepared by the home office?       Y       36.00         38.00       If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.       N       38.00         39.00       If line 36 is yes, did the provider render services to other chain components? If yes, N       39.00       39.00         16       If line 36 is yes, did the provider render services to the home office?       N       39.00         40.00       If line 36 is yes, did the provider render services to the home office? If yes, see       N       40.00         11       If line 36 is yes, did the provider render services to the home office? If yes, see       N       40.00         41.00       Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectivel y.       JILL       HILL       41.00         42.00       Enter the telephone number and email address of the cost       317-583-3232       JILL. HILL1@ASCENSION.ORG       43.00	physicians during the cost reporting period: IT yes, see	Thisti de trons.		Y/N	Date	
36.00       Were home office costs claimed on the cost report?       Y       36.00       36.00         37.00       If line 36 is yes, has a home office cost statement been prepared by the home office?       Y       37.00       37.00         1f line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.       N       38.00       38.00         39.00       If line 36 is yes, did the provider render services to other chain components? If yes, N       See instructions.       39.00         40.00       If line 36 is yes, did the provider render services to the home office? If yes, see       N       40.00         1f line 36 is yes, did the provider render services to the home office? If yes, see       N       40.00         10.00       2.00       2.00       40.00         11.00       Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.       JILL       HILL       41.00         42.00       Enter the employer/company name of the cost report preparer       ST VINCENT HEALTH       42.00         43.00       Enter the telephone number and email address of the cost       317-583-3232       JILL. HILLI@ASCENSION. ORG       43.00				1.00	2.00	
37.00       If line 36 is yes, has a home office cost statement been prepared by the home office?       Y       37.00         38.00       If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.       N       38.00         39.00       If line 36 is yes, did the provider render services to other chain components? If yes, N       39.00       39.00         40.00       If line 36 is yes, did the provider render services to the home office? If yes, see       N       40.00         11 the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.       JILL       HILL       41.00         42.00       Enter the employer/company name of the cost report       ST VINCENT HEALTH       JILL. HILL1@ASCENSION.ORG       43.00						2/ 00
38.00       If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.       N       38.00         39.00       If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.       N       39.00         40.00       If line 36 is yes, did the provider render services to the home office? If yes, see       N       40.00         10.00       If line 36 is yes, did the provider render services to the home office? If yes, see       N       40.00         41.00       Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.       JILL       HILL       41.00         42.00       Enter the employer/company name of the cost report preparer.       ST VINCENT HEALTH       42.00         43.00       Enter the telephone number and email address of the cost       317-583-3232       JILL. HILL1@ASCENSION. ORG       43.00	37.00 If line 36 is yes, has a home office cost statement been	prepared by the	home office?			
39.00       If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.       N       39.00         40.00       If line 36 is yes, did the provider render services to the home office? If yes, see N       N       40.00         Instructions.         1.00       2.00         Cost Report Preparer Contact Information         IIIL         IIIL         HILL         All colspan="2">All colspan="2">All colspan="2">Cost Report Preparer Contact Information         IIIL         All colspan="2">All colspan="2">All colspan="2">All colspan="2">Cost Report Preparer Contact Information         IIIL         All colspan="2">All colspan="2">All colspan="2">All colspan="2">Cost Report Preparer Contact Information         All colspan="2">All colspan="2">All colspan="2">Cost report preparer in columns 1, 2, and 3, respectively.         All colspan="2">All colspan="2">All colspan="2">All colspan="2">All colspan="2">All colspan="2">All colspan="2">All colspan="2">Cost report preparer in columns 1, 2, and 3, respectively.         All colspan="2">All colspan="2"         All colspan=	38.00 If line 36 is yes, was the fiscal year end of the home o	ffice different	from that of	Ν		38.00
40.00       If line 36 is yes, did the provider render services to the home office? If yes, see       N       40.00         instructions.       1.00       2.00       1.00	39.00 If line 36 is yes, did the provider render services to ot			Ν		39.00
Cost Report Preparer Contact Information     I.00     2.00       41.00     Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.     JILL     HILL     41.00       42.00     Enter the employer/company name of the cost report preparer.     ST VINCENT HEALTH     42.00       43.00     Enter the telephone number and email address of the cost     317-583-3232     JILL. HILL1@ASCENSION. ORG     43.00		e home office?	lf yes, see	N		40.00
Cost Report Preparer Contact Information         41.00       Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.       JILL       HILL       41.00         42.00       Enter the employer/company name of the cost report preparer.       ST VINCENT HEALTH       42.00         43.00       Enter the telephone number and email address of the cost       317-583-3232       JILL.HILL1@ASCENSION.ORG       43.00			-			
<ul> <li>41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.</li> <li>42.00 Enter the employer/company name of the cost report preparer.</li> <li>43.00 Enter the telephone number and email address of the cost 317-583-3232</li> <li>43.00 JILL.HILL1@ASCENSION.ORG</li> <li>43.00</li> </ul>		1.	00	2.	00	
respectively.42.00Enter the employer/company name of the cost reportpreparer.43.00Enter the telephone number and email address of the cost317-583-3232JILL. HILL1@ASCENSION. ORG43.00	41.00 Enter the first name, last name and the title/position	JILL		HILL		41.00
43.00 Enter the telephone number and email address of the cost 317-583-3232 JILL. HILL1@ASCENSION. ORG 43.00	respecti vel y.					40.05
	preparer.		LIH			
		317-583-3232		JI LL. HI LL1@ASC	ENSI ON. ORG	43.00

Heal th	Financial Systems ST. V	VINCENT RAN	OOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIO	ONNAI RE	Provider CCN:		eriod:	Worksheet S-2	
					rom 07/01/2017 o 06/30/2018		
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/pc	osition	REIMBURSEMENT MAN	AGER			41.00
	held by the cost report preparer in columns 1, 2	2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost repo	ort					42.00
	preparer.						
43.00	Enter the telephone number and email address of	the cost					43.00
	report preparer in columns 1 and 2, respectively	у.					

<sup>11/28/2018 4:47</sup> pm Y: \28750 - St. Vincent Randolph\300 - Medicare Cost Report\20180630\HFS Files\28750-18.mcrx

	Financial Systems S AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		OLPH HOSPITAL Provider CO	CN: 15-1301	Peri od:	u of Form CMS- Worksheet S-3	
					From 07/01/2017 To 06/30/2018	Part I	pared
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available 3.00	4,00	5.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2.00	9, 12			1.0
. 00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	00.00	20	, 12	01,020.00		1.0
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.0
. 00 . 00	HMO IPF Subprovider HMO IRF Subprovider						3.0
i. 00	Hospital Adults & Peds. Swing Bed SNF					0	
5.00 5.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF					0	
. 00	Total Adults and Peds. (exclude observation		25	9, 12	34, 320. 00		
	beds) (see instructions)						
. 00	INTENSIVE CARE UNIT						8.
. 00	CORONARY CARE UNIT						9.
0. 00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGI CAL INTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY	43.00	0.5			0	
4.00	Total (see instructions)		25	9, 12	34, 320. 00	0	
5.00 6.00	CAH visits SUBPROVIDER - IPF					0	15. 16.
7.00	SUBPROVIDER - IRF						17.
8.00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.
D. 00	NURSI NG FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY						22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
4.00	HOSPI CE						24.
1. 10	HOSPICE (non-distinct part)	30.00					24.
5.00	CMHC - CMHC						25.
5.00	RURAL HEALTH CLINIC						26.
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
7.00	Total (sum of lines 14-26)		25			_	27.
8.00	Observation Bed Days					0	
9.00	Ambulance Trips						29.
0.00 1.00	Employee discount days (see instruction) Employee discount days - IRF						30.
2.00	Labor & delivery days (see instructions)		0		0		31.
2.00	Total ancillary labor & delivery room		0		0		32.
∠. ∪⊺	outpatient days (see instructions)						JZ.
3.00	LTCH non-covered days						33.
	LTCH site neutral days and discharges						33.

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA	AL DATA	Provider CC	F	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part I Date/Time Pre 11/28/2018 4:	pared:
	I/P Days	/ O/P Visits	/ Trips	Full Time E		
Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
<ul> <li>NO Hospital Adults &amp; 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)</li> <li>NO HMO and other (see instructions)</li> <li>HMO and other (see instructions)</li> <li>HMO IPF Subprovider</li> <li>HMO HASPITAL Adults &amp; Peds. Swing Bed SNF</li> <li>HMO Hospital Adults &amp; Peds. Swing Bed SNF</li> <li>Hoo Hospital Adults &amp; Peds. (exclude observation beds) (see instructions)</li> <li>O Total Adults and Peds. (exclude observation beds) (see instructions)</li> <li>O Total Adults CARE UNIT</li> <li>O CORONARY CARE UNIT</li> <li>O SURGICAL INTENSIVE CARE UNIT</li> <li>O OTHER SPECIAL CARE (SPECIFY)</li> <li>O NURSERY</li> <li>O Total (see instructions)</li> <li>O CAH visits</li> <li>O SUBPROVIDER - IPF</li> <li>O SUBPROVIDER</li> </ul>	563 14, 146	29 67 1, 089	1, 430 1, 430 1, 471 1, 471 1, 902 46, 434	0.00	87.63	15.00 16.00 17.00 18.00
<ul> <li>9.00 SKILLED NURSING FACILITY</li> <li>0.00 NURSING FACILITY</li> <li>1.00 OTHER LONG TERM CARE</li> <li>2.00 HOME HEALTH AGENCY</li> <li>3.00 AMBULATORY SURGICAL CENTER (D. P.)</li> <li>4.00 HOSPICE</li> <li>4.10 HOSPICE (non-distinct part)</li> <li>5.00 CMHC - CMHC</li> <li>6.00 RURAL HEALTH CLINIC</li> <li>6.25 FEDERALLY QUALIFIED HEALTH CENTER</li> <li>7.00 Total (sum of lines 14-26)</li> <li>8.00 Observation Bed Days</li> <li>9.00 Ambulance Trips</li> <li>0.00 Employee discount days (see instruction)</li> <li>1.00 Employee discount days - IRF</li> <li>2.00 Labor &amp; delivery days (see instructions)</li> <li>2.01 Total ancillary labor &amp; delivery room outpatient days (see instructions)</li> <li>3.00 LTCH non-covered days</li> <li>3.01 LTCH site neutral days and discharges</li> </ul>		0 0 36	( 338 16 ( 148	0.00 0.00	0. 00 87. 63	

1.00 Hos 8 e Hos for 2.00 HMC 3.00 HMC 4.00 HMC 5.00 Hos 6.00 Hos 7.00 Tot bec 8.00 INT 9.00 COP 10.00 BUF 11.00 SUF 12.00 OTF 13.00 NUF 14.00 Tot 15.00 CAP 16.00 SUE 17.00 SUE	AND HOSPITAL HEALTH CARE COMPLEX STATISTIC, Component spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IPF Subprovider 0 IPF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation	Full Time Equivalents Nonpaid Workers 11.00	Title V 12.00 0	-		Total All Patients 15.00	pared:
8 e Hos for 2.00 HMC 3.00 HMC 5.00 Hos 6.00 Hos 7.00 Tot bec 8.00 INT 9.00 COP 10.00 BUF 11.00 SUF 12.00 OTH 13.00 NUF 14.00 Tot 15.00 CAP	spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation	Equivalents Nonpaid Workers	12.00	Title XVIII 13.00 14	Ti tl e XI X 14.00 3 27	Pati ents 15.00	1.00
8 e Hos for 2.00 HMC 3.00 HMC 5.00 Hos 6.00 Hos 7.00 Tot bec 8.00 I NT 9.00 COP 10.00 BUF 11.00 SUF 12.00 OTH 13.00 NUF 14.00 Tot 15.00 CAP	spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation	Workers	12.00	13.00 14	14.00 3 27	Pati ents 15.00	1.00
8 e Hos for 2.00 HMC 3.00 HMC 5.00 Hos 6.00 Hos 7.00 Tot bec 8.00 I NT 9.00 COP 10.00 BUF 11.00 SUF 12.00 OTH 13.00 NUF 14.00 Tot 15.00 CAP	exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation			14	3 27	15.00	1.00
8 e Hos for 2.00 HMC 3.00 HMC 5.00 Hos 6.00 Hos 7.00 Tot bec 8.00 I NT 9.00 COP 10.00 BUF 11.00 SUF 12.00 OTH 13.00 NUF 14.00 Tot 15.00 CAP	exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation	11.00		14	3 27		1.00
8 e Hos for 2.00 HMC 3.00 HMC 5.00 Hos 6.00 Hos 7.00 Tot bec 8.00 INT 9.00 COP 10.00 BUF 11.00 SUF 12.00 OTH 13.00 NUF 14.00 Tot 15.00 CAP	exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation		0			307	1.00
Hos           for           2.00         HMC           3.00         HMC           4.00         HMC           5.00         Hos           6.00         Hos           7.00         Tot           bec         E           8.00         INT           9.00         COF           10.00         BUF           11.00         SUF           12.00         OTH           13.00         NUF           14.00         Tot           15.00         CAH           16.00         SUE           17.00         SUE	spice days)(see instructions for col. 2 r the portion of LDP room available beds) O and other (see instructions) O IPF Subprovider O IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation			3	4 125		
for           2.00         HMC           3.00         HMC           4.00         HMC           5.00         Hos           6.00         Hos           7.00         Tot           bec         B.00           9.00         COF           11.00         SUF           12.00         OTH           13.00         NUF           14.00         Tot           15.00         CAH           16.00         SUE           17.00         SUE	r the portion of LDP room available beds) O and other (see instructions) O IPF Subprovider O IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation			3	1 125		1
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3.00         HMC           4.00         HMC           5.00         Hos           6.00         Hos           7.00         Tot           8.00         INT           9.00         COF           10.00         BUF           11.00         SUF           12.00         OTF           13.00         NUF           14.00         Tot           15.00         CAF           16.00         SUF           17.00         SUF	0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation				4 135		2.00
5.00 Hos 6.00 Hos 7.00 Tot bec 8.00 I NT 9.00 COP 10.00 BUF 11.00 SUF 12.00 OTH 13.00 NUF 14.00 Tot 15.00 CAH 16.00 SUE 17.00 SUE	spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation				0		3.00
6.00 Hos 7.00 Tot bee 8.00 INT 9.00 COR 10.00 BUF 11.00 SUF 12.00 OTH 13.00 NUF 14.00 Tot 15.00 CAH 16.00 SUE 17.00 SUE	spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation				0		4.00
7.00         Total bec           8.00         INT           9.00         COR           10.00         BUF           11.00         SUF           12.00         OTH           13.00         NUF           14.00         Total           15.00         CAR           16.00         SUF           17.00         SUF	tal Adults and Peds. (exclude observation						5.00
bec           8.00         I NT           9.00         COR           10.00         BUF           11.00         SUF           12.00         OT+           13.00         NUF           14.00         Tot           15.00         CAF           16.00         SUF           17.00         SUF							6.00
8.00         INT           9.00         COF           10.00         BUF           11.00         SUF           12.00         OTF           13.00         NUF           14.00         Tot           15.00         CAF           16.00         SUE           17.00         SUE							7.00
9.00         COF           10.00         BUF           11.00         SUF           12.00         OTF           13.00         NUF           14.00         Tot           15.00         CAF           16.00         SUF           17.00         SUF	ds) (see instructions)						
10.00         BUF           11.00         SUF           12.00         OTF           13.00         NUF           14.00         Tot           15.00         CAF           16.00         SUF           17.00         SUF	TENSI VE CARE UNI T						8.00
11.00         SUF           12.00         OTH           13.00         NUF           14.00         Tot           15.00         CAH           16.00         SUF           17.00         SUF	RONARY CARE UNI T						9.00
12.00         0TH           13.00         NUF           14.00         Tot           15.00         CAH           16.00         SUE           17.00         SUE	RN INTENSIVE CARE UNIT						10.00
13.00         NUF           14.00         Tot           15.00         CAF           16.00         SUE           17.00         SUE	RGI CAL I NTENSI VE CARE UNI T						11.00
14.00 Tot 15.00 CAH 16.00 SUE 17.00 SUE	HER SPECIAL CARE (SPECIFY)						12.00
15. 00 CAH 16. 00 SUE 17. 00 SUE	RSERY	0.00		14		500	13.00
16.00 SUE 17.00 SUE	tal (see instructions)	0.00	0	14	3 27	509	14.00
17.00 SUE	H visits BPROVIDER - IPF						15.00 16.00
	BPROVIDER - IRF						17.00
	BPROVIDER						18.00
	ILLED NURSING FACILITY						19.00
1	RSING FACILITY						20.00
	HER LONG TERM CARE						21.00
1	ME HEALTH AGENCY						22.00
23.00 AME	BULATORY SURGICAL CENTER (D. P.)						23.00
24.00 HOS	SPICE						24.00
24.10 HOS	SPICE (non-distinct part)						24.10
25.00 CMH	HC – CMHC						25.00
	RAL HEALTH CLINIC						26.00
26. 25 FEI	DERALLY QUALIFIED HEALTH CENTER	0.00					26.25
	tal (sum of lines 14-26)	0.00					27.00
	servation Bed Days						28.00
	bul ance Tri ps						29.00
	ployee discount days (see instruction)						30.00
	ployee discount days - IRF						31.00
	bor & delivery days (see instructions)						32.00
							32.01
	tal ancillary labor & delivery room				b		33.00
33.00 LTC 33.01 LTC	tal ancillary labor & delivery room tpatient days (see instructions) CH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA       Provider CCM: 15-1331       For distructions for 0.07/1000       To distructions for 0.07/10000       To distructions for 0.07/	Heal th	Financial Systems ST. VINCENT RANDOLPH	HOSPI TAL	In Lie	eu of Form CMS-2	2552-10		
To         06/30/2015         DutorTime Prepared: 11/22/20138 4.7 J pm           100         Cost to charge ratio (Worksheet C. Part I line 202 column 3 divided by line 202 column 8) Medicaid (see instructions for each line)         1.00           2.00         Not revenue From Medicaid         1.700, 145         2.00           0.00 Did your receive DSH or supplemental payments from Medicaid?         1.700, 145         2.00           0.01 Did your receive DSH or supplemental payments from Medicaid?         1.700, 145         2.00           0.01 Did your receive DSH mether DSH and/or supplemental payments from Medicaid?         1.00         2.01         1.700, 145         2.00           0.01 Difference between theres DSH and/or supplemental payments from Medicaid?         1.00         2.01         1.00         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         2.01         1.02         1.02         1.02         1.02         1.02				Peri od:	Worksheet S-1			
Incomponentated and indigent care cost computation         1.00           Incomponentated and indigent care cost computation         1.00           Incomponentated cost is through ratio (dorishet cost computation)         1.00           Incomponentated cost is instructions for each line)         1.00           Incomponentated cost is instructions for each line)         1.00           Int is is yes, does line 2 include all DSH and/or supplemental payments from Medical does line 2 include all DSH and/or supplementated payments from Medical does line 2 include all DSH and/or supplementated payments from Medical does line 2 include all DSH and/or supplementated payments from Medical does line 2 include all DSH and/or supplementated payments from Medical does line 2 include all DSH and/or supplementated payments from Medical does line 2 and 5: if 4.52.327           If ine a is now, does line 2 include all DSH and/or supplementated payments from Medical does line 2 and 5: if 4.52.327         0.00           If the all is period and one CHP cost line 1 times line 10         0.00         0.00         0.00           If one line cost line 1 times line 10         0.00         0.00         0.00         0.00           If one line cost line 1 digent care program (See instructions for each line)         0.00         0.00         0.00           If one line cost line 1 digent care program (See instructions for each line)         0.00         0.00         0.00           If one line cost line 1 digent care program (See instructions for each line)					Data /Tima Dra	nored.		
Image: construction of the second s				10 06/30/2018	11/28/2018 4:	pared: 47 pm		
Bucompensated and indigent care cost computation								
1.00       Cost to charge ratio (Worksheet C, Part I line 202 column 3) divided by line 202 column 8)       0.260924       1.00         2.00       Net revenue from Medicald       1.790,145       2.00         3.00       Did you receive DSK or supplemental payments from Medicaid?       N       3.00         4.00       If i line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?       N       4.00         0.01       If i line 4 is no, then enter DSH and/or supplemental payments from Medicaid?       N       4.00         0.01       Medicaid cost (line 1 times line 6)       23.617,498       6.00         0.01       Medicaid cost (line 1 times line 6)       9.00       Net revenue from stand-alone CHIP (see instructions for each line)       9.00         9.00       Net revenue from stand-alone CHIP (see instructions for each line)       0       9.00       10.00         9.00       Net revenue from stand-alone CHIP (see instructions for each line)       0       10.00       11.00         10.00       Stand-alone CHIP cost (line 1 times line 10)       0       11.00       11.00       11.00         10.00       Net revenue from state or local indigent care program (Not included in lines 2, 5 or 9)       0       13.00         10.00       Stand-alone CHIP cost for mathematine score time formathy for Medicaid, CHIP and state/local indigent care pr		Uncompanyated and indigent care eact computation			1.00			
Medicaid (see instructions for each line)         Head caid         1,700,142         2.00           00         Net revenue from Medicaid         1,700,142         2.00         3.00           01         Ju urceive DSH or supplemental payments from Medicaid?         1,700,146         3.00         3.00           01         If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?         3.00         3.00           0.00         Medicaid charges         1 incs.11ne 4.0         6.10,237         6.00         5.00           0.01         If rence between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if         4.372,227         8.00           0.01         Stand-alone CHP corparam (CHP) (see instructions for each line)         0         0         0.00           0.01         Stand-alone CHP corparam (CHP) (see instructions for each line)         0         10.00         11.00           12.00         Difference between ret revenue and costs for stand-alone CHP corparam (see instructions for each line)         0         11.00           12.00         Difference between ret revenue and costs for state or local indigent care program (lot line luded in lines 6 or 10.00         0         14.00           14.00         Difference between net revenue and costs for state or local indigent care program (lot included in lines 6 or 10.00         0	1 00		hed by line 202 colu	mn 8)	0.260924	1 00		
2.00       Net revenue from Medicaid       1, 790, 145       2.00         0.00       Did you receive DSI or supplemental payments from Medicaid?       1, 790, 145       2.00         4.00       If line 3 is sy, does line 2 include all DSI and/or supplemental payments from Medicaid?       N       3.00         4.00       If line 4 is no, the menter DSI and/or supplemental payments from Medicaid?       N       4.00         6.00       Medicaid cost (line 1 times line 6)       0.00       0.00       2.3,617,498       0.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       4.372,227       8.00         9.00       Stand-alone CHP charages       0       9.00       10.00       9.00       9.00       10.00       9.00       10.00       9.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       11.00       10.00       15.00       15.00       15.00       15.00       15.00 <td>1.00</td> <td></td> <td>led by The 202 cord</td> <td></td> <td>0.200724</td> <td>1.00</td>	1.00		led by The 202 cord		0.200724	1.00		
4.00       If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?       4.00         5.00       If line 4 is no, then enter DSH and/or supplemental payments from Medicaid       5.00         6.00       Medicaid cost (line 1 times line 6)       23.617.498       6.00         8.00       Difference between net revolue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if       4.372,227       8.00         0.00       Stand-alone CHP cost (line 1 times line 10)       0	2.00				1, 790, 145	2.00		
5.00       If line 4 is no, then enter DSH and/or supplemental payments from Medicaid       0       5.00         6.00       Medicaid cost (line 1 times line 6)       0.10       23.617.496       6.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       4.372.327       8.00         9.00       Net revenue from stand-alone CHP       0       9.00       0	3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00		
6.00       Hedicaid charges       23, 617,498       6.00         7.00       Hedicaid cost (line 1 times line 6)       6.16,2,372       7.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       4,372,227         8.00       Stand-alone CHP charges       0       0         10.00       Stand-alone CHP charges       0       0         11.00       Stand-alone CHP charges       0       0         12.00       Difference between net revenue and costs for stand-alone CHP (line 11 minus line 9; if < zero then enter zero)				cai d?				
7.00       Medicaid cost (Line 1 times line 6)       6.162.372       7.00         8.00       Difference between net revenue and costs for Wedicaid program (Line 7 minus sum of Lines 2 and 5; if       4.372.227       8.00         9.00       Net revenue from stand-alone CHP       0       9.00       0.100       Stand-alone CHP Charges       0       9.00         9.00       Stand-alone CHP cost (Line 1 times line 10)       0       11.00       0       11.00         12.00       Difference between net revenue and costs for stand-alone CHP (Line 11 minus line 9; if < zero then enter zero).			n Medicaid		-			
8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       4, 372, 227       8.00         Children's Health Insurance Program (CHIP) (see instructions for each line)       0       9.00       0<								
c. zero them enter zero)       0         Children's Healt Insurance Program (CHLP) (see instructions for each line)       0         9.00       Net revenue from stand-al one CHLP       0         10.00       Stand-al one CHLP charges       0         11.00       Stand-al one CHLP cost (line 1 times line 10)       0         12.00       Difference between net revenue and costs for stand-al one CHLP (line 11 minus line 9; if < zero then one ter zero)			no 7 minus sum of l	ince 2 and E. if				
Children's Health Insurance Program (CHIP) (see instructions for each line)       9,00         Not revenue from Stand-alone CHIP cost (line 1 times line 10)       0         10:00 Stand-alone CHIP cost (line 1 times line 10)       0         12:00 Other state or local government indigent care program (set included on lines 2, 5 or 9)       0         14:00 Charges for patients covered under state or local indigent care program (Not included on lines 2, 5 or 9)       0         15:00 State or local indigent care program (set included on lines 2, 5 or 9)       0         16:00 Difference between net revenue and costs for state or local indigent care program (Not included on lines 6 or 10)       0         10:00 Not revenue from state or local indigent care program (Not included on lines 6 or 10)       0       15.00         16:00 Difference between net revenue and costs for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)       0       15.00         17:00 Private grants, donations, or endowment lincome restricted to funding charity care instructions for each line)       0       17.00         19:00 Total unrel Moursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 4, 372, 227       19.00         19:00 Total unrel Moursed or for Medicaid , CHIP and state and local indigent care programs (sum of lines 4, 372, 227       19.00         10:00 Cot patients approved for charity care and uninsured discounts (see instructions)       1.60       7.460.565       2.00	0.00		THE 7 INITIUS SUIT OF T	Thes z and 5, Th	4, 372, 227	0.00		
9.00       Net revenue from stand-alone CHIP       0       9.00         0.00       Stand-alone CHIP cost (line 1 times line 10)       0       0         12.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero).			each line)					
11.00       Stand-atone CHIP cost (line 1 times line 10)       0	9.00		,		0	9.00		
12.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then of the state or local government indigent care program (see instructions for each line)	10.00	Stand-al one CHIP charges			0	10.00		
enter zero)       enter zero)         13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0         14.00       Charges for patients covered under state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       0       15.00       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line)       0       15.00         17.00       Private grants, donations, or endowment income restricted to funding charity care instructions for each line)       0       17.00         17.00       Rorinst, donations, or endowment income restricted to funding charity care programs (sum of lines 4, 322, 227       0       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 4, 322, 227       19.00         19.00       Cost of patients appropriations or transfers for support of hospital operations       1.00       2.00       3.00         19.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1.670,758       7,460,565       20.00         10.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1.670,758       3.181,458       21.00 </td <td>11.00</td> <td></td> <td></td> <td></td> <td>-</td> <td></td>	11.00				-			
Uther state or local government indigent care program (Net included on lines 2, 5 or 9)         0         13.00           13.00         Net revenue from state or local indigent care program (Net included on lines 2, 5 or 9)         0         13.00           14.00         Charges for patients covered under state or local indigent care program (Net included in lines 6 or 10)         0         14.00           15.00         State or local indigent care program cost (line 1 times line 14)         0         15.00           16.00         Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0)         0           17.00         Private grants, donations, or endowment income restricted to funding charity care         0         17.00           18.00         Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 4, 372, 227         0         18.00           19.00         Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 4, 372, 227         19.00           19.00         Total unreimbursed care (see instructions for each line)         1.00         2.00         3.00           10.00         Covernment grants, appropriate spread discounts for the entire facility (see instructions)         1.670.758         7.460.565         20.00           10.00         Cot of patients approved for charity care and uninsured discounts (see instructions)	12.00		ne 11 minus line 9;	if < zero then	0	12.00		
13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13)       0       15.00         17.00       Private grants, donations, or endownent income restricted to Funding charity care instructions for each line)       0       17.00         17.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 4, 372, 227       0       0         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 4, 372, 227       19.00         19.00       Total unreimbursed cost for charity care and uninsured discounts for the entire facility (see instructions)       1.00       2.00       3.00         19.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1.500       1.600, 55       20.00         10.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1.600, 57, 788, 807       1.670, 758       3.181, 458       21.00         21.00<			ations for each lin					
14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13)       0       15.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       0       0       17.00         18.00       Total unreimbursed cost for Medicaid , CHIP and state/local indigent care programs (sum of lines 8, 12 and 16)       0       17.00       0       0       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)       0       17.00       2.00       0       18.00         20.00       Cotarity care charges and uninsured discounts for the entire facility (see instructions)       1.600       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       0       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2	13 00				0	13 00		
10)       10.0								
16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero).								
13: If < zero then enter zero)	15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00		
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)       17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00       4,372,227       19.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines a, 12 and 16)       10.00       2.00       3.00         19.00       Charity care charges and uninsured discounts for each line)       1.00       2.00       3.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       5,789,807       1,670,758       7,460,565       20.00         10.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1,510,700       1,670,758       3,181,458       21.00         22.00       Payments received from patients for amounts previously written off as charity care       1,00       22.00       2.843,370,73       22.00         23.00       Cost of charity care (line 21 minus line 22)       1,222,103       1,622,282       2.844,382       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit       N       24.00 <td>16.00</td> <td colspan="7"></td>	16.00							
instructions for each line)       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       17.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       4, 372, 227       19.00         19.00       Incompensated Care (see instructions for each line)       0       2.00       3.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       5,789,807       1,670,758       7,460,565       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1,510,700       1,670,758       3,181,458       21.00         22.00       Payments received from patients for amounts previously written off as charity care       1,222,103       1,622,282       2,844,385       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit       N       24.00         imposed on patients covered by Medicaid or other indigent care program?       1,095,214       26.00         25.00       If line 24 is yes, enter								
17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       4, 372, 227       19.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       Total (col. 1       + col. 2)         19.00       Uninsured patients       Insured patients       - fotal (col. 1       + col. 2)         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       5, 789, 807       1, 670, 758       7, 460, 565       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1, 510, 700       1, 670, 758       3, 181, 458       21.00         22.00       Payments received from patients for amounts previously written off as charity care       1, 222, 103       1, 622, 282       2, 844, 385       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1, 00       24.00         25.00       Total bad debt expense for the entire hospital complex (see instruction			and state/local inc	igent care prograi	ns (see			
18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       4, 372, 227       19.00         19.00       8, 12 and 16)       Uninsured patients       Insured patients       Total (col. 1 + col. 2)         10.00       2.00       3.00       2.00       3.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       5, 789, 807       1, 670, 758       7, 460, 565       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1, 510, 700       1, 670, 758       3, 181, 458       21.00         22.00       Payments received from patients for amounts previously written off as charity care       288, 597       48, 476       337, 073       22.00         23.00       Cost of charity care (line 21 minus line 22)       1, 222, 103       1, 622, 282       2, 844, 385       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit inposed on patients covered by Medicaid or other indigent care program?       1       0       25.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit in tary l	17.00		ding charity care		0	17.00		
8, 12 and 16)       Uninsured patients       Insured patients       Insured patients       Insured patients       Total (col. 1 + col. 2)         20.00       Charity care (see instructions for each line)       1.00       2.00       3.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       5, 789, 807       1, 670, 758       7, 460, 565       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1, 510, 700       1, 670, 758       3, 181, 458       21.00         22.00       Payments received from patients for amounts previously written off as charity care       288, 597       48, 476       337, 073       22.00         23.00       Cost of charity care (line 21 minus line 22)       1, 222, 103       1, 622, 282       2, 844, 385       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1       0       25.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       1, 095, 214       26.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       1, 095, 214       26.00         27.01       Medicare alowable bad de	18.00	Government grants, appropriations or transfers for support of hos	spital operations		0	18.00		
Uncompensated Care (see instructions for each line)Uninsured patientsInsured patientsTotal (col. 1 + col. 2)20.00Charity care charges and uninsured discounts for the entire facility (see instructions)5, 789, 8071, 670, 7587, 460, 56520.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)1, 510, 7001, 670, 7583, 181, 45821.0022.00Payments received from patients for amounts previously written off as charity care288, 59748, 476337, 07322.0023.00Cost of charity care (line 21 minus line 22)1, 222, 1031, 622, 2822, 844, 38523.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?1, 0025.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit1, 095, 21426.0026.00Total debt expense for the entire hospital complex (see instructions)1, 095, 21426.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)137, 65428.0027.01Medicare and non-reimbursable Medicare bad debt expense (see instructions)371, 06329.0028.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371, 06329.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371, 06329.0029.00C	19.00		ndigent care progra	ms (sum of lines	4, 372, 227	19.00		
patientspatients+ col. 2)1.002.003.0020.00Charity care (see instructions for each line)20.00Charity care charges and uninsured discounts for the entire facility (see instructions)5, 789, 8071, 670, 7587, 460, 56520.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)1, 510, 7001, 670, 7583, 181, 45821.0022.00Payments received from patients for amounts previously written off as charity care288, 59748, 476337, 07322.0023.00Cost of charity care (line 21 minus line 22)1, 222, 1031, 622, 2822, 844, 38523.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1, 095, 21426.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)957, 56027.0128.00Cost of nucompensated care (line 23 column 3 plus line 29)3, 215, 44830.00			Uni nsure	d Insured	Total (col. 1			
Uncompensated Care (see instructions for each line)20.00Chari ty care charges and uninsured discounts for the entire facility (see instructions)5, 789, 8071, 670, 7587, 460, 56520.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)1, 510, 7001, 670, 7583, 181, 45821.0022.00Payments received from patients for amounts previously written off as charity care clarity care288, 59748, 476337, 07322.0023.00Cost of charity care (line 21 minus line 22)1, 222, 1031, 622, 2822, 844, 38523.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?1, 095, 21426.0026.00Total bad debt expense for the entire hospital complex (see instructions)1, 095, 21426.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)1, 095, 21426.0027.01Son Mon-Medicare allowable bad debts for the entire hospital complex (see instructions)957, 56027.0128.00Cost of non-Medicare and non-reimbursable bad debt expense (see instructions)371, 06329.0029.00Cost of non-Medicare and non-reimbursable bad debt expense (see instructions)371, 06329.0030.00Cost of non-Medicare and non-reimbursable bad debt expense (see instructions)371, 06329.0								
20. 00Charity care charges and uninsured discounts for the entire facility (see instructions)5, 789, 807 1, 670, 7581, 670, 758 7, 460, 56520. 0021. 00Cost of patients approved for charity care and uninsured discounts (see instructions)1, 510, 7001, 670, 7583, 181, 45821. 0022. 00Payments received from patients for amounts previously written off as charity care288, 59748, 476337, 07322. 0023. 00Cost of charity care (line 21 minus line 22)1, 222, 1031, 622, 2822, 844, 38523. 001. 0024. 00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25. 00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025. 0026. 00Total bad debt expense for the entire hospital complex (see instructions)1, 095, 21426. 0027. 01Medicare allowable bad debts for the entire hospital complex (see instructions)1, 095, 21426. 0027. 01Medicare allowable bad debts for the entire hospital complex (see instructions)957, 56428. 0128. 00Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)337, 05329. 0029. 00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)33, 215, 44830. 00		1	1.00	2.00	3.00			
(see instructions)1, 670, 7583, 181, 45821.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)1, 510, 7001, 670, 7583, 181, 45821.0022.00Payments received from patients for amounts previously written off as charity care288, 59748, 476337, 07322.0023.00Cost of charity care (line 21 minus line 22)1, 222, 1031, 622, 2822, 844, 38523.001.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1, 095, 21426.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)957, 56027.0128.00Non-Medicare bad debt expense (see instructions)1371, 06329.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371, 06329.0030.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371, 06329.0030.00Cost of nucompensated care (line 23 column 3 plus line 29)3, 215, 44830.00	~~ ~~			007 1 (70 750	7 4 6 5 6			
21.00Cost of patients approved for charity care and uninsured discounts (see instructions)1, 510, 7001, 670, 7583, 181, 45821.0022.00Payments received from patients for amounts previously written off as charity care288, 59748, 476337, 07322.0023.00Cost of charity care (line 21 minus line 22)1, 222, 1031, 622, 2822, 844, 38523.001.001.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1, 095, 21426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)622, 41427.0028.00Non-Medicare bad debt expense (see instructions)137, 65428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371, 06329.0030.00Cost of non-Medicare (line 23 column 3 plus line 29)3, 215, 44830.00	20.00		ity 5, 789,	807 1,670,758	7, 460, 565	20.00		
instructions)1222.00Payments received from patients for amounts previously written off as charity care288,59748,476337,07322.0023.00Cost of charity care (line 21 minus line 22)1,222,1031,622,2822,844,38523.001.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1,095,21426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)1,095,21426.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)957,56027.0128.00Non-Medicare bad debt sfor the entire hospital complex (see instructions)137,65428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371,06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,215,44830.00	21 00		ts (see 1 510	700 1 670 758	3 181 458	21 00		
charity care 23.00charity care (line 21 minus line 22)1, 222, 1031, 622, 2822, 844, 38523.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1, 095, 21426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)1, 095, 21426.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)957, 56027.0128.00Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371, 06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3, 215, 44830.00	21.00			1,010,100	0,101,100	21.00		
23.00       Cost of charity care (line 21 minus line 22)       1, 222, 103       1, 622, 282       2, 844, 385       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       N       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       0       25.00       0       1, 095, 214       26.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       1, 095, 214       26.00       26.00         27.01       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       1, 095, 214       26.00         28.00       Non-Medicare bad debt expense (see instructions)       957, 60       27.01         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       371, 063       29.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       3, 215, 448       30.00	22.00	Payments received from patients for amounts previously written or	°f as 288,	597 48, 476	337, 073	22.00		
24. 00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit       N       24. 00         25. 00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       N       25. 00         25. 00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       N       25. 00         26. 00       Total bad debt expense for the entire hospital complex (see instructions)       1, 095, 214       26. 00         27. 00       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       1, 095, 214       26. 00         27. 01       Medicare allowable bad debts for the entire hospital complex (see instructions)       622, 414       27. 00         28. 00       Non-Medicare bad debt expense (see instructions)       957, 560       27. 01         28. 00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       371, 063       29. 00         30. 00       Cost of uncompensated care (line 23 column 3 plus line 29)       3, 215, 448       30. 00	~~ ~~		1 000					
24.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limitN24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1,095,21426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)622,41427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)957,56027.0128.00Non-Medicare bad debt expense (see instructions)137,65428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371,06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,215,44830.00	23.00	Cost of charity care (line 21 minus line 22)	1, 222,	103 1, 622, 282	2,844,385	23.00		
24.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limitN24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1,095,21426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)622,41427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)957,56027.0128.00Non-Medicare bad debt expense (see instructions)137,65428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371,06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,215,44830.00					1 00			
imposed on patients covered by Medicaid or other indigent care program?25.001f line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit25.0026.00Total bad debt expense for the entire hospital complex (see instructions)1,095,21426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)1,095,21426.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)622,41427.0028.00Non-Medicare bad debt expense (see instructions)137,65428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371,06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,215,44830.00	24.00	Does the amount on line 20 column 2, include charges for patient	days beyond a lengt	h of stay limit		24.00		
stay limit1,095,21426.0026.00Total bad debt expense for the entire hospital complex (see instructions)1,095,21426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)622,41427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)957,56027.0128.00Non-Medicare bad debt expense (see instructions)137,65428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371,06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,215,44830.00		imposed on patients covered by Medicaid or other indigent care pl	rogram?	-				
26.00Total bad debt expense for the entire hospital complex (see instructions)1,095,21426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)622,41427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)957,56027.0128.00Non-Medicare bad debt expense (see instructions)137,65428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371,06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,215,44830.00	25.00		indigent care progr	am's length of	0	25.00		
27.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)622, 41427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)957, 56027.0128.00Non-Medicare bad debt expense (see instructions)137, 65428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371, 06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3, 215, 44830.00	26 00		cuctions)		1 005 214	26 00		
27.01Medicare allowable bad debts for the entire hospital complex (see instructions)957,56027.0128.00Non-Medicare bad debt expense (see instructions)137,65428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371,06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,215,44830.00								
28.00Non-Medicare bad debt expense (see instructions)137,65428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371,06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,215,44830.00								
29.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)371,06329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,215,44830.00								
			nse (see instruction	s)		29.00		
31.00  Total unreimbursed and uncompensated care cost (line 19 plus line 30) 7,587,675 31.00								
	31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)		7, 587, 675	31.00		

Health Financial Systems	ST. VINCENT RANDO	LPH HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (		Provider C		Period:	Worksheet A	
				rom 07/01/2017		
				o 06/30/2018	Date/Time Pre 11/28/2018 4:	
Cost Center Description	Sal ari es	Other	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	
GENERAL SERVICE COST CENTERS	1		1 10/ 10			
1.00 00100 CAP REL COSTS-BLDG & FLXT		1, 126, 131			1, 126, 131	
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	6 020	498, 682 2, 096, 871			498, 682 2, 090, 841	
5.00 00500 ADMINISTRATIVE & GENERAL	-6, 030 744, 713					
7.00 00700 OPERATION OF PLANT	68, 776	4, 597, 583 1, 132, 077			5, 342, 296 1, 200, 853	•
8.00 00800 LAUNDRY & LINEN SERVICE	00,770	75, 250			75, 250	
9. 00 00900 HOUSEKEEPING	-15, 245	453, 285			438, 040	•
10. 00 01000 DI ETARY	-13, 243	434, 990			202, 870	•
11. 00 01100 CAFETERI A	0	434, 770			232, 120	
13. 00 01300 NURSI NG ADMI NI STRATI ON	517, 205	54, 158			571, 363	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	21, 458			21, 462	•
15. 00 01500 PHARMACY	287, 785	1, 577, 175			1, 864, 960	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	1, 859			1, 859	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 586, 887	200, 724	1, 787, 611	-684, 887	1, 102, 724	30.00
43.00 04300 NURSERY	0	0	(	207, 895	207, 895	43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 O5000 OPERATI NG ROOM	349, 691	343, 633	693, 324		619, 668	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(		473, 760	
54.00 05400 RADI OLOGY-DI AGNOSTI C	671, 371	388, 886			1, 060, 336	•
57.00 05700 CT SCAN	0	0		-	0	•
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	85			0	
	0	1,807,444			1, 807, 444	
65. 00 06500 RESPIRATORY THERAPY	434, 348	71, 805			506, 153	
65. 01 03950 SLEEP LAB	117, 584	3, 011			120, 595	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	245, 381	13, 534 0			258, 915 16, 989	•
68.00 06800 SPEECH PATHOLOGY	16, 989 9, 957	0			9, 957	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 937	22, 610			129, 522	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 907			2, 907	
73. 00 07300 DRUGS CHARGED TO PATIENTS	190, 086	40, 715			210, 968	
OUTPATIENT SERVICE COST CENTERS	170,000	40,713	230,00	17,000	210,700	/ 5. 00
90. 00 09000 CLINIC	0	2, 797	2, 79	7 -2, 797	0	90.00
91. 00 09100 EMERGENCY	856, 010	1, 393, 759			2, 242, 377	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		.,,	_/	.,	_, _ , _ , _ ,	92.00
SPECIAL PURPOSE COST CENTERS				1		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 075, 508	16, 361, 429	22, 436, 937	7 0	22, 436, 937	118.00
NONREI MBURSABLE COST CENTERS	· · · · · ·	· · · ·			i	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0 0	0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	36, 715	8, 370	45, 085	ō 0	45, 085	192.00
194.00 07950 OTHER NRCC - PUBLIC RELATIONS	0	0	(	0 0	0	194.00
194.0107951 OTHER NRCC - FOUNDATION	212	6, 824	7,036	5 O		194. 01
194.0207952OTHER NRCC - GRANTS	4, 508	12, 870				194. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	6, 116, 943	16, 389, 493	22, 506, 436	5 O	22, 506, 436	200.00

 ST.
 VINCENT
 RANDOLPH
 HOSPITAL

 OF
 EXPENSES
 Provider
 CCN:
 15-1301
 Period:

In Lieu of Form CMS-2552-10 Worksheet A

To         06/30/2018         Date/Time         Prepared: 11/28/2018 4: 47 pm           Cost         Center         Description         Adjustments         Net         Expenses         To         06/30/2018 4: 47 pm           100         OttoOL CAP REL COSTS - NURLE COULT         -00.         7.00         -00.         7.00         -00. <t< th=""><th>RECLA</th><th>SSIFICATION AND ADJUSIMENTS OF IRIAL BALANCE O</th><th>F EXPENSES</th><th>Provider C</th><th>CN: 15-1301</th><th>From 07/01/2017</th><th>WORKSNEET A</th></t<>	RECLA	SSIFICATION AND ADJUSIMENTS OF IRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-1301	From 07/01/2017	WORKSNEET A
Cost Center Description         Adj ustments (See A.9)         Net Expenses for Allocation           1.00         Cond CAP REL COST - ELUG & FLXT         -601, 850         524, 281         1.00           2.00         DOXOG CAP REL COST-SHUGE & GUIP         0         498, 682         2.00           0.00         COM OPERATION OF PLANT         1, 593, 354         6, 535, 641         5.00           0.00         DOXOG DEPRATION OF PLANT         1, 593, 354         6, 535, 641         5.00           0.00         COM OPERATION OF PLANT         0         1, 200, 653         7.00           0.00         COM OPERATION OF PLANT         0         1, 200, 653         8.00           0.00         COM OPERATION OF PLANT         0         0         7.35         8.00           0.00         OTOG DIETARY         -0         202, 870         10.00         10.00           11.00         CARTON MIRSI KK AMAIN ISTRATION         -106         577, 257         13.00         13.00           13.00         OTAGO MIRSI KK AMAIN ISTRATION         -112, 803         989, 921         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00							
Cóse A-8)         For Al iocation           6.00         7.00           1.00         CONDO CAP REL COSTS -ENDLO & FIXT         -601, 850         524, 281         1.00           2.00         CONDO CAP REL COSTS -WILL E GUI P         0         498, 682         2.00           3.00         CONDO CAP REL COSTS -WILL E GUI P         0         498, 682         2.00           3.00         CONDO CHARTINO REPHITS DEPRANTMENT         -1, 706         2.089, 645         4.00           5.00         CONDO CHARTINO REPLANT         0         1, 200, 653         7.00           8.00         CONDO CHARTINO REPLANT         0         7.250         8.00           9.00         CONDO CHARTINO REPLANT         0         7.250         8.00           10.00         CONDO CHARTINO REPLANT         -64, 870         202, 670         110.00           11.00         CONDO CHARTINO REPLANT         -7.152         1, 863, 808         150.00           11.00         CHARTINO REPLANT         -7.175         1, 863, 808         150.00           12.00         CHARTINO REPLANT         -1.175         1, 863, 808         150.00           13.00         CHARTINO RUMENT REPLANT         -1.128, 803         499, 921         30.00           13.		Cost Center Description	Adiustments	Net Expenses			
GENERAL SERVICE COST CENTRES         1.00           1.00         000000 CAP REL COSTS-HUDG & FIXT         -601,850         524,281         1.00           2.00         00200 CAP REL COSTS-WUBLE EQUIP         0         448,682         2.00           0.00         00000 CMPUCYEE BERFITS DEPARTIENT         1.776         2.008,9045         4.00           5.00         00500 ADMINISTRATIVE & GENERAL         1.593,345         6.935,641         5.00           7.00         00700 OPERATION OF PLANT         0         1.200,853         7.00           8.00         000800 IAUNDRY & LINEN SERVICE         0         75,250         8.00           10.00         01000 OPERATION OF PLANT         0         2.02,870         10.00           11.00         01100 OLO CAFFERIA         -64,877         167,243         11.00           13.00         01300 NURSING ADMINISTRATION         -106         571,257         13.00           14.00         1400 OLANDINIS REVICE COST CENTERS         17,755         64         15.00           10.00         01000 AUNIST SERVICE COST CENTERS         30.00         473,760         52.00           52.00         05200 OLEVICEYR NOR ALAROR ROOM         -143,760         55.00         55.00           52.00         05400 OLA							
1.00     00100 (AP REL COSTS - MURL E OUIP     -601,850     524,281     1,00       2.00     0200 (CAP REL COSTS - MURL E OUIP     0,448,662     2,00       4.00     00400 (EMPLOYEE BENEFITS DEPARTMENT     -1,766     2,089,045     4,00       7.00     00700 (DPERATION OF PLANT     1,593,345     6,955,641     5,00       8.00     00800 (ADMIN ISTENTIVE & GENERIS ENVICE     0     75,250     8,00       9.00     00900 (NUSKEEPING     0     438,040     9,00       10.00     01000 (TATRY     0     22,870     11,00       11.00     01100 (AFTERIA ADMINISTRATION     -106,571,257     13,00       13.00     01300 (TATRAL, SERVICES & SUPPLY     -20     21,442     14,00       15.00     01600 (HDICAL, PECORDS & LI BEARY     -1,795     64     16,00       10.00     000000 (ADURSTING ADMINISTRATION     -112,803     999,921     30,00       30.00     03000 (ADURSTING ADMINISTRATION     -138,500     481,168     50,00       10.00     00000 (ADURSTING ADMINISTRATION     -172,603     999,921     30,00       30.00     03000 (ADURSTING ADMINISTRATION     -138,500     481,168     50,00       30.00     05000 (ADURSTING ROOM     -138,500     481,168     50,00       30.00     05000 (A				7.00	1		
2.00         00200 (AP REL COSTS_MUBLE EDUI P         0         498,682         2.00           4.00         0400 (DME)CYEE BERET IS DEPARTIMENT         1,796         2.008,045         4.00           5.00         00500 ADMIN STRATIVE & GENERAL         1,593,345         6,935,641         5.00           0.00         00500 (DMENCYEE BERENT IS DEPARTIMENT         1,200,853         7.00           0.00         00500 (MUSEKEPI NG         0         438,040         9.00           0.00         010.00 (DICATERIA         -64,877         167,243         11.00           11.00         01300 (URISING ADMINISTRATION         -106         571,257         13.00           0.00         01500 (MEDICAL RECORDS & LIBRARY         -1,755         64         15.00           10.00         01500 (MUSEKERY         -128,503         999,921         43.00           0.00         05000 OPENATINO ROM         -138,500         473,760         52.00           52.00         05500 OPELIVERY ROM & LABOR ROM         -143,760         52.00         550,00           52.00         05500 UPELIVERY ROM & LABOR ROM         -1445,1,664         56.00         56.00           52.00         05500 UPELIVERY ROM & LABOR ROM         -120,595         555,227         56.00         56.0		GENERAL SERVICE COST CENTERS					
4. 00       00400       EMPLOYEE BENEFITS DEPARTMENT       -1,796       2,089,045       4,00         5. 00       00700       PERATION OF PLANT       0,1200,833       7,00         6. 00       00000       LINEN SERVICE       0,75,250       8,00         9. 00       00000       LINEN SERVICE       0,438,400       9,00         10. 00       01000       LINEN SERVICE       0,75,250       10,00         11. 00       01100       CAPETERIA       -64,877       10,22,870       11,00         13. 00       01100       CAPETERIA       -64,877       16,3808       15,00         15. 00       01000       NURSI NG ADMINI STRATION       -1,152       1,863,808       16,00         16. 00       01000       ERVICE COST CENTERS       10,000       16,00       10,000	1.00	00100 CAP REL COSTS-BLDG & FIXT	-601, 850	524, 281			1.00
5. 00         00500 ADMINISTRATIVE & GENERAL         1, 593, 345         6, 925, 641         5. 00           7. 00         00700 OPERATION OF PLANT         0         1, 200, 853         7. 00           8. 00         00800 LAUMORY & LINEN SERVICE         0         75, 250         8. 00           9. 00         00900 HOUSEKEEPING         0         202, 870         10. 00           11. 00         1100 OLIDO CAFETERIA         -64, 877         11. 60, 300         13. 00           11. 00         CALSTRAL SERVICES & SUPPLY         -20         21, 442         14. 00           15. 00         DISOO PHAMARY Y         -1, 152         1, 663, 808         15. 00           16. 00         OIGO MEDICAL RECORDS & LIBRARY         -1, 795         64         16. 00           IMPATI ENT ROUTINE SERVICE COST CENTERS         -112, 803         969, 921         30. 00         30. 00           30. 00         03000 ADUIRS NR ROM         -138, 500         443, 168         50. 00           30. 00         05200 DELIVERV ROM & LABOR ROM         -138, 500         443, 168         50. 00           52. 00         05200 DELIVERV ROM & LABOR ROM         -138, 500         443, 166         52. 00           53. 00         05000 DESONARONTIC         -145         1, 060, 191	2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	498, 682			2.00
7.00         00700 (DPERATION OF PLANT         1.200, 853         7.00           8.00         00800 LAINDRY & LINEN SERVICE         0         75, 250         8.00           9.00         00000 LAINDRY & LINEN SERVICE         0         75, 250         9.00           10.00         01000 DIETARY         0         202, 870         10.00           11.00         01100 CAFETERIA         -64, 877         167, 243         11.00           13.00         01300 NURSI NG ADMINISTRATION         -106         571, 257         13.00           14.00         01400 CENTRAL SERVICES & SUPPLY         -20         21, 442         14.00           15.00         01500 PHARMACY         -1, 1752         1, 863, 80B         15.00           16.00         10600 MEDICAL RECORDS & LI BRARY         -1, 1795         64         16.00           10.00         0000 ADULTS & PEDIATRICS         -112, 803         989, 921         30.00           30.00         03000 NUBUS A KERVICE COST CENTERS         -0         207, 985         43.00           50.00         05000 DELIVERY NOM & LABOR ROOM         -138, 500         431, 168         52.00         52.00           50.00         05000 RESPR ATIORY THERAPY         -2,868         1,804, 576         55.00         55	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 796	2, 089, 045			4.00
8. 00         00800 [LAUNDRY & LINEN SERVICE         0         75, 250         8. 00           9.00         00900 [HOUSEKEEPING         0         238, 040         9. 00           10.00         01000 [LETARY         0         202, 870         10. 00           11.00         0100 [CAFETERIA         -64, 877         137, 243         11. 00           11.00         0100 CAFETERIA         -64, 877         13, 257         13. 00           14.00         01400 [CENTRAL SERVICES & SUPPLY         -2.0         21, 442         14. 00           15.00         01500 [PLARMACY         -1, 152         1, 863, 808         15. 00           15.00         01600 MEDI CAL RECORDS & LI BRARY         -1, 1765         64         16. 00           18.00         03000 AUNASERY         0         207, 895         43. 00           30.00         03000 AUNASERY         0         207, 895         43. 00           30.00         05200 DELIVERY ROOM & LABOR ROOM         -138, 500         64. 166. 00         57. 00           52.00         05200 ORD RADI LORY NOT LO RONGTI C         -145         1, 060, 191         54. 00           53.00         05000 ORSPIRATORY THERAPY         -2.668         1, 804, 756         55. 827           56.00 <td>5.00</td> <td>00500 ADMINISTRATIVE &amp; GENERAL</td> <td>1, 593, 345</td> <td>6, 935, 641</td> <td></td> <td></td> <td>5.00</td>	5.00	00500 ADMINISTRATIVE & GENERAL	1, 593, 345	6, 935, 641			5.00
9.00         00900 H0USEKEEPING         0         438.00         9.00           10.00         01000 DIETARY         0         202.870         10.00           13.00         01300 NURSING ADMINISTRATION         -106         571,257         13.00           14.00         01400 CENTRAL SERVICES & SUPPLY         -20         21,442         14.00           15.00         01500 PHARMACY         -1,175         1,863.808         15.00           16.00         01600 MEDICAL RECORDS & LI BRARY         -1,1795         64         16.00           10.00         03000 NURSIS PRV         0         207.95         43.00           43.00         04300 NURSIS PRV CC COST CENTERS         -112,803         989,921         30.00           50.00         05000 DELIVERY NOM & LABOR ROOM         -138,500         431.168         52.00           50.00         05000 DELIVERY NOM & LABOR ROOM         0         473,760         52.00           50.00         05600 DELIVERY NOM & LABOR ROOM         0         0         58.00           65.00         05600 MAGHETIC RESONNCE I MAGING (MRI )         0         0         58.00           66.00         06600 MAGENTAL THERAPY         -22.688         1,804,576         65.01           66.00	7.00	00700 OPERATION OF PLANT	0	1, 200, 853			7.00
10.00         01000         DIETARY         0         202.870         10.00           11.00         0100         CAFETERIA         -64.877         167.243         11.00           13.00         01300         NURSING ADMINI STRATION         -04.877         167.243         13.00           14.00         01400 CENTRAL SERVICES & SUPPLY         -20         2.1.42         14.00           15.00         01500 MEDICAL RECORDS & LIBRARY         -1.152         1.863.808         15.00           16.00         01600 MEDICAL RECORDS & LIBRARY         -1.795         64         16.00           10.000 MURSING SAULTS & PEDIATRICS         -112.803         989.921         30.00         30.00           30.00         03000 ADOULTS & FEDIATRICS         -11.803         989.921         30.00         30.00           30.00         03000 ADOUNTSERY         0         207.895         43.00         43.00           ANCILLARY SERVICE COST CENTERS         -145         1.060.91         52.00         52.00         52.00         65.00 (FASTING ROM         52.00         52.00         52.00         52.00         52.00         53.00         54.00         57.00         54.00         57.00         58.00         58.00         58.00         58.00         65	8.00	00800 LAUNDRY & LINEN SERVICE	0	75, 250			8.00
11.00       01100       CAFETERIA       -64.877       167.243       11.00         13.00       01300       NURSING ADIN IN STRATION       -10.6       571,257       14.00         14.00       01400       CENTRAL SERVICES & SUPPLY       -20       21.442       14.00         15.00       01500       PHARMACY       -1,152       1.8.03.808       15.00         0.00       03000       MURDICAL RECORDS & LIBRARY       -117.903       989.921       30.00         0.00       03000       AUGO ADULTS & SERVICE COST CENTERS       0       207.895       43.00         0.00       03000       AUGU RADICAR & LABOR ROOM       0       473.760       52.00       52.00         50.00       DESCOU PERATING ROMI       -138,500       481,168       50.00       52.00         50.00       DESCOU RADIC CONCE LIMAGING (MRI)       0       0       73.760       54.00         51.00       DESCOU RESPIRATIORY THERAPY       -22.668       1.8.04,576       60.00       60.00         65.00       DESON AREPTIC RATORY THERAPY       0       120.595       65.01       65.01         66.00       DEGON PERSPIRATORY THERAPY       0       120.595       65.01       65.01         66.00 <t< td=""><td>9.00</td><td>00900 HOUSEKEEPI NG</td><td>0</td><td>438, 040</td><td></td><td></td><td>9.00</td></t<>	9.00	00900 HOUSEKEEPI NG	0	438, 040			9.00
13.00       D1300       RURSI NG ADMI NI STRATI ON       -106       571, 257       13.00         14.00       D1400       CENTAL SERVI CES & SUPPLY       -20       21, 442       14.00         15.00       D1500       PHARMACY       -1, 152       1, 863, 808       15.00         16.00       D1600 MEDI CAL EECORDS & LI BRARY       -1, 795       64       16.00         18.00       D1600 MURES ERVI CE COST CENTERS       999, 921       30.00       30.00         30.00       03000 ADULTS & PEDI ATRI CS       -112, 803       989, 921       30.00         30.00       03000 MURES RY       0       207, 895       43.00         ANCILLARY SERVICE COST CENTERS       -112, 803       989, 921       30.00         0.00       05000 OPERATI NG ROM       -138, 500       481, 168       50.00         50.00       05200 DELI VERV ROM & LABOR ROM       0       473, 760       52.00         51.00       05700 CT SCAN       0       0       0       57.00         56.00       06500 MASNETI C RESONANCE I MAGI MG (MRI )       0       0       0       65.00         0.00       0600 CLABORATORY       -2,266 S1,827       65.01       66.01       66.01         60.00       06000 RESPI	10.00	01000 DI ETARY	0	202, 870			10.00
14.00       CHTRAL SERVICES & SUPPLY       -20       21, 442       14.00         15.00       01500       PHARMACY       -1, 152       1, 863, 808       15.00         10.00       D1600 MEDICAL RECORDS & LIBRARY       -1, 152       6.4       16.00         INPATTENT ROUTINE SERVICE COST CENTERS       -112, 803       989, 921       30.00         0.00       03000 ADULTS & PEDIATRICS       -112, 803       989, 921       30.00         43.00       04300 NURSERY       0       207, 895       43.00         50.00       05000 DELIVERY ROOM & LABOR ROOM       -138, 500       481, 168       50.00         52.00       05400 RADICIS CENTERS       -112, 803       989, 921       30.00         53.00       05400 RADICIS CE COST CENTERS       -112, 803       989, 921       30.00         54.00       05400 RADICIS CE COST CENTERS       -112, 803       989, 921       30.00         55.00       05500 DELIVERY ROOM & LABOR ROOM       0       473, 760       52.00       54.00         56.00       05400 RADICIGON - DI AGNOSTIC       -144, 81, 168       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00 <td>11.00</td> <td>01100 CAFETERI A</td> <td>-64, 877</td> <td>167, 243</td> <td></td> <td></td> <td>11.00</td>	11.00	01100 CAFETERI A	-64, 877	167, 243			11.00
15.00       01500       PHARMACY       -1,152       1,863,808       15.00         16.00       01600       MEDICAL RECORDS & LIBRARY       -1,795       64       16.00         10.00       03000       ADULTS & PEDIATRICS       -112,803       989,921       30.00         30.00       03000       ADULTS & PEDIATRICS       -138,500       43.00         30.00       05000       OPECATING ROOM       -138,500       481,168       50.00         50.00       05000       DECLIVERY ROOM & LABOR ROOM       0       473,760       52.00         51.00       05200       DELIVERY ROOM & LABOR ROOM       0       0       57.00         51.00       05000       DECIVERY ROOM & LABOR ROOM       0       0       58.00         60.00       06000       LEDRAROFY       -2,868       1,804,576       60.00         61.00       0600       LEPLAB       0       120,595       65.01         63.01       03950       SLEPLAB       0       120,595       65.01         64.00       0600       PECIAL THERAPY       0       258,915       66.01         65.00       06500       RESPIRATORY       THERAPY       0       129,522       71.00	13.00	01300 NURSING ADMINISTRATION	-106	571, 257			13.00
15.00       01500       PHARMACY       -1,152       1,863,808       15.00         16.00       01600       MEDICAL RECORDS & LIBRARY       -1,795       64       16.00         30.00       03000       ADULTS & PEDIATRICS       -112,803       989,921       30.00         30.00       03000       ADULTS & PEDIATRICS       -112,803       989,921       30.00         30.00       05000       DESTRY       0       207,895       43.00         ANCILLARY SERVICE COST CENTERS       -138,500       481,168       50.00       50.00         50.00       05000       DEALIVERY ROM & LABOR ROM       0       473,760       52.00         51.00       05100 CT SCAN       0       0       0       57.00       50.00         50.00       05000 LABORATORY       -2,868       1.804,576       60.00       60.00         65.00       06500 RESPI RATORY THERAPY       -22,668       1.804,576       65.01       65.01         61.01       0.957       0       9,957       65.01       65.01       65.01         61.01       0.957       0       9,957       65.01       66.01       66.00       60.00       600       66.00       9.00       9.00       9.00	14.00	01400 CENTRAL SERVICES & SUPPLY	-20	21, 442			14.00
16.00       01600 [MEDI CAL, RECORDS & LI BRARY       -1,795       64       16.00         30.00       03000 ADULTS & EPCI ATRICS       -112,803       989,921       30.00         43.00       04300 [MURSERY       0       207,895       30.00         ANCILLARY SERVICE COST CENTERS       0       43.00       650.00       05000 [PERATING ROOM       -138,500       481,168       50.00         50.00       05000 [PERATING ROOM       -138,500       481,168       50.00       52.00         50.00       05500 [DELVERY ROOM & LABOR ROOM       0       473,760       54.00       54.00         50.00       05500 [MAGNETIC RESONANCE IMAGING (MRI)       0       0       0       58.00         60.00       05000 [RSPIRATORY THERAPY       -22,668       1,804,576       66.00         61.00       05000 [RSPIRATORY THERAPY       -22,668       1,804,576       66.00         62.00       0500 [SEEP LAB       0       120,595       65.01         63.00       06000 [ASDIR TRORY THERAPY       0       258,915       66.00         64.00       06000 [SEEP LAB       0       120,595       65.01         65.00       067.00       0       9,957       66.00         70.00       070	15.00	01500 PHARMACY	-1, 152				15.00
INPATIENT ROUTINE SERVICE COST CENTERS	16.00						16.00
30. 00       00							
43.00       04300       NURSERY       0       207, 895       43.00         ANCI LLARY SERVICE COST CENTERS       -       -       -       50.00       50.00       05000       OPERATING ROM       -138, 500       481, 168       50.00       52.00       52.00       52.00       52.00       052.00       DELIVERY ROM & LABOR ROM       0       473, 760       52.00       52.00       52.00       05.00       0.00       0       0       57.00       57.00       57.00       57.00       57.00       57.00       58.00       0.00       0.00       0       0       0       60.00       60.00       60.00       60.00       60.00       60.00       60.00       65.00       65.00       65.00       65.00       65.01       65.01       65.01       65.01       65.01       65.01       66.01       66.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00	30.00	03000 ADULTS & PEDIATRICS	-112,803	989, 921			30.00
ANCI LLARY SERVICE COST CENTERS           50. 00         05000         0PERATI NG ROOM         -138,500         481,168         50.00           52.00         05200         DELIVERY ROM & LABOR ROOM         0         473,760         52.00           54.00         D5400 RADI OLOGY-DI AGNOSTI C         -1445         1,060,191         54.00           57.00         D5700 CT SCAN         0         0         0         58.00           60.00         06500 RESPI RATORY THERAPY         -2,268         1,804,576         60.00           65.00         06500 RESPI RATORY THERAPY         -3226         505,827         65.00           65.01         03950 SLEEP LAB         0         120,595         65.01           66.00         06700 CUZHATI ONAL THERAPY         0         258,915         65.00           71.00         00         0         9,957         68.00         71.00           72.00         07200 I MPL. DEV. CHARGED TO PATI ENTS         0         219,962         72.00           73.00         07300 DRUGS CHARGED TO PATI ENTS         0         210,968         72.00           73.00         07300 DRUGS CHARGED TO PATI ENTS         0         210,968         72.00           73.00         09000 ELI NI C	43.00	04300 NURSERY					43.00
52.00       05200       DELI VERY ROOM & LABOR ROOM       0       473,760       52.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       -145       1,060,191       54.00         57.00       CT SCAN       0       0       0       58.00       05800       MAGNETI C RESONANCE I MAGING (MR1)       0       0       58.00       60.00       0       58.00       60.00       60.00       58.00       65.00       65.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       650.01       660.00       660.00       660.00       660.00       660.00       660.00       660.00       660.00       660.00       660.00       660.00       660.00       660.00       660.00       660.00       70.00       700.01       68.00       70.00       700.01       68.00       70.00       700.01       88.00       71.00       71.00       71.00       71.00       71.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.0				· · · ·			
54.00       05400       RADI OLOGY-DI AGNOSTI C       -145       1,060,191       54.00         57.00       05700       CT SCAN       0       0       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0       0       57.00         58.00       06000       LABORATORY       -2,868       1,804,576       60.00         65.01       03950       SLEEP LAB       0       120,595       65.01         66.00       06000       PHYSI CAL THERAPY       0       258,915       66.00         67.00       06000       SPECH PATHOLOGY       0       9,957       68.00         68.00       06000 SPEECH PATHOLOGY       0       9,957       68.00         71.00       07100 IMEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       129,522       71.00         73.00       07300 DRUGS CHARGED TO PATI ENTS       0       2,907       73.00         71.00       07300 DRUGS CHARGED TO PATI ENTS       0       210,968       73.00         71.00       07000 ELINIC       -519,416       1,722,961       90.00         90.00       09200 [OBSERVATION BEDS (NON-DI STI NCT PART)       91.00       91.00       92.00         92.00       SPECI AL PURPOSE	50.00	05000 OPERATI NG ROOM	-138, 500	481, 168			50.00
57.00       05700       CT SCAN       0       0       57.00         58.00       05800       MAGNETIC RESONANCE I MAGING (MRI )       0       0       60.00         60.00       CABORATORY       -2.8.68       1, 804, 576       60.00         65.00       06500       RESPI RATORY THERAPY       -326       505, 827       65.00         65.01       03950       SLEEP LAB       0       120, 595       65.01         66.00       06600       PHSI CAL THERAPY       0       258, 915       66.00         66.00       06600       SPEECH PATHOLOGY       0       9, 957       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       2, 907       71.00         73.00       07300       DRUES CHARGED TO PATI ENTS       0       2, 907       73.00         07300       DRUGS CHARGED TO PATI ENTS       0       210, 968       73.00         09.00       09000       CLI NI C       0       0       91.00         90.00       09000       DEMERGENCY       -519, 416       1, 722, 961       91.00         91.00       BUTPATI ENT SERVI CE COST CENTERS       0       45, 085       192.00         180.00 <td< td=""><td>52.00</td><td>05200 DELIVERY ROOM &amp; LABOR ROOM</td><td>0</td><td>473, 760</td><td></td><td></td><td>52.00</td></td<>	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	473, 760			52.00
58.00       05800       MAGNETIC RESONANCE I MAGI NG (MRI)       0       0         60.00       06000       LABORATORY       -2,868       1,804,576       60.00         65.00       06500       RESPI RATORY THERAPY       -326       505,827       65.01         66.00       03950       SLEEP LAB       0       120,595       65.01         66.00       06000       PHYSI CAL THERAPY       0       258,915       66.00         67.00       06000       CCUPATI ONAL THERAPY       0       16,989       67.00         68.00       06600       SPECH PATHOLOGY       0       9,957       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       2.907       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       210,968       72.00         90.00       O9000       CLI NI C       0       0       2.907       72.00         91.00       O9000       CLI NI C       0       0       90.00       91.00       90.00         92.00       D9200       DSERVATI ON BEDS (NON-DI STI NCT PART)       -519,416       1,722,961       91.00       92.00         92.00       190.00       IFT, FLOWER, C	54.00	05400 RADI OLOGY-DI AGNOSTI C	-145	1, 060, 191			54.00
60.00       06000       LABORATORY       -2,868       1,804,576       60.00         65.00       06500       RESPI RATORY THERAPY       -326       505,827       65.01         66.00       06600       PHYSI CAL THERAPY       0       120,595       66.00         67.00       06600       OCUPATI ONAL THERAPY       0       16,989       67.00         68.00       06800       SPEECH PATHOLOGY       0       9,957       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       129,522       71.00         72.00       07200       INPL. DEV. CHARGED TO PATI ENTS       0       2,907       72.00         73.00       D7300       DRUGS CHARGED TO PATI ENTS       0       2,907       72.00         73.00       D9000       CLI NI C       -519,416       1,722,961       90.00         90.00       O9000       CLI NI C       -519,416       1,722,961       91.00         92.00       DBSERVATI ON BEDS (NON-DI STI NCT PART)       -519,416       1,722,961       91.00         92.00       D9200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       91.00       92.00       92.00         910.00       IT, FLOWER, COFFEE SHOP & CANTEEN       0 <td>57.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>57.00</td>	57.00		0	0			57.00
60.00       06000       LABORATORY       -2,868       1,804,576       60.00         65.00       06500       RESPI RATORY THERAPY       -326       505,827       65.01         66.00       06600       PHYSI CAL THERAPY       0       120,595       66.00         67.00       06600       OCUPATI ONAL THERAPY       0       16,989       67.00         68.00       06800       SPEECH PATHOLOGY       0       9,957       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       129,522       71.00         72.00       07200       INPL. DEV. CHARGED TO PATI ENTS       0       2,907       72.00         73.00       D7300       DRUGS CHARGED TO PATI ENTS       0       2,907       72.00         73.00       D9000       CLI NI C       -519,416       1,722,961       90.00         90.00       O9000       CLI NI C       -519,416       1,722,961       91.00         92.00       DBSERVATI ON BEDS (NON-DI STI NCT PART)       -519,416       1,722,961       91.00         92.00       D9200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       91.00       92.00       92.00         910.00       IT, FLOWER, COFFEE SHOP & CANTEEN       0 <td>58.00</td> <td>05800 MAGNETIC RESONANCE IMAGING (MRI)</td> <td>0</td> <td>0 0</td> <td></td> <td></td> <td>58.00</td>	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0 0			58.00
65. 01       03950       SLEEP LAB       0       120, 595       65. 01         66. 00       06000       PHYSI CAL THERAPY       0       258, 915       66. 00         67. 00       0CCUPATI ONAL THERAPY       0       16, 989       67. 00         68. 00       06800       SPECH PATHOLOGY       0       9, 957       68. 00         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       129, 522       71. 00         72. 00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0       2, 907       72. 00         73. 00       07300       DRUGS CHARGED TO PATIENTS       0       210, 968       73. 00         00.00       09000       CLI NI C       0       0       0       90. 00         90. 00       09000       CLI NI C       -519, 416       1, 722, 961       91. 00         92. 00       092000       DBSERVATI ON BEDS (NON-DI STI NCT PART)       92. 00       92. 00       92. 00         92. 00       092000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       18. 00         NOREL MBURSABLE COST CENTERS         190. 00       19200       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       45, 085 </td <td>60.00</td> <td></td> <td>-2, 868</td> <td>1, 804, 576</td> <td></td> <td></td> <td>60.00</td>	60.00		-2, 868	1, 804, 576			60.00
66.00       06600       PHYSI CAL THERAPY       0       258, 915       66.00         67.00       0CCUPATI ONAL THERAPY       0       16, 989       67.00         68.00       06800       SPEECH PATHOLOGY       0       9, 957       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       129, 522       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       2, 907       72.00         73.00       07300 DRUGS CHARGED TO PATIENTS       0       210, 968       73.00         001707       09000 CLINIC       0       0       90.00       90.00         90.00       09000 CLINIC       0       0       90.00       90.00         91.00       09100 EMERGENCY       -519, 416       1, 722, 961       91.00         92.00       09200 OBSERVATION BEDS (NON-DISTINCT PART)       92.00       92.00         SPECIAL PURPOSE COST CENTERS       118.00       118.00       118.00       118.00         NORREI MBURSABLE COST CENTERS       0       0       0       190.00       192.00       19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       190.00         192.00       192000 PHYSI CLANS' PRI VATE OFFI CES       0 <td>65.00</td> <td>06500 RESPI RATORY THERAPY</td> <td>-326</td> <td>505, 827</td> <td></td> <td></td> <td>65.00</td>	65.00	06500 RESPI RATORY THERAPY	-326	505, 827			65.00
67.00       06700       0CCUPATI ONAL THERAPY       0       16,989       67.00         68.00       06800       SPEECH PATHOLOGY       0       9,957       68.00         71.00       OTIO0       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       129,522       71.00         72.00       07300       DRUGS CHARGED TO PATI ENTS       0       2,907       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       210,968       72.00         90.00       OUTPATI ENT SERVICE COST CENTERS       0       210,968       90.00         90.00       O9000       CLI NI C       0       0       90.00         91.00       O9000       EMERGENCY       -519,416       1,722,961       91.00         92.00       OSERVATI ON BEDS (NON-DI STI NCT PART)       SPECI AL PURPOSE COST CENTERS       91.00       92.00         118.00       SPECI AL PURPOSE COST CENTERS       118.00       190.00       19000       GFT, FLOWER, COFFEE SHOP & CANTEEN       190.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       45,085       192.00         194.00       19200       OTHER NRCC - PUBLIC RELATI ONS       102,614       102,614       194.00         194.02<	65.01	03950 SLEEP LAB	0	120, 595			65.01
68.00       06800       SPEECH PATHOLOGY       0       9,957       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       129,522       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       2,907       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       210,968       73.00         00       07900       CLI NI C       0       0       90.00       90.00         90.00       09000       CLI NI C       0       0       90.00       90.00         91.00       09100       EMERGENCY       -519,416       1,722,961       91.00       92.00         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       SPECIAL PURPOSE COST CENTERS       92.00       92.0	66.00	06600 PHYSI CAL THERAPY	0	258, 915			66.00
71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       129, 522       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       2, 907       72. 00         73. 00       07300       DRUGS CHARGED TO PATIENTS       0       210, 968       73. 00         0000       0000       CLINIC       0       210, 968       73. 00         90. 00       09000       CLINIC       0       90. 00       90. 00         91. 00       090200       DBSERVATION BEDS (NON-DISTINCT PART)       91. 00       92.00       9200         92. 00       092000       DBSERVATION BEDS (NON-DISTINCT PART)       91. 00       92. 00       92.00         SPECIAL PURPOSE COST CENTERS       118. 00       NONREI MBURSABLE COST CENTERS       118. 00       118. 00         190. 00       19200       PHYSICI ANS' PRIVATE OFFICES       0       45, 085       190. 00         192. 00       192000       OTHER NRCC - PUBLIC RELATIONS       102, 614       102, 614       102, 614         194. 00       07950       OTHER NRCC - FOUNDATION       0       7, 036       194. 01         194. 02       07952       OTHER NRCC - GRANTS       0       17, 378       194. 02	67.00	06700 OCCUPATI ONAL THERAPY	0	16, 989			67.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       2,907       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       210,968       73.00         00TPATIENT SERVICE COST CENTERS       0       0       0       90.00         90.00       09000       CLINIC       0       0       90.00         91.00       09000       DSERVATION BEDS (NON-DISTINCT PART)       -519,416       1,722,961       91.00         92.00       D92001       DSERVATION BEDS (NON-DISTINCT PART)       -519,416       1,722,961       91.00         92.00       D92002       OBSERVATION BEDS (NON-DISTINCT PART)       -519,416       1,722,961       92.00         SPECIAL PURPOSE COST CENTERS       118.00	68.00	06800 SPEECH PATHOLOGY	0	9, 957			68.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0       210,968       73.00         0UTPATIENT SERVICE COST CENTERS       0       0       0       90.00       90.00       90.00         90.00       09100       EMERGENCY       -519,416       1,722,961       91.00       91.00         92.00       09200 (DSERVATION BEDS (NON-DISTINCT PART)       -519,416       1,722,961       92.00       92.00         SPECIAL PURPOSE COST CENTERS       118.00       SUBTOTALS (SUM OF LINES 1 through 117)       147,691       22,584,628       118.00         190.00       19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       45,085       192.00         194.00       07950       OTHER NRCC - PUBLI C RELATIONS       102,614       102,614       102,614         194.01       07952       OTHER NRCC - GRANTS       0       7,036       194.01         194.02       07952       OTHER NRCC - GRANTS       0       17,378       194.02	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	129, 522			71.00
OUTPATI ENT SERVICE COST CENTERS         0         0         0         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         90.00         91.00         92.00         92.00         09200         0BEDS (NON-DI STINCT PART)         92.00 <td>72.00</td> <td>07200 IMPL. DEV. CHARGED TO PATIENTS</td> <td>0</td> <td>2, 907</td> <td></td> <td></td> <td>72.00</td>	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 907			72.00
90. 00       09000       CLINIC       0       0       90. 00         91. 00       09100       EMERGENCY       -519, 416       1, 722, 961       91. 00         92. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       92. 00       92. 00         SPECIAL PURPOSE COST CENTERS         118. 00       SUBTOTALS (SUM OF LINES 1 through 117)       147, 691       22, 584, 628       118. 00         NONREI MBURSABLE COST CENTERS         190. 00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0         192. 00       19200       PHYSI CI ANS' PRI VATE OFFICES       0       45, 085       192. 00         194. 00       07950       OTHER NRCC - PUBLIC RELATIONS       102, 614       102, 614       194. 01         194. 01       07951       OTHER NRCC - FOUNDATION       0       7, 036       194. 01         194. 02       07952       OTHER NRCC - GRANTS       0       17, 378       194. 02	73.00	07300 DRUGS CHARGED TO PATIENTS	0	210, 968			73.00
91. 00       09100       EMERGENCY       -519, 416       1, 722, 961       91. 00         92. 00       O9200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       92. 00       92. 00         SPECI AL PURPOSE COST CENTERS         118. 00       SUBTOTALS (SUM OF LINES 1 through 117)       147, 691       22, 584, 628       118. 00         NONREI MBURSABLE COST CENTERS         190. 00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0         192. 00       19200       PHYSI CI ANS' PRI VATE OFFICES       0       45, 085       192. 00         194. 00       07950       OTHER NRCC - PUBLI C RELATI ONS       102, 614       102, 614       194. 00         194. 01       07951       OTHER NRCC - FOUNDATI ON       0       7, 036       194. 01         194. 02       07952       OTHER NRCC - GRANTS       0       17, 378       194. 02		OUTPATIENT SERVICE COST CENTERS					
92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         92.00           SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         147,691         22,584,628         118.00           NONREI MBURSABLE COST CENTERS           190.00         1900 GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         0         45,085         192.00           194.00         07950         OTHER NRCC - PUBLI C RELATIONS         102,614         102,614         194.01           194.01         07951         OTHER NRCC - GRANTS         0         17,378         194.02	90.00	09000 CLI NI C	0	0 0	)		90.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         147,691         22,584,628         118.00           NONREI MBURSABLE COST CENTERS         100         0         190.00         192.00         1975.00         190.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         194.01         194.01         194.01         194.01         194.01         194.01         194.01         194.02	91.00	09100 EMERGENCY	-519, 416	1, 722, 961			91.00
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         147,691         22,584,628         118.00           NONREI MBURSABLE COST CENTERS         100.00         1900.00         197.00         197.00         197.00         190.00         192.00         194.00         194.00         194.00         194.00         194.00         194.01         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02 <td< td=""><td>92.00</td><td>09200 OBSERVATION BEDS (NON-DISTINCT PART)</td><td></td><td></td><td></td><td></td><td>92.00</td></td<>	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
NONREI MBURSABLE COST CENTERS           190.00         190000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         45,085         192.00           194.00         07950         OTHER NRCC - PUBLI C RELATI ONS         102,614         102,614         194.01           194.01         07951         OTHER NRCC - GRANTS         0         7,036         194.02							
NONREI MBURSABLE COST CENTERS           190.00         190000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         45,085         192.00           194.00         07950         OTHER NRCC - PUBLI C RELATI ONS         102,614         102,614         194.01           194.01         07951         OTHER NRCC - GRANTS         0         7,036         194.02	118.0	0 SUBTOTALS (SUM OF LINES 1 through 117)	147, 691	22, 584, 628			118.00
192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       0       45,085       192.00         194.00       07950       OTHER NRCC - PUBLI C RELATIONS       102,614       102,614       194.00         194.01       07951       OTHER NRCC - FOUNDATION       0       7,036       194.01         194.02       07952       OTHER NRCC - GRANTS       0       17,378       194.02		NONREI MBURSABLE COST CENTERS					
194. 00       07950       OTHER NRCC - PUBLIC RELATIONS       102, 614       194. 00         194. 01       07951       OTHER NRCC - FOUNDATION       0       7, 036       194. 01         194. 02       07952       OTHER NRCC - GRANTS       0       17, 378       194. 02	190.0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 0	)		190.00
194. 01       07951       OTHER NRCC - FOUNDATION       0       7,036       194. 01         194. 02       07952       OTHER NRCC - GRANTS       0       17, 378       194. 02	192.0	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	45, 085			192.00
194. 02 07952 OTHER NRCC - GRANTS 0 17, 378 194. 02	194.0	0 07950 OTHER NRCC - PUBLIC RELATIONS	102, 614	102, 614			194.00
	194.0	1 07951 OTHER NRCC - FOUNDATION	0	7,036	,		194.01
200.00          TOTAL (SUM OF LINES 118 through 199)         250,305         22,756,741         200.00	194.0		0	17, 378			194. 02
	200.0	0   TOTAL (SUM OF LINES 118 through 199)	250, 305	22, 756, 741			200.00

	Financial Systems	S	F. VINCENT RANDO				u of Form CMS-2	
RECLAS	SI FI CATI ONS			Provider C	CN: 15-1301	Period: From 07/01/2017	Worksheet A-6	
						To 06/30/2018	Date/Time Pre	pared.
						10 00,00,2010	11/28/2018 4:4	47 pm
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A – CAFETERIA							
1.00	CAFETERI A		0	232, 120				1.00
	TOTALS		0	232, 120				
	B - NURSERY RECLASS							
1.00	NURSERY	43.00	18 <u>2, 9</u> 23	25, 884				1.00
			182, 923	25, 884				
	C - DELIVERY & LABOR ROOM							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	41 <u>6, 8</u> 53	<u>58, 9</u> 85				1.00
			416, 853	58, 985				
	D - MEDI CAL SUPPLI ES CHARGED							
1.00	CENTRAL SERVICES & SUPPLY	14.00		4				1.0
2.00	MEDI CAL SUPPLI ES CHARGED TO	71.00		106, 912				2.00
	PATI ENTS							
3.00								3.0
4.00								4.0
5.00								5.0
6.00								6.0
7.00		+	+					7.0
			0	106, 916				
	E – HOUSEKEEPING			-1				
1.00	HOUSEKEEPING	9.00	<u>15, 2</u> 45	0				1.00
	TOTALS		15, 245	0				
	F - MRI			0.5				
1.00	RADI OLOGY-DI AGNOSTI C	54.00		<u>85</u> 85				1.00
			0	85				
	G - CLINIC	00.00		0 707				
1.00	ADULTS & PEDIATRICS			<u> </u>				1.0
			0	2, 797				
500.00	Grand Total: Increases		615, 021	426, 787				500.00

ECLASSI FI	I CATI ONS			Provi der (	CCN: 15-1301	Peri od:	Worksheet A-6
						From 07/01/2017 To 06/30/2018	Date/Time Prepare
							11/28/2018 4:47
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ret	<u>F.</u>	
	6.00	7.00	8.00	9.00	10.00		
	- CAFETERIA				1		
	<u>ETARY</u>		• •	23 <u>2, 1</u> 20		Q	1
	TALS		0	232, 120	)		
	- NURSERY RECLASS				1		
. 00 <u>ADI</u>	ULTS & PEDIATRICS		18 <u>2, 9</u> 23	25,884		_	1
			182, 923	25, 884			
	- DELIVERY & LABOR ROOM				1		
. 00 <u>ADI</u>	ULTS & PEDIATRICS	30.00	41 <u>6, 8</u> 53	5 <u>8, 9</u> 85		_	1
			416, 853	58, 985	5		
	- MEDI CAL SUPPLIES CHARGED				1		
	ULTS & PEDIATRICS	30.00		3, 039			1
	RSERY	43.00		912			2
	ERATING ROOM	50.00		73, 656			3
	LIVERY ROOM & LABOR ROOM	52.00		2, 078			4
	DI OLOGY-DI AGNOSTI C	54.00		6			5
	UGS CHARGED TO PATIENTS	73.00		19, 833			6
. OO EME	ERGENCY			7, 392			7
_			0	106, 916			
	- HOUSEKEEPING						
	USEKEEPING	9.00	0	15, 245		0	1
	TALS		0	15, 245			
	- MRI				1	1	
	GNETIC RESONANCE IMAGING	58.00		85	5		1
(Mł	<u>RI)</u>					_	
0			0	85			
-	- CLINIC	00.00		0.707	-		
00 <u>CLI</u>	<u>INIC</u>			2, 797		4	1
			0	2, 797		_	
00.00  Gra	and Total: Decreases		599, 776	442, 032	2		500

Heal th	Financial Systems S	T. VINCENT RAND	OLPH HOSPITAL		Inlie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der CC		Period: From 07/01/2017 To 06/30/2018	Worksheet A-7 Part I	pared:
				Acqui si ti on			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	696, 652	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	18, 761, 348	0		0 0	29, 196	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	512, 142	0		0 0	0	5.00
6.00	Movable Equipment	5, 853, 905	255, 857		0 255, 857	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25, 824, 047	255, 857		0 255, 857	29, 196	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	25, 824, 047	255, 857		0 255, 857	29, 196	10.00
		Ending Balance	Fully			· · · · ·	
		J	Depreciated				
			Assets				
		6.00	7.00	1			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES		•			
1.00	Land	696, 652	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	18, 732, 152	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	512, 142	0				5.00
6.00	Movable Equipment	6, 109, 762	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	26, 050, 708	0				8.00
9.00	Reconciling Items	0	0				9,00
10.00	Total (line 8 minus line 9)	26, 050, 708	0				10.00
			U.	I			

Heal th	Financial Systems S	T. VINCENT RAN	OOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 07/01/2017 Fo 06/30/2018	Worksheet A-7 Part II Date/Time Pre 11/28/2018 4:	pared:
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	611, 848	0	494, 67	5 19, 360	248	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	478, 888	0	(	291	0	2.00
3.00	Total (sum of lines 1-2)	1, 090, 736	0	494, 67	5 19, 651	248	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 126, 131				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19, 503	498, 682				2.00
3.00	Total (sum of lines 1-2)	19, 503	1, 624, 813				3.00

Heal th	Financial Systems	ST. VINCENT RANI	DOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2017 To 06/30/2018		oared:
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPI TAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1,00	2.00	3,00	4,00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	1.00	0.00	
1.00	CAP REL COSTS-BLDG & FIXT	19, 940, 946	0	19, 940, 94	6 0. 765467	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6, 109, 762	0	6, 109, 76	2 0. 234533	0	2.00
3.00	Total (sum of lines 1-2)	26, 050, 708	0	26, 050, 70	8 1.000000	0	3.00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6,00	7.00	8,00	9,00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 9, 998	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 478, 888	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 488, 886	0	3.00
			SL	JMMARY OF CAPI			
	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 C	ENTERS		_			
1.00	CAP REL COSTS-BLDG & FIXT	494, 675				524, 281	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	=		0 19, 503		2.00
3.00	Total (sum of lines 1-2)	494, 675	19, 651	24	8 19, 503	1, 022, 963	3.00

Heal th	Fi nan	ci al	Systems
AD IIIST	MENTS	TO I	EXPENSES

Health Financial Systems	S	T. VINCENT RAN	DOLPH HOSPITAL		u of Form CMS-25	52-1
ADJUSTMENTS TO EXPENSES				Period: From 07/01/2017 To 06/30/2018	Worksheet A-8 Date/Time Prepa	red:
			Expense Classification or		11/28/2018 4:47	
			To/From Which the Amount is			
Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00 Investment income - CAP REL	1.00 B	2.00 -494,675	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.0
2.00 COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	о	2. 0
COSTS-MVBLE EQUIP (chapter 2) 1 Investment income - other		0	CAL REE COSTS-WVDEE EQUIT	0.00		3.0
(chapter 2) I. 00 Trade, quantity, and time		0		0.00		4. C
discounts (chapter 8)						
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. C
b.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.0
7.00 Telephone services (pay stations excluded) (chapter 21)		0	5	0.00	0	7.0
3.00 Television and radio service		0		0.00	О	8. C
(chapter 21) 9.00 Parking lot (chapter 21) 10.00 Provider-based physician	A-8-2	0 -734, 679		0.00		9. 0 10. 0
adjustment 11.00 Sale of scrap, waste, etc.		C		0.00		11.0
(chapter 23) 12.00 Related organization transactions (chapter 10)	A-8-1	2, 426, 548	3		0 1	12. 0
3.00 Laundry and Linen service		0		0.00		13. (
<ul> <li>4.00 Cafeteria-employees and guest</li> <li>5.00 Rental of quarters to employe and others</li> </ul>		-64, 877 C	CAFETERI A	11.00 0.00		14. ( 15. (
6.00 Sale of medical and surgical supplies to other than		O		0.00	0 1	16. C
7.00 Sale of drugs to other than		0		0.00	0 1	17.0
patients 8.00 Sale of medical records and		C		0.00	0 1	18. 0
abstracts 19.00 Nursing and allied health education (tuition, fees,		C		0.00	0 1	19. C
books, etc.) 0.00 Vending machines		C		0.00	0 2	20. 0
1.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0 2	21. (
2.00 Interest expense on Medicare overpayments and borrowings t	0	O		0.00	0 2	22. (
<ul> <li>repay Medicare overpayments</li> <li>Adjustment for respiratory therapy costs in excess of</li> </ul>	A-8-3	C	RESPI RATORY THERAPY	65.00	2	23. (
24.00 I imitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00	2	24. C
15.00 Itilization (chapter 14) by Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00	2	25.0
(chapter 21) 6.00 Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0 2	26. (
COSTS-BLDG & FIXT 7.00 Depreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0 2	27.0
8.00 Non-physician Anesthetist		C	*** Cost Center Deleted ***	19.00	2	28. C
<ul> <li>9.00 Physicians' assistant</li> <li>0.00 Adjustment for occupational therapy costs in excess of</li> </ul>	A-8-3	0	OCCUPATI ONAL THERAPY	0.00	0 2	29. ( 30. (
limitation (chapter 14) 0.99 Hospice (non-distinct) (see		n	ADULTS & PEDIATRICS	30.00		30. 9
i nstructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68.00		31. C
pathology costs in excess of limitation (chapter 14)	A-0-3					
32.00 CAH HIT Adjustment for Depreciation and Interest		C	1	0.00	0 3	32.0

Heal th	Financial Systems	S	T. VINCENT RAN	DOLPH HOSPITAL	In Li€	eu of Form CMS-:	2552-10
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 07/01/2017 To 06/30/2018		narod
					10 00/30/2018	11/28/2018 4:	47 pm
				Expense Classification of	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	PROVIDER ASSESSMENT TAX	A	-708, 374	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
	ADJUSTMENT						
33.01	PROMOTIONAL ITEMS	A	-2, 522	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER OPERATING INCOME	В	-5,260	ADMI NI STRATI VE & GENERAL	5.00	0	33. 02
33.03	OTHER PHARMACY REVENUE	В	-666	PHARMACY	15.00	0	33.03
33.04	OTHER HIM REVENUE	В	-1, 795	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	CHARI TABLE EXPENSE	A	-590	ADMI NI STRATI VE & GENERAL	5.00	0	33.05
33.06	OTHER OPERATING INCOME	В	-522	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	OTHER RADIOLOGY REVENUE	В	-105	RADI OLOGY-DI AGNOSTI C	54.00	0	33.07
33.08	DONATI ONS	A	-590	ADMI NI STRATI VE & GENERAL	5.00	0	33.08
33.09	LOBBYING OFFSET	A	-312	ADMI NI STRATI VE & GENERAL	5.00	0	33.09
33.10	LATE PENALTY FEES	A	-20	CENTRAL SERVICES & SUPPLY	14.00	0	33.10
33.11	PAVILION DEPRECIATION	A	-2,507	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 11
33.12	CARRYFORWARD ON HOSPITAL DEPR.	A	-104, 668	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	HOSPI TALI STS BENEFI TS	A		EMPLOYEE BENEFITS DEPARTMEN			
33.14	HOSPITALISTS WAGES	A		ADULTS & PEDIATRICS	30.00		
33.15	ENTERTAI NMENT	A		ADMI NI STRATI VE & GENERAL	5.00		
33.16	ENTERTAI NMENT	A	-106	NURSING ADMINISTRATION	13.00	0	33.16
33.17	ENTERTAI NMENT	A		PHARMACY	15.00		
33. 18	ENTERTAI NMENT	A		ADULTS & PEDIATRICS	30.00		
33.19	ENTERTAI NMENT	A		RESPI RATORY THERAPY	65.00	0	
33.20	ACCRUED INCENTIVES	A	1, 574	EMPLOYEE BENEFITS DEPARTMEN			00.20
33. 21	CORPORATE SPONSORSHI P	A		ADMI NI STRATI VE & GENERAL	5.00	0	00.2.
33. 22	OTHER LAB REVENUE	В	-2,868	LABORATORY	60.00	0	33. 22
50.00	TOTAL (sum of lines 1 thru 49)		250, 305				50.00
	(Transfer to Worksheet A,					1	1

 (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).

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	ST. VINCENT RAM	NDOLPH HOSPITAL	In Lie	eu of Form CMS-	2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME			ME Provider CCN: 15-1301	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 07/01/2017 To 06/30/2018		epared:
					11/28/2018 4:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED 0	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	361, 379		1.00
2.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	5, 737, 106	3, 774, 551	2.00
3.00			HOME OFFICE - MARKETING	102, 614	0	3.00
3.01			SVH CHARGEBACKS	150, 756		3. 01
3.02			SVH CHARGEBACKS	34, 140	34, 140	
3.03	9.00	HOUSEKEEPING	SVH CHARGEBACKS	-46, 499	-46, 499	
3.04	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	505	505	3.04
3.05	15.00	PHARMACY	SVH CHARGEBACKS	4,000	4,000	3.05
3.06	54.00	RADI OLOGY-DI AGNOSTI C	SVH CHARGEBACKS	116, 100	116, 100	3.06
3.07	194.01	OTHER NRCC - FOUNDATION	SVH CHARGEBACKS	-33, 282	-33, 282	3.07
3.08	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	494, 675	494, 675	3.08
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			6, 921, 494	4, 494, 946	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

has no	ot been posted to Worksheet A,	columns 1 and/or 2, the	amount allowable sh	ould be indicated in column	4 of this part.	
				Related Organization(s) an	d/or Home Office	
				0 11		1
						1
						1
	Symbol (1)	Name	Percentage of	Name	Percentage of	
	Symbol (1)	Name		Name		1
			Ownershi p		Ownershi p	1
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELAT	FED 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.

i ci indui					
6.00	G	ST. VINCENT HEA	1.00 ST. VINCENT HEA	1.00	6.00
7.00	G	ASCENSI ON	1.00 ASCENSI ON	1.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	HOME OFFICE			100.00
	non-financial) specify:				

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems	ST. VINCENT RANDOLPH HOSPITAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANIZATIONS AND HOME Provider CCN: 15-1301	Period: From 07/01/2017	Worksheet A-8-1
OFFICE COSTS			Date/Time Prepared:

Net Adjustments (col. 4 minus col. 5)*         Wkst. A-7 Ref.           6.00         7.00           A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:         1.00           1.00         361, 379         0         2.00           1.00         361, 379         0         2.00           3.00         102, 614         0         3.01           3.02         0         0         3.02           3.03         0         0         3.02           3.04         0         0         3.04           3.05         0         0         3.04           3.07         0         0         3.06           3.07         0         0         3.07           3.08         0         9         3.08           4.00         0         0         3.08           5.00         2,426,548         0         5.00						11/28/2018 4	47 pm
(col. 4 minus col. 5)*         7.00           A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:         1.00           1.00         361,379         0         2.00           3.00         102,614         0         3.00           3.01         0         0         3.02           3.03         0         0         3.02           3.04         0         0         3.04           3.05         0         0         3.05           3.06         0         0         3.05           3.07         0         0         3.06           3.07         0         0         3.04           3.07         0         0         3.06           3.07         0         0         3.06           3.07         0         0         3.08           4.00         0         0         3.08		Net	Wkst. A-7 Ref.				
col. 5)*		Adjustments					
6.00         7.00           A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:         1.00           1.00         361,379         0         2.00           2.00         1,962,555         0         3.00           3.01         0         0         3.01           3.02         0         0         3.02           3.03         0         0         3.03           3.04         0         0         3.04           3.05         0         0         3.05           3.06         0         0         3.07           3.08         0         9         3.08           4.00         0         9         3.08		(col. 4 minus					
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:         1.00           1.00         361,379         0         1.00           2.00         1,962,555         0         2.00           3.00         102,614         0         3.01           3.02         0         0         3.02           3.03         0         0         3.03           3.04         0         0         3.04           3.05         0         0         3.05           3.06         0         0         3.05           3.07         0         0         3.07           3.08         0         9         3.08           4.00         0         0         4.00		col. 5)*					
HOME OFFICE COSTS:         1.00           361, 379         0         1.00           2.00         1, 962, 555         0         2.00           3.00         102, 614         0         3.01           3.01         0         0         3.01           3.02         0         0         3.02           3.03         0         0         3.03           3.04         0         0         3.04           3.05         0         0         3.05           3.06         0         0         3.06           3.07         0         0         3.06           3.08         0         9         3.08           4.00         0         0         4.00		6.00	7.00				
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRAM	SACTIONS WITH RELATED C	DRGANIZATIONS OR CLAIMED	
2.00       1,962,555       0       2.00         3.00       102,614       0       3.00         3.01       0       0       3.01         3.02       0       0       3.02         3.03       0       0       3.03         3.04       0       3.04       3.04         3.05       0       0       3.05         3.06       0       3.05       3.06         3.07       0       0       3.07         3.08       0       9       3.08         4.00       0       0       4.00		HOME OFFICE CO	STS:				
3.00       102,614       0       3.00         3.01       0       0       3.01         3.02       0       0       3.02         3.03       0       0       3.03         3.04       0       3.04       3.04         3.05       0       3.05       3.05         3.06       0       3.05       3.05         3.07       0       0       3.07         3.08       0       9       3.08         4.00       0       0       4.00	1.00	361, 379	0				1.00
3.01       0       0       3.01         3.02       0       0       3.02         3.03       0       0       3.03         3.04       0       0       3.04         3.05       0       0       3.05         3.06       0       0       3.07         3.08       0       9       3.08         4.00       0       0       4.00	2.00	1, 962, 555	0				2.00
3.02       0       0       3.02         3.03       0       0       3.03         3.04       0       0       3.04         3.05       0       0       3.05         3.06       0       0       3.06         3.07       0       0       3.06         3.08       0       9       3.08         4.00       0       0       4.00	3.00	102, 614	0				3.00
3.03       0       0       3.03         3.04       0       0       3.04         3.05       0       0       3.05         3.06       0       0       3.06         3.07       0       0       3.07         3.08       0       9       3.08         4.00       0       0       4.00	3.01	0	0				3. 01
3.04       0       0       3.04         3.05       0       0       3.05         3.06       0       0       3.06         3.07       0       0       3.07         3.08       0       9       3.08         4.00       0       0       4.00	3.02	0	0				3. 02
3.05       0       0       3.05         3.06       0       0       3.06         3.07       0       0       3.07         3.08       0       9       3.08         4.00       0       0       4.00	3.03	0	0				3.03
3.06       0       3.06         3.07       0       0         3.08       0       9         4.00       0       0	3.04	0	0				3.04
3.07       0       0       3.07         3.08       0       9       3.08         4.00       0       0       4.00	3.05	0	0				3.05
3.08         0         9         3.08         4.00<	3.06	0	0				3.06
3.08         0         9         3.08         4.00<	3.07	0	0				3.07
4.00 0 0 4.00		0	9				1
		0	0				
		2, 426, 548					1

\* 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.

	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
-			

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

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

i ei iibui	Sement under title Aviii.	
6.00	ADMI NI STRATI ON	6.00
7.00	ADMI NI STRATI ON	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

- B. Corporation, partnership, or other organization has financial interest in provider.
   C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related

organi zati on. E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

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

	Trinaner ar byste		ST. THOERT IG					
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (	CCN: 15-1301	Peri od:	Worksheet A-8	3-2
						From 07/01/2017		
						To 06/30/2018		
							11/28/2018 4:	
	Wkst. A Line #		Total	Professi onal	Provi der		Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	76, 583	76, 583	C	0	0	1.00
2.00	50.00	OPERATING ROOM	138, 500	138, 500	C	0	0	2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	40	40	C	0	0	3.00
4.00	65.00	RESPI RATORY THERAPY	140	140	C	0	0	4.00
5.00	91.00	EMERGENCY	1, 266, 872	519, 416	747, 456	0	0	5.00
6.00	0.00		0	0	0		0	6.00
7.00	0.00			0	0	-	0	7.00
8.00	0.00			0		0	0	8.00
9.00	0.00	4	0	0		0	0	9,00
			0	0		0	0	
10.00	0.00		0	0		0	0	10.00
200.00			1, 482, 135				0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		Identifier	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	C	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	C	0	0	2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	3.00
4.00		RESPI RATORY THERAPY	0	0	C	0	0	4.00
5.00		EMERGENCY	0	0	0	0	0	5.00
6.00	0.00			0		0	0	6.00
7.00	0.00			0		0	0	7.00
8.00	0.00		0	0		0	0	8.00
			0	0		0	0	
9.00	0.00		0	0	L L	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			0	0	-		0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	C	76, 583		1.00
2.00	50.00	OPERATING ROOM	0	0	C	138, 500		2.00
3.00		RADI OLOGY-DI AGNOSTI C	0	0	C			3.00
4.00		RESPI RATORY THERAPY	0	0	0	140		4.00
5.00		EMERGENCY	0	0		1.10		5.00
6.00	0.00			0 0		0		6.00
7.00	0.00			0		-		7.00
				-	-			
8.00	0.00		0	Ŭ	-	0		8.00
9.00	0.00		0					9.00
10.00	0.00		0	-	C	-		10.00
200.00			0	0	C	734, 679		200.00

	LLOCATION - GENERAL SERVICE COSTS	T. VINCENT KAN	Provi der CC	F	Period: From 07/01/2017	Worksheet B Part I	
				T	o 06/30/2018	Date/Time Pre 11/28/2018 4:	pared:
			CAPI TAL REL	ATED COSTS		11/28/2018 4:	4/pm
			CAFITAL KEL	AILD COSIS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)				-	
		0	1.00	2.00	4.00	4A	
4 00	GENERAL SERVICE COST CENTERS	504.004	504.004				1 1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT	524, 281	524, 281	400 / 02			1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	498, 682 2, 089, 045	0	498, 682 C			2.00 4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	2, 089, 045 6, 935, 641	82, 480			7, 351, 489	
7.00	00700 OPERATION OF PLANT	1, 200, 853	31, 327	29, 797		1, 285, 512	
8.00	00800 LAUNDRY & LINEN SERVICE	75, 250	4, 277	4, 068		83, 595	
9.00	00900 HOUSEKEEPING	438,040	4,009			445, 863	
10.00	01000 DI ETARY	202, 870	14, 875	14, 149		231, 894	
11.00	01100 CAFETERIA	167, 243	3, 502	3, 331		174,076	
13.00	01300 NURSI NG ADMI NI STRATI ON	571, 257	962	915			
14.00	01400 CENTRAL SERVICES & SUPPLY	21, 442	0	C		21, 442	
15.00	01500 PHARMACY	1, 863, 808	0	C	98, 481	1, 962, 289	
16.00	01600 MEDICAL RECORDS & LIBRARY	64	9, 910	9, 426		19, 400	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	989, 921	61, 050				
43.00	04300 NURSERY	207, 895	835	795	62, 597	272, 122	43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	481, 168	51, 621	49, 100			
52.00	05200 DELIVERY ROOM & LABOR ROOM	473, 760	15, 697	14, 930			
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	1, 060, 191	41, 584	39, 554 C		1, 371, 073 0	
57.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		-	0	
60.00	06000 LABORATORY	1, 804, 576	11, 647	11, 079	-	1, 827, 302	
65.00	06500 RESPI RATORY THERAPY	505, 827	12, 155	11, 562			
65.00	03950 SLEEP LAB	120, 595	2, 833				
66.00	06600 PHYSI CAL THERAPY	258, 915	20, 080				
67.00	06700 OCCUPATI ONAL THERAPY	16, 989	2, 118			26, 936	
68.00	06800 SPEECH PATHOLOGY	9, 957	0	C		13, 364	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	129, 522	11, 246	10, 697		151, 465	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 907	0	C	0 0	2, 907	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	210, 968	7, 731	7, 354	65, 048	291, 101	73.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0	C		0	
91.00	09100 EMERGENCY	1, 722, 961	28, 393	27, 007	292, 876		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
110.00	SPECIAL PURPOSE COST CENTERS	22 504 (20)	410.000	207.010	2 074 020	22.2(2.000	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	22, 584, 628	418, 332	397, 910	2, 074, 938	22, 363, 800	118.00
100.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	855	814	0	1 660	190.00
190.00	19200 PHYSI CLANS' PRI VATE OFFICES	45,085		99, 120			
192.00	07950 OTHER NRCC - PUBLIC RELATIONS	102, 614	441	419		103, 474	
	07951 OTHER NRCC - FOUNDATION	7,036	441	419			194.00
194.02	07952 OTHER NRCC - GRANTS	17, 378	0	C			194.02
200.00		, 0, 0	, i i i i i i i i i i i i i i i i i i i		., 010		200.00
201.00			0	C	0 0		201.00
202.00		22, 756, 741	524, 281	498, 682	2, 089, 045		
		·					

Heal th	Financial Systems S	ST. VINCENT RANI	OLPH HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1301 P	eriod:	Worksheet B	
					rom 07/01/2017	Part I	
				1	0 06/30/2018	Date/Time Pre 11/28/2018 4:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	noooenteerinto	51211111	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS			•			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	7, 351, 489					5.00
7.00	00700 OPERATION OF PLANT	613, 455	1, 898, 967				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	39, 892	19, 785	143, 272			8.00
9.00	00900 HOUSEKEEPI NG	212, 769	18, 549	0	677, 181		9.00
10.00	01000 DI ETARY	110, 661	68, 815	0	25, 045	436, 415	10.00
11.00	01100 CAFETERI A	83, 070	16, 199	0	5, 896	0	11.00
13.00	01300 NURSING ADMINISTRATION	357, 964	4, 452	0	1, 620	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	10, 232	0	0	0	0	14.00
15.00	01500 PHARMACY	936, 418	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	9, 258	45, 846	0	16, 686	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			1
30.00	03000 ADULTS & PEDIATRICS	684, 991	282, 432	53, 053	102, 792	436, 415	30.00
43.00	04300 NURSERY	129, 859	3, 864	632	1, 406	0	43.00
	ANCILLARY SERVICE COST CENTERS			•			1
50.00	05000 OPERATI NG ROOM	334, 786	238, 812	18, 489	86, 916	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	308, 770	72, 617	1, 439	26, 429	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	654, 286	192, 379	20, 020	70, 017	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000 LABORATORY	872, 001	53, 883	0	19, 611	0	60.00
65.00	06500 RESPI RATORY THERAPY	323, 632	56, 233	0	20, 466	0	65.00
65.01	03950 SLEEP LAB	79, 388	13, 108	0	4, 771	0	65.01
66.00	06600 PHYSI CAL THERAPY	182, 324	92, 897	0	33, 810	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	12, 854	9, 800	0	3, 567	0	67.00
68.00	06800 SPEECH PATHOLOGY	6, 377	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	72, 280	52, 029	0	18, 936	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 387	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	138, 915	35, 768	0	13, 018	0	73.00
	OUTPATIENT SERVICE COST CENTERS			_			
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	988, 406	131, 354	49, 639	47, 807	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		7, 163, 975	1, 408, 822	143, 272	498, 793	436, 415	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	796	3, 957	0	1, 440	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	124, 542	482, 108	0	175, 462	0	192.00
194.00	07950 OTHER NRCC - PUBLIC RELATIONS	49, 379	2, 040	0	743	0	194.00
194.01	07951 OTHER NRCC - FOUNDATION	3, 768	2, 040	0	743	0	194.01
194.02	07952 OTHER NRCC - GRANTS	9, 029	0	0	0	0	194.02
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)	7, 351, 489	1, 898, 967	143, 272	677, 181	436, 415	202.00
							-

	J	T. VINCENT RANI	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Pre 11/28/2018 4:	
	Cost Center Description		NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	1	11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 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 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	IOTOOLDTETARY	270 241					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	279, 241 25, 527					13.00
13.00	01400 CENTRAL SERVICES & SUPPLY	25, 527	1, 139, 686	31, 6	7.4		14.00
14.00	01500 PHARMACY	9, 957		31,0	0 2, 908, 664		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	9, 937			0 2, 908, 004	91, 190	•
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	<u> </u>		0 0	71, 170	10.00
30.00	03000 ADULTS & PEDI ATRI CS	54, 461	415, 104		0 0	3, 609	30.00
43.00	04300 NURSERY	9, 429			0 0	964	
10.00	ANCI LLARY SERVI CE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	11,070		<u> </u>	701	10.00
50.00	05000 OPERATI NG ROOM	17,017	129, 711		0 0	6, 542	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	21, 490			0 0	2, 197	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	34, 904			0 0	26, 507	•
57.00	05700 CT SCAN	0			0 0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0		0 0	24, 613	60.00
65.00	06500 RESPI RATORY THERAPY	25, 070	0		0 0	3, 977	65.00
65.01	03950 SLEEP LAB	6, 167	0		0 0	995	65.01
66.00	06600 PHYSI CAL THERAPY	13, 475	0		0 0	2, 096	66.00
67.00	06700 OCCUPATI ONAL THERAPY	711	0		0 0	109	67.00
68.00	06800 SPEECH PATHOLOGY	465	0		0 0	33	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		30, 9		0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	-	69		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 104	0		0 2, 908, 664	0	73.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0			0 0	0	
91.00	09100 EMERGENCY	47, 123	359, 191		0 0	19, 548	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	275, 900	1, 139, 686	31, 6	2, 908, 664	01 100	118.00
116.00	NONREI MBURSABLE COST CENTERS	275,900	1, 139, 000	31,0	2, 900, 004	91, 190	118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 139			0 0		190.00
	07950 OTHER NRCC - PUBLIC RELATIONS	0					192.00
	07951 OTHER NRCC - FOUNDATION	0			0 0		194.00
	07952 OTHER NRCC - GRANTS	202			0 0		194.01
200.00		202				0	200.00
201.00	,	0	0		0 0	0	201.00
202.00	5	279, 241	1, 139, 686	31, 6	2, 908, 664		202.00
50		,	,,	2.70	,, 501	,	

Heal th	Financial Systems S	T. VINCENT RAND	OOLPH HOSPITAL		In Lieu of Form CMS	S-2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: Worksheet B From 07/01/2017 Part I	
					To 06/30/2018 Date/Time P 11/28/2018	repared:
	Cost Center Description	Subtotal	Intern &	Total	11/20/2010	4.47 pm
			Residents Cost			
			& Post			
			Stepdown Adjustments			
		24.00	25.00	26.00	—	
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.00 8.00
8.00 9.00	00900 HOUSEKEEPING					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					15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	3, 468, 274	0	3, 468, 27		30.00
43.00		490, 149	0	490, 14	19	43.00
50, 00	ANCILLARY SERVICE COST CENTERS	1, 533, 827	0	1, 533, 82	7	50,00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 243, 784	0	1, 243, 78		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 369, 186	0	2, 369, 18		54.00
57.00	05700 CT SCAN	2,007,100	o		0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o		0	58.00
60.00	06000 LABORATORY	2, 797, 410	0	2, 797, 41	10	60.00
65.00	06500 RESPI RATORY THERAPY	1, 107, 557	0	1, 107, 55	57	65.00
65.01	03950 SLEEP LAB	270, 789	0	270, 78	39	65.01
66.00	06600 PHYSI CAL THERAPY	706, 667	0	706, 66		66.00
67.00	06700 OCCUPATI ONAL THERAPY	53, 977	0	53, 97		67.00
68.00	06800 SPEECH PATHOLOGY	20, 239	0	20, 23		68.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	325, 689	0	325, 68		71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	4, 989 3, 397, 570	0	4, 98 3, 397, 57		72.00 73.00
73.00	OUTPATIENT SERVICE COST CENTERS	3, 377, 370	V	3, 377, 37		/3.00
90.00	09000 CLINIC	0	0		0	90.00
91.00	09100 EMERGENCY	3, 714, 305	0	3, 714, 30	5	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0			92.00
	SPECIAL PURPOSE COST CENTERS					
118.00		21, 504, 412	0	21, 504, 41	2	118.00
	NONREI MBURSABLE COST CENTERS	7.0(0				-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,862	0	7,86		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NRCC - PUBLIC RELATIONS	1, 046, 232	0	1, 046, 23		192.00 194.00
	07950 OTHER NRCC - POBLIC RELATIONS 07951 OTHER NRCC - FOUNDATION	155, 636 14, 447	0	155, 63 14, 44		194.00
	07951 OTHER NRCC - FOUNDATION 07952 OTHER NRCC - GRANTS	28, 152	0	28, 15		194.01
200.00		20, 132	0		0	200.00
201.00		0	0		0	201.00
202.00	5	22, 756, 741	0	22, 756, 74	11	202.00
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Heal th	Fi nar	nci al	Syste	ems		
				DEL	ATED	0

In Lieu of Form CMS-2552-10

	FI nanci al Systems S TON OF CAPITAL RELATED COSTS	I. VINCENI RANI	Provider CC	CN: 15-1301 Pe Fr Tc	eriod: com 07/01/2017	u of Form CMS-2 Worksheet B Part II Date/Time Pre 11/28/2018 4:	pared:
	Cost Center Description	Directly Assigned New Capital	CAPI TAL REL BLDG & FI XT	ATED COSTS	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						1 1.00
	DO200 CAP REL COSTS-BEDG & TTXT						2.00
	DO400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
	20500 ADMI NI STRATI VE & GENERAL	365,007	82, 480	78, 453	525, 940	0	5.00
	DO700 OPERATION OF PLANT	10, 111	31, 327	29, 797	71, 235	0	7.00
	DO800 LAUNDRY & LINEN SERVICE	2,990		4, 068	11, 335	0	
	DO900 HOUSEKEEPING	113		3, 814	7, 936	0	9.00
	D1000 DI ETARY	0		14, 149	29, 024	0	10.00
	D1100 CAFETERI A	0		3, 331	6, 833	0	11.00
	D1300 NURSI NG ADMI NI STRATI ON	696		915	2, 573	0	13.00
	D1400 CENTRAL SERVICES & SUPPLY	0,0	0	0	2, 3, 3	0	14.00
	D1500 PHARMACY	27, 424	-	0	27, 424	0	15.00
	D1600 MEDICAL RECORDS & LIBRARY	27, 424	9, 910	9, 426	19, 336	0	•
	INPATIENT ROUTINE SERVICE COST CENTERS	0	7, 710	7,420	17, 330	0	10.00
30.00	D3000 ADULTS & PEDIATRICS	1,008	61, 050	58, 069	120, 127	0	30. 00
	D4300 NURSERY	0		795	1, 630	0	43.00
	ANCI LLARY SERVICE COST CENTERS		000	,,,,	1,000		10.00
	D5000 OPERATI NG ROOM	72	51, 621	49, 100	100, 793	0	50. 00
	D5200 DELIVERY ROOM & LABOR ROOM	0	15, 697	14, 930	30, 627	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	221, 533		39, 554	302, 671	0	54.00
	D5700 CT SCAN	0	0	0	0	0	57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	ō	0	58.00
	D6000 LABORATORY	-14,052	11, 647	11, 079	8, 674	0	60.00
	06500 RESPI RATORY THERAPY	25, 749		11, 562	49, 466	0	65.00
	03950 SLEEP LAB	40		2, 695	5, 568	0	65.01
	D6600 PHYSI CAL THERAPY	1, 250		19, 100	40, 430	0	66.00
	06700 OCCUPATI ONAL THERAPY	0		2, 015	4, 133	0	67.00
	D6800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 246	10, 697	21, 943	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	86	7, 731	7, 354	15, 171	0	73.00
	DUTPATIENT SERVICE COST CENTERS	I					
90.00	09000 CLI NI C	0	0	0	0	0	1 90. OC
91.00	D9100 EMERGENCY	55	28, 393	27, 007	55, 455	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	642, 082	418, 332	397, 910	1, 458, 324	0	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	855	814	1, 669	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	104, 212	99, 120	203, 332	0	192.00
	07950 OTHER NRCC - PUBLIC RELATIONS	0	441	419	860	0	194.00
	07951 OTHER NRCC - FOUNDATION	0	441	419	860		194.01
194.02	07952 OTHER NRCC - GRANTS	0	0	0	0	0	194. 02
200.00	Cross Foot Adjustments	1			0		200.00
201.00	Negative Cost Centers		0	0	о	0	201.00
202.00	TOTAL (sum lines 118 through 201)	642,082	524, 281	498, 682	1, 665, 045	0	202.00
						-	

Heal th	Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					From 07/01/2017 To 06/30/2018	Part II	norod.
					To 06/30/2018	Date/Time Pre 11/28/2018 4:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		-		-		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	525, 940					5.00
7.00	00700 OPERATION OF PLANT	43, 887	115, 122				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	2,854	1, 199				8.00
9.00	00900 HOUSEKEEPI NG	15, 222	1, 124		24, 282		9.00
10.00	01000 DI ETARY	7, 917	4, 172		0 898	42, 011	1
11.00	01100 CAFETERI A	5, 943			211	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	25, 609	270		58	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	732	0		0 0	0	
15.00	01500 PHARMACY	66, 993	0		0 0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	662	2, 779		598	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDIATRICS	49, 005	17, 122			42, 011	1
43.00	04300 NURSERY	9, 290	234	6	8 50	0	43.00
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	23, 951	14, 478			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	22, 090				0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	46, 808	11, 663	2, 150	2, 511	0	
57.00	05700 CT SCAN	0	0		0 0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
60.00	06000 LABORATORY	62, 384	3, 267		0 703	0	
65.00	06500 RESPI RATORY THERAPY	23, 153			0 734	0	
65.01	03950 SLEEP LAB	5, 680	795		0 171	0	
66.00	06600 PHYSI CAL THERAPY	13, 044	5, 632		0 1, 212	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	920	594		0 128	0	67.00
68.00	06800 SPEECH PATHOLOGY	456	0		0 0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 171	3, 154	(	0 679	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	99	0	(	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 938	2, 168		0 467	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	70, 716	7, 963	5, 33	1,714	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		512, 524	85, 407	15, 38	8 17, 885	42, 011	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	57	240	(	0 52	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	8, 910	29, 227	(	0 6, 291	0	192.00
194.00	07950 OTHER NRCC - PUBLIC RELATIONS	3, 533	124	(	27	0	194.00
	07951 OTHER NRCC - FOUNDATION	270	124		27	0	194.01
194.02	07952 OTHER NRCC – GRANTS	646	0	(	0 0	0	194. 02
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)	525, 940	115, 122	15, 38	8 24, 282	42, 011	202.00

	J	T. VINCENT RAN			In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Pre 11/28/2018 4:	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 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	12.0/0					10.00
11.00 13.00	01100 CAFETERIA	13,969					11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 277	29, 787 0	7	22		13.00
14.00 15.00	01500 PHARMACY	498	-	73	0 94, 915		14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	490			0 94, 915	22 275	•
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		<u> </u>	23, 375	10.00
30.00	03000 ADULTS & PEDI ATRI CS	2,725	10, 850		0 0	926	30.00
43.00	04300 NURSERY	472			0 0	247	43.00
40.00	ANCI LLARY SERVICE COST CENTERS	-772	1,070		<u> </u>	277	+5.00
50, 00	05000 OPERATING ROOM	851	3, 390		0 0	1, 679	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,075			0 0	564	52.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 746			0 0	6, 777	54.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0		0 0	6, 316	60.00
65.00	06500 RESPI RATORY THERAPY	1, 254	0		0 0	1, 020	65.00
65.01	03950 SLEEP LAB	309	0		0 0	255	65. 01
66.00	06600 PHYSI CAL THERAPY	674	0		0 0	538	66.00
67.00	06700 OCCUPATI ONAL THERAPY	36			0 0	28	67.00
68.00	06800 SPEECH PATHOLOGY	23			0 0	9	68.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0		71		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		1	6 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	505	0		0 94, 915	0	73.00
00.00	OUTPATIENT SERVICE COST CENTERS						
90.00		0	-		0 0	0	90.00
91.00	09100 EMERGENCY	2, 357	9, 388		0 0	5, 016	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118.00		13, 802	29, 787	73	94, 915	22 275	118.00
116.00	NONREIMBURSABLE COST CENTERS	13, 602	29,101	/:	94,910	23, 375	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	157	0		0 0		192.00
	07950 OTHER NRCC - PUBLIC RELATIONS	0	-		0 0		194.00
	07951 OTHER NRCC - FOUNDATION	0	-		0 0		194.00
	07952 OTHER NRCC - GRANTS	10	-		0 0		194.02
200.00						0	200.00
201.00	,	0	0		0 0	0	201.00
202.00	5	13, 969	29, 787	73	94, 915	23, 375	202.00

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Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lieu of Form CMS	5-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	N: 15-1301	Period: Worksheet B From 07/01/2017 Part II	
				To 06/30/2018 Date/Time Pi	repared:
				11/28/2018	4:47 pm
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	24.00	25.00	26.00	—	
GENERAL SERVICE COST CENTERS	21100	20100	20100		
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 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 CAFETERIA					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 MEDI CAL RECORDS & LI BRARY					16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	050.450		050.45		
30. 00 03000 ADULTS & PEDI ATRI CS	252, 150	0	252, 15		30.00
43.00 04300 NURSERY	13, 869	0	13, 86	09	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	150, 245	0	150, 24	16	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	64, 142	0	64, 14		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	374, 326	0	374, 32		54.00
57. 00 05700 CT SCAN	0	0	574, 52	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o o		0	58.00
60. 00 06000 LABORATORY	81, 344	0	81, 34	•	60.00
65. 00 06500 RESPIRATORY THERAPY	79,036	0	79, 03		65.00
65. 01 03950 SLEEP LAB	12, 778	o	12, 77		65.01
66.00 06600 PHYSI CAL THERAPY	61, 530	0	61, 53		66.00
67.00 06700 OCCUPATI ONAL THERAPY	5, 839	o	5, 83		67.00
68.00 06800 SPEECH PATHOLOGY	488	0	48	38	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 663	0	31, 66	63	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	115	0	11	15	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	123, 164	0	123, 16	54	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	0		0	90.00
91.00 09100 EMERGENCY	157, 940	0	157, 94	40	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0			92.00
SPECIAL PURPOSE COST CENTERS				1	
118.00 SUBTOTALS (SUM OF LINES 1 through 117	7) 1, 408, 629	0	1, 408, 62	29	118.00
NONREI MBURSABLE COST CENTERS	0.010			10	-100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,018	0	2, 01		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	247,917	0	247, 91		192.00
194. 00 07950 OTHER NRCC - PUBLIC RELATIONS	4, 544	0	4, 54		194.00
194. 01 07951 OTHER NRCC - FOUNDATION	1, 281	0	1, 28		194.01
194. 02 07952 OTHER NRCC - GRANTS	656	0	65		194.02
200.00 Cross Foot Adjustments	0	0		0	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	1, 665, 045	0	1, 665, 04	0	201.00 202.00
202.00 TOTAL (Sum TIMES TTO THE OUGH 201)	1,005,045	I U	1,005,04	+5	1202.00

In Lieu of Form CMS-2552-10

Health Financial Systems	ST. VINCENT RANI	DOLPH HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				From 07/01/2017		
				To 06/30/2018	Date/Time Pre 11/28/2018 4:	epared:
		LATED COSTS			11/20/2010 4.	47 pili
	CAPITAL KEI	LATED CUSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUI P	EMPLOYEE	Reconciliation		·
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS			
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	78, 458					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	70, 100					2.00
		78, 458		-		
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	-	-,			4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	12, 343	12, 343	744, 92	5 -7, 351, 489	15, 405, 252	5.00
7.00 00700 OPERATION OF PLANT	4, 688	4, 688	68, 77	6 0	1, 285, 512	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	640	640		0 0	83, 595	8.00
9. 00 00900 HOUSEKEEPI NG	600			0 0	445, 863	
10. 00 01000 DI ETARY	2, 226				231, 894	
11. 00 01100 CAFETERIA	524			0 0	174, 076	
13.00 01300 NURSING ADMINISTRATION	144	144	517, 20	5 0	750, 123	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	21, 442	14.00
15.00 01500 PHARMACY	0	0	287, 78	5 0	1, 962, 289	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 483	1, 483		0 0		
INPATIENT ROUTINE SERVICE COST CENTERS	., 100	., 100				1
30. 00 03000 ADULTS & PEDIATRICS	9, 136	9, 136	953, 75	2 0	1, 435, 417	30.00
						1
43. 00 04300 NURSERY	125	125	182, 92	3 0	272, 122	43.00
ANCILLARY SERVICE COST CENTERS		1				-
50.00 OPERATING ROOM	7, 725					
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 349	2, 349	416, 85	3 0	647, 035	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	6, 223	6, 223	671, 37	1 0	1, 371, 073	54.00
57.00 05700 CT SCAN	0			0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0		
	-	-		0 0		
	1, 743			-		
65. 00 06500 RESPI RATORY THERAPY	1, 819				678, 179	
65. 01 03950 SLEEP LAB	424	424	117, 58	4 0	166, 360	65.01
66. 00 06600 PHYSI CAL THERAPY	3,005	3, 005	245, 38	1 0	382, 065	66.00
67.00 06700 OCCUPATIONAL THERAPY	317	317	16, 98	9 0	26, 936	67.00
68.00 06800 SPEECH PATHOLOGY	0				13, 364	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 683	-		0 0		1
	1,003	1,003		-		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0		
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 157	1, 157	190, 08	6 0	291, 101	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	4, 249	4, 249	855, 85	6 0	2, 071, 237	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS		J		1	L	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	62,603	62, 603	6, 063, 48	2 -7.351.489	15, 012, 311	118 00
NONREI MBURSABLE COST CENTERS	02,000	02,000	0,000,10	7,001,107	10,012,011	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	100	100		0 0	1 440	100 00
	128					190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	15, 595					
194.0007950 OTHER NRCC - PUBLIC RELATIONS	66	66		0 0	103, 474	194.00
194.0107951OTHER NRCC - FOUNDATION	66	66		0 0		194.01
194.0207952 OTHER NRCC - GRANTS	0	0	4, 50	8 0		194.02
200.00 Cross Foot Adjustments		l	.,	- U		200.00
201.00 Negative Cost Centers						200.00
5	E04 004	400 (00	2 000 04	-	7 051 400	
202.00 Cost to be allocated (per Wkst. B,	524, 281	498, 682	2, 089, 04		7, 351, 489	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	6. 682314	6. 356038	0. 34220	2	0. 477207	
204.00 Cost to be allocated (per Wkst. B,				0	525, 940	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0.00000	0	0.034140	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						200.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
						207.00
Parts III and IV)	1	I	I	T	I	I.

COST A	Financial Systems S LLOCATION - STATISTICAL BASIS	T. VINCENT RANI	Provider C		Period:	u of Form CMS- Worksheet B-1	
					From 07/01/2017 To 06/30/2018	Date/Time Pre 11/28/2018 4:	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
-	GENERAL SERVICE COST CENTERS						1
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA	61, 427 640 600 2, 226 524	70, 471 0 0	60, 18	6 100	161, 371	1.0 2.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0
	01300 NURSI NG ADMI NI STRATI ON	144	0	14	4 0	14, 752	13.0
	01400 CENTRAL SERVICES & SUPPLY	0	-		0 0	0	
	01500 PHARMACY	0			0 0	5, 754	
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	1, 483	0	1, 48	3 0	0	16.0
30.00	03000 ADULTS & PEDI ATRI CS	9, 136	26, 095	9, 13	6 100	31, 471	30. 0
	04300 NURSERY	125				5, 449	
	ANCI LLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	7,725				9, 834	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	2, 349 6, 223				12, 419 20, 171	
	05700 CT SCAN	0, 223			0 0	20, 171	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
60.00	06000 LABORATORY	1, 743	-		-	0	
65.00	06500 RESPI RATORY THERAPY	1, 819	0	1, 81	9 0	14, 488	65.0
	03950 SLEEP LAB	424				3, 564	
66.00	06600 PHYSI CAL THERAPY	3,005				7, 787	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	317	0		7 0 0 0	411 269	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 683	-		-	209	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0		.,	0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	1, 157	0	1, 15	7 0	5, 839	
	OUTPATIENT SERVICE COST CENTERS	1		1			
	09000 CLINIC	0			0 0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 249	24, 416	4, 24	9 0	27, 232	91.0 92.0
92.00	SPECIAL PURPOSE COST CENTERS						92.0
118.00		45, 572	70, 471	44, 33	2 100	159, 440	118.0
	NONREI MBURSABLE COST CENTERS			· ·		· · · · · · · · · · · · · · · · · · ·	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	128					190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	15, 595					192.0
	07950 OTHER NRCC - PUBLIC RELATIONS 07951 OTHER NRCC - FOUNDATION	66 66	0		0 0		194. 0 194. 0
	07952 OTHER NRCC - GRANTS	00		6			194.0
200.00					0	,	200. 0
201.00	Negative Cost Centers						201.0
202.00		1, 898, 967	143, 272	677, 18	1 436, 415	279, 241	202.0
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	30. 914207	2. 033063	11. 25128	3 4, 364. 150000	1.730429	203 0
204.00		115, 122				13, 969	
205.00		1. 874127	0. 218359	0. 40344	3 420. 110000	0.086565	205. 0
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 0
207.00	NAHE unit cost multiplier (Wkst. D,						207.0
	Parts III and IV)			1			1

	ancial Systems S CATLON - STATLSTICAL BASIS	ST. VINCENT RAND	Provi der CC	N: 15-1301	Peri od:	u of Form CMS-255 Worksheet B-1
					From 07/01/2017 To 06/30/2018	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			SUPPLY	REQUIS.)	LIBRARY	
		(DI RECT NURS.	(COSTED		(GROSS	
		HRS.)	REQUIS.)	15.00	CHARGES)	
CEN		13.00	14.00	15.00	16.00	
	ERAL SERVICE COST CENTERS 00 CAP REL COSTS-BLDG & FIXT					
	00 CAP REL COSTS-BLDG & FIXT					
	00 EMPLOYEE BENEFITS DEPARTMENT					
	00 ADMINISTRATIVE & GENERAL					
	00 OPERATION OF PLANT					
	00 LAUNDRY & LINEN SERVICE					
	00 HOUSEKEEPING					
	00 DI ETARY					1
	00 CAFETERI A					1
	00 NURSI NG ADMI NI STRATI ON	86, 405				1
	00 CENTRAL SERVICES & SUPPLY	0	132, 430			1
	00 PHARMACY	0	0	10, 0	00	1
	00 MEDICAL RECORDS & LIBRARY	0	o	10,0	0 73, 112, 787	1
	ATIENT ROUTINE SERVICE COST CENTERS	-	- 1			
	00 ADULTS & PEDIATRICS	31, 471	0		0 2, 894, 365	3
	00 NURSERY	5, 449	0		0 773, 290	4
	I LLARY SERVICE COST CENTERS	0,113			0 1101210	
	OO OPERATING ROOM	9,834	0		0 5, 246, 508	5
	00 DELIVERY ROOM & LABOR ROOM	12, 419	0		0 1, 762, 208	5
	00 RADI OLOGY-DI AGNOSTI C	0	0		0 21, 240, 525	5
	OO CT SCAN	0	0		0 0	5
3. 00 058	OO MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	5
	00 LABORATORY	0	0		0 19, 737, 755	6
5. 00 065	00 RESPI RATORY THERAPY	0	0		0 3, 188, 946	6
5.01 039	50 SLEEP LAB	0	0		0 797, 689	6
5.00 066	00 PHYSI CAL THERAPY	0	0		0 1, 681, 109	6
7.00 067	00 OCCUPATIONAL THERAPY	0	0		0 87, 678	6
3. 00 068	00 SPEECH PATHOLOGY	0	0		0 26, 735	6
1.00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	129, 523		0 0	7
2.00 072	00 IMPL. DEV. CHARGED TO PATIENTS	0	2, 907		0 0	7
	00 DRUGS CHARGED TO PATIENTS	0	0	10, 0	00 0	7
	PATIENT SERVICE COST CENTERS					
	00 CLINIC	0	0		0 0	9
	00 EMERGENCY	27, 232	0		0 15, 675, 979	9
	00 OBSERVATION BEDS (NON-DISTINCT PART)					9
	CIAL PURPOSE COST CENTERS					
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	86, 405	132, 430	10, 0	00 73, 112, 787	11
	REIMBURSABLE COST CENTERS					
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	
	00 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	19
	50 OTHER NRCC - PUBLIC RELATIONS	0	0		0 0	19
	51 OTHER NRCC - FOUNDATION	0	0		0 0	19
	52 OTHER NRCC - GRANTS	0	0		0 0	19
0.00	Cross Foot Adjustments					20
1.00	Negative Cost Centers	1 100 (0)	04 (74	0 000 (		20
2.00	Cost to be allocated (per Wkst. B,	1, 139, 686	31, 674	2, 908, 6	64 91, 190	20
2 00	Part I)	12 100047	0 220175	200 0444	0.001047	
3.00	Unit cost multiplier (Wkst. B, Part I)	13. 190047	0. 239175	290.8664		20
4.00	Cost to be allocated (per Wkst. B,	29, 787	732	94, 9	15 23, 375	20
	Part II)	0.044707	0 005507	0 4045	0.000000	
05.00	Unit cost multiplier (Wkst. B, Part	0. 344737	0. 005527	9.4915	00 0. 000320	20
16 00	NAME adjustment amount to be allocated					20
06.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					20
	NAHE unit cost multiplier (Wkst. D,					20
07.00						

		ST. VINCENT RANI	DOLPH HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	-	Period: From 07/01/2017 To 06/30/2018	Date/Time Pre 11/28/2018 4:	
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)				5.00	
	LNDATIENT DOUTINE CEDVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.440.074	1	0.440.07	4		
	03000 ADULTS & PEDIATRICS	3, 468, 274		3, 468, 27		0	00.00
		490, 149		490, 14	9 0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	1, 533, 827		1 522 02	7 0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	1, 243, 784		1, 533, 82 1, 243, 78		0	00.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 369, 186		2, 369, 18		0	•
	05700 CT SCAN	2, 309, 160		2, 309, 10		0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
	06000 LABORATORY	2, 797, 410		2, 797, 41	0 0	0	60.00
	06500 RESPIRATORY THERAPY	1, 107, 557	0			0	65.00
	03950 SLEEP LAB	270, 789	-	270, 78		0	65.01
	06600 PHYSI CAL THERAPY	706, 667		706, 66		0	66.00
	06700 OCCUPATI ONAL THERAPY	53, 977		53, 97		0	
	06800 SPEECH PATHOLOGY	20, 239		20, 23		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	325, 689		325, 68		0	•
	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 989		4, 98		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 397, 570		3, 397, 57	0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS		I				
90.00	09000 CLI NI C	0			0 0	0	90.00
91.00	09100 EMERGENCY	3, 714, 305		3, 714, 30	5 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	648, 024		648, 02	4	0	92.00
200.00	Subtotal (see instructions)	22, 152, 436	0	22, 152, 43	6 0	0	200. 00
201.00	Less Observation Beds	648, 024		648, 02	4	0	201.00
202.00	Total (see instructions)	21, 504, 412	C	21, 504, 41	2 0	0	202.00

Health Financial Systems S	T. VINCENT RAND	OLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: Worksheet From 07/01/2017 Part I To 06/30/2018 Date/Time 11/28/2018		
		Title	XVIII	Hospi tal	Cost	
	Charges					
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00 03000 ADULTS & PEDI ATRI CS	2, 396, 577		2, 396, 57			30.00
43. 00 04300 NURSERY	773, 290		773, 29	0		43.00
ANCI LLARY SERVICE COST CENTERS	I					
50. 00 05000 OPERATI NG ROOM	1, 680, 894	3, 565, 614				1
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 296, 312	465, 896				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	612, 441	20, 628, 084	21, 240, 52		0. 000000	
57.00 05700 CT SCAN	0	0		0 0.000000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000		1
60. 00 06000 LABORATORY	1, 130, 275	18, 607, 480				
65. 00 06500 RESPI RATORY THERAPY	867, 337	2, 321, 609			0. 000000	
65.01 03950 SLEEP LAB	0	797, 689				1
66. 00 06600 PHYSI CAL THERAPY	26, 147	1, 654, 962				
67.00 06700 OCCUPATI ONAL THERAPY	12, 715	74, 962				
68.00 06800 SPEECH PATHOLOGY	3, 079	23, 656				1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	425, 411	805, 024			0. 000000	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	26, 634				
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 206, 882	6, 839, 790	8, 046, 67	2 0. 422233	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS	,					
90. 00 09000 CLINIC	0	0		0 0. 000000		
91. 00 09100 EMERGENCY	245, 711	15, 430, 268				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	34, 716	463, 072			0. 000000	1
200.00 Subtotal (see instructions)	10, 711, 787	71, 704, 740	82, 416, 52	7		200.00
201.00 Less Observation Beds						201.00
202.00   Total (see instructions)	10, 711, 787	71, 704, 740	82, 416, 52	7		202.00

Health Financial Systems	ST. VINCENT RANDO	LPH HOSPITAL	In Lieu of Form CMS-2552-1			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prep 11/28/2018 4:4	oared: 17 pm	
		Title XVIII	Hospi tal	Cost		
Cost Center Description	PPS Inpatient Ratio 11.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY					30. 00 43. 00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00	
57.00 05700 CT SCAN	0. 000000				57.00	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000				58.00	
60. 00 06000 LABORATORY	0. 000000				60.00	
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00	
65. 01 03950 SLEEP LAB	0.00000				65.01	
66. 00 06600 PHYSI CAL THERAPY	0.00000				66.00	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0. 000000				67.00	
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000 S 0. 000000				68.00 71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000				72.00	
OUTPATIENT SERVICE COST CENTERS	0.00000				75.00	
90. 00 09000 CLINIC	0.000000				90.00	
91. 00 09100 EMERGENCY	0.000000				91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00	
200.00 Subtotal (see instructions)	, , , , , , , , , , , , , , , , , , , ,				200.00	
201.00 Less Observation Beds					201.00	
202.00 Total (see instructions)					202.00	

		ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2017 To 06/30/2018		
			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	3, 468, 274		3, 468, 27		3, 468, 274	30.00
	04300 NURSERY	490, 149		490, 14	9 0	490, 149	43.00
	ANCI LLARY SERVI CE COST CENTERS		i	1			
	05000 OPERATING ROOM	1, 533, 827		1, 533, 82		1, 533, 827	50.00
	05200 DELIVERY ROOM & LABOR ROOM	1, 243, 784		1, 243, 78		1, 243, 784	52.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 369, 186		2, 369, 18	6 0	2, 369, 186	54.00
	05700 CT SCAN	0			0 0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
	06000 LABORATORY	2, 797, 410		2, 797, 41		2, 797, 410	
	06500 RESPI RATORY THERAPY	1, 107, 557	C			1, 107, 557	
	03950 SLEEP LAB	270, 789	0	270, 78		270, 789	
	06600 PHYSI CAL THERAPY	706, 667	0	706, 66		706, 667	
	06700 OCCUPATI ONAL THERAPY	53, 977	0	53, 97		53, 977	67.00
	06800 SPEECH PATHOLOGY	20, 239		20, 23		20, 239	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	325, 689		325, 68		325, 689	
	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 989		4, 98		4, 989	
	07300 DRUGS CHARGED TO PATIENTS	3, 397, 570		3, 397, 57	0 0	3, 397, 570	73.00
	OUTPATIENT SERVICE COST CENTERS	-					
	09000 CLI NI C	0			0 0	0	
	09100 EMERGENCY	3, 714, 305		3, 714, 30		3, 714, 305	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	648, 024		648, 02		648, 024	
200.00	Subtotal (see instructions)	22, 152, 436	0	22, 152, 43		22, 152, 436	
201.00	Less Observation Beds	648, 024		648, 02		648, 024	
202.00	Total (see instructions)	21, 504, 412	0	21, 504, 41	2 0	21, 504, 412	202.00

Health Financial Systems S	T. VINCENT RAND	OLPH HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Pre 11/28/2018 4:	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 396, 577		2, 396, 57			30.00
43.00 04300 NURSERY	773, 290		773, 29	0		43.00
ANCI LLARY SERVI CE COST CENTERS				-		-
50. 00 05000 OPERATI NG ROOM	1, 680, 894	3, 565, 614			0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 296, 312	465, 896				
54.00 05400 RADI OLOGY-DI AGNOSTI C	612, 441	20, 628, 084	21, 240, 52		0. 000000	
57.00 05700 CT SCAN	0	0		0 0. 000000		•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0. 000000		
60. 00 06000 LABORATORY	1, 130, 275	18, 607, 480			0.00000	
65. 00 06500 RESPI RATORY THERAPY	867, 337	2, 321, 609			0. 000000	
65.01 03950 SLEEP LAB	0	797, 689			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	26, 147	1, 654, 962			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	12, 715	74, 962			0. 000000	•
68.00 06800 SPEECH PATHOLOGY	3, 079	23, 656			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	425, 411	805, 024			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	26, 634			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 206, 882	6, 839, 790	8, 046, 67	2 0. 422233	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0. 000000		
91.00 09100 EMERGENCY	245, 711	15, 430, 268			0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	34, 716	463, 072			0. 000000	
200.00 Subtotal (see instructions)	10, 711, 787	71, 704, 740	82, 416, 52	7		200.00
201.00 Less Observation Beds						201.00
202.00  Total (see instructions)	10, 711, 787	71, 704, 740	82, 416, 52	7		202.00

		ST. VINCENT RANDO			Lieu of Form CMS-2552-1	
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1301	Peri od: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Pre 11/28/2018 4:	epared: 47 pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	04300 NURSERY					43.00
-	ANCI LLARY SERVI CE COST CENTERS					
	05000 OPERATI NG ROOM	0. 000000				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	05700 CT SCAN	0. 000000				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
	06000 LABORATORY	0. 000000				60.00
	06500 RESPI RATORY THERAPY	0. 000000				65.00
	03950 SLEEP LAB	0. 000000				65.01
	06600 PHYSI CAL THERAPY	0. 000000				66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
	06800 SPEECH PATHOLOGY	0.00000				68.00 71.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
	07200 DRUGS CHARGED TO PATIENTS	0.000000				73.00
	OUTPATIENT SERVICE COST CENTERS	0.000000				/ 3.00
	09000 CLINIC	0. 000000				90.00
	09100 EMERGENCY	0. 000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Pre 11/28/2018 4:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	r				
50.00 05000 OPERATING ROOM	150, 245				1, 440	
52.00 05200 DELIVERY ROOM & LABOR ROOM	64, 142				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	374, 326	21, 240, 525			2, 487	54.00
57.00 05700 CT SCAN	0	0	0.00000		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.00000	0 0	0	58.00
60. 00 06000 LABORATORY	81, 344			224, 154	924	60.00
65. 00 06500 RESPI RATORY THERAPY	79, 036			4 459, 009	11, 376	
65. 01 03950 SLEEP LAB	12, 778	797, 689	0. 01601	9 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	61, 530	1, 681, 109	0. 03660	14, 958	547	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 839	87, 677	0. 06659	6, 818	454	67.00
68.00 06800 SPEECH PATHOLOGY	488	26, 735	0. 01825	3 3, 079	56	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 663	1, 230, 435	0. 02573	3 167, 265	4, 304	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	115	26, 634	0. 00431	8 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	123, 164	8, 046, 672	0. 01530	6 389, 718	5, 965	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
91.00 09100 EMERGENCY	157, 940	15, 675, 979	0. 01007	5 5, 303	53	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	47, 113	497, 788	0. 09464	5 0	0	92.00
200.00 Total (lines 50 through 199)	1, 189, 723	79, 246, 660		1, 461, 744	27,606	200 00

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D		
THROUGH COSTS				From 07/01/2017 To 06/30/2018		narod	
				10 00/30/2018	11/28/2018 4:		
		Title	e XVIII	Hospi tal	Cost		
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health		
	Anestheti st	Post-Stepdown	-	Post-Stepdown			
	Cost	Adjustments		Adjustments			
	1.00	2A	2.00	3A	3.00		
ANCI LLARY SERVI CE COST CENTERS							
50.00 O5000 OPERATING ROOM	0	C		0 0	0	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00	
57.00 05700 CT SCAN	0	C		0 0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00	
60. 00 06000 LABORATORY	0	C		0 0	0	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00	
65. 01 03950 SLEEP LAB	0	C		0 0	0	65.01	
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	C	)	0 0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	c c		0 0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0	C	)	0 0	0	90.00	
91.00 09100 EMERGENCY	0	C		0 0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00	
200.00 Total (lines 50 through 199)	0	c		0 0	0	200. 00	

11/28/2018 4:47 pm Y: \28750 - St. Vincent Randolph\300 - Medicare Cost Report\20180630\HFS Files\28750-18.mcrx

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-1301         Period: Fino 07/01/201         Porksheet D Part IV Dart I Dart I D	Health Financial Systems	ST. VINCENT RANDOLPH HOSPITAL			In Lieu of Form CMS-2552-10			
Cost Center Description         All Other Medical Education Cost         Total Cost (sum of col 4)         Total Cost (sum of col. 2, 3 and 4)         Total Outpatient Cost (sum of col. 2, 3 and 4)         Ratio of Cost to Charges (col. 5 + col. 7)           ANCILLARY SERVICE COST CENTERS		RVICE OTHER PASS	S Provider C		From 07/01/2017	Part IV Date/Time Pre		
Medical         (sum of col 1)         Outpatient Cost (sum of col 2, 3 and 4)         (cfrom Wkst. C, 0)         to Charges (col 5 + col 7)           ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           50.00         05000 DELIVERY ROOM & LABOR ROOM         0         0         5.246,508         0.000000         52.00           52.00         05100 GUOY-DI AGNOSTIC         0         0         0         1,762,208         0.000000         52.00           54.00         05400 RADI OLOGY-DI AGNOSTIC         0         0         0         0         0.000000         52.00           58.00         05500 CH KOM & LABOR ROOM         0         0         0         0         0.000000         52.00           58.00         05400 RADI OLOGY-DI AGNOSTIC         0         0         0         0         0.000000         52.00           60.00         06600 LABORATORY         0         0         0         0         0.000000         58.00         0.000000         58.00         0.000000         58.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00			Title	XVIII	Hospi tal	Cost		
ANCI LLARY SERVICE COST CENTERS         Cost (sum of cl. 2, 3 and 4)         Part I, col. (col. 5 + col. 7)           ANCI LLARY SERVICE COST CENTERS	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost		
4)         col. 2, 3 and 4)         8)         7)           4.00         5.00         6.00         7.00         8.00           ANCI LLARY SERVICE COST CENTERS         0         0         0         7.00         8.00           50.00         05000 DELI VERY ROOM         0         0         0         5.246,508         0.000000         52.00           52.00         05200 DELI VERY ROOM & LABOR ROOM         0         0         0         1.762,208         0.000000         52.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0         0         0         0         0.000000         52.00           57.00         05700 CT SCAN         0         0         0         0         0.000000         58.00           68.00         D6800 MAGNETI C RESONANCE I MAGI NG (MRI )         0         0         0         0         0.000000         58.00           65.01         03950 SLEEP LAB         0         0         0         77, 689         0.000000         66.00           66.00         06600         PHYSI CAL THERAPY         0         0         0         77, 77         0.000000         67.00           67.00         06700         0COPATI ONAL THERAPY         0		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges		
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM         0         0         0         7.00         8.00           52.00         05000         OPERATING ROOM         0         0         0         5.246,508         0.000000         52.00           52.00         05200         DELI VERY ROOM & LABOR ROOM         0         0         1.762,208         0.000000         52.00           54.00         OS400         RADI OLOGY-DI AGNOSTI C         0         0         0         0         0.000000         54.00           57.00         05700         CT SCAN         0         0         0         0.000000         58.00           60.00         LABORATORY         0         0         0         0.000000         58.00           65.00         O6500         RESPIRATORY THERAPY         0         0         0         0.000000         65.01           65.01         03950         SLEEP LAB         0         0         0         0         0         0.000000         65.01           66.00         O6600         PHYSI CAL THERAPY         0         0         0         1.68.1109         0.000000         67.00           66.00		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.		
4.00         5.00         6.00         7.00         8.00           ANCILLARY SERVICE COST CENTERS			4)	col. 2, 3 and	l 8)	7)		
ANCI LLARY         SERVICE         COST         CENTERS           50.00         05000         OPERATING         ROOM         0         0         52.00         52.00         05200         DELI VERY         ROOM         0         0         0         1, 762, 208         0.000000         52.00           54.00         05400         RADI LLGRY         ROOM & LABOR ROOM         0         0         0         1, 762, 208         0.000000         54.00           57.00         05700         CT         SCAN         0         0         0         0         0.000000         57.00           58.00         05800         MAGRETI C         RESONANCE         IMAGI NG (MRI )         0         0         0         0.000000         58.00           60.00         06000         LABORATORY         0         0         0         0         0.000000         65.00           65.01         03950         SLEEP LAB         0         0         0         77.689         0.000000         66.00           68.00         OEADO         0         0         0         77.689         0.000000         67.00           68.00         OBGOO         0         0         0         0				.,				
50.00         05000         0PERATING ROOM         0         0         5,246,508         0.00000         50.00           52.00         05200         DELIVERY ROOM & LABOR ROOM         0         0         1,762,208         0.000000         52.00           54.00         O5400 RADIOLOGY-DIAGNOSTIC         0         0         0         21,240,525         0.000000         52.00           57.00         O5700         CT SCAN         0         0         0         0.000000         58.00           60.00         05800         MAGNETIC RESONANCE IMAGING (MRI)         0         0         0         0.000000         58.00           60.00         06500         RADRATORY         0         0         0         0.000000         58.00           64.00         06500         RESPIRATORY THERAPY         0         0         0         797,689         0.000000         65.01           65.01         03950         SLEEP LAB         0         0         0         797,689         0.000000         65.01           66.00         06600         PHYSI CAL THERAPY         0         0         0         787,677         0.000000         65.00           67.00         06700         0         0 </td <td></td> <td>4.00</td> <td>5.00</td> <td>6.00</td> <td>7.00</td> <td>8.00</td> <td></td>		4.00	5.00	6.00	7.00	8.00		
52.00       05200       DELIVERY ROOM & LABOR ROOM       0       0       1,762,208       0.000000       52.00         54.00       05400       RADIOLOGY-DIAGNOSTIC       0       0       21,240,525       0.000000       54.00         57.00       05700       CT SCAN       0       0       0       0.000000       57.00         58.00       MAGNETIC RESONANCE IMAGING (MRI)       0       0       0       0.000000       58.00         60.00       06000       LABORATORY       0       0       0       0.000000       65.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       797,689       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       777,689       0.000000       65.01         67.00       06700       CCUPATI ONAL THERAPY       0       0       0       87,677       0.000000       68.00         68.00       064800       SPECH PATHOLOGY       0       0       1,230,435       0.000000       67.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       1,230,435       0.000000       72.00 <td< td=""><td></td><td>T</td><td>-</td><td></td><td>- F</td><td></td><td></td></td<>		T	-		- F			
54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       21, 240, 525       0.00000       54.00         57.00       05700       CT SCAN       0       0       0       0.00000       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       0.000000       58.00         60.00       06000       LABORATORY       0       0       0       0.000000       65.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       797, 689       0.000000       65.00         65.01       03950       SLEEP LAB       0       0       0       797, 689       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       87, 677       0.000000       65.00         67.00       06700       OCUPATI ONAL THERAPY       0       0       0       87, 677       0.000000       68.00         67.00       06700       OCUPATI ONAL THERAPY       0       0       0       1, 230, 435       0.000000       71.00         72.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       26, 634       0.000000		0	0					
57.00       05700       CT SCAN       0       0       0       0.000000       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0       0       0       0.000000       58.00         60.00       06000       LABORATORY       0       0       0       0.000000       60.00         65.01       03950       SLEEP LAB       0       0       0       77,689       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       797,689       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       1,681,109       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       87,677       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       1,230,435       0.000000       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       26,735       0.000000       72.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       26,634<	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 762, 208	0.000000	52.00	
58.00       05800       MAGNETI C RESONANCE I MAGING (MRI)       0       0       0       0.000000       58.00         60.00       06000       LABORATORY       0       0       0       19,737,755       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       3,188,946       0.000000       65.00         65.01       03950       SLEEP LAB       0       0       0       797,689       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       1,681,109       0.000000       65.01         66.00       06000       PCOUPATI ONAL THERAPY       0       0       0       1,681,109       0.000000       65.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       1,681,109       0.000000       67.00         68.00       08600       SPEECH PATHOLOGY       0       0       0       26,735       0.000000       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       0       26,634       0.000000       72.00         73.00       07200       IMPL. DEV. CHARGED TO PATIENTS	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		21, 240, 525	0.00000	54.00	
60.00       06000       LABORATORY       0       0       19,737,755       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       3,188,946       0.000000       65.00         65.01       03950       SLEEP       LAB       0       0       0       797,689       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       1,681,109       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       87,677       0.000000       68.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       26,735       0.000000       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       26,634       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       26,634       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS	57.00 05700 CT SCAN	0	0		0 0	0.00000	57.00	
65.00       06500       RESPI RATORY THERAPY       0       0       3, 188, 946       0.000000       65.00         65.01       03950       SLEEP LAB       0       0       0       797, 689       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       1, 681, 109       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       87, 677       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       26, 735       0.000000       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       1, 230, 435       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       2, 634       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       8, 046, 672       0.000000       72.00         74.00       09000       CLI NI C       0       0       0       0.000000       90.00         91.00       09100       EMERGENCY       0       0       0       0.000000       <	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.00000	58.00	
65. 01       03950       SLEEP LAB       0       0       797,689       0.000000       65. 01         66. 00       06600       PHYSI CAL THERAPY       0       0       0       1,681,109       0.000000       66. 00         67. 00       06700       OCCUPATI ONAL THERAPY       0       0       0       87,677       0.000000       67. 00         68. 00       06800       SPEECH PATHOLOGY       0       0       0       26,735       0.000000       68. 00         71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       1,230,435       0.000000       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       26,634       0.000000       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0       0       8,046,672       0.000000       72. 00         71. 00       09000       CLI NI C       0       0       0       0.000000       90. 00         90. 00       09100       EMERGENCY       0       0       0       0.000000       91. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       497,788	60. 00 06000 LABORATORY	0	0		0 19, 737, 755	0.00000	60.00	
66.00       06600       PHYSI CAL THERAPY       0       0       1, 681, 109       0.000000       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       0       0       87, 677       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       26, 735       0.000000       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       1, 230, 435       0.000000       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       0       26, 634       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       8,046,672       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000       72.00         74.00       09000       CLI NI C       0       0       0       0.000000       90.00         91.00       09100       EMERGENCY       0       0       0       0.000000       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       497,788 <td< td=""><td>65. 00 06500 RESPI RATORY THERAPY</td><td>0</td><td>0</td><td></td><td>3, 188, 946</td><td>0.00000</td><td>65.00</td></td<>	65. 00 06500 RESPI RATORY THERAPY	0	0		3, 188, 946	0.00000	65.00	
67.00       06700       OCCUPATIONAL THERAPY       0       0       87,677       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       26,735       0.000000       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       1,230,435       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       26,634       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       8,046,672       0.000000       73.00         OUTPATI ENT SERVICE COST CENTERS         OUTPATI ENT SERVICE COST CENTERS         90.00       09000       CLI NI C       0       0       0.000000       90.00         91.00       09100       EMERGENCY       0       0       0       0.000000       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       497,788       0.000000       92.00	65.01 03950 SLEEP LAB	0	0		0 797, 689	0.00000	65.01	
68.00       06800       SPEECH PATHOLOGY       0       0       26,735       0.000000       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       1,230,435       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       26,634       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       8,046,672       0.000000       73.00         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0.000000       70.00       70.00       70.00       90.00       0.000000       70.00       70.00         90.00       09000       CLINIC       0       0       0       0       0.000000       90.00         91.00       09100       EMERGENCY       0       0       0       0.000000       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       0       0       497,788       0.000000       92.00	66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 681, 109	0.00000	66.00	
71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         1, 230, 435         0.000000         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         0         26, 634         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         0         0         8,046,672         0.000000         73.00           0UTPATI ENT SERVICE COST CENTERS         0         0         0         0         0         0.000000         90.00           90.00         09000         CLI NI C         0         0         0         0         0.000000         91.00           91.00         09100         EMERGENCY         0         0         0         0.000000         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         0         0         497, 788         0.000000         92.00	67.00 06700 OCCUPATIONAL THERAPY	0	0		0 87, 677	0.00000	67.00	
72. 00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         0         26, 634         0.000000         72. 00           73. 00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         8,046,672         0.000000         73. 00           0UTPATIENT SERVICE COST CENTERS         0         0         0         0         0         0.000000         73. 00           90. 00         09000         CLINIC         0         0         0         0.000000         90. 00           91. 00         09100         EMERGENCY         0         0         0         15, 675, 979         0.000000         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         0         497, 788         0.000000         92. 00	68.00 06800 SPEECH PATHOLOGY	0	0		26, 735	0.00000	68.00	
73. 00         07300         DRUGS CHARGED TO PATIENTS         0         0         8,046,672         0.000000         73.00           0UTPATIENT SERVICE COST CENTERS         0         0         0         0         0.000000         90.00         90.00         0         0.000000         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         92.00         00         0         0         91.00         92.00         92.00         058ERVATI ON BEDS (NON-DI STI NCT PART)         0         0         0         497,788         0.000000         92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 230, 435	0.000000	71.00	
OUTPATI ENT_SERVICE_COST_CENTERS           90. 00         09000         CLINIC         0         0         0.00         90.00           91. 00         09100         EMERGENCY         0         0         0         15, 675, 979         0.000000         91.00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         0         0         497, 788         0.000000         92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		26, 634	0.000000	72.00	
90. 00         09000         CLINIC         0         0         0         0.00000         90. 00           91. 00         09100         EMERGENCY         0         0         0         15, 675, 979         0.000000         91. 00           92. 00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         0         497, 788         0.000000         92. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 8, 046, 672	0.00000	73.00	
91. 00         09100         EMERGENCY         0         0         15, 675, 979         0. 00000         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DISTINCT PART)         0         0         0         497, 788         0. 000000         92. 00	OUTPATIENT SERVICE COST CENTERS						1	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 497, 788 0. 000000 92. 00	90. 00 09000 CLI NI C	0	0		0 0	0.00000	90.00	
	91. 00 09100 EMERGENCY	0	0		0 15, 675, 979	0.00000	91.00	
200.00         Total (lines 50 through 199)         0         0         79, 246, 660         200.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		497, 788	0.000000	92.00	
	200.00   Total (lines 50 through 199)	0	0		79, 246, 660		200. 00	

Health Financial Systems S	T. VINCENT RANDO	OLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider CC	CN: 15-1301	Period: From 07/01/2017 To 06/30/2018		pared: 47 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	50, 299		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	141, 141		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	224, 154		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	459, 009		0 0	0	65.00
65. 01 03950 SLEEP LAB	0. 000000	0		0 0	0	65.01
66.00 06600 PHYSI CAL THERAPY	0. 000000	14, 958		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	6, 818		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	3, 079		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	167, 265		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0, 000000	389, 718		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90, 00 09000 CLINIC	0, 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0, 000000	5, 303		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 461, 744		0 0	-	200. 00

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Pre 11/28/2018 4:	
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 292352		900, 21	4 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 705810			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 111541		5, 957, 86	2 0	0	54.00
57.00 05700 CT SCAN	0. 000000			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0 0	0	58.00
60. 00 06000 LABORATORY	0. 141729		3, 978, 75	7 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 347311	0	1, 241, 03	9 0	0	65.00
65. 01 03950 SLEEP LAB	0. 339467	0	115, 79	6 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 420358	0	582, 51	3 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 615635	0	15, 33	1 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 757023	0	14, 76	9 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 264694	0	291, 60	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 187317	0	3, 26	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 422233	0	1, 964, 34	0 410	0	73.00
OUTPATIENT SERVICE COST CENTERS		•	•			
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 236942	0	3, 778, 36	5 1, 476	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 301807	0	178, 09	1 0	0	92.00
200.00 Subtotal (see instructions)		0	19, 021, 94	4 1, 886	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	19, 021, 94	4 1, 886	0	202.00

Health Financial Systems	S	T. VINCENT RAN	OOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC			Worksheet D Part V Date/Time Pre 11/28/2018 4:	
				XVIII	Hospi tal	Cost	
		Cos					
Cost Center [	Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANTERS	6.00	7.00				
ANCI LLARY SERVICE		2(2,170	0				50.00
50. 00 05000 OPERATING R00		263, 179	0				50.00
52. 00 05200 DELIVERY ROOM			0				52.00
54. 00 05400 RADI OLOGY-DI A	AGNUSTIC	664, 546	0				54.00
57.00 05700 CT SCAN		0	0				57.00
	DNANCE IMAGING (MRI)	U 5 ( 0, 005	0				58.00
60. 00 06000 LABORATORY		563, 905					60.00
65. 00 06500 RESPI RATORY 1	THERAPY	431, 026					65.00
65.01 03950 SLEEP LAB		39, 309	0				65.01
66. 00 06600 PHYSI CAL THEF		244, 864	0				66.00
67.00 06700 0CCUPATI ONAL		9, 438					67.00
68.00 06800 SPEECH PATHOL		11, 180	0				68.00
	LIES CHARGED TO PATIENTS	77, 185	0				71.00
72.00 07200 IMPL. DEV. CH		612					72.00
73.00 07300 DRUGS CHARGE		829, 409	173				73.00
OUTPATIENT SERVICE	COST CENTERS	1					
90. 00 09000 CLI NI C		0	0				90.00
91.00 09100 EMERGENCY		895, 253					91.00
	BEDS (NON-DISTINCT PART)	231, 840					92.00
	e instructions)	4, 261, 746	523				200.00
201.00 Less PBP Clir Only Charges	nic Lab. Services-Program	0					201.00
	(line 200 - line 201)	4, 261, 746	523				202.00

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provider C	CN: 15-1301	Peri od:	Worksheet D	
		Component		From 07/01/2017 To 06/30/2018		norod.
		component	CCN: 15-Z301	To 06/30/2018	Date/Time Pre 11/28/2018 4:	
		Title	XVIII S	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 292352			0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 705810			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 111541			0 0	0	
57.00 05700 CT SCAN	0. 000000			0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0 0	0	
60. 00 06000 LABORATORY	0. 141729	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 347311	0		0 0	0	65.00
65. 01 03950 SLEEP LAB	0. 339467	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 420358	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 615635	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 757023	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 264694	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 187317	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 422233	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		·	•	·		1
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 236942	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 301807	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Progra	n			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems S	T. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1301	Peri od:	Worksheet D	
		Component (	CCN: 15-Z301	From 07/01/2017 To 06/30/2018	Part V Date/Time Pre	epared:
					11/28/2018 4:	
			XVIII	Swing Beds - SNF	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				-
ANCI LLARY SERVI CE COST CENTERS	0	0				50,00
	0	0				
	0	0				52.00 54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	0	0				54.00
	0	0				57.00
	0	0				
	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
65. 01 03950 SLEEP LAB	0	0				65.01
66.00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 07/01/2017 To 06/30/2018		
			e XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Nursing School	Allied Healt	Allied Health	All Other	
	Post-Stepdown	-	Post-Stepdow	n Cost	Medi cal	
	Adj ustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				· ·		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
43. 00 04300 NURSERY	0	0		o o	0	43.00
200.00 Total (lines 30 through 199)	0	0		o o	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		· · · ·		
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	1, 76	8 0.00	38	30.00
43. 00 04300 NURSERY		0	43	1 0.00	29	43.00
200.00 Total (lines 30 through 199)		0	2, 19	9	67	200.00
Cost Center Description	I npati ent				•	
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	· ·					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	1					

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL	T. VINCENT RANDOLPH HOSPITAL			2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2017 To 06/30/2018		narod
				10 00/30/2018	Date/Time Pre 11/28/2018 4:4	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
65. 01 03950 SLEEP LAB	0	0		0 0	0	65.01
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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		-				
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00   Total (lines 50 through 199)	0	0		0 0	0	200. 00

APPORTI ONMENT OF I INPATI ENT/OUTPATI ENT ANCI LLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-1301         Period: Period: To 06/30/2018         Worksheet D Part IV Date/Time Prepared: 11/28/2018         Provider CCN: 15-1301           Import Cost         Title XIX         Hospital         Cost         Total Outpatient         Cost         Part IV Date/Time Prepared: 11/28/2018         Part IV Cost         Part IV Date/Time Prepared: 11/28/2018         Part IV Cost         Part IV Cost	Health Financial Systems	ST. VINCENT RANDOLPH HOSPITAL			In Lieu of Form CMS-2552-10			
Cost Center Description         All Other Medical Education Cost         Total Cost (sum of col 1 through col. 2, 3 and 4)         Total Charges (csum of col. 2, 3 and 4)         Total Charges (csum of col. 2, 3 and 4)         Ratio of Cost to Charges (csl. 5 + col. 8)           ANCILLARY SERVICE COST CENTERS         0		ERVICE OTHER PASS	S Provider C		From 07/01/2017	Part IV Date/Time Pre		
Medical Education Cost         (sum of col 4)         Outpatient Cost (sum of 4)         (from Wkst. C, 0st (sum of col. 2, 3 and 4)         to Charges (col. 5 + col. 7)           4.00         5.00         6.00         7.00         8.00           4.00         5.00         6.00         7.00         8.00           50.00         05000 (DPERATING ROM 4)         0         0         0         0         0.00         5.246,508         0.000000         50.00           52.00         05200 DELI VERY ROM & LABOR ROM 0         0         0         0         0         1,762,208         0.000000         52.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0         0         0         0         0         0.000000         54.00           57.00         05700 CT SCAN         0         0         0         0         0.000000         58.00           60.00         04600 LABORATORY         0         0         0         0         0.000000         58.00           65.01         03505 SLEEP LAB         0         0         0         0         0         0.000000         65.01           66.00         0600 PHSPI RATORY THERAPY         0         0         0         0         0         0.000000<			Ti tl	e XIX	Hospi tal	Cost		
Education Cost         through col.         Cost (sum of col. 2, 3 and 4)         Part I, col.         (col. 5 + col. 7)           ANCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           50.00         05000         OPERATING ROOM         0         0         5.246,508         0.000000         52.00           52.00         05200         DELIVERY ROOM & LABOR ROOM         0         0         1,762,208         0.000000         52.00           54.00         05400         RADI JLOGY-DI AGNOSTI C         0         0         0         0.000000         52.00           54.00         05600         RADI JLOGY-DI AGNOSTI C         0         0         0         0.000000         57.00           58.00         05800         MAGNETI C RESONANCE I MAGI NG (MRI )         0         0         0         0.000000         58.00           60.00         6600         PHYSI CAL THERAPY         0         0         0         0.000000         65.00           65.01         03950         SLEP LAB         0         0         0         77.689         0.000000         66.00           66.00         06000         PHYSI CAL THERAPY         0         0         0         26,634	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost		
4)         col. 2, 3 and 4)         7)           4.00         5.00         6.00         7.00         8.00           50.00         05000 [0PERATI ING ROOM         0         0         5.246,508         0.000000         52.00           52.00         05200 [DELI VERY ROOM & LABOR ROOM         0         0         0         1,762,208         0.000000         52.00           54.00         05400 [RAID LOGV-DI AGNOSTI C         0         0         0         21,240,525         0.000000         57.00           57.00         05700 [CT SCAN         0         0         0         0         0.000000         58.00           60.00         LABOR ROFTI C         0         0         0         0         0.000000         57.00           58.00         05800 [MGNETI C RESONANCE I MAGI NG (MRI )         0         0         0         0.000000         58.00           60.00         06000 [LABORATORY         0         0         0         0         0.000000         56.00           65.01         03950 [LEEP LAB         0         0         0         77,689         0.000000         65.01           66.00         06600 [PHYSI CAL THERAPY         0         0         0         26,735		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges		
ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           50.00         05000         OPERATI NG ROOM         0         0         0.52.00         5.246, 508         0.000000         52.00           54.00         05200         DELI VERY ROM & LABOR ROOM         0         0         1.762, 208         0.000000         54.00           54.00         05400         RADI LGGY-DI AGNOSTI C         0         0         0         21, 240, 525         0.000000         54.00           57.00         05700         CT SCAN         0         0         0         0         0.000000         58.00           60.00         66000         LABOR RATORY         0         0         0         0.000000         58.00           65.00         06500         RESPI RATORY         0         0         0         0         0.000000         65.01           65.00         06600         PH SI CAL THERAPY         0         0         0         777, 689         0.000000         65.01           66.00         06000         CH PATHOLOGY         0         0         0         1.681, 109         0.000000         66.00           71.00         07100 <td< td=""><td></td><td>Education Cost</td><td>through col.</td><td>Cost (sum of</td><td>Part I, col.</td><td>(col. 5 ÷ col.</td><td></td></td<>		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.		
4.00         5.00         6.00         7.00         8.00           ANCI LLARY SERVICE COST CENTERS			4)	col. 2, 3 and	(8 1	7)		
ANCI LLARY SERVICE COST CENTERS           50.00         05000 (PERATI NG ROOM         0         0         5,246,508         0.000000         50.00           52.00         05200 (DELI VERY ROOM & LABOR ROOM         0         0         0         1,762,208         0.000000         52.00           54.00         05400 (RADI OLOGY-DI AGNOSTI C         0         0         0         21,240,525         0.000000         54.00           57.00         05700 (CT SCAN         0         0         0         0         0.000000         58.00           58.00         05800 MAGNETI C RESONANCE I MAGI NG (MRI )         0         0         0         0.000000         58.00           60.00         06600 LABORATORY         0         0         0         0         0.000000         65.00           65.01         03950 SLEEP LAB         0         0         0         3.188,946         0.000000         65.00           66.00         06600 PHYSI CAL THERAPY         0         0         0         87.677         0.000000         68.00           66.00         06600 SPEECH PATHOLOGY         0         0         0         1,230,435         0.000000         68.00           71.00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI E								
50.00         05000         0PERATING ROOM         0         0         0         5, 246, 508         0, 000000         50.00           52.00         05200         DELIVERY ROOM & LABOR ROOM         0         0         1, 762, 208         0, 000000         52.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         21, 240, 525         0, 000000         54.00           57.00         05700         CT SCAN         0         0         0         0, 000000         58.00           058.00         05800         MAGNETI C RESONANCE I MAGI NG (MRI )         0         0         0         0, 000000         58.00           60.00         06000         LABORATORY         0         0         0         0, 000000         68.00           65.01         03950         SLEEP LAB         0         0         0         19, 737, 755         0, 000000         65.01           64.00         066000         PHYSI CAL THERAPY         0         0         0         77, 689         0, 000000         65.01           65.01         03950         SLEEP LAB         0         0         0         1, 681, 109         0, 000000         65.01           64.00 </td <td></td> <td>4.00</td> <td>5.00</td> <td>6.00</td> <td>7.00</td> <td>8.00</td> <td></td>		4.00	5.00	6.00	7.00	8.00		
52.00       05200       DELIVERY ROOM & LABOR ROOM       0       0       1,762,208       0.000000       52.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       21,240,525       0.000000       54.00         57.00       05700 CT SCAN       0       0       0       0       0.000000       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0       0       0       0.000000       58.00         60.00       06000       LABORATORY       0       0       0       19,737,755       0.000000       65.00         65.01       03950       SLEEP LAB       0       0       0       797,689       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       77.00       0.000000       66.00         67.00       06700       0CUPATI ONAL THERAPY       0       0       0       26,735       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       1,230,435       0.000000       67.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       1,230,435<		-		1	1	1		
54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       21, 240, 525       0.000000       54.00         57.00       05700       CT SCAN       0       0       0       0.000000       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       0.000000       58.00         60.00       06000       LABORATORY       0       0       0       0.000000       60.00         65.01       03950       SLEEP LAB       0       0       0       77, 755       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       797, 689       0.000000       65.01         66.00       06700       OCUPATI ONAL THERAPY       0       0       0       797, 689       0.000000       67.00         67.00       06700       OCUPATI ONAL THERAPY       0       0       0       87, 677       0.000000       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       26, 634       0.000000       72.00         72.00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0       0       0       26, 634       0		0	C					
57.00       05700       CT SCAN       0       0       0       0.000000       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       0.000000       58.00         60.00       06000       LABORATORY       0       0       0       19,737,755       0.000000       60.00         65.01       03950       SLEEP LAB       0       0       0       797,689       0.000000       65.01         66.00       06000       PHYSI CAL THERAPY       0       0       0       797,689       0.000000       65.01         67.00       06700       0CUPATI IONAL THERAPY       0       0       0       77       0.000000       65.01         64.00       06600       PHYSI CAL THERAPY       0       0       0       87,77       0.000000       65.01         65.01       06500       CCUPATI IONAL THERAPY       0       0       0       87,77       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       71.00       70.00       68.00       71.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00<		0	( C					
58.00         05800         MAGNETIC RESONANCE I MAGING (MRI)         0         0         0         0.000000         58.00           60.00         06000         LABORATORY         0         0         0         19,737,755         0.000000         60.00           65.00         06500         RESPIRATORY THERAPY         0         0         0         3,188,946         0.000000         65.00           65.01         03950         SLEEP LAB         0         0         0         797,689         0.000000         65.01           66.00         06600         PHYSI CAL THERAPY         0         0         0         1,681,109         0.000000         66.00           67.00         06700         00         0         87,677         0.000000         67.00           68.00         06800         SPEECH PATHOLOGY         0         0         0         87,677         0.000000         68.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0         0         0         2.6,334         0.000000         72.00           72.00         07200         IMPL.         DEV. CHARGED TO PATIENTS         0         0         0         2.6,634         0.000000         72.00 <td></td> <td>0</td> <td>C</td> <td></td> <td>0 21, 240, 525</td> <td></td> <td></td>		0	C		0 21, 240, 525			
60.00       06000       LABORATORY       0       0       19, 737, 755       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       3, 188, 946       0.000000       65.00         65.01       03950       SLEEP LAB       0       0       0       797, 689       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       797, 689       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       797, 689       0.000000       65.01         67.00       06700       0CUPATI ONAL THERAPY       0       0       0       81, 109       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       26, 735       0.000000       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       26, 634       0.000000       72.00         73.00       07200 IMPL.       DEV. CHARGED TO PATI ENTS       0       0       0       8.046, 672       0.000000       73.00         00.00000       CLI NI C       0       0		0	C		0 0			
65.00         06500         RESPIRATORY THERAPY         0         0         3, 188, 946         0.000000         65.00           65.01         03950         SLEEP LAB         0         0         0         797, 689         0.000000         65.01           66.00         06600         PHYSI CAL THERAPY         0         0         0         797, 689         0.000000         65.01           66.00         06600         PHYSI CAL THERAPY         0         0         0         0         1, 681, 109         0.000000         66.00           67.00         06700         0CUPATI ONAL THERAPY         0         0         0         87, 677         0.000000         67.00           68.00         08600         SPEECH PATHOLOGY         0         0         0         26, 735         0.000000         68.00           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         1, 230, 435         0.000000         71.00           72.00         07300         DRUGS CHARGED TO PATI ENTS         0         0         0         8, 046, 672         0.000000         72.00           73.00         OUTPATI ENT SERVICE COST CENTERS         0         0         0	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0. 000000	58.00	
65.01       03950       SLEEP LAB       0       0       797,689       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       0       1,681,109       0.000000       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       0       0       87,677       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       26,735       0.000000       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       1,230,435       0.000000       71.00         72.00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0       0       0       26,634       0.000000       72.00         73.00       07300 DRUGS CHARGED TO PATI ENTS       0       0       0       8,046,672       0.000000       72.00         74.00       09000 CLI NI C       0       0       0       0.000000       90.00       90.00         90.00       09100 EMERGENCY       0       0       0       0.000000       91.00         92.00       09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       497,788       0.000000	60. 00 06000 LABORATORY	0	C		0 19, 737, 755	0.000000	60.00	
66.00         06600         PHYSI CAL THERAPY         0         0         0         1, 681, 109         0.000000         66.00           67.00         06700         0CCUPATI ONAL THERAPY         0         0         0         87, 677         0.000000         67.00           68.00         06800         SPEECH PATHOLOGY         0         0         0         26, 735         0.000000         68.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         0         0         1, 230, 435         0.000000         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         0         0         26, 634         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         8, 046, 672         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         0.000000         72.00           90.00         09000         CLINIC         0         0         0         0.000000         90.00           91.00         09100         EMERGENCY         0         0         0         0.000000         91.00	65. 00 06500 RESPI RATORY THERAPY	0	C		0 3, 188, 946	0.000000	65.00	
67.00       06700       0CCUPATI ONAL THERAPY       0       0       87,677       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       26,735       0.000000       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       0       1,230,435       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       26,634       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       8,046,672       0.000000       72.00         00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       8,046,672       0.000000       72.00         09000       CLINIC       0       0       0       0.000000       90.00       90.00         91.00       09100       EMERGENCY       0       0       0       0.000000       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       0       0       497,788       0.000000       92.00		0	C		0 797, 689	0.000000	65.01	
68.00         06800         SPEECH PATHOLOGY         0         0         0         26,735         0.000000         68.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         0         0         1,230,435         0.000000         71.00           72.00         07200         IMPL.         DEV. CHARGED TO PATIENTS         0         0         0         26,634         0.000000         72.00           73.00         DRUGS CHARGED TO PATIENTS         0         0         0         8,046,672         0.000000         73.00           0UTPATIENT SERVICE COST CENTERS         0         0         0         0.000000         90.00         90.00         90.00         90.00         90.00           90.00         09100         EMERGENCY         0         0         0         0.000000         91.00         91.00         92.00         9200         0BSERVATION BEDS (NON-DI STINCT PART)         0         0         0         497,788         0.000000         92.00	66. 00 06600 PHYSI CAL THERAPY	0	C		0 1, 681, 109	0.000000	66.00	
71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0         0         1, 230, 435         0.000000         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         0         0         26, 634         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         8, 046, 672         0.000000         73.00           0UTPATIENT SERVICE COST CENTERS         0         0         0         0.000000         90.00         90.00         90.00         90.00         90.00         90.00         91.00         91.00         0         0         0         91.00         92.00         08SERVATION BEDS (NON-DISTINCT PART)         0         0         0         497, 788         0.000000         92.00	67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 87, 677	0.000000	67.00	
72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         0         26,634         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         8,046,672         0.000000         73.00           0UTPATIENT SERVICE COST CENTERS         0         0         0         0         0.000000         73.00           90.00         09000         CLINIC         0         0         0         0.000000         90.00           91.00         09100         EMERGENCY         0         0         0         0.000000         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         0         0         497, 788         0.000000         92.00	68.00 06800 SPEECH PATHOLOGY	0	C		0 26, 735	0.000000	68.00	
73. 00         07300         DRUGS CHARGED TO PATIENTS         0         0         8,046,672         0.000000         73.00           0UTPATIENT SERVICE COST CENTERS         0         0         0         0.000000         0         0.000000         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         90.00         91.00         91.00         91.00         91.00         92.00         052RVATI ON BEDS (NON-DI STINCT PART)         0         0         0         497,788         0.000000         92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 1, 230, 435	0.00000	71.00	
OUTPATI ENT_SERVICE_COST_CENTERS           90.00         09000         CLINIC         0         0         0.00000         90.00           91.00         09100         EMERGENCY         0         0         0         15, 675, 979         0.000000         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         0         0         497, 788         0.000000         92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 26, 634	0.000000	72.00	
90.00         09000         CLINIC         0         0         0         0.00000         90.00           91.00         09100         EMERGENCY         0         0         0         15, 675, 979         0.000000         91.00           92.00         09200         OBSERVATION         BEDS (NON-DISTINCT PART)         0         0         0         497, 788         0.000000         92.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	)	0 8, 046, 672	0.000000	73.00	
91.00         09100         EMERGENCY         0         0         15, 675, 979         0.000000         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0         0         0         497, 788         0.000000         92.00	OUTPATIENT SERVICE COST CENTERS							
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 497, 788 0. 000000 92. 00	90. 00 09000 CLINIC	0	C	)	0 0	0.000000	90.00	
	91. 00 09100 EMERGENCY	0	C		0 15, 675, 979	0.000000	91.00	
200.00         Total (lines 50 through 199)         0         0         79, 246, 660         200.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 497, 788	0.000000	92.00	
	200.00 Total (lines 50 through 199)	0	C		0 79, 246, 660		200.00	

Health Financial Systems S	T. VINCENT RAND	OLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	EVICE OTHER PASS	Provider CC	CN: 15-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Pre 11/28/2018 4:	pared: 47 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.	-	Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0.000000	125, 032		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	83, 335		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	67, 947		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60.00 06000 LABORATORY	0. 000000	80, 573		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	35, 611		0 0	0	65.00
65. 01 03950 SLEEP LAB	0. 000000	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0, 000000	84, 666		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · ·					
90, 00 09000 CLINIC	0,000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0,000000	31, 451		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		508, 615		0 0	-	200.00

Health Financial Syste

ST.	VI NCENT	RANDOLPH	HOSPI TAL	

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ST. VINCENT RANDO	LPH HOSPITAL	In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1301	Peri od:	Worksheet D-1	
			From 07/01/2017 To 06/30/2018		
		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			1, 809	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 768	
3.00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	rivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ped days)		1, 430	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	21	6.00
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	am dave) through Decombo	21 of the cost	0	7.00
7.00	reporting period	Jill days) thi ough becember	ST OF THE COST		7.00
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December :	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)	-			
9.00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	531	9.00
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private i	nom davs)	16	10.00
10.00	through December 31 of the cost reporting period (see instruc		com days)		10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private i	room days) after	16	11.00
	December 31 of the cost reporting period (if calendar year, e				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva-	te room days)	0	12.00
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13.00
10.00	after December 31 of the cost reporting period (if calendar v				10.00
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14.00
	Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only)			0	16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (	of the cost		17.00
17.00	reporting period	the ough becember of t			17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost		18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	f the cost	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	137.32	20 00
	reporting period				
	Total general inpatient routine service cost (see instruction			3, 468, 274	
22.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22.00
23 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportio	na neriod (line 6	0	23.00
20.00	x line 18)		ig period (inte o		20.00
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
26.00	x line 20) Total swing-bed cost (see instructions)			78, 606	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 389, 668	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	1
29.00 30.00	Private room charges (excluding swing-bed charges) 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 0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)				33.00
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 3, 389, 668	
57.00	27 minus line 36)	and private room cost di	nerentiar (IIIIe	3, 307, 008	57.00
	PART I I - HOSPI TAL AND SUBPROVI DERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				
38.00	Adjusted general inpatient routine service cost per diem (see	-		1, 917. 23	
39.00 40.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			1, 018, 049 0	
	Total Program general inpatient routine service cost (line 39			1, 018, 049	
	The second second in the second			, , , , , , , , , , , , , , , , , , , ,	

	Financial Systems ATION OF INPATIENT OPERATING COST	ST. VINCENT RANDO	Provi der C	CN: 15-1301	Peri od:	u of Form CMS- Worksheet D-1	
					From 07/01/2017 To 06/30/2018	Date/Time Pre	naro
					10 00/30/2018	11/28/2018 4:	
		· · · ·		XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costl	Total	Average Per		Program Cost (col. 3 x col.	
			iipati eiit bays	col. 2)	-	(COL 3 X COL	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0	0	0.	0 00	0	42
. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	S					43
. 00	CORONARY CARE UNIT						43
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1 00	
. 00	Program inpatient ancillary service cost (W	Ikst D-3 col 3	Line 200)			<u>1.00</u> 444,535	48
. 00	Total Program inpatient costs (sum of lines			ns)		1, 462, 584	
	PASS THROUGH COST ADJUSTMENTS	¥ ? 1					
. 00	Pass through costs applicable to Program in	patient routine s	services (from	Wkst. D, sur	n of Parts I and	0	50
. 00	)  Pass through costs applicable to Program in	nationt ancillary	, sorvicos (fr	om What D	rum of Parts II	0	51
. 00	and IV)	parient and fidly	SELVICES (11	UNI WASL. D, S	sum of Fails II		, 51
. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52
. 00	Total Program inpatient operating cost excl		ated, non-phy	sician anestl	netist, and	0	53
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	56
. 00	Difference between adjusted inpatient opera	ting cost and tar	rget amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	0					
. 00	Lesser of lines 53/54 or 55 from the cost r market basket	eporting period e	andi ng 1996, u	puated and co	silipounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upc	lated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lin					0	61
	which operating costs (line 53) are less th		s (lines 54 x	60), or 1% of	f the target		
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62
. 00	Allowable Inpatient cost plus incentive pay	ment (see instruc	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine co	sts through Decem	nber 31 of the	cost reporti	ng period (See	30, 676	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	etc ofter Decombo	r 21 of the c	act reporting	a pariod (Saa	30, 676	65
. 00	instructions) (title XVIII only)	ISTS ALLEL DECEMBE		ost reportinț	g period (see	30, 070	
. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	64 plus line 6	5)(title XVI	I only). For	61, 352	66
	CAH (see instructions)				•		
. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 c	f the cost re	eporting period	0	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ne costs after De	cember 31 of	the cost rep	orting period	0	68
. 00	(line 13 x line 20)			the cost rep	si ting period	0	
. 00	Total title V or XIX swing-bed NF inpatient					0	69
~~~	PART III - SKILLED NURSING FACILITY, OTHER						1 70
. 00 . 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service	5		• •	)		70
. 00	Program routine service cost (line 9 x line		ne 70 ÷ mie	2)			72
. 00	Medically necessary private room cost appli		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine ser						74
. 00	Capital -related cost allocated to inpatient	routine service	costs (from W	orksheet B, I	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76
. 00	Program capital -related costs (line 9 x lin						77
. 00	Inpatient routine service cost (line 74 min						78
. 00	Aggregate charges to beneficiaries for exce						79
. 00	Total Program routine service costs for com	•	ost limitation	(line 78 mi)	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem lim Inpatient routine service cost limitation (		1				81
. 00	Reasonable inpatient routine service cost						83
. 00	Program inpatient ancillary services (see i	•	-				84
. 00	Utilization review - physician compensation	(see instruction					85
. 00	Total Program inpatient operating costs (su		ough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction					338	8 87
			1100 2)			1, 917. 23	
. 00	Adjusted general inpatient routine cost per	alem (line 27 ÷	Tine Z)			1,717.20	

Health Financial Systems S	T. VINCENT RAM	DOLPH HOSPITAL		In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 07/01/2017	Worksheet D-1	
				To 06/30/2018	Date/Time Pre 11/28/2018 4:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST	·				
90.00 Capital-related cost	252, 150	3, 468, 274	0.07270	2 648, 024	47, 113	90.00
91.00 Nursing School cost		3, 468, 274	0. 00000	0 648, 024	0	91.00
92.00 Allied health cost		3, 468, 274	0. 00000	0 648, 024	0	92.00
93.00 All other Medical Education	(	3, 468, 274	0. 00000	0 648, 024	0	93.00

<sup>11/28/2018 4:47</sup> pm Y: \28750 - St. Vincent Randolph\300 - Medicare Cost Report\20180630\HFS Files\28750-18.mcrx

ST.	VI NCENT	RANDOLPH	HOSPI TAL	

If the XIX         Incrt In Present           0x01         The XIX         Idep1tal         Cost           0x01         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present           1.00         Inpatient days         Incrt In Present         Incrt In Present		Financial Systems ST. VINCENT RANDO ATION OF INPATIENT OPERATING COST	LPH HOSPITAL Provider CCN: 15-1301	Peri od:	u of Form CMS-2 Worksheet D-1	
Cost Center Description         1.00           PMAT IE ALL FORMULES COMPONENTS         1.00           Impact Inter Adv.         1.00           2:00         Inspation To day (socialing setrag-bed add description bed days.)         1.00           3:00         Impact Inter Adv.         1.00           3:01         Impact Inter Adv.         1.00           3:02         Impact Inter Adv.         1.00           3:03         Impact Inter Adv.         1.00           3:04         Impact Inter Adv.         1.00           3:05         Impact Inter Adv.         1.00           3:06         Impact Inter Adv.         1.00           3:07         Inter Adv.         1.00           3:08         Impact Inter Adv.         1.00           3:08         Impact Inter Adv.         1.00           3:09         Inter Adv.         1.00           3:00         Impact Inter Adv.         1.00           3:00         Impact Inter Adv.         1.00           3:00         Impact Inter Adv.         1.00 <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>						
PART I - ALL PROVIDER COMPONENTS         1.00           IMPAILINE DAYS         Impailtent days (including private room days and seing-bad days, excluding numbern)         1,807           100         Impailtent days (including private room days, accluding numbern)         1,807           2.00         Private room days (excluding saing-bed and observation bed days)         1,208           2.01         Trial saing-bed SK (yee inpatient days (including private room days)         1,208           2.02         Trial saing-bed SK (yee inpatient days (including private room days) through December 31 of the cost         21           6.03         Trial saing-bed SK (yee inpatient days (including private room days) after December 31 of the cost         0           7.00         Trial saing-bed SK (yee inpatient days (including private room days) after December 31 of the cost         0           0.04         Trial saing-bed SK (yee inpatient days applicable to title XVII only (including private room days)         0           1.00         Trial saing-bed SK (yee inpatient days applicable to title XVII only (including private room days)         0           1.05         Saing-bed SK (yee inpatient days applicable to title XVII only (including private room days)         0           1.00         Saing-bed SK (yee inpatient days applicable to XII only (including private room days)         0           1.00         Saing-bed SK (yee inpatient days applicable to XIX only (including private roo		Cost Center Description	Title XIX	Hospi tal	Cost	
IMPATENT EARS         Impattent days         Including private room days, and swing-bed days, excluding newborn)         1,768           2.00         Inpattent days         (including private room days, excluding swing-bed and newborn days)         0.3           4.00         Semi-private room days         (including private room days, excluding swing-bed and observation bed days)         1.430           4.00         Semi-private room days         (including private room days)         (including private room days)         1.430           4.00         Total swing-bed SR type inpattent days         (including private room days)         after excenter 31 of the cost         21           7.00         Terger ting period         (including private room days)         after excenter 31 of the cost         20           7.00         Terger ting period         (including private room days)         after Excenter 31 of the cost         20           7.00         Total swing-bed SR type inpattent days splicable to the Program (excluding swing-bed and exps)         38         9           7.00         Total swing-bed SR type inpattent days splicable to the VSR in period         38         9           7.00         Total swing-bed SR type inpattent days splicable to the VSR in period         38         9           7.00         Total swing-bed SR type inpattent days splicable to the VSR in period         38         9					1.00	
1.00       Inpatient days (including private room days, and soing-bed days, excluding newtorm)       1,600         1.01       Inpatient days (including private room days, actualing soing-bed and newtorm days)       1,600         3.00       Private room days (actualing soing-bed days)       1,600         3.00       Private room days (actualing soing-bed days)       1,900         4.00       Total soing-bed SWE type inpatient days (including private room days) after becember 31 of the cost       200         6.00       Total soing-bed SWE type inpatient days (including private room days) after becember 31 of the cost       0         7.00       Treporting period       (including private room days) after becember 31 of the cost       0         0.00       Total soing-bed KE type inpatient days (including private room days) after becember 31 of the cost       0       0         0.01       Total soing-bed KE type inpatient days applicable to title XVII only (including private room days)       0       0         1.00       Sing-bed SWE type inpatient days applicable to title XVII only (including private room days)       0       0         1.00       Sing-bed KE type inpatient days applicable to title XVII only (including private room days)       0       0         1.00       Sing-bed KE type inpatient days applicable to title XVII only (including private room days)       0       0       0         1.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
3.00       Frivate room days (excluding seing-bed and observation bed days). If you have only private room days.       0       3.         4.00       Semi-private room days (excluding seing-bed and observation bed days).       11.       you have only private room days.       1430         4.00       Semi-private room days (excluding seing-bed and observation bed days).       11.       you have only private room days.       1430         4.00       Semi-private room days (excluding private room days) after December 31 of the cost reporting period.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.       10.<	1.00	Inpatient days (including private room days and swing-bed day			1, 809	1.00
4.00       Semi-private road mays (excluding sering-bed and observation bed days)       1,430       4.00         5.00       Total sering-bed SW type inpatient days (including private room days) shrough December 31 of the cost reporting period.       1,630       4.00         7.00       Total sering-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period.       7,0         7.00       Total sering-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period.       8,00         9.00       Total sering-bed SW type inpatient days applicable to the Program (excluding sering-bed and newborn days).       10,00         9.00       Total sering-bed SW type inpatient days applicable to titles W it is ine).       10,00         9.00       Total cost reporting period.       1, cale days).       10,00         9.00       Total cost reporting period.       1, cale days applicable to titles W it is is o'n XIX only (including private room days).       10,00         9.00       Total cost reporting period.       1, cale days applicable to titles V or XIX only (including private room days).       10,00         9.00       Total cost reporting period.       1, cale days applicable to services through December 31 of the cost reporting period.       10,00         9.00       Norte-becaber 31 of the cost reporting period.       1, cale days applicable to services through December 31 of the cost reporting period.		Private room days (excluding swing-bed and observation bed da		rivate room days,		2.00 3.00
6.00       Total saving-bed SMF type inpatient days (including private room days) after December 31 of the cost       7.0         7.00       Total saving-bed WF type inpatient days (including private room days) after December 31 of the cost       0.8         8.00       Total saving-bed WF type inpatient days (including private room days) after December 31 of the cost       0.8         9.00       Total saving-bed WF type inpatient days explicable to the Program (excluding swing-bed and neaborn days)       10         10.00       Swing-bed SWF type inpatient days explicable to title XVII only (including private room days) after December 31 of the cost reporting period (see instructions)       0       10         10.00       Swing-bed SWF type inpatient days applicable to title XVI only (including private room days)       0       11         10.00       Swing-bed WF type inpatient days applicable to title XVI only (including private room days)       0       12         11.00       Swing-bed WF type inpatient days applicable to the Program (excluding private room days)       0       13         12.00       Swing-bed WF type inpatient days applicable to the Program (excluding private room days)       0       14         12.00       Medi carle for swing-bed SWF services applicable to services after December 31 of the cost reporting period       14         13.00       Swing-bed AUSTEWFF       Swing-bed SWF services applicable to services after December 31 of the cost reporting period       1		Semi-private room days (excluding swing-bed and observation I		er 31 of the cost		4.00 5.00
7.00       Total saving-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (Table and the sing)       0       7.00         8.00       Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (Table and the sing)       0       8.00         9.00       Total inpatient days including private room days applicable to the Program (excluding private room days)       0       0         1.00       Sing-bed SNF type Inpatient days applicable to the Norgram (excluding private room days)       0       10         1.00       Sing-bed SNF type Inpatient days applicable to title SVI in Unit (including private room days)       0       11         1.00       Sing-bed NF type Inpatient days applicable to title SVI on XIX only (Including private room days)       0       13         1.00       Sing-bed NF type Inpatient days applicable to title SVI on XIX only (Including private room days)       0       14         1.00       Medi care rate for swing-bed SNF services applicable to the Program (excluding swing-bed days)       0       14         1.00       Medi care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       13       13         1.00       Medi care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       14       14         1.00       Medi care rate for	6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	21	6.00
8.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost       0       8.00         9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)       38.00       9.00         9.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after to title swing motion of the cost reporting period (see instructions)       0       10.00         9.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)       0       12.         10.00       Swing-bed NF type inpatient days applicable to title XV and Y (including private room days)       0       13.         11.00       Swing-bed NF type inpatient days applicable to title XV and Y (including private room days)       0       13.         12.00       Swing-bed NF type inpatient days applicable to title XV and Y (including private room days)       0       14.         15.00       Total unrsery days (title V or XIX only)       20       16.         16.00       Wedicaid rate for swing-bed NF services applicable to services after December 31 of the cost       17.         17.00       Wedi caid rate for swing-bed NF services applicable to services after December 31 of the cost       137.32         10.00       Wedi caid rate for swing-bed NF services applicable t	7.00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7.00
newborn days)       0.1         newborn days)       0.1         100       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)       0         100       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)       0         11.       December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         12.       Dswing-bed NF type inpatient days applicable to title XV or XIX only (including private room days)       0         12.       Dswing-bed NF type inpatient days applicable to title SV or XIX only (including swing-bed days)       0         13.       Dswing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)       0         14.0       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.         15.00       Nursery days (title V or XIX only)       291       16.         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line cost reporting period (line cost reporting period (line cost reporting period (line for swing-bed NF services applicable to services after December 31 of the cost reporting period (line for swing-bed SNF type services after December 31 of the cost reporting period (line for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for swing-bed cost splicable to NF type services after December 31 of the cost re	8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8.00
Itroügh December <sup>2</sup> 31 of the cost reporting period (if calendar year, enter 0 on this line)       0.11.         December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0.12.         Itrough December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0.12.         Itrough December 31 of the cost reporting period       0.12.         Itrough December 31 of the cost reporting period       0.12.         Itrough December 31 of the cost reporting period       0.13.         Itrough December 31 of the cost reporting period       0.14.         Ito Main December 31 of the cost reporting period       0.14.         Ito Main December 31 of the cost reporting period       0.14.         Ito Main December 31 of the cost reporting period       0.14.         Ito Main December 31 of the cost reporting period       11.         Ito Main December 31 of the cost reporting period       11.         Ito Main December 31 of the cost reporting period       11.         Ito Main December 31 of the cost       11.         Ito Main December 31 of the cost reporting period       11.         Ito Main December 31 of the cost       137.32         Ito Main December 31 of the cost reporting period       13.7.32         Ito Main December 31 of the cost reporting period       13.468.274         Ito Main December 31 of the cost reporting period		newborn days)	0			9.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)         1           100 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0           110 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0           111 Attraction (including private)         0           112 Attraction (including private)         0           113 Attraction (including private)         0           114 Ob Medical IV necessary private room days applicable to the Program (excluding swing-bed days)         0           115 Ob         Nursery days (title V or XIX only)         20           116 Ob         Wardser rate for swing-bed SNF services applicable to services after December 31 of the cost         117.           118 Ob         Medicar rate for swing-bed SNF services applicable to services after December 31 of the cost         117.           118 Ob         Medicar rate for swing-bed SNF services applicable to services after December 31 of the cost         117.           119 Ob         Medical rate for swing-bed NF services applicable to services after December 31 of the cost         117.           120 Ob         Medical rate for swing-bed NF services applicable to services after December 31 of the cost         113.           121 Otal general inpatient routine service cost (see instructions)         3.468.274         21.           120 Otal		through December 31 of the cost reporting period (see instruc	ctions)		-	10.00
through December 31 of the cost reporting period       13.         100       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         11.00       Medical ly necessary private room days applicable to the Program (excluding swing-bed days)       0       14.         15.00       Nursery days (title V or XIX only)       29       16.         16.00       Nursery days (title V or XIX only)       29       16.         17.0       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 s v. line 17).       13.       468,274       21.         20.00       Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (line 6 s v. line 18).       3.       468,274       21.         21.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 s v. line 18).       3.       468,274       21.       22.       3.       468,274       21.       22.       23.       Swing-bed cost applicable to NF type services		December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	5	-	12.00
14.00       Idedically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       29         16.00       Nursery days (title V or XIX only)       29         17.00       Medicater rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.         18.00       Medicater rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (aid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (aid rate for swing-bed NF services of the services after December 31 of the cost reporting period (line 5 x line 17)       3. 468, 274       21.         20.00       Medicade cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)       3. 468, 274       21.         21.00       Total general inpatient routine service sets through December 31 of the cost reporting period (line 6 x line 18)       23.         22.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       24.00         23.00       Swing-bed cost (see instructions)       7.8 (ine 20)       7.8 (ine 20)         24.00       Swing-bed cost (see instructions)       7.8 (ine 20)       3.89, 668       27.         24.00       General inpatient routithe service cost cet of swing-bed and observ		through December 31 of the cost reporting period		5,	-	13.00
16.00       Nursery days (title V or XIX only)       29         16.00       SWING BED ADJUSTMENT       17         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       17.00         10.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.         10.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period line for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)       3. 468.274 21.         21.00       Total general inpatient routine service cost (see instructions)       3. 468.274 21.       0.         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 17)       0.       24.         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)       24.         25.00       Stine 20)       78.606 26.       3.389.682         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       78.606 26.         27.00       General inpatient routine service cost reporting period (line 8 x line 30)       0.000000         28.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       78.606 26. </td <td></td> <td>Medically necessary private room days applicable to the Prog</td> <td></td> <td></td> <td>-</td> <td>14.00</td>		Medically necessary private room days applicable to the Prog			-	14.00
17.00       Wedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         19.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       137.32         19.00       Medicare for swing-bed NF services applicable to services after December 31 of the cost reporting period       137.32         20.00       Total general inpatient routine service cost (see instructions)       3.468,274       21.         21.00       Total general inpatient routine services after December 31 of the cost reporting period (line 5 x line 17)       3.468,274       21.         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0       23.         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       78.606       25.         25.00       Swing-bed cost (see instructions)       78.606       26.       27.         26.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       3.389.668       27.         27.00       General inpatient routine service cost reporting repoid (line 21 minus line 26)       0       29.		Nursery days (title V or XIX only)				15.00 16.00
18.00       Medicare <sup>-</sup> rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         19.00       Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period       137.32         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       137.32         20.00       Medicaid rate for swing-bed NF services cost (see instructions)       3.468,274       21.         21.00       Total general inpatient routine service cost (see instructions)       3.468,274       21.         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)       0       23.         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       24.         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       25.         26.00       Total swing-bed cost (see instructions)       78,666       26.         27.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 28)       0         26.00       Forelal inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       3.389,668       27.         27.00 <td>17.00</td> <td>Medicare rate for swing-bed SNF services applicable to service</td> <td>ces through December 31 c</td> <td>of the cost</td> <td></td> <td>17.00</td>	17.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 c	of the cost		17.00
reporting period20.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost137.3220.00Total general inpatient routine service cost (see instructions)3,468,27421.00Total general inpatient routine services through December 31 of the cost reporting period (line3,468,27422.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line023.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8025.00Swing-bed cost (see instructions)78,60626.00Total swing-bed cost (see instructions)78,60627.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)3,389,66827.00General inpatient routine service charges (excluding swing-bed charges)020.00Swing-bed cost sepil excluding swing-bed charges)020.01General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000021.00Average perid em private room charge differential (line 32 minus line 33)(see instructions)0.0023.00Average perid em private room charge differential (line 3 x line 35)024.00 <td< td=""><td>18. 00</td><td>Medicare rate for swing-bed SNF services applicable to service</td><td>ces after December 31 of</td><td>the cost</td><td></td><td>18.00</td></td<>	18. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost		18.00
reporting period3, 468, 27421.21.00Total general inpatient routine service cost (see instructions)3, 468, 27421.22.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 622.23.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 623.24.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8025.00Total swing-bed cost (see instructions)78,60626.00Total swing-bed cost (see instructions)78,60627.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)3,389,66827.00Private room charges (excluding swing-bed charges)028.00General inpatient routine service cost charges (excluding swing-bed charges)029.00Private room charges (excluding swing-bed charges)020.01Semi-private room charge (line 29 + line 3)020.02Average periate room charge differential (line 32 minus line 33)(see instructions)020.03Average periate room cost differential (line 34 x line 31)00020.04Average periate room cost differential (line 34 x line 35)0021.04Average periaten routine servic		reporting period	C C			
22.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)022.23.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 18)023.24.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)024.25.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)024.26.00Total swing-bed cost (see instructions)78,60626.27.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)3,389,66827.28.00General inpatient routine service cost charges (excluding swing-bed and observation bed charges)028.29.00Private room charges (excluding swing-bed charges)028.31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.32.00Average private room per diem charge (line 29 + line 3)0.00032.33.00Average per diem private room charge differential (line 32 minus line 33)(see instructions)0.00035.35.00Average per diem private room cost differential (line 3 x line 35)0.0036.37.00General inpatient routine service cost per dem of seing-bed cost and private room cost differential (line 3 x line 35)3.38.00Private room cost differential digustment (line 3 x line 35)0.0037.00General inpatient routine service cost per diem seing-b		reporting period		he cost		
23.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)23.24.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)24.25.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)25.26.00Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)78,606 3,389,66827.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.00General inpatient routine service charges (excluding swing-bed and observation bed charges)029.00Private room charges (excluding swing-bed charges)030.00Semi-private room charges (excluding swing-bed charges)031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.00Average semi-private room charge (line 29 + line 3)0.0032.00Average per diem private room charge differential (line 34 x line 31)0.0035.00Average per diem private room cost differential (line 3 x line 35)0.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389,6683.37.00Average per diem private room cost net of swing-bed cost and private room cost differential (line 		Swing-bed cost applicable to SNF type services through Decem		ing period (line		21.00 22.00
7 x line 19)       7 x line 19)       25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       25.         26.00       Total swing-bed cost (see instructions)       78,606       26.         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       3,389,668       27.         28.00       General inpatient routine service charges (excluding swing-bed charges)       0       28.         29.00       Private room charges (excluding swing-bed charges)       0       29.         30.00       Semi-private room charges (excluding swing-bed charges)       0       29.         31.00       General inpatient routine service cost/charge ratio (line 27 ± line 28)       0.000000       31.         32.00       Average private room per diem charge (line 30 ± line 4)       0.00       32.         34.00       Average per diem private room cost differential (line 32 minus line 33) (see instructions)       0.00       34.         35.00       Average per diem private room cost differential (line 3 x line 35)       0       36.       37.         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.       37.       0       36.         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differen	23.00		r 31 of the cost reportin	ng period (line 6	0	23.00
x line 20)78,60626.00Total swing-bed cost (see instructions)78,60627.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)3,389,66827.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT28.00General inpatient routine service charges (excluding swing-bed charges)029.00Private room charges (excluding swing-bed charges)030.00Semi-private room charges (excluding swing-bed charges)031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.000000 31.32.00Average private room per diem charge (line 29 + line 3)0.00033.00Average semi-private room cost differential (line 34 × line 31)0.0035.00Average per diem private room cost differential (line 34 × line 31)0.00036.00Private room cost differential adjustment (line 3 × line 35)037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389,66837.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389,66837.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389,66837.00General inpatient routine service cost per diem (see instructions)9.00Adjusted general inpatient routine service cost (line 9 × line 38)9.00Adjusted general inpatient routine service cost (line 9 × line 38)9.00Adjusted general inpatient routine service cost (line 9 × line 38)9.00Medically neces		7 x line 19)	•		-	24.00
27. 00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)3, 389, 66827.PRI VATEROOM DIFFERENTIAL ADJUSTMENT28. 00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.29. 00Pri vate room charges (excluding swing-bed charges)029.030. 00Semi-pri vate room charges (excluding swing-bed charges)030.31. 00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031. 00Average pri vate room per diem charge (line 29 + line 3)0.00032. 00Average pri vate room cost differential (line 30 + line 4)0.00034. 00Average per diem pri vate room cost differential (line 34 x line 31)0.00035. 00Pri vate room cost differential adjustment (line 3 x line 35)037. 00General inpatient routine service cost per diem grivate room cost differential (line 3 x line 35)037. 00Adjusted general inpatient routine service cost per Applicable to the Program (line 14 x line 35)1, 917. 2338. 00Adjusted general inpatient routine service cost (line 9 x line 38)1, 917. 2339. 00Program general inpatient routine service cost (line 9 x line 38)72. 8539. 00Medi cally necessary pri vate room cost applicable to the Program (line 14 x line 35)040. 00Medi cally necessary pri vate room cost applicable to the Program (line 14 x line 35)40.		x line 20)	31 of the cost reporting	period (line 8	-	
28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.29.00Private room charges (excluding swing-bed charges)029.30.00Semi-private room charges (excluding swing-bed charges)030.31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.000000031.32.00Average private room per diem charge (line 29 + line 3)0.0032.33.00Average per diem private room per diem charge (line 30 + line 4)0.0032.34.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0033.35.00Average per diem private room cost differential (line 3 x line 31)0.0034.37.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389, 66837.37.00General inpatient routine service cost per diem (see instructions)0.0036.37.00Average per diem private room cost applicable to the Program (line 14 x line 35)1, 917.2338.38.00Adjusted general inpatient routine service cost per diem (see instructions)1, 917.2338.39.00Program general inpatient routine service cost (line 9 x line 38)72, 85539.40.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.		General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)			27.00
30.00Semi-private room charges (excluding swing-bed charges)030.31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.32.00Average private room per diem charge (line 29 + line 3)0.0032.33.00Average semi-private room per diem charge (line 30 + line 4)0.0032.34.00Average per diem private room cost differential (line 34 x line 31)0.0034.55.00Average per diem private room cost differential (line 3 x line 35)0.0036.37.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389, 66837.27minus line 36)0.0036.PART II - HOSPITAL AND SUBPROVIDERS ONLY0.0036.PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 917. 2338.00Adjusted general inpatient routine service cost (line 9 x line 38)1, 917. 2339.00Program general inpatient routine service cost (line 9 x line 38)72, 85540.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0	28.00		ed and observation bed ch	narges)	0	28.00
31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000       31.         32.00       Average private room per diem charge (line 29 + line 3)       0.000       32.         33.00       Average semi-private room per diem charge (line 30 + line 4)       0.00       32.         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.000       34.         5.00       Average per diem private room cost differential (line 3 x line 31)       0.00       34.         60.00       Private room cost differential adjustment (line 3 x line 35)       0       36.         7.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389, 668       37.         7.01       General inpatient routine service cost per diem (see instructions)       0       36.         9.00       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 917.23       38.         70.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.					-	29.00
32.00       Average private room per diem charge (line 29 + line 3)       0.00       32.         33.00       Average semi-private room per diem charge (line 30 + line 4)       0.00       33.         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       34.         36.00       Private room cost differential adjustment (line 3 x line 35)       0.00       35.         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389, 668       37.         70       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       38.00         88.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 917. 23         99.00       Program general inpatient routine service cost (line 9 x line 38)       72, 855       39.         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.			÷line 28)			30.00 31.00
33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       33.         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389, 668)       37.         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       38.         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 917. 23         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       1, 917. 23         39.00       Program general inpatient routine service cost applicable to the Program (line 14 x line 35)       0         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0			20)			32.00
34.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0034.35.00Average per diem private room cost differential (line 34 x line 31)0.0035.36.00Private room cost differential adjustment (line 3 x line 35)036.37.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389, 66837.27 minus line 36)PART II - HOSPITAL AND SUBPROVIDERS ONLY38.PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 917. 2338.00Adjusted general inpatient routine service cost (line 9 x line 38)1, 917. 2339.00Program general inpatient room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0						33.00
36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 3, 389, 668)       37.         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       38.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 917. 23         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 917. 23         39.00       Program general inpatient routine service cost (line 9 x line 38)       72, 855         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0			inus line 33)(see instruc	ctions)		34.00
37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 389, 668 27 minus line 36)       37.         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, 917.23       38.         39.00       Program general inpatient routine service cost (line 9 x line 38)       72, 855         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0		5 1 1	ine 31)		0.00	35.00
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)       1,917.23       38.         39.00       Program general inpatient routine service cost (line 9 x line 38)       72,855       39.         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.		General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	-	36.00 37.00
38.00Adjusted general inpatient routine service cost per diem (see instructions)1,917.2338.39.00Program general inpatient routine service cost (line 9 x line 38)72,85539.40.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
39.00Program general inpatient routine service cost (line 9 x line 38)72,85539.40.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.						
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.						
						39.00
						40.00

OMPUT	ATION OF INPATIENT OPERATING COST		Provid	er CC	CN: 15-1301	Peri od:	Worksheet D-1	1
						From 07/01/2017 To 06/30/2018	B Date/Time Pre	
				Ti †I	e XIX	Hospi tal	11/28/2018 4: Cost	47 pr
		tal	Total		Average Per	Program Days	Program Cost	
	I npati e	ent Cost	Inpati ent	Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		00	2.00		3.00	4.00	5.00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	490, 149		431	1, 137.	24 29	32, 980	42.
. 00	INTENSIVE CARE UNIT							43.
. 00	CORONARY CARE UNIT							44.
. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45.
. 00 . 00	OTHER SPECIAL CARE (SPECIFY)							47.
	Cost Center Description						1.00	
. 00	Program inpatient ancillary service cost (Wkst. D-3	, col. 3	, line 200	))			169, 940	) 48.
. 00	Total Program inpatient costs (sum of lines 41 thro				ns)		275, 775	<u>49</u> .
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient	routine	servi ces	from	Wkst D su	m of Parts I and	l c	50.
. 00	III)	outine	Sel VICes		WKST. D, Su			/ <sup>30.</sup>
. 00	Pass through costs applicable to Program inpatient a	ancillar	y service	s (fr	om Wkst. D,	sum of Parts II	C	51.
. 00	and IV) Total Program excludable cost (sum of lines 50 and 5	51)					C	52.
3.00	Total Program inpatient operating cost excluding ca		lated, noi	n-phy	sician anest	netist, and	C	
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION							-
. 00	Program di scharges						C	54
. 00	Target amount per discharge						0.00	
. 00	Target amount (line 54 x line 55)	t and to	ract omou	s+ (1	ino E4 minuc	Lino E2)	0	
. 00 . 00	Difference between adjusted inpatient operating cos Bonus payment (see instructions)	t and ta	irget alloui	11 (1	The so minus	TThe 53)		
. 00	Lesser of lines 53/54 or 55 from the cost reporting	peri od	endi ng 19	96, u	pdated and c	ompounded by the	-	
. 00	market basket Lesser of lines 53/54 or 55 from prior year cost re	port un	dated by	tho m	arkat backat		0.00	60
. 00	If line 53/54 is less than the lower of lines 55, 5					the amount by	0.00	
	which operating costs (line 53) are less than expec	ted cost						
. 00	amount (line 56), otherwise enter zero (see instruc Relief payment (see instructions)	tions)					C	62.
. 00	Allowable Inpatient cost plus incentive payment (se	e instru	ictions)					
	PROGRAM INPATIENT ROUTINE SWING BED COST		1 01	° 11		h h (0		
. 00	Medicare swing-bed SNF inpatient routine costs throu instructions)(title XVIII only)	ugn Dece	ember 31 of	- τne	cost report	ng period (See	C	64.
. 00	Medicare swing-bed SNF inpatient routine costs after	r Decemb	er 31 of	the c	ost reportin	g period (See	C	65.
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine cost	c (lino	44 pluc li	no 4	E) (+; +  o X)/I		C	66.
. 00	CAH (see instructions)	s (inte	o4 prus ri	ne o	s)(lille xvi	n onry). For		00
. 00	Title V or XIX swing-bed NF inpatient routine costs	through	December	31 o	f the cost r	eporting period	C	67.
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs	after D	ecember 3	lof	the cost ren	orting period		68
5. 00	(line 13 x line 20)		CCCIIDCI 5		the cost rep	bi ting period		/ 00.
9.00	Total title V or XIX swing-bed NF inpatient routine				,		C	) 69.
). 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING I Skilled nursing facility/other nursing facility/ICF.					)		70.
. 00	Adjusted general inpatient routine service cost per					, ,		71.
. 00	Program routine service cost (line 9 x line 71)		(1) 44		95)			72.
. 00	Medically necessary private room cost applicable to Total Program general inpatient routine service cos				ne 35)			73.
5.00	Capital -related cost allocated to inpatient routine				orksheet B,	Part II, column		75.
00	26, line 45)							_,
. 00 . 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)							76.
. 00	Inpatient routine service cost (line 74 minus line							78.
. 00	Aggregate charges to beneficiaries for excess costs							79.
. 00 . 00	Total Program routine service costs for comparison Inpatient routine service cost per diem limitation	ιο της α	ost limita	iti on	(IINE /8 mi	ius line /9)		80.
. 00	Inpatient routine service cost per diem rimitation Inpatient routine service cost limitation (line 9 x	line 81	)					82.
. 00	Reasonable inpatient routine service costs (see ins	truction	· .					83.
. 00	Program inpatient ancillary services (see instruction		nc)					84.
. 00 . 00	Utilization review - physician compensation (see in: Total Program inpatient operating costs (sum of line							85.
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUG		5)					
7.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (I						338 1, 917. 23	
3. 00								

Health Financial Systems S	T. VINCENT RA	DOLPH HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 07/01/2017	Worksheet D-1	
				To 06/30/2018		pared: 47 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	252, 15	0 3, 468, 274	0.07270	2 648, 024	47, 113	90.00
91.00 Nursing School cost		0 3, 468, 274	0. 00000	0 648, 024	0	91.00
92.00 Allied health cost		0 3, 468, 274	0.00000	0 648, 024	0	92.00
93.00 All other Medical Education		3, 468, 274	0.00000	0 648, 024	0	93.00

<sup>11/28/2018 4:47</sup> pm Y: \28750 - St. Vincent Randolph\300 - Medicare Cost Report\20180630\HFS Files\28750-18.mcrx

Health Financial Systems ST. VINCENT RA	ANDOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	CN: 15-1301	Peri od:	Worksheet D-3	
			From 07/01/2017 To 06/30/2018	Date/Time Pre	narod
			10 00/ 30/ 2010	11/28/2018 4:	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2,00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			767, 275		30.00
43. 00 04300 NURSERY			101, 215		43.00
ANCI LLARY SERVICE COST CENTERS		I			+3.00
50. 00 05000 OPERATI NG ROOM		0, 2923	52 50, 299	14, 705	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 7058		0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1115	41 141, 141	15, 743	54.00
57.00 05700 CT SCAN		0.0000	0 00	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	0 00	0	58.00
60. 00 06000 LABORATORY		0. 1417	29 224, 154	31, 769	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 3473	11 459, 009	159, 419	65.00
65. 01 03950 SLEEP LAB		0. 3394		0	65.01
66. 00 06600 PHYSI CAL THERAPY		0. 4203			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 6156			
68.00 06800 SPEECH PATHOLOGY		0. 7570			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2646		44, 274	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1873		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4222	33 389, 718	164, 552	73.00
OUTPATIENT SERVICE COST CENTERS		0.0000			
90. 00 09000 CLINIC		0.0000		0	90.00
91.00 09100 EMERGENCY		0.2369		1, 257	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	\ \	1. 30180		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98			1, 461, 744		200.00
201.00 Less PBP Clinic Laboratory Services-Program only ch 202.00 Net charges (line 200 minus line 201)	arges (rine 61)		1 461 744		201.00
202.00 Net charges (line 200 minus line 201)		I	1, 461, 744		202.00

Health Financial Systems ST. VINCENT RANDOLPH HC	SPI TAL	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Prov	/ider CCN: 15-1301	Period:	Worksheet D-3	
Com	oonent CCN: 15-Z301	From 07/01/2017 To 06/30/2018	Date/Time Pre	narod:
Com	JUNEITE CON. 15-2301	10 00/30/2018	11/28/2018 4:	
	Title XVIII	Swing Beds - SNF		
Cost Center Description	Ratio of Cos	t Inpatient	Inpati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		0		30, 00
30. 00  03000  ADULTS & PEDI ATRI CS 43. 00  04300  NURSERY		0		43.00
ANCI LLARY SERVICE COST CENTERS				43.00
50. 00 OS000 OPERATI NG ROOM	0. 29235	52 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.7058		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 11154		39	54.00
57. 00 05700 CT SCAN	0. 00000		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.00000		0	58.00
60. 00 06000 LABORATORY	0. 14172		884	60.00
65. 00 06500 RESPI RATORY THERAPY	0.3473	1 27, 696	9, 619	65.00
65. 01 03950 SLEEP LAB	0. 33946	07 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 42035	58 2, 798	1, 176	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 61563	35 2, 551	1, 570	67.00
68.00 06800 SPEECH PATHOLOGY	0. 75702		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 26469		2, 517	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 1873		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 42223	33 24, 622	10, 396	73.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0.0000		0	90.00
91.00 09100 EMERGENCY	0. 23694		0	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1.30180		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1)	73, 766	26, 201	
201.00 Less PBP Clinic Laboratory Services-Program only charges (lin	1e ol)	0		201.00
202.00 Net charges (line 200 minus line 201)		73, 766		202.00

Health Financial Systems ST. VINCENT RANDOLI	PH HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1301	Peri od:	Worksheet D-3	
			From 07/01/2017 To 06/30/2018	Date/Time Pre	nared
			10 00/ 30/ 2010	11/28/2018 4:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			39, 621		30, 00
43. 00 04300 NURSERY			36, 569		43.00
ANCI LLARY SERVICE COST CENTERS			00,007		101.00
50. 00 05000 OPERATI NG ROOM		0. 2923	52 125, 032	36, 553	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 7058	10 83, 335	58, 819	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1115	41 67, 947	7, 579	54.00
57.00 05700 CT SCAN		0.0000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	0 0	0	58.00
60. 00 06000 LABORATORY		0. 1417:			60.00
65. 00 06500 RESPI RATORY THERAPY		0. 3473		12, 368	65.00
65. 01 03950 SLEEP LAB		0. 3394		0	65.01
66. 00 06600 PHYSI CAL THERAPY		0. 4203		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 6156		0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 7570		0	68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 2646		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1873		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 42223	33 84, 666	35, 749	73.00
0UTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC		0.0000		0	00.00
		0.0000		0	90.00 91.00
91.00 09100 EMERGENCY		0.2369		7, 452	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (sum of lines 50 through 94 and 96 through 98)		1. 30180		0	92.00
200.00Total (sum of lines 50 through 94 and 96 through 98)201.00Less PBP Clinic Laboratory Services-Program only charges	(lino (1)		508, 615 0		200.00
201.00 [Less PBP cirilic Laboratory Services-Program only charges 202.00 [Net charges (line 200 minus line 201)	(1116 01)		508, 615		201.00
zuz. vuj jivet chaliges (TTTE zuu illi tius TTTE zut)		I	000,015		202.00

CALCUL	Financial Systems ST. VINCENT RANDOL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1301	Peri od: From 07/01/2017	u of Form CMS-2 Worksheet E Part B	2002 10
			To 06/30/2018	Date/Time Pre	
		Title XVIII	Hospi tal	11/28/2018 4: Cost	47 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			4, 262, 269	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	tions)		0	
4.00	Outlier payment (see instructions)			0	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5	ctions)		0.000	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
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		0	
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 4, 262, 269	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			1,202,207	11.00
10.00	Reasonable charges				1 1 2 . 0 2
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ine 69)			12.00
	Total reasonable charges (sum of lines 12 and 13)			0	
	Customary charges				
15.00 16.00	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for		0	0	15.00
10.00	had such payment been made in accordance with 42 CFR §413.13(		on a chargebasi's	0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0. 000000	
18.00	Total customary charges (see instructions)	ly if line 19 exceeds li	no 11) (coo	0	
19.00	Excess of customary charges over reasonable cost (complete onl instructions)	Ty IT TTHE 18 exceeds T	ne II) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds li	ne 18) (see	0	20.00
21 00	instructions)			4 204 002	21 00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			4, 304, 892	1
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			53, 626	25 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH, see instructions	)	2, 986, 575	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	plus the sum of lines 2	2 and 23] (see	1, 264, 691	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			1, 264, 691	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			32 1, 264, 659	31.00
52.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)		1, 204, 037	52.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	
34.00	Allowable bad debts (see instructions)			925, 199	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		601, 379 490, 877	
37.00	Subtotal (see instructions)			1, 866, 038	
	MSP-LCC reconciliation amount from PS&R			0	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	s)		0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration	3)		0	1
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00 40.01	Subtotal (see instructions) Sequestration adjustment (see instructions)			1, 866, 038 37, 321	1
40. 02	Demonstration payment adjustment amount after sequestration				40.02
	Interim payments			1, 671, 708	1
42.00 43.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 157, 009	
44.00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	chapter 1,		43.00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90 00	Torrarian outrior amount (See Thatructions)				
90. 00 91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	91.00 92.00 93.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1301	Period: From 07/01/2017 To 06/30/2018		pared: 47 pm
		Title	XVIII	Hospi tal	Cost	
		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		1, 224, 43	37	1, 560, 008	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero					3.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	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 02/15/2018	111, 700	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					0.50
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50 3.51
3.51				0	0	3.51
3.52				0	0	3.52
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	111, 700	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 224, 43	37	1, 671, 708	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5.92 5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
5. 77	5. 50-5. 98)			0	Ŭ	5.77
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		89, 21	19	157, 009	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 313, 65		1, 828, 717	7. OC
				Contractor	NPR Date	
		C	)	Number 1.00	(Mo/Day/Yr) 2.00	
			,	1.00	2.00	

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Co Component	CN: 15-1301 CCN: 15-Z301	Period: From 07/01/201 To 06/30/201		pared
		Title	xvi i	Swing Beds - SN		., bu
		Inpatien	it Part A		nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		63, 35		0	1.0
00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero					3.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.0
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		•			
01	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03				0	0	
04				0	0	
05	Dravidar to Dragram			0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.
50 51				0	0	
52				0	0	
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.
~ ~	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		63, 35	55	0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	1	1		-	
D1	TENTATI VE TO PROVI DER			0	0	
02 03				0	0	
55	Provider to Program			0	0	· .
50	TENTATI VE TO PROGRAM			0	0	5.
51				0	0	5.
52				0	0	5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6.
01	the cost report. (1) SETTLEMENT TO PROVIDER		23, 30	15	0	6.
)1 )2	SETTLEMENT TO PROVIDER		23, 30	0		
)2 )0	Total Medicare program liability (see instructions)		86, 66	-	0	
				Contractor	NPR Date	1.
				Number	(Mo/Day/Yr)	
			C	1.00	2.00	

LCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pro	ovider CCN: 15-1301	Peri od:	Worksheet E-2	
	Cor	nponent CCN: 15-Z301	From 07/01/2017 To 06/30/2018	Date/Time Pre 11/28/2018 4:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
C	OMPUTATION OF NET COST OF COVERED SERVICES				
	npatient routine services - swing bed-SNF (see instructions)		61, 966	0	
	npatient routine services - swing bed-NF (see instructions)				2.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,		26, 463	0	3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru			0.00	
	Per diem cost for interns and residents not in approved teaching nstructions)	program (see		0.00	4
	Program days		32	0	5
	nterns and residents not in approved teaching program (see instr	uctions)		0	
	Jtilization review - physician compensation - SNF optional method		0		7
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	3	88, 429	0	8
00 0	Primary payer payments (see instructions)		0	0	9
00	Subtotal (line 8 minus line 9)		88, 429	0	10
	Deductibles billed to program patients (exclude amounts applicabl	e to physician	0	0	11
	professional services)		00.100	_	1.0
	Subtotal (line 10 minus line 11)		88, 429	0	
	Coinsurance billed to program patients (from provider records) (e For physician professional services)	xci ude coi nsurance	0	0	13
	30% of Part B costs (line 12 x 80%)			0	14
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		88, 429	0	
	DTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)				16
	Rural community hospital demonstration project (§410A Demonstrati	on) payment	0		16
l	adjustment (see instructions)				
	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruct	ions)	0	0	
	Fotal (see instructions) Sequestration adjustment (see instructions)		88, 429	0	
	Demonstration payment adjustment amount after sequestration)		1, 769	0	
	nterim payments		63, 355	0	
	Fentative settlement (for contractor use only)		00,000	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, and	21)	23, 305	0	
	Protested amounts (nonallowable cost report items) in accordance	-	0	0	23
(	chapter 1, §115.2				
	ural Community Hospital Demonstration Project (§410A Demonstrati				
	s this the first year of the current 5-year demonstration period	under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Medicare swing-bed SNF inpatient routine service costs (from Wkst	D_1 Pt II line	-		201
	56 (title XVIII hospital))				201
	Medicare swing-bed SNF inpatient ancillary service costs (from Wk	st. D-3, col. 3, lir	ne		202
	200 (title XVIII swing-bed SNF))				
3.00	Fotal (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				204
	computation of Demonstration Target Amount Limitation (N/A in fir	st year of the curre	ent 5-year demonst	ration	
	eriod) Medicare swing-bed SNF target amount				1205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)			205 206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme				200
	Program reimbursement under the §410A Demonstration (see instruct				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, c		1		208
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructio	ns)			209
	Reserved for future use				210
	omparision of PPS versus Cost Reimbursement				
5.00	Fotal adjustment to Medicare swing-bed SNF PPS payment (line 209 nstructions)	plus line 210) (see			215

ALCUL.	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1301	Peri od:	Worksheet E-3	2552
LOOL			From 07/01/2017	Part V	
			To 06/30/2018		
		Title XVIII	Hocpital	11/28/2018 4: Cost	47 p
			Hospi tal	COST	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR ME	EDICARE PART A SERVICES - CO	ST REIMBURSEMENT		
00	Inpatient services			1, 462, 584	
00	Nursing and Allied Health Managed Care payment (see ins	structions)		0	
00	Organ acquisition			0	
00	Subtotal (sum of lines 1 through 3)			1, 462, 584	
00	Primary payer payments	>		0	-
00	Total cost (line 4 less line 5). For CAH (see instructi	ons)		1, 477, 210	6
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
00	Routi ne servi ce charges			0	1 7
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
	Total reasonable charges			0	
	Customary charges				1
. 00	Aggregate amount actually collected from patients liabl	e for payment for services o	n a charge basis	0	] 11
. 00	Amounts that would have been realized from patients lia	able for payment for services	on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 47	13.13(e)			
	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)			0	
5.00	Excess of customary charges over reasonable cost (compl	ete only if line 14 exceeds	line 6) (see	0	15
00	instructions)			0	1 1
5.00	Excess of reasonable cost over customary charges (compl instructions)	ete oni y 11 11ne 6 exceeds 1	ine 14) (See	0	16
7.00	Cost of physicians' services in a teaching hospital (se	e instructions)		0	17
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
3. 00	Direct graduate medical education payments (from Works)	neet E-4, line 49)		0	118
9.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 477, 210	19
0. 00	Deductibles (exclude professional component)			157, 780	20
. 00	Excess reasonable cost (from line 16)			0	21
2.00	Subtotal (line 19 minus line 20 and 21)			1, 319, 430	22
	Coinsurance			0	
	Subtotal (line 22 minus line 23)			1, 319, 430	
	Allowable bad debts (exclude bad debts for professional	services) (see instructions	)	32, 361	
	Adjusted reimbursable bad debts (see instructions)			21,035	
	Allowable bad debts for dual eligible beneficiaries (se	ee instructions)		13, 869	
	Subtotal (sum of lines 24 and 25, or line 26)			1, 340, 465	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	quati ana)		0	
	Pioneer ACO demonstration payment adjustment (see instr			0	1 - 1
	Demonstration payment adjustment amount before sequest			0	
	Subtotal (see instructions) Sequestration adjustment (see instructions)			1, 340, 465 26, 809	
	Demonstration payment adjustment amount after sequestra	ation		20,809	
	Interim payments			1, 224, 437	
	Tentative settlement (for contractor use only)			1, 224, 437	
	Balance due provider/program (line 30 minus lines 30.07	1 20.02 21 and 22)		89, 219	
3.00	Balance que provider/prodram (Line 30 minus Lines 30 0				

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1301	Peri od:	Worksheet E-3	
			From 07/01/2017 To 06/30/2018	Part VII Date/Time Pre 11/28/2018 4:-	
		Title XIX	Hospi tal	Cost	., .
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR	XIX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		275, 775	_	1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0	0	3
00 00	Subtotal (sum of lines 1, 2 and 3) Inpatient primary payer payments		275, 775 0	0	4
00	Outpatient primary payer payments		0	0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		275, 775	0	7
00	COMPUTATION OF LESSER OF COST OR CHARGES		270,770		1 '
	Reasonable Charges				1
00	Routi ne servi ce charges		39, 621		1 8
00	Ancillary service charges		508, 615	0	9
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		548, 236	0	12
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
. 00	basis Amounts that would have been realized from patients liable for	on 0	0	14	
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.000000	
	Total customary charges (see instructions)	548, 236	0	16	
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	272, 461	0	17
8. 00	line 4) (see instructions)	viflipo 4 oxcoods li	ne 0	0	18
5. 00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y II IIIe 4 exceeds II	ne u	0	
9.00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	20
	Cost of covered services (enter the lesser of line 4 or line 1		275, 775	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	23
. 00	Program capital payments		0		24
	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	26
	Subtotal (sum of lines 22 through 26)		0	0	27
	Customary charges (title V or XIX PPS covered services only)		0	0	28
0. 00	Titles V or XIX (sum of lines 21 and 27)		275, 775	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1
00 .	Excess of reasonable cost (from line 18)		0	0	30
. 00 2. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		275, 775 0	0	31
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	275, 775	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	37
	Subtotal (line 36 ± line 37)		275, 775	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	-	39
	Total amount payable to the provider (sum of lines 38 and 39)		275, 775	0	
	Interim payments		275, 775	0	41
2. 00	Balance due provider/program (line 40 minus line 41)		0	0	42
	Protested amounts (nonallowable cost report items) in accordan		0	0	43

	ancial Systems ST. VINCENT RANG IEET (If you are nonproprietary and do not maintain accounting records, complete the General Fund column	Provider C		riod: om 07/01/2017	u of Form CMS-2 Worksheet G	
ly)			То		Date/Time Pre 11/28/2018 4:	
		General Fund	Purpose Fund	ndowment Fund	Plant Fund	
CUP	RENT ASSETS	1.00	2.00	3.00	4.00	
	h on hand in banks	92, 215	0	0	0	1 1
	porary investments	0	0	0	0	
00 Note	es recei vabl e	0	0	0	0	3
	ounts receivable	7, 256, 237	0	0	0	
	er receivable	1, 013, 243	0	0	0	
	owances for uncollectible notes and accounts receivable	-3, 946, 779	0	0	0	
	entory paid expenses	356, 671 74, 436	0	0	0	
	er current assets	/4,430	0	0	0	
	from other funds	0	0	0	0	
	al current assets (sum of lines 1-10)	4, 846, 023	0	o	0	
	ED ASSETS		· · · · · · ·			
00 Land		696, 652	0	0	0	
1	d improvements	0	0	0	0	
	umulated depreciation	0	0	0	0	1 .
	l dings	18, 732, 152	0	0	0	
	umulated depreciation sehold improvements	-9, 794, 538	0	0	0	
1	umulated depreciation		0	0	0	
	ed equipment	512, 142	0	0	0	
	umulated depreciation	-443, 323	0	0	0	
. 00 Auto	omobiles and trucks	12, 322	0	0	0	21
. 00 Acci	umul ated depreciation	-12, 322	0	0	0	22
1 -	or movable equipment	6, 097, 440	0	0	0	
	umulated depreciation	-4, 585, 927	0	0	0	
	or equipment depreciable	0	0	0	0	
	umulated depreciation designated Assets		0	0	0	
	umulated depreciation		0	0	0	
	or equipment-nondepreciable	0	0	0	0	
	al fixed assets (sum of lines 12-29)	11, 214, 598		0	0	
OTHE	ER ASSETS					
	estments	0	0	0	0	
	osits on Leases	0	0	0	0	
	from owners/officers	0	0	0	0	
	er assets al other assets (sum of lines 31-34)	68, 330 68, 330	0	0	0	
	al assets (sum of lines 11, 30, and 35)	16, 128, 951	0	0	0	
	RENT LIABILITIES	10, 120, 931	U	V	0	1 30
	ounts payable	1, 856, 648	0	0	0	37
1	aries, wages, and fees payable	551, 450	0	0	0	38
	roll taxes payable	81, 559	0	0	0	
	es and loans payable (short term)	190, 690	0	0	0	
	erred income	0	0	0	0	
	elerated payments	0	0	0	0	42
	to other funds er current liabilities	3, 388, 123	0	0	0	
	al current liabilities (sum of lines 37 thru 44)	6, 068, 470		0	0	
	G TERM LIABILITIES	0,000,170				
	tgage payable	0	0	0	0	46
.00 Note	es payabl e	13, 380, 097	0	0	0	47
	ecured Loans	0	0	О	0	
	er long term liabilities	0	0	0	0	
	al long term liabilities (sum of lines 46 thru 49)	13, 380, 097	0	0	0	
	al liabilities (sum of lines 45 and 50)	19, 448, 567	0	0	0	51
	eral fund balance	-3, 319, 616				52
	cific purpose fund	0,017,010	0			53
	or created - endowment fund balance - restricted			О		54
	or created - endowment fund balance - unrestricted			o		55
	erning body created - endowment fund balance			0		56
	nt fund balance - invested in plant				0	57
	nt fund balance - reserve for plant improvement,				0	58
	lacement, and expansion					-
	al fund balances (sum of lines 52 thru 58)	-3, 319, 616	0	0	0	
.00  Tota	al liabilities and fund balances (sum of lines 51 and	16, 128, 951	0	0	0	60

Health Financial Systems         S           STATEMENT OF CHANGES IN FUND BALANCES         S		T. VINCENT RANDO	Provider CCN: 15-1301 Period:		od:	eu of Form CMS-2552-10 Worksheet G-1		
					From To	07/01/2017 06/30/2018	Date/Time Pro 11/28/2018 4	
		General	Fund	Speci al	Purpo	ose Fund	Endowment Fund	1
		1.00	2.00	3.00		4.00	5.00	
. 00	Fund balances at beginning of period	1.00	-4, 046, 176	3.00		4.00	5.00	1.0
2.00	Net income (loss) (from Wkst. G-3, line 29)		-684, 951					2.0
. 00	Total (sum of line 1 and line 2)		-4, 731, 127			0		3.0
. 00	DONATIONS	34, 671			0		(	
. 00		0			0		(	
. 00		0			0		(	
. 00		0			0		(	
. 00		0			0		(	
. 00 0. 00	Total additions (sum of line 4.0)	0	24 471		0	0	(	9.0
1.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		34, 671 -4, 696, 456			0		11.0
2.00	Transfer from Affiliates	-1, 376, 842	-4, 090, 430		0	0	(	
2.00 3.00	ROUNDING	-1, 370, 842			0		(	
4.00		0			0			
5.00		0			0		(	
6.00		0			Ō		(	
7.00	Roundi ng	0			0		(	17.0
8.00	Total deductions (sum of lines 12-17)		-1, 376, 840			0		18.0
9.00	Fund balance at end of period per balance		-3, 319, 616			0		19.0
	sheet (line 11 minus line 18)							
		Endowment Fund	Diant					
			Trant	Fund				
		6.00	7.00	Fund 8.00				
	Fund balances at beginning of period				0			
.00	Net income (loss) (from Wkst. G-3, line 29)	6.00 0			Ŭ			2. (
. 00 . 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00			0			2. ( 3. (
. 00 . 00 . 00	Net income (loss) (from Wkst. G-3, line 29)	6.00 0			Ŭ			2. 3. 4.
. 00 . 00 . 00 . 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00 0			Ŭ			2. 3. 4. 5.
. 00 . 00 . 00 . 00 . 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00 0			Ŭ			2.0 3.0 4.0 5.0 6.0
. 00 . 00 . 00 . 00 . 00 . 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00 0			Ŭ			2. ( 3. ( 4. ( 5. ( 6. ( 7. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00 0			Ŭ			2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00 0			Ŭ			2. 3. 4. 5. 6. 7. 8. 9.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net income (loss) (From Wkst. G-3, line 29) Total (sum of line 1 and line 2) DONATIONS	6.00 0			Ŭ			2. 3. 4. 5. 6. 7. 8. 9. 10.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00	Net income (loss) (From Wkst. G-3, line 29) Total (sum of line 1 and line 2) DONATIONS Total additions (sum of line 4-9)	6.00 0			Ŭ			2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00	Net income (loss) (From Wkst. G-3, line 29) Total (sum of line 1 and line 2) DONATIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00 0			Ŭ			2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) DONATIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates	6.00 0			Ŭ			2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. ( 14. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) DONATIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates	6.00 0			Ŭ			2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. ( 14. ( 15. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) DONATIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates ROUNDING	6.00 0			Ŭ			2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. ( 14. ( 15. ( 16. (
2.00 3.00 5.00 5.00 7.00 3.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 7.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) DONATIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates ROUNDING Rounding	6.00 0			Ŭ			2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 11. ( 12. ( 13. ( 14. ( 15. ( 15. ( 15. ( 17. ( 17. (
1.00 2.00 3.00 5.00 5.00 7.00 3.00 11.00 12.00 3.00 4.00 15.00 15.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) DONATIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates ROUNDING	6.00 0			Ŭ			1. C 2. C 3. C 4. C 5. C 7. C 8. C 9. C 10. C 11. C 12. C 13. C 14. C 15. C 15

STATEM	Financial Systems ST. VINCENT RANDOLF ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	15-1301		riod: om 07/01/2017 06/30/2018	Worksheet G-2 Parts I & II Date/Time Pre 11/28/2018 4:	pared:
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
1 00	General Inpatient Routine Services			(0)		E 474 0/0	1 1 00
1.00	Hospi tal		5, 471, 26	60		5, 471, 260	•
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER Swing bed - SNF			0		0	4.00
5.00 6.00	5			0		0	
6.00 7.00	Swing bed - NF			0		0	7.00
7.00 8.00	SKILLED NURSING FACILITY NURSING FACILITY						8.00
8.00 9.00	OTHER LONG TERM CARE						9.00
	Total general inpatient care services (sum of lines 1-9)		5, 471, 26	60		5, 471, 260	
10.00	Intensi ve Care Type Inpatient Hospital Services		5,471,20		I	5,471,200	10.00
11.00	INTENSIVE CARE UNIT						11.00
	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
	OTHER SPECIAL CARE (SPECIFY)						15.00
	Total intensive care type inpatient hospital services (sum of	lines		0		0	
10.00	11-15)			Ŭ		0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		5, 471, 26	60		5, 471, 260	17.00
18.00	Ancillary services		5, 965, 18		54, 811, 730	60, 776, 912	
19.00	Outpatient services		280, 42		15, 887, 928	16, 168, 355	
20.00	RURAL HEALTH CLINIC			0	0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	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
	Other Patient Service Revenue			0	396	396	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	11, 716, 86	69	70, 700, 054	82, 416, 923	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES				00 504 404		
	Operating expenses (per Wkst. A, column 3, line 200)			~	22, 506, 436		29.00
30.00	ADD (SPECI FY)			0			30.00
31.00				0 0			31.00
32.00				0			32.00
33.00				0			33.00
34.00 35.00				0			34.00
36.00	Tatal additions (sum of lines 20 25)			0	0		36.00
36.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)			0	0		36.00
37.00				0			37.00
39.00				0			39.00
40.00				0			40.00
40.00				0			40.00
42.00	Total deductions (sum of lines 37-41)				0		41.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfer			22, 506, 436		42.00
. 5. 55	to Wkst. G-3, line 4)				22,000,400		10.00

	Health Financial Systems         ST. VINCENT RANDOLPH HOSPITAL         In Li           STATEMENT OF REVENUES AND EXPENSES         Provider CCN: 15-1301         Period:				
			From 07/01/2017		
			To 06/30/2018	Date/Time Pre 11/28/2018 4:	
			·	1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		82, 416, 923	1.00
2.00	Less contractual allowances and discounts on patients' accounts	unts		61, 189, 057	2.00
3.00	Net patient revenues (line 1 minus line 2)			21, 227, 866	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	e 43)		22, 506, 436	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-1, 278, 570	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			-89	6.00
7.00	Income from investments			1, 034	7.00
8.00	Revenues from telephone and other miscellaneous communication	on services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			63, 315	14.00
15.00	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			2, 228	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			494, 042	
23.00	Governmental appropriations			0	23.00
24.00	Other			8, 473	
24.01	GRANTS			10, 000	
24.02	NET ASSETS RELEASED FROM RESTRICTION			10, 186	
24.05	Lab Servi ces			2, 868	
	Dietary Revenue			1, 562	
25.00	Total other income (sum of lines 6-24)			593, 619	
26.00	Total (line 5 plus line 25)			-684, 951	
	LOSS ON INTEREST RATE SWAPS			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-684, 951	29.00