This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can resu	t in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	deemed overpayments (4)	2 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 05-31-2019
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provi der CCN: 15-2020	Peri od: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/26/2018 12:48 pm
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically filed cost report		Date: 11/26/20	018 Time: 12:48 pm
use only	2. [] Manually submitted cost report			
	3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or "L		esubmitted this co	ost report
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report for (3) Settled with Audit 9. [N]Final Report for (4) Reopened (5) Amended	or this Provider CCN 12.		
DADT II CEDT	TELCATION			

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST VINCENT SETON SPECIALITY HOSPITAL (15-2020) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Ti tl	e
Data	
Date	

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	247, 569	0	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	247, 569	0	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. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2020 Peri od: Worksheet S-2 From 07/01/2017 Part I Date/Time Prepared: 06/30/2018 11/26/2018 10:36 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 8050 TOWNSHIP LINE ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zip Code: 46260 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST VINCENT SETON 152020 26900 2 02/08/2003 Ν 0 3.00 SPECIALITY HOSPITAL Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2017 06/30/2018 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 Ν 23 00 2 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,	Pt. I.		N .			59.00
			NAHE 413.85	Worksheet		Pass-Thr		
			Y/N	Line #		Qual i fi c		
					(Cri teri or	n Code	
			1. 00	2.00		3. 00	0	
60.00 Are you claiming nursing and allied health education			N					60.00
any programs that meet the criteria under §413.85? (See Ins	structions) IME	Direct GME	IME		Di rect	CME	
	1711	I IVIE	DITECT GWE	INE		Direct	GIVIE	
	1. 00	2. 00	3. 00	4.00		5. 00	0	
61.00 Did your hospital receive FTE slots under ACA	N		5. 55		0. 00		-	61. 00
section 5503? Enter "Y" for yes or "N" for no in								
column 1. (see instructions)								
61.01 Enter the average number of unweighted primary care								61. 01
FTEs from the hospital's 3 most recent cost reports								
ending and submitted before March 23, 2010. (see								
instructions)								(1.00
61. 02 Enter the current year total unweighted primary care								61. 02
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								
ACA). (see instructions)								
61.03 Enter the base line FTE count for primary care								61. 03
and/or general surgery residents, which is used for								
determining compliance with the 75% test. (see								
instructions)								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	X IDENTIFICATION DA	TA	Provi der C	CN: 15-2020	Peri od: From 07/01/2017 To 06/30/2018		pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4. 00	5. 00	
Enter the number of unweighted pri surgery allopathic and/or osteopat current cost reporting period. (see Enter the difference between the b and/or general surgery FTEs and th primary care and/or general surger 61.04 minus line 61.03). (see inst Enter the amount of ACA §5503 awar	hic FTEs in the instructions). aseline primary e current year's y FTE counts (line ructions)						61. 0
used for cap relief and/or FTEs th	J						01.0
care or general surgery. (see inst	ructi ons)	Prov	gram Name	Program Cod	e Unweighted IME	Unweighted	
		FIO	gi alli Nalle	Frogram cou	FTE Count	Direct GME FTE Count	
			1. 00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specify specialty, if any, and the number for each new program. (see instruc column 1, the program name. Enter program code. Enter in column 3, t unweighted count. Enter in column FTE unweighted count.	of FTE residents tions) Enter in in column 2, the he IME FTE 4, the direct GME				0. 00		61. 1
1. 20 Of the FTEs in line 61.05, specify program specialty, if any, and the residents for each expanded progra instructions) Enter in column 1, t Enter in column 2, the program cod 3, the IME FTE unweighted count. E the direct GME FTE unweighted coun	number of FTE m. (see he program name. e. Enter in column nter in column 4,				0.00	0.00	61. 2
						1. 00	
ACA Provisions Affecting the Healt					riad far which	0.00	62. C
2.00 Enter the number of FTE residents your hospital received HRSA PCRE f2.01 Enter the number of FTE residents	unding (see instruc	ctions)					62.0
during in this cost reporting peri				ns)			
Teaching Hospitals that Claim Resi 3.00 Has your facility trained resident				ost reporting	period? Enter	N	63. 0
"Y" for yes or "N" for no in colum				67. (see inst	ructions)		
				Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Year				This base yea	nr is your cost i	reporting	
period that begins on or after Jul. 4.00 Enter in column 1, if line 63 is y in the base year period, the number resident FTEs attributable to rota settings. Enter in column 2 the nesident FTEs that trained in your of (column 1 divided by (column 1	es, or your facilit r of unweighted nor tions occurring in umber of unweighted hospital. Enter ir	y traine n-primary all nonp non-pri n column	ed residents / care brovider mary care 3 the ratio	0.	0.00	0. 000000	64.0
	Program Name		gram Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	

1.00

Unwei ghted FTEs Nonprovi der Si te

3. 00

2.00

Unweighted FTEs in Hospital

4.00

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

5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2020 Peri od: Worksheet S-2 From 07/01/2017 Part I Date/Time Prepared: 06/30/2018 11/26/2018 10:36 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

lealth Financial Systems ST VINCENT SETON SPECIALITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2020 Pe	eri od:	u of Form CMS Worksheet S	
	rom 07/01/2017	Part I Date/Time P 11/26/2018	repared:
		1. 00	
Long Term Care Hospi tal PPS		1.00	
Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no. TEFRA Providers	period? Enter	Y N	80. 00 81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o		N	85. 00
36.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	1		86. 0
37.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87. 0
1000(u)(1)(b)(v1)? Effet 1 101 yes 01 N 101 Hb.	V	XI X	
Title Ward VIV Coming	1. 00	2. 00	
Title V and XIX Services OO. 00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Υ	90.0
yes or "N" for no in the applicable column. 21.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in	l N	Υ	01.0
21.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	IN IN	Y	91.0
P2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.0
93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93. 0
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 0
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95. 0
26.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N N	N	96. 0
97.00 filine 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97. 0
28.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	N	N	98. 0
column 1 for title V, and in column 2 for title XIX. 108.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 109.01 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	N	N	98. 0
title XIX.			
28.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	N	N	98. 0
for title V, and in column 2 for title XIX. 28.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	N	N	98. 0
reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			
Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N	N	98. 0
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	N	N	98. 0
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			
28.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98. 0
Rural Providers			
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N N		105. 0 106. 0
for outpatient services? (see instructions)			
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If	N		107. 0

yes, the GME elimination is not made on Wkst. B, Pt. I, colline reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the	N		108. 00		
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4.00	
109.00 f this hospital qualifies as a CAH or a cost provider, are					109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
					1

	1. 00	
110.00Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110.00
Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

Health Financial Systems ST VINCENT SETON SPEC				eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-2020		eriod: fom 07/01/2017 o 06/30/2018		epared:
			1. 00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to column tegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	t reporting period? Enumn 1 is Y, enter the icipating in column 2.		N		111.00
Mi goal Langua Cost Danasti na Lafarmati an			1.0	0 2.00 3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers. Pub. 15-1, chapter 22, §2208.1.	If column 2 is "E", en for long term care (i) based on the definit	ter i nclud	n column es n CMS		115. 00
116.00 Is this facility classified as a referral center? Enter "Y" for 117.00 Is this facility legally-required to carry malpractice insuration.	nce? Enter "Y" for yes				116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence policial m-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if the pol	icy i	s 2		118. 00
	Premi ur	ns	Losses	Insurance	
	1.00		2. 00	3.00	
118.01 List amounts of malpractice premiums and paid losses:	104	4, 845		0	0 118. 01
			1. 00	2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 119.00 DO NOT USE THIS LINE		S	N		118. 02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold I §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment: Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes (lifies for the Outpation	or	N	N	120. 00
121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	table devices charged	to	N		121. 00
122.00 Does the cost report contain healthcare related taxes as defile Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			N		122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no. I	f	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter	er the certification d	ate			126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter	r the certification da	te			127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter	r the certification da	te			128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter		e in			129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, en	nter the certification				130. 00
date in column 1 and termination date, if applicable, in column 131.00 of this is a Medicare certified intestinal transplant center,		on			131. 00
date in column 1 and termination date, if applicable, in column 132.00 If this is a Medicare certified islet transplant center, enter		te			132. 00
in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter		te			133. 00
in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (0PO), enter the and termination date, if applicable, in column 2.		1			134. 00
All Providers	CL LL OUS SIL		1.		1
140.00 Are there any related organization or home office costs as dechapter 10? Enter "Y" for yes or "N" for no in column 1. If yeare claimed, enter in column 2 the home office chain number.	es, and home office co		Υ	15H046	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2020 Peri od: Worksheet S-2 From 07/01/2017 Part I 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number

Name: ST VINCENT HEALTH | Contractor's Name: WPS Contractor's Number: 08101 141 00 Name: ST VINCENT HEALTH 141 00 142.00 Street: 250 WEST 96TH STREET PO Box: 142.00 143.00 City: INDIANAPOLIS 46290 143. 00 State: Zip Code: 1 00 144.00 Are provider based physicians' costs included in Worksheet A? N 144. 00 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section

1876 Medicare days in column 2. (see instructions)

	Financial Systems ST VINCENT SETON SPEC AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-2020	Peri od: From 07/01/2017 To 06/30/2018		epared:
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	er all dates in t	the	
	Provider Organization and Operation					1
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N		1.00
			Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	3, "V" for	N			2.00
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug r or its the board	N			3.00
			Y/N	Туре	Date	
			1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi	fied Public	Υ	A		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avaicolumn 3. (see instructions) If no, see instructions.	lable in				
5. 00	Are the cost report total expenses and total revenues differenthose on the filed financial statements? If yes, submit reco		N			5. 00
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lf yes, is t	he provider is	S N		6. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see ins	tructions.		N		7.00
8. 00	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.	nd/or renewe	d during the	N		8.00
9. 00	Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.	renewed in	the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11. 00
					Y/N 1. 00	
	Bad Debts					4
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement	ts waived? I	fyes, see ins	structions.	N	14.00
15. 00	Did total beds available change from the prior cost reporting				N N	15. 00
		Y/N	rt A Date	Y/N	t B Date	
		1. 00	2. 00	3. 00	4. 00	
	PS&R Data	1. 50	2.00	3.00	1.00	
16. 00	Was the cost report prepared using the PS&R Report only?	Υ	10/09/2018	Y	10/09/2018	16. 00

	ורשת שמום					
16.00	Was the cost report prepared using the PS&R Report only?	Υ	10/09/2018	Υ	10/09/2018	16.00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	N		N		17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Heal th	Financial Systems ST VINCENT SETON SP	PECLALITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10		
HOSPI T			Peri od: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Pre 11/26/2018 10	pared:			
			i pti on	Y/N	Y/N			
20.00	LE Line 1/ on 17 in one of the DCOD		0	1. 00	3. 00	20.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N	Date	Y/N	Date			
	I V	1.00	2. 00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)					
	Capital Related Cost							
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made dur	ing the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entere	ed into during	this cost re	porting period?	N	24. 00		
05.00	If yes, see instructions					05.00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repoi	rting perioa?	IT yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see	N	26. 00		
27. 00	instructions. Has the provider's capitalization policy changed during the	cost reporti	na period2 lf	vae submit	N	27. 00		
27.00	copy.	e cost reportir	ig perrou: II	yes, subili t	IV.	27.00		
00.00	Interest Expense		, .					
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	nterea into aui	ring the cost	reporting	N	28. 00		
29. 00	Did the provider have a funded depreciation account and/or		ebt Service R	eserve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		deht? If ves	500	N	30.00		
00.00	instructions.	arrey wren new	debt. 11 yes	, 300	.,	00.00		
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	, see	N	31.00		
	Purchased Services					1		
32. 00	Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32. 00		
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		na to compoti	tivo bidding? If	N	33. 00		
33.00	no, see instructions.	orred pertariiri	ig to competi	tive bruding: 11	IV	33.00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	n provi der-ba	sed physi ci ans?	N	34. 00		
35. 00	If line 34 is yes, were there new agreements or amended exi	sting agreemen	nts with the	provi der-based	N	35. 00		
	physicians during the cost reporting period? If yes, see in	nstructions.			D 1			
				Y/N 1. 00	Date 2.00			
	Home Office Costs							
36.00				Υ		36. 00		
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Υ		37. 00		
38. 00		ice different	from that of	N		38. 00		
00.00	the provider? If yes, enter in column 2 the fiscal year end	d of the home o	offi ce.			00.00		
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compoi	nents? IT yes	, 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		
	i nstructi ons.							
	1.00 2.							
41. 00	Cost Report Preparer Contact Information		41. 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.	DERRI CK		LUND		41.00		
42. 00	Enter the employer/company name of the cost report	ST VINCENT HEA	ALTH			42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost	317-583-3293		DERRI CK. LUND@A	SCENSLONHEALTH	43. 00		
	report preparer in columns 1 and 2, respectively.	333 5273		. ORG	TENO ONIENEIII	.5. 55		

Heal th	Financial Systems	ST VINCENT SETON S	SPECI	ALITY HOSPI	TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE		Provider C	CN: 15-2020		i od:	Worksheet S-2)
						Fro To			narod:
						10	00/30/2016	11/26/2018 10	:pareu.) <u>: 36_am_</u>
				3.	. 00				
	Cost Report Preparer Contact Information	ı							
41.00	Enter the first name, last name and the	ti tle/posi ti on	REI	MBURSEMENT	MANAGER				41.00
	held by the cost report preparer in col	umns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the	cost report							42. 00
	preparer.								
43.00	Enter the telephone number and email add								43. 00
	report preparer in columns 1 and 2, res	oecti vel y.							

Heal th Financial Systems ST VINCENT SETON SPECIALITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: Provider CCN: 15-2020

						То	06/30/2018	Date/Time Pre 11/26/2018 10	
								I/P Days / 0/P	
								Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	
	·	Line Number			Avai I abl e				
		1. 00		2.00	3.00		4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		72	26, 28	0	0. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2.00
3.00	HMO IPF Subprovider								3.00
4.00	HMO I RF Subprovi der								4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							0	
6.00	Hospital Adults & Peds. Swing Bed NF			70	2/ 20		0.00	0	
7. 00	Total Adults and Peds. (exclude observation			72	26, 28	U	0. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT								8. 00
9. 00	CORONARY CARE UNIT								9.00
10.00	BURN INTENSIVE CARE UNIT								10.00
11. 00	SURGICAL INTENSIVE CARE UNIT								11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)								12. 00
13. 00	NURSERY								13. 00
14. 00	Total (see instructions)			72	26, 28	.0	0.00	0	14. 00
15. 00	CAH visits			12	20, 20		0.00	0	15. 00
16. 00	SUBPROVI DER - I PF								16.00
17. 00	SUBPROVI DER - I RF								17. 00
18. 00	SUBPROVI DER								18. 00
19. 00	SKILLED NURSING FACILITY								19. 00
20. 00	NURSING FACILITY								20.00
21. 00	OTHER LONG TERM CARE								21. 00
22. 00	HOME HEALTH AGENCY								22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)								23. 00
24.00	HOSPI CE								24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25.00	CMHC - CMHC								25. 00
26.00	RURAL HEALTH CLINIC								26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0	26. 25
27.00	Total (sum of lines 14-26)			72					27. 00
28.00	Observation Bed Days							0	28. 00
29. 00	Ambul ance Trips								29. 00
30.00	Employee discount days (see instruction)								30. 00
31.00	Employee discount days - IRF								31. 00
32. 00	Labor & delivery days (see instructions)			0		0			32. 00
32. 01	Total ancillary labor & delivery room								32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days								33. 00
33. 01	LTCH site neutral days and discharges				1				33. 01

Heal th Financial Systems ST VINCENT SETON SPECIALITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN:

Provider CCN: 15-2020

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 07/01/2017 Part I
To 06/30/2018 Date/Time Prepared:
11/26/2018 10:36 am

						11/26/2018 10	:36 am
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
			7.00	Pati ents	& Residents	Payrol I	
1. 00	Hearital Adulta & Dada (aslumna E. / 7 and	6.00	7. 00 91	8.00	9. 00	10.00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	9, 012	91	14, 832			1.00
2.00	HMO and other (see instructions)	2, 242	0				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	9, 012	91	14, 832			7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	9, 012	91	14, 832	0.00	222. 00	14. 00
15.00	CAH visits	0	0	C			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	C			24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	222. 00	27. 00
28. 00	Observation Bed Days		0	C			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF			C			31. 00
32.00	Labor & delivery days (see instructions)	o	0	C			32.00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

Heal th Financial Systems ST VINCENT SETON SPECIALITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN:

Provi der CCN: 15-2020

Peri od: Worksheet S-3
From 07/01/2017
To 06/30/2018 Date/Ti me Prepared: 11/26/2018 10:24 cm

						11/26/2018 10	:36 am
		Full Time Equivalents		Di sch	narges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0 244		431	1.00
2.00	HMO and other (see instructions) HMO IPF Subprovider			56	0		2.00
4.00	HMO I RF Subprovi der				O		4. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00		0 244	3	431	14. 00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - I PF						16.00
17. 00 18. 00	SUBPROVI DER						17. 00 18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)						31. 00 32. 00
32. 00	Total ancillary labor & delivery room						32. 00
32.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges			ď			33. 01
	, , , , , , , , , , , , , , , , , , ,	' '		'	1		

Heal th	Financial Systems ST VI	NCENT SETON SPEC	CIALITY HOSPI	TAL	In Lie	eu of Form CMS-2	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
					rom 07/01/2017	5 . (7) 5	
					o 06/30/2018	Date/Time Pre 11/26/2018 10	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	. 30 aiii
	cost center bescription	Sai ai i es	Other	+ col . 2)	ons (See A-6)	Trial Balance	
				1 001. 2)	0113 (000 11 0)	(col . 3 +-	
						col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		2.00	0.00		0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		719, 823	719, 823	-182	719, 641	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		135, 495	135, 495	0	135, 495	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	3, 179, 223	3, 179, 223			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 583, 811	8, 991, 203	10, 575, 014			5. 00
7. 00	00700 OPERATION OF PLANT	0	994, 341	994, 341		1	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	o	108, 035	108, 035			
9. 00	00900 HOUSEKEEPI NG	o o	396, 723	396, 723		396, 723	
10. 00	01000 DI ETARY		746, 799				
13. 00	01300 NURSI NG ADMI NI STRATI ON	787, 640	77, 173	864, 813			
15. 00	01500 PHARMACY	1, 325, 035	1, 630, 534				
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 323, 033	1, 030, 334	2, 955, 569		2, 913, 590	1
		24 024	1 707	-	_	1	1
17. 00 18. 00	01700 SOCIAL SERVICE	24, 826	1, 787	26, 613		,	
18.00	01851 PASTORAL CARE	0	U) 0	0	18. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 055 050	2 002 520	0 147 50	000 700	0.24/ 700	20.00
30. 00	03000 ADULTS & PEDI ATRI CS	7, 055, 059	2, 092, 538	9, 147, 597	-900, 798	8, 246, 799	30.00
F0 00	ANCILLARY SERVICE COST CENTERS	474 770	04.457	0// 00/	75 404	100 710	
50.00	05000 OPERATING ROOM	171, 770	94, 456				
54.00	05400 RADI OLOGY-DI AGNOSTI C	79, 395	96, 360	175, 755			
54. 01	03630 ULTRA SOUND	54, 058	674			54, 732	
57. 00	05700 CT SCAN	44, 584	10, 113			l	
60. 00	06000 LABORATORY	0	416, 155	416, 155	0		
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	2, 027, 105	405, 190				
66. 00	06600 PHYSI CAL THERAPY	374, 147	37, 599				
67. 00	06700 OCCUPATI ONAL THERAPY	249, 565	19, 886				
68. 00	06800 SPEECH PATHOLOGY	173, 555	24, 634	198, 189	0	198, 189	
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	946	3, 848	4, 794	0	4, 794	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	142	10	152	1, 100, 206	1, 100, 358	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	576, 628	576, 628	-1, 536	575, 092	74.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE		0	C	0	0	113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	13, 951, 638	20, 759, 227	34, 710, 865	0	34, 710, 865	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
191.00	19100 RESEARCH	0	0	C	0	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	o	0	(0	0	192. 00
	19300 NONPALD WORKERS	o	0	(0	0	193. 00
194.00	07950 BIOTERRORISM GRANT	o	4, 275	4, 275	0	4, 275	194. 00
	07951 MARKETI NG	o	0		o		194. 01
200.00	TOTAL (SUM OF LINES 118 through 199)	13, 951, 638	20, 763, 502	34, 715, 140	0	34, 715, 140	200.00
		. '	'	•			•

 Heal th Financial
 Systems
 ST VINCENT SETON SPECIALITY HOSPITAL

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN:

Provi der CCN: 15-2020

Peri od: From 07/01/2017 To 06/30/2018 Date/Time Prepared:

			11/26/2018 10	:36 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-14, 549	705, 092		1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	0	135, 495		2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 179, 223		4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	-3, 432, 286	7, 148, 237		5. 00
7.00 00700 OPERATION OF PLANT	0	994, 341		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	108, 035		8. 00
9. 00 00900 HOUSEKEEPI NG	0	396, 723		9. 00
10. 00 01000 DI ETARY	-93, 324	653, 475		10.00
13.00 O1300 NURSING ADMINISTRATION	0	861, 860		13. 00
15. 00 01500 PHARMACY	0	2, 913, 590		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		16.00
17. 00 01700 SOCIAL SERVICE	0	26, 613		17. 00
18. 00 01851 PASTORAL CARE	0	0		18. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	0	8, 246, 799		30. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	190, 740		50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	175, 755		54.00
54. 01 03630 ULTRA SOUND	0	54, 732		54. 01
57. 00 05700 CT SCAN	0	46, 091		57. 00
60. 00 06000 LABORATORY	0	416, 155		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
65. 00 06500 RESPI RATORY THERAPY	0	2, 362, 230		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	408, 599		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	268, 488		67. 00
68.00 06800 SPEECH PATHOLOGY	0	198, 189		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	4, 794		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 100, 358		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
74. 00 07400 RENAL DIALYSIS	0	575, 092		74. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE	0	0	1	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-3, 540, 159	31, 170, 706		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	l control of the cont	190. 00
191. 00 19100 RESEARCH	0	0	l control of the cont	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
193. 00 19300 NONPAI D WORKERS	0	0		193. 00
194. 00 07950 BI OTERRORI SM GRANT	0	4, 275		194. 00
194. 01 07951 MARKETI NG	154, 010	154, 010		194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	-3, 386, 149	31, 328, 991		200. 00

1.00

TOTALS

500.00 Grand Total: Increases

ADMINISTRATIVE & GENERAL

1.00

500.00

RECLASSI FI CATI ONS Provi der CCN: 15-2020 Worksheet A-6 Peri od: From 07/01/2017 To 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am Increases Cost Center Li ne # Sal ary 0ther 2. 00 5.00 3.00 4.00 A - DRUGS CHARGED TO PATIENTS 1.00 PHARMACY 15.00 1,889 1.00 2.00 0.00 0 2.00 0 4.00 0.00 0 4.00 0 6.00 0.00 0 6.00 TOTALS 0 1, 889 B - MEDICAL SUPPLIES CHARGED TO PATIENT ADMINISTRATIVE & GENERAL 5.00 1.00 0 1.00 5, 327 0 2.00 0.00 2.00 3.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 1, 100, 206 3.00 PATI ENTS 4.00 0 0.00 4.00 0 0 0 5.00 0.00 5.00 0 6.00 0.00 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 8.00 1, 105, 533 T0TALS C - NON-CAPITAL INTEREST EXPENSE

0

0

182

182

1, 107, 604

5.00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6 From 07/01/2017 To 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am Provider CCN: 15-2020

						11/26/2018 10	<u>:36 am</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - DRUGS CHARGED TO PATIENTS	5					
1.00	ADULTS & PEDIATRICS	30.00	0	82	0		1.00
2.00	OPERATING ROOM	50.00	0	9	0		2.00
4.00	CT SCAN	57. 00	0	262	0		4.00
6.00	RENAL DIALYSIS	74.00	0	1, 536	0		6.00
	TOTALS		0	1, 889			
	B - MEDICAL SUPPLIES CHARGED	TO PATIENT					
1.00	NURSING ADMINISTRATION	13. 00	0	2, 953	0		1.00
2.00	PHARMACY	15. 00	0	43, 868	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	900, 716	0		3.00
4.00	OPERATING ROOM	50.00	0	75, 477	0		4.00
5.00	CT SCAN	57. 00	0	8, 344	0		5.00
6.00	RESPIRATORY THERAPY	65. 00	0	70, 065	0		6.00
7.00	PHYSI CAL THERAPY	66.00	0	3, 147	0		7.00
8.00	OCCUPATI ONAL THERAPY	67. 00	0	963	0		8.00
	TOTALS — — — — —			1, 105, 533	B		
	C - NON-CAPITAL INTEREST EXPE	NSE					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	182	11		1.00
	TOTALS — — — — —			₁₈₂			
500.00	Grand Total: Decreases		0	1, 107, 604			500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-2020 Peri od: Worksheet A-7 From 07/01/2017 Part I Date/Time Prepared: 06/30/2018 11/26/2018 10:36 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 847, 629 0 1.00 0 0 2.00 Land Improvements 3, 157 0 2.00 3.00 Buildings and Fixtures 15, 952, 903 3.00 0 0 Building Improvements 0 4.00 166, 523 0 0 0 4.00 5.00 Fixed Equipment 984, 867 0 0 5.00 0 6.00 Movable Equipment 5, 008, 593 233, 830 233, 830 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 22, 963, 672 233, 830 233, 830 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 22, 963, 672 233, 830 10.00 10.00 0 233, 830 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 847, 629 0 1.00 2.00 Land Improvements 0 2.00 3, 157 15, 952, 903 3.00 Buildings and Fixtures 0 3.00 0) 4.00 Building Improvements 166, 523 4.00 5.00 Fi xed Equipment 984, 867 0 5.00 Movable Equipment 0 6.00 5, 242, 423 6.00 7.00 HIT designated Assets 0 7.00

23, 197, 502

23, 197, 502

0

Health Financial Systems	ST VINCENT SETON SPECIALITY HOSPITAL	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-2020		Worksheet A-7
		From 07/01/2017	
		To 0//20/2010	Doto/Time Dranared.

				Ť	0 06/30/2018	Date/Time Prep 11/26/2018 10	
			SU	MMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Longo	Interest	Insurance (see	Taxes (see	
	cost center bescription	Depi eci ati on	Lease	Titterest	instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	705, 091	0	14, 732	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	135, 495	0	2. 00
3.00	Total (sum of lines 1-2)	705, 091	0	14, 732	135, 495	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		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					
1.00	CAP REL COSTS-BLDG & FIXT	0	719, 823				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	135, 495				2. 00
3.00	Total (sum of lines 1-2)	l ol	855, 318				3. 00

Heal th	Financial Systems ST V	NCENT SETON SP	PECIALITY HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
					From 07/01/2017		nonod.
					Го 06/30/2018	Date/Time Pre 11/26/2018 10	
		COMI	PUTATION OF RAT	TLOS	ALLOCATION OF	OTHER CAPITAL	, 00 am
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
	·		Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	17, 104, 292	0	17, 104, 292	0. 773499	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	5, 008, 593	0	5, 008, 593	0. 226501	0	2. 00
3.00	Total (sum of lines 1-2)	22, 112, 885	0	22, 112, 88	1. 000000	0	3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			_		1
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(705, 091	0	1
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		705, 091	0	3. 00
			Sl	JMMARY OF CAPI	TAL		

Interest

11. 00

1 0 1

Insurance (see

instructions)

12.00

135, 495 135, 495 Taxes (see

instructions)

13.00

0 0 0 0ther

Capi tal -Rel ate d Costs (see

instructions)

14.00

0

Total (2) (sum of cols. 9

through 14)

15.00

705, 092 135, 495 840, 587

1.00

2. 00

Cost Center Description

CAP REL COSTS-BLDG & FIXT

CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)

1.00

2.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-2020 Peri od: Worksheet A-8 From 07/01/2017 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL -14,549 CAP REL COSTS-BLDG & FLXT 1. 00 В 1.00 11 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other В -182 ADMINISTRATIVE & GENERAL 5.00 11 3.00 (chapter 2) Trade, quantity, and time 4 00 0 4 00 0 00 0 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 Provider-based physician 10.00 10.00 A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 -3, 357, 815 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -90, 752 DI ETARY 10.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines -2, 572 DI ETARY 10.00 20.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 24.00 Adjustment for physical A-8-3 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 27.00 2.00 27.00 COSTS-MVBLE EQUIP 28.00 0 *** Cost Center Deleted *** 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29 00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest 33. 00 MI SCELLANEOUS INCOME -61 ADMINISTRATIVE & GENERAL В 5.00 0 33.00

Heal th	Financial Systems	ST VI	NCENT SETON SP	PECIALITY HOSPITAL	In Lie	eu of Form CMS-2	2552-10
	MENTS TO EXPENSES			Provider CCN: 15-2020	Peri od:	Worksheet A-8	
					From 07/01/2017 To 06/30/2018		nared:
					10 00/30/2010	11/26/2018 10	: 36 am
				Expense Classification			
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 01	LATE PENALTY FEE	A	-107	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	LOBBYING OFFSET	A	-400	ADMINISTRATIVE & GENERAL	5.00	0	33. 02
33. 03	INCENTIVE COMP SALARY ACCRUAL	A	73, 815	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	INCENTIVE COMP FICA ACCRUAL	A	6, 474	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
50.00	TOTAL (sum of lines 1 thru 49)		-3, 386, 149				50.00
	(Transfer to Warkahaat A	1					

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

(Transfer to Worksheet A, column 6, line 200.)

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

 B. Amount Received if cost cannot be determined.
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
- Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-2020

Worksheet A-8-1

Peri od: From 07/01/2017 OFFICE COSTS 06/30/2018 Date/Time Prepared:

					11/26/2018 10): 36 am
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			·	Allowable Cost	Included in	i
					Wks. A, column	i
					5	i
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					I
1.00	0.00			0	0	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3, 960, 771	7, 472, 596	2. 00
3.00	194. 01	MARKETI NG	HOME OFFICE	154, 010	0	3. 00
3.01	4. 00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	458, 107	458, 107	3. 01
3.02	5. 00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	124	124	3. 02
3.03	7. 00	OPERATION OF PLANT	SVH CHARGEBACK	829	829	3. 03
3.04	13. 00	NURSING ADMINISTRATION	SVH CHARGEBACK	144, 732	144, 732	3. 04
3.05	15. 00	PHARMACY	SVH CHARGEBACK	10, 192	10, 192	3. 05
3.06	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACK	1, 925	1, 925	3. 06
3.07	0.00			0	O	3. 07
3.08	54. 00	RADI OLOGY-DI AGNOSTI C	SVH CHARGEBACK	25, 087	25, 087	3. 08
3. 10	65. 00	RESPI RATORY THERAPY	SVH CHARGEBACK	275	275	3. 10
3. 11	66. 00	PHYSI CAL THERAPY	SVH CHARGEBACK	12, 195	12, 195	3. 11
3. 13	67. 00	OCCUPATIONAL THERAPY	SVH CHARGEBACK	12, 195	12, 195	3. 13
3. 14	68. 00	SPEECH PATHOLOGY	SVH CHARGEBACK	12, 195	12, 195	3. 14
4.00	1.00	CAP REL COSTS-BLDG & FIXT	AH INTEREST CAPITAL	14, 549	14, 549	4. 00
4.01	5. 00	ADMINISTRATIVE & GENERAL	AH INTEREST A&G	182	182	4. 01
4.02	0.00			0	o	4. 02
4.03	0.00			0	o	4. 03
4.04	0.00			0	o	4. 04
4.05	0.00			0	o	4. 05
5.00	TOTALS (sum of lines 1-4).			4, 807, 368	8, 165, 183	5. 00
	Transfer column 6, line 5 to					l
	Worksheet A-8, column 2,					l
	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.

•		1			
			Related Organization(s) and/	or Home Office	
			ŭ , ,		
Symbol (1)	Name	Percentage of	Name	Percentage of	
3 , , ,		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			
	. ,				

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

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

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

5.00 | -3,357,815 | | 5.00

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

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 	cordinate transfer 2, the amount arrowable should be that cated the obtain 1 of this part.	
Related Organization(s)		
and/or Home Office		
Type of Business		
.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
6. 00		
0.00		
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.

6.00	6.00
7. 00	7.00
8. 00	8.00
9. 00	9.00
10.00	10.00
7. 00 8. 00 9. 00 10. 00 100. 00	100.00

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

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COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-2020 Peri od: Worksheet B From 07/01/2017 Part I 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 705, 092 705, 092 2.00 00200 CAP REL COSTS-MVBLE EQUIP 135, 495 135, 495 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 179, 223 3, 179, 223 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 7, 148, 237 37, 334 7 174 360, 911 7 553 656 5 00 00700 OPERATION OF PLANT 7.00 994, 341 35, 331 6,789 0 1,036,461 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 108, 035 5, 768 1, 108 0 114, 911 8.00 9.00 00900 HOUSEKEEPI NG 396, 723 8, 012 1,540 o 406, 275 9.00 01000 DI ETARY 687, 567 10 00 653, 475 28, 597 5 495 10 00 0 13.00 01300 NURSING ADMINISTRATION 861, 860 46, 539 8, 943 179.483 1, 096, 825 13.00 01500 PHARMACY 2, 913, 590 16, 792 3, 227 301, 942 3, 235, 551 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 7, 629 9, 095 16.00 16, 00 1.466 01700 SOCIAL SERVICE 4, 191 37, 266 17.00 26, 613 805 5.657 17.00 18.00 01851 PASTORAL CARE 5, 171 994 6, 165 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 8, 246, 799 472, 578 03000 ADULTS & PEDIATRICS 10, 417, 857 30.00 90, 815 1, 607, 665 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 190, 740 5, 057 972 39, 142 235, 911 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 175, 755 9,092 1,747 18, 092 204, 686 54.00 03630 ULTRA SOUND 54, 732 54.01 12, 318 67,050 54.01 0 05700 CT SCAN 57.00 46, 091 2.415 464 10, 160 59, 130 57.00 06000 LABORATORY 416, 155 1, 975 379 418, 509 60.00 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 C 0 65.00 06500 RESPIRATORY THERAPY 2, 362, 230 3.580 688 461, 927 2, 828, 425 65.00 66.00 06600 PHYSI CAL THERAPY 408, 599 5, 015 964 85, 259 499, 837 66.00 06700 OCCUPATI ONAL THERAPY 268, 488 5, 015 56, 870 67.00 964 331, 337 67.00 68.00 06800 SPEECH PATHOLOGY 198, 189 5, 001 961 39, 549 243, 700 68.00 69.00 06900 ELECTROCARDI OLOGY C C 0 Λ 69.00 216 07000 ELECTROENCEPHALOGRAPHY 4,794 5,010 70.00 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 100, 358 0 0 32 1, 100, 390 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 72 00 0 C 0 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS C 0 0 0 73.00 07400 RENAL DIALYSIS 575, 092 74.00 0 0 0 575, 092 74.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 705, 092 135, 495 3, 179, 223 118.00 31, 170, 706 31, 170, 706 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 O 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193. 00 194. 00 07950 BI OTERRORI SM GRANT 0 0 4 275 194 00 4 275 0 194. 01 07951 MARKETI NG 154,010 C 0 0 154, 010 194. 01 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 201. 00

31, 328, 991

705, 092

31, 328, 991 202. 00

3, 179, 223

135, 495

202.00

TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-2020

				''	00/30/2018	11/26/2018 10	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	
	, , , , , , , , , , , , , , , , , , ,	& 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 ADMINISTRATIVE & GENERAL	7, 553, 656					5. 00
7.00	00700 OPERATION OF PLANT	329, 294					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	36, 508					8. 00
9.00	00900 HOUSEKEEPI NG	129, 078	l		552, 656		9, 00
10.00	01000 DI ETARY	218, 447	61, 756		25, 546	993, 316	10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	348, 472	1		41, 575	0	1
15. 00	01500 PHARMACY	1, 027, 967	36, 262		15, 000	0	
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 890	1		6, 815	0	1
17. 00	01700 SOCIAL SERVICE	11, 840			3, 744	0	
18. 00	01851 PASTORAL CARE	1, 959			4, 619	0	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,737	11, 107		4,017	0	10.00
30. 00	03000 ADULTS & PEDI ATRI CS	3, 309, 852	1, 020, 559	163, 875	422, 171	993, 316	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	3,307,032	1,020,007	103,073	722, 171	773, 310	30.00
50. 00	05000 OPERATING ROOM	74, 951	10, 922	0	4, 518	0	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	65, 031	19, 634		8, 122	0	54.00
54. 01	03630 ULTRA SOUND	21, 302		1	0, 122	0	54. 01
57. 00	05700 CT SCAN	18, 786	l e		2, 157	0	57. 00
60.00	06000 LABORATORY	132, 964	4, 264	1	1, 764	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	132, 704	0	1	1, 704	0	63.00
65. 00	06500 RESPIRATORY THERAPY	898, 619			3, 198	0	65.00
66. 00	06600 PHYSI CAL THERAPY	158, 803			4, 480	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	105, 269			4, 480	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	77, 426	l	1	4, 467	0	68.00
69.00	06900 ELECTROCARDI OLOGY	77,420	10, 799		4, 407	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 592	0		0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	349, 605	1		0	0	
71.00	07200 I MPL. DEV. CHARGED TO PATTENTS	349, 003		0	0	0	,
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			0	0	
74.00	07400 RENAL DIALYSIS	182, 712		_	0	0	
74.00	SPECIAL PURPOSE COST CENTERS	102, 712		1	<u></u>	U	74.00
112 00	11300 I NTEREST EXPENSE						113. 00
118.00	l l	7, 503, 367	1, 365, 755	163, 875	552, 656	993, 316	
110.00	NONREI MBURSABLE COST CENTERS	7, 503, 307	1, 303, 733	103, 675	332, 030	773, 310	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	O	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0		191. 00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		191.00
	19200 PHTSICIANS PRIVATE OFFICES	0	0		0		193. 00
	1	1 250	0		U		193.00
	07950 BIOTERRORISM GRANT 07951 MARKETING	1, 358			0		194. 00
		48, 931		1	ا	U	200. 00
200.00	1 1		,			_	
201.00		7 552 454	1 245 755	163, 875	[[]	993, 316	201. 00
202. 00	TOTAL (sum lines 118 through 201)	7, 553, 656	1, 365, 755	103, 8/5	552, 656	993, 316	1202.00

Health Financial Systems ST VINCENT SETON SPECIALITY HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-2020 Peri od: Worksheet B From 07/01/2017 Part I 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am OTHER GENERAL SERVI CE SOCIAL SERVICE PASTORAL CARE Cost Center Description NURSI NG **PHARMACY** MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY 13.00 15.00 17.00 18.00 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 01300 NURSING ADMINISTRATION 1.587.375 13 00 01500 PHARMACY 15.00 4, 314, 780 01600 MEDICAL RECORDS & LIBRARY 16.00 0 35, 274 01700 SOCIAL SERVICE 17.00 0 61, 900 C 01851 PASTORAL CARE 23, 910 18.00 0 O Ω INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 23, 910 30.00 1, 105, 217 0 13, 184 61, 900 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 23, 191 0 725 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 440 0 0 03630 ULTRA SOUND 54.01 0 0 234 0 0 0 0 0 0 0 0 0 0 05700 CT SCAN 0 0 57 00 148 0 06000 LABORATORY 60.00 0 0 3,830 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 06500 RESPIRATORY THERAPY 65.00 330, 571 8,804 0 06600 PHYSI CAL THERAPY 65,633 66.00 681 0 06700 OCCUPATIONAL THERAPY 67.00 38, 267 693 0 06800 SPEECH PATHOLOGY 24, 496 68.00 307 0 06900 ELECTROCARDI OLOGY 0 69.00 0 0 C 07000 ELECTROENCEPHALOGRAPHY 0 Ω 70.00 0

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-2020

| Period: | Worksheet B | From 07/01/2017 | Part | To 06/30/2018 | Date/Time Prepared:

				To 06/30/201	8 Date/Time Prepared: 11/26/2018 10:36 am
Cost Center Description	Subtotal	Intern &	Total		1172072010 10.30 aiii
·		Residents Cost			
		& Post			
		Stepdown			
	24.00	Adjustments	27, 00		
GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5. 00
7.00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
13.00 01300 NURSING ADMINISTRATION					13. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17.00 01700 SOCIAL SERVICE					17. 00
18. 00 01851 PASTORAL CARE					18. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	17, 531, 841	0	17, 531, 84	11	30.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	350, 218	0	350, 21		50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	297, 913	0	297, 91		54. 00
54. 01 03630 ULTRA SOUND	88, 586	0	88, 58		54. 01
57. 00 05700 CT SCAN	85, 436	0	85, 43		57. 00
60. 00 06000 LABORATORY	561, 331	0	561, 33	31	60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	63. 00
65. 00 06500 RESPIRATORY THERAPY	4, 077, 348	0	4, 077, 34		65. 00
66. 00 06600 PHYSI CAL THERAPY	740, 264	0	740, 26		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	490, 876	0	490, 87		67. 00
68. 00 06800 SPEECH PATHOLOGY	361, 195	0	361, 19		68. 00
69. 00 06900 ELECTROCARDI OLOGY	((04	0	, ,,	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6,604	0	6, 60 1, 450, 85		70. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 450, 850 0	0	1, 430, 63	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 319, 358	0	4, 319, 35	-	73.00
74. 00 07400 RENAL DIALYSIS	758, 597	0	758, 59		74.00
SPECIAL PURPOSE COST CENTERS	730, 377	ΟĮ	730, 3	7.7	74.00
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	31, 120, 417	o	31, 120, 41	17	118. 00
NONREI MBURSABLE COST CENTERS	01/120/11/	<u> </u>	0.7.207.1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190. 00
191. 00 19100 RESEARCH	o	o		0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192. 00
193. 00 19300 NONPALD WORKERS	o	o		0	193. 00
194.00 07950 BIOTERRORISM GRANT	5, 633	o	5, 63	33	194. 00
194. 01 07951 MARKETI NG	202, 941	ō	202, 94		194. 01
200.00 Cross Foot Adjustments	0	O	,	0	200. 00
201.00 Negative Cost Centers	o	0		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	31, 328, 991	O	31, 328, 99	91	202. 00
· · · · · · · · · · · · · · · · · · ·	,				·

						11/26/2018 10:	:36 am_
			CAPI TAL REI	_ATED COSTS			
	Cost Center Description	Di rectl y	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2.00	2A	4. 00	
	ERAL SERVICE COST CENTERS				T		
	OO CAP REL COSTS-BLDG & FIXT						1.00
	COO CAP REL COSTS-MVBLE EQUIP		_	_	_	_	2. 00
	00 EMPLOYEE BENEFITS DEPARTMENT	0	0		0	0	4. 00
	OOO ADMINISTRATIVE & GENERAL	542, 443	37, 334		586, 951	0	5. 00
	OO OPERATION OF PLANT	0	35, 331		42, 120	0	7. 00
	300 LAUNDRY & LINEN SERVICE	0	5, 768		6, 876	0	8. 00
	000 HOUSEKEEPI NG	0	8, 012		9, 552	0	9. 00
	000 DI ETARY	0	28, 597		34, 092	0	10. 00
13.00 013	OO NURSING ADMINISTRATION	0	46, 539	8, 943	55, 482	0	13.00
15. 00 015	OO PHARMACY	0	16, 792	3, 227	20, 019	0	15. 00
16. 00 016	000 MEDICAL RECORDS & LIBRARY	0	7, 629	1, 466	9, 095	0	16. 00
	OO SOCIAL SERVICE	0	4, 191	805	4, 996	0	17. 00
	51 PASTORAL CARE	0	5, 171	994	6, 165	0	18. 00
	ATIENT ROUTINE SERVICE COST CENTERS				., .,		
	000 ADULTS & PEDIATRICS	0	472, 578	90, 815	563, 393	0	30.00
	ILLARY SERVICE COST CENTERS			<u> </u>	· · ·		
	000 OPERATING ROOM	0	5, 057	972	6, 029	0	50.00
54.00 054	OO RADI OLOGY-DI AGNOSTI C	0	9, 092	1, 747	10, 839	0	54.00
	30 ULTRA SOUND	0	0		ol	0	54. 01
	OO CT SCAN	0	2, 415		2, 879	0	57. 00
	000 LABORATORY	0	1, 975		2, 354	0	60.00
	000 BLOOD STORING, PROCESSING & TRANS.	0	0		2,001	0	63. 00
	000 RESPI RATORY THERAPY	0	3, 580		4, 268	0	65. 00
	000 PHYSI CAL THERAPY	0	5, 015		5, 979	0	66. 00
	OO OCCUPATIONAL THERAPY	0	5, 015		5, 979	0	67. 00
	SOO SPEECH PATHOLOGY	0	5, 001		5, 962	0	68. 00
	OO ELECTROCARDI OLOGY	0	3,001	0	0, 702	0	69. 00
	000 ELECTROENCEPHALOGRAPHY	0	0		Ö	0	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	70.00
	100 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
	OO DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
		0	0		0	0	
	ON RENAL DIALYSIS	U	0	l ol	υ	U	74. 00
	CIAL PURPOSE COST CENTERS						440.00
	OO I NTEREST EXPENSE	F 42 442	705 000	125 405	1 202 020	0	113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	542, 443	705, 092	135, 495	1, 383, 030	0	118. 00
	REI MBURSABLE COST CENTERS		^		ام	0	400.00
	OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	00 RESEARCH	0	0		0		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	NONPALD WORKERS	0	0	0	0	-	193. 00
	50 BIOTERRORISM GRANT	0	0	0	0		194. 00
	751 MARKETI NG	0	0	0	0		194. 01
200. 00	Cross Foot Adjustments				0		200. 00
201. 00	Negative Cost Centers		0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	542, 443	705, 092	135, 495	1, 383, 030	0	202. 00

| Peri od: | Worksheet B | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-2020

13. 00 01300 NURSI NG ADMI NI STRATI ON 27, 077 4, 982 0 1, 538 0 15. 00 01500 PHARMACY 79, 876 1, 798 0 555 0	red:
SENERAL PLANT LI NEN SERVI CE S 00 7 00 8 00 9 00 10 00	o alli
CENERAL SERVICE COST CENTERS	
1. 00	
2. 00 00200 CAP REL COSTS-MVBLE EQUI P 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 586, 951 7. 00 00700 OPERATI ON OF PLANT 25, 587 67, 707 8. 00 00800 LAUNDRY & LI NEN SERVI CE 2, 837 617 10, 330 9. 00 00900 HOUSEKEEPI NG 10, 030 858 0 20, 440 10. 00 01000 DI ETARY 16, 974 3, 062 0 945 55, 073 13. 00 01300 NURSI NG ADMI NI STRATI ON 27, 077 4, 982 0 1, 538 0 15. 00 01500 PHARMACY 79, 876 1, 798 0 555 0	
4. 00	1.00
5.00 00500 ADMI NI STRATI VE & GENERAL 586, 951 7.00 00700 OPERATI ON OF PLANT 25, 587 67, 707 8.00 00800 LAUNDRY & LI NEN SERVI CE 2, 837 617 10, 330 9.00 00900 HOUSEKEEPI NG 10, 030 858 0 20, 440 10.00 01000 DI ETARY 16, 974 3, 062 0 945 55, 073 13.00 01300 NURSI NG ADMI NI STRATI ON 27, 077 4, 982 0 1, 538 0 15.00 01500 PHARMACY 79, 876 1, 798 0 555 0	2.00
7. 00 00700 OPERATION OF PLANT 25, 587 67, 707 8. 00 00800 LAUNDRY & LI NEN SERVI CE 2, 837 617 10, 330 9. 00 00900 HOUSEKEEPI NG 10, 030 858 0 20, 440 10. 00 01000 DI ETARY 16, 974 3, 062 0 945 55, 073 13. 00 01300 NURSI NG ADMINI STRATI ON 27, 077 4, 982 0 1, 538 0 15. 00 01500 PHARMACY 79, 876 1, 798 0 555 0	4.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 2,837 617 10,330 9. 00 00900 HOUSEKEEPI NG 10,030 858 0 20,440 10. 00 01000 DI ETARY 16,974 3,062 0 945 55,073 13. 00 01300 NURSI NG ADMI NI STRATI ON 27,077 4,982 0 1,538 0 15. 00 01500 PHARMACY 79,876 1,798 0 555 0	5.00
9. 00 00900 HOUSEKEEPING 10,030 858 0 20,440 10. 00 01000 DI ETARY 16,974 3,062 0 945 55,073 13. 00 01300 NURSI NG ADMI NI STRATI ON 27,077 4,982 0 1,538 0 15. 00 01500 PHARMACY 79,876 1,798 0 555 0	7.00
10. 00 01000 DI ETARY 16, 974 3, 062 0 945 55, 073 13. 00 01300 NURSI NG ADMI NI STRATI ON 27, 077 4, 982 0 1, 538 0 15. 00 01500 PHARMACY 79, 876 1, 798 0 555 0	8.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 27, 077 4, 982 0 1, 538 0 15. 00 01500 PHARMACY 79, 876 1, 798 0 555 0	9. 00
15. 00 01500 PHARMACY 79, 876 1, 798 0 555 0	10. 00
	13. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 225 817 0 252 0	15. 00
	16. 00
17. 00 01700 SOCI AL SERVI CE 920 449 0 138 0	17. 00
18. 00 01851 PASTORAL CARE 152 554 0 171 0	18. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 257, 195 50, 594 10, 330 15, 614 55, 073	30. 00
ANCILLARY SERVICE COST CENTERS	
	50. 00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 5, 053 973 0 300 0	54. 00
54. 01 03630 ULTRA SOUND 1, 655 0 0 0 0	54. 01
57. 00 05700 CT SCAN 1, 460 259 0 80 0	57. 00
	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0	63. 00
	65. 00
66. 00 06600 PHYSI CAL THERAPY 12, 339 537 0 166 0	66. 00
	67. 00
68. 00 06800 SPEECH PATHOLOGY 6, 016 535 0 165 0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 124 0 0 0 0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 27, 165 0 0 0	71. 00
72.00 07200 1 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0	72. 00
	73. 00
	74. 00
SPECIAL PURPOSE COST CENTERS	
	13. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 583,043 67,707 10,330 20,440 55,073 1	18. 00
NONREI MBURSABLE COST CENTERS	
	90. 00
	91. 00
	92. 00
	93. 00
	94. 00
	94. 01
	00.00
	01. 00
202.00 TOTAL (sum lines 118 through 201) 586,951 67,707 10,330 20,440 55,073 2	J2. 00

0 194, 01

0 201.00

7, 042 202. 00

200. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-2020 Peri od: Worksheet B From 07/01/2017 Part II 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am OTHER GENERAL SERVI CE SOCIAL SERVICE PASTORAL CARE Cost Center Description NURSI NG **PHARMACY** MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY 13.00 15.00 17.00 18.00 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 89.079 13.00 13 00 01500 PHARMACY 15.00 102, 248 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 10, 389 16.00 01700 SOCIAL SERVICE 17.00 0 C 6,503 17.00 C 01851 PASTORAL CARE 18.00 7,042 18.00 0 Ω 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 30.00 62,022 3, 897 6, 503 7,042 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 1, 301 213 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 129 0 0 54.00 03630 ULTRA SOUND 54.01 0 0 69 0 0 0 0 0 0 0 0 0 0 0 54.01 0 05700 CT SCAN 0 0 57.00 57 00 43 0 06000 LABORATORY 60.00 0 0 1, 126 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 63.00 06500 RESPIRATORY THERAPY 65.00 18, 551 0 2,588 0 65.00 06600 PHYSI CAL THERAPY 3, 683 0 200 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 2, 147 204 0 67.00 06800 SPEECH PATHOLOGY 1, 375 90 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 0 0 07000 ELECTROENCEPHALOGRAPHY 0 Ω 70.00 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 251 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 102, 248 0 73.00 1, 346 07400 RENAL DIALYSIS 74 00 233 0 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 89, 079 102, 248 10, 389 <u>6,</u> 503 7, 042 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 0 191. 00 19100 RESEARCH 0 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194. 00 07950 BI OTERRORI SM GRANT 0 0 0 o 0 194.00

0

89, 079

C

102, 248

0

10, 389

0

6, 503

194. 01 07951 MARKETI NG

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202.00

202.00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-2020 Peri od: Worksheet B From 07/01/2017 Part II 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adj ustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 01851 PASTORAL CARE 18.00 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 031, 663 0 1, 031, 663 30.00 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14,075 14,075 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 17, 294 0 17, 294 54.00 03630 ULTRA SOUND 1,724 54.01 0 1, 724 54.01 57.00 05700 CT SCAN 0 4, 721 57.00 4 721 06000 LABORATORY 0 60.00 14,088 14,088 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 06500 RESPIRATORY THERAPY 65.00 95, 733 0 95, 733 65.00 22, 904 06600 PHYSI CAL THERAPY 22, 904 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 17, 213 17, 213 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 14, 143 14, 143 06900 ELECTROCARDI OLOGY 69.00 69.00 0 C 70.00 07000 ELECTROENCEPHALOGRAPHY 124 0 70.00 124 27, 416 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 27, 416 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 103.594 0 103.594 73.00 07400 RENAL DIALYSIS 74.00 14, 430 0 14, 430 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1, 379, <u>122</u> 1, 379, 122 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 191. 00 19100 RESEARCH 0 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 194. 00 07950 BI OTERRORI SM GRANT 106 0 106 194. 00 194. 01 07951 MARKETI NG 194. 01 3,802 0 3,802 200.00 Cross Foot Adjustments 0 0 C 200. 00 201.00 Negative Cost Centers 201.00

1, 383, 030

1, 383, 030

202.00

TOTAL (sum lines 118 through 201)

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-2020 Peri od: Worksheet B-1 From 07/01/2017 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 49,633 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 49, 633 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 13, 951, 638 4.00 00500 ADMINISTRATIVE & GENERAL 23, 775, 335 5 00 2 628 2 628 1, 583, 811 -7, 553, 656 5 00 00700 OPERATION OF PLANT 7.00 2,487 2, 487 C 1,036,461 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 406 406 114, 911 8.00 00900 HOUSEKEEPI NG 564 564 0 0 406, 275 9.00 9.00 Ó 01000 DI ETARY 687, 567 2.013 2.013 10 00 10 00 0 13.00 01300 NURSING ADMINISTRATION 3, 276 3, 276 787, 640 0 1, 096, 825 13.00 01500 PHARMACY 0 3, 235, 551 15.00 1, 182 1, 182 1, 325, 035 15.00 0 01600 MEDICAL RECORDS & LIBRARY 9, 095 16.00 16, 00 537 537 01700 SOCIAL SERVICE 37, 266 17.00 295 295 24, 826 17.00 18.00 01851 PASTORAL CARE 364 6, 165 18.00 364 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 7, 055, 059 10, 417, 857 30.00 33, 266 33, 266 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 171, 770 235, 911 50.00 356 356 54.00 05400 RADI OLOGY-DI AGNOSTI C 640 640 79, 395 0 204, 686 54.00 03630 ULTRA SOUND 0 54.01 54.058 67,050 54.01 0 C 05700 CT SCAN 57.00 170 170 44, 584 59, 130 57.00 06000 LABORATORY 139 418, 509 60.00 139 C 0 0 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 65.00 06500 RESPIRATORY THERAPY 2, 027, 105 2, 828, 425 65.00 252 252 66.00 06600 PHYSI CAL THERAPY 353 353 374, 147 499, 837 66.00 06700 OCCUPATI ONAL THERAPY 249, 565 67.00 353 353 0 331, 337 67.00 173, 555 68.00 06800 SPEECH PATHOLOGY 352 352 243, 700 68.00 69.00 06900 ELECTROCARDI OLOGY 0 C C Λ 69.00 07000 ELECTROENCEPHALOGRAPHY 0 946 5,010 70.00 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 142 1, 100, 390 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 72 00 C 0 Λ 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 0 73.00 07400 RENAL DIALYSIS 74.00 0 575, 092 74.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM_OF_LINES_1 through 117) 49,633 13, 951, 638 -7, 553, 656 118.00 49,633 23, 617, 050 118. 00 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 191. 00 191. 00 19100 RESEARCH 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193. 00 194. 00 07950 BI OTERRORI SM GRANT 0 0 4 275 194 00 Ω 194. 01 07951 MARKETI NG 0 C 0 154, 010 194. 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 3, 179, 223 202.00 Cost to be allocated (per Wkst. B, 705.092 135, 495 7, 553, 656 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 14. 206113 2.729938 0. 317710 203. 00 0.227875 204.00 Cost to be allocated (per Wkst. B, 586, 951 204. 00 Part II) 0. 024687 205. 00 205 00 Unit cost multiplier (Wkst. B, Part 0.000000 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207.00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 Peri od: Worksheet B-1 From 07/01/2017 To 06/30/2018 Date/Time Prepared: Provider CCN: 15-2020

				T	06/30/2018	Date/Time Pre 11/26/2018 10	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	. 30 alli
	·	PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATIENT	ADMI NI STRATI ON	
		(SQUARE FEET)	(POUNDS OF		DAYS)	(DIDECT NUDC	
			LAUNDRY)			(DI RECT NURS. HRS.)	
		7. 00	8.00	9. 00	10.00	13. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1.00
1	00200 CAP REL COSTS-MVBLE EQUIP						2. 00 4. 00
4	DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL			•			5. 00
	00700 OPERATION OF PLANT	44, 518					7. 00
	DO800 LAUNDRY & LINEN SERVICE	406	i e				8. 00
	00900 HOUSEKEEPI NG	564	0				9. 00
	D1000 DI ETARY	2, 013	0	2,010			10.00
1	D1300 NURSING ADMINISTRATION D1500 PHARMACY	3, 276	0	3, 276		299, 251 0	13. 00 15. 00
	D1600 MEDICAL RECORDS & LIBRARY	1, 182 537	0	1, 182 537	0	0	16. 00
	01700 SOCIAL SERVICE	295	0		0	Ö	17. 00
1	D1851 PASTORAL CARE	364	0	l .	0	0	18. 00
I	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	33, 266	100	33, 266	14, 832	208, 355	30. 00
	ANCILLARY SERVICE COST CENTERS	05/		05/		4 070	F0 00
1	D5000 OPERATING ROOM D5400 RADIOLOGY-DIAGNOSTIC	356 640	l	1			50. 00 54. 00
4	03630 ULTRA SOUND	040				0	54. 00
	05700 CT SCAN	170	1		_	ő	57. 00
4	06000 LABORATORY	139	O			0	60.00
	D6300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	-	0	63. 00
1	06500 RESPI RATORY THERAPY	252	ł	252		62, 319	65. 00
1	06600 PHYSI CAL THERAPY	353	ŀ	353		12, 373	66.00
1	D6700 OCCUPATI ONAL THERAPY D6800 SPEECH PATHOLOGY	353 352		353 352		7, 214 4, 618	67. 00 68. 00
4	06900 ELECTROCARDI OLOGY	0	0	0		4,018	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	Ö	ő	_	Ö	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	_	0	72. 00
	D7300 DRUGS CHARGED TO PATIENTS	0	0	0	_	0	73. 00
	D7400 RENAL DIALYSIS SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	74. 00
	11300 INTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	44, 518	100	43, 548	14, 832	299, 251	
	NONREI MBURSABLE COST CENTERS						
1	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	1			190. 00
1	19100 RESEARCH	0	0	0	0		191. 00
1	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	0	0	0		192. 00 193. 00
	07950 BI OTERRORI SM GRANT	0		0	0		193.00
1	07951 MARKETI NG	0	ĺ	Ö	0		194. 01
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 365, 755	163, 875	552, 656	993, 316	1, 587, 375	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	30. 678714	1, 638. 750000	12. 690732	66. 971143	5. 304494	202 00
203.00	Cost to be allocated (per Wkst. B,	67, 707	l '	1			
201.00	Part II)	3,,,0,	10, 330	25, 140	33, 373	3,, 3,,	
205.00	Unit cost multiplier (Wkst. B, Part	1. 520890	103. 300000	0. 469367	3. 713120	0. 297673	205. 00
206. 00							206. 00
200.00	(per Wkst. B-2)						200.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
1	Parts III and IV)	1	I	I			l

Health Financial Systems	ST VINCENT SETON SPE	ECIALITY HOSPI	TAL	In Lie	u of Form CMS-2552-1
COST ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-2020 P	eri od:	Worksheet B-1
			F	rom 07/01/2017 o 06/30/2018	Date/Time Prepared:
			'	0 00/30/2018	11/26/2018 10:36 am
		<u> </u>		OTHER GENERAL	
				SERVI CE	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	(COSTED	RECORDS &	(TOTAL DATE ENT	(TOTAL PATIENT	
	REQUIS.)	LI BRARY	(TOTAL PATIENT	DAYS)	
		(GROSS CHARGES)	DAYS)		
	15. 00	16. 00	17. 00	18. 00	
GENERAL SERVICE COST CENTERS	1 .0.00	10.00	171.00	10.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5. 00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
13. 00 01300 NURSI NG ADMINI STRATI ON 15. 00 01500 PHARMACY	1, 000				13. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	96, 992, 719			16. 00
17. 00 017000 MEDICAL RECORDS & ELBRART		70, 772, 717 N	14, 832		17. 00
18. 00 01851 PASTORAL CARE		0) 14,032		18.00
INPATIENT ROUTINE SERVICE COST CENTER			ή	11,002	10.00
30. 00 03000 ADULTS & PEDIATRICS	0	36, 304, 725	14, 832	14, 832	30.00
ANCILLARY SERVICE COST CENTERS				· · · ·	
50. 00 05000 OPERATING ROOM	0	1, 991, 739	C	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 208, 183	B C	0	54. 00
54. 01 03630 ULTRA SOUND	0	644, 153	B C	0	54. 0
57.00 05700 CT SCAN	0	405, 877	1	0	57. 00
60. 00 06000 LABORATORY	0	10, 522, 819	1		60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRA	1	0	0	-	63. 00
65. 00 06500 RESPIRATORY THERAPY	0	24, 187, 451	1	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	O	1, 871, 183	1	0	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	1, 904, 837 842, 045	1	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	042, 043		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		4, 450	1	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	FLENTS 0	2, 347, 630	1	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 317, 333	ol o		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,000	12, 578, 244		o	73. 00
74.00 07400 RENAL DIALYSIS	o	2, 179, 383	1	o	74. 00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 throu	ıgh 117) 1,000	96, 992, 719	14, 832	14, 832	118. 00
NONREI MBURSABLE COST CENTERS			.r		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CAN	1	0			190. 00
191. 00 19100 RESEARCH	0	0	1		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	١	0		0	192. 00 193. 00
194. 00 07950 BI OTERRORI SM GRANT		0		0	194. 00
194. 01 07951 MARKETI NG		0		0	194. 0
200.00 Cross Foot Adjustments		O	Ί		200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst.	B, 4, 314, 780	35, 274	61, 900	23, 910	202. 00
Part I)					
203.00 Unit cost multiplier (Wkst. B,	Part I) 4, 314. 780000	0. 000364	4. 173409	1. 612055	203. 00
204.00 Cost to be allocated (per Wkst.	B, 102, 248	10, 389	6, 503	7, 042	204. 00
Part II)					
205.00 Unit cost multiplier (Wkst. B,	Part 102. 248000	0. 000107	0. 438444	0. 474784	205. 00
NAME adjustment amount to be al	Located				207.00
206.00 NAHE adjustment amount to be al (per Wkst. B-2)	rocated				206. 00
207.00 NAHE unit cost multiplier (Wkst	r. D.				207. 00
Parts III and IV)					[207.00
•	'		•	. '	,

Health Financial Systems	ST VINCENT SETON SPECIALITY HOSPITAL			In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-2020	From 07/01/2017	Worksheet C Part I Date/Time Pre 11/26/2018 10	
		Title	XVIII	Hospi tal	PPS	
				0 1		

			'	0 00/30/2018	11/26/2018 10	:36 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1			_		
30. 00 03000 ADULTS & PEDIATRICS	17, 531, 841		17, 531, 841	0	17, 531, 841	30. 00
ANCILLARY SERVICE COST CENTERS	050.040		050.010		050.010	
50. 00 05000 OPERATI NG ROOM	350, 218		350, 218		350, 218	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	297, 913		297, 913		297, 913	
54. 01 03630 ULTRA SOUND	88, 586		88, 586		88, 586	
57. 00 05700 CT SCAN	85, 436		85, 436		85, 436	
60. 00 06000 LABORATORY	561, 331		561, 331	0	561, 331	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	4 077 040		4 077 046	0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	4, 077, 348	0	4, 077, 348		4, 077, 348	1
66. 00 06600 PHYSI CAL THERAPY	740, 264	0	740, 264		740, 264	
67. 00 06700 OCCUPATI ONAL THERAPY	490, 876	0	490, 876		490, 876	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	361, 195	Ü	361, 195		361, 195	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	4 404		, , , ,	0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6,604		6, 604		6, 604	
72. 00 07700 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 450, 850		1, 450, 850		1, 450, 850 0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 319, 358		4, 319, 358		4, 319, 358	
73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	4, 319, 358 758, 597		758, 597		4, 319, 358 758, 597	
SPECIAL PURPOSE COST CENTERS	730, 397		/30, 397	U	730, 397	74.00
113. 00 11300 NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	31, 120, 417	0	31, 120, 417	0	31, 120, 417	
201. 00 Less Observation Beds	31, 120, 417	U	31, 120, 417	J		201.00
202. 00 Total (see instructions)	31, 120, 417	0	31, 120, 417	0	31, 120, 417	
202.00 10101 (366 111311 4611 0113)	31, 120, 417	U	31, 120, 417	١	31, 120, 417	1202.00

Health Financial Systems	ST VINCENT SETON SPI	ECLALITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	1	Period: From 07/01/2017 To 06/30/2018	11/26/2018 10	pared: :36 am
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpatient Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS		7.00	0.00	7.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	36, 304, 725		36, 304, 72	5		30.00
ANCILLARY SERVICE COST CENTERS			, ,			1
50. 00 05000 OPERATI NG ROOM	1, 982, 639	9, 100	1, 991, 73	9 0. 175835	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 144, 669	63, 514	1, 208, 18	0. 246579	0.000000	54.00
54. 01 03630 ULTRA SOUND	643, 220	933			0.000000	
57.00 05700 CT SCAN	405, 877	0	405, 87	7 0. 210497	0.000000	57. 00
60. 00 06000 LABORATORY	10, 508, 538	14, 281	10, 522, 81		0.000000	1
63.00 06300 BLOOD STORING, PROCESSING & TRAN	1	0		0.000000	0.000000	
65. 00 06500 RESPI RATORY THERAPY	24, 180, 757	6, 694			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	1, 871, 183	0	1, 871, 18		0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	1, 904, 837	0	1, 904, 83		0. 000000	
68. 00 06800 SPEECH PATHOLOGY	842, 045	0	842, 04		0. 000000	1
69. 00 06900 ELECTROCARDI OLOGY	0	0		0.000000	0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 450	27, 025	4, 45		0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	ENTS 2, 310, 695	36, 935	2, 347, 63		0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	12, 486, 432	91, 812	12, 578, 24	0. 000000 4 0. 343399	0. 000000 0. 000000	1
74. 00 07400 RENAL DI ALYSI S	2, 179, 383	91,012	2, 179, 38		0.000000	1
SPECIAL PURPOSE COST CENTERS	2, 177, 303	0	2, 177, 30	0. 340077	0.000000	74.00
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	96, 769, 450	223, 269	96, 992, 71	9		200.00
201.00 Less Observation Beds	76,767,188	220, 20,	, ,,,_, , .			201. 00
202.00 Total (see instructions)	96, 769, 450	223, 269	96, 992, 71	9		202. 00

				1172072010 10.30 dill
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Rati o			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 175835			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 246579			54.00
54. 01 03630 ULTRA SOUND	0. 137523			54. 01
57. 00 05700 CT SCAN	0. 210497			57. 00
60. 00 06000 LABORATORY	0. 053344			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 168573			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 395613			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 257700			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 428950			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1. 484045			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 618006			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 343399			73.00
74. 00 07400 RENAL DI ALYSI S	0. 348079			74.00
SPECIAL PURPOSE COST CENTERS	· ·			
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
				'

Health Financial Systems	ST VINCENT SETON SPECIALITY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-2020	Peri od:	Worksheet C	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	F	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Pre 11/26/2018 10	pared: :36 am
		Ti tl	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						
30. 00 03000 ADULTS & PEDIATRICS	17, 531, 841		17, 531, 841	0	0	30.00
ANCILLARY SERVICE COST CENTERS		ı				
50. 00 05000 OPERATI NG ROOM	350, 218		350, 218		0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	297, 913		297, 913		0	54.00
54. 01 03630 ULTRA SOUND	88, 586		88, 586		0	54. 01
57. 00 05700 CT SCAN	85, 436		85, 436		0	57. 00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	561, 331		561, 331		0	60. 00 63. 00
65. 00 06500 RESPIRATORY THERAPY	4, 077, 348	_	4, 077, 348	,	0	65.00
66. 00 06600 PHYSI CAL THERAPY	740, 264		740, 264		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	490, 876	l e	490, 876		0	67.00
68. 00 06800 SPEECH PATHOLOGY	361, 195	l e	361, 195		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	301, 173	0	301, 175		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	6, 604		6, 604	,	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 450, 850		1, 450, 850		0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0		1, 100, 000	o o	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 319, 358		4, 319, 358	0	0	73. 00
74. 00 07400 RENAL DIALYSIS	758, 597		758, 597		0	1
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	31, 120, 417	0	31, 120, 417	0	0	200. 00
201.00 Less Observation Beds	0)	0	201.00
202.00 Total (see instructions)	31, 120, 417	0	31, 120, 417	o o	0	202. 00

96 769 450

96, 992, 719

223, 269

201.00

202. 00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems ST	VINCENT SETON SP	PECIALITY HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2017 To 06/30/2018		pared: :36 am
		Ti tl e	xVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
INDATI ENT. DOUTLINE CEDIU DE COCT. CENTEDO	1. 00	2.00	3. 00	4. 00	5. 00	
30.00 ADULTS & PEDIATRICS	1, 031, 663		1, 031, 66	3 14, 832	69. 56	30.00
200.00 Total (lines 30 through 199)	1, 031, 663		1, 031, 66	·	•	200. 00
Cost Center Description	Inpati ent Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	1, 001, 00	5 11,002		250. 00
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	9, 012 9, 012		1			30. 00 200. 00

Health Financial Systems ST V	INCENT SETON SP	PECIALITY HOSPI	TAL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 07/01/2017		nanad.
				Го 06/30/2018	Date/Time Prep 11/26/2018 10	pared: ·36 am
		Title	XVIII	Hospi tal	PPS	. 00 am
Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
'		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col.		column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	14, 075	1, 991, 739	0. 00706	7 1, 982, 639	14, 011	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 294	1, 208, 183	0. 01431	968, 718	13, 866	54.00
54. 01 03630 ULTRA SOUND	1, 724	644, 153	0. 00267	82, 175	220	54. 01
57.00 05700 CT SCAN	4, 721	405, 877	0. 01163:	2 170, 581	1, 984	57. 00
60. 00 06000 LABORATORY	14, 088	10, 522, 819	0. 00133	7, 306, 502	9, 783	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0. 000000	0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	95, 733	24, 187, 451	0. 00395	16, 179, 814	64, 040	65. 00
66. 00 06600 PHYSI CAL THERAPY	22, 904	1, 871, 183	0. 01224	1, 127, 210	13, 797	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	17, 213	1, 904, 837	0. 00903	1, 139, 003	10, 292	67. 00
68. 00 06800 SPEECH PATHOLOGY	14, 143	842, 045	0. 01679	5 513, 470	8, 624	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 000000	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	124	4, 450	0. 02786			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 416	2, 347, 630	0. 011678	1, 548, 379	18, 082	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 000000	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	103, 594	12, 578, 244	0. 00823	7, 989, 881	65, 805	73. 00
74. 00 07400 RENAL DI ALYSI S	14, 430	2, 179, 383	0. 00662	1, 341, 496	8, 882	74. 00
200.00 Total (lines 50 through 199)	347, 459	60, 687, 994		40, 354, 318	229, 510	200. 00

Nursing School Nurs	Heal th Finar	ncial Systems S1	T VINCENT SETON SF	PECIALITY HOSPI	TAL	In Lie	eu of Form CMS-:	2552-10
Nursing School Nurs	APPORTI ONME	NT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		F	From 07/01/2017 To 06/30/2018	Part III Date/Time Pre 11/26/2018 10	pared: :36 am
Post-Stepdown Adjustments Amount (see instructions) Amount (see							PPS	
Adjustments		Cost Center Description			Allied Health	Allied Health	All Other	
INPATI ENT ROUTINE SERVICE COST CENTERS 1A			Post-Stepdown		Post-Stepdown	Cost	Medi cal	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30.00 ADULTS & PEDI ATRI CS 0 0 0 0 0 0 0 0 0			Adjustments		Adjustments		Education Cost	
30.00			1A	1.00	2A	2. 00	3. 00	
Total (lines 30 through 199)								
Cost Center Description	30.00 03000	ADULTS & PEDIATRICS	0	0	(0	0	30.00
Adjustment Amount (see instructions) Secolusia Days Secolusia Program Days	200.00	Total (lines 30 through 199)	0	0	(0	0	200. 00
Amount (see instructions) 1 through 3, minus col. 4) 4.00 5.00 6.00 7.00 8.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 0 14,832 0.00 9,012 30.00 200.00 Total (lines 30 through 199) 0 14,832 9,012 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 30.00 ADULTS & PEDIATRICS 0 30.00 30.00 3000 ADULTS & PEDIATRICS 0 30.00		Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
INPATI ENT ROUTI NE SERVI CE COST CENTERS			Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
1.00 5.00 6.00 7.00 8.00								
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0			instructions)					
30. 00			4. 00	5. 00	6. 00	7. 00	8. 00	
Total (lines 30 through 199) 0								
Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 OJOUG ADULTS & PEDIATRICS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00 03000	ADULTS & PEDIATRICS	0	0			9, 012	30. 00
Program Pass-Through Cost (col. 7 x col. 8) 9.00	200.00	Total (lines 30 through 199)		0	14, 832	2	9, 012	200. 00
Pass-Through Cost (col. 7 x col. 8) 9.00		Cost Center Description						
Cost (col. 7 x col. 8) 9.00								
Col 8 9.00								
9.00 I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0 30.00			Cost (col. 7 x					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS								
30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00			9. 00					
200,00 Total (Lines 30 through 199) 0 200,00			0					
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	200. 00	Total (lines 30 through 199)	0					200. 00

Peri od: Worksheet D
From 07/01/2017
To 06/30/2018 Date/Time Prepared: 11/26/2018 10: 36 am THROUGH COSTS

						117 207 2010 10	. 00 am
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	l o		0	0	54.00
54. 01	03630 ULTRA SOUND	0	0		0	0	54. 01
57. 00	05700 CT SCAN	0	0		0	0	57. 00
60.00	06000 LABORATORY	0	0			0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	١			o o	63.00
65. 00	06500 RESPI RATORY THERAPY	0	0			0	65.00
66. 00	06600 PHYSI CAL THERAPY					0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY					0	67.00
	· ·	0	0			0	
68. 00	06800 SPEECH PATHOLOGY	0	0			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(0	0	74.00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	ST VINCENT SETON SPEC	ALITY HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-2020	Peri od: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/26/2018 10:36 am

				'	0 00/30/2016	11/26/2018 10:	
			Ti tl e	xVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ILLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0	C	(1, 991, 739		
	00 RADI OLOGY-DI AGNOSTI C	0	C	(1, 208, 183	0.000000	
	30 ULTRA SOUND	0	C	(644, 153	0.000000	
57. 00 057	00 CT SCAN	0	C	(405, 877	0.000000	57. 00
	00 LABORATORY	0	C	(10, 522, 819	0.000000	
63. 00 063	00 BLOOD STORING, PROCESSING & TRANS.	0	C	(0	0.000000	63. 00
65. 00 065	00 RESPI RATORY THERAPY	0	C	(24, 187, 451	0.000000	65. 00
66. 00 066	00 PHYSI CAL THERAPY	0	C	(1, 871, 183	0.000000	66. 00
67. 00 067	OO OCCUPATI ONAL THERAPY	0	C	(1, 904, 837	0.000000	67. 00
	00 SPEECH PATHOLOGY	0	C	(842, 045	0.000000	68. 00
69. 00 069	00 ELECTROCARDI OLOGY	0	C	(0	0.000000	69. 00
70.00 070	OO ELECTROENCEPHALOGRAPHY	0	C	(4, 450	0.000000	70. 00
71. 00 071	OO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	(2, 347, 630	0.000000	71. 00
72. 00 072	00 IMPL. DEV. CHARGED TO PATIENTS	0	C	(0	0.000000	72.00
73. 00 073	OO DRUGS CHARGED TO PATIENTS	0	C	(12, 578, 244	0.000000	73.00
74.00 074	00 RENAL DIALYSIS	0	C	(2, 179, 383	0. 000000	74.00
200.00	Total (lines 50 through 199)	0	C	(60, 687, 994		200. 00

Health Financial Systems ST V	INCENT SETON SPE	CLALITY HOSPI	TAL	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provi der CC		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Pre 11/26/2018 10	pared: :36 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	1, 982, 639		9, 100	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	968, 718		0 25, 645	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	82, 175		933	0	54. 01
57.00 05700 CT SCAN	0. 000000	170, 581		0	0	57. 00
60. 00 06000 LABORATORY	0. 000000	7, 306, 502		0 14, 281	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	16, 179, 814		0 6, 694	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 127, 210		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 139, 003		0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	513, 470		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	4, 450		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 548, 379		0 36, 935	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	7, 989, 881		91, 812	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	1, 341, 496		0 0	0	74.00
200.00 Total (lines 50 through 199)	1	40, 354, 318		0 185, 400	0	200. 00

Health Financial Systems ST V	INCENT SETON SP	ECIALITY HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO		Period: From 07/01/2017 To 06/30/2018		
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 175835	9, 100		0	1, 600	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 246579	25, 645		0	6, 324	54.00
54.01 03630 ULTRA SOUND	0. 137523	933		0	128	
57.00 05700 CT SCAN	0. 210497	0	(0	0	57. 00
60. 00 06000 LABORATORY	0. 053344	14, 281		0	762	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 168573	6, 694		0	1, 128	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 395613	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 257700	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 428950	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1. 484045	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 618006	36, 935		0	22, 826	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. 343399	91, 812		0	31, 528	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 348079	0		0	0	74. 00
200.00 Subtotal (see instructions)		185, 400		0 0	64, 296	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		185, 400		0 0	64, 296	202. 00

			1	o 06/30/2018	Date/lime Prepa 11/26/2018 10:3	
		Title	xVIII	Hospi tal	PPS	
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS	1	1	1			
50. 00 05000 OPERATI NG ROOM	0	0			1	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 03630 ULTRA SOUND		0				54. 01
57. 00 05700 CT SCAN		0			l l	57.00
60. 00 06000 LABORATORY	0	0				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0				63.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY		0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0			l l	67.00
68. 00 06800 SPEECH PATHOLOGY		0				68. 00
69. 00 06900 ELECTROCARDI OLOGY		0			l l	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0			l l	70. 00 71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS		0				71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0			l l	73. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS 74. 00 07400 RENAL DIALYSIS		0			l l	74. 00
200.00 Subtotal (see instructions)		0				200. 00
201.00 Less PBP Clinic Lab. Services-Program					1	200. 00
Only Charges					2	.01.00
202.00 Net Charges (line 200 - line 201)		0			2	202. 00
202.00	1	1 0	П		I [∠]	.02.00

Health Financial Systems ST V	INCENT SETON SP	ECIALITY HOSPI	TAL	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 07/01/2017	Worksheet D Part I	
				To 06/30/2018		pared: :36 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 031, 663	0	1, 031, 66	14, 832	69. 56	30. 00
200.00 Total (lines 30 through 199)	1, 031, 663		1, 031, 66	14, 832		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	91	6, 330			·	30. 00
200.00 Total (lines 30 through 199)	91	6, 330				200. 00

Health Financial Systems ST V	NCENT SETON SP	ECLALITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider Co		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Pre 11/26/2018 10	pared:
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	. (column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	14, 075	1, 991, 739	0. 00706	7 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 294	1, 208, 183	0. 01431	4 1, 887	27	54. 00
54. 01 03630 ULTRA SOUND	1, 724	644, 153	0. 00267	6 0	0	54. 01
57. 00 05700 CT SCAN	4, 721	405, 877	0. 01163	2 0	0	57. 00
60. 00 06000 LABORATORY	14, 088	10, 522, 819	0. 00133	9 7, 979	11	60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0 0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	95, 733	24, 187, 451	0. 00395	8 47, 146	187	65. 00
66. 00 06600 PHYSI CAL THERAPY	22, 904	1, 871, 183	0. 01224	0 6, 063	74	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	17, 213	1, 904, 837	0.00903	6, 044	55	67. 00
68. 00 06800 SPEECH PATHOLOGY	14, 143	842, 045	0. 01679	6 1, 025	17	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	124	4, 450	0. 02786	5 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 416	2, 347, 630	0. 01167	8 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	103, 594	12, 578, 244	0. 00823	6 0	0	73.00
74.00 07400 RENAL DIALYSIS	14, 430	2, 179, 383	0. 00662	1 0	0	74.00
200.00 Total (lines 50 through 199)	347, 459	60, 687, 994		70, 144	371	200. 00

Health Financial Systems S	T VINCENT SETON SF	PECIALITY HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COS	TS Provider CO	F	Period: From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 10	
			e XIX	Hospi tal	Cost	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	00.00
200.00 Total (lines 30 through 199)	0	0	(0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati 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	
I NPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	14, 832		91	30.00
200.00 Total (lines 30 through 199)		0	14, 832	2	91	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
200.00 Total (lines 30 through 199)	0					200. 00

THROUGH COSTS

			Ti tI	e XIX	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
54. 01	03630 ULTRA SOUND	0	0	(0	0	54. 01
57.00	05700 CT SCAN	0	0	(0	0	57. 00
60.00	06000 LABORATORY	0	0	(0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(0	0	74. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	ST VINCENT SETON SPECI	ALITY HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-2020	Peri od:	Worksheet D

From 07/01/2017 Part IV To 06/30/2018 Date/Time Prepared: THROUGH COSTS 11/26/2018 10:36 am Title XIX Hospi tal Cost Total Charges Cost Center Description All Other Total Cost Total Ratio of Cost to Charges Medi cal (sum of col 1 Outpati ent (from Wkst. C, Cost (sum of col. 2, 3 and Education Cost through col. Part I, col. (col. 5 ÷ col 8) 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 1, 991, 739 50.00 05000 OPERATING ROOM 0 0.000000 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1, 208, 183 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54.01 03630 ULTRA SOUND 0 0 644, 153 0.000000 54.01 57.00 05700 CT SCAN 0 0 405, 877 0.000000 57.00 0) 0 06000 LABORATORY 60.00 10, 522, 819 0.000000 60.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 63.00 65.00 06500 RESPIRATORY THERAPY 24, 187, 451 0.000000 65.00 66.00 0 0 06600 PHYSI CAL THERAPY 1, 871, 183 0.000000 66.00 0 0 06700 OCCUPATI ONAL THERAPY 1, 904, 837 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 842, 045 0.000000 68.00 06900 ELECTROCARDI OLOGY 0 0.000000 69.00 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 4. 450 0.000000 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2, 347, 630 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0.000000 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 12, 578, 244 0.000000 73.00 0 74.00 07400 RENAL DIALYSIS 2, 179, 383 0.000000 74.00

60, 687, 994

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems ST VI	NCENT SETON SPE	CLALLTY HOSPL	TAI	In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS		Provider CO	CN: 15-2020	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV	pared:
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	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	0		0	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 887		0	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	0		0	0	54. 01
57.00 05700 CT SCAN	0. 000000	0		0	0	57. 00
60. 00 06000 LABORATORY	0. 000000	7, 979		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0.000000	47, 146		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	6, 063		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	6, 044		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 025		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70. 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	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74. 00
200.00 Total (lines 50 through 199)		70, 144		0	0	200. 00

	Financial Systems	ST VINCENT SETON SPEC		In Lie	u of Form CMS-2	<u>2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-2020	Peri od:	Worksheet D-1	
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 10	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
	<u> </u>				1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private ro	3 3	,		14, 832	1
2.00	Inpatient days (including private ro				14, 832	
3.00	Private room days (excluding swing-b	oed and observation bed da	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding sw	ing had and observation b	ad days)		14, 832	4. 00
4. 00 5. 00	Total swing-bed SNF type inpatient of			r 21 of the cost	14, 632	1
5.00	reporting period	lays (flictually private to	oni days) thi ough becembe	1 31 OF THE COST	U	3.00
6. 00	Total swing-bed SNF type inpatient of	lavs (including private ro	om days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year,		om days) arter becomber	or or the cost	Ŭ	0.00
7. 00	Total swing-bed NF type inpatient da		m days) through December	31 of the cost	0	7. 00
	reporting period		3 .			
3. 00	Total swing-bed NF type inpatient da		m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year,					
9. 00	Total inpatient days including priva	ite room days applicable t	o the Program (excluding	swing-bed and	9, 012	9. 00
	newborn days)					40.00
10. 00	Swing-bed SNF type inpatient days ap			oom days)	0	10. 00
11. 00	through December 31 of the cost repo Swing-bed SNF type inpatient days ap			oom days) after	0	11. 00
11.00	December 31 of the cost reporting pe			oolii days) ai tei	U	11.00
12. 00	Swing-bed NF type inpatient days app			e room days)	0	12. 00
	through December 31 of the cost repo		y (- · · · · · · · · · · · · · · · · · · ·		
13. 00	Swing-bed NF type inpatient days app	olicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost report					
	Medically necessary private room day		am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX o	onl y)			0	
16. 00	Nursery days (title V or XIX only)				0	16. 00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF serv	d and applicable to comit	aa thaaligh Dagamhaa 21 a	f the cost	0.00	17. 00
17.00	reporting period	rices applicable to service	es through becember 31 d	T the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF serv	vices applicable to servic	es after December 31 of	the cost	0. 00	18. 00
10. 00	reporting period	rees approcable to service	es arter becomber or or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF servi	ces applicable to service	s through December 31 of	the cost	0.00	19. 00
	reporting period	• •	3			
20. 00	Medicaid rate for swing-bed NF servi	ces applicable to service	s after December 31 of t	he cost	0.00	20. 00
	reporting period					
21. 00	Total general inpatient routine serv	•	,		17, 531, 841	
22. 00	Swing-bed cost applicable to SNF typ	oe services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17)	a comiliana aftan Dacamban	21 of the cost resenting	a ported (line (0	23. 00
23.00	Swing-bed cost applicable to SNF typ x line 18)	be services after becember	31 of the cost reportin	g period (iine o	U	23.00
24. 00	Swing-bed cost applicable to NF type	services through Decembe	r 31 of the cost reporti	na period (lipe	0	24. 00
.4.00	7 x line 19)	, ser vices thi ough beceilibe	i 31 of the cost reporti	ng period (Title		24.00
25. 00	Swing-bed cost applicable to NF type	e services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)		, , , ,			
26. 00	Total swing-bed cost (see instruction	ons)			0	26. 00
					i	1

2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	14, 832 0	2. 00 3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	14, 832	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	9, 012	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	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	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT	0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	17, 531, 841 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		24.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00 25. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	U	25.00
26. 00	Total swing-bed cost (see instructions)	17 521 041	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	17, 531, 841	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	17, 531, 841	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 182. 03	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	10, 652, 454	39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	10, 052, 454	40. 00
41. 00		10, 652, 454	

	Financial Systems ST V ATION OF INPATIENT OPERATING COST	INCENT SETON SPE		TAL CN: 15-2020	Peri od: From 07/01/2017 To 06/30/2018		pared:
			Ti tl e	e XVIII	Hospi tal	11/26/2018 10 PPS	. 30 alli
	Cost Center Description	Total Inpatient Costl	Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	11.00	2.00	0.00	11 00	0.00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	door dontor bood per on					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	, line 200)			8, 885, 818	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ons)		19, 538, 272	49. 00
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sun	n of Parts I and	626, 875	50. 00
51. 00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	atient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	229, 510	51. 00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				856, 385	52. 00
53. 00	Total Program inpatient operating cost exclu	,	lated, non-phy	sician anesth	netist, and	18, 681, 887	1
	medical education costs (line 49 minus line			,	·		
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program di scharges	0					
55. 00	Target amount per discharge	0.00	1				
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tai	raet amount (1	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	ing cost and tai	rget amount (i	The 30 minus	111le 33)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period o	endi ng 1996, ι	updated and co	ompounded by the	0.00	
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the m	market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	f the target		
42.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
62. 00 63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	cit (see mistru	etrons)			<u> </u>	03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	e cost reporti	ng period (See	0	64. 00
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the d	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line o	64 plus line 6	55)(title XVII	I only). For	0	66. 00
00.00	CAH (see instructions)		o. p. 40	,, (, and the second se	00.00
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)					_	
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 ± line	. 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N					0	07.00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c						71. 00
72.00	Program routine service cost (line 9 x line	,					72. 00
73. 00	Medically necessary private room cost applic	9	•	,			73. 00
74. 00	Total Program general inpatient routine serv				Domt III		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	COSTS (Trom V	vorksneet B, F	art II, COLUMN		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital related costs (line 9 x line						77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00

### Of OTHER SPECIAL CARE (SPECIFY) Cost Center Description 1.00		SURGICAL INTENSIVE CARE UNIT		[4
48.00 Program inpatient ancillary service cost (Wkst. D-3. col. 3, line 200) 1.00 48.00 Program inpatient ancillary service cost (Wkst. D-3. col. 3, line 200) 8, 885, 885, 810 48.00 Program inpatient costs (sum of lines 41 through 48) (soe instructions) 19, 538, 27 50.00 Pass TiRROUGH COST ADJUSTNENNS 19, 538, 27 50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts II and 626, 87 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV) 52.01 Pass prough costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV) 52.01 Pass prough costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV) 53.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV) 54.00 Program excludable cost (sun of lines 50 and 51) 55.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV) 56.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV) 56.00 Program inpatient operating cost sext and pass pass pass pass pass pass pass pas								4
8.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 8, 885, 81 9, 00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 19, 538, 72 PASS TREQUENCE COST ADJUSTMENTS 10, 538, 72 PASS TREQUENCE COST ADJUSTMENTS 1113 1113 1115 1116 1117 1117 1118 1119 1119 1119 1119 1119	. 00	, ,						T
8.00 Program inpatient ancillary service cost (West D-3, col. 3, line 200) 9. Total Program inpatient costs (sum of lines 41 Hrough 48) (see instructions) 9. Total Program inpatient costs (sum of lines 41 Hrough 48) (see instructions) 19.538. 72 9. Pass Through costs applicable to Program inpatient routine services (from West. D, sum of Parts II and 11) 1.00 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III) 1.01 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III) 1.02 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III) 1.03 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III) 1.04 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III) 1.05 Program discharges 1.06 Program discharges 1.07 Program discharges 1.08 Program discharges 1.08 Program discharges 1.08 Program discharges 1.09 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 1.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 1.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 1.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 1.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 1.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 1.00 Difference between adjusted inpatient costs (line 53 program line 1996, updated and compounded by the market basket 1.00 Difference between adjusted inpatient program (line 55, by 60, or 1% of the target by 60 Difference by 60 Dif		555 5511 55551 Pt. 611					1. 00	+
19. 508. 27 PASS THROUGH COST AUDISTIENTS PASS THROUGH COST AUDISTIENTS PASS THROUGH COST AUDISTIENTS 11.00 PASS through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) 11.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and III) 12.01 10.01	3. 00	Program inpatient ancillary service cost (Wkst	. D-3, col. 3	3, line 200)			8, 885, 818	3 4
Deads THROUGH COST ADJUSTNEMTS 1.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and II) 1.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II and III) 2.00 Total Program excludable cost (sum of lines 50 and 51) 3.00 Total Program excludable cost (sum of lines 50 and 51) 3.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 4.00 Program and discharges 6.00 Target amount per discharge 6.00 Target amount (line 54 x line 55) 8.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 9.00 Ease of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 1.00 If line 53/54 is less than the lower of lines 55, 90 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 8.00 Relief payment (see instructions) 8.00 R					ns)		19, 538, 272	
111 110 Pass through costs applicable to Program Inpatient ancillary services (from Wist. D, sum of Parts II and IV) 299, 51 and IV) 299, 51 and IV) 300 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 186, 88 18						'	,	
229, 51 and IV) 200 Total Program excludable cost (sum of lines 50 and 51) 300 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 301 Target AMOUNT AND LIMIT COMPUTATION 400 Program discharges 400 Target amount per discharges 500 Target amount per discharges 600 Target amount per discharges 700 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 800 Bonus payment (see instructions) 800 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 900 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 900 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 900 Reliefs payment (see instruc	0. 00	Pass through costs applicable to Program inpat	ient routine	services (from	Wkst. D, sum	of Parts I and	626, 875	5 5
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7.00 or 1 arget amount (line 54 x line 55) 8.00 and 1 arget amount (line 56 minus line 53) 8.00 and 1 arget amount (see instructions) 8.00 bear of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 8.00 bear of lines 53/54 or 55 from prior year cost report, updated by the market basket 8.00 bear of lines 53/54 or 55 from prior year cost report, updated by the market basket 8.00 bear of lines 53/54 or 55 from prior year cost report, updated by the market basket 8.00 bear of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 8.00 all owable Inpatient cost plus incentive payment (see instructions) 9.00 All owable Inpatient cost plus incentive payment (see instructions) 9.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 9.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) 9.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 9.01 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 13 x line 20) 9.01 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 9.01 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only) 9.01 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9.02 All outset general inpatient routine service costs (line 67 + line 68) 9.03 All outset general inpatient routine service costs (line 72 + line 73) 9.04 All outset general inpatient routine service costs (line 72 + line 73) 9.05 All outset general inpatient routine service costs (line 74 nine XI) 9.06 Per diem capita		o o					0	- I '
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Program capital -related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)	- 1							١.
8.00 Inpatient routine service cost (line 74 minus line 77) 9.00 Aggregate charges to beneficiaries for excess costs (from provider records) 0.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 1.00 Inpatient routine service cost per diem limitation 2.00 Inpatient routine service cost limitation (line 9 x line 81) 3.00 Reasonable inpatient routine service costs (see instructions) 4.00 Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)								
Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		9 1	,					
Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 1.00 Inpatient routine service cost per diem limitation 2.00 Inpatient routine service cost limitation (line 9 x line 81) 3.00 Reasonable inpatient routine service costs (see instructions) 4.00 Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		1	,		`			
1.00 Inpatient routine service cost per diem limitation 2.00 Inpatient routine service cost limitation (line 9 x line 81) 3.00 Reasonable inpatient routine service costs (see instructions) 4.00 Program inpatient ancillary services (see instructions) 5.00 Utilization review - physician compensation (see instructions)	1				· *.	- 1: 70)		
2.00 Inpatient routine service cost limitation (line 9 x line 81) 3.00 Reasonable inpatient routine service costs (see instructions) 4.00 Program inpatient ancillary services (see instructions) 5.00 Utilization review - physician compensation (see instructions)				cost limitation	(line /8 minu	s line 79)		
3.00 Reasonable inpatient routine service costs (see instructions) 4.00 Program inpatient ancillary services (see instructions) 5.00 Utilization review - physician compensation (see instructions)	1			1)				
4.00 Program inpatient ancillary services (see instructions) 5.00 Utilization review - physician compensation (see instructions)				* .				
5.00 Utilization review - physician compensation (see instructions)				15)				
				nc)				
6 OO llotal Drogram innationt operating costs (sum of lings 92 through 95)				•				
6.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				n ough oo)				Η,
	- t		111100011 0031				0	5 8
			em (line 27 ±	- line 2)			0.00	
							0. 00 n	5 8

Health Financial Systems ST V	INCENT SETON SP	ECIALITY HOSPI	TAL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 10	pared: :36 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 031, 663	17, 531, 841	0. 05884	5 0	0	90. 00
91.00 Nursing School cost	0	17, 531, 841	0.00000	0	0	91.00
92.00 Allied health cost	0	17, 531, 841	0.00000	0	0	92. 00
93.00 All other Medical Education	0	17, 531, 841	0. 00000	0 0	0	93. 00

Heal th	Financial Systems ST VIN	CENT SETON SPECIA	ALITY HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-2020	Peri od:	Worksheet D-1	
				From 07/01/2017		
				To 06/30/2018		
			Title XIX	Hospi tal	11/26/2018 10	: 30 alli
	Coot Conton Decemintion		TI LIE XIX	Hospi tal	Cost	
	Cost Center Description				1 00	
	DART I ALL DROWLDED COMPONENTS			<u> </u>	1. 00	
	PART I - ALL PROVIDER COMPONENTS					-
4 00	I NPATI ENT DAYS				44.000	1
1.00	Inpatient days (including private room days an				14, 832	
2.00	Inpatient days (including private room days, e				14, 832	
3.00	Private room days (excluding swing-bed and obs	servation bed days	s). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.					
4.00	Semi-private room days (excluding swing-bed an				14, 832	
5.00	Total swing-bed SNF type inpatient days (inclu	ıdi ng pri vate roor	m days) through Decembe	er 31 of the cost	0	5. 00
	reporting period					
6. 00	Total swing-bed SNF type inpatient days (inclu		m days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on					
7.00	Total swing-bed NF type inpatient days (includ	ling private room	days) through December	31 of the cost	0	7.00
	reporting period					
8.00	Total swing-bed NF type inpatient days (includ		days) after December 3	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on	rthis line)				
9.00	Total inpatient days including private room da	ys applicable to	the Program (excluding	swing-bed and	91	9. 00
	newborn days)					
10.00						10.00
	through December 31 of the cost reporting period (see instructions)					
11.00	Swing-bed SNF type inpatient days applicable t			room days) after	0	11. 00
	December 31 of the cost reporting period (if c					
12.00	Swing-bed NF type inpatient days applicable to		only (including privat	e room days)	0	12.00
	through December 31 of the cost reporting peri					
13.00	Swing-bed NF type inpatient days applicable to				0	13.00
	after December 31 of the cost reporting period	l (if calendar yea	ar, enter O on this lir	ne)		
14.00	Medically necessary private room days applicab	le to the Program	m (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)				0	15.00
16.00	Nursery days (title V or XIX only)				0	16. 00
	SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services appli	cable to services	s through December 31 c	of the cost	0.00	17. 00
	reporting period					
18.00	Medicare rate for swing-bed SNF services appli	cable to services	s after December 31 of	the cost	0.00	18. 00
	reporting period					
19.00	Medicaid rate for swing-bed NF services applic	able to services	through December 31 of	the cost	0.00	19.00
	reporting period					
20.00	Medicaid rate for swing-bed NF services applic	able to services	after December 31 of t	he cost	0.00	20.00
	reporting period					
21.00	Total general inpatient routine service cost (see instructions)		17, 531, 841	21.00
22. 00	Swing-bed cost applicable to SNF type services	through December	r 31 of the cost report	ing period (line	0	22. 00
	5 x line 17)	-	·			
23.00	Swing-bed cost applicable to SNF type services	after December 3	31 of the cost reportir	ng period (line 6	0	23.00
	x line 18)		•			
24.00	Swing-bed cost applicable to NF type services	through December	31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)	-	·	- •		
25.00	Swing-bed cost applicable to NF type services	after December 3	1 of the cost reporting	period (line 8	0	25. 00
	x line 20)			•		

		1.00	
	PART I - ALL PROVIDER COMPONENTS		l
4 00	INPATIENT DAYS	44.000	1 00
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14, 832	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14, 832	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		1
4.00	Semi-private room days (excluding swing-bed and observation bed days)	14, 832	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		1
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		l
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		l
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		l
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	91	9.00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)	-	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	ol	11.00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	ĭ	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	ĭ	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	۷	13.00
14. 00	Medically 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)	0	
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		l
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		l
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		l
21. 00	Total general inpatient routine service cost (see instructions)	17, 531, 841	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	1
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	ol	23. 00
	x line 18)	-	
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
2 00	7 x line 19)	ĭ	
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
20.00	In line 20)	ĭ	20.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	17, 531, 841	
27.00		17, 551, 641	27.00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0	20.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	o	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	17, 531, 841	
200	27 minus line 36)	, 50., 511	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
20 00		1 102 02	20 00
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 182. 03	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	107, 565	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	107, 565	41.00

COMPUI	ATION OF INPATIENT OPERATING COST		Provi der CC	1	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Pre	pared:
			Ti +I	e XIX	Hospi tal	11/26/2018 10 Cost	:36 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
			Inpatient Days	Diem (col. 1 -		(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4.00	<u>4)</u> 5. 00	
12. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Unit	S					1
13.00	INTENSIVE CARE UNIT						43.00
4. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
6. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
8. 00	Program inpatient ancillary service cost (W	lkst D 2 sol 2	Line 200)			1. 00	48. 00
9. 00	Total Program inpatient costs (sum of lines			ns)		13, 236 120, 801	1
7. 00	PASS THROUGH COST ADJUSTMENTS	r r em ough 10) (See mistractio	113)		120,001	17.00
0. 00	Pass through costs applicable to Program in	patient routine	services (from	Wkst. D, sum	of Parts I and	0	50. 00
1. 00		nationt ancillar	v sarvicas (fr	om Wkst D si	m of Darts II	0	51.00
1.00	and IV)	ipatrent ancirrai	y services (ii	OIII WKSt. D, St	am or rarts ir	O	31.00
2. 00	Total Program excludable cost (sum of lines					0	52. 00
3. 00	Total Program inpatient operating cost excl		lated, non-phy	sician anesthe	etist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	: 52)					-
4. 00	Program discharges					0	54.00
5. 00	Target amount per discharge					0.00	
6. 00	Target amount (line 54 x line 55)					0	
7. 00	Difference between adjusted inpatient opera	iting cost and ta	rget amount (I	ine 56 minus I	i ne 53)	0	
8. 00 9. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	enorting period	endina 1006 u	ndated and cor	mounded by the	0.00	
7. 00	market basket	eportring perrou	ending 1770, a	paatea ana con	iipodrided by the	0.00	37.00
0. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
1. 00	If line 53/54 is less than the lower of lin					0	61. 00
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		S (Tines 54 X	60), OF 1% OF	the target		
2. 00	Relief payment (see instructions)	. Thisti dott ons)				0	62.00
3. 00	Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)			0	63. 00
4 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	usts through Doso	mbor 21 of the	cost roportir	na nori od (Soo	0	64. 00
4. 00	instructions)(title XVIII only)	ists through bece	iliber 31 of the	cost reportir	ig perrou (see	U	04.00
5. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	ost reporting	peri od (See	0	65. 00
	instructions)(title XVIII only)			=> (
66.00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line 6	b)(title XVIII	only). For	0	66. 00
7. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost re	portina period	0	67. 00
	(line 12 x line 19)	· ·		·			
8. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost repor	rting period	0	68. 00
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)		0	69. 00
7. 00	PART III - SKILLED NURSING FACILITY, OTHER						1 07.00
0. 00	Skilled nursing facility/other nursing faci						70. 00
1.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.00
2. 00 3. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 1/ v li	ne 35)			72. 00 73. 00
4. 00	Total Program general inpatient routine ser	9	•	ne 30 <i>)</i>			74.00
5. 00	Capital -related cost allocated to inpatient		· ·	orksheet B, Pa	art II, column		75. 00
	26, line 45)		•				
6.00	Per diem capital related costs (line 75 ÷ l						76.00
77. 00 78. 00	Program capital-related costs (line 9 x lin	us line 77)					77. 00 78. 00

Health Financial Systems ST V	INCENT SETON SP	ECIALITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 10	pared: :36 am_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 031, 663	17, 531, 841	0. 05884	5 0	0	90.00
91.00 Nursing School cost	0	17, 531, 841	0.00000	0	0	91. 00
92.00 Allied health cost	0	17, 531, 841	0.00000	0	0	92. 00
93.00 All other Medical Education	0	17, 531, 841	0. 00000	0 0	0	93. 00

Health Fina	nncial Systems ST VINCENT SETON SPECIA	NITV HOSDI	ΤΛΙ	Inlie	u of Form CMS-2	2552_10
		Provi der C		Peri od:	Worksheet D-3	
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 10	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			4.00	0.00	2)	
LAIDA	THENT POUTLING CERVILOR COOT CENTERS		1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS			04 700 505		
	O ADULTS & PEDI ATRI CS			21, 729, 595		30. 00
	LLARY SERVICE COST CENTERS O OPERATING ROOM		0. 17583	1, 982, 639	348, 617	50.00
	O RADI OLOGY-DI AGNOSTI C		0. 1756.		· ·	ł
	O ULTRA SOUND		0. 2405		· ·	
	O CT SCAN		0. 13732			57. 00
	O LABORATORY		0. 05334			
	O BLOOD STORING, PROCESSING & TRANS.		0.00000		0	1
1	O RESPI RATORY THERAPY		0. 1685		2, 727, 480	
1	O PHYSI CAL THERAPY		0. 3956			66. 00
67. 00 0670	OCCUPATIONAL THERAPY		0. 25770			67. 00
68. 00 0680	SPEECH PATHOLOGY		0. 4289	50 513, 470	220, 253	68. 00
69.00 0690	O ELECTROCARDI OLOGY		0. 00000	00	0	69. 00
70.00 0700	O ELECTROENCEPHALOGRAPHY		1. 48404	4, 450	6, 604	70. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 61800		956, 908	71. 00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS		0.00000	00	0	72. 00
	O DRUGS CHARGED TO PATIENTS		0. 3433		2, 743, 717	l
	O RENAL DIALYSIS		0. 3480			1
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			40, 354, 318		
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)			40, 354, 318		202. 00

Hool +h	Financial Systems ST VINCENT SETON SPECI	ALLEY HOCDI	TAI	المانا	eu of Form CMS-2	DEE2 10
	Financial Systems ST VINCENT SETON SPECI NT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
111171112	AN ANOTEEN SERVICE COST AN ORTHORNER	Trovider of	ON. 10 2020	From 07/01/2017 To 06/30/2018		pared:
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
H-	03000 ADULTS & PEDI ATRI CS			81, 113		30. 00
	ANCILLARY SERVICE COST CENTERS			,_l		
	D5000 OPERATING ROOM		0. 17583		0	
	D5400 RADI OLOGY-DI AGNOSTI C		0. 24657		l .	
	D3630 ULTRA SOUND		0. 13752		0	54. 01
	D5700 CT SCAN		0. 21049		0	57. 00
	D6000 LABORATORY		0. 05334 0. 00000		l .	60. 00 63. 00
	D6300 BLOOD STORING, PROCESSING & TRANS. D6500 RESPIRATORY THERAPY		0.00000		7 040	
	06600 PHYSI CAL THERAPY		0. 16857	•		66.00
	D6700 OCCUPATI ONAL THERAPY		0. 3956	•		67.00
	06800 SPEECH PATHOLOGY		0. 23770			
	06900 ELECTROCARDI OLOGY		0. 00000		0	69.00
4	D7000 ELECTROCARD GLOGT		1. 48404		0	
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 61800		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 34339		0	73.00
	07400 RENAL DIALYSIS		0. 34807		0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0.34007	70, 144		200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		70, 144		201.00
202. 00	Net charges (line 200 minus line 201)	(5 01)		70, 144	1	202. 00

Health Financial Systems	ST VINCENT SETON SPECIALITY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-2020	Peri od: From 07/01/2017 Part B To 06/30/2018 Date/Ti me Prepared:

			10 06/30/2018	11/26/2018 10:	
		Title XVIII	Hospi tal	PPS	. 30 aiii
		1 2 2			
				1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES				1 00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	tions)		0 64, 296	1. 00 2. 00
3. 00	OPPS payments	ti ons)		25, 633	
4. 00	Outlier payment (see instructions)			25, 655	
4. 01	Outlier reconciliation amount (see instructions)			Ö	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0	
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	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES				11.00
	Reasonable charges				İ
12.00	Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15 00	Customary charges	normant for convices on	a charge basis		1 1 5 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for				15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(. 3	ii a ciiai gebasi s	ا	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0. 000000	17.0
	Total customary charges (see instructions)			0	18.0
19. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 18 exceeds li	ne 11) (see	0	19.00
	instructions)		10) (
20. 00	Excess of reasonable cost over customary charges (complete onlinstructions)	ly if line 11 exceeds li	ne 18) (see	0	20.00
21. 00	Lesser of cost or charges (see instructions)			o	21. 00
	Interns and residents (see instructions)			o o	
	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	•		25, 633	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (for CAH, see instructions)	2411		0	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for			3, 831	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) prinstructions)	prus the sum of filles 22	and 23] (See	21, 802	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 50)		o	28.00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	•		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			21, 802	30.00
	Primary payer payments			0	
32. 00	Subtotal (line 30 minus line 31)	250)		21, 802	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE COMPOSITE RATE ESRD (from Wkst. I-5, line 11)	LES)		0] 33. 00
	Allowable bad debts (see instructions)				
35. 00	Adjusted reimbursable bad debts (see instructions)			Ö	35. 0
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	36.0
37.00	Subtotal (see instructions)			21, 802	37. 0
38. 00	MSP-LCC reconciliation amount from PS&R			0	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	
39. 50	Prioneer ACO demonstration payment adjustment (see instructions	S)			39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	and davices (see instruc	tions)	0	39. 9 39. 9
39. 98 39. 99	RECOVERY OF ACCELERATED DEPRECIATION	ca devices (see Histiac	11 0113)		1
	Subtotal (see instructions)			21, 802	1
40. 01	Sequestration adjustment (see instructions)				40. 0
40. 02	Demonstration payment adjustment amount after sequestration			0	40.0
	Interim payments			21, 366	ı
42.00	Tentative settlement (for contractors use only)			0	
43.00	Balance due provider/program (see instructions)	acc with CMS Dub 15 2	chantar 1	0	
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	cnapter I,	0	44.0
	TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	90.0
	Outlier reconciliation adjustment amount (see instructions)			Ö	1
91.00				0.00	92.0
91. 00 92. 00	The rate used to calculate the Time Value of Money		l	i 0.00	1 /2.0
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00

From 07/01/2017 Part I 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 16, 099, 022 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 3.02 0 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 3.53 0 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 16, 099, 022 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 21, 366 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 247, 569 0 6.01 SETTLEMENT TO PROGRAM 6 02 0 6.02 7.00 Total Medicare program liability (see instructions) 16, 346, 591 21, 366 7.00 Contractor NPR Date (Mo/Day/Yr) Number 0 1 00 2 00 8.00 Name of Contractor 8.00

Provider CCN: 15-2020

Peri od:

Health Financial Systems	ST VINCENT SETON SPECI	ALITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-2020	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part IV Date/Time Prepared: 11/26/2018 10:36 am

PART IV - MEDICARE PART A SERVICES - LTCH PPS 1.00				10 00/00/2010	11/26/2018 10	
PART I V - MEDICARE PART A SERVICES - LTCH PPS			Title XVIII	Hospi tal	PPS	
PART I I / - MEDICARE PART A SERVICES - LTCH PPS						
1.00 Net Federal PPS Payments (see instructions)					1. 00	
Full standard payment amount						
1.02 Short stay outlier standard payment amount 0 0 0.02 1.03 1.03 1.04 1.05 1.0	1.00					
1.03 Site neutral payment amount - Cost 0 1.03 1.04 2.00 0.01 1.03 1.03 1.04 2.00 0.01 1.03 1.04 2.00 0.01 1.03 1.05 1	1.01	Full standard payment amount			14, 748, 560	1. 01
1.04	1.02	Short stay outlier standard payment amount			0	1. 02
2.770, 475 2.00					0	1. 03
Total PPS Payments (sum of lines 1 and 2)		Site neutral payment amount - IPPS comparable			0	1. 04
A. 00 Nursing and Allied Health Managed Care payments (see instructions) 0 4, 00 0rgan acquisition (DD NOT USE THIS LINE) 5.00 6.00 0rgan acquisition (DD NOT USE THIS LINE) 5.00 6.00 0rgan acquisition (DD NOT USE THIS LINE) 5.00 6.00 0rgan acquisition (DD NOT USE THIS LINE) 5.00 6.00 0rgan acquisition (DD NOT USE THIS LINE) 5.00 0.00 0rgan acquisition (DD NOT USE THIS LINE) 7.00 7.00 0.00 0rgan acquisition (DD NOT USE THIS LINE) 7.00 7.00 0.						
5.00					17, 519, 035	3. 00
0. 0 0 0 0 0 0 0 0 0	4.00	Nursing and Allied Health Managed Care payments (see instructi	ons)		0	4. 00
2.00	5.00	Organ acquisition (DO NOT USE THIS LINE)				5. 00
8. 00 Primary payer payments 0 8. 00 9. 00 Subtotal (line 7 less line 8). 17, 519, 035 9. 00 10. 00 Deductibles 13, 204 10. 00 11. 00 Subtotal (line 9 minus line 10) 17, 505, 831 11. 00 11. 00 Subtotal (line 11 minus line 10) 17, 505, 831 11. 00 11. 00 Subtotal (line 11 minus line 12) 16, 291, 238 13. 00 14. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 598, 396 14. 00 14. 00 15. 00 Allowable bad debts (exclude bad debts (see instructions) 338, 957 15. 00 16. 680, 195 15. 00 16. 680, 195 17. 00 18. 00 19. 00	6.00	Cost of physicians' services in a teaching hospital (see insti	ructions)		_	
9.00 Subtotail (line 7 less line 8). 17,519,035 9.00 10.00 Deductibles 13,204 10.00 11.00 Subtotal (line 9 minus line 10) 17,519,035 9.00 12.00 Coinsurance 1,214,593 12.00 13.00 Subtotal (line 11 minus line 12) 1,214,593 12.00 14.00 All owable bad debts (exclude bad debts for professional services) (see instructions) 598,396 14.00 15.00 Adjusted reimbursable bad debts (see instructions) 388,957 15.00 16.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 598,396 16.00 17.00 Subtotal (sum of lines 13 and 15) 16,680,195 17.00 18.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 16,680,195 17.00 18.00 Diver payses through costs (see instructions) 0 19.00 0 19.00 20.00 Outlier payments reconciliation 0 20.00 0 20.00 21.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 20.00 0 21.00 21.50 Ploneer ACO demonstration payment adjustment amount before sequestration 0 21.00 0 21.00	7.00	Subtotal (see instructions)			17, 519, 035	7. 00
10.00 Deductibles 13, 204 10.00 11.00 Subtotal (line 9 minus line 10) 17,505,831 11.00 17,505,831 13.00 17,505,831 13.00 16,291,238 13.00 14.00 16,291,238 13.00 14.00 16,291,238 14.00 16,291,238 16.00 16,291,238 1	8.00	Pri mary payer payments			0	8. 00
11.00 Subtotal (line 9 minus line 10) 17,505,831 11.00 12.00 Coinsurance 1,214,593 12.00 13.00 Subtotal (line 11 minus line 12) 16,291,238 13.00 14.00 All owable bad debts (exclude bad debts for professional services) (see instructions) 598,396 14.00 15.00 Adjusted reimbursable bad debts (see instructions) 598,396 14.00 15.00 Adjusted reimbursable bad debts (see instructions) 598,396 14.00 15.00 Adjusted reimbursable bad debts (see instructions) 598,396 14.00 15.00 Adjusted reimbursable bad debts (see instructions) 598,396 14.00 15.00	9.00	Subtotal (line 7 less line 8).			17, 519, 035	9. 00
1, 214, 593 12. 00 13. 00 Subtotal (line 11 minus line 12) 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 13. 00 16, 291, 238 15. 00 16, 291, 238 15. 00 16, 291, 238 15. 00 16, 291, 238 15. 00 16, 291, 238 15. 00 16, 291, 238 16, 291, 238 16, 291, 238 18. 00 19.	10.00	Deducti bl es			13, 204	10. 00
13.00 Subtotal (line 11 minus line 12) 16, 291, 238 13.00 14.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 598, 396 14.00 15.00 Adjusted reimbursable bad debts (see instructions) 388, 957 15.00 16.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 598, 396 16.00 17.00 Subtotal (sum of lines 13 and 15) 16, 680, 195 17.00 18.00 19.00 Other pass through costs (see instructions) 0 18.00 19.00 00 00 00 00 00 00 00	11. 00	Subtotal (line 9 minus line 10)			17, 505, 831	11. 00
14.00	12.00	Coinsurance			1, 214, 593	12.00
15. 00	13.00	Subtotal (line 11 minus line 12)			16, 291, 238	13. 00
16.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 17.00 Subtotal (sum of lines 13 and 15) 18.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 19.00 Other pass through costs (see instructions) 20.00 Outlier payments reconciliation 21.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 21.50 Pioneer ACO demonstration payment adjustment (see instructions) 22.00 Total amount payable to the provider (see instructions) 22.01 Sequestration adjustment (see instructions) 22.02 Demonstration payment adjustment amount after sequestration 22.03 Sequestration adjustment (see instructions) 23.00 Interim payments 24.00 Tentative settlement (for contractor use only) 25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24) 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 598, 396 16.00 16, 680, 195 17.00 18.00 19.00 19.00 19.00 20.00 21.00 21.00 21.00 21.50 22.00 22.01 22.02 23.00 24.00 25.00 26.00 27.70, 475 27.70, 475 27.70, 475 28.00 29.00 20.01 20.01 20.02 20.02 20.03 20.03 20.04 20.04 20.05 20.06 20.06 20.07 20.07 20.08 20.08 20.09 20.09 20.09 20.00	14.00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)			
17. 00 Subtotal (sum of lines 13 and 15) 16, 680, 195 17. 00 18. 00 19.	15. 00	Adjusted reimbursable bad debts (see instructions)				
18.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 18.00 19.00 0 19.00 0 19.00 0 0 19.00 19.00	16. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		598, 396	16. 00
19.00 Other pass through costs (see instructions) 0 19.00 20.00 Outlier payments reconciliation 0 20.00 21.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 21.00 21.50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 21.50 21.99 Demonstration payment adjustment amount before sequestration 0 21.99 22.00 Total amount payable to the provider (see instructions) 16,680,195 22.00 22.01 Sequestration adjustment (see instructions) 333,604 22.01 22.02 Demonstration payment adjustment amount after sequestration 0 22.02 23.00 Interim payments 16,099,022 23.00 24.00 Tentative settlement (for contractor use only) 0 24.00 25.00 Bal ance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24) 247,569 25.00 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 51.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 2,770,475 50.00 50.00 The rate used to calculate the Time Value of	17. 00	Subtotal (sum of lines 13 and 15)			16, 680, 195	17. 00
20. 00 Outlier payments reconciliation 0 20. 00 21. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 21. 00 21. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 21. 00 21. 99 Demonstration payment adjustment amount before sequestration 0 21. 99 22. 01 Total amount payable to the provider (see instructions) 16, 680, 195 22. 00 22. 01 Sequestration adjustment (see instructions) 333, 604 22. 01 22. 02 Demonstration payment adjustment amount after sequestration 0 22. 02 23. 00 Interim payments 16, 099, 022 23. 00 24. 00 Tentative settlement (for contractor use only) 24. 00 24. 00 25. 00 Bal ance due provi der/program (line 22 minus lines 22.01, 22.02, 23 and 24) 247, 569 25. 00 26. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26. 00 51. 00 Oitjginal outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 2, 770, 475 50. 00 50. 00 The rate used to calculate the Time Value of Money (see instructions) 0. 00 52. 00	18. 00	Direct graduate medical education payments (from Wkst. E-4, Ii	ne 49)		0	18. 00
21.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 21.00 21.50 21.50 21.99 22.00 21.99 22.00 22.01 22.01 22.02 23.00 23.30 24.00 23.00 24.00 25.00 25.00 26.00	19. 00	Other pass through costs (see instructions)			0	19. 00
21.50 Pi oneer ACO demonstration payment adjustment (see instructions) 21.99 Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions) Demonstration payment (see instructions) Sequestration adjustment (see instructions) Sequestration adjustment amount after sequestration Demonstration payment adjustment amount after sequestration 16, 680, 195 22. 00 333, 604 22. 01 Demonstration payment adjustment amount after sequestration 16, 099, 022 23. 00 Interim payments Tentative settlement (for contractor use only) Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24) Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 Society of the provider of the	20.00	Outlier payments reconciliation			0	20. 00
21.99 Demonstration payment adjustment amount before sequestration 0 21.99 22.00 Total amount payable to the provider (see instructions) 16,680,195 22.00 22.01 22.02 Demonstration payment adjustment amount after sequestration 0 22.01 22.02 23.00 Interim payment adjustment amount after sequestration 0 22.02 23.00 24.00 25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24) 247,569 25.00 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 26.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 2,770,475 50.00 0 0 0 0 0 0 0 0 0	21. 00				0	21. 00
22.00 Total amount payable to the provider (see instructions) 22.01 Sequestration adjustment (see instructions) 22.02 Demonstration payment adjustment amount after sequestration 23.00 Interim payments 24.00 Tentative settlement (for contractor use only) 25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24) 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) The rate used to calculate the Time Value of Money (see instructions) 16, 680, 195 22.00 22.01 22.02 23.00 24.00 25.00 26.00 27.00 28.00 29.00 20.		Pioneer ACO demonstration payment adjustment (see instructions	5)		0	21. 50
22.01 Sequestration adjustment (see instructions) 333, 604 22.01	21. 99	Demonstration payment adjustment amount before sequestration			0	21. 99
22. 02 23. 00 Interim payments Interim payments Tentative settlement (for contractor use only) 25. 00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) The rate used to calculate the Time Value of Money (see instructions) 0 22. 02 23. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 21. 00 22. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 27. 70, 475 27. 70, 475 27. 70, 475 27. 70 28. 770, 475 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 24. 00 24. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 27. 70, 475 27. 70, 475 28. 00 29. 00 20. 00 20. 00 20. 00 21. 00 22. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 26. 00 27. 70, 475 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 26. 00 27. 70, 475 27. 70, 4		Total amount payable to the provider (see instructions)			16, 680, 195	22. 00
23.00 Interim payments Tentative settlement (for contractor use only) 25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24) 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 50.00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money (see instructions) 16, 099, 022 23.00 24.00 24.00 25.00 26.00 26.00 27,70, 475 50.00 51.00 The rate used to calculate the Time Value of Money (see instructions) 0.00 52.00	22. 01	Sequestration adjustment (see instructions)			333, 604	22. 01
Tentative settlement (for contractor use only) 24.00 25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24) 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) The rate used to calculate the Time Value of Money (see instructions) 24.00 25.00 26.00 27.00 27.00 28.00 29.00 29.00 20.0	22. 02	Demonstration payment adjustment amount after sequestration			_	
25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24) 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 25.00 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money (see instructions) Outlier reconciliation adjustment amount (see instructions) Double Temple Te	23.00	Interim payments			16, 099, 022	23. 00
26.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	24. 00	Tentative settlement (for contractor use only)			0	24. 00
\$115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 52.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 50.00 Outlier reconciliation adjustment amount (see instructions)					247, 569	
TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 50.00 Outlier reconciliation adjustment amount (see instructions) 50.00 The rate used to calculate the Time Value of Money (see instructions) 50.00 The rate used to calculate the Time Value of Money (see instructions) 50.00 The rate used to calculate the Time Value of Money (see instructions) 50.00 The rate used to calculate the Time Value of Money (see instructions)	26.00		nce with CMS Pub. 15-2, o	chapter 1,	0	26. 00
50.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)						
51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 0 51.00 0.00 52.00						
52.00 The rate used to calculate the Time Value of Money (see instructions) 0.00 52.00			structions)			1
53.00 lime Value of Money (see instructions) 0 53.00			uctions)			1
	53. 00	lime Value of Money (see instructions)			0	53. 00

Health Financial Systems	ST VINCENT SETON SPECIALITY HOSPITAL			n Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-2020	Peri od:	Worksheet E-3		

From 07/01/2017 Part VII To 06/30/2018 Date/Time Prepared: 11/26/2018 10:36 am Hospi tal Title XIX Cost Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 120, 801 1.00 2.00 Medical and other services Λ 2.00 3.00 Organ acquisition (certified transplant centers only) 3.00 Subtotal (sum of lines 1, 2 and 3) 4.00 120, 801 4.00 Inpatient primary payer payments 5.00 5.00 Outpatient primary payer payments 6.00 Ω 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 120, 801 0 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 81, 113 8.00 9.00 Ancillary service charges 0 9.00 70.144 10.00 Organ acquisition charges, net of revenue 10.00 0 Incentive from target amount computation 11 00 11 00 0 12.00 Total reasonable charges (sum of lines 8 through 11) 151, 257 0 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 151, 257 16.00 17.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 30 456 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 18.00 0 (see instructions) 19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 20.00 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 120, 801 0 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers 22.00 0 0 22.00 Other than outlier payments 23.00 Outlier payments 0 23.00 Λ 0 24.00 Program capital payments 24.00 0 25.00 Capital exception payments (see instructions) 25.00 Routine and Ancillary service other pass through costs 26.00 26 00 0 Subtotal (sum of lines 22 through 26) 0 27.00 0 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 120, 801 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 120, 801 0 31.00 32.00 Deducti bl es 32.00 0 0 33 00 33 00 Coi nsurance 0 0 34.00 Allowable bad debts (see instructions) 0 Λ 34.00 Utilization review 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 120, 801 36, 00 36, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 0 37.00 38.00 Subtotal (line 36 ± line 37) 120, 801 38.00 0 Direct graduate medical education payments (from Wkst. E-4) 39.00 39.00 120, 801 40.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 41.00 Interim payments 120, 801 0 41.00 Balance due provider/program (line 40 minus line 41) 42.00 0 42.00

43.00

0

0

Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,

43.00

chapter 1, §115.2

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

Provider CCN: 15-2020 | Period: From 07/01/20

Peri od: From 07/01/2017 To 06/30/2018 Worksheet G Date/Time Prepared: 11/26/2018 10:36 am

oni y)					11/26/2018 10	: 36 am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes recei vabl e	0	0	0	0	3. 00
4.00	Accounts receivable	12, 631, 039		0	0	
5.00	Other recei vable	1, 420, 587		0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	-6, 295, 016		0	0	1
7.00	Inventory	410, 587		0	0	1
8. 00 9. 00	Prepaid expenses Other current assets	1, 216 254, 397		0	0	1
10.00	Due from other funds	254, 347		0	0	
11. 00	Total current assets (sum of lines 1-10)	8, 422, 810	1	_	0	1
	FIXED ASSETS	0,122,010	1	<u> </u>		
12.00	Land	847, 629	0	0	0	12. 00
13.00	Land improvements	3, 157	0	0	0	13.00
14.00	Accumulated depreciation	-3, 157	0	0	0	14. 00
15. 00	Bui I di ngs	17, 104, 292	1	0	0	
16. 00	Accumulated depreciation	-9, 371, 830		0	0	
17. 00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumulated depreciation	0	0	0	0	
19. 00 20. 00	Fixed equipment Accumulated depreciation	0		0	0	1
21. 00	Automobiles and trucks		0	0	0	1
22. 00	Accumulated depreciation		o o	0	0	
23. 00	Major movable equipment	5, 416, 929		o	0	
24. 00	Accumulated depreciation	-4, 193, 588	1	0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	
28. 00	Accumulated depreciation	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0 000 400	0	0	0	
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	9, 803, 432	! 0	0	0	30. 00
31. 00	Investments	0	0	0	0	31. 00
32. 00	Deposits on Leases		1	0	0	32. 00
33. 00	Due from owners/officers	l o	o o	o	0	
34. 00	Other assets	13, 011	0	0	0	1
35.00	Total other assets (sum of lines 31-34)	13, 011	0	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	18, 239, 253	0	0	0	36. 00
	CURRENT LIABILITIES	1				
37. 00	Accounts payable	813, 536	1		0	1
38. 00	Sal ari es, wages, and fees payable	497, 285	1	0	0	
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	467, 710		0	0	39. 00 40. 00
41. 00	Deferred income			0	0	1
42. 00	Accel erated payments					42. 00
43. 00	Due to other funds	Ö	o	0	0	1
44.00	Other current liabilities	3, 508, 900	o o	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	5, 287, 431	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	1	0	0	
47. 00	Notes payable	0	1	0	0	1
48. 00	Unsecured Loans	200 4/5	0	0	0	1
49. 00 50. 00	Other long term liabilities	398, 465		0	0	1
51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	398, 465 5, 685, 896			0	
31.00	CAPITAL ACCOUNTS	3,003,070	0	<u> </u>	0	31.00
52. 00	General fund balance	12, 553, 357	,			52. 00
53.00	Specific purpose fund	, ,	0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted		1	0		55. 00
56. 00	Governing body created - endowment fund balance		1	0		56. 00
57. 00	Plant fund balance - invested in plant		1		0	1
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
E0 00	replacement, and expansion	10 550 257			_	50.00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	12, 553, 357 18, 239, 253		0	0	59. 00 60. 00
00.00	[59]	10, 237, 233				00.00
	, ·	•	•	'	•	•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-2020

Peri od: Worksheet G-1 From 07/01/2017 To 06/30/2018 Date/Time Prepared:

					10 00/30/2010	11/26/2018 10	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		12, 246, 284	1			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-821, 424	1			2. 00
3.00	Total (sum of line 1 and line 2)		11, 424, 860				3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00	T + 1 - 11111 (C + 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	0			0	0	
10.00	Total additions (sum of line 4-9)		0 404 060	1			10.00
11.00	Subtotal (line 3 plus line 10)	1 120 750	11, 424, 860	1		7	11.00
12.00	TRANSFER OF INVESTMENTS TO HO	-1, 128, 758			0	0	12.00
13.00	MI SC	261			0	0	13.00
14. 00 15. 00		0			0	0 0	14. 00 15. 00
16. 00		0			0	0	16.00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)	١	-1, 128, 497	,	9		18.00
19. 00	Fund balance at end of period per balance		12, 553, 357				19.00
17.00	sheet (line 11 minus line 18)		12, 555, 557		· ·	1	17.00
		Endowment Fund	PI ant	Fund		•	
		6.00	7. 00	8.00			
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4. 00	Additions (credit adjustments) (specify)		0	1			4. 00
5. 00			0	,			5. 00
6.00			0)			6.00
7.00			0	1			7. 00
8.00			0	1			8. 00
9.00			0)			9. 00
10.00	Total additions (sum of line 4-9)	o			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	TRANSFER OF INVESTMENTS TO HO		0				12. 00
13.00	MI SC		0	1			13. 00
14.00			0	1			14. 00
15. 00			0	1			15. 00
16. 00			0	1			16. 00
17. 00			0	1			17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	0		1	0		19. 00
	sheet (line 11 minus line 18)	1		I	I		l

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 Systems
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 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 15-2020

		T	o 06/30/2018	Date/Time Pre 11/26/2018 10	
	Cost Center Description	Inpatient	Outpati ent	Total	- 00 am
		1.00	2. 00	3.00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	35, 026, 400		35, 026, 400	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	C		0	5. 00
6.00	Swing bed - NF			0	6. 00
7. 00	SKILLED NURSING FACILITY				7. 00
8.00	NURSI NG FACILITY				8. 00
9.00	OTHER LONG TERM CARE	05.007.400		05 007 100	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	35, 026, 400		35, 026, 400	10. 00
11 00	Intensive Care Type Inpatient Hospital Services	T			11 00
11. 00 12. 00	INTENSIVE CARE UNIT				11. 00 12. 00
12.00	BURN INTENSIVE CARE UNIT				12.00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines		,	0	16. 00
10.00	11-15)			O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	35, 026, 400	,	35, 026, 400	17. 00
18. 00	Ancillary services	61, 743, 050	1	61, 966, 319	18. 00
19. 00	Outpati ent servi ces	0.7.1.0,000	0	0	19. 00
20. 00	RURAL HEALTH CLINIC		o	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		o	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC				24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)	C	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	96, 769, 450	223, 269	96, 992, 719	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES	1	0.4 745 440		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		34, 715, 140		29. 00
30.00	ADD (SPECIFY)	C			30.00
31.00			1		31.00
32. 00 33. 00					32. 00 33. 00
34. 00					34.00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00	DEBUCT (SECTIT)				38. 00
39. 00					39. 00
40. 00					40.00
41. 00)		41. 00
42. 00	Total deductions (sum of lines 37-41)		o		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		34, 715, 140		43. 00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems ST V	NCENT SETON SPECIALITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	TATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-2020 Period:			Worksheet G-3	
			From 07/01/2017	5	
			To 06/30/2018	Date/Time Pre 11/26/2018 10	
				11/20/2010 10	. 30 alli
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	L column 3 line 28)		96, 992, 719	1. 00
2.00	Less contractual allowances and discounts on			63, 388, 730	
3.00	Net patient revenues (line 1 minus line 2)	patrents accounts		33, 603, 989	•
4. 00	Less total operating expenses (from Wkst. G-	2 Part II line 43)		34, 715, 140	ł
5.00	Net income from service to patients (line 3			-1, 111, 151	5. 00
3.00	OTHER I NCOME	illi ilus Ti ile 4)		-1, 111, 131	3.00
6.00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			0	1
8.00	Revenues from telephone and other miscellane	ous communication services		0	
9. 00					
10.00	Purchase di scounts			0	ı
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking lot receipts			0	12. 00
13. 00	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and que	ete		90, 752	
15. 00	Revenue from rental of living quarters	313		70, 732	ı
	Revenue from sale of medical and surgical su	nnlies to other than nationts		0	
17. 00	Revenue from sale of drugs to other than pat			0	1
18. 00	Revenue from sale of medical records and abs			0	
	Tuition (fees, sale of textbooks, uniforms,			0	
20. 00	Revenue from gifts, flowers, coffee shops, a	•		0	20.00
21. 00	Rental of vending machines	nd carreen		2, 572	
22. 00	Rental of hospital space			2, 3/2	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER MI SCELLANEOUS REVENUE		1	61	24.00
24. 00	OTHER WISCELLANEOUS REVENUE			01	
24. 01	OTHER (SPECIFY)			0	1
	Total athen income (our of lines (24)			02.205	

93, 385

-1, 017, 766 -196, 083 -259 27. 00

-196, 342 28. 00 -821, 424 29. 00

25.00

25.00 Total (Sther income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 BAD DEBT EXPENSE
27.01 NONOPERATING GAINS

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