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	el ect Expen 07/01 corre i nstr provi	ronic ses p /2017 ct, c uctic sion	cally prepare 7 and 6 comple ons, e: of he	filed c ed by S ending te and xcept a alth ca	or manu ST. VIN 06/30/ prepar as note are ser	ally sub CENT WIL 2018 and ed from ed. I fu	mitted LIAMSF toth thebd rther ndtha	l cost PORT HO ne best poks an certif at the	report an SPITAL (of my kn d records y that I	nd th 15- nowle s of am	atement an he Balance 1307) for edge and b the provi familiar w ntified in	Sheet the co belief, der in vith the	and Sta st repo this re accorda laws a	atement orting eport a ance wi and reg	t of Rev period and stat th appl gulatior	venue begi temer licat ns re	e and nning nt are t ole egarding	rue,	
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			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	-240, 112	-337, 872	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-146, 606	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		128, 029		0	10.00
10.01	RURAL HEALTH CLINIC II	0		128, 507		0	10.01
200.00	Total	0	-386, 718	-81, 336	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.

		IDENTIFICATION DATA	Provio	ler CCN: 1	15-1307	Period: From 07/01 To 06/30	/2017 /2018	Part I Date/T	ieet S-2 ime Pre 2018 3:	epare
	1.00	2.00		3.00			4.00	/		
00	Hospital and Hospital Health Care Co	PO Box:								1
00 00	Street: 412 NORTH MONROE City: WILLIAMSPORT	State: IN	Zin Cod	e: 47993	Coun	ty: WARREN				1.
00	orey. Wreer work over	Component Name	CCN	CBSA	Provi der		Payme	ent Sys	tem (P,	2.
			Number	Number	Туре	Certified		, 0, or		
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		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospital and Hospital-Based Componer Hospital	ST. VINCENT	151307	99915	1	07/01/1966	5 N	0	0	3.
00	nospi tai	WILLIAMSPORT HOSPITAL	151507	99910	'	0770171900				J.
00	Subprovider - IPF									4.
00	Subprovider - IRF									5.
00	Subprovider - (Other)									6.
00	Swing Beds - SNF	ST. VINCENT	15Z307	99915		02/01/1988	3 N	0	N	7.
		WILLIAMSPORT SWING BEDS								
00	Swing Beds - NF									8.
00 . 00	Hospital-Based SNF Hospital-Based NF									9.
. 00	Hospital - Based OLTC									111.
00	Hospital -Based HHA									12
00										13
00	Hospi tal -Based Hospi ce									14
00	Hospital-Based Health Clinic - RHC	NORTH CLINIC	153993	99915		05/06/200	I N	0	N	15
01	Hospital-Based Health Clinic - RHC	SOUTH CLINIC	153994	99915		08/01/2001	I N	0	N	15
	11									
00	Hospital-Based Health Clinic - FQHC									16
00	Hospital-Based (CMHC) I									17
00	Renal Dialysis Other									18
00	other					From		T	0:	17
						1.00			00	1
00	Cost Reporting Period (mm/dd/yyyy)					07/01/2	2017	06/30)/2018	20
00	Type of Control (see instructions)					6				21
	Inpatient PPS Information									
00	Does this facility qualify and is it								N	22
	share hospital adjustment, in accord									
	for yes or "N" for no. Is this facil				(0) (D: -1.1					
	amondmont hosnital?) In column 2 on			12.106(c)	(2) (Pi ckl					
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JSPI	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		То	07/0 06/3	1/2017 0/2018	Par Dat 11/2	t e/Tim 26/20	18 3:	pared 30 pm
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out- Sta Medic eligi unpa	te aid ble id	Medic HMO d	ays	0th Medi da	cai d ys	
- 00	Le this annulate is an LDC anten the in state	1.00	2.00	3.00	4.0		5.0		6.	00	25.0
5. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0		0		0			25.
					Ur	ban/R 1. 0	ural S	Date	2.00		-
5.00	Enter your standard geographic classification (not wa	ide) status	at the beg	uinnina of t	he	1.0	2	>	2.00		26. (
7.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	rural. uge) status "2" for ru cation in u	at the end ural. If ap column 2.	l of the cos plicable,	st		2				27. 35.
	effect in the cost reporting period.										
					E	Beginn 1. (E	ndi ng 2. 00		
5.00	Enter applicable beginning and ending dates of SCH st	atus. Subs	cript line	36 for numb	ber	1.0			2.00		36.
	of periods in excess of one and enter subsequent date										07
7.00 7.01	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th	e MDH tran	sitional pa	yment in	IS	N	(37. 37.
	accordance with FY 2016 OPPS final rule? Enter "Y" fo	or yes or "	N" for no.	(see							
. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of										38.
	enter subsequent dates.					Y/	N		Y/N		
						1.0	00		2.00		1
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (ii)? eage requi	Enter in co rements in	lumn 1 "Y" accordance		N			N		39.
). 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. Ente	r "Y" for y			N			N	<u></u>	40.
							V 1.0			XI X 3. 00	+
	Prospective Payment System (PPS)-Capital										
. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce					lance	N		N N	N N	45. 46.
. 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c	. L, Pt. I	II and Wkst	. L-1, Pt.	I thro	0	N		N	N	47.
. 00	Is the facility electing full federal capital payment Teaching Hospitals	? Enter "	Y" for yes	or "N" for	no.		N		N	N	48.
. 00 . 00	Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p					5	N				56. 57.
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N h of this ", complete	" for no in cost report e Worksheet	i column 1. ing period?	lf col P Ente	umn 1 er "Y"					
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	oursement f	or physicia	ins' service	es as		N				58.
00	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I. NAHE 413.8 Y/N	85 W	orksh Li ne	eet A		s-Thr i fi ca		59.
				1711		Line					
. 00 . 00								Crit	eri on	Code	
				1.00		2. (00	Crit	eri on 3.00		

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA			CN: 15-1307	Period: From 07/01/2017 To 06/30/2018	11/26/2018 3:	pared
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see				0.00	. 0. 00	61.0
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. (
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. C
1. 04	-						61.0
1. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61.
						1.00	
	ACA Provisions Affecting the Health Resources and Ser				nied fen whiel	0.00	
2.00 2.01	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s	ng Health Cen see instructio	ter (THC) int			62.0 62.0
3. 00		ettings	during this c	<u>67. (see inst</u>	ructions)	N	63. (
				Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settinas	1.00 This base yea	2.00 Iris your cost r	3.00 Teporting	
4. 00	period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair aprimar all nor l non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.			64. (

	EX IDENTIFICATION D	AIA Provider		eriod: com 07/01/2017	Worksheet S-2 Part I	<u></u>
			Tc		Date/Time Pre	
	Program Name	Program Code	Unweighted	Unweighted	11/26/2018 3: Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
-	1.00	2.00	Si te 3. 00	4.00	5.00	-
00 Enter in column 1, if line 63	1.00	2.00	0.00	0.00) 65.
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Settin				
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column	ry care resident 3 the ratio of	Unwei ghted	Unweighted	Ratio (col. 3/	
			FTÈs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
)0 Enter in column 1, the program	1.00	2.00	Nonprovi der Si te 3.00	Hospital 4.00	4))	_
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	Nonprovi der Si te	Hospi tal	4))	_
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	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00 0.00	4)) 5.00 0.000000	_
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)	25		Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.00</u>	4)) 5.00 0.000000	0 67.
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)	≥S rchiatric Facility (Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.00</u>	4)) 5.00 0.000000	0 67.
<pre>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)</pre>	2S /chiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac ≳ 412.424 (d)(1)(iii :ate which program y	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	Hospi tal 4.00 0.00 1.00 rovi der? N he most o. (see i ng o.	4)) 5.00 0.000000	- -
<pre>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)</pre>	2S cchiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y y PPS nabilitation Facilit	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for rear began during thi	Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	Hospi tal 4.00 0.00 1.00 rovi der? N he most o. (see i ng o.	4)) 5.00 0.000000 0.0000000 0.00000000000	_

	Financial Systems ST. VINCENT WILLIAMS AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN:	15-1307	Period: From 07/01/2017 To 06/30/2018	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 11/26/2018 3:	2 epared:
					1.00	-
	Long Term Care Hospital PPS					
80. 00 81. 00	Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			g period? Enter	N N	80.00 81.00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) T Did this facility establish a new Other subprovider (excluded		5		N	85. 00 86. 00
37.00	<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>	classified und	ler sectior		N	87.00
				V 1.00	XI X 2.00	_
	Title V and XIX Services			1.00	2.00	
0. 00	Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	services? Ente	er "Y" for	N	Y	90.00
1.00	Is this hospital reimbursed for title V and/or XIX through the		either in	N	N	91.00
2 00	full or in part? Enter "Y" for yes or "N" for no in the applic Are title XIX NF patients occupying title XVIII SNF beds (dual		1)? (see		Y	92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable	e column.				
3.00	Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.	title V and X	(IX? Enter	N	N	93.00
4.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, an applicable column.	d "N" for no i	n the	N	N	94.00
	If line 94 is "Y", enter the reduction percentage in the appli-			0.00	0.00	95.00
5. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes o applicable column.	r "N" for no i	n the	N	N	96.00
	If line 96 is "Y", enter the reduction percentage in the appli-			0.00	0.00	97.00
3. 00	Does title V or XIX follow Medicare (title XVIII) for the inte stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for			N	Y	98.00
	column 1 for title V, and in column 2 for title XIX.					
3. 01	Does title V or XIX follow Medicare (title XVIII) for the repo C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for titl				Y	98.0
2 02	title XIX.	ulation of ob	orvotion	N	Y	98. 02
). UZ	Does title V or XIX follow Medicare (title XVIII) for the calc bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			IN IN	T	90.02
3 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critic	al access host	nital (CAH)	N	N	98. 03
5. 05	reimbursed 101% of inpatient services cost? Enter "Y" for yes					/0.00
8. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH re	imbursed 101%	of	N	N	98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in c					
3. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back	the RCE disal	I owance or	N	Y	98. 05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col column 2 for title XIX.	umn 1 for titl	e V, and i	n		
8. 06	Does title V or XIX follow Medicare (title XVIII) when cost re	imbursed for \	Vkst. D,	N	Y	98.00
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.	for title V,	and in			
	Rural Providers					
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-in	clusive methor	of navmer	t N		105.00
	for outpatient services? (see instructions)		1 9			
07.00	If this facility qualifies as a CAH, is it eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1			N		107.00
	yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2			t		
08.00	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the CR	NA fee schedul	e? See 42	N		108.00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal ()coupati apo	L Speech	Docpi ratory	
		1.00)ccupationa 2.00	I Speech 3.00	Respiratory 4.00	
J9. OC	If this hospital qualifies as a CAH or a cost provider, are	Y	Ν	N	N	109.00
	therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
					1.00	_
10.00	Did this hospital participate in the Rural Community Hospital	Demonstration	project (8	410A	1.00 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 applicable.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	F	veriod: rom 07/01/201 o 06/30/2018		-2 repared:
		1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	N	2.00	111.00
		1. (00 2.00 3.0	0
 Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no i is yes, enter the method used (A, B, or E only) in column 2. If column 2 3 either "93" percent for short term hospital or "98" percent for long ter psychiatric, rehabilitation and long term hospitals providers) based on t Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" 	is "E", enter i erm care (includ the definition i N" for no.	in column des in CMS		115. 00
117.00 Is this facility legally-required to carry malpractice insurance? Enter " no.	3			117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 claim-made. Enter 2 if the policy is occurrence.	if the policy i	is 1		118.00
	Premi ums	Losses	Insurance	
	1.00			_
118.01 List amounts of malpractice premiums and paid losses:	1. 00 161, 564	2.00 4	3.00	0 118. 01
		1.00	2.00	_
118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing c and amounts contained therein.		N		118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for t Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no.	(" for yes or the Outpatient	N	Ν	119.00 120.00
121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.	es charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		Y	5.00	122.00
<u>Transplant Center Information</u> 125.00Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certi in column 1 and termination date, if applicable, in column 2.	fication date			126.00
127.00 If this is a Medicare certified heart transplant center, enter the certified heart transplant center, enter the certified heart transplant center.	fication date			127.00
128.00 If this is a Medicare certified liver transplant center, enter the certified liver transplant center. enter the certified liver transplant center.	fication date			128. 00
129.00 If this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2.	cation date in			129.00
130.00 If this is a Medicare certified pancreas transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2.	rti fi cati on			130. 00
131.00 If this is a Medicare certified intestinal transplant center, enter the c	certi fi cati on			131.00
date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certified is column 1 and termination date in column 2.	fication date			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 the certified other in column 1 and termination date if caplicable in column 2.	fication date			133.00
 in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2. 	in column 1			134.00
All Providers 140.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home		Y	15H046	140.00

	EX IDENTIFICATION DA	ATA	Provider CC	N: 15-1307	Peri od	:	Worksheet S-	2
						7/01/2017 6/30/2018		
1.00		2.00				3.00	11/26/2018 3	<u>30 pin</u>
If this facility is part of a cha home office and enter the home of		ter on li			name and		of the	
41.00 Name: ST. VINCENT HEALTH	Contractor's N				ctor's Nu	mber: 0810)1	141. (
42.00 Street: 250 W. 96TH ST. SUITE 215	PO Box:							142.
43.00 City: INDIANAPOLIS	State:	IN		Zip Coc	de:	4629	0	143.
							1.00	-
44.00 Are provider based physicians' co	sts included in Work	ksheet A?					Y	144.
45.00 f costs for renal services are c		1				1.00	2.00	145.
 45. 0011 Costs for renar services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 46. 00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i 	" for yes or "N" for clude Medicare utili for no in column 2. gy changed from the	r no in c ization f previous	olumn 1. lf c or this cost ly filed cost	column 1 is reporting : report?	lf	N		146.
yes, enter the approval date (mm/	dd/yyyy) in column 2	2.						_
							1.00	-
47.00 Was there a change in the statist	ical basis? Enter "\	Y" for ye	s or "N" for	no.			N N	147.
48.00 Was there a change in the order o	f allocation? Enter	"Y" for	yes or "N" fo	or no.			N	148.
49.00 Was there a change to the simplif	ied cost finding met	thod? Ent				: +1 o 1/	N Title VIV	149.
			Part A 1.00	Part B 2.00		<u>itle V</u> 3.00	Title XIX 4.00	-
Does this facility contain a prov	ider that qualifies	for an e			cation o			
or charges? Enter "Y" for yes or			it for Part A	and Part B		2 CFR §413	. 13)	
55.00 Hospi tal			N	N		N	N	155.
56.00 Subprovi der – IPF 57.00 Subprovi der – IRF			N N	N N		N N	N N	156. 157.
58. 00 SUBPROVI DER			i N			IN I	IN IN	158.
59.00 SNF			Ν	N		Ν	N	159.
60. 00 HOME HEALTH AGENCY			Ν	Ν		Ν	N	160. (
61. 00 CMHC				N		N	N	161. (
							1.00	-
Multicampus								
					- · · ·			415
65.00 Is this hospital part of a Multic	ampus hospital that	has one	or more campu	ises in diff	ferent CE	3SAs?	N	165. (
	ampus hospital that Name	has one	or more campu County		ferent CE Zip Code	SAs?	N FTE/Campus	165. (
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.		has one	•				FTE/Campus 5.00	
65.00 Is this hospital part of a Multic	Name	has one	County	State Z	Zip Code	CBSA	FTE/Campus 5.00	165. (00 166. (
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in 	Name	has one	County	State Z	Zip Code	CBSA	FTE/Campus 5.00	
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 	Name 0 T) incentive in the	American	County 1.00 Recovery and	State 2 2.00	Zip Code 3.00	CBSA	FTE/Campus 5.00 0.0	00 166.
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1) 	Name 0 1 0 1 <	American Enter "Y" meaningf	County 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	State 2 2.00 d Reinvestm N" for no.	Zip Code 3.00 ent Act	CBSA 4.00	FTE/Campus 5.00 0.0	167.
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is 	Name 0 T) incentive in the r under §1886(n)? E 05 is "Y") and is a HIT assets (see inst not a meaningful use	American Enter "Y" meaningf tructions er, does	County 1.00	State 2 2.00 d Reinvestm N" for no. e 167 is "Y"	Zip Code 3.00 ent Act '), enter or a harc	CBSA 4.00	FTE/Campus 5.00 0.0	00 166. 167. 0168.
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1) reasonable cost incurred for the exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful 	Name 0 T) incentive in the r under §1886(n)? E 05 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is ")	American Enter "Y" meaningf tructions er, does or "N" fr	County 1.00	State 2 2.00 2.00 d Reinvestm N" for no. 167 is "Y" - qualify for nstructions	<u>Zip Code</u> 3.00 ent Act '), enter or a harcos)	CBSA 4.00	FTE/Campus 5.00 0.0 0.0	00 166. 167. 0 168. 168.
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1) reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 	Name 0 T) incentive in the r under §1886(n)? E 05 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is ")	American Enter "Y" meaningf tructions er, does or "N" fr	County 1.00	State 2 2.00 2.00 d Reinvestm N" for no. 167 is "Y" - qualify for nstructions	<u>Zip Code</u> 3.00 ent Act '), enter or a harco s) s "N"), e	CBSA 4.00	FTE/Campus 5.00 0.0 0.0 1.00 N Y 0.0	
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful transition factor. (see instruction) 	Name 0 T) incentive in the r under §1886(n)? E 05 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is ") ons)	American Enter "Y" meaningf tructions er, does or "N" fi Y") and i	County 1.00	State 2 2.00 A Reinvestm N" for no. 167 is "Y" qualify fo nstructions (line 105 is	<u>Zip Code</u> 3.00 ent Act '), enter or a harco s) s "N"), e	CBSA 4.00	FTE/Campus 5.00 0.0 0.0 1.00 N Y 0.0	100 166. 167. 0 168. 168. 168. 00 169.
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful transition factor. (see instruction) 	Name 0 T) incentive in the r under §1886(n)? E 05 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is ") ons)	American Enter "Y" meaningf tructions er, does or "N" fi Y") and i	County 1.00	State 2 2.00 A Reinvestm N" for no. 167 is "Y" qualify fo nstructions (line 105 is	<u>Zip Code</u> 3.00 ent Act '), enter or a harco s) s "N"), e	CBSA 4.00	FTE/Campus 5.00 0.0 0.0 1.00 N Y 0.0	100 166. 167. 0 168. 168. 168. 00 169.
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) '69.00 If this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR 	Name 0 T) incentive in the r under §1886(n)? E 05 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is ") ons)	American Enter "Y" meaningf tructions er, does or "N" fi Y") and i	County 1.00	State 2 2.00 A Reinvestm N" for no. 167 is "Y" qualify fo nstructions (line 105 is	<u>Zip Code</u> 3.00 ent Act '), enter or a harco s) s "N"), e	CBSA 4.00	FTE/Campus 5.00 0.0 0.0 1.00 N Y 0.0	00 166. 167. 0 168. 168.

OSPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1307	Period: From 07/01/2017	Worksheet S-: Part II	
				To 06/30/2018	Date/Time Pro 11/26/2018 3	
				Y/N	Date	<u> </u>
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
00	Provider Organization and Operation	haring of	* +	N		
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.
			Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	Program? If nn 3, "V" for	N			2.
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.
		-	Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	°or Compiled,	N			4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If ves. is th	ne provider is	s N		6.
	the legal operator of the program?	5				
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	0	al education	Ν		9.
0. 00	Was an approved Intern and Resident GME program initiated o		he current	Ν		10.
. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.
					Y/N	
					1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes		1.000		Y	1 1 2
. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	oolicy change c	luring this co		Y N	12. 13.
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	[*] yes, see ins	structions.	N	14
. 00	Did total beds available change from the prior cost reporti		yes, see inst t A		N t B	15
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	10/10/2018	Y	10/10/2018	16
. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	N		N		17
	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)					
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19

Health Financial Systems

In Lieu of Form CMS-2552-10

Health Financial Systems ST. VINCENT WILL	I AMSPORT HOSPIT	AL	In Lie	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (CCN: 15-1307	Period: From 07/01/2017 To 06/30/2018	Date/Time P	repared:
	Dosor	ipti on	Y/N	11/26/2018 Y/N	<u>3:30 pm</u>
		0	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		0	N	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		Ν		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS I	HOSPI TALS)		1.00	
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes, se	ee instructions			N	22.00
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	sals made dur	ing the cost	Ν	23.00
24.00 Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	porting period?	Ν	24.00
25.00 Have there been new capitalized leases entered into during instructions.	g the cost repo	rting period?	lf yes, see	Ν	25.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during instructions.	the cost report	ing period? I	f yes, see	Ν	26.00
27.00 Has the provider's capitalization policy changed during the	he cost reporti	ng period? If	yes, submit	Ν	27.00
copy. Interest Expense					
28.00 Were new loans, mortgage agreements or letters of credit of period? If yes, see instructions.	entered into du	ring the cost	reporting	N	28.00
29.00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see ins		ebt Service R	eserve Fund)	Ν	29.00
30.00 Has existing debt been replaced prior to its scheduled main instructions.	turity with new	debt? If yes	, see	Ν	30.00
31.00 Has debt been recalled before scheduled maturity without i instructions.	issuance of new	debt? If yes	, see	Ν	31.00
Purchased Services					
32.00 Have changes or new agreements occurred in patient care so arrangements with suppliers of services? If yes, see inst		ed through co	ntractual	Ν	32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 aproved no, see instructions.	pplied pertaini	ng to competi	tive bidding? If	Ν	33.00
Provi der-Based Physi ci ans					
34.00 Are services furnished at the provider facility under an a	arrangement witl	h provider-ba	sed physi ci ans?	Y	34.00
If yes, see instructions.35.00If line 34 is yes, were there new agreements or amended ex	xisting agreeme	nts with the	provi der-based	N	35.00
physicians during the cost reporting period? If yes, see	instructions.		× / /• 1	5.1	
			Y/N	Date	
Home Office Costs			1.00	2.00	
36.00 Were home office costs claimed on the cost report?			Y		36.00
37.00 If line 36 is yes, has a home office cost statement been If yes, see instructions.	prepared by the	home office?			37.00
38.00 If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end			Ν		38.00
39.00 If line 36 is yes, did the provider render services to oth			, N		39.00
40.00 If line 36 is yes, did the provider render services to the instructions.	e home office?	lf yes, see	Ν		40.00
		00		00	
Cost Depart Dropanon Contact Laformation	1	. 00	2.	00	
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JILL		HILL		41.00
respectively. 42.00 Enter the employer/company name of the cost report	ST. VINCENT H	EALTH			42.00
preparer. 43.00 Enter the telephone number and email address of the cost	3175833519		JI LL. HI LL1@ASC	ENSLON ORG	43.00
report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems	AMSPORT HOSPITAL	u of Form CMS-2	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN: 1		Period: From 07/01/2017	Worksheet S-2 Part II	
				Т	o 06/30/2018	Date/Time Pre 11/26/2018 3:	
			3.00				
l.	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the t	itle/position	REIMBURSEMENT MANA	GER			41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the co	ost report					42.00
	preparer.						
43.00	Enter the telephone number and email addr	ress of the cost					43.00
	report preparer in columns 1 and 2, respe	ecti vel y.					

^{11/26/2018 3:30} pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

-		VINCENT WILLIA				u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part I Date/Time Prep 11/26/2018 3:3	
	Component	Worksheet A	No. of Beds	Bed Days		I/P Days / O/P Visits / Trips Title V	
	component	Line Number	No. of beds	Avai I abl e	on the field of the	in the v	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00	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) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	30. 00	16	5, 84	40 37, 224. 00	0	1.00 2.00 3.00 4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	-	16	5, 84	40 37, 224. 00	0 0	6. 00 7. 00
8.00 9.00 10.00 11.00 12.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						8.00 9.00 10.00 11.00 12.00
$\begin{array}{c} 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ \end{array}$	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	43. 00	16	5, 84	40 37, 224. 00	0 0 0	13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00 26. 01 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC RURAL HEALTH CLINIC II FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	30.00 88.00 88.01 89.00	16 0		0	0 0 0	24. 10 25. 00 26. 00 26. 01 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

11/26/2018 3:30 pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

HOSPI 1	<u>Financial Systems</u> ST. TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	VINCENT WILLIAN AL DATA	Provider C			ri od:	u of Form CMS-2 Worksheet S-3	
					Fro To	om 07/01/2017 06/30/2018	Part I Date/Time Pre 11/26/2018 3:	
		I/P Days	/ O/P Visits	/ Trips	Full Time		qui val ents	
	Component	Title XVIII	Title XIX	Total All Patients	٦	Total Interns & Residents	Employees On Payroll	
	1	6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 156	8	1, 5	51			1.00
2.00	HMO and other (see instructions)	236	65					2.00
3.00 4.00	HMO IPF Subprovider HMO IRF Subprovider	0	0					3.00
5.00	Hospital Adults & Peds. Swing Bed SNF	615	0	6	87			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	010	0		2			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 771	8	2, 2	40			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)		0					12.00
13.00		1 771	0		0	0.00	70 40	13.00
14.00 15.00	Total (see instructions)	1,771	8	2, 2		0.00	79.43	
16.00	CAH visits SUBPROVIDER - IPF	25, 221	1, 048	66, 29	90			15.00
17.00	SUBPROVIDER - IRF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPICE							24.00
24. 10	HOSPICE (non-distinct part)	0	0		0			24.10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC	2, 990	205	15, 5		0.00	19.19	
26.01	RURAL HEALTH CLINIC II	5, 616	162	16, 04		0.00	16.96	
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	
27.00 28.00	Total (sum of lines 14-26)		0	7.	17	0.00	115.58	27.00
29.00	Observation Bed Days Ambulance Trips	469	0	/	17			28.00
30.00	Employee discount days (see instruction)	407			0			30.00
31.00	Employee discount days - IRF				0			31.00
32.00	Labor & delivery days (see instructions)	0	0		0			32.00
32.01	Total ancillary labor & delivery room	J. J	0		0			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

	Financial Systems ST. TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part I Date/Time Pre 11/26/2018 3:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	1	11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ \hline \\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ \hline \\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 01\\ 26.\ 25\\ 27.\ 00\\ 26.\ 01\\ 26.\ 02\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ \hline \end{array}$	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) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC II FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0.00 0.00 0.00 0.00 0.00 0.00	0	3	54 3 54 3 54 3	477	1.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 24.00 25.00 26.01 26.01 26.01 26.01 26.01 26.00 26.01 26.00 27.00 28.00 29.00 30.00 31.00
32. 00 32. 01 33. 00	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		31.00 32.00 32.01 33.00 33.00

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1307	Peri od:	Worksheet S-8	
			Component	CCN: 15-3993	From 07/01/2017 To 06/30/2018	Date/Time Pre	pared [.]
						11/26/2018 3:	
					RHC I	Cost	
					1	00	
	Clinic Address and Identification					00	
1.00	Street				1731 RINGER LA	NE	1.00
				ty	State	ZIP Code	
2.00	City, State, ZIP Code, County		1. WI LLI AMSPORT	00	2.00	3.00 47993	2.00
2.00	crty, State, Zir code, county		WILLIAWSFORT			47993	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for u			0	3.00
					<u>nt Award</u> 1.00	Date	
	Source of Federal Funds				1.00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ac	t)				ĺ	5.00
6.00	Health Services for the Homeless (Section 340	(d), PHS Act)					6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
9.01							9.01
9.02							9.02
9.03							9.03
9.04							9.04
9.05 9.06							9.05 9.06
9.00 9.07							9.00
9.08						ĺ	9.08
9.09							9.09
9.10							9.10
					1.00	2.00	
10.00	Does this facility operate as other than a ho	spital-based R	HC or FQHC? En	ter "Y" for	N	0	10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of						
	hours.)	other operati	on(s) and the	operating			
		Sun	day	M	londay	Tuesday	
		from	to	from	to	from	
	Eacility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11, 00	Facility hours of operations (1) CLINIC			07:00	19:00	07:00	11.00
10.55					1.00	2.00	10.55
	Have you received an approval for an exception		5		N		12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu				N	0	13.00
	number of providers included in this report.						
	numbers below.		•				
					der name	CCN number	
14 00	RHC/FQHC name, CCN number				1.00	2.00	14.00
14.00		Y/N	V	XVIII	XI X	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and					1	
	4 the number of program visits performed by					1	
	Intern & Residents for titles V, XVIII, and					1	
	XIX, as applicable. Enter in column 5 the					1	
	number of total visits for this provider.					1	
	(see instructions)	I		I	l	l	I

Health Financial Systems ST.	VINCENT WILLI	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1307	Peri od:	Worksheet S-8	3
		Component	CCN: 15-3993	From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 3:	epared: 30 pm
		_		RHC I	Cost	
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County		WARREN				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)			_			
11.00 CLINIC	19: 00	07:00	19:00	07:00	19:00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07:00	19:00				11.00

^{11/26/2018 3:30} pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Peri od:	Worksheet S-8	
			Component	CCN: 15-3994	From 07/01/2017 To 06/30/2018	Date/Time Pre	nared
			component	CON. 13 3774	10 00/ 30/ 2010	11/26/2018 3:	
				-	RHC II	Cost	
					1	00	-
	Clinic Address and Identification				I.	00	
1.00	Street				440 W. SONGER	LANE	1.00
	· · · · ·		Ci	ty	State	ZIP Code	
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		VEEDERSBURG		I N	47987	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u	ırban		0	3.00
	· · · · · · · · · · · · · · · · · · ·				nt Award	Date	
					1.00	2.00	
4 00	Source of Federal Funds	Act		1		1	1 4 00
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac						4.00 5.00
6.00	Health Services for the Homeless (Section 340						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
9. 01 9. 02							9. 01 9. 02
9.02 9.03							9.02
9.04							9.04
9.05							9.05
9.06							9.06
9.07							9.07
9.08							9.08
9.09 9.10							9. 09 9. 10
7.10	<u> </u>						7.10
					1.00	2.00	
10. 00	Does this facility operate as other than a hory yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of	ite number of o	other operation	ns in column	N	0	10.00
	hours.)	C C					
	-	Sun from	iday to	from N	londay to	Tuesday from	
		1,00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)		1			1	
11.00	CLINIC			07: 00	17: 50	07:00	11.00
					1.00	0.00	
12.00	Have you received an approval for an exception	n to the produ	ictivity standa	urd2	1.00 N	2.00	12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report. numbers below.	lin CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section n 2 the	N	0	•
				Provi	ider name	CCN number	
					1.00	2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N 1.00	V	XVIII	XI X	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
13.00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						
			I	1	ļ	I	1

Health Financial Systems ST.	VINCENT WILLI	AMSPORT HOSPIT	4L	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FOHC STATISTICAL DATA		Provider C	CN: 15-1307	Period:	Worksheet S-8	3
		Component	CCN: 15-3994	From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 3:	epared: 30 pm
				RHC II	Cost	
		Cou	unty			
		4.	00			
2.00 City, State, ZIP Code, County	FOUNTAI N					2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)		·				
11.00 CLINIC	17: 50	07:00	17: 50	07:00	17: 50	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07:00	17: 50				11.00

^{11/26/2018 3:30} pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

Heal th Fi	nanci al	System	IS			
HOSPI TAL	LINCOMPE	NSATED		I NDI GENT	CARE	DATA

ST. VINCENT WILLIAMSPORT HOSPITAL Provider CCN: 15-1307 Period:

In Lieu of Form CMS-2552-10 Worksheet S-10

1105111	AE ONCOMPENSATED AND THUT CENT CARE DATA		N. 13-1307	From 07/01/2017	worksheet 5-1	0
				To 06/30/2018	Date/Time Pre	pared:
				10 00/00/2010	11/26/2018 3:	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by li	ne 202 columr	18)	0.265348	1.00
	Medicaid (see instructions for each line)					1
2.00	Net revenue from Medicaid				-1, 124, 453	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	tal payment	s from Medica	ni d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr		0	5.00		
6.00	Medi cai d charges	om mear ear	a		13, 996, 744	
7.00	Medicaid cost (line 1 times line 6)				3, 714, 008	7.00
8.00	Difference between net revenue and costs for Medicaid program ((lino 7 min	us sum of liv	oc 2 and 5: if	4, 838, 461	8.00
0.00	<pre>c zero then enter zero)</pre>		us sum of ffi	ies z anu o, Ti	4, 030, 401	0.00
	Children's Health Insurance Program (CHIP) (see instructions for	r oach lin	2)			
9.00	Net revenue from stand-al one CHIP		=)		0	9.00
					0	
10.00	Stand-al one CHIP charges				-	
11.00	Stand-alone CHIP cost (line 1 times line 10)			с н	0	
12.00	Difference between net revenue and costs for stand-alone CHIP ((line 11 mi	nus line 9; i	t < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see inst					1
13.00	Net revenue from state or local indigent care program (Not incl				0	
14.00	Charges for patients covered under state or local indigent care	e program (l	Not included	in lines 6 or	0	14.00
	10)					1
15.00	State or local indigent care program cost (line 1 times line 14				0	
16.00	Difference between net revenue and costs for state or local inc	digent care	program (III	ne 15 minus line	0	16.00
	13; if < zero then enter zero)	<u> </u>	// / / /			
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indig	jent care program	ns (see	
	instructions for each line)					1
17.00	Private grants, donations, or endowment income restricted to fu				0	
18.00	Government grants, appropriations or transfers for support of h			· • • • •	0	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local	indigent of	care programs	s (sum of lines	4, 838, 461	19.00
	8, 12 and 16)				T + + (+ 4	
			Uni nsured	Insured	Total (col. 1	
			patients 1.00	patients 2.00	+ col. 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fac	sility	3, 887, 14	18 916, 981	4, 804, 129	20.00
20.00	(see instructions)	JIIILY	3,007,14	710, 701	4,004,129	20.00
21.00	Cost of patients approved for charity care and uninsured discou	ints (soo	1, 031, 4	916, 981	1, 948, 428	21.00
21.00	instructions)		1,001,4	, , , , , , , , , , , , , , , , , , , ,	1, 740, 420	21.00
22.00	Payments received from patients for amounts previously written	off as	67, 30	51 0	67, 361	22.00
22.00	charity care	orr do	0770		0,,001	22.00
23.00	Cost of charity care (line 21 minus line 22)		964, 0	916, 981	1, 881, 067	23.00
				,	.,	
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patier	nt days bey	ond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care	program?		-		
25.00	If line 24 is yes, enter the charges for patient days beyond the	ne indigent	care program	's length of	0	25.00
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see ins	structions)			929, 850	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex		336, 857	27.00		
27.01	Medicare allowable bad debts for the entire hospital complex (s		518, 241	27.01		
28.00	Non-Medicare bad debt expense (see instructions)				411, 609	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	instructions`		290, 604	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	N	,		2, 171, 671	
31.00		ne 30)			7, 010, 132	
		/			, , , , , , , , , , , , , , , , , , , ,	

LOLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	- EXPENSES	Provider C	F	Period: From 07/01/2017 Fo 06/30/2018	Worksheet A Date/Time Pre	pared
					00/00/2010	11/26/2018 3:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS		10/ 200	10(22)	1 750	104 470	1 1 0
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT		186, 228			184, 478	
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		560, 536			560, 536	
3.00	00300 OTHER CAPITAL RELATED COSTS	11 000	0	0 4/1 00	, i i i i i i i i i i i i i i i i i i i	0	
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT	11, 980	2, 450, 013			2, 461, 993	
5.00	00500 ADMI NI STRATI VE & GENERAL	873, 398	4, 314, 160			5, 189, 308	
7.00	00700 OPERATION OF PLANT	0	339, 631	339, 63		339, 631	
3.00	00800 LAUNDRY & LINEN SERVICE	0	0			0	
9.00	00900 HOUSEKEEPING	0	258, 566			258, 566	
0.00	01000 DI ETARY	0	25, 730			25, 730	
3.00	01300 NURSI NG ADMI NI STRATI ON	172, 768	7, 891	180, 659		180, 659	
4.00	01400 CENTRAL SERVICES & SUPPLY	688	7, 967	8, 655		8, 655	
15.00	01500 PHARMACY	166, 882	373, 998			540, 880	
6.00	01600 MEDI CAL RECORDS & LI BRARY	0	577	57	7 0	577	16. (
	INPATIENT ROUTINE SERVICE COST CENTERS			1 000 111		1 001 101	1
0.00	03000 ADULTS & PEDIATRICS	998, 891	239, 224			1, 234, 106	
13.00	04300 NURSERY	0	0	(0 0	0	43.0
	ANCI LLARY SERVI CE COST CENTERS	F00.07/	202 551	014 40		701 547	1 50 0
50.00		520, 876	293, 551	814, 42		791, 547	
53.00	05300 ANESTHESI OLOGY	0	205 425	, · · · · · · · · · · · · · · · · · · ·		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	549, 659	385, 425			935, 084	
0.00	06000 LABORATORY	34, 591	1, 212, 519			1, 247, 110	
5.00	06500 RESPIRATORY THERAPY	21,081	48, 322			69, 403	
6.00	06600 PHYSI CAL THERAPY	214, 064	66, 920			280, 984	
58.00	06800 SPEECH PATHOLOGY	0	0	(, i i i i i i i i i i i i i i i i i i i	0	
1.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	10, 484	10, 484		47, 104	
2.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	36, 613			36, 613	
3.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	792	792	2 0	792	73. (
8. 00	08800 RURAL HEALTH CLINIC	1, 195, 519	372, 083	1, 567, 602	2 -12, 519	1, 555, 083	88. (
38. 00 38. 01	08801 RURAL HEALTH CLINIC II	1, 195, 519	363, 315				
	09100 EMERGENCY						
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	963, 584	1, 322, 114	2, 285, 698	3 -9, 731	2, 275, 967	91.0
2.00	OTHER REIMBURSABLE COST CENTERS						92.0
5.00	09500 AMBULANCE SERVICES	413, 178	46, 275	459, 453	3 0	459, 453	95.0
5.00	SPECIAL PURPOSE COST CENTERS	413, 170	40, 273	437,430		437, 433	75.0
18.00		7, 443, 689	12, 922, 934	20, 366, 623	3 0	20, 366, 623	1118 (
10.00	NONREI MBURSABLE COST CENTERS	7,443,009	12, 722, 734	20, 300, 020		20, 300, 023	1.10.1
93 00	19300 NONPAI D WORKERS	0	0	(0 0	0	193. (
	19301 ORTHO CLINIC	307, 692	21, 750			329, 442	
	19303 COMMUNITY MED CLINIC	307, 042	21,750	327,442			193. (
	17303 CONNONT FE WED CEINIC	U	0		ין ע	0	1173.0
	07950 MARKETI NG		2, 313	2, 313		2, 313	101 1

In Lieu of Form CMS-2552-10 Worksheet A

RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-1307	Peri od:	Worksheet A	
					From 07/01/2017 To 06/30/2018	Date/Time Pre	narod
					10 00/ 30/ 2010	11/26/2018 3:	30 pm
	Cost Center Description	Adjustments	Net Expenses		· · ·		
			or Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-139, 745	44, 733				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	560, 536				2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0				3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-26, 241	2, 435, 752				4.00
5.00	00500 ADMINI STRATI VE & GENERAL	537, 803	5, 727, 111				5.00
7.00	00700 OPERATION OF PLANT	0	339, 631				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0				8.00
9.00	00900 HOUSEKEEPI NG	0	258, 566				9.00
10.00	01000 DI ETARY	-16, 810	8, 920				10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	180, 659				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-25	8, 630				14.00
15.00	01500 PHARMACY	0	540, 880				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	577				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	1, 234, 106				30.00
43.00	04300 NURSERY	0	0				43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	-554, 291	237, 256				50.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-103, 299	831, 785				54.00
60.00	06000 LABORATORY	0	1, 247, 110				60.00
65.00	06500 RESPI RATORY THERAPY	0	69, 403				65.00
66.00	06600 PHYSI CAL THERAPY	-1, 564	279, 420				66.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	47, 104				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	36, 613				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-93	699				73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	-29, 114	1, 525, 969				88.00
88. 01	08801 RURAL HEALTH CLINIC II	-58, 558	1, 623, 806				88.01
91.00	09100 EMERGENCY	-22, 137	2, 253, 830				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	-741	458, 712				95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-414, 815	19, 951, 808				118.00
	NONREI MBURSABLE COST CENTERS						
	19300 NONPALD WORKERS	0	0				193.00
193.01	19301 ORTHO CLINIC	0	329, 442				193. 01
193.02	19303 COMMUNITY MED CLINIC	0	0				193. 02
194.00	07950 MARKETI NG	94,674	96, 987				194.00
200.00	TOTAL (SUM OF LINES 118 through 199)	-320, 141	20, 378, 237				200. 00

Heal th	Financial Systems	ST.	VINCENT WILLI	AMSPORT HOSPIT	AL	In Lie	u of Form CMS-	-2552-10
RECLASS	SI FI CATI ONS			Provider (CCN: 15-1307	Period: From 07/01/2017	Worksheet A-	6
						To 06/30/2018	Date/Time Pro 11/26/2018 3	epared: 30 pm
		Increases						
	Cost Center	Line #	Salary	0ther				
	2.00	3.00	4.00	5.00				
	A - ADMINISTRATIVE & GENERAL							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 750				1.00
	TOTALS		0	1, 750				
	B - RHC RECLASS							
1.00	RURAL HEALTH CLINIC II	88.01	12, 519	0				1.00
	TOTALS		12, 519	0				
	C – Medical Supplies							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00		36, 620				1.00
	PATI ENTS							
2.00								2.00
3.00								3.00
			0	36, 620				
500.00	Grand Total: Increases		12, 519	38, 370				500.00
	Grand Total: Increases		0 0 12, 519					

Heal th	Financial Systems	ST.	VINCENT WILLI	AMSPORT HOSPIT	AL	In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet A- Date/Time Pr 11/26/2018 3	
		Decreases						
	Cost Center	Line #	Salary	0ther	Wkst. A-7 Ref	·		
	6.00	7.00	8.00	9.00	10.00			
	A - ADMINISTRATIVE & GENERAL							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	1, 750		9		1.00
	FIXT							
	TOTALS		0	1, 750				
	B - RHC RECLASS							
1.00	RURAL HEALTH CLINIC	88.00	12, 519	0		0		1.00
	TOTALS		12, 519	o				
	C – Medical Supplies		· · · · · ·			· ·		1
1.00	ADULTS & PEDIATRICS	30.00		4, 009				1.00
2.00	OPERATING ROOM	50.00		22, 880				2.00
3.00	EMERGENCY	91.00		9, 731				3.00
				36, 620				
500.00	Grand Total: Decreases		12, 519	38, 370				500.00

Hear th Fina	anci al systems si.	VINCENT WILLIF	AMSPORT HUSPITA			Lieu of Form CMS-	2552-10
RECONCI LI A	TION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-1307	Period: From 07/01/2 To 06/30/2		epared:
				Acqui si ti on	IS		
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
PART	I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00 Land	b	174, 050	0		0	0 0	1.00
2.00 Land	d Improvements	159, 079	0		0	0 0	2.00
3.00 Bui I	dings and Fixtures	8, 291, 636	128, 890		0 128,	890 C	3.00
4.00 Buil	ding Improvements	0	0		0	0 0	4.00
5.00 Fixe	ed Equipment	1, 649, 197	27, 593		0 27,	593 C	5.00
6.00 Mova	able Equipment	3, 875, 221	0		0	0 47, 224	6.00
7.00 HIT	designated Assets	0	0		0	0 0	7.00
8.00 Subt	total (sum of lines 1-7)	14, 149, 183	156, 483		0 156,	483 47, 224	8.00
9.00 Reco	onciling Items	0	0		0	0 0	9.00
10. 00 Tota	al (line 8 minus line 9)	14, 149, 183	156, 483		0 156,	483 47, 224	10.00
		Endi ng Bal ance	Fully				
		-	Depreciated				
			Assets				
		6.00	7.00				
PART							
1.00 Land	b	174, 050	0				1.00
2.00 Land	d Improvements	159, 079	0				2.00
3.00 Bui I	dings and Fixtures	8, 420, 526	0				3.00
4.00 Buil	ding Improvements	0	0				4.00
5.00 Fixe	ed Equipment	1, 676, 790	0				5.00
6.00 Mova	able Equipment	3, 827, 997	0				6.00
7.00 HIT	designated Assets	0	0				7.00
8.00 Subt	total (sum of lines 1–7)	14, 258, 442	0				8.00
9.00 Reco	onciling Items	0	0				9.00
10. 00 Tota	al (line 8 minus line 9)	14, 258, 442	0				10.00

Heal th	Fi nanci al	Systems	
DECONC			COSTS

ST.	VI NCENT	WI LLI AMSPORT	HOSPI TAL

In Lieu of Form CMS-2552-10

RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	1	Period: From 07/01/2017 To 06/30/2018	Worksheet A-7 Part II Date/Time Prep 11/26/2018 3:3	pared: 30 pm
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	· · ·	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	21, 990	0	141, 49	4 9, 927	12, 817	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	473, 463	86, 469		0 604	0	2.00
3.00	Total (sum of lines 1-2)	495, 453	86, 469	141, 49	4 10, 531	12, 817	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	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	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	186, 228				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	560, 536	1			2.00
3.00	Total (sum of lines 1-2)	0	746, 764				3.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	1L	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	F	Period: From 07/01/2017 To 06/30/2018	Worksheet A-7 Part III Date/Time Prep 11/26/2018 3:3	pared: 30 pm
	COMI	PUTATION OF RAT	10S	ALLOCATION OF		<u>50 piii</u>
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	10, 430, 445	0	10, 430, 445	0. 731528	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	3, 827, 997		3, 827, 997			2.00
3.00 Total (sum of lines 1-2)	14, 258, 442		14, 258, 442			3.00
	ALLOCA	TION OF OTHER C	CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6,00	7.00	8,00	9,00	10,00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	C	20, 240	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	C C	473, 463	86, 469	2.00
3.00 Total (sum of lines 1-2)	0	0	C	493, 703	86, 469	3.00
		SL	IMMARY OF CAPI1	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	1, 749			0	44, 733	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	604			560, 536	2.00
3.00 Total (sum of lines 1-2)	1, 749	10, 531	12, 817	0	605, 269	3.00

Heal th	Fi nanc	i al	Systems
AD JUST	MENTS 1	0 F	XPENSES

ST VINCENT WILLIAMSPORT HOSPITAL

In Lieu of Form CMS-2552-10

Heal th	Financial Systems	ST.	VINCENT WILLI	AMSPORT HOSPITAL	In Li€	eu of Form CMS-2	2552-10
	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 07/01/2017 To 06/30/2018	Date/Time Prep	pared:
				Expense Classification o	Workshoot A	11/26/2018 3:	30 pm
				To/From Which the Amount is			
					2		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1.00 B	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00	1.00
1.00	REL COSTS-BLDG & FIXT (chapter		-137,743	FIXT	1.00		1.00
0.00	2)						0.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE	2.00	0	2.00
	2)						
3.00	Investment income - other	В	-1, 750	ADMI NI STRATI VE & GENERAL	5.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		O		0.00	0	4.00
	discounts (chapter 8)						
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
7 00	suppliers (chapter 8)						7 00
7.00	Telephone services (pay stations excluded) (chapter		U		0.00	0	7.00
	21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provi der-based physi ci an	A-8-2	-322, 440			0	10. 00
11.00	adjustment Sale of scrap, waste, etc.		O		0.00	0	11.00
11.00	(chapter 23)		0		0.00	0	11.00
12.00	Related organization	A-8-1	1, 836, 212	2		0	12.00
13.00	transactions (chapter 10) Laundry and linen service		O		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00		14.00
15.00	Rental of quarters to employee		0		0.00	0	15.00
16.00	and others Sale of medical and surgical		O		0.00	0	16.00
	supplies to other than						
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
	patients		Ū		0.00		
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees,						
20.00	books, etc.) Vending machines		0		0.00	0	20.00
21.00	Income from imposition of		0		0.00		21.00
	interest, finance or penalty						
22.00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to						
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
20.00	therapy costs in excess of		Ū		00.00		20.00
24.00	limitation (chapter 14)	4.0.2	1 5/4	PHYSICAL THERAPY	((00		24.00
24.00	Adjustment for physical therapy costs in excess of	A-8-3	-1, 304	PHISICAL THERAPT	66.00		24.00
	limitation (chapter 14)						
25.00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
	(chapter 21)						
26.00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		O	FIXT NEW CAP REL COSTS-MVBLE	2.00	0	27.00
	COSTS-MVBLE EQUIP			EQUI P			
28.00 29.00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00		28.00 29.00
29.00 30.00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***		1	29.00 30.00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
		· ·		1	1	· ·	

ADJUSTMENTS TO EXPENSES Provider CCN: 15-1307 Period: From 07/01/2017 To 06/30/2018 Worksheet A-8 Date/Time Prepared: 11/26/2018 3: 30 pm Image: Cost Center Description Basi s/Code (2) Amount Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Image: Cost Center Description Image: Cost Center Description
To 06/30/2018 Date/Time Prepared: 11/26/2018 3: 30 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Image: Cost Center Description Basi s/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. Cost Center Description Basi s/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 32.00 CAH HIT Adjustment for Depreciation and Interest 0 0 0.00 0 32.00 33.00 MISSION POINT SAVINGS B -16,753 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.00 33.01 REV OFFSET - ADMIN B -478,100 ADMINI STRATI VE & GENERAL 5.00 0
11/26/2018 3: 30 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 33.00 MISSION POINT SAVINGS B -16, 753 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0 0 33.
To/From Which the Amount is to be Adjusted To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 32.00 CAH HIT Adjustment for Depreciation and Interest 1.00 2.00 3.00 4.00 5.00 33.00 MISSION POINT SAVINGS B -16,753 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.00 33.01 REV OFFSET - ADMIN B -478,100 ADMINISTRATIVE & GENERAL 5.00 0 33.00
Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 32.00 CAH HIT Adjustment for Depreciation and Interest 1.00 2.00 3.00 4.00 5.00 33.00 MISSION POINT SAVINGS B -16,753 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.00 33.01 REV OFFSET - ADMIN B -478,100 ADMINISTRATIVE & GENERAL 5.00 0 33.00
1.00 2.00 3.00 4.00 5.00 32.00 CAH HI T Adjustment for Depreciation and Interest 0 0 0.00 0 32.00 33.00 MI SSI ON POI NT SAVINGS B -16,753 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.00 33.01 REV OFFSET - ADMIN B -478,100 ADMINI STRATI VE & GENERAL 5.00 0 33.00
1.00 2.00 3.00 4.00 5.00 32.00 CAH HI T Adjustment for Depreciation and Interest 0 0 0.00 0 32.00 33.00 MI SSI ON POI NT SAVINGS B -16,753 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.00 33.01 REV OFFSET - ADMIN B -478,100 ADMINI STRATI VE & GENERAL 5.00 0 33.00
1.00 2.00 3.00 4.00 5.00 32.00 CAH HI T Adjustment for Depreciation and Interest 0 0 0.00 0 32.00 33.00 MI SSI ON POI NT SAVINGS B -16,753 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.00 33.01 REV OFFSET - ADMIN B -478,100 ADMINI STRATI VE & GENERAL 5.00 0 33.00
1.00 2.00 3.00 4.00 5.00 32.00 CAH HI T Adjustment for Depreciation and Interest 0 0 0.00 0 32.00 33.00 MI SSI ON POI NT SAVINGS B -16,753 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.00 33.01 REV OFFSET - ADMIN B -478,100 ADMINI STRATI VE & GENERAL 5.00 0 33.00
32. 00 CAH HI T Adjustment for Depreciation and Interest 0 0.00 0 32. 0 33. 00 MI SSI ON POI NT SAVINGS B -16, 753 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 0 33. 01 REV OFFSET - ADMIN B -478, 100 ADMINI STRATI VE & GENERAL 5. 00 0 33. 0
Depreciation and InterestB-16,753EMPLOYEE BENEFITS DEPARTMENT4.00033.0033.01REV OFFSET - ADMINB-478,100ADMINISTRATIVE & GENERAL5.00033.00
33.00 MI SSI ON POI NT SAVINGS B -16, 753 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.0 0 33.01 REV OFFSET - ADMIN B -478, 100 ADMINI STRATI VE & GENERAL 5.00 0 33.0
33. 01 REV OFFSET - ADMIN B -478, 100 ADMINI STRATI VE & GENERAL 5. 00 0 33. 0
33. 02 REV_OFFSET - FOOD_SERVICES B -16, 810 DI ETARY 10. 00 0 33. 0
33. 04 REV OFFSET - OR B -334, 961 OPERATING ROOM 50. 00 0 33. 0
33. 05 REV OFFSET - RADI OLOGY B -189 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 0
33.06 REV OFFSET - DRUGS B -93 DRUGS CHARGED TO PATIENTS 73.00 0 33.0
33. 07 LOBBYING A -312 ADMINI STRATI VE & GENERAL 5. 00 0 33. 0
33. 08 PROVI DER TAX A -721, 230 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 0
33. 09 CHARI TABLE CONTRI BUTI ONS A -590 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 0
33. 10 I NCENTI VE ACCRUAL ADJUSTMENT A -9, 488 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 1
33. 11 NON-RHC SALARIES A -29, 114 RURAL HEALTH CLINIC 88. 00 0 33. 1
33. 12 NON-RHC SALARIES A -58, 558 RURAL HEALTH CLINICII 88. 01 0 33. 1
33. 13 PROMOTI ONAL A -1, 753 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 1
33. 14 LATE PENALTY FEE A -25 CENTRAL SERVICES & SUPPLY 14. 00 0 33. 1
33. 15 LOSS ON SALE DI SPOSAL A -22, 137 EMERGENCY 91. 00 0 33. 1
33. 16 LOSS ON SALE DI SPOSAL A -741 AMBULANCE SERVICES 95. 00 0 33. 1
50.00 TOTAL (sum of lines 1 thru 49) -320,141 50.0
(Transfer to Worksheet A,
column 6, line 200.)

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	ST. VINCENT WILL	AMSPORT HOSPITAL	In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	8-1
OFFICE	COSTS			From 07/01/2017 To 06/30/2018		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
1.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	333, 418	0	1, 00
2.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	4, 904, 038		
3.00			HOME OFFICE - MARKETING	94, 674	0	3.00
3.01	4.00		SVH CHARGEBACKS	157, 761	157, 761	3.01
3.02	15.00		SVH CHARGEBACKS	31, 571	31, 571	3.02
3.03	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	1, 250	1, 250	3.03
3.04	54.00	RADI OLOGY-DI AGNOSTI C	SVH CHARGEBACKS	27, 192	27, 192	3.04
3.05	65.00	RESPI RATORY THERAPY	SVH CHARGEBACKS	37, 360	37, 360	3.05
3.06	91.00	EMERGENCY	SVH CHARGEBACKS	1, 853	1, 853	3.06
3.08	1.00	NEW CAP REL COSTS-BLDG & FIX	INTEREST EXPENSE	141, 494	141, 494	3.08
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			5, 730, 611	3, 894, 399	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownership		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	SVH	100.00 ST. VINCENT HEALTH	100.00	6.00
7.00	G	ASCENSI ON	100.00 ASCENSI ON	100.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	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.

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

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

					11/26/2018 3:	30 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	1
	HOME OFFICE CO	STS:				1
1.00	333, 418	0				1.00
2.00	1, 408, 120	0				2.00
3.00	94, 674	0				3.00
3.01	0	0				3. 01
3.02	0	0				3. 02
3.03	0	0				3.03
3.04	0	0				3.04
3.05	0	0				3.05
3.06	0	0				3.06
3.08	0	11				3.08
4.00	0	0				4.00
5.00	1, 836, 212					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.

TIAS TIOL	been posted to worksheet A,	condinins i and/or z, the amount an owable should be indicated in condinin 4 of th	iis part.
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELAT	ED 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 XULU

r er inpur	sement under titte XVIII.		
6.00	ADMI NI STRATI ON		6.00
7.00	ADMI NI STRATI ON		7.00
8.00			8.00
9. 00 10. 00			9.00
10.00			10.00
100.00		1	100.00

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

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

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

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

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

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

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

Health Financial Systems

ST. VINCENT WILLIAMSPORT HOSPITAL In Lieu of Form CMS-2552-10

PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT	Provi der CCN: 15-1307 Peri od:			Worksheet A-8	8-2	
					-	From 07/01/2017 To 06/30/2018		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	11/26/2018 3: Physi ci an/Prov	
	WRSt. A LINE π	I denti fi er	Remuneration	Component	Component		ider Component	
		i denti i i ei	Remarker a tron	component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		OPERATING ROOM	219, 330	219, 330	0.00		0	1.00
2.00		RADI OLOGY-DI AGNOSTI C	103, 110		0	0	0	2.00
3.00		EMERGENCY	1, 155, 296			0	0	3.00
4.00	0.00		0				0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0, 00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00	0.00		1, 477, 736	322, 440	1, 155, 296	Ū	0	200.00
-	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		Identifier	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATI NG ROOM	0	0	0	0	0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		OPERATING ROOM	0	0	-			1.00
2.00		RADI OLOGY-DI AGNOSTI C	0	0	0	103, 110		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0. 00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0. 00		0	0	0	0		10.00
200.00			0	0	0	322, 440		200.00

	VABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	VINCENT WILLIAM FURNISHED BY	Provi der CC		Period: From 07/01/2017 To 06/30/2018 Physical Therapy	Date/Time Prep 11/26/2018 3:3	-3 pared:
						1.00	
1 00	PART I - GENERAL INFORMATION		· 、				1 00
1.00 2.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	(see instruct	Tons)			26 390	
3.00	Number of unduplicated days in which supervis	sor or therapist	was on provi	der site (se	e instructions)	0	
4.00	Number of unduplicated days in which therapy	assistant was o				0	4.00
F 00	nor therapist was on provider site (see instr	,		- +			F 00
5.00 6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera				hy therany	0 128	5.00 6.00
0.00	assistant and on which supervisor and/or ther				5 15	120	0.00
	instructions)		5				
7.00 8.00	Standard travel expense rate					9.57 0.00	7.00
0.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	8.00
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	858.		0.00	
10.00	AHSEA (see instructions)	0.00	0.00	53.		0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	0.00	0.00	26.	61		11.00
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01	Number of travel hours (offsite)	0	0		0		12.01
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00 13.01
15.01	Number of milles univer (offsite)	0	0		0		15.01
						1.00	
4.4.00	Part II - SALARY EQUIVALENCY COMPUTATION	10					1 4 4 9 9
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,	,				0	14.00 15.00
16.00	Assistants (column 3, line 9 times column 3,					45, 686	
17.00	Subtotal allowance amount (sum of lines 14 ar		atory therapy	or lines 14	-16 for all	45, 686	
	others)						10.00
18.00 19.00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					0	18.00 19.00
20.00	Total allowance amount (sum of lines 17-19 for		herapy or lin	es 17 and 18	for all others)	45, 686	
	If the sum of columns 1 and 2 for respiratory	therapy or col	umns 1-3 for	physical the	erapy, speech path		
	occupational therapy, line 9, is greater than		o entries on l	ines 21 and	22 and enter on	line 23	
21.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by su	m of columns	1 and 2 line 9	0.00	21.00
21.00	for respiratory therapy or columns 1 thru 3,					0.00	21.00
22.00	Weighted allowance excluding aides and traine	es (line 2 time	es line 21)			0	
23.00	Total salary equivalency (see instructions)					45, 686	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	ANCE AND TRAVEL	EXPENSE COMP	JIAIIUN - Pr	OVIDER SITE		-
24 00							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or					0 0	25.00 26.00
25.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				3 and 4 for all	0	25.00 26.00
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	for respiratory	/ therapy or s	um of lines		0 0	25. 00 26. 00 27. 00
25. 00 26. 00 27. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	for respiratory travel expense	/ therapy or s	um of lines		0 0 0	25. 00 26. 00 27. 00
25. 00 26. 00 27. 00 28. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	for respiratory travel expense Expense	/ therapy or s at the provid	um of lines		0 0 0	25.00 26.00 27.00 28.00
25. 00 26. 00 27. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	for respiratory travel expense Expense of columns 1 and	/ therapy or s at the provid	um of lines		0 0 0	25. 00 26. 00 27. 00 28. 00 29. 00
25.00 26.00 27.00 28.00 29.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	for respiratory travel expense Expense of columns 1 and line 12)	therapy or s at the provid 2, line 12)	um of lines er site (sum		000000000000000000000000000000000000000	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
25.00 26.00 27.00 28.00 29.00 30.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29	<pre>/ therapy or s at the provid ////////////////////////////////////</pre>	um of lines er site (sum	n of lines 26 and	0 0 0 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times the sum of Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line	<pre>/ therapy or s at the provid ////////////////////////////////////</pre>	um of lines er site (sum	n of lines 26 and	0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00
25.00 26.00 27.00 28.00 29.00 30.00 31.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line	v therapy or s at the provid d 2, line 12) 0 and 30 for a 13 for respir 28)	um of lines er site (sum unders) atory therap	n of lines 26 and	0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	<pre>/ therapy or s at the provid 1 2, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an</pre>	um of lines er site (sum Il others) atory therap d 31) d 32)	n of lines 26 and		25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	<pre>/ therapy or s at the provid 1 2, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an</pre>	um of lines er site (sum Il others) atory therap d 31) d 32)	n of lines 26 and		25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	<pre>/ therapy or s at the provid 1 2, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an</pre>	um of lines er site (sum Il others) atory therap d 31) d 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	<pre>/ therapy or s at the provid 1 2, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an</pre>	um of lines er site (sum Il others) atory therap d 31) d 32)	n of lines 26 and		25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o NOCE AND TRAVEL	v therapy or s at the provid 12, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	um of lines er site (sum Il others) atory therap d 31) d 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sum	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NNCE AND TRAVEL	v therapy or s at the provid 12, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	um of lines er site (sum Il others) atory therap d 31) d 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NNCE AND TRAVEL	<pre>/ therapy or s at the provid 1 2, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU 4 6)</pre>	um of lines er site (sum Il others) atory therap d 31) d 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWE Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NCE AND TRAVEL	<pre>/ therapy or s at the provid 1 2, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU 4 6)</pre>	um of lines er site (sum Il others) atory therap d 31) d 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NCE AND TRAVEL	<pre>/ therapy or s at the provid 1 2, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU 4 6)</pre>	um of lines er site (sum Il others) atory therap d 31) d 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o expense (sum o NCE AND TRAVEL n of lines 5 and Expense D1 times column n 3, line 10) n of columns 1-3	<pre>/ therapy or s at the provid 1 2, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU 4 6) 2, line 10) 3, line 13.01)</pre>	um of lines er site (sum ll others) atory therap d 31) d 32) TATION - SEF	n of lines 26 and by or sum of <u>RVICES OUTSIDE PRO</u>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (column 3, line 12.01 times column Subtotal (sum of columns 1 and 2, line 12.07 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - 0	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o expense (sum o NCE AND TRAVEL n of lines 5 and Expense D1 times column n 3, line 10) n of columns 1-3	<pre>/ therapy or s at the provid 1 2, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU 4 6) 2, line 10) 3, line 13.01)</pre>	um of lines er site (sum ll others) atory therap d 31) d 32) TATION - SEF	n of lines 26 and by or sum of <u>RVICES OUTSIDE PRO</u>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o expense (sum o NNCE AND TRAVEL n of lines 5 and Expense 1 times column n 3, line 10) n of columns 1-3 offsite Services	<pre>/ therapy or s at the provid 1 2, line 12) 0 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU 4 6) 2, line 10) 3, line 13.01) ; Complete on</pre>	um of lines er site (sum ll others) atory therap d 31) d 32) TATION - SEF	n of lines 26 and by or sum of EVICES OUTSIDE PRO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00

al th Financial Systems ST. EASONABLE COST DETERMINATION FOR THERAPY SERVICES I ITSIDE SUPPLIERS	VINCENT WILLIAM FURNISHED BY	Provider CC	CN: 15-1307	Period: From 07/01/2017 To 06/30/2018	11/26/2018 3:	pared:
				Physical Therapy	Cost	
					1.00	
.00 Optional travel allowance and optional travel	expense (sum of	flines 42 an	d 43 - see in	structions)	0	46.00
	Therapists	Assistants	Aides	Trainees	Total	
	1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION	0.00	0.00			0.00	47.00
7.00 Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.00
period (if column 5, line 47, is zero or equal to or greater than 2,080, do not						
complete lines 48-55 and enter zero in each						
column of line 56)						
3.00 Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00
0.00 Total overtime (including base and overtime	0.00	0.00				49.00
allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0.00		
CALCULATION OF LIMIT						
0.00 Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50. OC
(divide the hours in each column on line 47						
by the total overtime worked - column 5,						
line 47)						
.00 Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51.00
for one full-time employee times the						
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE						
2.00 Adjusted hourly salary equivalency amount	0.00	53. 21	0.0	0.00		52.00
(see instructions)						
8.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.00
52)						
1.00 Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
line 49 or line 53)						
5.00 Portion of overtime already included in	0	0		0 0		55.00
hourly computation at the AHSEA (multiply						
line 47 times line 52)	0	0		0 0	0	
b.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	0		0 0	0	56.00
y , ,						
the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3						
for all others.)						
					1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	ADJUSTMENT				
7.00 Salary equivalency amount (from line 23)					45, 686	57.00
8.00 Travel allowance and expense - provider site	(from lines 33,	34, or 35))			0	
0.00 Travel allowance and expense - Offsite servic)		0	59.0
0.00 Overtime allowance (from column 5, line 56)			·		0	60.0
.00 Equipment cost (see instructions)					0	61.00
2.00 Supplies (see instructions)					0	62.0
8.00 Total allowance (sum of lines 57-62)					45, 686	63.0
1.00 Total cost of outside supplier services (from	your records)				47, 250	
5.00 Excess over limitation (line 64 minus line 63		enter zero)			1, 564	
LINE 33 CALCULATION		,		•		1
00.00 Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others		0	100. 0
00.01 Line 27 = line 7 times line 3 for respiratory				others	0	100.0
00.02 Line 33 = line 28 = sum of lines 26 and 27	15				0	100.0
LINE 34 CALCULATION						1
)1.00 Line 27 = line 7 times line 3 for respiratory	therapy or sum	of lines 3 a	nd 4 for all	others	0	101.00
01.01 Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for al	II others		0	101. 0 [.]
						101.02
					-	1
01.02 Line 34 = sum of lines 27 and 31						
	sum of lines 29	and 30 for al	II others		0	102.00
01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				mns 1-3, line		102. 0 102. 0
D1.02Line 34 = sum of lines 27 and 31LINE 35CALCULATIOND2.00Line 31 = line 29 for respiratory therapy or				mns 1-3, line		

In Lieu of Form CMS-2552-10 Worksheet B

Health Fina	ncial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	L	In Lie	u of Form CMS-2	2552-10
	TION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1307	Period:	Worksheet B	
					From 07/01/2017	Part I	
					To 06/30/2018	Date/Time Pre	pared:
				1755 00070		11/26/2018 3:	30 pm
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
		for Cost	FLXT	EQUI P	BENEFI TS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
		0	1.00	2.00	4.00	4A	
	RAL SERVICE COST CENTERS						
1.00 00100	O NEW CAP REL COSTS-BLDG & FIXT	44, 733	44, 733				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	560, 536		560, 53	6		2.00
4.00 00400	O EMPLOYEE BENEFITS DEPARTMENT	2, 435, 752	0		0 2, 435, 752		4.00
5.00 00500	O ADMINISTRATIVE & GENERAL	5, 727, 111	3, 652	45, 75	9 274, 877	6, 051, 399	5.00
7.00 00700	O OPERATION OF PLANT	339, 631	6, 393	80, 09		426, 119	7.00
	O LAUNDRY & LINEN SERVICE	0	179	2, 24		2, 427	8.00
	O HOUSEKEEPI NG	258, 566	44	55		259, 167	9.00
	0 DI ETARY	8, 920	0		0 0	8, 920	
	NURSING ADMINISTRATION	180, 659	476			241, 471	13.00
				5, 96			
	O CENTRAL SERVICES & SUPPLY	8, 630	0		0 217	8, 847	14.00
	0 PHARMACY	540, 880	0		0 52, 521	593, 401	15.00
	0 MEDICAL RECORDS & LIBRARY	577	1, 529	19, 16	0 0	21, 266	16.00
	TIENT ROUTINE SERVICE COST CENTERS						
	0 ADULTS & PEDIATRICS	1, 234, 106	5, 446	68, 23		1, 622, 161	
	0 NURSERY	0	0		0 0	0	43.00
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	237, 256	3, 735	46, 80		451, 730	
	O ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400	0 RADI OLOGY-DI AGNOSTI C	831, 785	2, 968	37, 18	5 172, 989	1, 044, 927	54.00
60.00 06000	0 LABORATORY	1, 247, 110	1, 274	15, 97	0 10, 887	1, 275, 241	60.00
65.00 06500	0 RESPI RATORY THERAPY	69, 403	772	9,67	6 6, 635	86, 486	65.00
66.00 06600	O PHYSI CAL THERAPY	279, 420	1, 686	21, 12	9 67, 370	369, 605	66.00
68.00 06800	SPEECH PATHOLOGY	0	0		0 0	0	68.00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 104	479	6,00	5 0	53, 588	
	OIMPL. DEV. CHARGED TO PATIENT	36, 613	0	-,	0 0	36, 613	72.00
	O DRUGS CHARGED TO PATIENTS	699	406	5, 08		6, 189	
	ATIENT SERVICE COST CENTERS	0//	400	5,00	т <u></u>	0,107	/ 5. 00
	O RURAL HEALTH CLINIC	1, 525, 969	3, 905	48, 93	8 372, 315	1, 951, 127	88.00
	1 RURAL HEALTH CLINIC II	1, 623, 806	5, 545	69, 48		2, 113, 971	88.00
	0 EMERGENCY						
		2, 253, 830	3, 315	41, 54	1 303, 260	2, 601, 946	1
	O OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	R REIMBURSABLE COST CENTERS	150 310	0.505	<u>.</u>	100.001	(00, (07	
	O AMBULANCE SERVICES	458, 712	2, 505	31, 38	4 130, 036	622, 637	95.00
	AL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	19, 951, 808	44, 309	555, 22	7 2, 338, 915	19, 849, 238	118.00
	EI MBURSABLE COST CENTERS	ГТ					
	O NONPAID WORKERS	0	0		0 0		193.00
	1 ORTHO CLINIC	329, 442	424	5, 30	9 96, 837	432, 012	
	3 COMMUNITY MED CLINIC	0	0		0 0		193. 02
194.0007950	0 MARKETI NG	96, 987	0		0 0	96, 987	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0		o o		201.00
202.00	TOTAL (sum lines 118 through 201)	20, 378, 237	44, 733	560, 53	6 2, 435, 752	20, 378, 237	
1							

Healt	n Financial Systems SI.	VINCENI WILLIA	AMSPORT HUSPITA	<u>L</u>	In Lie	u of Form CMS-	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provider CO		eriod:	Worksheet B	
					rom 07/01/2017	Part I	
				T	06/30/2018	Date/Time Pre 11/26/2018 3:	pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	cost center bescription	& GENERAL	PLANT	LINEN SERVICE	HOUSEKEELTING	DILIANI	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	7.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1 1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	6, 051, 399					5.00
7.00	00700 OPERATION OF PLANT	179, 985					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 025					8.00
9.00	00900 HOUSEKEEPI NG	109, 467		0	369, 701		9.00
10.00		3, 768		0	307,701	12, 688	
13.00		101, 993		Ű	5, 104	12,000	13.00
14.00		3, 737		0	5, 104	0	14.00
14.00		250, 642		0	0	0	15.00
16.00		8, 982	36, 720	0	14 401	0	16.00
16.00	INPATIENT ROUTINE SERVICE COST CENTERS	8,982	30, 720	0	16, 401	0	10.00
20.00		(OF 17)	120 777	3, 349	E0 412	12, 688	20.00
30.00 43.00		685, 172 0			58, 413 0	12, 688	•
43.00	ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	43.00
F0 00		100.002	00.707	1 504	40.060	0	F0 00
50.00 53.00		190, 803	89, 707 0	1, 584	40, 069		
		Ŭ	, s	0 372	Ŭ	0	53.00
54.00		441, 358			31, 832	-	54.00
60.00		538, 639		0	13, 671	0	60.00
65.00		36, 530		0	8, 283	0	65.00
66.00		156, 114			18, 087	0	66.00
68.00		0	0	0	0	0	68.00
71.00		22, 635			5, 140	0	71.00
72.00		15, 465		0	0	0	
73.00		2, 614	9, 744	0	4, 352	0	73.00
	OUTPATIENT SERVICE COST CENTERS				44.000		
88.00		824, 121	0		41, 892	0	
88.01		892, 903		169	59, 486	0	88.01
91.00		1, 099, 015	79, 614	1, 116	35, 561	0	91.00
92.00							92.00
	OTHER REIMBURSABLE COST CENTERS	0 (0.001	(0.117		<u> </u>		0.5 0.0
95.00		262, 991	60, 147	223	26, 865	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.0		5, 827, 959	595, 929	7, 760	365, 156	12, 688	118.00
	NONREI MBURSABLE COST CENTERS	1					
	0 19300 NONPAI D WORKERS	0	-	0	0		193.00
	1 19301 ORTHO CLINIC	182, 474	10, 175	0	4, 545		193. 01
	2 19303 COMMUNITY MED CLINIC	0	0	0	0		193. 02
	0 07950 MARKETI NG	40, 966	0	0	0	0	194.00
200.0	5						200.00
201.0	5	0	0	0	0		201.00
202.0	0 TOTAL (sum lines 118 through 201)	6, 051, 399	606, 104	7, 760	369, 701	12, 688	202.00

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ST.	VI NCENT	WI LLI AMSPORT	HOSPI TAL

In Lieu of Form CMS-2552-10

Heal th	Financial Systems SI.	VINCENT WILLIA	MSPORT HUSPITE		In Lie	U OT FORM CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 07/01/2017 Fo 06/30/2018		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	11/26/2018 3: Subtotal	SU plii
	cost center bescription		SERVICES &	PHARMACY	RECORDS &	Subtotal	
		ADMI NI STRATI ON					
		13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	24.00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	24.00	-
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1					1.00
2.00	00200 NEW CAP REL COSTS-BEDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	359, 994					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	12, 584				14.00
15.00	01500 PHARMACY	0	0	844, 04	3		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	(0 83, 369		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDI ATRI CS	151, 377	0	(0 6, 950	2, 670, 887	30.00
43.00	04300 NURSERY	0	0	(o c	0	43.00
	ANCI LLARY SERVI CE COST CENTERS	· · · · ·					
50.00	05000 OPERATI NG ROOM	49, 173	0	(0 6, 351	829, 417	50.00
53.00	05300 ANESTHESI OLOGY	0	0	(0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		20, 035	1, 609, 789	1
60.00	06000 LABORATORY	8,838	0		15, 319	1, 882, 315	
65.00	06500 RESPIRATORY THERAPY	4, 333	0		1, 929		
66.00	06600 PHYSI CAL THERAPY	28, 163	0		2, 128		
68.00	06800 SPEECH PATHOLOGY	28, 103	0		2, 120	015, 335	1
		-	0 7 000				1
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	7,080			99, 951	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	5, 504		0	57, 582	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	844, 043	3 0	866, 942	73.00
00.00	OUTPATIENT SERVICE COST CENTERS				0 700	0 004 054	00.00
88.00	08800 RURAL HEALTH CLINIC	0	0		3, 708		
88.01	08801 RURAL HEALTH CLINIC II	0	0		3, 575	3, 070, 104	
91.00	09100 EMERGENCY	118, 110	0	(20, 412	3, 955, 774	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	,			1		
95.00	09500 AMBULANCE SERVI CES	0	0		2, 962	975, 825	95.00
	SPECIAL PURPOSE COST CENTERS	1			1		
118.00		359, 994	12, 584	844, 043	3 83, 369	19, 611, 078	118.00
	NONREI MBURSABLE COST CENTERS	1			1		
	19300 NONPAI D WORKERS	0	0	(0 0		193.00
	19301 ORTHO CLINIC	0	0	(0 0	629, 206	
193.02	19303 COMMUNITY MED CLINIC	0	0	(0 0	0	193.02
194.00	07950 MARKETI NG	0	0	(0 0	137, 953	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	(0 0		201.00
202.00	S S	359, 994	12, 584	844, 04	3 83, 369	20, 378, 237	202.00
							•

Health Financial Systems SI	. VINCENI WILLIAM	SPORT HOSPITAL	In Lieu of Form CM	S-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1	I307 Period: Worksheet B From 07/01/2017 Part I To 06/30/2018 Date/Time P 11/26/2018	repared:
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26. 00		
GENERAL SERVICE COST CENTERS	25.00	20.00		_
SENERAL SENERAL <t< td=""><td></td><td></td><td></td><td>1.00 2.00 4.00 5.00 7.00 8.00</td></t<>				1.00 2.00 4.00 5.00 7.00 8.00
9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY				9.00 10.00 13.00 14.00 15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	0	2 (70 007		20.00
30. 00 03000 ADULTS & PEDIATRICS 43. 00 04300 NURSERY	0	2, 670, 887 0		30.00 43.00
ANCI LLARY SERVI CE COST CENTERS		000 417		
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	0	829, 417 0		50.00
	0	-		53.00 54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	1,609,789		60.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	1, 882, 315 156, 106		65.00
66. 00 06600 PHYSI CAL THERAPY	0	615, 335		66.00
68. 00 06800 SPEECH PATHOLOGY	0	015, 355		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	99, 951		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	57, 582		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	866, 942		73.00
OUTPATIENT SERVICE COST CENTERS	U	000, 712		/ 0. 00
88.00 08800 RURAL HEALTH CLINIC	0	2, 821, 051		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	3, 070, 104		88.01
91.00 09100 EMERGENCY	0	3, 955, 774		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0	975, 825		95.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	19, 611, 078		118.00
NONREI MBURSABLE COST CENTERS				
193.00 19300 NONPALD WORKERS	0	0		193.00
193. 01 19301 ORTHO CLINIC	0	629, 206		193. 01
193.02 19303 COMMUNITY MED CLINIC	0	0		193. 02
194. 00 07950 MARKETI NG	0	137, 953		194.00
200.00 Cross Foot Adjustments	0	0		200. 00
201.00 Negative Cost Centers	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	20, 378, 237		202.00

	TI ON OF CAPITAL RELATED COSTS	VINCENT WILLIP	Provi der CO	CN: 15-1307 P	eriod: rom 07/01/2017 o 06/30/2018	Worksheet B Part II Date/Time Pre 11/26/2018 3:	pared:
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
			1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	21	4.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	333, 418	3, 652	45, 759	382, 829	0	5.00
7.00	00700 OPERATION OF PLANT	0	6, 393	80, 095	86, 488	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	179	2, 248	2, 427	0	8.00
9.00	00900 HOUSEKEEPI NG	0	44	557	601	0	9.00
10.00	01000 DI ETARY	0	0	0	0	0	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	476	5, 962	6, 438	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	1, 529	19, 160	20, 689	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					-	
30.00	03000 ADULTS & PEDI ATRI CS	0	5, 446	68, 237		0	30.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
F0 00	ANCI LLARY SERVI CE COST CENTERS		2 725	44,000	E0 E42	0	
50.00 53.00	05300 ANESTHESI OLOGY	0	3, 735 0	46, 808	50, 543 0	0	50.00 53.00
53.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 968	0	3	0	54.00
60.00	06000 LABORATORY	0	1, 274	15, 970		0	60.00
65.00	06500 RESPIRATORY THERAPY	0	772	9, 676		0	65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 686	21, 129		0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	21, 12,	22,010	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	479	6, 005	6, 484	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0,000	0, 101	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	406	5, 084	5, 490	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	3, 905	48, 938	52, 843	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	5, 545	69, 489	75, 034	0	88. 01
91.00	09100 EMERGENCY	0	3, 315	41, 541	44, 856	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	2, 505	31, 384	33, 889	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		333, 418	44, 309	555, 227	932, 954	0	118.00
	NONREI MBURSABLE COST CENTERS				1		
	19300 NONPAI D WORKERS	0	0	0	-		193.00
	19301 ORTHO CLINIC	0	424	5, 309			193.01
	19303 COMMUNITY MED CLINIC	0	0	0	0		193.02
	07950 MARKETI NG	0	0	0	0	0	194.00
200.00				-	0	~	200.00
201.00		222 440	0		0		201.00
202.00	TOTAL (sum lines 118 through 201)	333, 418	44, 733	560, 536	938, 687	0	202.00

	i Filidiici di Systellis SI.	VINCENT WILLIF	AMSPORT HUSPITE				2552-10
ALLOC	ATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1307 Pe Fi To	eriod: com 07/01/2017 o 06/30/2018	Worksheet B Part II Date/Time Pre 11/26/2018 3:	pared: 30 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	382, 829					5.00
7.00	00700 OPERATION OF PLANT	11, 386	97, 874				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	65	696	3, 188			8.00
9.00	00900 HOUSEKEEPI NG	6, 925	172	0	7, 698		9.00
10.00	01000 DI ETARY	238	0	0	0	238	10.00
13.00	01300 NURSING ADMINISTRATION	6, 452	1, 845	0	106	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	236	0	0	0	0	14.00
15.00	01500 PHARMACY	15, 856	0	0	0	0	15.00
16.00		568	5, 930	0	342	0	
101.00	INPATIENT ROUTINE SERVICE COST CENTERS	000	0,700		012	<u> </u>	10100
30.00		43, 346	21, 118	1, 374	1, 216	238	30.00
43.00		0	21,110	0	0	0	
101 00	ANCI LLARY SERVICE COST CENTERS	-				<u> </u>	101.00
50.00	05000 OPERATI NG ROOM	12,071	14, 486	651	834	0	50.00
53.00		0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	27, 921	11, 508	153	663	0	54.00
60.00	06000 LABORATORY	34,076	4, 942	0	285	0	60.00
65.00	06500 RESPIRATORY THERAPY	2, 311	2, 995	0	172	0	65.00
66.00	06600 PHYSI CAL THERAPY	9,876	6, 539	306	377	0	66.00
68.00		0	0,007	0	0	0	68.00
71.00		1, 432	1, 858	0	107	0	71.00
72.00		978		0	0	0	
73.00		165	1, 573	0	91	0	•
70.00	OUTPATIENT SERVICE COST CENTERS	100	1,070	0	7.1	0	/ 0. 00
88.00		52, 136	0	83	872	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	56, 487	0	70	1, 239	0	88.01
91.00		69, 531	12, 856	459	740	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,,001	12,000	107	, 10	Ū	92.00
72.00	OTHER REIMBURSABLE COST CENTERS				I		1 12:00
95.00		16, 637	9, 713	92	559	0	95.00
70.00	SPECIAL PURPOSE COST CENTERS	10,007	7,710	72		0	70.00
118.0		368, 693	96, 231	3, 188	7, 603	238	118.00
110.0	NONREI MBURSABLE COST CENTERS	000,070	70,201	0,100	7,000	200	110.00
193 0	0 19300 NONPAI D WORKERS	0	0	0	0	0	193.00
	1 19301 ORTHO CLINIC	11, 544	1, 643	0	95		193.01
	2 19303 COMMUNITY MED CLINIC	0	1,045	0	75		193.02
	007950 MARKETI NG	2, 592	0	0	0		194.00
200.0		2, 372	0	0	0	0	200.00
200.0	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	200.00
201.0	5	382, 829	97, 874	3, 188	7, 698		201.00
202.0		502,027	,,,0/4	5, 100	7,070	200	1202.00

Heal th	Fina	inci	al S	yste	ems		
		OF	CADI	TAI	DEL	ATED	1

	ATION OF CAPITAL RELATED COSTS	VINCENT WILLIA	Provi der C	CN: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Pre 11/26/2018 3:	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS	1					1
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	14, 841					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	236				14.00
15.00	01500 PHARMACY	0	0				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 27, 529		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			r			
30.00	03000 ADULTS & PEDIATRICS	6, 241	0		0 2, 298	149, 514	1
43.00	04300 NURSERY	0	0		0 0	0	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	0.007		[0 0 100	00.740	50.00
50.00	05000 OPERATING ROOM	2,027	0		0 2, 100	82, 712	1
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 6, 623 0 5 064	87,021	
60.00		364	•		0,001	61, 975	1
65.00		179	0		0 638 0 703	16, 743	
66.00	06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY	1, 161	0		0 703	41, 777 0	
68.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	133			-	
71.00		0			0 0	10, 014	1
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	103 0		-	1, 081	72.00 73.00
73.00	OUTPATIENT SERVICE COST CENTERS	U	0	15, 85	0 0	23, 175	/3.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0 1, 226	107, 160	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0		0 1, 182	134, 012	
91.00	09100 EMERGENCY	4,869	0		0 6, 716	140, 027	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,007	0		0,710	140, 027	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVICES	0	0		0 979	61, 869	95.00
75.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0		0 ///	01,007	/0.00
118.00		14, 841	236	15, 85	6 27, 529	917, 080	1118 00
	NONREI MBURSABLE COST CENTERS		200	10,00	27,027	7177000	
193.00	19300 NONPAI D WORKERS	0	0		0 0	0	193.00
	19301 ORTHO CLINIC	0	0		0 0		193.01
	2 19303 COMMUNITY MED CLINIC	0	0		0 0		193.02
	07950 MARKETI NG	0	0		0 0		194.00
200.00			0				200.00
201.00	5	0	0		0 0		201.00
202.00	5	14, 841	236	15, 85	6 27, 529		
							•

		VINCENT WILLIA			IN LIEU OF FO	rm CMS-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider (CCN: 15-1307		
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	_		
		25.00	26.00			
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5.00 7.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPING					9.00
10.00	01000 DI ETARY					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	I				
30.00	03000 ADULTS & PEDI ATRI CS	0	149, 51	4		30.00
43.00	04300 NURSERY	0		o		43.00
	ANCILLARY SERVICE COST CENTERS	· · · · · ·				
50.00	05000 OPERATI NG ROOM	0	82, 71	2		50.00
53.00	05300 ANESTHESI OLOGY	0	(o		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	87, 02	1		54.00
60.00	06000 LABORATORY	0	61, 97			60.00
	06500 RESPI RATORY THERAPY	0	16, 74	•		65.00
66.00	06600 PHYSI CAL THERAPY	0	41, 77	1		66.00
68.00	06800 SPEECH PATHOLOGY	0		0		68.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	10, 01			71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	1, 08			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	23, 17	5		73.00
00.00	OUTPATIENT SERVICE COST CENTERS	0	107 1/	0		00_00
	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	107, 16 134, 01			88. 00 88. 01
91.00	09100 EMERGENCY	0	140, 02			91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	140, 02	'		91.00
72.00	OTHER REIMBURSABLE COST CENTERS	U U				92.00
95.00	09500 AMBULANCE SERVICES	0	61, 86	9		95.00
70.00	SPECIAL PURPOSE COST CENTERS		01,00	/		/0.00
118.00		0	917, 08	0		118.00
	NONREI MBURSABLE COST CENTERS		,	-1		
193.00	19300 NONPALD WORKERS	0		0		193.00
	19301 ORTHO CLINIC	0	19, 01	5		193.01
193.02	19303 COMMUNITY MED CLINIC	0		o		193.02
194 00	07950 MARKETI NG	0	2, 59	2		194.00
174.00	Cross Foot Adjustments	0		ol		200.00
200.00		U 0		9		1200.00
		0		0		201.00

ST. VINCENT WILLIAMSPORT HOSPITAL

In Lieu of Form CMS-2552-10

9.00 00900 HOUSEKEEPING 52 52 0 0 259 10.00 D1400 DETARY 0 0 0 0 8 13.00 D1300 NURSI NG ADMI NI STRATI ON 557 557 172, 768 0 241 14.00 O1400 CENTRAL SERVI CES & SUPPLY 0 0 688 0 88 15.00 O1500 PHARMACY 0 0 166,882 0 593 16.00 01600 MEDI CAL RECORDS & LI BRARY 1,790 1,790 0 0 21 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 6,375 6,375 998,891 0 1,622 0 0 0 0 0 0 0 0 0 43.00 OBGO0 OPERATI NG ROOM 4,373 4,373 520,876 0 451 53.00 05300 ANESTHESI OLOGY 0 <t< th=""><th>Prepared: 3:30 pm VE</th></t<>	Prepared: 3:30 pm VE
Cost Center Description CAPITAL RELATED COSTS FLAT NEW RELDG & FLAT NEW RELDG & FLAT NEW RELDG & SALARIES) NEW RELDG & Reconcil i ati on ADMI NI STRA & CENERA (ACCUM. COST) 1.00 2.00 4.00 5A 5.00 0.00 00100 NEW CAP REL COSTS-BLOG & FLAT 52.368 5.00 5.00 1.00 00100 NEW CAP REL COSTS-BLOG & FLAT 52.368 7.739,401 6.051,399 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 7.739,401 7.739,401 5.00 00500 ADMI NI STRATIVE & GENERAL 4,275 4,275 873,398 -6,051,399 14,326 7.00 00700 OPERATION OF PLANT 7.483 0 0 0 259 10.00 10400 CENTRAL SERVICE 210 210 0 0 225 10.00 01000 INETARY 0 0 0 259 2 2 0 0 259 10.00 1030 NURSING ADMINISTRATION 5557 5577 172,768 241 1 0 0 2 2 2 0<	3: 30 pm VE
Cost Center Description CAPITAL RELATED COSTS EMPLOYEE Reconciliation ADMINISTRA NEW BLDG & FIXT (SQUARE FEET) NEW WBLE FOULP (SQUARE FEET) EMPLOYEE BENEFITS DEPARTMENT Reconciliation ADMINISTRA 1.00 00100 NEW CAP REL COSTS-ENDED & 00200 NEW CAP REL COSTS-ENDED & FIXT 52,368	3: 30 pm VE
Cost Center Description CAPITAL RELATED COSTS Reconciliation ADMINISTRA NEW BLOG & FIX NEW BLOG & FIX NEW WDBLE EQUIP (SOUARE FEET) ENPLOYEE BENEFITS DEPARTMENT (GROSS SALARLESS) Reconciliation ADMINISTRA & GENERAL 1.00 00100 [NEW CAP REL COSTS-BLOG & FIXT 2.00 00200 [NEW CAP REL COSTS-MURLE FOULP 4.00 52,368 7,739,401 0 2.00 00400 [EMPLOYEE BENEFITS DEPARTMENT 0 0 7,739,401 0 4.323 5.00 00500 [ADMINISTRATIVE & GENERAL 4,275 4,275 873,398 -6,051,399 14,326 7.00 00700 [PERATIN ON OF PLANT 7,483 7,483 0 0 0 9.00 00900 [DUGSTEKEPINC 52 52 0 0 226 10.00 1400 [ETARY 0 0 0 241 14.00 01400 [ETARY 0 0 6,375 557 172,768 0 241 14.00 01400 [ETARY 0 0 0 0 0 241 15.00 01500 [PHARMACY <	VE
FIXT (SQUARE FET) COUP (SQUARE FET) BENEFITS (SQUARE FET) BENEFITS DEPARTMENT (GROSS SALARIES) & GENERAL (ACCUM, COST) 6 5 0 2.00 4.00 5A 5.00 1.00 00100 NEW CAP REL COST CENTERS 52,368	
FIXT (SQUARE FET) COUP (SQUARE FET) BENEFITS (SQUARE FET) BENEFITS DEPARTMENT (GROSS SALARIES) & GENERAL (ACCUM, COST) 6 5 0 2.00 4.00 5A 5.00 1.00 00100 NEW CAP REL COST CENTERS 52,368	
General Service Cost Centers (Souare Feet) (Souare Feet) (Souare Feet) (Cacum Cost) 1.00 2.00 4.00 5A 5.00 2.00 00100 New CAP REL COSTS-BLDG & FLXT 52,368 5.00 5.01 5.0	
FEET) FEET) GROSS SALARI ES) COST) 0 0.00 2.00 4.00 5A 5.00 2.00 00200 NEW CAP REL COSTS -BLDG & FI XT 52,368 7.739,401 7.739,401 2.00 00200 NEW CAP REL COSTS -NVBLE EQUI P 52,368 7.739,401 7.739,401 5.00 00500 ADMIN ISTRATI VE & GENERAL 4.275 4.275 8.73,398 -6,051,399 14,326 7.00 00700 OPERATION OF PLANT 7.483 7,483 0 0 426 8.00 0800 LAUNDRY & LINEN SERVICE 210 210 0 0 22 9.00 09090 HOUSEKEPI NG 552 52 0 0 28 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 688 0 8 15.00 01500 PLANMACY 0 0 0 688 0 8 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 0 0 0 0 0 0	
CENTRAL SERVICE COST CENTERS 1.00 2.00 4.00 5A 5.00 1.00 00100 NEW CAP REL COSTS-ELIG & FLXT 52,368 52,352 52,00 0,229 52,00 0,0229 52,52 0,00 0,00 0,00 216 241 31,00 0,00 0,00 241 41,40 61,400 688 0 88 53,00 53,00 53,00 53,316 0 1,622 0 0 211 1,400 1,622 0 0 0 0 0	
I.00 2.00 4.00 5A 5.00 GENERAL SERVI CE COST CENTERS	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLOG & FIXT 52,368 4.00 00200 NEW CAP REL COSTS-WBLE EQUIP 52,368 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 0 5.00 00500 ADM INISTRATIVE & GENERAL 4,275 4,275 873,398 -6,051,399 14,326 7.00 00700 OPERATION OF PLANT 7,483 7,483 0 0 426 8.00 00800 LAUNDRY & LI NEN SERVICE 210 210 0 0 22 9.00 00900 HOUSEKEEPING 52 52 0 0 28 1.000 1000 DI ETARY 0 0 0 0 88 0 241 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 243 15.00 1500 PHARMACY 1,790 1,790 0 21 14.400 01400 CENTAL SERVICE COST CENTERS 0 0 0	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 52,368 52,368 2.00 00200 NEW CAP REL COSTS-WBLE EQUIP 52,368 4.00 00400 EMPLOYEE BENETIS DEPARTMENT 0 0 5.00 00500 ADMI NI STRATI VE & GENERAL 4,275 4,275 873,398 -6,051,399 14,326 8.00 00800 LAUNDRY & LINEN SERVICE 210 210 0 0 2259 9.00 00900 HOUSEKEEPING 52 52 0 0 259 10.00 DISON DURSKEEPING 52 557 172,768 241 14.00 OHADI NISTRATI ON 557 557 172,768 241 14.00 OHADIN STRATI ON 557 557 172,768 241 14.00 OHADI RECORDS & LI BRARY 1,790 1,790 0 253 16.00 MEDI CAL RECORDS & LI BRARY 1,790 1,790 0 21 1NPATI ENT ROUTI NE SERVICE COST CENTERS 50.00 0 0 <	_
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 52, 368 6 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 0 7, 739, 401 5.00 00500 ADMIN ISTRATI VE & GENERAL 4, 275 4, 275 873, 398 -6, 051, 399 14, 326 7.00 00700 OPERATI ON OF PLANT 7, 483 7, 483 0 0 426 8.00 00800 LAUNDRY & LINEN SERVI CE 210 210 0 0 25 9.00 00900 HOUSEKEEPI NG 52 52 0 0 259 10.00 D1300 NURSI NG ADMINI STRATI ON 557 557 172, 768 0 241 14.00 O1400 CENTRAL SERVI CES & SUPPLY 0 0 668 0 8 15.00 01500 PHARMACY 1, 790 1, 790 0 0 21 10.00 03000 ADULTS & PEDI ATRI CS 6, 375 6, 375 998, 891 0 1, 622 30.00<	1 1 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 7,739,401 5.00 00500 ADMI NI STRATI VE & GENERAL 4,275 4,275 873,398 -6,051,399 14,326 7.00 00700 OPERATI ON OF PLANT 7,483 7,483 0 0 426 8.00 00800 LAUNDRY & LINEN SERVICE 210 210 0 0 259 9.00 00900 HOUSEKEEPI NG 52 52 0 0 289 13.00 01300 NURSI NG ADMI NI STRATI ON 557 1577 172,768 0 241 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 0 688 0 88 15.00 01500 PHARMACY 0 0 0 0 291 10.00 DIGOM ADULTS & PEDI ATRI CS 6,375 6,375 998,891 0 1,622 11.00 03000 ADULTS & PEDI ATRI CS 6,375 6,375 998,891 0 1,622 14.30 04300 NURSERY 1,790 0 0 0 0	1.00 2.00
5.00 00500 ADMI NI STRATI VE & GENERAL 4, 275 4, 275 873, 398 -6, 051, 399 14, 326 7.00 00700 OPERATI ON OF PLANT 7, 483 7, 483 0 0 246 8.00 00800 LAUNDRY & LI NEN SERVI CE 210 210 0 0 225 9.00 00900 HOUSEKEEPI NG 527 557 172, 768 0 241 10.00 D1300 NURSI NG ADMI NI STRATI ON 557 557 172, 768 0 241 14.00 CINTRAL SERVI CES & SUPPLY 0 0 688 0 88 15.00 D1600 MEDI CAL RECORDS & LI BRARY 1, 790 1, 790 0 0 211 10.00 03000 ADULTS & PEDI ATRI CS 6, 375 6, 375 998, 891 0 1, 622 30.00 03000 NURSERY 0 0 0 0 0 0 0 0 1, 622 43.00 OS3000 NULTS & PEDI ATRI CS	4.00
7.00 00700 0PERATION OF PLANT 7,483 7,483 0 0 426 8.00 00800 LAUNDRY & LINEN SERVICE 210 210 0 0 2 9.00 00900 HOUSEKEEPING 52 52 0 0 259 10.00 01000 DIETARY 0 0 0 8 0 241 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 688 0 8 15.00 01500 PHARMACY 0 0 166,882 0 593 16.00 01600 MEDICAL RECORDS & LI BRARY 1,790 1,790 0 0 21 INPART ENT ROUTINE SERVICE COST CENTERS	
8.00 00800 LAUNDRY & LINEN SERVICE 210 210 0 0 22 9.00 00900 HOUSEKEEPING 52 52 0 0 259 10.00 01000 DI ETARY 0 0 0 0 88 0 28 13.00 01300 NURSI NG ADMI NI STRATI ON 557 557 172, 768 0 241 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 0 688 0 88 15.00 01500 PHARMACY 0 0 0 688 0 88 16.00 01600 MEDI CAL RECORDS & LI BRARY 1, 790 1, 790 0 0 21 1NPATI ENT ROUTI NE SERVI CE COST CENTERS 6, 375 6, 375 998, 891 0 1, 622 43.00 03000 AURSERY 0 0 0 0 0 50.00 05500 OPERATI NG ROOM 4, 373 4, 373 520, 876 0 <td< td=""><td></td></td<>	
9.00 00900 HOUSEKEEPING 52 52 0 0 259 10.00 D1400 DETARY 0 0 0 0 8 13.00 D1300 NURSI NG ADMI NI STRATI ON 557 557 172, 768 0 241 14.00 O1400 CENTRAL SERVI CES & SUPPLY 0 0 688 0 88 15.00 O1500 PHARMACY 0 0 166,882 0 593 16.00 01600 MEDI CAL RECORDS & LI BRARY 1,790 1,790 0 0 21 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 6,375 6,375 998,891 0 1,622 0 0 0 0 0 0 0 0 0 43.00 OBGO0 OPERATI NG ROOM 4,373 4,373 520,876 0 451 53.00 05300 ANESTHESI OLOGY 0 <t< td=""><td>27 8.00</td></t<>	27 8.00
10.00 01000 DI ETARY 0 0 0 8 13.00 01300 NURSI NG ADMI NI STRATI ON 557 557 172, 768 0 241 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 0 688 0 8 15.00 01500 PHARMACY 0 0 166,82 0 21 16.00 01600 MEDI CAL RECORDS & LI BRARY 1,790 1,790 0 0 21 10.00 03000 ADULTS & PEDI ATRI CS 6,375 6,375 998,891 0 1,622 43.00 03000 NURSERY 0 0 0 0 0 0 0 0 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 4,373 4,373 520,876 0 451 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 1,044 60.00 06400 RADI OLOGY-DI LAGNOSTI C 3,474 <td< td=""><td></td></td<>	
13.00 01300 NURSI NG ADMI NI STRATI ON 557 557 172, 768 0 241 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 0 688 0 88 15.00 01500 PHARMACY 0 0 0 6688 0 993 16.00 01600 MEDI CAL RECORDS & LI BRARY 1,790 1,790 0 0 21 1NPATI ENT ROUTI NE SERVI CE COST CENTERS 1,790 1,790 0 0 1,622 30.00 03000 ADULTS & PEDI ATRI CS 6,375 6,375 998,891 0 1,622 43.00 04300 NURSERY 0 0 0 0 0 750.00 05000 OPERATI NG ROOM 4,373 4,373 520,876 0 451 54.00 05300 ANESTHESI OLOGY 0 0 0 0 0 1,492 55.00 06400 RABORATORY 1,492 1,492 34,591 0 1,275 65.00 06600 PHYSI CAL THERAPY 904 904	20 10.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 688 0 88 15.00 01500 PHARMACY 0 0 166,882 0 593 16.00 01600 MEDICAL RECORDS & LI BRARY 1,790 1,790 0 0 21 INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6,375 6,375 998,891 0 1,622 43.00 04300 NURSERY 0 1,044	
15.00 01500 PHARMACY 0 0 166,882 0 593 16.00 01600 MEDI CAL_RECORDS & LI BRARY 1,790 1,790 0 0 21 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 6,375 6,375 998,891 0 1,622 43.00 04300 NURSERY 0 1,622 0 1,622 0 0 0 0 0 0 0	47 14.00
16.00 MEDI CAL_RECORDS & LI BRARY 1,790 1,790 0 0 21 INPATI ENT ROUTI NE_SERVI CE_COST_CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 6,375 6,375 998,891 0 1,622 43.00 04300 NURSERY 0 <td></td>	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 6,375 6,375 998,891 0 1,622 43.00 O4300 NURSERY 0	
30.00 03000 ADULTS & PEDIATRICS 6,375 6,375 998,891 0 1,622 43.00 04300 NURSERY 0 0 0 0 0 0 ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4,373 4,373 520,876 0 451 53.00 05300 ANESTHESI OLOGY 0 1,044 0 3,674 3,474 549,659 0 1,275 65.00 06500 RESPI RATORY 1,492 1,492 34,591 0 1,275 65.00 06600 PHYSI CAL THERAPY 904 904	00 10.00
43.00 NURSERY 0 0 0 ANCI LLARY SERVICE COST CENTERS	61 30.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 4, 373 4, 373 520, 876 0 451 53.00 05300 ANESTHESI OLOGY 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 474 3, 474 549, 659 0 1, 044 60.00 06000 LABORATORY 1, 492 1, 492 34, 591 0 1, 275 65.00 06500 RESPI RATORY THERAPY 904 904 21, 081 0 86 66.00 06600 PHYSI CAL THERAPY 1, 974 1, 974 214, 064 0 369 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 36 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 561 561 0 0 36 73.00 07300 DRUGS CHARGED TO PATI ENTS </td <td>0 43.00</td>	0 43.00
53.00 05300 ANESTHESI OLOGY 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,474 3,474 549,659 0 1,044 60.00 06000 LABORATORY 1,492 1,492 34,591 0 1,275 65.00 06500 RESPI RATORY THERAPY 904 904 21,081 0 86 66.00 06600 PHYSI CAL THERAPY 1,974 1,974 214,064 0 369 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 561 561 0 0 366 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 475 475 0 0 6	
54.00 05400 RADI OLOGY-DI AGNOSTI C 3,474 3,474 549,659 0 1,044 60.00 06000 LABORATORY 1,492 1,492 34,591 0 1,275 65.00 06500 RESPI RATORY THERAPY 904 904 21,081 0 86 66.00 06000 PHYSI CAL THERAPY 1,974 1,974 214,064 0 369 68.00 06000 SPEECH PATHOLOGY 0 0 0 0 0 0 0 369 561 561 0 0 0 369 <td>30 50.00</td>	30 50.00
60.00 06000 LABORATORY 1,492 1,492 34,591 0 1,275 65.00 06500 RESPI RATORY THERAPY 904 904 21,081 0 86 66.00 06600 PHYSI CAL THERAPY 1,974 1,974 214,064 0 369 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 561 561 0 0 369 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 366 73.00 07300 DRUGS CHARGED TO PATI ENTS 475 475 0 0 6	0 53.00
65.00 06500 RESPI RATORY THERAPY 904 904 21,081 0 86 66.00 06600 PHYSI CAL THERAPY 1,974 1,974 214,064 0 369 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 561 561 0 0 53 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 366 73.00 07300 DRUGS CHARGED TO PATI ENTS 475 475 0 0 6	27 54.00
66.00 06600 PHYSI CAL THERAPY 1,974 1,974 214,064 0 369 68.00 06800 SPEECH PATHOLOGY 0 533 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 561 561 0 0 369	41 60.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 561 561 0 0 53 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 0 0 36 73.00 07300 DRUGS CHARGED TO PATI ENTS 475 475 0 0 6	86 65.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 561 561 0 53 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 0 36 73.00 07300 DRUGS CHARGED TO PATIENTS 475 475 0 0 6	05 66.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 0 0 36 73.00 07300 DRUGS CHARGED TO PATI ENTS 475 475 0 0 6	0 68.00
73.00 07300 DRUGS CHARGED TO PATI ENTS 475 475 0 0 6	88 71.00
	13 72.00
	89 73.00
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC 4, 572 4, 572 1, 183, 000 0 1, 951	
88. 01 08801 RURAL HEALTH CLINIC II 6, 492 1, 319, 049 0 2, 113	
91. 00 09100 EMERGENCY 3, 881 3, 881 963, 584 0 2, 601	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	92.00
OTHER REI MBURSABLE COST CENTERS	27 05 00
95. 00 09500 AMBULANCE SERVICES 2, 932 2, 932 413, 178 0 622 SPECIAL PURPOSE COST CENTERS	95.00
	39 118.00
NONREI MBURSABLE COST CENTERS	39 118.00
193. 00 19300 NONPAI D WORKERS 0 0 0 0	0 193.00
	12 193. 01
193. 02 19303 COMMUNITY MED CLINIC 0 0 0	0 193.02
	87 194.00
200.00 Cross Foot Adjustments	200.00
201.00 Negative Cost Centers	201.00
, , , , , , , , , , , , , , , , , , ,	99 202.00
Part I)	
	82 203.00
	29 204.00
Part II)	27 20 11 00
	21 205. 00
206.00 NAHE adjustment amount to be allocated	206.00
(per Wkst. B-2)	
207.00 NAHE unit cost multiplier (Wkst. D,	207.00
Parts III and IV)	

Heal th Financial	Systems
COCT ALLOCATION	

In Lieu of Form CMS-2552-10

	Financial Systems SI.	VINCENT WILLIA	AMSPORT HOSPITA			u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provider C		eri od:	Worksheet B-1	
					rom 07/01/2017	Date/Time Pre	narod
					00/30/2018	11/26/2018 3:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	NURSI NG	
	cost center bescription	PLANT	LINEN SERVICE	(SQUARE		ADMI NI STRATI ON	
		(SQUARE FEET)	(POUNDS OF	FEET)	SERVED)		
			LAUNDRY)	1	JERVED	(DI RECT	
						NRSING HRS)	
		7.00	8.00	9.00	10.00	13.00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	9.00	10.00	13.00	
1 00			1	1			1 1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW 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	29, 546					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	210	84, 892				8.00
9.00	00900 HOUSEKEEPI NG	52	0	40, 348			9.00
10.00	01000 DI ETARY	0	C	0	100		10.00
13.00	01300 NURSING ADMINISTRATION	557	0	557	0	87, 574	
14.00	01400 CENTRAL SERVICES & SUPPLY	0		001	0	0	
15.00	01500 PHARMACY	0		0	0	0	
		-	-	-	-		
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 790	C	1, 790	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	6.075	<u> </u>		100	04.005	
30.00	03000 ADULTS & PEDIATRICS	6, 375			100	36, 825	
43.00	04300 NURSERY	0	0	0 0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 373	17, 325	4, 373	0	11, 962	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0 0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 474	4,070	3, 474	0	0	54.00
60.00	06000 LABORATORY	1, 492			0	2, 150	60.00
65.00	06500 RESPI RATORY THERAPY	904		904	0	1, 054	
66.00	06600 PHYSI CAL THERAPY	1, 974			0	6, 851	
					0		
68.00	06800 SPEECH PATHOLOGY	0		0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	561	0	561	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	-	0 0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	475	0	475	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	2, 218	4, 572	0	0	88.00
88. 01	08801 RURAL HEALTH CLINIC II	0	1, 852	6, 492	0	0	88.01
91.00	09100 EMERGENCY	3, 881	12, 211	3, 881	0	28, 732	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			.,			92.00
,2,00	OTHER REIMBURSABLE COST CENTERS		1	1			/2:00
95.00	09500 AMBULANCE SERVICES	2, 932	2, 442	2, 932	0	0	95.00
75.00	SPECIAL PURPOSE COST CENTERS	2,752	2,442	2, 752	0	0	75.00
118.00		29,050	04 000	20.052	100	07 574	110 00
118.00		29,050	84, 892	39, 852	100	87, 574	118.00
100.00		0				0	100.00
	19300 NONPAI D WORKERS	0			0		193.00
	19301 ORTHO CLINIC	496	0	496	0		193.01
193.02	19303 COMMUNITY MED CLINIC	0	0	0 0	0	0	193.02
194.00	07950 MARKETI NG	0	0	0 0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	5	1					201.00
202.00	0	606, 104	7, 760	369, 701	12, 688	359, 994	
202.00	Part I)	000,104	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	007,701	12,000	007,774	
203.00		20. 513911	0. 091410	9. 162809	126.880000	4. 110741	203 00
204.00		97, 874	3, 188	7, 698	238	14, 841	204.00
005 53	Part II)			0 1007	0 0000	0.1/0/	005 05
205.00		3. 312597	0. 037554	0. 190790	2.380000	0. 169468	205.00
206.00							206.00
	(per Wkst. B-2)						
207.00							207.00
	Parts III and IV)						
			•		'		

Heal th Financial	Systems
COCT ALLOCATION	

Heal th	Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-1307	Peri od:	Worksheet B-1	
					From 07/01/2017 To 06/30/2018	Date/Time Pre	pared.
						11/26/2018 3:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL			
		SERVICES & SUPPLY	(COSTED REQUI S.)	RECORDS & LI BRARY			
		(DI RECT COSTS)	REQUIS.)	(GROSS			
		(DIRECT COSTS)		CHARGES)			
		14.00	15.00	16.00			
	GENERAL SERVICE COST CENTERS			•			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW 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 HOUSEKEEPING						9.00
10. 00 13. 00	01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON						10.00 13.00
13.00	01400 CENTRAL SERVICES & SUPPLY	83, 717					14.00
	01500 PHARMACY	03,717	100				15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0	68, 540, 79	24		16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS			00,010,71	· •		10.00
30.00	03000 ADULTS & PEDI ATRI CS	0	0	5, 715, 30)3		30.00
43.00	04300 NURSERY	0	0		0		43.00
	ANCILLARY SERVICE COST CENTERS	·					
	05000 OPERATI NG ROOM	0	0	5, 222, 70)7		50.00
53.00	05300 ANESTHESI OLOGY	0	0		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	16, 476, 06			54.00
	06000 LABORATORY	0	0	12, 597, 98			60.00
65.00		0	0	1, 586, 24			65.00
	06600 PHYSI CAL THERAPY	0	0	1, 749, 77	6		66.00
68.00 71.00	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47 104	0		0		68.00 71.00
	07200 IMPL. DEV. CHARGED TO PATTENTS	47, 104 36, 613	0		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	30, 013	100		0		73.00
70.00	OUTPATIENT SERVICE COST CENTERS		100		0		/0.00
88.00	08800 RURAL HEALTH CLINIC	0	0	3, 049, 08	31		88.00
	08801 RURAL HEALTH CLINIC II	0	0	2, 940, 08			88.01
91.00	09100 EMERGENCY	0	0	16, 767, 58	37		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	1					
95.00	09500 AMBULANCE SERVICES	0	0	2, 435, 95	57		95.00
110 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	02 717	100	(0 540 70	24		1110 00
118.00	NONREIMBURSABLE COST CENTERS	83, 717	100	68, 540, 79	/4		118.00
193 00	19300 NONPAI D WORKERS	o	0		0		193.00
	19301 ORTHO CLINIC	0	0		0		193.00
	19303 COMMUNITY MED CLINIC	0	0		0		193.02
	07950 MARKETI NG	0	0		0		194.00
200.00							200.00
201.00							201.00
202.00	Cost to be allocated (per Wkst. B,	12, 584	844, 043	83, 36	9		202.00
	Part I)						
203.00		0. 150316	8, 440. 430000	0.00121			203.00
204.00		236	15, 856	27, 52	29		204.00
005 00	Part II)	0.000010	150 5/0000				005 00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 002819	158. 560000	0.00040	12		205.00
206.00							206.00
200.00	(per Wkst. B-2)						
207.00							207.00
	Parts III and IV)						

	. VINCENT WILLI					2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 07/01/2017		
				To 06/30/2018	Date/Time Pre 11/26/2018 3:	
		Title	e XVIII	Hospi tal	Cost	JU pili
				Costs	0001	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS					•	
30. 00 03000 ADULTS & PEDI ATRI CS	2, 670, 887		2, 670, 88	7 0	0	30.00
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	829, 417		829, 41	7 0	0	1 00.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 609, 789		1, 609, 78	9 0	0	54.00
60. 00 06000 LABORATORY	1, 882, 315		1, 882, 31	5 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	156, 106	0	156, 10	6 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	615, 335	0	615, 33	5 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	99, 951		99, 95	1 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	57, 582		57, 58	2 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	866, 942		866, 94	2 0	0	73.00
OUTPATIENT SERVICE COST CENTERS				_		
88.00 08800 RURAL HEALTH CLINIC	2, 821, 051		2, 821, 05	1 0	0	00.00
88.01 08801 RURAL HEALTH CLINIC II	3, 070, 104		3, 070, 10	4 0	0	00101
91. 00 09100 EMERGENCY	3, 955, 774		3, 955, 77	4 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	647, 996		647, 99	6	0	92.00
OTHER REIMBURSABLE COST CENTERS	-1			-1		
95. 00 09500 AMBULANCE SERVICES	975, 825		975, 82			95.00
200.00 Subtotal (see instructions)	20, 259, 074		20, 259, 07			200.00
201.00 Less Observation Beds	647, 996		647, 99	6		201.00
202.00 Total (see instructions)	19, 611, 078	(C	19, 611, 07	8 0	0	202.00

Hear the Financial Systems 31.	VINCENT WILLIP	WSPURI HUSPIIF		III LIE		2002-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Peri od:	Worksheet C	
				From 07/01/2017	Part I	
				To 06/30/2018		
		T: +1 -		lla ani tal	11/26/2018 3:	30 pm
			XVIII	Hospi tal	Cost	
		Charges	T I I I I		TEEDA	
Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
	(00	7.00	0.00	0.00	Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 481, 140		4, 481, 14			30.00
43. 00 04300 NURSERY	0			0		43.00
ANCI LLARY SERVI CE COST CENTERS	I					
50.00 OPERATING ROOM	151, 088	5, 071, 619	5, 222, 70			
53.00 05300 ANESTHESI OLOGY	0	0		0 0. 000000		
54.00 05400 RADI OLOGY-DI AGNOSTI C	734, 196	15, 741, 871			0. 000000	
60. 00 06000 LABORATORY	996, 557	11, 601, 428			0. 000000	1
65. 00 06500 RESPI RATORY THERAPY	84, 836	1, 501, 410	1, 586, 24	6 0. 098412	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	309, 201	1, 440, 575	1, 749, 77	6 0. 351665	0.000000	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0.000000	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	692, 721	882, 892	1, 575, 61	3 0. 063436	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	37, 352	190, 977	228, 32	9 0. 252189	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 030, 078	2, 532, 168	3, 562, 24	6 0. 243369	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS			•	÷		
88.00 08800 RURAL HEALTH CLINIC	0	3, 049, 081	3, 049, 08	1		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	2, 940, 085	2, 940, 08	5		88.01
91.00 09100 EMERGENCY	200, 660	16, 566, 927	16, 767, 58	7 0. 235918	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	79, 037	1, 155, 126	1, 234, 16	3 0. 525049	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
95.00 09500 AMBULANCE SERVICES	0	2, 435, 957	2, 435, 95	7 0. 400592	0.000000	95.00
200.00 Subtotal (see instructions)	8, 796, 866					200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8, 796, 866	65, 110, 116	73, 906, 98	2		202.00
				I		

Health	Financial Systems SI.	VINCENT WILLIAM	SPORT HUSPITAL	In Lie	J OT FORM CMS-	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1307	Peri od:	Worksheet C	
				From 07/01/2017	Part I	
				To 06/30/2018	Date/Time Pre	
			Title XVIII	Hospi tal	<u>11/26/2018 3:</u> Cost	30 pm
	Cost Center Description	PPS Inpatient			CUSI	
	cost center bescription	Ratio				
		11.00				
I	NPATIENT ROUTINE SERVICE COST CENTERS	11.00				
	D3000 ADULTS & PEDIATRICS					30.00
	D4300 NURSERY					43.00
-	ANCILLARY SERVICE COST CENTERS	1 1				
50.00	D5000 OPERATI NG ROOM	0.000000				50.00
53.00 0	D5300 ANESTHESI OLOGY	0.000000				53.00
54.00 0	D5400 RADI OLOGY-DI AGNOSTI C	0.000000				54.00
60.00	D6000 LABORATORY	0. 000000				60.00
65.00 0	06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00 0	D6600 PHYSI CAL THERAPY	0. 000000				66.00
68.00 0	D6800 SPEECH PATHOLOGY	0.000000				68.00
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
C	DUTPATIENT SERVICE COST CENTERS					
88.00 0	D8800 RURAL HEALTH CLINIC					88.00
88.01 0	D8801 RURAL HEALTH CLINIC II					88. 01
91.00	D9100 EMERGENCY	0.000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
	OTHER REIMBURSABLE COST CENTERS	1 1				
	09500 AMBULANCE SERVI CES	0. 000000				95.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

11/26/2018 3:30 pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

Health Financial Systems ST.	VINCENT WILLIA	AMSPURI HUSPITA	۹L .	In Lie	U OT FORM CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 07/01/2017	Part I	
				To 06/30/2018		
					11/26/2018 3:	30 pm
		liti	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1	-1		
30. 00 03000 ADULTS & PEDIATRICS	2, 670, 887		2, 670, 88	7 0	2, 670, 887	30.00
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	829, 417		829, 41	7 0	829, 417	50.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 609, 789		1, 609, 78	9 0	1, 609, 789	54.00
60. 00 06000 LABORATORY	1, 882, 315		1, 882, 31	5 0	1, 882, 315	60.00
65. 00 06500 RESPI RATORY THERAPY	156, 106	0	156, 10	6 0	156, 106	65.00
66. 00 06600 PHYSI CAL THERAPY	615, 335	0	615, 33	5 0	615, 335	66.00
68.00 06800 SPEECH PATHOLOGY	0	l o		o o	0	68,00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	99, 951		99, 95	1 0	99, 951	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	57, 582		57, 58		57, 582	1
73.00 07300 DRUGS CHARGED TO PATIENTS	866, 942		866, 94		866, 942	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	2, 821, 051		2, 821, 05	1 0	2, 821, 051	88.00
88.01 08801 RURAL HEALTH CLINIC II	3, 070, 104		3, 070, 10		3, 070, 104	
91. 00 09100 EMERGENCY	3, 955, 774		3, 955, 77		3, 955, 774	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	647,996		647,99		647, 996	
OTHER REIMBURSABLE COST CENTERS	011,770		017,77		011,770	72.00
95. 00 09500 AMBULANCE SERVICES	975, 825		975, 82	5 0	975, 825	95 00
200.00 Subtotal (see instructions)	20, 259, 074		20, 259, 07		20, 259, 074	1
201.00 Less Observation Beds	647, 996		20, 239, 07		20, 239, 074 647, 996	
201.00 Total (see instructions)	19, 611, 078					1
	19,011,078	0	19,011,07	0 0	19,011,078	202.00

^{11/26/2018 3:30} pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

Hearth Financial Systems SI.	VINCENT WILLIF	MSPORT HUSPITA	AL .	In Lie	U OF FORM CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2017 To 06/30/2018	11/26/2018 3:	
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 481, 140		4, 481, 14	0		30.00
43. 00 04300 NURSERY	0			0		43.00
ANCI LLARY SERVI CE COST CENTERS			-			
50.00 05000 OPERATING ROOM	151, 088	5, 071, 619	5, 222, 70	0. 158810	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	734, 196	15, 741, 871	16, 476, 06	0. 097705	0. 000000	54.00
60. 00 06000 LABORATORY	996, 557	11, 601, 428	12, 597, 98	0. 149414	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	84, 836	1, 501, 410	1, 586, 24	6 0. 098412	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	309, 201	1, 440, 575	1, 749, 77	6 0. 351665	0. 000000	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	692, 721	882, 892	1, 575, 61	3 0.063436	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	37, 352	190, 977	228, 32	.9 0. 252189	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 030, 078	2, 532, 168	3, 562, 24	6 0. 243369	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	3, 049, 081	3, 049, 08	0. 925214	0.000000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	2, 940, 085	2, 940, 08	5 1.044223	0. 000000	88.01
91.00 09100 EMERGENCY	200, 660	16, 566, 927	16, 767, 58	0. 235918	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	79, 037	1, 155, 126	1, 234, 16	0. 525049	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	0	2, 435, 957	2, 435, 95	7 0. 400592	0.000000	95.00
200.00 Subtotal (see instructions)	8, 796, 866	65, 110, 116	73, 906, 98	2		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8, 796, 866	65, 110, 116	73, 906, 98	2		202.00
				i i		

				Date/Time Pre 11/26/2018 3:	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
D. 00 03000 ADULTS & PEDIATRICS					30.00
3. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS					
D. 00 05000 OPERATING ROOM	0.000000				50.00
3. 00 05300 ANESTHESI OLOGY	0.000000				53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000				54.00
D. 00 06000 LABORATORY	0. 000000				60.00
5. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
6. 00 06600 PHYSI CAL THERAPY	0.000000				66.00
3. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
3. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
OUTPATIENT SERVICE COST CENTERS					
3. 00 08800 RURAL HEALTH CLINIC	0.000000				88.00
3. 01 08801 RURAL HEALTH CLINIC II	0.000000				88.01
1.00 09100 EMERGENCY	0.000000				91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
OTHER REI MBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES	0.000000				95.00
00.00 Subtotal (see instructions)					200.00
01.00 Less Observation Beds					201.00
D2.00 Total (see instructions)					202.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Pre 11/26/2018 3:	pared: 30 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	00.710	5 000 707	0.0450		4 70/	
50. 00 05000 OPERATI NG ROOM	82, 712	5, 222, 707				
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	87, 021					1
60. 00 06000 LABORATORY	61, 975					1
65. 00 06500 RESPI RATORY THERAPY	16, 743					
66. 00 06600 PHYSI CAL THERAPY	41, 777					
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 014				2, 342	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 081				90	
73.00 07300 DRUGS CHARGED TO PATIENTS	23, 175	3, 562, 246	0.00650	06 555, 108	3, 612	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	107, 160				0	88.00
88.01 08801 RURAL HEALTH CLINIC II	134, 012				0	88. 01
91.00 09100 EMERGENCY	140, 027				0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	36, 274	1, 234, 163	0. 02939	92 10, 529	309	92.00
OTHER REIMBURSABLE COST CENTERS	1		1	- 1		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	741, 971	66, 989, 885		2, 081, 706	15, 591	200.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL .	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2017 To 06/30/2018		narod
				10 00/ 30/ 2016	11/26/2018 3:	
		Title	e XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	Non Physician	Nursing School	Nursing Schoo		Allied Health	
	Anesthetist	Post-Stepdown	Ŭ	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS				_		
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1			-		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88. 01
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1		1	1		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2017 To 06/30/2018	Part IV Date/Time Pre	narod
					11/26/2018 3:	
	_	Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,		
	Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	(8	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	-	1			
50. 00 05000 OPERATING ROOM	0	0		0 5, 222, 707		•
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 16, 476, 067		
60. 00 06000 LABORATORY	0	0		0 12, 597, 985		
65.00 06500 RESPI RATORY THERAPY	0	0		0 1, 586, 246		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 749, 776		•
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 575, 613		•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 228, 329		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 562, 246	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 3, 049, 081		•
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 2, 940, 085		
91. 00 09100 EMERGENCY	0	0		0 16, 767, 587		•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 234, 163	0.00000	92.00
OTHER REI MBURSABLE COST CENTERS			1			4
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	1	0 66, 989, 885		200.00

Health Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 3:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1	- 1	1	
50. 00 05000 OPERATI NG ROOM	0. 000000	107, 745		0 0	0	50.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	345, 527		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	519, 054		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	43, 168		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	113, 003		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	368, 541		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	19, 031		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	555, 108		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	10, 529		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)		2, 081, 706	1	0 0	0	200. 00

11/26/2018 3:30 pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2017 To 06/30/2018		
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 158810	0	2, 107, 87	3 0	0	00.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 097705	0	5, 561, 00	1 0	0	54.00
60. 00 06000 LABORATORY	0. 149414	0	5, 004, 97	3 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 098412	0	681, 66	2 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 351665	0	591, 18	8 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.063436	0	426, 40	3 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 252189	0	59, 49	2 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 243369	0	1, 051, 48	0 3, 184	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0.00000				0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	88.01
91. 00 09100 EMERGENCY	0. 235918	0	4, 690, 11	5 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 525049	l o	638, 44	9 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		· · · · · ·		1		
95. 00 09500 AMBULANCE SERVICES	0. 400592			0		95.00
200.00 Subtotal (see instructions)		l o	20, 812, 63	6 3, 184	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0	Ū	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	20, 812, 63	6 3, 184	0	202.00

Heal th Financ	ial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	۱L	In Lie	u of Form CMS-	2552-10
APPORTI ONMENT	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VAC		Provider CC			Worksheet D Part V Date/Time Pre 11/26/2018 3:	
				XVIII	Hospi tal	Cost	
		Cos					
(Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ARY SERVICE COST CENTERS	004 754					50.00
	OPERATING ROOM	334, 751	0				50.00
	ANESTHESI OLOGY	0	0				53.00
	RADI OLOGY-DI AGNOSTI C	543, 338					54.00
		747, 813					60.00
	RESPI RATORY THERAPY	67,084					65.00
	PHYSI CAL THERAPY	207, 900	0				66.00
	SPEECH PATHOLOGY	0	0				68.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 049					71.00
	IMPL. DEV. CHARGED TO PATIENT	15, 003					72.00
	DRUGS CHARGED TO PATIENTS	255, 898	775				73.00
	IENT SERVICE COST CENTERS	1					-
	RURAL HEALTH CLINIC	0	0				88.00
	RURAL HEALTH CLINIC II	0	0				88. 01
	EMERGENCY	1, 106, 483					91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	335, 217	0				92.00
	REIMBURSABLE COST CENTERS	i .					
	AMBULANCE SERVI CES	0					95.00
	Subtotal (see instructions)	3, 640, 536	775				200.00
	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	3, 640, 536	775				202.00

11/26/2018 3:30 pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2017 To 06/30/2018		
					11/26/2018 3:	30 pm
		Title		Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 05000 OPERATI NG ROOM	0. 158810			0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 097705	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 149414	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 098412	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 351665	0		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 063436	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 252189	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 243369	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	88.01
91. 00 09100 EMERGENCY	0. 235918	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 525049	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		•	•			1
95. 00 09500 AMBULANCE SERVICES	0. 400592			0		95.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health F	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1307	Peri od:	Worksheet D	
			Component (CCN: 15-Z307	From 07/01/2017 To 06/30/2018	Part V Date/Time Pre	nared
			component	56N. 15 2507	10 00/30/2010	11/26/2018 3:	
			Title	XVIII	Swing Beds - SNF		
			sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.) 6.00	(see inst.) 7.00				
	ANCILLARY SERVICE COST CENTERS	0.00	7.00				
	D5000 OPERATI NG ROOM	0	0				50.00
	D5300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	D6000 LABORATORY	0	0				60.00
	06500 RESPI RATORY THERAPY	0	0				65.00
	06600 PHYSI CAL THERAPY	0	0				66,00
68.00 0	06800 SPEECH PATHOLOGY	0	0				68,00
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 0	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
C	DUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0				88.00
	08801 RURAL HEALTH CLINIC II	0	0				88. 01
	09100 EMERGENCY	0	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	OTHER REIMBURSABLE COST CENTERS		1	1			4
	09500 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	0	0				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0				202.00

Cost Center Description		Titl	e XIX	Period: From 07/01/2017 To 06/30/2018 Hospital	Date/Time Pre 11/26/2018 3: Cost	pared: 30 pm
INPATI ENT ROUTI NE SERVI CE COST CENTERS	Post-Stepdown Adjustments		Allied Health	Allied Health		
INPATI ENT ROUTI NE SERVI CE COST CENTERS	Post-Stepdown Adjustments	Nursing School			All Other	
	Adjustments		Post-Stendowr			
			rost stopaom	n Cost	Medi cal	
	1A		Adjustments		Education Cost	
		1.00	2A	2.00	3.00	
				-		
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
3. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
·	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,			5 5	
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	2, 26	8 0.00	8	30.00
3. 00 04300 NURSERY		0		0.00	0	43.00
200.00 Total (lines 30 through 199)		0	2, 26	8	8	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 & PEDIATRICS	0					30.00
3. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2017 To 06/30/2018		narod
				10 00/30/2016	11/26/2018 3:	
		Ti tl	e XIX	Hospi tal	Cost	<u> </u>
Cost Center Description	Non Physician	Nursing School	Nursing Schoo		Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1			1		
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	C		0 0	0	88. 01
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1	-	1			
95. 00 09500 AMBULANCE SERVICES					l I	95.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2017 To 06/30/2018		narod
				10 00/ 30/ 2010	11/26/2018 3:	30 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,		
	Education Cost	5	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	(8	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0	0		0 5, 222, 707		
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 16, 476, 067		
60. 00 06000 LABORATORY	0	0		0 12, 597, 985		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 586, 246		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 749, 776		•
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0. 000000	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 575, 613		•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 228, 329		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 562, 246	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS				1		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 3, 049, 081		•
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 2, 940, 085		
91. 00 09100 EMERGENCY	0	0		0 16, 767, 587	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 234, 163	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS				1		
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	0		0 66, 989, 885		200.00

Health Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-1307	Period: From 07/01/2017	Worksheet D Part IV	
				To 06/30/2018		
		Titl	e XIX	Hospi tal	Cost	<u>30 piii</u>
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.	U	Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0.000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	6, 220		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	4, 434		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	310		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 795		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	10, 519		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
91.00 09100 EMERGENCY	0. 000000	879		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)		25, 157		0 0	0	200. 00

11/26/2018 3:30 pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

ST.	VI NCENT	WI LLI AMSPORT	HOSPI TAL

In Lieu of Form CMS_2552_10

From 87/2017 Display Display Display <th></th> <th>Financial Systems ST. VINCENT WILLIAMS ATION OF INPATIENT OPERATING COST</th> <th>PORT HOSPITAL Provider CCN: 15-1307</th> <th>In Lie Period:</th> <th>u of Form CMS-2 Worksheet D-1</th> <th></th>		Financial Systems ST. VINCENT WILLIAMS ATION OF INPATIENT OPERATING COST	PORT HOSPITAL Provider CCN: 15-1307	In Lie Period:	u of Form CMS-2 Worksheet D-1	
Desk THE AVIII Desk Cost 0001 Cost Center Description 1.00 1.00 1001 Inpatient days (including private room days and saing-bed days, excluding newtorn) 2.268 2. 100 Inpatient days (including private room days, excluding sing-bed and exervation bed days). If you have only private room days. 0.268 2.268 2. 100 Cost of the days (including private room days. excluding vivate room days). If you have only private room days. 0.268<	01			From 07/01/2017	Date/Time Pre	pared:
PART 1 - ALL PROVIDER COMPONENTS 1.00 100 Implified Days (incluing private room days and sping-bod days, excluding newborn) 2.957 100 Implified Days (incluing private room days, excluding newborn) 2.957 2.00 Private room days (excluding saing-bed and observation bed days) 17 you have only private room days, do not complete this line) 3.00 2.01 Total saing-bed SK type inpatient days (including private room days) through December 31 of the cost reporting period (inclendera year, enter 0 on this line) 3.01 2.00 Total saing-bed SK type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 3.01 2.00 Total saing-bed SK type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 3.01 2.00 Total inspection days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 3.01 3.00 String-bed SK type inpatient days applicable to title XVII only (including private room days) 3.01 3.00 String-bed SK type inpatient days applicable to title XVII only (including private room days) 0 1.2 3.01 December 31 of the cos		Cost Contor Description	Title XVIII	Hospi tal		
IMPART LET DAYS Impart Let TAYS 00 Inpattert days (including private room days, axcluding saing-bed and nextorn days) 2,268 2.00 Find tert days (including private room days, axcluding saing-bed and nextorn days) 0.3 4.00 Semi-private room days (excluding saing-bed and observation bed days) 1.551 4.00 Semi-private room days (excluding saing-bed and observation bed days) 1.551 4.01 Total saing-bed SR type inpattent days (including private room days) after December 31 of the cost 344 7.00 Treporting period 1.551 4. 8.00 Total saing-bed SR type inpattent days (including private room days) after December 31 of the cost 1 9.00 Total saing-bed SR type inpattent days (including private room days) after December 31 of the cost 1 9.00 Total saing-bed SR type inpattent days applicable to the Program (excluding saing-bed and 1.569 9.00 Total saing-bed SR type inpattent days applicable to the Program (excluding private room days) 307 10.00 Saing-bed SR type inpattent days applicable to the Program (excluding private room days) 307 10.01 Saing-bed SR type inpattent days applicable to the VI to VI inpote Anoon days) 307					1.00	
1.00 Inpatient days (including private room days, and asing-bed days, excluding newborn) 2.767 1.00 Inpatient days (including private room days, excluding swing-bed and observation bed days). If you have only private room days, days and the private room days, days and the private room days. 0.8 1.00 Finite room days (excluding swing-bed and observation bed days). If you have only private room days. 1.551 1.00 Finite room days (excluding swing-bed and observation bed days). 1.551 1.00 Finite room days (excluding swing-bed and observation bed days). 1.551 1.00 Finite room days. 1.561 1.00 Finite room days. 1.511 1.00 Sing-bed SN: type inpatient days applicable to title XVII only (including private room days) 307 1.00 Sing-bed SN: type inpatient days applicable to title XVII noly (including private room days) 311<						
3.00 Frivate room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 1.		Inpatient days (including private room days and swing-bed days				1.00
4.00 Semi-private room days (excluding swing-bed and observation bed days) 1,551 4,344 0.10 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 344 5. 7.00 Tropperiod (if calendar year, enter 0 on this line) 7.0 7.0 7.00		Private room days (excluding swing-bed and observation bed day		rivate room days,		
6.00 Total safing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost 17. 7.00 Total safing-bed NF type inpatient days (including private room days) after December 31 of the cost 1 8.00 Total safing-bed NF type inpatient days (including private room days) after December 31 of the cost 1 9.00 Total safing-bed SNF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 307 10.00 Sning-bed SNF type inpatient days applicable to title XVI only (including private room days) 317 10.00 Sning-bed NF type inpatient days applicable to titles VVI on this line) 307 10.00 Sning-bed NF type inpatient days applicable to titles VVI on this line) 318 10.00 Sning-bed NF type inpatient days applicable to the Program (excluding private room days) 112 11.00 Sning-bed NF type inpatient days applicable to the Program (excluding private room days) 118 11.00 Sning-bed NF type inpatient days applicable to services through December 31 of the cost reporting period 118 11.00 Sning-bed NF type inpatient days applicable to services after December 31 of the cost reporting period 118 11.00 <t< td=""><td></td><td>Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo</td><td></td><td>er 31 of the cost</td><td></td><td>4.00 5.00</td></t<>		Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost		4.00 5.00
7.00 Total safing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) applicable to the Program (excluding private room days) and through December 31 of the cost reporting period (including private room days) applicable to thitle XVII not 114 (XII ncluding private room days) applicable to the View (Including private room tay) app	6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	343	6.00
8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 1 8. 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and new days) including private room days) 11.156 9. 9.00 Total inpatient days including private room days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 307 10. 9.00 Swing-bed SW type Inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 307 10. 10.00 Swing-bed SW 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) 11. 11.00 Medical rotes reporting period (if calendar year, enter 0 on this line) 0 14. 12.00 Ming-bed SW type inpatient days applicable to services through December 31 of the cost 17. 12.00 Medical rate for swing-bed SW services applicable to services after December 31 of the cost 17. 13.00 Wedical drate for swing-bed WF services applicable to services after December 31 of the cost 13. 12. 10.00 Medical rate for swing-bed WF services applicable to services after December 31 of the cost 13.	7.00	Total swing-bed NF type inpatient days (including private roor	n days) through Decembe	r 31 of the cost	1	7.00
9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and historic days) 1, 156 9. 10.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after becember 31 of the cost reporting period (ic elender year, enter 0 on this line) 307 10. 11.00 Swing-bed SNF type inpatient days applicable to title V XVI only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 308 11. 12.00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 0 12. 13.00 Swing-bed NF type inpatient days applicable to title V or XIX only (including swing-bed days) 0 14. 14.00 Head Lity necessary private room days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 15.00 Nurser rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year) 16. 10.00 Modic are rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (ine period if are for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 0 SN ing-bed Cost applicable to SNF type services after December 31 of the cost reporting period (line 0 SN ing-bed cost applicable to SNF type services after December 31 of the cost reporting period	8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December	31 of the cost	1	8. 00
10.00 Swing-bed Swift Type inpatient days applicable to title XVIII only (including private room days) 307 10. 11.00 Swing-bed Swift Type inpatient days applicable to title XVIII only (including private room days) 307 10. 11.00 Swing-bed SW Type inpatient days applicable to title XVIII only (including private room days) 11. 308 11. 12.00 Swing-bed W Type inpatient days applicable to titles V or XIX only (including private room days) 0 12. 13.00 Swing-bed W Type inpatient days applicable to titles V or XIX only (including private room days) 0 14. 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. 15.00 Total nursery days (title V or XIX only) 0 15. 16.00 Medically necessary private room days applicable to services through December 31 of the cost 17. 17.00 Medical rate for swing-bed SWF services applicable to services through December 31 of the cost 137. 32 19. 17.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost 137. 32 19. 18.00 Medical rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x 1137. 32 20. 20. 20.	9.00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	1, 156	9. 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) 308 12:00 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 0 13:00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 14:00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 15:00 Total nursery days (title V or XIX only) 0 16:00 Wedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 17. 17:00 Medicaid rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18. 10:00 Vedicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 13. 10:00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 12. 10:00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x i line 20) 2. 10:00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x i line 20) 2.	10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	307	10.00
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 (if calendar year, enter 0 on this line). 0 12. 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. 14:00 Medically necessary private room days applicable to the Program (excluding swing-bed days). 0 14. 15:00 Total nursery days (title V or XIX only). 0 15. 0 Nursery days (title V or XIX only). 0 16. 17:00 Medicare rate for swing-bed SN F services applicable to services after December 31 of the cost reporting period. 18. 18. 18. 18. 18. 18. 18. 13.7.22 19. 12. 13.7.22 19. 12. 13.7.22 10. 13. 13. 13. 12. 13. 12. 20. 13. 13. 13. 12. 13. 12. 13. 12. 13. 12. 13. 12. 12. 13. 12. 13. 12. 13. 12. 13. 12. 13. 12. 13. 12	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private	room days) after	308	11. OC
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. 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. 15.00 Nursery days (title V or XIX only) 0 15. 16.00 Nursery days (title V or XIX only) 0 16. 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 17. 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 13.7.32 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x in 17). 2.6.07.887 2.1.6.7.887 12.00 Wing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x in 18). 2.2.670.887 2.2.670.887 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x in 17). 2.2.670.887 2.2.670.887 2.2.670.887 13.01 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x in 18). 2.2.670.887 2.2.670.887 2.2.670.887	12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		te room days)	0	12.00
14.00 Wedically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 14.00 Total nursery days (title V or XIX only) 0 15. 15.00 Nursery days (title V or XIX only) 0 16. 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 17. 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 137.32 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 137.32 20.00 Medicaid rate for swing-bed NF services cost (see instructions) 2, 670,887 21. 21.00 Total general inpatient routine service cost (see instructions) 2, 670,887 21. 22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 32. 23.00 Swing-bed cost (see instructions) 2. 2. 60. 24.00 Swing-bed cost (see instructions) 621.157 26. 26.00 General inpatient routine service cost net of swing-bed and observation bed charges) 0. 2. 26.00 General inpatient routine	13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
16.00 Nursery days (title V or XIX only) 0 16.00 SWING BED ADJUSTMENT 0 17.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 17. 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18. 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 137.32 20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 2.670,887 21.00 Total general inpatient routine service cost (see instructions) 2.670,887 21. 22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 5 x line 17) 2 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 2 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 2 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 2 26.00 Total swing-bed cost (see instructions) 2 2 2 26.0		Medically necessary private room days applicable to the Progra				
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 17.00 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18.00 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 137.32 10.00 Total general inpatient routine service cost (see instructions) 2.670,887 21.00 Total general inpatient routine services after December 31 of the cost reporting period (line 5 x line 17) 2.670,887 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 2.670,887 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 24.01 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 20.01 26.00 Total swing-bed cost (see instructions) 621,157 26.00 Swing-bed cost (see instructions) 2.049,730 27.00 General inpatient routine service cost reporting wing-bed and observation bed charges) 0 28.00 General inpatient routine service cost reporting wing-bed and observation bed charges) 0 0		Nursery days (title V or XIX only)			-	
18.00 Wedicare Tarte for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18.00 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 137.32 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 137.32 10.00 Total general inpatient routine service cost (see instructions) 2,670,887 21.00 Total general inpatient routine services after December 31 of the cost reporting period (line 5 x line 18) 2 23.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 2 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 2 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 6 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 6 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 6 27.00 General inpatient routine service cost net of swing-bed and observation bed charges) 6 28.00 Private room ch	17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 (of the cost		17.00
19.00Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period137.3219.20.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period137.3220.20.00Total general inpatient routine service cost (see instructions)2,670,88721.22.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line s r line 17)2,670,88721.23.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)023.24.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)13724.25.00Swing-bed cost (see instructions)621,15726.26.00Total swing-bed cost (see instructions)621,15726.27.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT0028.00General inpatient routine service cost/charge ratio (line 27 + line 28)0030.00Semi private room charges (excluding swing-bed charges) 0.0000031.00General inpatient routine service cost/charge ratio (line 32 minus line 33) (see instructions) 0.000032.00Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.000032.00Average per diem private room charge STHROUGH COST ADJUSTMENT PROKAM INPATIENT OPERATION COST	18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18.00
20.00Medicaid "rate for swing-bed NF services applicable to services after December 31 of the cost reporting period137.3220.21.00Total general inpatient routine service cost (see instructions)2,670,88721.22.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 17)22.22.23.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 18)23.24.24.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 19)137.24.25.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)137.24.26.00Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT PRIVATE room charges (excluding swing-bed charges)028.00General inpatient routine service charges (excluding swing-bed and observation bed charges) 0029.00Private room charges (excluding swing-bed charges) 0030.00Seem private room per diem charge (line 30 + line 4) 30.000.00000031.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 34 x line 31) 00.0033.00Average per diem private room charge differential (line 34 x line 31) 00.0035.00Private room cost differential (line 34 x line 35) 0037.00Private room cost differential (line 34 x line 38) 0<	19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 o	f the cost	137.32	19.00
21.00Total general inpatient routine service cost (see instructions)2, 670, 88721.22.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)0023.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)1124.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)1126.00Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)1126.00Total swing-bed cost (see instructions)621,15726.27.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)2,049,73027.28.00Frivate room charges (excluding swing-bed charges)028.29.00Private room charges (excluding swing-bed charges)000.00000031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.000000031.32.00Average per diem private room per diem charge (line 30 + line 3)0.000000031.33.00Average per diem private room cost differential (line 34 x line 31)0.0033.34.00Average per diem private room cost differential (line 34 x line 31)0.0035.35.00Private room cost differential (line 34 x line 31)0.0035.36.00Private room cost differential (line 34 x line 33)0.0035.37.00General inpatient routine servic	20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of	the cost	137.32	20.00
23.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)23.24.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)13724.25.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)13725.26.00Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)621,15726.27.00General inpatient routine service charges (excluding swing-bed and observation bed charges)621,15726.28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.29.00Private room charges (excluding swing-bed charges)000.00.31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.32.00Average semi-private room per diem charge (line 29 + line 3)0.0000032.33.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0033.34.00Average per diem private room cost differential (line 3 x line 35)0037.37.00General inpatient routine service cost per diem (see instructions)0.0035.37.00Average per diem private room cost differential (line 3 x line 35)0.0036.37.00Average per diem private room cost BEFORE PASS THROUGH COST ADJUSTMENTS0.0035.38.00Adjuste		Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ting period (line		21.00 22.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 137 24. 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 137 25. 26.00 Total swing-bed cost (see instructions) 621,157 26. 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2,049,730 27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0 20.00 Semi-private room charges (excluding swing-bed charges) 0 0 20.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31. 21.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 32. 32.00 Average per diem private room cost differential djustment (line 3 x line 35) 0.00 33. 33.00 Average per diem private room cost differential (line 3 x line 35) 0.30. 36. 33.00 Average per diem private room cost differential adjustment (line 3 x line 35) 0.35. 0.36.	23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23.00
25.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)13725.26.00Total swing-bed cost (see instructions)621, 15726.27.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)2, 049, 73027.PRIVATE ROOM DIFFERENTIAL ADJUSTMENT29.029.28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.29.00Private room charges (excluding swing-bed charges)029.30.00Semi-private room charges (excluding swing-bed charges)030.31.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.32.00Average perivate room per diem charge (line 29 ÷ line 3)0.0032.33.00Average semi-private room charge differential (line 32 minus line 33) (see instructions)0.0034.35.00Average per diem private room cost differential (line 3 x line 31)0.0035.36.00Private room cost differential adjustment (line 3 x line 35)036.37.00General inpatient routine service cost per diem grivate room cost differential (line 3 x line 35)036.37.00Average per diem private room cost BEFORE PASS THROUGH COST ADJUSTMENTS2,049,73037.38.00Adjusted general inpatient routine service cost per diem (see instructions)903.7638.39.00Program general inpatient routine service cost per diem (see instructions)903.7638.	24.00	Swing-bed cost applicable to NF type services through December	- 31 of the cost report	ng period (line	137	24.00
26.00Total swing-bed cost (see instructions)621,15726.27.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)2,049,73027.PRIVATE ROOM DIFFERENTIAL ADJUSTMENT028.28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.29.00Private room charges (excluding swing-bed charges)029.30.00Semi-private room charges (excluding swing-bed charges)030.31.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.32.00Average private room per diem charge (line 30 ÷ line 4)0.00032.34.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.00034.35.00Private room cost differential adjustment (line 3 x line 35)00.0035.37.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)36.37.PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS903.7638.38.00Adjusted general inpatient routine service cost (line 9 x line 38)1,044,74739.40.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.	25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	137	25. 00
PRI VATE ROOM DI FFERENTI AL ADJUSTMENT28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.29.00Private room charges (excluding swing-bed charges)029.30.00Semi-private room charges (excluding swing-bed charges)029.31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.32.00Average private room per diem charge (line 29 + line 3)0.00032.33.00Average semi-private room charge differential (line 30 + line 4)0.0033.34.00Average per diem private room charge differential (line 34 x line 31)0.0034.35.00Average per diem private room cost differential (line 3 x line 35)0.0035.37.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 049, 730)37.27 minus line 36)PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS903.7638.00Adjusted general inpatient routine service cost (line 9 x line 38)1, 044, 74739.00Program general inpatient routine service cost (line 9 x line 38)1, 044, 74739.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0		Total swing-bed cost (see instructions)	(line 21 minus line 24)			26.00
29.00Private room charges (excluding swing-bed charges)029.30.00Semi-private room charges (excluding swing-bed charges)030.31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000032.00Average private room per diem charge (line 29 + line 3)0.0033.00Average per vate room per diem charge (line 30 + line 4)0.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0035.00Average per diem private room cost differential (line 3 x line 31)0.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 049, 730)36.37.00Part 11 - HOSPI TAL AND SUBPROVI DERS ONLY0.00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS903.7638.00Adj usted general inpatient routine service cost per diem (see instructions)903.7639.00Program general inpatient routine service cost (line 9 x line 38)1, 044, 74740.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
30.00Semi-private room charges (excluding swing-bed charges)030.31.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.32.00Average private room per diem charge (line 29 ÷ line 3)0.0032.33.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0032.34.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0034.35.00Average per diem private room cost differential (line 34 x line 31)0.0034.36.00Private room cost differential adjustment (line 3 x line 35)0.0035.37.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 049, 730)37.27 minus line 36)PART 11 - HOSPI TAL AND SUBPROVI DERS ONLY903.76PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS903.7638.00Adjusted general inpatient routine service cost per diem (see instructions)903.7639.00Program general inpatient routine service cost (line 9 x line 38)1, 044, 74740.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0			d and observation bed c	narges)		
31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.32.00Average private room per diem charge (line 29 + line 3)0.0032.33.00Average semi-private room per diem charge (line 30 + line 4)0.0033.34.00Average per diem private room charge differential (line 32 minus line 33)(see instructions)0.0034.35.00Average per diem private room cost differential (line 34 x line 31)0.0034.36.00Private room cost differential adjustment (line 3 x line 35)036.37.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 049, 730)37.27minus line 36)036.PART 11 - HOSPI TAL AND SUBPROVIDERS ONLY038.PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS903.7638.00Adjusted general inpatient routine service cost (line 9 x line 38)1, 044, 74740.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0					-	29.00 30.00
32.00 Average private room per diem charge (line 29 + line 3) 0.00 32. 33.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 33. 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34. 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36. 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 049, 730 37. 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY 7. PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 903.76 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 903.76 39.00 Program general inpatient routine service cost (line 9 x line 38) 1, 044, 747 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0			÷line 28)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33. 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34. 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36. 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,049,730 37. 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY 7. PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 903.76 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 1,044,747 90.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0			/			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34. 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36. 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,049,730 37. 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY 37. PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 903.76 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 1,044,747 90.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0						
36.00 Private room cost differential adjustment (line 3 x line 35) 0 36. 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 049, 730) 37. 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY 27. PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 903.76 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 903.76 39.00 Program general inpatient routine service cost (line 9 x line 38) 1,044,747 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0	34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instru	ctions)	0.00	34.00
36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 0 2.049,730 36.00 2.049,730 37.00 27.00 27.00 27.00 27.00 37.00 27.00 37.00 27.00 37.00 27.00 37.00 37.00 27.00 37.00 27.00 38.00 36.00 36.00 36.00 36.00 36.00 9.00 36.00 9.00 36.00 9.00 36.00 36.00 37.00 38.00 37.00 37.00 38.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00			, ,			
PART II - HOSPITÁL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 903.76 39.00 Program general inpatient routine service cost (line 9 x line 38) 1,044,747 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0	36.00	Private room cost differential adjustment (line 3 x line 35)		fferential (line	-	36.00 37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38.00Adjusted general inpatient routine service cost per diem (see instructions)903.7639.00Program general inpatient routine service cost (line 9 x line 38)1,044,74740.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0		27 minus line 36)	· · · · · · · · · · · · · · · · · · ·			
38.00Adjusted general inpatient routine service cost per diem (see instructions)903.7638.39.00Program general inpatient routine service cost (line 9 x line 38)1,044,74739.40.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.			JSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.	38.00				903.76	38.00
					1, 044, 747	39.00
		3 31 11 0	. ,			40.00 41.00

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In Lieu of Form CMS-2552-10

COMPUT	ATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-1307	Period: From 07/01/2017	Worksheet D-1	
					To 06/30/2018	Date/Time Pre 11/26/2018 3:	
			Title	XVIII	Hospi tal	Cost	<u>50 pm</u>
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient CostIr	ipatient Days	col. 2	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.0	0 0	0	42.00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL INTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			341, 214	48.00
	Total Program inpatient costs (sum of lines 4			ns)		1, 385, 961	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine se	ervices (from	Wkst. D, sum	of Parts I and	0	50.00
	111)						E1 00
51.00	Pass through costs applicable to Program inpa and IV)	attent and trary	Services (II	UM WKSL. D, S	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines !					0	52.00
53.00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 9		ated, non-phy	sician anesth	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program discharges					0	54.00
	Target amount per discharge						55.00
	Target amount (line 54 x line 55)	ing cost and tar	not amount (l	ino E4 minuc	Lino E2)	0	56.00 57.00
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and targ	jet allount (i	The so minus	TTHE 55)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period er	nding 1996, u	pdated and co	mpounded by the	-	59.00
(0.00	market basket					0.00	(0.00
60.00 61.00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0. 00 0	60. 00 61. 00
01.00	which operating costs (line 53) are less than					0	01.00
	amount (line 56), otherwise enter zero (see i				5		
	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	Tons)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the	cost reporti	ng period (See	277, 454	64.00
45 00	instructions)(title XVIII only)	te after December	- 21 of the e	act raparting	pariod (Saa	270 250	45 00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)		ST OF THE C	ost reporting	period (see	278, 358	05.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 64	1 plus line 6	5)(title XVII	I only). For	555, 812	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through [December 31 o	f the cost re	porting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of	the cost repo	rting period	0	68.00
	(line 13 x line 20)						
69.00	Total title V or XIX swing-bed NF inpatient N PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
	Skilled nursing facility/other nursing facili						70.00
71.00 72.00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71.00 72.00
	Medically necessary private room cost application	,	íline 14 x li	ne 35)			73.00
	Total Program general inpatient routine servi	0	•				74.00
75.00	Capital-related cost allocated to inpatient (routine service o	costs (from W	orksheet B, P	art II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line	,					77.00
	Inpatient routine service cost (line 74 minus						78.00
	Aggregate charges to beneficiaries for excess	• •		· · ·	us line 70)		79.00
80.00 81.00	Total Program routine service costs for compa Inpatient routine service cost per diem limi				us IIIE /7)		80.00 81.00
	Inpatient routine service cost limitation (li						82.00
83.00	Reasonable inpatient routine service costs ()				83.00
84.00	Program inpatient ancillary services (see ins		-)				84.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00 86.00
20.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						22.00
	Total observation bed days (see instructions)					717	87.00
	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		ine 2)			903. 76 647, 996	
57.00	usservation bed cost (The or A The 00) (Set					047, 770	07.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2017	Worksheet D-1	
				To 06/30/2018	Date/Time Pre 11/26/2018 3:	pared: 30 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	149, 514	2, 670, 887	0. 05597	9 647, 996	36, 274	90.00
91.00 Nursing School cost	0	2, 670, 887	0.00000	0 647, 996	0	91.00
92.00 Allied health cost	0	2, 670, 887	0.00000	0 647, 996	0	92.00
93.00 All other Medical Education	0	2, 670, 887	0. 00000	0 647, 996	0	93.00

^{11/26/2018 3:30} pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

	Financial Systems ST. VINCENT WILLIAMS ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1307	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2017 To 06/30/2018		
		Title XIX	Hospi tal	11/26/2018 3: Cost	30 pi
	Cost Center Description		- Hoopi tui	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s excluding newborn)		2, 957	1.
00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		2, 268	2.
00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		1, 551	4.
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	343	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om dave) after December	21 of the cost	344	6
50	reporting period (if calendar year, enter 0 on this line)	un days) arter becenber	ST OF THE COST	544	0
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	1	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	1	8
50	reporting period (if calendar year, enter 0 on this line)	in days) arter becember t	in on the cost	1	0.
00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	8	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	room days)	0	10
	through December 31 of the cost reporting period (see instruc	tions)	5,	-	
00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room davs)	0	12
	through December 31 of the cost reporting period		5 /	-	
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr			0	14
00	Total nursery days (title V or XIX only)		-	0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 d	of the cost		17
~~	reporting period				10
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	137.32	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of 1	he cost	137.32	20
	reporting period				
	Total general inpatient routine service cost (see instruction		ing ported (line	2, 670, 887	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17)	er 31 of the cost report	ing period (ine	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	137	21
. 00	7 x line 19)	i si oi the cost reporti	ng period (inne	157	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	137	25
. 00	x line 20) Total swing-bed cost (see instructions)			621, 157	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 049, 730	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abcomuction had a		0	1 20
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	a and observation bed cr	larges)	0	
00	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
00	Average per diem private room cost differential (line 34 x li			0.00	35
00	Private room cost differential adjustment (line 3 x line 35)	and private and and the	fforontial (1)	0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	Tierential (Tine	2, 049, 730	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		1	002 74	20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			903.76 7,230	
	Medically necessary private room cost applicable to the Progr			0	
	Total Program general inpatient routine service cost (line 39			7, 230	41

Heal th	Fi nanci al	Systems	

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In Lieu of Form CMS-2552-10

Heal th Fi	nancial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL	In Lie	eu of Form CMS-2	2552-10
COMPUTATI	ION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
					From 07/01/2017 To 06/30/2018		narod
					10 00/ 30/ 2010	11/26/2018 3:	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per	Program Days		
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
42.00 NU	JRSERY (title V & XIX only)	1.00					42.00
	itensive Care Type Inpatient Hospital Units				<u> </u>		12100
	NTENSI VE CARE UNI T						43.00
44.00 CO	DRONARY CARE UNI T						44.00
	JRN INTENSIVE CARE UNIT						45.00
	JRGI CAL INTENSI VE CARE UNI T						46.00
47.00 01	THER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	cost center bescription					1.00	
48.00 Pr	rogram inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			4, 246	48.00
	otal Program inpatient costs (sum of lines 4	11 through 48)((see instructio	ons)		11, 476	49.00
	SS THROUGH COST ADJUSTMENTS						
	ass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50.00
) ass through costs applicable to Program inpa	atient ancillar	ry services (fr	om Wkst D s	um of Parts II	0	51.00
	nd IV)		y services (11				
52.00 To	otal Program excludable cost (sum of lines !	50 and 51)				0	52.00
	otal Program inpatient operating cost exclue		elated, non-phy	/sician anesth	etist, and	0	53.00
	edical education costs (line 49 minus line !	52)					
	RGET AMOUNT AND LIMIT COMPUTATION					0	54.00
	arget amount per discharge					0.00	
	arget amount (line 54 x line 55)					0.00	
	fference between adjusted inpatient operati	ng cost and ta	arget amount (I	ine 56 minus	line 53)	0	
1	onus payment (see instructions)	5	5		,	0	58.00
	esser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, u	updated and co	mpounded by the	0.00	59.00
	arket basket					0.00	10.00
	esser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	60.00 61.00
	nich operating costs (line 53) are less than				2	0	01.00
	nount (line 56), otherwise enter zero (see i				the target		
	elief payment (see instructions)	,				0	62.00
	lowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	63.00
	COGRAM INPATIENT ROUTINE SWING BED COST		- 01 C II				1 / 1 00
	edicare swing-bed SNF inpatient routine cos nstructions)(title XVIII only)	ts through Dece	emper 31 of the	e cost reporti	ng period (See	0	64.00
	edicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the c	cost reporting	period (See	0	65.00
	nstructions)(title XVIII only)			1 5			
	otal Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66.00
	AH (see instructions)	acata through	December 21	f the east we	posting posied		47.00
	tle V or XIX swing-bed NF inpatient routine ine 12 x line 19)	e costs through	1 December 31 C	on the cost re	porting period	0	67.00
	tle V or XIX swing-bed NF inpatient routine	e costs after [December 31 of	the cost repo	rting period	0	68.00
	ine 13 x line 20)						
	otal title V or XIX swing-bed NF inpatient n NT III – SKILLED NURSING FACILITY, OTHER NU		`			0	69.00
	killed nursing facility/other nursing facili						70.00
1	djusted general inpatient routine service of						71.00
	rogram routine service cost (line 9 x line						72.00
73.00 Me	edically necessary private room cost applica	able to Program	m (line 14 x li	ne 35)			73.00
	otal Program general inpatient routine servi	•					74.00
	apital-related cost allocated to inpatient (routine service	e costs (from W	lorksheet B, P	art II, column		75.00
1	6, line 45) er diem capital-related costs (line 75 ÷ lin	2)					76.00
	rogram capital -related costs (line 9 x line						77.00
	npatient routine service cost (line 74 minus						78.00
	ggregate charges to beneficiaries for excess		provider record	ls)			79.00
80.00 To	otal Program routine service costs for compa		cost limitatior	n (line 78 min	us line 79)		80.00
	npatient routine service cost per diem limi		1)				81.00
	npatient routine service cost limitation (li						82.00
82.00 I n	perception in protion to reaction a second s					1	83.00
82.00 In 83.00 Re	easonable inpatient routine service costs (s		15)			1	81 00
82.00 I n 83.00 Re 84.00 Pr	rogram inpatient ancillary services (see in	structions)					84.00 85.00
82.00 I n 83.00 Re 84.00 Pr 85.00 Ut		structions) (see instructio	ons)				84.00 85.00 86.00
82. 00 In 83. 00 Re 84. 00 Pr 85. 00 Ut 86. 00 To PAI	rogram inpatient ancillary services (see in tilization review - physician compensation	structions) (see instruction of lines 83 th	ons)				85.00 86.00
82.00 In 83.00 Re 84.00 Pr 85.00 Ut 86.00 To PAI 87.00 To	rogram inpatient ancillary services (see in tilization review – physician compensation otal Program inpatient operating costs (sum NRT IV – COMPUTATION OF OBSERVATION BED PASS otal observation bed days (see instructions)	structions) (see instructions) of lines 83 the THROUGH COST	ons) hrough 85)			717	85.00 86.00 87.00
82.00 In 83.00 Re 84.00 Pr 85.00 Ut 86.00 To PAI 87.00 88.00 Ad	rogram inpatient ancillary services (see institution review - physician compensation tilization review - physician compensation otal Program inpatient operating costs (sum RT IV - COMPUTATION OF OBSERVATION BED PASS	structions) (see instructions) of lines 83 th THROUGH COST diem (line 27 diem)	ons) hrough 85) ÷ line 2)			717 903. 76 647, 996	85. 00 86. 00 87. 00 88. 00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2017	Worksheet D-1	
				To 06/30/2018	Date/Time Pre 11/26/2018 3:	pared: 30 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	149, 514	2, 670, 887	0. 05597	9 647, 996	36, 274	90.00
91.00 Nursing School cost	0	2, 670, 887	0.00000	0 647, 996	0	91.00
92.00 Allied health cost	0	2, 670, 887	0.00000	0 647, 996	0	92.00
93.00 All other Medical Education	0	2, 670, 887	0.00000	647, 996	0	93.00

^{11/26/2018 3:30} pm Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20180630 \HFS \20180630 Williamsport.mcr

Health Financial Systems ST. VINCENT WILLIAMSF	PORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 1		Period:	Worksheet D-3	
			rom 07/01/2017 o 06/30/2018	Date/Time Pre	narod
		'	0 00/30/2018	11/26/2018 3:	
	Title XVI		Hospi tal	Cost	
Cost Center Description	Rat	io of Cost	I npati ent	Inpati ent	
	To	o Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			2 500 274		30.00
43. 00 04300 NURSERY			2, 588, 374		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 158810	107, 745	17, 111	50.00
53. 00 05300 ANESTHESI OLOGY		0.000000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.097705		33, 760	
60. 00 06000 LABORATORY		0. 149414		77, 554	
65. 00 06500 RESPI RATORY THERAPY		0.098412	43, 168	4, 248	65.00
66. 00 06600 PHYSI CAL THERAPY		0.351665	113, 003	39, 739	66.00
68.00 06800 SPEECH PATHOLOGY		0.00000	0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.063436	368, 541	23, 379	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 252189		4, 799	
73.00 07300 DRUGS CHARGED TO PATIENTS		0.243369	555, 108	135, 096	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	88.00
88.01 08801 RURAL HEALTH CLINIC II		0.00000		0	88.01
91.00 09100 EMERGENCY		0.235918		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 525049	10, 529	5, 528	92.00
0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES					95.00
			2 001 704	241 214	
200.00Total (sum of lines 50 through 94 and 96 through 98)201.00Less PBP Clinic Laboratory Services-Program only charges	(Lino 61)		2, 081, 706	341, 214	200.00
201.00 [Less PBP cirilic Laboratory Services-Program only charges 202.00] Net charges (line 200 minus line 201)			2, 081, 706		201.00
zoz. oo met charges (The zoo minus The zor)			2,001,700		202.00

Health Financial Systems ST. VINCENT WILLIAMSPO	RT HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovider CCN: 15-		eriod:	Worksheet D-3	
	Component CCN: 15		rom 07/01/2017 0 06/30/2018	Date/Time Pre	narod
	Somporterit Cont. 13	-2307	0 00/ 30/ 2010	11/26/2018 3:	
	Title XVIII	S	wing Beds - SNF		
Cost Center Description		of Cost	Inpati ent	I npati ent	
	To C	Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		. 00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	-		0		30.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					10.00
50. 00 05000 OPERATI NG ROOM		0.158810	8, 268	1, 313	50.00
53. 00 05300 ANESTHESI OLOGY		0.000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.097705	73, 115	7, 144	54.00
60. 00 06000 LABORATORY		0.149414	153, 375	22, 916	
65. 00 06500 RESPI RATORY THERAPY		0.098412		1, 031	1
66. 00 06600 PHYSI CAL THERAPY		0.351665		52, 155	
68.00 06800 SPEECH PATHOLOGY		0.000000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.063436		10, 622	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.252189		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 243369	185, 744	45, 204	73.00
0UTPATI ENT_SERVI CE_COST_CENTERS 88. 00 08800 RURAL HEALTH_CLINI C		0.000000		0	88.00
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II		0.000000		0	1
91. 00 log100 EMERGENCY		0. 235918		0	1
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0. 525049		365	
OTHER REIMBURSABLE COST CENTERS		0. 020017	070	000	/2.00
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			747, 437	140, 750	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			747, 437		202.00

Health Financial Systems ST. VINCENT WILLIAMSPORT HOSP	TAL	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider	CCN: 15-1307	Peri od:	Worksheet D-3	;
		From 07/01/2017 To 06/30/2018	Date/Time Pre	pared.
		10 00/00/2010	11/26/2018 3:	
	tle XIX	Hospi tal	Cost	
Cost Center Description	Ratio of Cos		Inpatient	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		07.400		
30. 00 03000 ADULTS & PEDI ATRI CS		27, 133		30.00
43.00 04300 NURSERY		0		43.00
ANCI LLARY SERVI CE COST CENTERS	0.4500			
50.00 05000 OPERATI NG ROOM	0. 1588		0	
53.00 05300 ANESTHESI OLOGY	0.0000		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.0977			
60.00 LABORATORY	0. 1494			•
65. 00 06500 RESPI RATORY THERAPY	0.0984		-	
66. 00 06600 PHYSI CAL THERAPY	0. 3516		0	
68.00 06800 SPEECH PATHOLOGY	0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.0634			
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 2521		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 2433	69 10, 519	2, 560	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 9252		0	
88.01 08801 RURAL HEALTH CLINIC II	1.0442		0	
91. 00 09100 EMERGENCY	0. 2359			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 5250	49 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				-
95. 00 09500 AMBULANCE SERVI CES				95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		25, 157	4, 246	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)	0		201.00
202.00 Net charges (line 200 minus line 201)	1	25, 157		202.00

In Lieu of Form CMS-2552-10

<u>He</u> al th	Financial Systems ST. VINCENT WILLIAM	ISPORT HOSPI TAL	In Lie	u of Form CMS-2	<u>255</u> 2-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Pre 11/26/2018 3:	pared:
		Title XVIII	Hospi tal	Cost	<u>30 pili</u>
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			3, 641, 311	
2.00	Medical and other services reimbursed under OPPS (see instruction	ctions)		0	
3.00 4.00	OPPS payments Outlier payment (see instructions)			0	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	•
6.00	Line 2 times line 5			0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	
10.00	Organ acqui si ti ons	10, col. 13, the 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3, 641, 311	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	
	Total reasonable charges (sum of lines 12 and 13)			0	
	Customary charges				1
	Aggregate amount actually collected from patients liable for			0	
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13		on a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0.000000	17.00
	Total customary charges (see instructions)			0	
19.00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds li	ne 11) (see	0	19.00
00.00	instructions)		10) (0	20.00
20. 00	Excess of reasonable cost over customary charges (complete or instructions)	niy if line il exceeds ii	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			3, 677, 724	21.00
	Interns and residents (see instructions)			0	22.00
	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			47, 164	25.00
	Deductibles and Coinsurance relating to amount on line 24 (for	or CAH, see instructions)	1	3, 094, 224	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	2 and 23] (see	536, 336	27.00
00 00	instructions)			0	20.00
	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29))		536, 336	•
	Primary payer payments			775	
32.00	Subtotal (line 30 minus line 31)			535, 561	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	I CES)		0	33.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			493, 901	
	Adjusted reimbursable bad debts (see instructions)			321, 036	
36.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		309, 125	
	Subtotal (see instructions)			856, 597	
	MSP-LCC reconciliation amount from PS&R			0	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for repla		ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			856, 597	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			17, 132 0	1
	Interim payments			1, 177, 337	
	Tentative settlement (for contractors use only)			0	
13.00	Balance due provider/program (see instructions)			-337, 872	
44.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions)			0	93.00 94.00
74. UU	Total (sum of lines 91 and 93)			0	74.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1307	Period: From 07/01/2017 To 06/30/2018		pared: 30 pm
		Title	XVIII	Hospi tal	Hospital Cost	
		Inpatient Part A		Par	Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1, 296, 7	25	1, 069, 137	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			0 02/08/2018	108, 200	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04				0	0	3.04
3.05	Provider to Program			0	0	3.05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.50				0	0	3.50
3.52				0	0	3. 52
3.53				0	0	3.53
3.54				0	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	108, 200	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 296, 7	25	1, 177, 337	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR	1				
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	1 1				
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02 5.03				0	0	5.02 5.03
5.05	Provider to Program			0	0	5.03
5.50	TENTATI VE TO PROGRAM			0	0	5. 5C
5.51				0	0	5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6. 01
6. 01 6. 02	SETTLEMENT TO PROVIDER		240, 1	12	337, 872	6.01
0.02 7.00	Total Medicare program liability (see instructions)		1, 056, 6		839, 465	7.02
			1,000,0	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		C)	1.00	2.00	
8.00	Name of Contractor					8.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C			iod: m 07/01/2017		
		Component CCN: 15-Z307		10	06/30/2018	Date/Time Pre 11/26/2018 3:	
		Title	XVIII	Swi	ng Beds - SNF		
		Inpatien	t Part A		Par	tВ	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00	Total interim payments paid to provider		826, 6	65		C	
00	Interim payments payable on individual bills, either			0		C) 2.
	submitted or to be submitted to the contractor for						
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero						
00	List separately each retroactive lump sum adjustment						3
00	amount based on subsequent revision of the interim rate						1
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider	-					
01	ADJUSTMENTS TO PROVIDER			0		C	
02				0		C	
03				0		C	
04				0 0		0	
05	Provider to Program			0		0) 3
50	ADJUSTMENTS TO PROGRAM			0		(5 3
51				0		C	
52				0		C	
53				0		C) 3
54				0		C) 3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		C) 3
~~	3.50-3.98)		00/ /				
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		826, 6	65		C	4
	appropriate)						
	TO BE COMPLETED BY CONTRACTOR						
00	List separately each tentative settlement payment after						5
	desk review. Also show date of each payment. If none,						
	write "NONE" or enter a zero. (1)						-
01	Program to Provider TENTATIVE TO PROVIDER	I	[0		C	5 5
01	TENTATIVE TO PROVIDER			0			
03				0		C	
	Provider to Program						
50	TENTATI VE TO PROGRAM			0		C	
51				0		C	
52				0		C	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		C) 5
00	Determined net settlement amount (balance due) based on						6
2.5	the cost report. (1)						
01	SETTLEMENT TO PROVIDER			0		C	6 0
02	SETTLEMENT TO PROGRAM		146, 6			C	
00	Total Medicare program liability (see instructions)		680, 0	59	_	С) 7
					Contractor	NPR Date	
)		Number 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor		,		1.00	2.00	8

Heal th	Financial Systems ST. VINCENT WILLIAMS	PORT HOSPI TAL	In Lie	u of Form CMS-	2552-10			
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1307	Peri od:	Worksheet E-1				
			From 07/01/2017	Part II				
			To 06/30/2018	Date/Time Pre 11/26/2018 3:				
		Title XVIII	Hospi tal	Cost	<u>30 pili</u>			
			noopritui	0001				
				1.00				
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS							
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		1.00					
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12							
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2							
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00			
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 [6.00			
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00			
	line 168							
8.00	Calculation of the HIT incentive payment (see instructions)				8.00			
9.00	Sequestration adjustment amount (see instructions)				9.00			
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00			
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH							
	Initial/interim HIT payment adjustment (see instructions)				30.00			
	Other Adjustment (specify)		``		31.00			
32.00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.							

LCUL		Provider CCN: 15-1307 Component CCN: 15-Z307	Period: From 07/01/2017 To 06/30/2018	Worksheet E-2 Date/Time Pre	
		•		11/26/2018 3:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
1	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient routine services - swing bed-SNF (see instructions)		561, 370	0	
00	Inpatient routine services - swing bed-NF (see instructions)				2.
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		142, 158	0	3.
00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst Per diem cost for interns and residents not in approved teachin			0.00	4.
00	instructions)	g program (see		0.00	4.
00	Program days		615	0	5.
00	Interns and residents not in approved teaching program (see ins	tructions)	010	0	
00	Utilization review - physician compensation - SNF optional meth		0	0	7.
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		703, 528	0	
00	Primary payer payments (see instructions)		0	0	
. 00	Subtotal (line 8 minus line 9)		703, 528	0	10
00	Deductibles billed to program patients (exclude amounts applica	ble to physician	0	0	11
	professional services)				
. 00	Subtotal (line 10 minus line 11)		703, 528	0	12
00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	10, 532	0	13
	for physician professional services)			_	
00	80% of Part B costs (line 12 x 80%)	、	(00.00)	0	
. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	692, 996	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
50 55	Pioneer ACO demonstration payment adjustment (see instructions) Rural community hospital demonstration project (§410A Demonstra	tion) novmont	0		16
55	adjustment (see instructions)	tron) payment	0		16
. 99	Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		1, 449	0	
	Adjusted reimbursable bad debts (see instructions)		942	0	
	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	0	
00	Total (see instructions)		693, 938	0	19
. 01	Sequestration adjustment (see instructions)		13, 879	0	19
02	Demonstration payment adjustment amount after sequestration)		0	0	19
00	Interim payments		826, 665	0	20
00	Tentative settlement (for contractor use only)		0	0	21
00	Balance due provider/program (line 19 minus lines 19.01, 20, an	d 21)	-146, 606	0	
00	Protested amounts (nonallowable cost report items) in accordanc	e with CMS Pub. 15-2,	0	0	23
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstra				1000
	Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no.	od under the 21st			200
	Cost Reimbursement				
1 00	Medicare swing-bed SNF inpatient routine service costs (from Wk	st D-1 Pt II line			201
	66 (title XVIII hospital))				
2. 00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, lin	ie		202
	200 (title XVIII swing-bed SNF))				
3. 00	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				204
	Computation of Demonstration Target Amount Limitation (N/A in f	irst year of the curre	nt 5-year demonst	ration	
	beriod)				0.05
	Medicare swing-bed SNF target amount	1 204)			205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 tim				206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse Program reimbursement under the §410A Demonstration (see instru				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,		1		207
. 00	and 3)	cor. r, sun or rifles	1		200
, 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruct	ions)			209
	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement				1-10
1	Total adjustment to Medicare swing-bed SNF PPS payment (line 20				215

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1307	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Pre 11/26/2018 3:	pare
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MED	DICARE PART A SERVICES - COST	REIMBURSEMENT		
. 00	Inpatient services			1, 385, 961	
. 00	Nursing and Allied Health Managed Care payment (see inst	tructions)		0	
. 00	Organ acquisition			0	
00	Subtotal (sum of lines 1 through 3)			1, 385, 961	
00	Primary payer payments			0	5
00	Total cost (line 4 less line 5). For CAH (see instruction	ons)		1, 399, 821	6
	COMPUTATION OF LESSER OF COST OR CHARGES				-
~~	Reasonable charges				- 1
00 00	Routine service charges Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
00	Total reasonable charges			0	
0.00	Customary charges			0	
. 00	Aggregate amount actually collected from patients liable	e for navment for services on	a charge basis	0	1 11
2.00	Amounts that would have been realized from patients liable		0	0	
00	had such payment been made in accordance with 42 CFR 413		in a charge basis	0	1 2
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13
. 00	Total customary charges (see instructions)			0	
5.00	Excess of customary charges over reasonable cost (comple	ete onlvifline 14 exceeds li	ne 6) (see	0	
	instructions)	,			
b. 00	Excess of reasonable cost over customary charges (comple	ete only if line 6 exceeds lir	ne 14) (see	0	16
	instructions)				
1.00	Cost of physicians' services in a teaching hospital (see	e instructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Direct graduate medical education payments (from Workshe	eet E-4, line 49)		0	
	Cost of covered services (sum of lines 6, 17 and 18)			1, 399, 821	
. 00	Deductibles (exclude professional component)			334, 848	
. 00	Excess reasonable cost (from line 16)			0	
	Subtotal (line 19 minus line 20 and 21)			1, 064, 973	
. 00	Coinsurance			1,675	
. 00	Subtotal (line 22 minus line 23)			1, 063, 298	
. 00	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		22, 891	
	Adjusted reimbursable bad debts (see instructions)	a i patruati apa)		14, 879	
	Allowable bad debts for dual eligible beneficiaries (see Subtotal (sum of lines 24 and 25, or line 26)	e mistructrons)		7, 255 1, 078, 177	
9.00 9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 078, 177 0	
. 00 . 50	Pioneer ACO demonstration payment adjustment (see instru	uctions)		0	
. 50	Demonstration payment adjustment amount before sequestra			0	
. 99	Subtotal (see instructions)			1, 078, 177	
. 01	Sequestration adjustment (see instructions)			21, 564	
	Demonstration payment adjustment amount after sequestrat	tion		21, 304	
. 002	Interim payments			1, 296, 725	
	Tentative settlement (for contractor use only)			1, 2, 0, 720	
	Balance due provider/program (line 30 minus lines 30.01,	. 30.02. 31. and 32)		-240, 112	
	Protested amounts (nonallowable cost report items) in ac			0	

Heal th	Fi nanci	al	Systems	
CALCUL	ATLON O	= RF	TIMBURSEMENT	SETTLEME

In Lieu of Form CMS-2552-10

	Financial Systems ST. VINCENT WILLIAMSF	PORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Pre	pared:
				11/26/2018 3:	30 pm
		Title XIX	Hospital	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		-
1 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient hospital/SNF/NF services		11 474		1 1 00
1.00 2.00	Medical and other services		11, 476	0	1.00
3.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		11, 476	0	
5.00	Inpatient primary payer payments		11, 470	0	5.00
6.00	Outpatient primary payer payments		Ŭ	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		11, 476	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				1
8.00	Routi ne servi ce charges		51, 831		8.00
9.00	Ancillary service charges		25, 157	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		76, 988	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
14 00	basis	normant for convious on		0	14 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 4		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CIR 3413. 13(e)	0. 000000	0.000000	15.00
	Total customary charges (see instructions)		76, 988	0.000000	•
17.00	Excess of customary charges over reasonable cost (complete onl	vifline 16 exceeds	65, 512	0	•
	line 4) (see instructions)	5		-	
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18.00
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instr	-	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 1		11, 476	0	21.00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ol	0	22.00
	Other than outlier payments Outlier payments		0	0	
	Program capital payments		0	0	24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	•
	Subtotal (sum of lines 22 through 26)		0	0	•
	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		11, 476	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		11, 476	0	
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review	1.22)	0	0	35.00
36.00 37.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1 33)	11, 476	0	•
	Subtotal (line 36 ± 1 line 37)		11, 476	0	
	Direct graduate medical education payments (from Wkst. E-4)		11,470	0	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		11, 476	0	
41.00	Interim payments		11, 476	0	
	Balance due provider/program (line 40 minus line 41)		0	0	•
42,00					
42.00 43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2.	0	0	43.00

	Financial Systems ST. VINCENT WILLIA E SHEET (If you are nonproprietary and do not maintain uppe accounting accords, complete the Capacal Fund column	Provider C		Period: From 07/01/2017	u of Form CMS- Worksheet G	
und-t nl y)	ype accounting records, complete the General Fund column			To 06/30/2018	Date/Time Pre 11/26/2018 3:	
		General Fund	Speci fi c	Endowment Fund		<u>30 p</u>
		1.00	Purpose Fund 2.00	3.00	4.00	-
	CURRENT ASSETS		2100	0100		
00	Cash on hand in banks	213, 842		0 0	0	
00	Temporary investments	0		0 0	0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	5, 987, 460		0 0	0	
00	Other receivable	134, 728		0 0	0	
00 00	Allowances for uncollectible notes and accounts receivable	-3, 036, 394 262, 029		0 0	0	
00	Inventory Prepaid expenses	202, 029		0 0	0	
00	Other current assets	6, 890		0 0	0	
). 00	Due from other funds	1, 515, 232		0 0	0	
1.00	Total current assets (sum of lines 1-10)	5, 084, 082		0 0	0	
	FI XED ASSETS		1			1
2.00	Land	174, 050		0 0	0	12
3.00	Land improvements	159, 079		0 0	0	13
1.00	Accumulated depreciation	-106, 154		0 0	0	14
5.00	Bui I di ngs	8, 420, 526		0 0	0	
5.00	Accumulated depreciation	-4, 887, 929		0 0	0	
7.00	Leasehold improvements	0		0 0	0	
3.00	Accumulated depreciation	0		0 0	0	
9.00	Fixed equipment	1, 676, 790		0 0	0	
0.00	Accumulated depreciation	-897, 136		0 0	0	
1.00 2.00	Automobiles and trucks Accumulated depreciation	51, 450 -51, 450		0 0	0	
3.00	Major movable equipment	3, 776, 547		0 0	0	
4.00	Accumul ated depreciation	-3, 110, 709			0	
5.00	Mi nor equi pment depreciable	3, 110, 707		0 0	0	
5.00	Accumulated depreciation	0		0 0	0	
7.00	HIT designated Assets	0		0 0	0	
3. 00	Accumulated depreciation	0		o o	0	28
9.00	Mi nor equipment-nondepreciable	0		0 0	0	29
0. 00	Total fixed assets (sum of lines 12-29)	5, 205, 064		0 0	0	30
	OTHER ASSETS					
1.00	Investments	251, 935		0 0	0	
2.00	Deposits on Leases	0		0 0	0	
3.00	Due from owners/officers	0		0 0	0	
4.00	Other assets	6, 579			0	
5.00	Total other assets (sum of lines 31-34)	258, 514			0	
5.00	Total assets (sum of lines 11, 30, and 35)	10, 547, 660	234, 89	1 0	0	36
7.00	CURRENT LI ABI LI TI ES	671, 977		0 0	0	37
3.00	Accounts payable Salaries, wages, and fees payable	707, 180		0 0	0	
9.00 9.00	Payroll taxes payable	07, 180		0 0	0	
). 00	Notes and Loans payable (short term)	54, 544		0 0		40
1.00	Deferred income	01,011		0 0	0	
2.00	Accel erated payments	0				42
3.00	Due to other funds	2, 031, 875		o o	0	43
4.00	Other current liabilities	1, 476, 448		0 0	0	44
5.00	Total current liabilities (sum of lines 37 thru 44)	4, 942, 024		0 0	0	45
	LONG TERM LIABILITIES		1			
5.00	Mortgage payable	0		0 0	0	
7.00	Notes payable	0		0 0	0	
3.00	Unsecured Loans	3, 827, 178		0	0	
9.00	Other long term liabilities				0	
0.00	Total long term liabilities (sum of lines 46 thru 49)	3, 827, 178		0 0 0 0	0	
1.00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	8, 769, 202	1	0 0	0	1 21
2.00	General fund balance	1, 778, 458				52
3.00	Specific purpose fund	1, 770, 400	234, 89	1		53
1. 00	Donor created - endowment fund balance - restricted		234,09			54
5.00	Donor created - endowment fund balance - unrestricted			0		55
5.00	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant			0	0	
3.00	Plant fund balance - reserve for plant improvement,				0	
- 0	replacement, and expansion				0	
		1 770 450	234, 89	1 0	0	59
9.00	Total fund balances (sum of lines 52 thru 58)	1, 778, 458	234,07	0	0	10,

	Financial Systems ST. ENT OF CHANGES IN FUND BALANCES	VINCENT WILLIAM	Provider CC		Period:	u of Form CMS-2 Worksheet G-1	2002-10
STATE	LINE OF CHANGES FILLFOND DALANCES		Frovider cc	N. 13-1307	From 07/01/2017 To 06/30/2018		
		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		1, 535, 849		485, 057		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		614, 074		105 053		2.00
3.00	Total (sum of line 1 and line 2)		2, 149, 923		485, 057		3.00
4.00 5.00	Additions (credit adjustments) (specify)	0			0	0	4.00
5.00 6.00	Contributions/Donations/Grant Revenue	234, 891		-250, 10	0	0	6.00
7.00	contributions/ bonations/ or anti- Revenue	234,071		200, 1	0	0	7.00
8.00		0			0	0	8.00
9.00	Rounding	0			0	0	9.00
10.00	Total additions (sum of line 4-9)		234, 891		-250, 166		10.00
11.00	Subtotal (line 3 plus line 10)		2, 384, 814		234, 891		11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14.00	Transfers from Affiliates	-56, 193			0	0	14.00
15.00		0			0	0	15.00
16.00	Released Capital	662, 549			0	0	16.00
17.00		0	(0) 05/		0	0	17.00
18.00 19.00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance		606, 356 1, 778, 458		0 234, 891		18.00 19.00
19.00	sheet (line 11 minus line 18)		1, 770, 400		234,091		19.00
	sneet (The Thinnus The To)	Endowment Fund	PI ant	Fund			
	Sheet (The Thinnus The To)						
		6.00	Pl ant 7.00	Fund 8. 00			
1.00	Fund balances at beginning of period				0		1.00
2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	6.00			0		2.00
2.00 3.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	7.00				2.00 3.00
2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	6.00			0		2.00 3.00 4.00
2.00 3.00 4.00 5.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	6.00	7.00		0		2.00 3.00 4.00 5.00
2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	7.00		0		2.00 3.00 4.00
2.00 3.00 4.00 5.00 6.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	6.00	7.00		0		2.00 3.00 4.00 5.00 6.00
2.00 3.00 4.00 5.00 6.00 7.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	6.00	7.00		0		2.00 3.00 4.00 5.00 6.00 7.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue Rounding Total additions (sum of line 4-9)	6.00	7.00		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00	7.00		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue Rounding Total additions (sum of line 4-9)	6.00	7.00		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	6.00	7.00		0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00	7.00		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Transfers from Affiliates	6.00	7.00		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	6.00	7.00		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Transfers from Affiliates Released Capital	6.00 0 0 0 0	7.00				2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Transfers from Affiliates	6.00	7.00		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00

TEME	INT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1307		riod: om 07/01/2017 06/30/2018	Worksheet G-2 Parts I & II Date/Time Pre 11/26/2018 3:	epare
	Cost Center Description		Inpati ent		Outpati ent	Total	
-			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
	General Inpatient Routine Services						
	Hospi tal		5, 555, 0	75		5, 555, 075	
	SUBPROVIDER - IPF						2
	SUBPROVIDER - IRF						3
	SUBPROVIDER						4
	Swing bed - SNF			0		0	
	Swing bed - NF			0		0	-
	SKILLED NURSING FACILITY						7
	NURSING FACILITY						8
	OTHER LONG TERM CARE						9
-	Total general inpatient care services (sum of lines 1-9)		5, 555, 0	75		5, 555, 075	5 10
	ntensive Care Type Inpatient Hospital Services		1				
	INTENSIVE CARE UNIT						11
	CORONARY CARE UNIT						12
	BURN INTENSIVE CARE UNIT						13
	SURGI CAL I NTENSI VE CARE UNI T						14
	THER SPECIAL CARE (SPECIFY)						15
	Total intensive care type inpatient hospital services (sum c	oflines		0		0) 16
	11-15)	~					
	Total inpatient routine care services (sum of lines 10 and 1	6)	5, 555, 0		00 400 070	5, 555, 075	
	Ancillary services		4, 036, 5		38, 402, 878	42, 439, 414	
	Outpatient services		279, 6		17, 708, 597	17, 988, 294	
	RURAL HEALTH CLINIC			0	3, 049, 081	3, 049, 081	
	RURAL HEALTH CLINIC II			0	2, 940, 085	2, 940, 085	
	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
	HOME HEALTH AGENCY			~	0 405 057	2 425 057	22
	AMBULANCE SERVICES			0	2, 435, 957	2, 435, 957	
							24
	AMBULATORY SURGICAL CENTER (D. P.)						25
				~		0	26
	OTHER (SPECIFY)			0	0 648, 027		
	Ortho Clinic Tatal actient revenues (cum of lines 17, 27)(transfer column	2 to Wkot	0 071 2	<u> </u>		648, 027	
	Total patient revenues (sum of lines 17-27)(transfer column G-3, line 1)	3 LO WKSL.	9, 871, 3	08	65, 184, 625	75, 055, 933	3 28
	PART II - OPERATING EXPENSES						
	Operating expenses (per Wkst. A, column 3, line 200)		1		20, 698, 378		29
	ADD (SPECIFY)			0	20,070,070		30
00 /				0			31
00				0			32
00				0			33
00				0			34
00				0			35
	Total additions (sum of lines 30-35)			J	0		36
	DEDUCT (SPECIFY)			0	0		37
00				0			38
00				0			39
00				0			40
00				0			40
	Total deductions (sum of lines 37-41)			9	0		41
	Total operating expenses (sum of lines 29 and 36 minus line	12) (transfer			20, 698, 378		42
UU I	TOTAL OPERATING EXPENSES (SUII OF FITTES 24 dru so III MUS FITTE	42) (U diisi el	1		20,070,3/8		1 4 3

Health Financial Systems

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ST. VINCENT WILLIAM	ISPORT HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
STATEN	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1307	Peri od:	Worksheet G-3		
			From 07/01/2017			
			To 06/30/2018			
				11/26/2018 3:	30 pm	
				1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			75, 055, 933	1.00	
2.00	Less contractual allowances and discounts on patients' accou	nts		55, 319, 523	2.00	
3.00	Net patient revenues (line 1 minus line 2)			19, 736, 410	3.00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line		20, 698, 378	4.00		
5.00	5.00 Net income from service to patients (line 3 minus line 4)					
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00	Income from investments			7, 507	7.00	
8.00	Revenues from telephone and other miscellaneous communication		0	8.00		
9.00	Revenue from television and radio service			0	9.00	
10.00	Purchase di scounts			0	10.00	
11.00	Rebates and refunds of expenses			0	11.00	
12.00	Parking lot receipts			0	12.00	
13.00	Revenue from Laundry and Linen service			277	13.00	
14.00	Revenue from meals sold to employees and guests			0	14.00	
15.00				0	15.00	
16.00	Revenue from sale of medical and surgical supplies to other	than nationts		0	16.00	
17.00		than patrents		0	17.00	
18.00	Revenue from sale of medical records and abstracts			5, 356	18.00	
19.00				5, 350	19.00	
20.00				0	20.00	
	Revenue from gifts, flowers, coffee shops, and canteen Rental of vending machines			0		
21.00	8			0	21.00	
22.00				-	22.00	
23.00	Governmental appropriations			0	23.00	
24.00	OTHER (SPECIFY)			0	24.00	
24.01	Other - Credentialing			744, 344	24.01	
24.02	Other - Pharmacy Services			93	24.02	
24.04				169, 713		
24. 11	Other - Grant Revenue			200, 863		
24.14	Other - Food Services			16, 810		
24. 15	Other - State Program Revenue			46, 750		
24. 19	Other - South Clinic			47, 321	24.19	
24.22	Other - Unrestr Donation Revenue			1, 942	24.22	
24.23	Other - Phys Fund Rev IC			334, 925	24.23	
24.24	Other - Unclaimed Property Exemptions			141	24.24	
25.00	Total other income (sum of lines 6-24)			1, 576, 042	25.00	
26.00	Total (line 5 plus line 25)			614, 074	26.00	
27.00	OTHER EXPENSES (SPECI FY)			0	27.00	
28.00				0	28.00	
29.00	Net income (or loss) for the period (line 26 minus line 28)			614, 074	29.00	

Health Financial Systems ST.		VINCENT WILLIAMSPORT HOSPITAL			In Lieu of Form CMS-2552-10			
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1307	Peri od:	Worksheet M-1		
					From 07/01/2017			
			Component	CCN: 15-3993	To 06/30/2018			
					RHC I	11/26/2018 3:	30 pm	
		Componention	Other Costs	Total (agl (Reclassi fi cati	Cost Reclassified		
		Compensati on	other costs		ons	Trial Balance		
				+ col. 2)	UNS	(col. 3 + col.		
						4)		
		1.00	2.00	3.00	4.00	5.00		
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00		
1.00	Physi ci an	420, 811	0	420, 81	1 0	420, 811	1.00	
2.00	Physician Assistant	420,011	0	420,01		0	2.00	
3.00	Nurse Practitioner	361,077	0	361, 07	7 -12, 519		3.00	
4.00	Visiting Nurse	001,077		301, 07	0 12,017	0	4.00	
5.00	Other Nurse	219, 509		219, 50	9 0	219, 509		
6.00	Clinical Psychologist	217, 307		217, 50		217, 307	6.00	
7.00	Clinical Social Worker	0				0	7.00	
8.00	Laboratory Techni ci an	0				0	8.00	
9.00	Other Facility Health Care Staff Costs	194, 122		194, 12	2 0	194, 122	9,00	
7.00 10.00	Subtotal (sum of lines 1 through 9)	1, 195, 519		1, 195, 51				
11.00	Physician Services Under Agreement	1, 175, 517	0	1, 175, 51	-12, 519	1, 183, 000	11.00	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00	
12.00	Other Costs Under Agreement	0	0			0	12.00	
	Subtotal (sum of lines 11 through 13)	0	0			0	13.00	
14.00 15.00	Medical Supplies	0	5, 609	5, 60		5, 609		
16.00	Transportation (Health Care Staff)	0	3, 009	5,00	9 0	5, 809		
17.00	Depreciation-Medical Equipment	0	0			0	17.00	
17.00	Professional Liability Insurance	0	0			0	17.00	
19.00	Other Health Care Costs	0	244 474	244 47		-		
20.00	Allowable GME Costs	0	366, 474	366, 47	4 0	366, 474	20.00	
20.00	Subtotal (sum of lines 15 through 20)	0	272 002	272.00	2	272.002		
21.00	Total Cost of Health Care Services (sum of	1 105 510	372, 083			372, 083		
22.00		1, 195, 519	372, 083	1, 567, 60	2 -12, 519	1, 555, 083	22.00	
	l i nes 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0		0 0	0	23.00	
24.00	Dental	0				0	23.00	
24.00	Optometry	0	0		0 0	0	24.00	
25.00	Tel eheal th	0				0	25.00	
25.01	Chronic Care Management	0	0		0 0	0	25.01	
26.02	All other nonreimbursable costs	0	0		0 0	0	25.02	
27.00	Nonallowable GME costs	0	0		0	0	20.00	
27.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	27.00	
20.00	through 27)	0	0		0	0	20.00	
	FACILITY OVERHEAD							
29.00	Facility Costs	0	0		0 0	0	29.00	
30.00	Admi ni strati ve Costs	0				0	30.00	
30.00	Total Facility Overhead (sum of lines 29 and	0				0	31.00	
51.00	30)	0	0				31.00	
32.00	Total facility costs (sum of lines 22, 28	1, 195, 519	372, 083	1, 567, 60	2 -12, 519	1, 555, 083	32.00	
52.00	and 31)	1, 175, 517	572,003	1, 307, 00	-12, 017	1, 555, 005	32.00	
			l	I	1	I	I	

		VINCENT WILLIA					
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN:	15-1307	Peri od:	Worksheet M-1	1
			Component CCN:	15-3003	From 07/01/2017 To 06/30/2018	Date/Time Pre	enared
			component con.	13-3773	10 00/30/2010	11/26/2018 3:	
					RHC I	Cost	00 piii
		Adjustments	Net Expenses		I.,		
			or Allocation				
			[col. 5 + col.]				
		ľ	6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS	0100					
1.00	Physi ci an	-26, 954	393, 857				1.00
2.00	Physician Assistant	20, 701	0,00,001				2.00
3.00	Nurse Practitioner	-2, 160	346, 398				3.00
4.00	Visiting Nurse	2,100	010, 070				4.00
5.00	Other Nurse	0	219, 509				5.00
6.00	Clinical Psychologist	0	217, 307				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	194, 122				9.00
9.00 10.00	Subtotal (sum of lines 1 through 9)	-29, 114	1, 153, 886				10.00
	Physician Services Under Agreement	-29, 114	1, 103, 000				11.00
11.00	5	0	0				12.00
2.00	Physician Supervision Under Agreement	0	0				
3.00	Other Costs Under Agreement	0	0				13.0
4.00	Subtotal (sum of lines 11 through 13)	0	0				14.0
15.00	Medical Supplies	0	5, 609				15.00
16.00	Transportation (Health Care Staff)	0	0				16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.0
19.00	Other Health Care Costs	0	366, 474				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	372, 083				21.0
22.00	Total Cost of Health Care Services (sum of	-29, 114	1, 525, 969				22.00
	lines 10, 14, and 21)						-
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.0
25.01	Tel eheal th	0	0				25.0
25.02	Chronic Care Management	0	0				25.0
26.00	All other nonreimbursable costs	0	0				26.0
27.00	Nonallowable GME costs						27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.0
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0				29.0
30.00	Administrative Costs	0	0				30.0
31.00	Total Facility Overhead (sum of lines 29 and	О	o				31.0
	30)						
32.00	Total facility costs (sum of lines 22, 28	-29, 114	1, 525, 969				32.00
	and 31)						1

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Period:	Worksheet M-1	
					rom 07/01/2017		
			Component (CCN: 15-3994	To 06/30/2018		
					RHC II	11/26/2018 3: Cost	30 pm
		Compensati on	Other Costs	Total (col 1	Recl assi fi cati	Reclassi fi ed	
		compensation	Uther Costs	+ col . 2)	ons	Trial Balance	
				+ COI. 2)	0113	(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS		2.00	0.00		0,00	
1.00	Physi ci an	568, 569	0	568, 56	9 0	568, 569	1.00
2.00	Physician Assistant	000,000	0	000,00	0	0	2.00
3.00	Nurse Practitioner	202, 168	0	202, 16	12, 519	-	3.00
4.00	Visiting Nurse	202,100	0	202,10	0	0	4.00
5.00	Other Nurse	328, 755	0	328, 75	5 0	328, 755	
6.00	Clinical Psychologist	0207700	0	020,70	0	0	
7.00	Clinical Social Worker	0	0			0	
8.00	Laboratory Techni ci an	0	0		0	0	8.00
9.00	Other Facility Health Care Staff Costs	207,038	0	207, 03	3 0	207, 038	
10.00	Subtotal (sum of lines 1 through 9)	1, 306, 530	0	1, 306, 53			
11.00	Physician Services Under Agreement	1,000,000	0	1,000,00	0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0			0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	4, 218	4, 21	0	U U	
16.00	Transportation (Health Care Staff)	0	4,210	7,21	0 0		
17.00	Depreciation-Medical Equipment	0	0			0	17.00
18.00	Professional Liability Insurance	0	0			0	18.00
19.00	Other Health Care Costs	0	359, 097	359, 09	7 0	359,097	
20.00	Allowable GME Costs	0	007,077	007,07		007,077	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	363, 315	363, 31	5 0	363, 315	
22.00	Total Cost of Health Care Services (sum of	1, 306, 530	363, 315	1, 669, 84			
22.00	lines 10, 14, and 21)	1, 300, 330	505, 515	1,007,04	12, 517	1,002,004	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0		24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0	(0 0	0	25.01
25.02	Chronic Care Management	0	0	(0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs	-	-				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)	-	-			-	
	FACILITY OVERHEAD			I			
29.00	Facility Costs	0	0	(0 0	0	29.00
30, 00	Administrative Costs	0	0	(0 0	0	
31.00	Total Facility Overhead (sum of lines 29 and	0	0		0 0	0	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 306, 530	363, 315	1, 669, 84	5 12, 519	1, 682, 364	32.00
	and 31)						

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPIT	AL	In Lie	u of Form CMS-	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Peri od:	Worksheet M-1	
					From 07/01/2017		
			Component	CCN: 15-3994	To 06/30/2018	Date/Time Pre 11/26/2018 3:	
					RHC II	Cost	<u>50 piii</u>
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	-58, 558	510, 011				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	214, 687				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	328, 755				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	207, 038	•			9.00
10.00	Subtotal (sum of lines 1 through 9)	-58, 558		•			10.00
11.00	Physician Services Under Agreement	0	0				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	4, 218				15.00
16.00	Transportation (Health Care Staff)	0	0				16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
19.00	Other Health Care Costs	0	359, 097				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	363, 315	•			21.00
22.00	Total Cost of Health Care Services (sum of	-58, 558	1, 623, 806				22.00
	lines 10, 14, and 21)						
~~ ~~	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	-				23.00
24.00	Dental	0	-	1			24.00
25.00	Optometry	0	0				25.00
25.01	Tel eheal th	0	0				25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs	0					27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	C				28.00
	through 27) FACILITY OVERHEAD						
29.00	Facility Costs	0	C				29.00
29.00	Administrative Costs	0		1			30,00
30.00	Total Facility Overhead (sum of lines 29 and	0					31.00
51.00	30)	0		<u></u>			31.00
32.00	Total facility costs (sum of lines 22, 28	-58, 558	1, 623, 806				32.00
52.00	and 31)	50, 550	1, 020, 000				52.00
			1	1			1

	2	VINCENT WILLIA				u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provider C	CN: 15-1307	Period:	Worksheet M-2	
			Component (From 07/01/2017 To 06/30/2018	Date/Time Pre	nared
			component	CON. 15 5775	10 00/ 30/ 2010	11/26/2018 3:	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
	VI OLTO AND DODUCTIVITY	1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	1. 62	6, 755	4, 20	6, 804		1.00
1.00 2.00	Physician Physician Assistant	0.00	0,755				2.00
2.00	Nurse Practitioner	3.00	8, 826				2.00
3.00 4.00	Subtotal (sum of lines 1 through 3)	4. 62	15, 581		13, 104		3.00 4.00
4.00 5.00	Visiting Nurse	0.00			13, 104	15, 581	4.00 5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.00
7.02	Di abetes Sel f Management Training (FQHC	0.00				0	7.02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	4. 62	15, 581			15, 581	8.00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VICES			
	Total costs of health care services (from Wk					1, 525, 969	
	Total nonreimbursable costs (from Wkst. M-1,					0	11.00
	Cost of all services (excluding overhead) (su					1, 525, 969	
	Ratio of hospital-based RHC/FQHC services (Total hospital-based RHC/FQHC overhead - (from			no 21)		1.000000 0	13.00 14.00
14.00	Parent provider overhead allocated to facili			ne 31)		1, 295, 082	
	Total overhead (sum of lines 14 and 15)	ty (see misting	.110115)			1, 295, 082	16.00
	Allowable GME overhead (see instructions)					1, 295, 082	17.00
	Enter the amount from line 16					1, 295, 082	18.00
	Overhead applicable to hospital-based RHC/FQ	HC services (Li	ne 13 x line 1	8)		1, 295, 082	
	Total allowable cost of hospital-based RHC/F					2, 821, 051	
0				/		_, , 001	

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provider C		Period:	Worksheet M-2	
			Component (From 07/01/2017 To 06/30/2018	Date/Time Pre	nared
			component	JON. 13 3774	10 00/ 30/ 2010	11/26/2018 3:	
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	2.00	3.00	3)	4 5.00	
	VI SI TS AND PRODUCTI VI TY	1.00	2.00	3.00	4.00	5.00	
	Positions						
1.00	Physi ci an	1.71	10, 797	4, 20	0 7, 182		1.00
2.00	Physician Assistant	0.00		2, 10			2.00
3.00	Nurse Practitioner	2.06	5, 245	2, 10	0 4, 326		3.00
4.00	Subtotal (sum of lines 1 through 3)	3. 77	16, 042		11, 508	16, 042	4.00
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4	3. 77	16, 042			16, 042	8.00
0 00	through 7)						0.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	D HOSPI TAL-BASE	D RHC/FQHC SER	VICES			
10.00	Total costs of health care services (from Wks	st. M-1, col. 7	7, line 22)			1, 623, 806	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11.00
12.00	Cost of all services (excluding overhead) (se	um of lines 10	and 11)			1, 623, 806	12.00
	Ratio of hospital-based RHC/FQHC services (1					1.000000	
	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		0	14.00
	Parent provider overhead allocated to facili	ty (see instruc	ctions)			1, 446, 298	
	Total overhead (sum of lines 14 and 15)					1, 446, 298	
	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16			•		1, 446, 298	
	Overhead applicable to hospital-based RHC/FQ					1, 446, 298	
20.00	Total allowable cost of hospital-based RHC/F	UHL SERVICES (S	sum of illnes 10	and 19)		3, 070, 104	20.00

	Provider CCN: 15-1307	Peri od:	Worksheet M-3	
RVICES	Component CCN: 15-3993	From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 3:	
	Title XVIII	RHC I	Cost	
		-	1, 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES		I	1.00	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst. M-2, line 20)		2, 821, 051	1 1.
00 Cost of vaccines and their administration (from Wkst. M-4, line			157, 770	
00 Total allowable cost excluding vaccine (line 1 minus line 2)	,		2, 663, 281	3.
00 Total Visits (from Wkst. M-2, column 5, line 8)			15, 581	4.
00 Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		0	5
00 Total adjusted visits (line 4 plus line 5)			15, 581	6
00 Adjusted cost per visit (line 3 divided by line 6)			170. 93	7
		Calculation (of Limit (1)	
		Prior to Jan.	On or After	
		1 (Rate Period	Jan. 1 (Rate	
		1)	Period 2)	
		1.00	2.00	-
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 00 Rate for Program covered visits (see instructions)	or your contractor)	82.30	83.45	8
00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		170.93	170. 93	9
.00 Program covered visits excluding mental health services (from c	contractor records)	1, 501	1, 489	10
.00 Program cost excluding costs for mental health services (line 9	9 x line 10)	256, 566	254, 515	11
.00 Program covered visits for mental health services (from contrac	ctor records)	0	0	12
.00 Program covered cost from mental health services (line 9 x line	e 12)	0	0	13
.00 Limit adjustment for mental health services (see instructions)		0	0	
.00 Graduate Medical Education Pass Through Cost (see instructions)				15
.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a		0	511, 081	
.01 Total program charges (see instructions)(from contractor's reco			545, 045	
. 02 Total program preventive charges (see instructions) (from provid			84, 134	
.03 Total program preventive costs ((line 16.02/line 16.01) times I .04 Total Program non-preventive costs ((line 16 minus lines 16.03)			78, 891	
.04 Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	and 18) times .80)		299, 526	16
. 05 Total program cost (see instructions)		0	378, 417	16
. 00 Primary payer amounts		0	110	
.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor		57, 783	
records)				
.00 Beneficiary coinsurance for RHC/FQHC services (see instructions records)	s) (from contractor		80, 626	19
. 00 Net Medicare cost excluding vaccines (see instructions)			378, 307	20
.00 Program cost of vaccines and their administration (from Wkst. N	1-4, line 16)		70, 953	
.00 Total reimbursable Program cost (line 20 plus line 21)			449, 260	
.00 Allowable bad debts (see instructions)			0	23
.01 Adjusted reimbursable bad debts (see instructions)			0	23
.00 Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		0	24
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
.50 Pioneer ACO demonstration payment adjustment (see instructions)			0	
. 99 Demonstration payment adjustment amount before sequestration			0	
.00 Net reimbursable amount (see instructions)			449, 260	
. 01 Sequestration adjustment (see instructions)			8, 985	
. 02 Demonstration payment adjustment amount after sequestration			0	
.00 Interim payments .00 Tentative settlement (for contractor use only)			312, 246 0	
	27 and 29		-	
.00 Balance due component/program (line 26 minus lines 26.01, 26.02 .00 Protested amounts (nonallowable cost report items) in accordanc			128, 029 0	30

	Provider CCN: 15-1307	Peri od:	Worksheet M-3	
RVI CES	Component CCN: 15-3994	From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 3:	
	Title XVIII	RHC II	Cost	<u> </u>
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES	What M 2 Line 20)		2 070 104	1 1.
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from 00 Cost of vaccines and their administration (from Wkst. M-4, lin			3, 070, 104 175, 379	
00 Total allowable cost excluding vaccine (line 1 minus line 2)	le 15)		2, 894, 725	
00 Total Visits (from Wkst. M-2, column 5, line 8)			2, 894, 725	
00 Physicians visits under agreement (from Wkst. M-2, column 5, 1	ine 9)		10, 042	
00 Total adjusted visits (line 4 plus line 5)	The 9)		16, 042	
00 Adjusted cost per visit (line 3 divided by line 6)			180.45	
		Cal cul ati on d		
		Drion to lon	On an Aftan	
		Prior to Jan. 1 (Rate Period	On or After	
		1)	Jan. 1 (Rate Period 2)	
		1,00	2.00	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	82.30	83.45	8
00 Rate for Program covered visits (see instructions)	e el gedi contractor,	180.45	180.45	
CALCULATION OF SETTLEMENT				
.00 Program covered visits excluding mental health services (from	contractor records)	2, 788	2, 828	1 10
.00 Program cost excluding costs for mental health services (line	9 x line 10)	503, 095	510, 313	11
.00 Program covered visits for mental health services (from contra	ctor records)	0	0	
.00 Program covered cost from mental health services (line 9 x lin	e 12)	0	0	13
.00 Limit adjustment for mental health services (see instructions)		0	0	14
.00 Graduate Medical Education Pass Through Cost (see instructions)			15
.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	1, 013, 408	
.01 Total program charges (see instructions)(from contractor's rec	-		807, 356	
. 02 Total program preventive charges (see instructions)(from provi			60, 846	
.03 Total program preventive costs ((line 16.02/line 16.01) times			76, 375	
. 04 Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		682, 402	16
(Titles V and XIX see instructions.)		0		16
.05 Total program cost (see instructions) .00 Primary payer amounts		0	758, 777 0	
.00 Primary payer amounts .00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		84, 031	
records)			04, 031	10
00 Beneficiary coinsurance for RHC/FQHC services (see instruction	s) (from contractor		132, 496	19
records)			102, 170	
00 Net Medicare cost excluding vaccines (see instructions)			758, 777	20
.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		83, 140	21
.00 Total reimbursable Program cost (line 20 plus line 21)			841, 917	22
.00 Allowable bad debts (see instructions)			0	23
.01 Adjusted reimbursable bad debts (see instructions)			0	23
.00 Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0	
. 50 Pioneer ACO demonstration payment adjustment (see instructions			0	
. 99 Demonstration payment adjustment amount before sequestration			0	
. 00 Net reimbursable amount (see instructions)			841, 917	
0.01 Sequestration adjustment (see instructions)			16, 838	
. 02 Demonstration payment adjustment amount after sequestration			04 570	26
.00 Interim payments .00 Tentative settlement (for contractor use only)			696, 572 0	
.00 Balance due component/program (line 26 minus lines 26.01, 26.0	2 27 and 20		128, 507	
. 00 Protested amounts (nonallowable cost report items) in accordan	,		128, 507	
	CE WILLIUWJ PUD. ID-II,		0	1 30

Heal th	Financial Systems ST. VINCENT WILLIAMS	PORT HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1307	Peri od:	Worksheet M-4	
VACCIN	E COST	Component CCN: 15-3993	From 07/01/2017 To 06/30/2018	Date/Time Prep 11/26/2018 3:3	
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 153, 886	1, 153, 886	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota				2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	,	864	840	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr		71, 866	11, 771	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus		72, 730	12, 611	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	eet M-1, col. 7, line 22)	1, 525, 969	1, 525, 969	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 295, 082	1, 295, 082	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot divided by line 6)	tal direct cost (line 5	0. 047662	0.008264	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	61, 726	10, 703	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	134, 456	23, 314	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	422	410	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10		318.62	56.86	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	182	228	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (th (line 12 x line 13)	neir) administration	57, 989	12, 964	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (thei of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			157, 770	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	ts (their)		70, 953	16. 00

Heal th	Financial Systems ST. VINCENT WILLIAMS	PORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1307	Peri od:	Worksheet M-4	
VACCIN	E COST	Component CCN: 15-3994	From 07/01/2017 To 06/30/2018	Date/Time Prep 11/26/2018 3:3	
		Title XVIII	RHC II	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 260, 491	1, 260, 491	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota			0. 000964	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir		930	1, 215	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	5 7	74, 250	16, 364	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	<i>,</i>	75, 180	17, 579	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	et M-1, col. 7, line 22)		1, 623, 806	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 446, 298		
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot divided by line 6)	al direct cost (line 5:	0. 046299	0. 010826	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	66, 962	15, 658	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	142, 142	33, 237	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	436	570	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10)/line 11)	326.01	58.31	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	218	207	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (th (line 12 x line 13)	neir) administration	71, 070	12, 070	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (thei of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			175, 379	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	ts (their)		83, 140	16.00

Health Financial Systems ST. VINCENT	WILLIAMSPORT HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR		Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-3993	From 07/01/2017 To 06/30/2018		
		RHC I	Cost	<u>50 pili</u>
			rt B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQH	С		312, 246	1.00
2.00 Interim payments payable on individual bills, either the contractor for services rendered in the cost repo "NONE" or enter a zero)	0	2.00
3.00 List separately each retroactive lump sum adjustment revision of the interim rate for the cost reporting p	20 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each			
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider 3.01			0	3. 01
3.02			0	3.01
3. 02			0	3.02
3.04			0	3.04
3. 05			0	3.05
Provider to Program				
3.50			0	3.50
3. 51			0	3. 51
3. 52			0	3. 52
3. 53			0	3.53
3. 54	50, 0, 00)		0	3.54
 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 27) 		ne	0 312, 246	3. 99 4. 00
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment aft	er desk review. Also show date	of		5.00
each payment. If none, write "NONE" or enter a zero.				
Program to Provider	* *			
5. 01			0	5.01
5. 02			0	5.02
5. 03			0	5.03
Provider to Program			0	E EO
5. 50 5. 51			0	5.50 5.51
5. 52			0	5.51
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5	50-5 98)		0	5.92
6.00 Determined net settlement amount (balance due) based			0	6.00
6.01 SETTLEMENT TO PROVIDER			128, 029	6.01
6.02 SETTLEMENT TO PROGRAM			0	6. 02
7.00 Total Medicare program liability (see instructions)			440, 275	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
	0	1.00	2.00	
8.00 Name of Contractor				8.00

Health Financial Systems ST. VINCENT WILLI	AMSPORT HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1307	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-3994	From 07/01/2017 To 06/30/2018		
		RHC II	11/26/2018 3:3 Cost	30 pm
			T B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC		1.00	696, 572	1.00
 Interim payments payable on individual bills, either submi the contractor for services rendered in the cost reporting "NONE" or enter a zero 			0	2.00
3.00 List separately each retroactive lump sum adjustment amoun revision of the interim rate for the cost reporting period payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider				
3.01			0	3. 01
3. 02			0	3. 02
3. 03			0	3.03
3. 04			0	3.04
3. 05			0	3.05
Provider to Program				
3. 50			0	3.50
3. 51			0	3.51
3. 52			0	3.52
3. 53 3. 54			0	3.53 3.54
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3	00)		0	3.54 3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (tran 27)			696, 572	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after de	esk review. Also show date o	f		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				F 01
5. 01 5. 02			0	5.01 5.02
5.02			0	5.02 5.03
Provider to Program			0	5.03
5.50			0	5.50
5. 50			0	5.50
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5	i. 98)		Ő	5.99
6.00 Determined net settlement amount (balance due) based on th			Ŭ	6.00
6.01 SETTLEMENT TO PROVIDER			128, 507	6.01
6.02 SETTLEMENT TO PROGRAM			0	6. 02
7.00 Total Medicare program liability (see instructions)			825, 079	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
	0	1.00	2.00	
8.00 Name of Contractor	1	1	1 1	8.00