Heal th Financia	al Systems ST VINCENT ANDERSON R	EGIONAL HOSPITA	In Lie	u of Form CMS-2552-10
This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can resu	It in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	deemed overpayments (4	2 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provi der CCN: 150088	Peri od: From 07/01/2015 To 06/30/2016	
PART I - COST	REPORT STATUS			117 227 2010 01 27 pm
Provi der use only	1. [X]Electronically filed cost report 2. []Manually submitted cost report		Date: 11/22/2	· · · · · · · · · · · · · · · · · · ·
	3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or "L		esubmitted this c	ost report
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report for (3) Settled with Audit 9. [N] Final Report for	or this Provider CCN 12.		

PART II - CERTIFICATION

(4) Reopened (5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST VINCENT ANDERSON REGIONAL HOSPITA (150088) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
	• • • • • • • • • • • • • • • • • • • •
T: -	tle
11	ire
Dat	te

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	199, 386	90, 127	-101, 784	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	11, 298	0		0	3. 00
4.00	SUBPROVI DER I						4. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	Total	0	210, 684	90, 127	-101, 784	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150088 Peri od: Worksheet S-2 From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/22/2016 3:25 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2015 JACKSON STREET 1.00 PO Box: 1.00 State: IN 2.00 City: ANDERSON Zi p Code: 46016-County: MADISON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST VINCENT ANDERSON 150088 11300 07/01/1966 N Р 0 3.00 1 REGIONAL HOSPITA Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF BENNETT REHAB. CENTER 15T088 11300 5 06/01/1989 Ν Ρ 0 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 ICF/IID 10.01 10.01 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospi tal -Based (CMHC) I 17.00 17. 10 Hospital - Based (CORF) I 17. 10 18.00 Renal Dialysis 18.00 19.00 19.00 Other From To: 1.00 2.00 07/01/2015 06/30/2016 20.00 20.00 Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) 1 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22 00 Υ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 22.01 Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N Ν 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 3 Ν 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no Out-of Medi cai d 0ther In-State In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d Medi cai d paid days el i gi bl e Medicai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 3.304 1, 377 13 2, 933 75 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 127 144 0 0 130 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

0.00

0.00

61.05

surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).
61.05 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)

ealth Financial Systems ST VINCENT AI OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der	CCN: 150088 F	Peri od: From 07/01/2015 To 06/30/2016		pared:
	Y/N	IME	Direct GME	IME	Direct GME	
O6 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)	1.00	2. 00 0. 00	3.00	4.00	5.00	61. 06
jan a a a garan a a a garan a a a a a a a a a a a a a a a a a a	Pro	ogram Name	Program Code	9	Unweighted Direct GME FTE Count	
10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3.00	4.00	61. 10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0. 00	0. 00	61. 20
ACA Provisions Affecting the Health Resources and Se	rui coc /	ldmi ni strati on	(UDCA)		1.00	
00 Enter the number of FTE residents that your hospital				iod for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instruction of the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progressing Hospitals that Claim Residents in Nonprovidents.	a Teachi gram. (s	<u>ee instruction</u>		your hospital	0.00	62. 01
.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co		peri od? Enter	N	63. 00
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in N	onneoul s	lan Cattinga T	1. 00	2.00	3.00	
period that begins on or after July 1, 2009 and befo			inis base year	is your cost i	eportring	
.00 Enter in column 1, if line 63 is yes, or your facili- in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	ty train n-primar all non d non-pr n column	ed residents by care provider imary care 3 the ratio	0.0	0. 00	0. 000000	64.00
Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		2. 00	3. 00	4. 00 0 0. 00	5. 00 0. 000000	65. OC
.00 Enter in column 1, if line 63			, 5.0	-1 0.00	1 3. 333300	33.00

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)

applicable column.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Fr	eriod: com 07/01/20		
		To		11/22/20	ne Prepareo 016 3:25 pm
			V 1. 00	2. 00	
5.00 If line 94 is "Y", enter the reduction percentage in the app	olicable colum	n.	0. 00	0.00	
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N	N	96.
7.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers		n.	0. 00	0.00	
O5.00 Does this hospital qualify as a critical access hospital (CA O6.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		hod of payment	N N		105. 106.
07.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst	ructions) If	N		107.
O8.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108.
	Physi cal 1.00	Occupati onal 2.00	Speech 3.00	Respi ra 4.00	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	N N	3. 00 N	N N	109.
				1.00	2
10.00 Did this hospital participate in the Rural Community Hospita		on project (410	A Demo)for	1. 00 N	110.
the current cost reporting period? Enter "Y" for yes or "N"	for no.				
			1.	. 00 2. 00	3. 00
Miscellaneous Cost Reporting Information 5.00 sthis an all-inclusive rate provider? Enter "Y" for yes or	- UNU	1 16	1 1	N I	0 115.
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 nt for long te	is "E", enter i rm care (includ	n column es		0 1113.
6.00 s this facility classified as a referral center? Enter "Y"			l l		
	•			N Y	
17.00 Is this facility legally-required to carry malpractice insur no. 18.00 Is the malpractice insurance a claims-made or occurrence pol	rance? Enter "	Y" for yes or "	N" for		116. 117. 118.
7.00 ls this facility legally-required to carry malpractice insur	rance? Enter "	Y" for yes or "	N" for s	Y 1	117. 118.
17.00 Is this facility legally-required to carry malpractice insur no. 18.00 Is the malpractice insurance a claims-made or occurrence pol	rance? Enter "	Y" for yes or "	N" for	Y	117. 118.
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence pol	rance? Enter "	Y" for yes or "	N" for s	Y 1	117. 118.
7.00 Is this facility legally-required to carry malpractice insur no. 8.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	rance? Enter "	Y" for yes or " if the policy i Premiums 1.00	N" for s Losses	Y 1 Insura 3.00	117. 118. Ince
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence polclaim-made. Enter 2 if the policy is occurrence.	rance? Enter "	Y" for yes or " if the policy i Premiums	N" for s Losses	Y 1 Insura	117. 118. Ince
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence polclaim-made. Enter 2 if the policy is occurrence.	rance? Enter "	Y" for yes or " if the policy i Premiums 1.00	N" for s Losses	Y 1 Insura 3.00	117. 118. 118. 0 0 118.
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence policiaim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.	rance? Enter " icy? Enter 1 center other	Y" for yes or " if the policy i Premiums 1.00 505,940 than the	N" for s Losses	1 Insura 3.00	117. 118. 0 118. 0 118.
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence polclaim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualid Hold Harmless provision in ACA §3121 and applicable amendments.	center other dule listing control of the control of	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient	N" for s Losses 2.00	1 Insura 3.00	117. 118. 0 0 118. 0 118.
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence policial claim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quelled Hold Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla	center other dule listing control column 1, "Yualifies for the this? (see inst	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient ructions)	N" for s Losses	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117 118 nnce 0 118 119 120
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 10.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implaints? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain state health or similar taxes?	center other dule listing control column 1, "Yualifies for the this? (see instantable device	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N"	N" for s Losses 2.00 1.00 N	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117 118 0 0 118 0 118 119 120
7.00 Is this facility legally-required to carry malpractice insurno. 3.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence. 3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information	center other dule listing control column 1, "Yualifies for the this? (see instantable device the Worksheet A	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	N" for s Losses 2.00 1.00 N	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117 118 0 0 118 0 118 119 120 121
7.00 Is this facility legally-required to carry malpractice insurno. 3.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence. 3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 3.00 NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that querical Hold Harmless provision in ACA §3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no. 3.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for	center other dule listing control column 1, "Yualifies for the this? (see instantable device the Worksheet A	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	N" for s Losses 2.00 1.00 N	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117 118 0 0 118 0 118 119 120 121
7.00 Is this facility legally-required to carry malpractice insurno. 3.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence. 3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 3.00 DN NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that question Hold Harmless provision in ACA §3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no. 3.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, en	center other dule listing content of the content other dule listing content of the content of th	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	N" for s Losses 2.00 1.00 N N	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117. 118 O 118. O 118. O 120. 121. O 122.
7.00 Is this facility legally-required to carry malpractice insurno. 3.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence. 3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 3.00 DO NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that querient Hold Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 3.00 Did this facility incur and report costs for high cost implationts? Enter "Y" for yes or "N" for no. 3.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. 3.00 Transplant Center Information 3.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 3.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2	center other dule listing content of the column 1, "Y ualifies for the column 1, "Y unter the certific center "Y" for yes and "N" the certific center the certific center the certific center center center the certific center	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date	N" for s Losses 2.00 1.00 N N	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117 118 0 0 118 0 118 0 120 121 0 122 125 126
7.00 Is this facility legally-required to carry malpractice insurno. 3.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence. 3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that question Hold Harmless provision in ACA \$3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implated patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 2 in column 1 and termination date, if applicable, in column 2 in c	center other dule listing control with the center other dule listing control with the center of the worksheet A control with the certificant of th	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	N" for s Losses 2.00 1.00 N N	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117. 118. 118. 0 0 118. 0 118. 119. 120. 121. 125. 126. 127.
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold tharmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implaint patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2.	center other dule listing content of the content other dule listing content of the content of th	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	N" for s Losses 2.00 1.00 N N	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117. 118. 118. 0 0 118. 0 119. 120. 121. 0 122. 125. 126. 127. 128.
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence polclaim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that questioned the Hold Harmless provision in ACA \$3121 and applicable amendments. 1.00 Did this facility incur and report costs for high cost implae patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2.	center other dule listing content of the center other dule listing content of the content of the center of the cen	Y" for yes or " If the policy i Premiums 1.00 505,940 than the ost centers Vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date cation date cation date in	N" for s Losses 2.00 1.00 N N	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117. 118. 118. 0 118. 119. 121. 125. 126. 127. 128. 129.
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence polclaim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that queried Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implations patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 7.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 8.00 If this is a Medicare certified lung transplant center, ent in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified lung transplant center, ent in column 1 and termination date, if applicable, in column 2 1.00 If this is a Medicare certified lung transplant center, ent in column 1 and termination date, if applicable, in column 2 1.00 If this is a Medicare certified lung transplant center, ent in column 1 and termination date, if applicable, in column 2 1.01 In this is a Medicare certified lung transplant center, enter column 2 1.02 In this is a Medicare certified lung tran	center other dule listing content of the center other dule listing content of the center dule device the center dule center duling the center duling	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date i cation date cation date in tification	N" for s Losses 2.00 1.00 N N	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117. 118. 0 0 118. 0 118. 119. 120.
7.00 Is this facility legally-required to carry malpractice insurno. 8.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DNOT USE THIS LINE 10.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that question Hold Harmless provision in ACA \$3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no. 11.00 Did this facility incur and report costs for high cost implations patients? Enter "Y" for yes or "N" for no. 12.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. 12.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 13.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 2 in this is a Medicare certified lang tra	center other dule listing content other dule listing content of the content of the content of the content of the center of the certification of the certific	Y" for yes or " if the policy i Premiums 1.00 505,940 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date ication date in tification derification ertification	N" for s Losses 2.00 1.00 N N	Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	117 118 0 0 118 0 118 0 120 121 0 122 125 126 127 128 129 130

Health Financial Systems	ST VINCENT ANDERSON					u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	CIDENTIFICATION DATA	Provi der	CCN: 150088	Period:	7/01/2015	Worksheet S- Part I	-2
					5/30/2016	Date/Time Pr	
						11/22/2016 3	3: 25 pm
					1. 00	2. 00	
133.00 If this is a Medicare certified ot	ner transplant center, er	nter the certif	ication date			2.00	133. 00
in column 1 and termination date,							
134.00 If this is an organ procurement or		the OPO number	in column 1				134. 00
and termination date, if applicable ALL Providers	e, In Column 2.						
140.00 Are there any related organization	or home office costs as	defined in CMS	Pub. 15-1.		Υ		140. 00
chapter 10? Enter "Y" for yes or "	N" for no in column 1. If	yes, and home	office cost	ts			
are claimed, enter in column 2 the		•	tions)				
1.00	2. (1 110 11		3. 00	6.11	
If this facility is part of a chai home office and enter the home off				name and	address	or the	
141. 00 Name:	Contractor's Name:	CONTRACTOR HAMB		ctor's Nu	mber:		141. 00
142.00 Street:	PO Box:						142. 00
143. 00 Ci ty:	State:		Zi p Coo	de:			143. 00
144 00 Are provider based physicians!	to included in Wentebast	12				1. 00 Y	144. 00
144.00 Are provider based physicians' cos	ts flictuded fli worksheet	A!				T	144.00
					1. 00	2. 00	
145.00 If costs for renal services are cl	aimed on Wkst. A, line 74	, are the cost	s for		N		145. 00
inpatient services only? Enter "Y"							
no, does the dialysis facility inc		n for this cost	reporting				
period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog		usly filed cos	t report?		N		146. 00
Enter "Y" for yes or "N" for no in				f	IN		140.00
yes, enter the approval date (mm/d							
147.00 Was there a change in the statistic	nal basis? Enter "V" for	voc or "N" for	no			1. 00 N	147. 00
148.00 Was there a change in the order of						N N	147. 00
149.00 Was there a change to the simplifi				or no.		N N	149. 00
		Part A	Part B		itle V	Title XIX	
		1.00	2.00		3.00	4. 00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or " 155.00 Hospi tal	N° for no for each compor	nent for Part A	and Part B	. (See 42	<u>' CFR 9413</u> N	3. 13) N	155. 00
156. 00 Subprovi der – IPF		Ϋ́	l N		N	N	156. 00
157. 00 Subprovi der - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N N		N	N	160. 00 161. 00
161. 00 CMHC 161. 10 CORF			N N		N N	N N	161. 00
101. 10 000			14		IV	TV.	101.10
						1.00	
Mul ti campus							
165.00 Is this hospital part of a Multica	mpus hospital that has or	ne or more camp	uses in dif1	ferent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State 2	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each		1.00	2.00	0.00	1. 00		00 166. 00
campus enter the name in column							
O, county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
jos. a.m. o (oss i iisti doti olis)							
						1.00	
Health Information Technology (HIT				ent Act			4
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10				') onto-	tho	Y	167. 00 0168. 00
reasonable cost incurred for the H			= 10/ IS Y), enter	THE		9100.00
168.01 If this provider is a CAH and is n			r qualify fo	or a hard	shi p		168. 01
exception under §413.70(a)(6)(ii)?	Enter "Y" for yes or "N"	for no. (see	instructions	s)	•		
169.00 If this provider is a meaningful u		lis not a CAH	(line 105 is	s "N"), e	nter the	0.5	50169.00
transition factor. (see instruction	15)					I	I

Health Financial Systems ST VINCENT ANDERSON REGIONAL HOSPITA In Lieu					2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150088 Period:					
			From 07/01/2015	Part I		
			To 06/30/2016	Date/Time Pre	pared:	
				11/22/2016 3:		
			Begi nni ng	Endi ng		
			1. 00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 06/30/2011 period respectively (mm/dd/yyyy)					170. 00	
				1.00	1	
171.00 If line 167 is "Y", does this pro	vider have any days for indivi	duals enrolled in sect	on 1876	N	171. 00	
Medicare cost plans reported on W	kst. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes a	nd "N" for no.			
(see instructions)						

	Financial Systems ST VINCENT ANDERSON RE FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Peri od:	u of Form CMS- Worksheet S-2	
1031 1	AL AND HOST THE HEALTH CARE RETWINDINGSEMENT QUESTIONINALINE	Trovider	CCN. 130000	From 07/01/2015 To 06/30/2016	Part II	epared:
				Y/N	Date	1
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N fomm/dd/yyyy format.	r all NO re	esponses. Ente	er all dates in t	he	
	COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the be	ginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in colu					
			Y/N	Date	V/I	
	II		1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare Progres, enter in column 2 the date of termination and in column 3 voluntary or "I" for involuntary.		N			2.00
3. 00			N			3. 00
	or medical supply companies) that are related to the provider					
	officers, medical staff, management personnel, or members of to directors through ownership, control, or family and other s					
	relationships? (see instructions)	amirar				
	Teratronships: (See Tristractions)		Y/N	Туре	Date	
			1.00	2.00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Certifi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avails	Compiled,	N			4. 00
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differer those on the filed financial statements? If yes, submit recond		N			5. 00
			1	Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities		 			4
5. 00	Column 1: Are costs claimed for nursing school? Column 2: If	yes, is th	ne provider is	S N		6. 00
7. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instr	uctions		Y		7. 00
3. 00	Were nursing school and/or allied health programs approved and	/or renewed	d during the	N N		8.00
	cost reporting period? If yes, see instructions.					
9. 00	Are costs claimed for Interns and Residents in an approved graph program in the current cost report? If yes, see instructions.	duate medio	cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated or r cost reporting period? If yes, see instructions.	enewed in	the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I &	R in an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	D-d D-b+-				1. 00	_
12. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, s	oo instruc	tions	I	Y	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection poli			ost reporting	N N	13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments	waived? I	f ves. see ins	structions.	N	14. 00
	Bed Complement					
15. 00	Did total beds available change from the prior cost reporting				N	15. 00
			rt A	Par		
		Y/N 1,00	Date	Y/N	Date	
	PS&R Data	1. 00	2.00	3. 00	4. 00	

	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Υ	11/01/2016	Y	11/01/2016	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Heal th	Financial Systems ST VINCENT ANDERSON	N REGIONAL HOSE	PLTA	In Lie	eu of Form CMS	-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 150088	Period: From 07/01/2015 To 06/30/2016		epared:		
			i pti on	Y/N	Y/N			
20.00	16 Line 1/ 17 in the many adjustments and to DC0D		0	1. 00	3.00	20.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N	Date	Y/N	Date			
		1.00	2.00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	HOSPI TALS)					
	Capital Related Cost							
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made duri	ng the cost	N	23. 00		
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entere	ed into durina	this cost ren	orting period?	N	24. 00		
21.00	If yes, see instructions	sa rinto darring	tiii 3 003t 1 op	or tring period.		21.00		
25. 00	Have there been new capitalized leases entered into during	the cost repor	rting period?	If yes, see	N	25. 00		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	as sost roporti	ng poriod2 Lf	. voc. coo	N	26. 00		
20.00	instructions.	ie cost reporti	ng perrou: II	yes, see	IN IN	20.00		
27. 00	Has the provider's capitalization policy changed during the	e cost reportir	ng period? If	yes, submit	N	27. 00		
	copy.							
28. 00	<pre>Interest Expense Were new Loans, mortgage agreements or Letters of credit er</pre>	ntered into du	ing the cost	reporting	N	28. 00		
	period? If yes, see instructions.							
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ebt Service Re	eserve Fund)	N	29. 00		
30. 00	Has existing debt been replaced prior to its scheduled matu		debt? If yes,	see	N	30.00		
	instructions.							
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see	N	31. 00		
	Purchased Services							
32.00	Have changes or new agreements occurred in patient care ser		ed through cor	itractual	N	32. 00		
22.00	arrangements with suppliers of services? If yes, see instru		++! +			22.00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 approx, see instructions.	olled pertainin	ng to competit	rive brading? IT		33. 00		
	Provi der-Based Physi ci ans							
34.00	Are services furnished at the provider facility under an ar	rangement with	n provi der-bas	ed physi ci ans?	Y	34.00		
25 00	If yes, see instructions.				V	25.00		
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		its with the p	rovi der-based	Y	35. 00		
				Y/N	Date			
	ll 055; 0 1			1. 00	2. 00			
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36.00		
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Ϋ́		37. 00		
	If yes, see instructions.							
38. 00				N		38. 00		
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			N		39. 00		
07.00	see instructions.	o. oa oopo.	.o			07.00		
40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	Υ		40. 00		
	i nstructi ons.							
		2.	00					
	Cost Report Preparer Contact Information							
41. 00	1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,							
	respectively.							
42.00	Enter the employer/company name of the cost report	ST VINCENT AND	DERSON REGIONA	L		42. 00		
12 00	preparer. Enter the telephone number and email address of the cost	HOSPI TA		VATUV ZAMBOSAS	TVI NCENT ODC	12 00		
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-646-8128		KATHY. ZAMBOS@S	IVINCENT. UKG	43. 00		
		•		į.				

Heal th	Financial Systems ST VINO	CENT ANDERSON	N REGIO	NAL HOSPITA		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST	I ONNAI RE	F	Provider CCN: 150088		eri od:	Worksheet S-2	2
					To	rom 07/01/2015 o 06/30/2016	Part II Date/Time Pre 11/22/2016 3:	pared: 25 pm
				3. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/	posi ti on	DI RECT	OR-BUDGET &				41.00
	held by the cost report preparer in columns 1,	2, and 3,	REI MBU	RSEMENT				
	respecti vel y.							
42.00	Enter the employer/company name of the cost re	port						42.00
	preparer.							
43.00	Enter the telephone number and email address of	f the cost						43.00
	report preparer in columns 1 and 2, respective	Iу.						

Health Financial Systems ST VINCENT ANDERSON REGIONAL HOSPITA

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: | Peri od: | Worksheet S-3 | From 07/01/2015 | Part I | Date/Time Prepared: | Provi der CCN: 150088

					'	0 00/30/2010	11/22/2016 3:	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		101	36, 966	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			101	36, 966	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		21	7, 686		0	8. 00
9.00	CORONARY CARE UNIT	32. 00		0			l	9. 00
10. 00	BURN INTENSIVE CARE UNIT	33. 00		0			0	10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	0	0.00	0	11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			122	44, 652	0.00	0	14. 00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		0			0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		13			0	17. 00
18. 00	SUBPROVI DER	42. 00		0			0	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0			0	19. 00
20. 00	NURSING FACILITY	45. 00		0			0	20. 00
20. 01	I CF/MR	45. 01		0	0	0. 00	0	20. 01
21. 00	OTHER LONG TERM CARE	46. 00		0	0		_	21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23. 00
24. 00	HOSPI CE	116. 00		0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25. 00	CMHC - CMHC	99. 00					0	25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			135				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions) LTCH non-covered days							33. 00
33.00	LIGH HOH-Covered days				I	l	I	55.00

Health Financial Systems ST VINCENT ANDERSON REGIONAL HOSPITA

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN:

Provi der CCN: 150088

| Peri od: | Worksheet S-3 | From 07/01/2015 | Part | To 06/30/2016 | Date/Time Prepared: | 11/22/2016 3: 25 pm

						11/22/2016 3:	25 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	9, 621	873	22, 539			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	3, 302	6, 042				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	336	373	_			4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	0 (04	0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	9, 621	873	22, 539			7. 00
8. 00	INTENSIVE CARE UNIT	3, 513	27	6, 079			8.00
9. 00	CORONARY CARE UNIT	0	o	0			9. 00
10.00	BURN INTENSIVE CARE UNIT	o	o	0			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	o	o	0			11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		685	816			13. 00
14.00	Total (see instructions)	13, 134	1, 585	29, 434	0.00	705. 40	14. 00
15.00	CAH visits	o	o	0			15. 00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16. 00
17.00	SUBPROVI DER - I RF	1, 189	28	2, 520	0.00	12. 30	17. 00
18. 00	SUBPROVI DER		0	0	0.00	0.00	18. 00
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
20.00	NURSING FACILITY		0	0	0.00	0.00	
20. 01	I CF/MR	0	0	0	0.00	0.00	
21. 00	OTHER LONG TERM CARE			0	0.00	0.00	
22. 00	HOME HEALTH AGENCY	0	0	0	0.00	0. 00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0. 00	1
24. 00	HOSPI CE	0	0	0	0.00	0. 00	
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC	0	0	0		0.00	
25. 10	CMHC - CORF	0	0	0		0.00	
26. 00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)		0.4	07/	0.00	717. 70	
28. 00	Observation Bed Days		86	976			28. 00
29. 00	Ambul ance Tri ps	0		•			29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF		7.5	122			31.00
32. 00	Labor & delivery days (see instructions)	0	75	122			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32. 01
33. 00	LTCH non-covered days	О					33. 00
	1	, 91	'		'	ı	

Health Financial Systems ST VINCENT ANDERSON REGIONAL HOSPITA

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: Provi der CCN: 150088

				To	06/30/2016	Date/Time Pre 11/22/2016 3:	
		Full Time	<u>'</u>	Di sch	arges	,,	
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	2, 386	1, 438	6, 441	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			F00			2 00
2. 00 3. 00	HMO and other (see instructions)			588	0		2. 00 3. 00
4. 00	HMO IPF Subprovider				0		4. 00
5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				۷		5.00
6.00	Hospital Adults & Peds. Swing Bed SNF						6.00
7. 00	Total Adults and Peds. (exclude observation	+			1		7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	2, 386	1, 438	6, 441	
15. 00	CAH visits	0.00	Ü	2,000	1, 100	0, 111	15. 00
16. 00	SUBPROVIDER - I PF	0.00	0	0	0	0	16. 00
17. 00	SUBPROVI DER - I RF	0.00	0	99	25	214	17. 00
18. 00	SUBPROVI DER	0.00	0		o	0	18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY	0.00					20. 00
20. 01	I CF/MR	0.00	0	0	o	0	20. 01
21.00	OTHER LONG TERM CARE	0.00				0	21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24.00	HOSPI CE	0.00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.22
33.00	LTCH non-covered days				I		33. 00

HOSPITAL WAGE INDEX INFORMATION

Date/Time Prepared: 11/22/2016 3:25 pm Adj usted Worksheet A Amount Recl assi fi cati Paid Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col (from Salaries in col. 5) Worksheet A-6) 3) col. 4 2.00 5.00 6. 00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200. 00 59, 039, 233 59, 039, 233 1, 627, 030. 00 36. 29 1.00 instructions) 2.00 Non-physician anesthetist Part 0 C 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 Physician-Part A -O 0.00 0.00 4.00 Admi ni strati ve 4.01 Physicians - Part A - Teaching 846, 170 846, 170 4, 692.00 180.34 4.01 5.00 Physician-Part B 2, 640, 245 2, 640, 245 15, 598. 00 169. 27 5.00 6.00 Non-physician-Part B 0.00 0.00 6.00 0 Interns & residents (in an 21 00 7.00 0 O 0.00 0.00 7.00 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office personnel 0.00 0.00 8.00 44 00 0.00 9 00 SNF 0 00 9 00 10.00 Excluded area salaries (see 6, 621, 412 1, 278, 132 7, 899, 544 378, 835. 00 20.85 10.00 instructions) OTHER WAGES & RELATED COSTS 922, 430 922, 430 12, 838. 95 71.85 11.00 Contract labor: Direct Patient 11.00 Care 12.00 Contract Labor: Top Level 24, 690 O 24, 690 1, 619. 43 15. 25 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 0 0 0.000.00 13.00 A - Administrative 14.00 Home office salaries & 19, 391, 229 0 19, 391, 229 408, 855.00 47. 43 14.00 wage-related costs Home office: Physician Part A 15.00 0 0.00 0.00 15.00 - Administrative 16.00 Home office and Contract 0 0 0.00 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS Wage-related costs (core) (see 13, 500, 157 0 13, 500, 157 17.00 17.00 instructions) Wage-related costs (other) Ω 18.00 18.00 0 0 (see instructions) 19.00 19 00 Excluded areas 2, 443, 596 0 2, 443, 596 20.00 Non-physician anesthetist Part 20.00 0 21.00 Non-physician anesthetist Part 0 21.00 22.00 Physician Part A -0 22.00 Administrative 22.01 Physician Part A - Teaching С 22.01 23.00 Physician Part B 0 23.00 0 24.00 Wage-related costs (RHC/FQHC) 0 0 24 00 25.00 Interns & residents (in an 0 25.00 approved program) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 26.00 4. 00 788, 281 788, 281 16, 654. 00 47. 33 26.00 Administrative & General -98, 900 168, 352. 00 80. 98 27.00 13, 633, 710 27.00 5.00 13, 732, 610 28.00 Administrative & General under 0.00 0.00 28.00 0 contract (see inst.) 29.00 Maintenance & Repairs 6.00 401, 715 401, 715 21, 174. 00 18.97 29.00 Operation of Plant 0.00 30.00 30.00 7 00 0 00 0 31.00 Laundry & Linen Service 8.00 0 0 0.00 0.00 31.00 32.00 Housekeepi ng 9.00 0 0 0.00 0.00 32.00 33.00 Housekeeping under contract 0 0 0.00 0.00 33.00 (see instructions) 39. 35 34 00 34.00 Di etarv 10.00 46, 154 -24, 904 21, 250 540.00 Di etary under contract (see 0.00 35.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 24, 904 24, 904 1, 835. 00 13. 57 36.00 0.00 Maintenance of Personnel 12 00 37 00 37 00 0 00 38.00 Nursing Administration 13.00 661, 776 661, 776 17, 122. 00 38. 65 38.00 C Central Services and Supply 446, 537 21, 168. 00 21.09 39.00 39.00 14.00 446, 537 40.00 Pharmacy 15.00 2, 918, 296 -146, 800 2, 771, 496 74, 887. 00 37. 01 40. 00

Heal th	Financial Systems	ST VI	NCENT ANDERSON	I REGIONAL HOSP	NAL HOSPITA		In Lieu of Form CMS-2552-10	
HOSPI T	AL WAGE INDEX INFORMATION			Provi der	CCN: 150088	Peri od:	Worksheet S-3	
						From 07/01/2015		
						To 06/30/2016		
							11/22/2016 3:	25 pm_
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2.00	3. 00	4.00	5. 00	6. 00	
41.00	Medical Records & Medical	16. 00	752, 200	0	752, 20	0 28, 514. 00	26. 38	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0		0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0		0.00	0.00	43.00
			ū	,	ı	-1	0.00	

Total overhead cost (see

instructions)

7.00

55. 68

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 150088 Peri od: Worksheet S-3 From 07/01/2015 To 06/30/2016 Part III Date/Time Prepared: 11/22/2016 3:25 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 55, 552, 818 55, 552, 818 1, 606, 740. 00 1.00 34.57 instructions) 2.00 6, 621, 412 1, 278, 132 7, 899, 544 378, 835. 00 20.85 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 48, 931, 406 -1, 278, 132 47, 653, 274 1, 227, 905. 00 38.81 3.00 minus line 2) 4.00 Subtotal other wages & related 20, 338, 349 20, 338, 349 423, 313. 38 48.05 4.00 costs (see inst.) Subtotal wage-related costs 28. 33 5.00 13, 500, 157 Ω 13, 500, 157 0.00 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 82, 769, 912 -1, 278, 132 81, 491, 780 1, 651, 218. 38 49 35

19, 747, 569

-245, 700

19, 501, 869

350, 246. 00

Health Financial Systems	ST VINCENT ANDERSON REG	I ONAL HOSPITA	In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE RELATED COSTS		Provider CCN: 150088	Peri od:	Worksheet S-3	
			From 07/01/2015		
			To 06/30/2016	Date/Time Pre	oared:
				11/22/2016 3:	25 pm_
				Amount	
				Reported	
				1. 00	
PART IV - WAGE RELATED COSTS					
Part A - Core List					

		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 312, 050	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	148, 602	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	797, 609	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Heal th Insurance (Purchased or Self Funded)	9, 858, 432	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	157, 548	10.00
11.00		104, 337	
12.00		0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	422, 690	13. 00
14. 00		0	14.00
15. 00		288, 603	15. 00
16, 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16, 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	2, 775, 735	17. 00
18.00	Medicare Taxes - Employers Portion Only	856, 069	18. 00
19.00		14, 888	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	16, 736, 563	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
			,

Health Financial Systems	ST VINCENT ANDERSON REGIONAL HOS	In Lie	u of Form CMS-2552-10	
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi de	CCN: 150088	Peri od: From 07/01/2015	Worksheet S-3
			110111 0770172013	

			10111 0770172013		
			To 06/30/2016	Date/Time Prep 11/22/2016 3:2	
	Cost Center Description		Contract Labor		25 pili
	oost conton bood. Fit on		1. 00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		24, 690	0	1. 00
2.00	Hospi tal		24, 690	0	2. 00
3.00	Subprovi der - I PF		0	0	3. 00
4.00	Subprovi der - IRF		0	0	4. 00
5.00	Subprovi der - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF		0	0	8. 00
9.00	Hospi tal -Based NF		0	0	9. 00
9. 01	Hospi tal -Based NF		0	0	9. 01
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12.00	Separately Certified ASC		0	0	12.00
13.00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14. 00
15. 00	Hospital-Based Health Clinic FQHC		0	0	15. 00
16. 00	Hospi tal -Based-CMHC		0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17. 00	Renal Dialysis		0	0	17. 00
18. 00	Other		0	0	18. 00

	Financial Systems ST VINCENT ANDERSON REGION				u of Form CMS-2	
HOSPI 1	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovi der (CCN: 150088	Peri od: From 07/01/2015	Worksheet S-10	0
				To 06/30/2016	Date/Time Pre 11/22/2016 3:	
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid Medicaid (see instructions for each line)	ed by lir	ne 202 column	1 8)	0. 268201	1.00
2. 00	Net revenue from Medicaid				37, 001, 178	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.00
4. 00	If line 3 is "yes", does line 2 include all DSH or supplemental page 1.	avments f	rom Medicaio	1?	Ϋ́	4.00
5. 00	If line 4 is "no", then enter DSH or supplemental payments from M				0	5.00
6.00	Medicaid charges				119, 750, 495	
7. 00	Medicaid cost (line 1 times line 6)				32, 117, 203	
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minu	s sum of lir	nes 2 and 5: if	0	1
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for ea	ch line)			1
9.00	Net revenue from stand-alone SCHIP				0	9.00
10.00	Stand-alone SCHIP charges				0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 mi	nus line 9;	if < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see instru					
13. 00	Net revenue from state or local indigent care program (Not include					13. 00
14. 00	Charges for patients covered under state or local indigent care p	rogram (N	lot included	in lines 6 or	0	14. 00
45 00	10)					45 00
15.00	State or local indigent care program cost (line 1 times line 14)		<i>(</i> 1.1	45 ' ''	0	
16. 00	00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)					16. 00
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fund	ing chari	ty care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of hos	9	,		0	
19. 00	Total unreimbursed cost for Medicaid, SCHIP and state and local			ns (sum of lines	-	19.00
17.00	8, 12 and 16)	rnar gent	care program	is (sum of filles	O	17.00
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
20.00	Total initial obligation of patients approved for charity care (a		18, 398, 7	53 0	18, 398, 763	20. 00
21 00	charges excluding non-reimbursable cost centers) for the entire for		4 024 E	57 0	4 024 547	21 00
21. 00	Cost of initial obligation of patients approved for charity care times line 20)	(Tine I	4, 934, 5	0	4, 934, 567	21. 00
22. 00	1		430, 5	31 0	430, 531	22. 00
	Cost of charity care (line 21 minus line 22)		4, 504, 0		4, 504, 036	
23.00	cost of chartty care (fine 21 millios fine 22)		4, 304, 0.	0	4, 304, 030	23.00
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient d		nd a Length o	of stay limit	N	24. 00
25. 00	imposed on patients covered by Medicaid or other indigent care prolifering 24 is "yes", charges for patient days beyond an indigent		ogram's lors	h of stay limit	0	25. 00
26. 00						
27. 00						
28. 00	Medicare bad debts for the entire hospital complex (see instruction Non-Medicare and non-reimbursable Medicare bad debt expense (line		: lino 27\		478, 931 6, 421, 365	
28.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (The			. 201	1, 722, 217	
30.00		se (IIIIe	i tilles iine	20)	6, 226, 253	
	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			6, 226, 253	
31 NN						

ASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	E OF EXPENSES	Provi der		eriod: rom 07/01/2015	Worksheet A	
				o 06/30/2016	Date/Time Pre 11/22/2016 3:	
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
	1.00	2. 00	3.00	4. 00	col . 4) 5.00	
GENERAL SERVICE COST CENTERS						
O 00100 NEW CAP REL COSTS-BLDG & FIXT O0101 NEW CAP REL COSTS-BLDG & FIXT		1, 855, 008			2, 592, 816 0	
0 00300 OTHER CAPITAL RELATED COSTS		0		0	0	
00400 EMPLOYEE BENEFITS DEPARTMENT	788, 281	10, 916, 829			11, 705, 110	
0 00500 ADMINISTRATIVE & GENERAL	13, 732, 610	35, 654, 748				
0 00600 MAINTENANCE & REPAIRS 0 00700 OPERATION OF PLANT	401, 715	7, 970, 156	1		8, 387, 629 0	1
0 00800 LAUNDRY & LINEN SERVICE	O	563, 542	1	_	563, 542	
00900 HOUSEKEEPI NG	o	2, 455, 325			2, 455, 325	
00 01000 DI ETARY 00 01100 CAFETERI A	46, 154	2, 892, 527	2, 938, 681		1, 352, 994	
00 01100 CAFETERTA 00 01200 MAI NTENANCE OF PERSONNEL		0		1, 585, 687 0	1, 585, 687 0	
00 01300 NURSI NG ADMINI STRATI ON	661, 776	346, 317	1, 008, 093	Ö	1, 008, 093	
00 01400 CENTRAL SERVICES & SUPPLY	446, 537	261, 443				
00 01500 PHARMACY 00 01600 MEDICAL RECORDS & LIBRARY	2, 918, 296 752, 200	21, 049, 325 620, 510			3, 575, 331 1, 372, 710	
00 01700 SOCIAL SERVICE	752, 200	620, 510	1, 3/2, /10	0	1, 372, 710	
00 01900 NONPHYSICIAN ANESTHETISTS	0	Ö	ď	Ö	0	
00 02000 NURSING SCHOOL	0	0	C	0	0	
00 02100 1&R SERVICES-SALARY & FRINGES APPRVD 00 02200 1&R SERVICES-OTHER PRGM COSTS APPRVD		0		0	0	ı –
00 02300 PARAMED ED PRGM	100, 294	16, 317	116, 611	-47	116, 564	
01 02301 SCH OF RADIOLOGY	72, 715	15, 841				
02 02302 PHARMACY RESI DENCY	82, 812	15, 334	98, 146	146, 800	244, 946	23
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 00 03000 ADULTS & PEDI ATRI CS	12, 960, 507	3, 458, 150	16, 418, 657	-3, 065, 720	13, 352, 937	30
00 03100 NTENSIVE CARE UNIT	3, 249, 362	1, 631, 310		1		
00 03200 CORONARY CARE UNIT	0	0	0	0	0	
00 03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	
00 03400 SURGICAL INTENSIVE CARE UNIT 00 04000 SUBPROVIDER - IPF	0	0	0	0	0	
00 04100 SUBPROVI DER - 1 PF	864, 318	288, 811	1, 153, 129	-20, 006		
00 04200 SUBPROVI DER	0	0	0	0	0	1
00 04300 NURSERY	0	0	C	739, 919		
00 04400 SKILLED NURSING FACILITY 00 04500 NURSING FACILITY	0	0	0	0	0	
01 04510 I CF/MR		0		0	0	
00 04600 OTHER LONG TERM CARE	0	0	C	0	0	46
ANCILLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM	1 552 750	21 214 050	22 0/0 717	0.000.227	14 0/0 400	۱.,
01 05000 OPERATING ROOM 01 05001 SURGERY CENTER	1, 553, 759	21, 314, 958 116, 611				50
00 05100 RECOVERY ROOM	o	0	_	0	0	
00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	110, 625		
00 05300 ANESTHESI OLOGY 00 05400 RADI OLOGY-DI AGNOSTI C	2, 940, 873	2, 486, 190	5, 427, 063	1, 060, 913 -723, 439		
00 05500 RADI OLOGY-THERAPEUTI C	912, 334	1, 511, 210		1		
00 05600 RADI OI SOTOPE	0	0	C	0	0	56
00 05700 CT SCAN	431, 444	103, 420			534, 864	
00 05800 MAGNETIC RESONANCE I MAGING (MRI) 00 05900 CARDIAC CATHETERIZATION	267, 244	616, 567 0			875, 736 0	
00 06000 LABORATORY	34, 363	6, 613, 277	1	_		
01 06001 BLOOD LABORATORY	O	O	C	0	0	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	C	0	0	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 00 06300 BLOOD STORING, PROCESSING & TRANS.		0		463, 856	0 463, 856	
00 06400 I NTRAVENOUS THERAPY	o	Ö	ď	0	0	1
00 06500 RESPIRATORY THERAPY	1, 171, 097	423, 372			1, 397, 498	
00 06600 PHYSICAL THERAPY 00 06700 OCCUPATIONAL THERAPY	1, 431, 553	556, 001 89, 218			1, 954, 672 1, 181, 820	
00 06800 SPEECH PATHOLOGY	1, 094, 677 157, 592	160, 295				
00 06900 ELECTROCARDI OLOGY	1, 774, 399	721, 488			2, 217, 176	
00 07000 ELECTROENCEPHALOGRAPHY	398, 435	262, 964	661, 399		651, 148	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		6, 954, 048		
00 07200 IMPL. DEV. CHARGED TO PATIENT 00 07300 DRUGS CHARGED TO PATIENTS		0		4, 933, 346 22, 674, 909		
00 07400 RENAL DIALYSIS		0		0	22, 074, 909	
00 07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	75
00 03190 CHEMOTHERAPY	856, 716	3, 124, 769	3, 981, 485	-2, 933, 809	1, 047, 676	76
OUTPATIENT SERVICE COST CENTERS O 08800 RURAL HEALTH CLINIC	0	O	C	0	0	88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o o	Ö			_	89

Cost Center Description		INCENT ANDERSON				eu of Form CMS-	2552-10
Cost Center Description	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der			Worksheet A	
11/22/2016.3 25 pm					From U//UI/2UI5 To 06/30/2016	Date/Time Dre	narod:
Cost Center Description					10 00/30/2010	11/22/2016 3:	25 pm
1.00	Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cati		
1.00 2.00 3.00 4.00 5.00 90.00 9				,			
1.00				ĺ	, ,		
90.00 090000 CLINIC 0 0 0 0 0 0 90.00 91.00 09000 MADRESON CENTER OP CLINIC 3, 435, 897 2, 052, 451 5, 488, 348 -445, 470 5, 042, 878 91.00 92.00 09200 09SERVATION BEDS (NON-DISTINCT PART) 90.01 91.00 09100 MEMER REGISTATION BEDS (NON-DISTINCT PART) 90.00 92.00 09200 09SERVATION BEDS (NON-DISTINCT PART) 90.00 90.00 92.00 09200 09SERVATION BEDS (NON-DISTINCT PART) 90.00						col . 4)	
9.0. 01 09001 ANDERSON CENTER OP CLINIC 0 0 0 0 718.667 70.867 90.00 90.00 09EMERCRUY S (NON-DISTINCT PART) 9.00 92.00 09EMERCRUY S (NON-DISTINCT PART) 9.00 9.00 92.00 09EMERCRUY S (NON-DISTINCT PART) 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.0		1.00	2. 00	3.00	4. 00	5. 00	
91.00 09100 DIRECRENCY 3,435,897 2,052,451 5,488,348 -445,470 5,042,878 91.00 09200 0SEREVATION BEDS (NON-DISTINCT PART) 92.00 09500 0SEREVATION BEDS (NON-DISTINCT PART) 92.00 09500 0SEREVATION BEDS (NON-DISTINCT PART) 92.00 09500 0MBULANCE SERVICES 0 0 0 0 0 0 0 0 0 0 0 95.00 95.00 09500 0MBULANCE SERVICES 0 0 0 0 0 0 0 0 0 0 0 95.00 96.00 99.00 0MBULANCE SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 95.00 99.00 99.00 0MBULANCE SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	90. 00 09000 CLI NI C	0	0		0 0	0	90.00
92. 00 09200 0958VATI ON BEDS (NON-DISTINCT PART) 92. 00 09400 000 09400 000 09400 000 09400 000 09500	90.01 09001 ANDERSON CENTER OP CLINIC	o	0		0 718, 667	718, 667	90. 01
OTHER REIMBURSABLE COST CENTERS	91. 00 09100 EMERGENCY	3, 435, 897	2, 052, 451	5, 488, 34	-445, 470	5, 042, 878	91.00
94.00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0 0 95.00 99.00 09600 0000 000 0 0 0 0 0 0 0 0 0 0 0 0	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
94.00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0 0 95.00 99.00 09600 0000 000 0 0 0 0 0 0 0 0 0 0 0 0	OTHER REIMBURSABLE COST CENTERS						1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 0 0 99.00 99. 00 09900 CMRC 0 0 0 0 0 0 0 0 0 0 0 99.00 99. 10 09910 CORPT 0 0 0 0 0 0 0 0 0 0 0 99.00 101. 00 10000 IARS SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0		0 0	0	94. 00
97. 00 O9700 DURBALE MEDICAL EQUI P-SOLD 0 0 0 0 0 0 0 0 0	95. 00 09500 AMBULANCE SERVICES	o	0		o o	0	95.00
99. 10 09900 CMRC 0 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0	96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0		o o	0	96.00
99.10 09910 009F 000F 0 0 0 0 0 0 0 0	97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0		o o	0	97. 00
100.00 10000 LAR SERVICES-NOT APPRVD PRGM 0 867 8.560 9.427 0 0 0 100.00	99. 00 09900 CMHC	o	0		o o	0	99. 00
1010 10100 10100 1000 EMBLITH AGENCY 867	99. 10 09910 CORF	o	0		o o	0	99. 10
SPECIAL PURPOSE COST CENTERS	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0		o o	0	100.00
SPECIAL PURPOSE COST CENTERS	101.00 10100 HOME HEALTH AGENCY	867	8, 560	9, 42	7 0	9, 427	101.00
105.00 10500 IDMEY ACQUISITION	SPECIAL PURPOSE COST CENTERS	•			<u>'</u>		1
107, 00 10700 LUVER ACQUISITION		0	0		0 0	0	105.00
108. 00 10800 LUNG ACQUISITION 0 0 0 0 0 108. 00 109. 00	106. 00 10600 HEART ACQUI SI TI ON	o	0		o o	0	106.00
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 111	107. 00 10700 LIVER ACQUISITION	o	0		o o	0	107. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	108.00 10800 LUNG ACQUISITION	o	0		o o	0	108.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		o	0		0 0	0	109.00
113.00 11300 11400 UTI LI ZATI ON REVIEW-SNF 0		o	0		o o	0	110.00
113.00 11300 11400 UTI LI ZATI ON REVIEW-SNF 0	111.00 11100 I SLET ACQUI SI TI ON	o	0		o o	0	111.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 0 0 0 0 114. 00 115.00 115			470, 840	470, 84	0 -470, 840	0	113.00
115. 00 115.00 11500 MBULATORY SURGICAL CENTER (D. P.)		0	0		0	l .	
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) 53, 537, 470 130, 656, 221 114, 180 0 111, 180 116. 00 182, 986, 136 182, 986, 146, 186, 186, 186, 186, 186, 186, 186, 18		o	0		0		
118. 00 SUBTOTALS (SUM OF LINES 1-117) 53,537,470 130,656,221 184,193,691 -1,207,555 182,986,136 118. 00		-1, 357	12, 537	11. 18	o o		
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT. FLOWER, COFFEE SHOP & CANTEEN 109,997 59,687 169,684 0 169,684 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3,154,449 1,631,952 4,786,401 -17,656 4,768,745 192. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 194. 10 194. 10							
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 109, 997 59, 687 169, 684 0 169, 684 191. 00 19100 19100 19200 19200 19200 19200 193000 19300 19300 19300 19300 19300					, , , , , , , , , , , , , , , , , , , ,	. , ,	1
191. 00 19100 RESEARCH 109, 997 59, 687 169, 684 0 169, 684 191. 00 19200		O	0		0 0	0	190.00
193. 00 19300 NONPAID WORKERS 194. 00 07950 FOUNDATION 125, 824 109, 542 235, 366 0 235, 366 194. 00 194. 02 07951 CHI LDREN'S CLINIC 194. 04 07952 HEALTH RESOURCE CENTER 194. 05 07953 ADOLESCENT RESIDENTIAL 194. 07 07954 COMMUNITY BENEFIT/MISSION 194. 10 07955 DME 194. 10 07955 DME 194. 10 07955 DME 194. 10 07955 DME 194. 10 07957 UNUSED SPACE 194. 13 07957 UNUSED SPACE 194. 14 07958 ADVERTSISING AND MARKETING 194. 15 07959 PHYSICIANS RECRUITING 194. 16 07960 MOB 194. 18 07962 MAB 194. 18 07962 MAB		109, 997	59, 687	169, 68	4 0	169, 684	191.00
193. 00 19300 NONPAID WORKERS 194. 00 07950 FOUNDATION 125, 824 109, 542 235, 366 0 235, 366 194. 00 194. 02 07951 CHI LDREN'S CLINIC 194. 04 07952 HEALTH RESOURCE CENTER 194. 05 07953 ADOLESCENT RESIDENTIAL 194. 07 07954 COMMUNITY BENEFIT/MISSION 194. 10 07955 DME 194. 10 07955 DME 194. 10 07955 DME 194. 10 07955 DME 194. 10 07957 UNUSED SPACE 194. 13 07957 UNUSED SPACE 194. 14 07958 ADVERTSISING AND MARKETING 194. 15 07959 PHYSICIANS RECRUITING 194. 16 07960 MOB 194. 18 07962 MAB 194. 18 07962 MAB	192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 154, 449	1, 631, 952	4, 786, 40	1 -17, 656	4, 768, 745	192. 00
194. 02 07951 CHI LDREN'S CLINIC 259, 891 135, 128 395, 019 0 395, 019 194. 02 194. 04 07952 HEALTH RESOURCE CENTER 64, 895 5, 680 70, 575 0 70, 575 194. 04 194. 05 194. 07 07954 COMMUNITY BENEFIT/MISSION 307, 501 158, 183 465, 684 0 465, 684 194. 07 194. 12 07955 DME 1, 479, 206 3, 682, 843 5, 162, 049 1, 806 5, 163, 855 194. 10 194. 12 07956 MED ONE/TWO 0 -4, 601 -4, 601 194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSISING AND MARKETING 0 -480 0 0 25, 175 194. 15 194. 16 07960 MOB 0 987 987 -50 937 194. 16 194. 18 07962 MAB 0 576 575 -7, 820 2, 455 194. 17 194. 18 18 197. 18		o	0		o o	0	193. 00
194. 04 07952 HEALTH RESOURCE CENTER 64, 895 5, 680 70, 575 0 70, 575 194. 04 194. 05 194. 07 07954 COMMUNI TY BENEFIT/MI SSI ON 307, 501 158, 183 465, 684 0 465, 684 194. 07 194. 12 07955 DME 1, 479, 206 3, 682, 843 5, 162, 049 1, 806 5, 163, 855 194. 10 194. 12 07956 MED 0NE/TWO 0 -4, 601 -4, 601 0 -4, 601 194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 0 0 194. 13 194. 14 15 07958 ADVERTSI SI NG AND MARKETI NG 0 987 9HYSI CI ANS RECRUI TI NG 194. 16 07960 MOB 0 987 987 -50 937 194. 16 194. 18 07962 MAB 0 576 575 -7, 820 2, 455 194. 17 194. 18 18 10 194. 18 18 197962 MAB	194. 00 07950 FOUNDATI ON	125, 824	109, 542	235, 36	6 0	235, 366	194. 00
194. 04 07952 HEALTH RESOURCE CENTER 64, 895 5, 680 70, 575 0 70, 575 194. 04 194. 05 194. 07 07954 COMMUNI TY BENEFIT/MI SSI ON 307, 501 158, 183 465, 684 0 465, 684 194. 07 194. 12 07955 DME 1, 479, 206 3, 682, 843 5, 162, 049 1, 806 5, 163, 855 194. 10 194. 12 07956 MED 0NE/TWO 0 -4, 601 -4, 601 0 -4, 601 194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 0 0 194. 13 194. 14 15 07958 ADVERTSI SI NG AND MARKETI NG 0 987 9HYSI CI ANS RECRUI TI NG 194. 16 07960 MOB 0 987 987 -50 937 194. 16 194. 18 07962 MAB 0 576 575 -7, 820 2, 455 194. 17 194. 18 18 10 194. 18 18 197962 MAB		1					
194. 05 07953 ADOLESCENT RESIDENTIAL 0 0 0 1, 206, 241 1, 206, 241 194. 05 194. 07 07954 COMMUNITY BENEFIT/MISSION 307, 501 158, 183 465, 684 0 465, 684 194. 07 194. 12 07956 MED ONE/TWO 0 -4, 601 -4, 601 0 -4, 601 194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 194. 13 194. 15 07959 PHYSICIANS RECRUITING 0 987 987 -50 937 194. 16 194. 17 07961 ASB 0 0 10, 275 104. 18 07962 MAB 0 576 0 575 575 -141 434 194. 18							
194. 10 07955 DME 1, 479, 206 3, 682, 843 5, 162, 049 1, 806 5, 163, 855 194. 10 194. 12 07956 MED ONE/TWO 0 -4, 601 -4, 601 0 -4, 601 0 -4, 601 0 -4, 601 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 05 07953 ADOLESCENT RESIDENTIAL	o	0		0 1, 206, 241	1, 206, 241	194. 05
194. 10 07955 DME 1, 479, 206 3, 682, 843 5, 162, 049 1, 806 5, 163, 855 194. 10 194. 12 07956 MED ONE/TWO 0 -4, 601 -4, 601 0 -4, 601 0 -4, 601 0 -4, 601 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		307, 501	158, 183	465, 68			
194. 12 07956 MED ONE/TWO 0 -4, 601 0 -4, 601 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 0 -480 -480 0 -480 194. 14 194. 15 07959 PHYSI CI ANS RECRUI TI NG 0 0 0 25, 175 25, 175 194. 15 194. 16 07960 MOB 0 987 987 -50 937 194. 16 194. 17 07961 ASB 0 10, 275 10, 275 -7, 820 2, 455 194. 17 194. 18 07962 MAB 0 575 575 -141 434 194. 18							
194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 0 -480 -480 0 -480 194. 14 194. 15 07959 PHYSI CI ANS RECRUI TI NG 0 0 0 25, 175 25, 175 194. 15 194. 16 07960 MOB 0 987 987 -50 937 194. 16 194. 17 07961 ASB 0 10, 275 10, 275 -7, 820 2, 455 194. 17 194. 18 07962 MAB 0 575 575 -141 434 194. 18	· · · · · · · · · · · · · · · · · · ·	1 1			· ·		1
194. 14 07958 ADVERTSISING AND MARKETING 0 -480 0 -480 194. 14 194. 15 07959 PHYSICIANS RECRUITING 0 0 0 25, 175 25, 175 194. 15 194. 16 07960 MOB 0 987 987 -50 937 194. 16 194. 17 07961 ASB 0 10, 275 10, 275 -7, 820 2, 455 194. 17 194. 18 07962 MAB 0 575 575 -141 434 194. 18		o					
194. 15 07959 PHYSI CI ANS RECRUI TI NG 0 0 0 25, 175 25, 175 194. 15 194. 16 07960 MOB 0 987 987 -50 937 194. 16 194. 17 07961 ASB 0 10, 275 10, 275 -7, 820 2, 455 194. 17 194. 18 07962 MAB 0 575 575 -141 434 194. 18		o	-480	-48	0 0		
194. 16 07960 MOB 0 987 987 -50 937 194. 16 194. 17 07961 ASB 0 10, 275 10, 275 -7, 820 2, 455 194. 17 194. 18 07962 MAB 0 575 575 -141 434 194. 18			0			•	
194. 17 07961 ASB 0 10, 275 10, 275 -7, 820 2, 455 194. 17 194. 18 07962 MAB 0 575 575 -141 434 194. 18		l	987	98			
194. 18 07962 MAB 0 575 575 -141 434 194. 18							
	200.00 TOTAL (SUM OF LINES 118-199)	59, 039, 233	136, 445, 992	195, 485, 22	5 0	195, 485, 225	200.00

Health Financial Systems ST VINCENT ANDERSON REGIONAL HOSPITA In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 150088 Period: Worksheet A

From 07/01/2015

06/30/2016 Date/Time Prepared: 11/22/2016 3:25 pm Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT -640, 638 1, 952, 178 1.00 00101 NEW CAP REL COSTS-BLDG & FIXT 1.01 1.01 3.00 00300 OTHER CAPITAL RELATED COSTS 3.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 996, 819 14, 701, 929 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL -9, 880, 655 39, 102, 815 5.00 00600 MAINTENANCE & REPAIRS 6.00 -732, 750 7, 654, 879 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE -761 8.00 562, 781 8 00 9.00 00900 HOUSEKEEPI NG -7, 115 2, 448, 210 9.00 10.00 01000 DI ETARY -806, 286 546, 708 10 00 01100 CAFETERI A 11 00 11 00 0 1, 585, 687 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION -1, 575 1,006,518 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 -19 444.063 14.00 3, 574, 549 01500 PHARMACY 15.00 -782 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 38, 789 1, 333, 921 16.00 01700 SOCIAL SERVICE 17.00 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 19.00 02000 NURSING SCHOOL 20.00 0 Ω 20 00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 22.00 02300 PARAMED ED PRGM 23.00 -358 116, 206 23.00 02301 SCH OF RADIOLOGY 23.01 172, 400 23.01 23.02 02302 PHARMACY RESIDENCY 244, 946 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS -49.28913, 303, 648 30 00 31.00 03100 INTENSIVE CARE UNIT 0 4, 549, 502 31.00 03200 CORONARY CARE UNIT 32.00 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 34.00 40.00 04000 SUBPROVI DER - I PF 40.00 04100 SUBPROVI DER - I RF 41.00 -5, 149 1, 127, 974 41.00 42 00 04200 SUBPROVI DER 0 42 00 04300 NURSERY 43.00 0 739, 919 43.00 04400 SKILLED NURSING FACILITY 0 44.00 C 44.00 45.00 04500 NURSING FACILITY 0 45.00 0 04510 | CF/MR 0 45.01 Ω 45.01 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50 00 -3, 361 14, 065, 129 05001 SURGERY CENTER 50.01 50.01 05100 RECOVERY ROOM 0 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 110, 625 52.00 05300 ANESTHESI OLOGY 1,060,913 53 00 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C -10, 188 4, 693, 436 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C -5, 333 2, 332, 343 55.00 05600 RADI OI SOTOPE 56, 00 56, 00 533, 650 05700 CT SCAN -1 214 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) -9, 331 866, 405 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 60.00 -59, 526 5, 464, 899 60.00 60 01 06001 BLOOD LABORATORY C 60 01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 463, 856 63.00 0 63.00 64.00 06400 INTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 1, 340, 473 65.00 -57, 025 65.00 06600 PHYSI CAL THERAPY 66.00 1, 952, 819 -1.85366.00 1, 181, 820 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY -11, 584 163, 718 68.00 69.00 06900 ELECTROCARDI OLOGY -73 2, 217, 103 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 -143, 622 507, 526 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 6, 954, 048 71.00 4, 933, 346 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 22, 674, 909 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 75.00 07500 ASC (NON-DISTINCT PART) 75.00 03190 CHEMOTHERAPY 76.00 1,047,676 76.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 90.00 09000 CLI NI C 0 90.00 09001 ANDERSON CENTER OF CLINIC 718.667 90.01 90 01

 Heal th Financial
 Systems
 ST VINCENT ANDERSON REGIONAL HOSPITA

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN

Provi der CCN: 150088

Cost Center Description				/22/2016 3: 25 pm
See A.8 For Al location 6.00 7.00	Cost Center Description	Adiustments	Net Expenses	
99. 00 09100 DEMERCENCY 99.00 4, 044, 817 99.00 99.00 09500 0055ERVATION BEDS (NON-DISTINCT PART) 92. 00 094. 00 094. 00 094. 00 094. 00 094. 00 094. 00 094. 00 094. 00 094. 00 096. 00 0	, , , , , , , , , , , , , , , , , , ,			
92. 00 09200 09SERVATION BEDS (NON-DISTINCT PART) 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 97		6.00	7. 00	
92. 00 09200 09SERVATION BEDS (NON-DISTINCT PART) 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 97	91. 00 09100 EMERGENCY	-998, 061	4, 044, 817	91.00
OTHER RELIBURSABLE COST CENTERS				92.00
94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 95. 00 095. 00 09500 ABULLANGS SERVICES 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1
95. 00 09500 AMBULANCE SERVICES 0 0 0 0 95. 00 97. 00 09700 0078ALE MEDICAL EQUIP-FENTED 0 0 0 0 97. 00 97. 00 09700 0078ALE MEDICAL EQUIP-SOLD 0 0 0 0 0 97. 00 99. 00 09900 0079C 007F 0 0 0 0 0 0 0 99. 10 09910 007F 0 0 0 0 0 0 0 100. 00 10000 1AR SERVICES-NOT APPRVD PROM 0 0 0 0 101. 00 10000 1AR SERVICES-NOT APPRVD PROM 0 0 0 0 101. 00 10000 1AR SERVICES-NOT APPRVD PROM 0 0 0 100. 00 105. 00 10500 1AR SERVICES-NOT APPRVD PROM 0 0 0 100. 00 106. 00 10500 1AR SERVICES-NOT APPRVD PROM 0 0 0 100. 00 106. 00 10500 1AR SERVICES-NOT APPRVD PROM 0 0 0 105. 00 106. 00 10600 1AR SERVICES-NOT APPRVD PROM 0 0 0 100. 00 107. 00 10700 10700 10700 10700 10700 10700 108. 00 10600 1AR SERVICES-NOT APPRVD PROM 0 0 0 100. 00 109. 00 10900 1AR SERVICES-NOT APPRVD PROM 0 0 0 100. 00 100. 00 10600 1AR SERVICES-NOT APPRVD PROM 0 0 0 100. 00 100. 00 10600 1AR SERVICES-NOT APPRVD PROM 0 0 100. 00 100. 00 10600 1AR SERVICES-NOT APPRVD PROM 0 0 100. 00 100. 00 10600 1AR SERVICES-NOT APPRVD PROM 0 0 100. 00 100. 00 10600 1AR SERVICES-NOT APPRVD PROM 0 0 100. 00 100. 00 10600 1AR SERVICES-NOT APPRVD PROM 0 0 100. 00 100. 00 10600 1AR SERVICES-NOT APPRVD PROM 0 0 100. 00 100. 00 10000 10000 10000 10000 100. 00 100. 00 100. 00 10000 10000 10000 10000 100. 00 100. 00 10000 10000 10000 10000 10000 10000 100. 00 100. 00 100000 100000 100000 100000 100000 1000000 100000		0	O	94 00
99. 00 09000 000000		0	ol o	
97.00 097.00 097.00 099.		0	ol o	
99. 00 09900 CMIC 0 0 0 99. 10 0991 CORP 0 0 0 99. 10 100. 00 101. 0			0	
99.10 09910 008F 00000 187 SERVI (ES-NOT APPRVD PRGM 0 0 0 0 100.0			0	
100. 00 10000 IAR SERVI (ESS-NOT APPRVD PRGM 0 0 100. 00 100.			0	
101.00 10100 HOME HEALTH AGENCY -9, 427 0			0	
SPECIAL PURPOSE COST CENTERS		-1		
105. 00 10500 KI DNEY ACQUISITION 0 0 0 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 108. 00 108. 00 109. 00 10		-9, 427	U	101.00
106. 00 106.00 LEART ACQUI SI TI ON 0 0 0 0 0 107. 00 107.00 107.00 107.00 107.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 109.00 111.00 1				105.00
107. 00 10700 LIVER ACQUISITION		1		
108.00 108.00 LUNG ACQUISITION 0 0 0 109.00		0	-	
109. 00 10900 PANCREAS ACQUISITION 0 0 0 111. 00 11100 INTESTI NAL ACQUISITION 0 0 0 0 0 111. 00 111100 INTESTI NAL ACQUISITION 0 0 0 0 0 111. 00 11110 ISLET ACQUISITION 0 0 0 0 0 111. 00 11100 INTEREST EXPENSE 0 0 0 0 0 113.00 INTEREST EXPENSE 0 0 0 0 0 114. 00 114. 00 11400 UTILIZATION REVIEW-SNF 0 0 0 0 0 115.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 115.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 115.00 HOSPI CE 0 114. 00 UTILIZATION REVIEW-SNF 0 0 0 0 115.00 UTILIZATION REVIEW-SNF UTILIZ		0	O	
110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 0 0 113. 00 1300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 113. 00 1300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	l l
111. 00 11100 ISLET ACQUISITION	· · · · · · · · · · · · · · · · · · ·	0	O	
113. 00 11300 I NTEREST EXPENSE		0	O	
114. 00		0	0	
115. 00	· · · · · · · · · · · · · · · · · · ·	0	0	• • • • • • • • • • • • • • • • • • •
116. 00 118. 00 119. 0		0	0	
118. 00 SUBTOTALS (SUM OF LINES 1-117) -10, 489, 125 172, 497, 011 172, 497, 011 180 190		-1	0	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT. FLOWER, COFFEE SHOP & CANTEEN 0 0 19100 19100 RESEARCH 191. 00 19100 19200 PHYSI CI ANS' PRI VATE OFFI CES -283, 458 4, 485, 287 192. 00 19300 NONPAI D WORKERS 0 0 193. 00 19300 NONPAI D WORKERS 0 0 193. 00 194. 00 195.			0	
190. 00 191. 00 191. 00 191. 00 191. 00 191. 00 191. 00 192. 00 192. 00 192. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 194. 00 195. 06 194. 00 195. 06 195. 06 196. 00 197. 00 198. 00 198. 00 199. 0	118.00 SUBTOTALS (SUM OF LINES 1-117)	-10, 489, 125	172, 497, 011	118. 00
191. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 193. 00 194. 00 19500 FOUNDATI ON 194. 00 19750 FOUNDATI ON 194. 00 19750 FOUNDATI ON 194. 00 19750 FOUNDATI ON 195. 00 196. 00 19750 FOUNDATI ON 19750 FOUNDATION 19750 FOUNDA				
192. 00 19200 19200 19200 19200 193000 193000 193000 193000 193000 193000 193000 19300	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
193. 00 19300 NONPAI D WORKERS 0 0 193. 00 194. 00 195. 00 1		-27, 699	141, 985	191. 00
194. 00 07950 FOUNDATION -145 235, 221 194. 00 194. 02 194. 04 19750 194. 05 194. 04 19750 194. 05 19750 194. 05 19750	192. 00 19200 PHYSICIANS' PRIVATE OFFICES	-283, 458	4, 485, 287	192. 00
194. 02 07951 CHI LDREN'S CLINIC		0	0	193. 00
194. 04 07952 HEALTH RESOURCE CENTER 0 70, 575 194. 04 194. 05 194. 07 194. 07 194. 07 194. 07 194. 10 1	194. 00 07950 FOUNDATI ON	-145	235, 221	194. 00
194. 05 07953 ADOLESCENT RESIDENTIAL 0 1, 206, 241 194. 05 194. 07 194. 10 194. 10 194. 10 194. 10 194. 12 194. 13 194. 14 1978 ADVERTSISING AND MARKETING 194. 15 1979 1	194. 02 07951 CHI LDREN' S CLI NI C	-17, 701	377, 318	194. 02
194. 07 07954 COMMUNI TY BENEFI T/MI SSI ON 194. 07 194. 10 194. 10 194. 12 194. 12 194. 13 194. 14 19755 194. 15 19756 194. 16 196. 17 194. 18 19796 194. 18 19796 194. 18 19796 19796 1979. 18 197	194. 04 07952 HEALTH RESOURCE CENTER	0	70, 575	194. 04
194. 10 07955 DME	194. 05 07953 ADOLESCENT RESIDENTIAL	0	1, 206, 241	194. 05
194. 10 07955 DME	194. 07 07954 COMMUNITY BENEFIT/MISSION	0	465, 684	194. 07
194. 12 07956 MED ONE/TWO 0 -4, 601 194. 12 194. 13 07957 UNUSED SPACE 0 0 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 1, 055, 097 1, 054, 617 194. 15 07959 PHYSI CI ANS RECRUI TI NG 0 25, 175 194. 16 07960 MOB -50, 027 194. 16 17 07961 ASB 0 2, 455 194. 18 07962 MAB 0 434 194. 18		-294, 807		
194. 13 07957 UNUSED SPACE 0 0 194. 13 13 14 14 07958 ADVERTSI SI NG AND MARKETI NG 1, 055, 097 1, 054, 617 194. 15 07959 PHYSI CI ANS RECRUI TI NG 0 25, 175 194. 16 07960 MOB -50, 964 -50, 027 194. 17 07961 ASB 0 2, 455 194. 18 07962 MAB 0 434 194. 18		1		
194. 14 07958 ADVERTSI SI NG AND MARKETI NG 194. 15 07959 PHYSI CI ANS RECRUI TI NG 194. 16 07960 MOB 194. 17 07961 ASB 0 2, 455 194. 18 07962 MAB 195. 097 1, 054, 617 0 25, 175 196. 18 07962 MAB 194. 18 07962 MAB				
194. 15 07959 PHYSI CI ANS RECRUI TI NG 194. 16 07960 MOB 194. 17 07961 ASB 0 2, 455 194. 18 07962 MAB 0 434 194. 18		1, 055, 097	٩	
194. 16 07960 MOB -50, 964 -50, 027 194. 16 194. 17 07961 ASB 0 2, 455 194. 17 194. 18 07962 MAB 0 434 194. 18		1, 333, 077		
194. 17 07961 ASB 0 2, 455 194. 17 194. 18 07962 MAB 0 434 194. 18		-50 964		
194. 18 07962 MAB 0 194. 18		1		
200. 00 101/10 (30m of Lines 110-177) -10,100,002 103,370,423		-10 108 802	•	
	233.33] 101/12 (3011 01 21/123 110 177)	10, 100, 002	.55, 575, 125	1200.00

ST VINCENT ANDERSON REGIONAL HOSPITA
Provider CCN: 150088 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: Worksheet A-6 From 07/01/2015 To 06/30/2016 Date/Ti me Prepared:

					1/22/2016 3: 25 pm
		Increases			
	Cost Center	Li ne #	Salary	0ther	
	2.00 A - PHARMACY/IV RECLASS	3. 00	4. 00	5. 00	
1. 00	DRUGS CHARGED TO PATIENTS	73.00	0	22, 674, 909	1. 00
2. 00	BROOS STARROLD TO TATTERTS	0.00	ő	0	2.00
	TOTALS			22, 674, 909	
	B - ANESTHESIA RECLASS				
1.00	ANESTHESI OLOGY	53. 00	0	1, 060, 913	1. 00
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	26, 037	2. 00
	TOTALS	+		1, 086, 950	
	C - MEDICAL SUPPLIES RECLASS		<u> </u>	1,000,750	
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	113, 154	1.00
	PATI ENTS				
2.00	IMPL. DEV. CHARGED TO	72. 00	0	17, 734	2. 00
	TOTALS — — — — —	+			
	D - CAFETERIA/CLASSIC CATERING	DECLASS	U _I	130, 888	
1.00	CAFETERI A	11.00	24, 904	1, 560, 783	1.00
	TOTALS		24, 904	1, 560, 783	
	E - MAB OTHER EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	10	1. 00
2.00	MAINTENANCE & REPAIRS	6.00	0	58	2.00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	32 41	3.00
4. 00	TOTALS	69.00			4. 00
	F - MAB DPRECIATION EXPENSE		O _I	141	
1.00	MAINTENANCE & REPAIRS	6.00	0	15, 700	1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	O	8, 700	2. 00
3.00	ELECTROCARDI OLOGY	69. 00	0	11, 126	3. 00
4. 00	ADMI NI STRATI VE & GENERAL		0	2,630	4. 00
	TOTALS		0	38, 156	
1. 00	G - MOB OTHER EXPENSE ADMINISTRATIVE & GENERAL	5. 00	0	9	1. 00
2. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	41	2.00
2.00	TOTALS	= = = = = =			2.00
	I - PROPERTY TAX RECLASS				
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	65, 000	1. 00
	FIXT	+			
	TOTALS J - INTEREST EXPENSE RECLASS		0	65, 000	
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	470, 840	1. 00
	FI XT			170,010	
	TOTALS			470, 840	
	K - ANDERSON CENTER OUTPATIENT				
1. 00	ANDERSON CENTER OP CLINIC	<u> </u>	624, 083	94, 584	1.00
	TOTALS L - WHOLE BLOOD RECLASS		624, 083	94, 584	
1.00	BLOOD STORING. PROCESSING &	63.00	O	463, 856	1.00
	TRANS	30.00		1007 000	155
	TOTALS		o	463, 856	
	M - CAPITAL RELATED DEPRECIATI				
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	1, 967, 076	1.00
2. 00	FIXT	0. 00	o	0	2. 00
3. 00		0.00	o	0	3. 00
4. 00		0.00	o	0	4. 00
	TOTALS		0	1, 967, 076	
	N - ADOLESCENT RESIDENTIAL REC				
1. 00	ADOLESCENT RESIDENTIAL	1 <u>94.</u> 05	<u>1, 047, 488</u>	15 <u>8, 7</u> 53	1.00
	TOTALS P - PHYSICIAN RECRUITMENT		1, 047, 488	158, 753	
1.00	PHYSICIANS RECRUITING	194. 15	0	25, 175	1. 00
50	TOTALS		- — 		1.00
	R - ASB OTHER EXPENSE	<u> </u>	-1		
1.00	DME	194. 10	0	709	 1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0. 00 0. 00	0	0	4. 00 5. 00
5. 00 6. 00		0.00	0	0	6. 00
7. 00		0.00	0	0	7. 00
	TOTALS			709	
	ı	'	'	Ų	•

ST VINCENT ANDERSON REGIONAL HOSPITA
Provider CCN: 150088 Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 07/01/2015 To 06/30/2016 Date/Ti me Prepared:

					11/22/2016	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	S - ASB DEPRECIATION EXPENSE					
1.00	OPERATING ROOM	50.00	0	615		1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 712		2. 00
3.00	RADI OLOGY-THERAPEUTI C	55. 00	0	2, 412		3. 00
4.00	PHYSI CAL THERAPY	66.00	0	1, 154		4. 00
5.00	CHEMOTHERAPY	76. 00	0	411		5. 00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	318		6. 00
7.00	DME	194. 10	0	1, 097		7. 00
	TOTALS		0	7, 719		
	T - PHYSICIAN					
1.00	ADULTS & PEDIATRICS	30.00	<u>86, 4</u> 00	0		1. 00
	TOTALS		86, 400	0		
	U - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	102, 840		1. 00
	FIXT					
2.00		0.00	•	0		2. 00
	TOTALS		0	102, 840		_
	V - RAD TECH PARAMED					
1.00	SCH OF RADIOLOGY	23. 01	83, 844	0		1. 00
	TOTALS		83, 844	0		_
	Y - INFECTION CONTROL		40 500			4
1.00	ADULTS & PEDIATRICS	30.00	<u> </u>	0		1. 00
	TOTALS	NEADLE DEVILO	12, 500	U		_
1 00	AB - MEDICAL SUPPLIES & IMPLA		ما	(014 057		1 00
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	6, 814, 857		1. 00
2 00	PATI ENTS	72.00		4 O1E (10		2.00
2. 00	IMPL. DEV. CHARGED TO PATIENT	72. 00	0	4, 915, 612		2. 00
3.00	PATTENT	0.00	0	0		3. 00
4. 00		0.00	o	0		4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
11. 00		0.00	o o	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	o o	0		13. 00
14. 00		0.00	o o	0		14. 00
15. 00		0.00	o o	0		15. 00
16. 00		0.00	ol O	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
. ,	TOTALS	— — 	— — ŏ	11, 730, 469		1
	AD - NURSERY & DELIVERY RM	L		,		
1.00	NURSERY	43.00	585, 427	154, 492		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	87, 527	23, 098		2. 00
	TOTALS		672, 954	177, 590		
	AE - PHARMACY RESIDENCY					
1.00	PHARMACY RESIDENCY	23. 02	146, 800	0		1.00
	TOTALS		146, 800	0		
	AF - SURGERY CTR - SURGERY PA	VI LI ON				
1.00	OPERATING ROOM	50.00	0	116, 611		1.00
	TOTALS			116, 611		
500.00	Grand Total: Increases		2, 698, 973	40, 873, 099		500.00
	•	'				•

Heal th	Financial Systems	ST VIN	ICENT ANDERSON	REGIONAL HOS	PITA	In Lie	u of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 150088	Peri od: From 07/01/2015	Worksheet A-6
						To 06/30/2016	Date/Time Prepared:
		Decreases					11/22/2016 3: 25 pm
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Re	f.	
	6. 00	7. 00	8.00	9. 00	10.00		
	A - PHARMACY/IV RECLASS	45.00		10.010.005	1		
1. 00 2. 00	PHARMACY CHEMOTHERAPY	15. 00 76. 00	0	19, 912, 835 2, 762, 074		0	1. 00 2. 00
2.00	TOTALS			22, 674, 909		9	2.00
	B - ANESTHESIA RECLASS						
1.00	OPERATING ROOM	50.00	0	1, 086, 950		0	1. 00
2. 00	TOTALS	0.00	0	00 1, 086, 950	 	<u>o</u>	2. 00
	C - MEDICAL SUPPLIES RECLASS		<u> </u>	1, 086, 950			
1. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	130, 888		0	1. 00
2.00		0.00	0	0)	o	2. 00
	TOTALS	0. DEOLAGO	0	130, 888	i .		
1.00	D - CAFETERIA/CLASSIC CATERIN DIETARY	10. 00	24, 904	1, 560, 783		ol	1.00
1.00	TOTALS — — —	10.00	24, 904	1, 560, 783		9	1.00
	E - MAB OTHER EXPENSE						
1.00		0.00	0	0		0	1.00
2. 00 3. 00		0. 00 0. 00	0	0		0	2.00
4.00	MAB	194. 18	0	141		0	4.00
	TOTALS						
	F - MAB DPRECIATION EXPENSE						
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	38, 156	1	9	1.00
2.00	FIAI	0.00	0	0)	9	2. 00
3. 00		0.00	O	0)	o	3. 00
4.00		0.00		0		9	4. 00
	TOTALS		0	38, 156)		
1.00	G - MOB OTHER EXPENSE	0.00	ol	0	1	0	1.00
2. 00	MOB	194. 16	o	50		o	2. 00
	TOTALS			50		1	
	I - PROPERTY TAX RECLASS	5 00			.1		
1.00	ADMI NI STRATI VE & GENERAL TOTALS		0	6 <u>5, 0</u> 00 65, 000		9	1.00
	J - INTEREST EXPENSE RECLASS		O _I	05,000	1		
1.00	INTEREST EXPENSE	113.00	0	470, 840		11	1.00
	TOTALS		0	470, 840			
1 00	K - ANDERSON CENTER OUTPATIEN ADULTS & PEDIATRICS		424 002	04 504			1 00
1.00	TOTALS	30. 00	62 <u>4, 0</u> 83 624, 083	9 <u>4, 5</u> 84 94, 584		0	1.00
	L - WHOLE BLOOD RECLASS		02 17 000	, ,, 00 .			
1.00	LABORATORY	60.00	0	463, 856		0	1.00
	TOTALS	TON DECLACE	0	463, 856			
1.00	M - CAPITAL RELATED DEPRECIAT NEW CAP REL COSTS-BLDG &	1.00	O	1, 829, 792		9	1.00
	FIXT			1,027,772			
2.00	OPERATING ROOM	50.00	0	4, 717		0	2. 00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	114, 622		0	3.00
4. 00	PHYSICIANS' PRIVATE OFFICES TOTALS	1 <u>92.</u> 00		1 <u>7, 9</u> 45 1, 967, 076		9	4. 00
	N - ADOLESCENT RESIDENTIAL RE	CLASS	<u> </u>	1, 707, 070	1		
1.00	ADULTS & PEDIATRICS	30.00	1, 047, 488	15 <u>8, 7</u> 53		Q	1. 00
	TOTALS		1, 047, 488	158, 753			
1.00	P - PHYSICIAN RECRUITMENT ADMINISTRATIVE & GENERAL	5. 00	0	25, 175		0	1.00
1.00	TOTALS			2 <u>5, 1</u> 75 25, 175		7	1.00
	R - ASB OTHER EXPENSE		3				
1.00	OPERATING ROOM	50.00	0	56		0	1.00
2.00	RADI OLOGY THERADELITI C	54. 00 55. 00	0	157		0	2.00
3. 00 4. 00	RADI OLOGY-THERAPEUTI C PHYSI CAL THERAPY	66.00	0	222 106		0	3. 00 4. 00
5. 00	CHEMOTHERAPY	76. 00	ō	38		o	5. 00
6. 00	PHYSICIANS' PRIVATE OFFICES	192.00	o	29		0	6. 00
7. 00	ASB	1 <u>94.</u> 17				<u>o</u>	7. 00
	TOTALS S - ASB DEPRECIATION EXPENSE		O	709	1		
1. 00	735 BEINEGIATION EXIENSE	0.00	0	0)	0	1.00
2.00		0.00	ō	0		0	2. 00
3.00		0.00	O	0		0	3.00
4. 00 5. 00		0. 00 0. 00	0	0		0	4. 00 5. 00
6.00		0.00	0	0		0	6. 00
7. 00	ASB	194. 17	Ö	7, 719		o o	7. 00
	·	<u> </u>	<u> </u>	•		*	

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 07/01/2015 Date/Time Prepared: Provi der CCN: 150088

					To	06/30/2016	Date/Time Prepared: 11/22/2016 3:25 pm
		Decreases					117 227 2010 G. 20 pm
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8.00	9. 00	10. 00		
	TOTALS		0	7, 719			
	T - PHYSICIAN						
1.00	ADMI NI STRATI VE & GENERAL	5.00	86, 400	0			1.00
	TOTALS		86, 400	C			
	U - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	102, 840			1.00
2.00		0.00	0	0)12		2. 00
	TOTALS		0	102, 840)		
	V - RAD TECH PARAMED						
1.00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00	83, 844	0	00		1.00
	TOTALS		83, 844)		
	Y - INFECTION CONTROL						
1.00	ADMI NI STRATI VE & GENERAL	5. 00	1 <u>2, 5</u> 00	0	00		1.00
	TOTALS		12, 500				
	AB - MEDICAL SUPPLIES & IMPLA						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	133, 010			1.00
2.00	PHARMACY	15. 00	0	332, 655	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	389, 168			3. 00
4.00	INTENSIVE CARE UNIT	31. 00	0	331, 170			4. 00
5.00	SUBPROVI DER - I RF	41. 00	0	20, 006	0		5. 00
6.00	OPERATING ROOM	50. 00	0	7, 825, 730	0		6. 00
7.00	PARAMED ED PRGM	23. 00	0	47			7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	649, 923	0		8. 00
9.00	RADI OLOGY-THERAPEUTI C	55.00	0	88, 058	0		9. 00
10.00	EMERGENCY	91. 00	0	445, 470			10.00
11. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	8, 075	0		11.00
	(MRI)						
12. 00	LABORATORY	60. 00	0	659, 359			12. 00
13.00	RESPI RATORY THERAPY	65.00	0	196, 971			13. 00
14. 00	PHYSI CAL THERAPY	66.00	0	33, 930			14. 00
15.00	OCCUPATI ONAL THERAPY	67. 00	0	2, 075			15. 00
16.00	SPEECH PATHOLOGY	68. 00	0	142, 585			16. 00
17. 00	ELECTROCARDI OLOGY	69. 00	0	289, 878			17. 00
18. 00	ELECTROENCEPHALOGRAPHY	70.00	0	10, 251			18. 00
19. 00	CHEMOTHERAPY	<u> 76.</u> 00	0	172, 108			19. 00
	TOTALS		0	11, 730, 469)		
	AD - NURSERY & DELIVERY RM						
1.00	ADULTS & PEDIATRICS	30. 00	672, 954	177, 590	1		1.00
2.00		0.00	0	0	<u> </u>		2. 00
	TOTALS		672, 954	177, 590			
	AE - PHARMACY RESIDENCY						_
1.00	PHARMACY	1500	146, 800	c			1.00
	TOTALS	\	146, 800	C)		
	AF - SURGERY CTR - SURGERY PA		_1				
1.00	SURGERY CENTER	50. 01	•	11 <u>6, 6</u> 11			1.00
F00 00	TOTALS		0	116, 611			500.00
500.00	Grand Total: Decreases		2, 698, 973	40, 873, 099	<i>'</i>		500.00

8.00

9.00

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 150088 Peri od: Worksheet A-7 From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/22/2016 3:25 pm Acqui si ti ons Begi nni ng Purchases Total Donati on Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 5, 292, 602 0 1.00 0 2.00 Land Improvements 1, 542, 569 3,010 2.00 3.00 63, 727, 422 1, 327, 417 1, 327, 417 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 34, 273, 497 0 3, 781, 596 5.00 0 6.00 Movable Equipment 47, 687, 536 2, 117, 688 2, 117, 688 6.00 0 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 152, 523, 626 3, 445, 105 3, 445, 105 3, 784, 606 8.00 9.00 Reconciling Items 0 9.00 3, 784, 606 Total (line 8 minus line 9) 152, 523, 626 3, 445, 105 10.00 0 3, 445, 105 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 5, 292, 602 0 1.00 2.00 Land Improvements 1, 539, 559 0 2.00 3.00 Buildings and Fixtures 65, 054, 839 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 30, 491, 901 0 5.00 Movable Equipment 0 6.00 49, 805, 224 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7)

152, 184, 125

152, 184, 125

0

0

Heal th	Financial Systems ST V	INCENT ANDERSON	REGIONAL HOSP	PLTA	In Lie	eu of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150088	Peri od:	Worksheet A-7	
					From 07/01/2015 To 06/30/2016		pared:
						11/22/2016 3:	
			Sl	UMMARY OF CAF	PI 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			nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 855, 008	0)	0	0	1. 00
1. 01	NEW CAP REL COSTS-BLDG & FLXT	0	0)	0	0	1. 01
3.00	Total (sum of lines 1-2)	1, 855, 008	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum	า			
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 855, 008	3			1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT	0	0				1. 01
3.00	Total (sum of lines 1-2)	0	1, 855, 008	в			3. 00

Heal th	Financial Systems ST VI	NCENT ANDERSON	REGIONAL HOSP	I TA	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150088	Peri od:	Worksheet A-7	
					From 07/01/2015	Part III	
					Γο 06/30/2016	Date/Time Pre	pared:
		2011		F1 00	1110017101105	11/22/2016 3:	25 pm
		COMP	PUTATION OF RAT	1105	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
	·		Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	NEW CAP REL COSTS-BLDG & FLXT	66, 810, 752	0	66, 810, 75	2 1. 000000	0	1. 00
1.01	NEW CAP REL COSTS-BLDG & FIXT	0	0		0.000000	0	1. 01
3.00	Total (sum of lines 1-2)	66, 810, 752	0	66, 810, 75	1. 000000	0	3. 00
		ALLOCAT	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		1, 378, 498	0	1. 00
1.01	NEW CAP REL COSTS-BLDG & FIXT	0	0		0	0	1. 01
3.00	Total (sum of lines 1-2)	0	0		1, 378, 498	0	3. 00
	,		Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)	Ů,	

11. 00

470, 840

0 470, 840

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
NEW CAP REL COSTS-BLDG & FIXT

1.01 NEW CAP REL COSTS-BLDG & FIXT 3.00 Total (sum of lines 1-2)

12.00

102, 840

102, 840

13.00

0 0 0 14.00

0 0 0 15.00

1, 952, 178

0 1. 01 1, 952, 178 3. 00

1.00

1.00

ST VINCENT ANDERSON REGIONAL HOSPITA In Lieu of Form CMS-2552-10

Provider CCN: 150088 | Period: | Worksheet A-8 | From 07/01/2015 | Period: | From 07/01/2015 | Period: | Perio Health Financial Systems
ADJUSTMENTS TO EXPENSES

					From 07/01/2015 Fo 06/30/2016	Date/Time Pre	pared:
				Expense Classification on		11/22/2016 3:	25 pm
				To/From Which the Amount is	to be Adjusted		
	0 1 0 1 0 1 1	D : (0 (0)		2 1 2 1	1	W 1 A 7 D C	
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	В	-470, 840	NEW CAP REL COSTS-BLDG & FLXT	1.00	9	1. 00
	2)						
1. 01	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FLXT	1. 01	0	1. 01
2. 00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	О	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0.00	О	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)		110 001	ADMINISTRATIVE & CENEDAL			
7. 00	Tel ephone services (pay stations excluded) (chapter	A	-110,081	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	21) Television and radio service		0		0.00	О	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	О	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-1, 258, 168			O	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	9, 863, 450			О	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	О	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-763, 244	DI ETARY	10. 00 0. 00		
16. 00	and others Sale of medical and surgical		0		0.00		
10.00	supplies to other than		O		0.00		10.00
17. 00	patients Sale of drugs to other than		0		0.00	О	17. 00
18. 00	patients Sale of medical records and	В	-38, 789	MEDICAL RECORDS & LIBRARY	16. 00	О	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00	o	19. 00
20. 00	books, etc.) Vending machines	В	20 140	DI ETARY	10.00		
	Income from imposition of	B	-39, 140	DILIANI	0.00		
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
20.00	therapy costs in excess of limitation (chapter 14)		, and the second		00.00		20.00
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
	COSTS-BLDG & FLXT			FIXT NEW CAP REL COSTS-BLDG &	1. 01		
26. 01	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			FIXT			
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2. 00		
28. 00 29. 00	1 3		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00		28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30.00
05	therapy costs in excess of limitation (chapter 14)			ADUI TO A DESCRIPTION			0.5
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
		,				'	

ONAL HOSPITA In Lieu of Form CMS-2552-10
Provider CCN: 150088 | Period: | Worksheet A-8 | From 07/01/2015 | To 06/20/001/2015 | Period: | Period: | Worksheet A-8 | Period: | Pe Health Financial Systems
ADJUSTMENTS TO EXPENSES ST VINCENT ANDERSON REGIONAL HOSPITA

Description Dest Cost Center Description Dest Cost Center Description Dest Cost Center Description Dest Cost Center Description Dest Cost Center Description Dest Cost Center Description Dest Cost Center Description Dest Cost Center Description De					Fi To	com 07/01/2015 0 06/30/2016	Date/Time Pre	
Tourism Which the Amount is to be Adjusted					Expense Classification on	Worksheet A	11/22/2016 3:	25 pm
1.00								
1.00								
1.00								
1.00								
31.00 MSC INCOME B		Cost Center Description	• • • • • • • • • • • • • • • • • • • •					
Pathology costs in excess of	31. 00	Adjustment for speech					5.00	31. 00
20.00 CARI HIT Adjustment For		pathology costs in excess of						
Depreciation and Interest	22.00					0.00	0	22 00
MISC. INCOME	32.00	1		C	,	0.00	O	32.00
33.07 MISC. INCOME		MISC. INCOME	1		l l		0	
18.50 INCOME			1		l I		0	
13.14 M SC. INCOME			1		l I		0	
MISC. INCOME B			1		l I			
35.00 MISC INCOME		1					ŭ	
39. 03 M SC INCOME B0.74playins CLAINS PRIVATE OFFICES 192. 00 0 35. 03 35. 03 35. 08 M SC INCOME B -33playade ED PRECIS 22. 00 0 35. 04 35. 09 M SC INCOME B -33playade ED PRECIS 20. 00 0 35. 09 35. 09 M SC INCOME B -37playade ED PRECIS 20. 00 0 35. 09 35. 11 MISC INCOME B -9.78plo.ABORATIC RESONANCE IMAGING 50. 00 0 35. 13 35. 14 MISC INCOME B -9.78plo.ABORATIC PRECISION FOR ELECTRIC PROCESS A 1. 18plays SIGN. THERAPY 60. 00 0 35. 16 6. 30 6. 30 17 MISC INCOME B -9.78plo.ABORATIC PROCESS A 1. 18plays SIGN. THERAPY 60. 00 0 35. 16 6. 30 6. 30 17 MISC INCOME B -1. 18plays SIGN. THERAPY 60. 00 0 35. 18 35. 20 MISC INCOME B -1. 18plays SIGN. THERAPY 60. 00 0 35. 18 35. 20 MISC INCOME B -1. 18plays SIGN. THERAPY 60. 00 0 35. 18 35. 20 MISC INCOME B -1. 18plays SIGN. THERAPY 70 60. 00 0 35. 18 35. 20 MISC INCOME B -1. 18plays SIGN. THERAPY 70 60. 00 0 35. 18 35. 20 MISC INCOME B -1. 18plays SIGN. THERAPY 70 60. 00 0 35. 18 35. 20 MISC INCOME B -1. 18plays SIGN. THERAPY 70 60. 00 0 35. 18 35. 20 MISC INCOME B -1. 18plays SIGN. THERAPY 70 60. 00 0 35. 18 35. 20 MISC INCOME B -1. 18plays SIGN. THERAPY 70 60. 00 0 35. 24 35. 24 90 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							0	
MISC INCOME		1	1		l I		0	
MISC INCOME B					l I		0	
MISC INCOME							0	
MISC I NCOME		1	1		l I		0	
35.16 MISC I NCOME				.,	i i			
SS 18 M IS C I NOOME					l l			
15.18 MISC I NCOME B		1	1		l I		ŭ	
15. 21					l I		Ö	
35. 22 0		MISC INCOME	В	-11, 919	CHILDREN'S CLINIC		0	
35. 24 MOME HEALTH CARE				C				
15.2 HOME HEALTH CARE				C			ŭ	
35. 27		1	A			101.00	0	
15. 27 0 0 0 0 0 35. 27 0 0 0 0 35. 27 0 0 0 0 35. 27 0 0 0 0 0 36. 00 0 0 0 0 0 0 36. 00 0 0 0 0 0 0 0 0 0		HOSPI CE	A	-11, 180	HOSPI CE		ŭ	
36. 00 PHYSICIANS' PHONE SERVICE A				C				
36. 02 BAD DEBT & RECOVERIES A -294, 747 DME 194, 10 0 36. 02		PHYSICIANS' PHONE SERVICE	A	-13, 490	ADMINISTRATIVE & GENERAL		0	
36. 03 BAD DEBT & RECOVERIES A -2.963 ADULTS & PEDIATRICS 30. 00 0 3 6. 03 36. 04 BAD DEBT & RECOVERIES A -5.783 CHILDREN'S CLINIC 194. 02 0 3 6. 04 36. 05 BAD DEBT & RECOVERIES A -144, 218 PHYSICIANS' PRIVATE OFFICES 192. 00 0 3 6. 05 36. 06 BAD DEBT & RECOVERIES A -144, 218 PHYSICIANS' PRIVATE OFFICES 192. 00 0 3 6. 05 36. 07 AHA-I HA LOBBYING DUES A -4. 085 ADMINISTRATIVE & GENERAL 5. 00 0 3 6. 07 36. 08 STARP A -6.97, 512 ADMINISTRATIVE & GENERAL 5. 00 0 3 6. 10 36. 10 11 INCOME/SALES TAX A -6.854 ADMINISTRATIVE & GENERAL 5. 00 0 3 6. 10 36. 13 INCOME/SALES TAX A -1.9CENTRAL SERVICES & SUPPLY 14. 00 0 3 6. 12 36. 15 INCOME/SALES TAX A -3.902 DETARY 10. 00 0 3 6. 13 36. 16 INCOME/SALES TAX A -1.3 SUBPROVIDER IRF 41. 00 0 3 6. 15 36. 16 INCOME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 18 36. 19 INCOME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 18 36. 19 INCOME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 18 36. 19 INCOME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 18 36. 20 INCOME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 19 36. 21 INCOME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 19 37. 01 INCOME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 19 38. 02 INCOME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 19 39. 01 ROME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 19 39. 01 ROME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 19 39. 01 ROME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 19 39. 01 ROME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 19 39. 01 ROME/SALES TAX A -1.20 RESPIRATORY THERAPY 65. 00 0 3 6. 19 39. 01 ROME/SALES TAX A -1.20 RESPIRATORY		1	1		l I			
36. 04 BAD DEBT & RECOVERIES A -5, 782 CHILDREN'S CLINIC 194, 02 0 36, 05 036, 05 036, 05 04 04 05 05 05 05 05			1				ŭ	
36. 06			1		l I		Ö	
36. 07 AHA-1HA LOBBYING DUES A -4,085 ADMI NI STRATI VE & GENERAL 5.00 0 36.07 36. 08 STARP A -697,512 ADMI NI STRATI VE & GENERAL 5.00 0 36.10 36. 10 INCOME/SALES TAX A -6,854 ADMI NI STRATI VE & GENERAL 5.00 0 36.11 36. 12 INCOME/SALES TAX A -19/CENTRAL SERVICES & SUPPLY 14.00 0 36.12 36. 13 INCOME/SALES TAX A -3,902 DI ETARY 10.00 0 36.13 36. 16 INCOME/SALES TAX A -13/DENTRAL SERVICES & SUPPLY 14.00 0 36.15 36. 16 INCOME/SALES TAX A -13/DENTRAL SERVICES & SUPPLY 14.00 0 36.15 36. 16 INCOME/SALES TAX A -12/DENTRAL SERVICES & SUPPLY 14.00 0 36.15 36. 16 INCOME/SALES TAX A -12/DENTRAL SERVICES & SUPPLY 14.00 0 36.15 36. 17 INCOME/SALES TAX A -12/DENTRAL SERVICES & SUPPLY 14.00 0 36.15 36. 18 INCOME/SALES TAX A -12/DERSPIRATORY THERAPY 65.00 0 36.16 36. 19 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.17 36. 20 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 21 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 22 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 21 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 22 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 21 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 22 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 21 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 22 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 21 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 22 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 36. 20 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0 36.20 37. 00 INCOME/SALES TAX A -12/DESPIRATORY THERAPY 65.00 0		BAD DEBT & RECOVERIES	A	-144, 218	PHYSICIANS' PRIVATE OFFICES			
36. 08 STARP A -697, 512 ADMI NI STRATI VE & GENERAL 5.00 0 36.00 36. 10 1 INCOME/SALES TAX A -6,854 ADMI NI STRATI VE & GENERAL 5.00 0 36.10 36. 12 INCOME/SALES TAX A -19/CENTRAL SERVI CES & SUPPLY 14.00 0 36.13 36. 13 INCOME/SALES TAX A -19/CENTRAL SERVI CES & SUPPLY 10.00 0 36.13 36. 15 INCOME/SALES TAX A -3,902/DIETRAT 10.00 0 36.13 36. 15 INCOME/SALES TAX A -13 SUBPROVI DER - IRF 41.00 0 36.13 36. 16 INCOME/SALES TAX A -120/RESPI RATORY THERAPY 65.00 0 36.15 36. 18 INCOME/SALES TAX A -1106/ADULTS & PEDI ATRICS 30.00 0 36.17 36. 19 INCOME/SALES TAX A -120/RESPI RATORY THERAPY 65.00 0 36.19 36. 20 INCOME/SALES TAX A -228/PHYSI CI ANS' PRI VATE OFFI CES 192.00 0 36.22 37. 00 PROVI DER TAX A -10,542/NEW CAP REL COSTS-BL		AHA_IHA I ORRVING DUES	Λ .	_4_085	ADMINISTRATIVE & CENERAL			
36. 10			1		l I			
36. 12	36. 10			· C		0. 00	0	36. 10
36. 13 INCOME/SALES TAX			1				_	
36. 15			1				_	
36. 17 10 10 10 10 10 10 10		1	1					
36. 18 36. 19 1NCOME/SALES TAX			1					
36. 19 INCOME/SALES TAX		INCOME/SALES TAX	A	-1, 166	ADULIS & PEDIATRICS			
36. 20 INCOME/SALES TAX		INCOME/SALES TAX	A	-120	RESPIRATORY THERAPY			
36. 22 INCOME/SALES TAX		INCOME/SALES TAX	1		l I		0	
37. 00 PROVIDER TAX		l control of the cont	1					
37. 01 CARRYFORWARD ADJUSTMENTS A -10, 542 NEW CAP REL COSTS-BLDG & 1. 00 9 37. 01 FLXT 37. 03 PHYSICIAN OFFICE DEPRECIATION A -7, 472 NEW CAP REL COSTS-BLDG & 1. 00 9 37. 03 FLXT 37. 04 0 0 0. 00 0 37. 04 37. 09 MAB DEPRECIATION IN CAP REL A -118, 146 NEW CAP REL COSTS-BLDG & 1. 00 9 37. 09 FLXT 38. 00 0 0 0. 00 0 38. 00 0 0. 00 0 38. 00 0. 00 0. 00 0 38. 04 38. 04 ADVERTISING & MARKETING A -2, 060 ADULTS & PEDIATRICS 30. 00 0. 38. 06 38. 07 ADVERTISING & MARKETING A -118, 757 ADMINISTRATIVE & GENERAL 5. 00 0. 38. 07 38. 10 A&G DUES & MEMBERSHIP A -739 ADMINISTRATIVE & GENERAL 5. 00 0. 38. 10 39. 00 A&G PURCHASED SERVICES A -38, 020 ADMINISTRATIVE & GENERAL 5. 00 0. 39. 00 39. 01 CORPORATION ADMINISTRATION A -36, 740 ADMINISTRATIVE & GENERAL 5. 00 0. 39. 01		1	1		l I			
37. 03 PHYSICIAN OFFICE DEPRECIATION A -7, 472 NEW CAP REL COSTS-BLDG & 1. 00 9 37. 03 FIXT 0. 00 0. 00 0. 37. 04 0. 00		1	1				9	
STATE STAT		DUNGLOLAN OFFLOE DEPOSOLATION			l I			07.00
37. 04 37. 09 MAB DEPRECIATION IN CAP REL A -118, 146 NEW CAP REL COSTS-BLDG & 1. 00 9 37. 09 18. 00 38. 00 38. 00 0 0 0 0 0 0 0 0	37.03	PHYSICIAN OFFICE DEPRECIATION	A	-7,472		1.00	9	37.03
38. 00 38. 04 38. 06 ADVERTI SI NG & MARKETI NG 38. 07 ADVERTI SI NG & MARKETI NG 38. 09 A&G DUES & MEMBERSHI P 38. 00 A&G PURCHASED SERVI CES 39. 00 A&G PURCHASED SERVI CES 30. 00 O 38. 00 0 38. 00 0 O 0 O 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 38. 00 0 39. 00	37. 04			C		0.00	0	37. 04
38. 00 0 0 0 0 0 38. 00 0 0 0 38. 00 0 0 38. 00 0 0 38. 00 0 0 38. 00 0 0 38. 00 0 0 0 0 0 0 0 0 0	37. 09	MAB DEPRECIATION IN CAP REL	A	-118, 146		1.00	9	37. 09
38. 04 0 0.00 0.38. 04 38. 06 ADVERTISING & MARKETING A -2,060 ADULTS & PEDIATRICS 30. 00 0.38. 06 38. 07 ADVERTISING & MARKETING A -118,757 ADMINISTRATIVE & GENERAL 5. 00 0.38. 07 38. 09 A&G MISC A -157,890 ADMINISTRATIVE & GENERAL 5. 00 0.38. 09 38. 10 A&G DUES & MEMBERSHIP A -739 ADMINISTRATIVE & GENERAL 5. 00 0.38. 09 39. 00 39. 00 39. 01 CORPORATION ADMINISTRATION A -36,740 ADMINISTRATIVE & GENERAL 5. 00 0.39. 01 39.	38 00				FTXI	0.00		38 00
38. 06 ADVERTISING & MARKETING A -2,060 ADULTS & PEDIATRICS 30.00 0 38.06 38. 07 ADVERTISING & MARKETING A -118,757 ADMINISTRATIVE & GENERAL 5.00 0 38.07 38. 09 A&G MISC A -157,890 ADMINISTRATIVE & GENERAL 5.00 0 38.09 38. 10 A&G DUES & MEMBERSHIP A -739 ADMINISTRATIVE & GENERAL 5.00 0 38.10 39. 00 A&G PURCHASED SERVICES A -38,020 ADMINISTRATIVE & GENERAL 5.00 0 39.00 39. 01 CORPORATION ADMINISTRATION A -36,740 ADMINISTRATIVE & GENERAL 5.00 0 39.01				0				
38. 09 A&G MISC A -157, 890 ADMINISTRATIVE & GENERAL 5. 00 0 38. 09 38. 10 A&G DUES & MEMBERSHIP A -739 ADMINISTRATIVE & GENERAL 5. 00 0 38. 10 39. 00 A&G PURCHASED SERVICES A -38, 020 ADMINISTRATIVE & GENERAL 5. 00 0 39. 00 39. 01 CORPORATION ADMINISTRATION A -36, 740 ADMINISTRATIVE & GENERAL 5. 00 0 39. 01	38. 06		1 1		l I	30.00		38. 06
38. 10			1					
39. 00 A&G PURCHASED SERVICES A -38, 020 ADMINISTRATIVE & GENERAL 5. 00 0 39. 00 39. 01 CORPORATION ADMINISTRATION A -36, 740 ADMINISTRATIVE & GENERAL 5. 00 0 39. 01		1	1		l I			
		1	1		l I			
IKAVEL &	39. 01		A	-36, 740	ADMINISTRATIVE & GENERAL	5. 00	0	39. 01
		IKAVEL &	<u> </u>		<u> </u>		 	<u> </u>

ADJUSTMENTS TO EXPENSES Provider CCN: 150088 Peri od: Worksheet A-8 From 07/01/2015 06/30/2016 Date/Time Prepared: 11/22/2016 3:25 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basi s/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 40.00 OTHER ADJUSTMENTS (SPECIFY) 40.00 0.00 41.00 0.00 41.00 42.00 MISC REVENUE LEASED BLDGS В -6, 714 ADMINISTRATIVE & GENERAL 5.00 42.00 43.00 MISC REVENUE LEASED BLDGS В -50, 964 MOB 194.16 43.00 -440, 498 MAINTENANCE & REPAIRS 44 00 MLSC REVENUE LEASED BLDGS 6.00 В 44 00 -7, 115 HOUSEKEEPI NG 44.03 MISC REVENUE LEASED BLDGS В 9.00 44.03 44.04 MISC REVENUE LEASED BLDGS В -768 PHARMACY 15.00 44.04 45 00 0 00 O 45 00 45.01 0.00 45.01 45.02 MISC REVENUE LEASED BLDGS В -78, 264 PHYSICIANS' PRIVATE OFFICES 192.00 45.02 45.03 0.00 45.03 45.04 0.00 45 04 45.05 0.00 45.05 45.06 0.00 45.06 45.07 45.07 0.00 45.08 45.08 0.00 45.09 0.00 45.09 45. 10 45. 10 0.00 0.00 45. 11 45. 11 45.12 0.00 45.12 45.13 0.00 45.13 45.14 45.14 0.00 45.15 0.00 45. 15 45.16 0.00 45.16 45.17 0.00 45.17 45.18 0.00 45.18 0.00 45.19 0 45.19 45.20 0.00 45.20 45. 21 0.00 45. 21 45. 22 0.00 45. 22 45, 23 45, 23 0.00 45. 24 0.00 45.24 45. 25 45. 25 0.00 45. 26 0.00 45.26 0 45. 27 0.00 45. 27 45. 28 0.00 45.28 45. 29 45. 29 0.00 45.30 0.00 45.30 45.31 0.00 45.31 45. 32 0.00 45. 32 45.33 0.00 45.33 45.34 0.00 45.34 45.35 0.00 45.35 45.36 45.36 0.00 45 37 45 37 0 00 45.38 0.00 45.38 45. 39 0.00 45.39 45.40 0.00 45.40 0.00 45 41 45.41 45.42 0.00 45.42 45. 43 0.00 45.43 45.44 0.00 45.44 45.45 45.45 0.00 45.46 0.00 45.46 45.47 0.00 45.47 45.48 0.00 45.48 45.49 0.00 45.49 45.50 0.00 45.50 45.51 0.00 45.51 0.00 45.52 45.52 45.53 0.00 45.53 45.54 45.54 0.00 45, 55 0.00 0 45, 55 45.56 0.00 45.56 45.57 0.00 45.57 45.58 0.00 45.58 45.59 45.59 0.00 0 0 45.60 0.00 45.60 45.61 0.00 0 45.61

In Lieu of Form CMS-2552-10 Health Financial Systems ST VINCENT ANDERSON REGIONAL HOSPITA ADJUSTMENTS TO EXPENSES Provider CCN: 150088 Peri od: Worksheet A-8 From 07/01/2015 06/30/2016 Date/Time Prepared: 11/22/2016 3:25 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 45. 62 0.00 45, 62 45.63 0.00 45.63 45.64 0.00 45.64 45.65 0.00 45.65 0.00 45.66 45.66 45.67 0.00 45.67 45.68 0.00 45.68 45.69 0.00 45.69 O 45.70 0.00 45.70 45.71 0.00 45.71 45. 72 45.72 0.00 45 73 45 73 0.00 45.74 0.00 45.74 45.75 0.00 45.75 45.76 0.00 45.76 45.77 0.00 45.77 45.78 0.00 45.78 45. 79 0.00 45. 79 45.80 0.00 o 45.80 45.81 45.81 0.00

-10, 108, 802

0.00

0.00

0.00

0.00

0.00

0.00 0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

45.82

45.83 45.84

45.85

45.86 45.87

45.89

45.90

45. 91

45. 92

45.93

45. 94

45.95

45. 96

45.97

45. 98 45. 99

50.00

0 45.88

0

TOTAL (sum of lines 1 thru 49)

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

45.82

45.83

45.84

45.85

45.86

45.87

45.88

45.89

45.90

45. 91

45. 92

45.93

45. 94

45.95

45.96

45.97

45.98

45.99

50.00

⁽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.

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

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

Provider CCN: 150088 | Period: From 07/01/2015 | To 06/30/2016 | Date/Time Prepared: 11/22/2016 3: 25 pm

				To 06/30/2016	Date/Time Pre 11/22/2016 3:	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			'	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATE	O ORGANIZATIONS OR	CLAI MED	
1.00		NEW CAP REL COSTS-BLDG & FIX	ASCENSION HEALTH - INTER	EST 428, 827	462, 465	1. 00
2.00	5. 00	ADMINISTRATIVE & GENERAL	ASCENSION HEALTH - INTERE	ST 7,766	8, 375	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION HEALTH - PENSIO	N 2, 341, 379	1, 148, 509	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST. VINCENT SELF INSURANC	E 9, 224, 230	7, 420, 152	4.00
4.01	0.00				o	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	21, 447, 395	15, 305, 484	4. 02
4.03	194. 14	ADVERTSISING AND MARKETING	HOME OFFICE	1, 055, 097	o	4. 03
4. 18	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH - CHARGEBACK	374, 034	374, 034	4. 18
4. 19	5. 00	ADMINISTRATIVE & GENERAL	SVH - CHARGEBACK	6, 671, 560	6, 671, 560	4. 19
4. 20		OPERATION OF PLANT	SVH - CHARGEBACK	-2, 085		4. 20
4. 21	15. 00	PHARMACY	SVH - CHARGEBACK	-20,000		4. 21
4. 22	16. 00		SVH - CHARGEBACK	590, 882		4. 22
4.33	23. 01	SCH OF RADIOLOGY	SVH - CHARGEBACK	10, 460		4. 33
4.34		ADULTS & PEDIATRICS	SVH - CHARGEBACK	616, 988		4. 34
4. 35			SVH - CHARGEBACK	137, 729		4. 35
4. 36			SVH - CHARGEBACK	58, 773		4. 36
4. 37			SVH - CHARGEBACK	6,000		4. 37
4. 38		ELECTROCARDI OLOGY	SVH - CHARGEBACK	110, 300		4. 38
4. 39			SVH - CHARGEBACK	-2, 340		4. 39
4. 40	•		SVH - CHARGEBACK	15, 318		4. 40
4. 41		l .	SVH - CHARGEBACK	865, 074		4. 41
4. 42	194. 10		SVH-CHARGEBACK	461, 638		4. 42
4. 43		ł	TRI MEDX	941	995	4. 43
4. 44		ADMINISTRATIVE & GENERAL	TRI MEDX	-7, 555	-7, 986	4. 44
4. 45		MAINTENANCE & REPAIRS	TRI MEDX	5, 121, 458	, , , , , , , , , , , , , , , , , , , ,	4. 45
4. 46		PHARMACY	TRI MEDX	241	255	4. 46
4. 47		OPERATING ROOM	TRI MEDX	15, 517	16, 403	4. 47
4. 48		RADI OLOGY-DI AGNOSTI C	TRI MEDX	56, 807	60, 049	4. 48
4. 49		RESPI RATORY THERAPY	TRI MEDX	1, 698		4. 49
4. 50		PHYSI CAL THERAPY	TRI MEDX	211	223	4. 50
4. 51		ELECTROCARDI OLOGY	TRI MEDX	1, 277		4. 51
4. 52	194. 10		TRI MEDX	1, 053		4. 52
4. 53	0.00	l .		1,033	1, 113	4. 53
4. 54	0.00	l .			ا	4. 54
4. 55	0.00					4. 55
5. 00	0.00		lo	49, 590, 673	39, 727, 223	5. 00
	amounts on Lines 1 4 (and sub		transformed in detail to W			3.00

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
]		Ownershi p		Ownershi p	
1. 00	2.00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	0.00	ST VINCENT HEALTH	100.00	6. 00
7.00	В	0.00	ASCENSION HEALT	100.00	7. 00
8.00		0.00		0.00	8. 00
9.00		0.00		0.00	9. 00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

Heal th	Financial Systems	ST VINCENT ANDERSO	N REGIONAL HOS	PITA	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provi der	CCN: 150088	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 07/01/2015 To 06/30/2016		pared:
						11/22/2016 3:	25 pm
				Related Organization(s) and		or Home Office	
	Symbol (1)	Name	Percentage of	1	Name	Percentage of	
			Ownershi p			Ownershi p	
	1. 00	2.00	3.00	4	4. 00	5. 00	

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

			11/2	2/2016 3:25 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIM	ED
	HOME OFFICE CO			
1.00	-33, 638			1. 00
2.00	-609	9		2.00
3.00	1, 192, 870	0		3. 00
4.00	1, 804, 078	0		4. 00
4. 01	0	0		4. 01
4. 02	6, 141, 911	0		4. 02
4. 03	1, 055, 097	0		4. 03
4. 18	0	0		4. 18
4. 19	0	0		4. 19
4. 20	0	0		4. 20
4. 21	0	0		4. 21
4. 22	0	0		4. 22
4. 33	0	0		4. 33
4.34	0	0		4. 34
4. 35	0	0		4. 35
4.36	0	0		4. 36
4. 37	0	0		4. 37
4. 38	0 0	0		4. 38
4. 39		0		4. 40
4. 40 4. 41		0		4. 40
4. 41		0		4. 42
4. 42	-54	0		4. 43
4. 44	431	0		4. 44
4. 45	-292, 252	0		4. 45
4. 46	-272, 232	0		4. 46
4. 47	-886	0		4. 47
4. 48	-3, 242	0		4. 48
4. 49	-5, 242	0		4. 49
4. 50	-12	0		4. 50
4. 51	-73	_		4. 51
4. 52	-60	0		4. 52
4. 53	0	0		4. 53
4. 54	0	0		4. 54
4. 55	0	0		4. 55
5 00	9 863 450			5.00

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

Related Organization(s) and/or Home Office		
and/or home office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	HEALTH SYSTEM		6. 00
7.00	HEALTH SYSTEM		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00		10	100. 00

Health Financial Systems	ST VINCENT ANDERSON REG	GIONAL HOSPITA	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der CCN: 150088	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 07/01/2015 To 06/30/2016	Date/Time Prepared: 11/22/2016 3:25 pm
Related Organization(s) and/or Home Office				
Type of Business				
6. 00				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

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

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

- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Peri od:

From 07/01/2015 06/30/2016 Date/Time Prepared: 11/22/2016 3:25 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3.00 4.00 5. 00 6. 00 7. 00 1. 00 1.00 0.00 0 41. 00 SUBPROVIDER - IRF 2.00 113, 250 0 113, 250 171, 400 1, 312 2.00 3.00 55. 00 RADI OLOGY-THERAPEUTI C 8, 751 8, 751 136, 700 3.00 52 136, 700 4.00 70. 00 ELECTROENCEPHALOGRAPHY 152, 400 135,000 17, 400 150 4.00 5.00 91. 00 EMERGENCY 1, 067, 250 998, 061 69, 189 171, 400 908 5.00 6.00 30.00 ADULTS & PEDIATRICS 12,500 12,500 136, 700 108 6.00 7.00 65. 00 RESPIRATORY THERAPY 99, 413 0 99, 413 171, 400 576 7.00 8.00 60. OO LABORATORY 8.00 77, 763 0 77, 763 171, 400 340 9.00 0.00 0 9.00 10.00 0.00 0 10.00 398<u>, 266</u> 1, 531, 327 1, 133, 061 200.00 3.446 200.00 Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Wkst. A Line # Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 12 1. 00 2.00 8.00 9.00 13.00 14.00 12.00 1.00 0.00 0 1.00 2.00 41. 00 SUBPROVI DER - I RF 108, 114 5, 406 0 0 0 2.00 3.00 55. 00 RADI OLOGY-THERAPEUTI C 3, 418 0 0 3.00 171 70. 00 ELECTROENCEPHALOGRAPHY 9, 858 0 0 0 0 4.00 493 4.00 5.00 91 ON EMERGENCY 74, 823 3, 741 0 5 00 6.00 30.00 ADULTS & PEDIATRICS 7, 098 355 6.00 7.00 65. 00 RESPIRATORY THERAPY 47, 465 2, 373 0 0 0 7.00 60. 00 LABORATORY 0 8.00 28, 017 1, 401 0 8.00 0 9.00 0.00 O C 9.00 0 10.00 0.00 10.00 278, 793 13, 940 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCF 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 1.00 0.00 0 41. 00 SUBPROVI DER - I RF 2.00 0 108, 114 5, 136 5, 136 2.00 3.00 55. 00 RADI OLOGY-THERAPEUTI C 0 3, 418 5, 333 5, 333 3.00 70. 00 ELECTROENCEPHALOGRAPHY 0 9, 858 4.00 4.00 7,542 142.542 74, 823 998, 061 5.00 91 ON EMERGENCY 0 5 00 6.00 30.00 ADULTS & PEDIATRICS 0 7, 098 5, 402 5, 402 6.00 7.00 65. 00 RESPIRATORY THERAPY 0 47, 465 51, 948 51, 948 7.00 0 60. 00 LABORATORY 8.00 28, 017 49, 746 49,746 8.00 0 9.00 0.00 Λ Λ C 9.00 10.00 0.00 0 10.00 200.00 278, 793 125, 107 1, 258, 168 200.00

Provi der CCN: 150088 | Peri od: | From 07/01/201

| Peri od: | Worksheet B | From 07/01/2015 | Part | | To 06/30/2016 | Date/Time Prepared: |

			To	06/30/2016	Date/Time Pre 11/22/2016 3:	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses	NEW BLDG &	NEW BLDG &	EMPLOYEE	Subtotal	
	for Cost	FLXT	FLXT	BENEFITS		
	Allocation (from Wkst A			DEPARTMENT		
	col. 7)					
	0	1. 00	1. 01	4. 00	4A	
GENERAL SERVICE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT	1, 952, 178	1, 952, 178				1.00
1. 01 00101 NEW CAP REL COSTS-BLDG & FIXT	1, 732, 170	1, 732, 170	o			1. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	14, 701, 929	29, 788	0	14, 731, 717		4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	39, 102, 815	0	0	3, 472, 948	42, 575, 763	5.00
6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT	7, 654, 879	268, 136 0	0	101, 593	8, 024, 608 0	6. 00 7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	562, 781	37, 859	0	o	600, 640	8.00
9. 00 00900 HOUSEKEEPI NG	2, 448, 210	47, 988	0	O	2, 496, 198	9. 00
10. 00 01000 DI ETARY	546, 708	133, 883	0	5, 374	685, 965	1
11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE OF PERSONNEL	1, 585, 687	0	0	6, 298 0	1, 591, 985 0	11. 00 12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 006, 518	23, 491	Ö	167, 362	1, 197, 371	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	444, 063	76, 285	0	112, 929	633, 277	14. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	3, 574, 549	22, 698	0	738, 034	4, 335, 281	
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	1, 333, 921	25, 079 0	0	190, 231 0	1, 549, 231 0	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20. 00 02000 NURSI NG SCH00L	0	0	0	0	0	20.00
21. 00 02100 I&R SERVI CES-SALARY & FRINGES APPRVD 22. 00 02200 I&R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	21. 00 22. 00
23. 00 02300 PARAMED ED PRGM	116, 206	625	0	25, 364	142, 195	
23. 01 02301 SCH OF RADI OLOGY	172, 400	529	0	39, 594	212, 523	
23. 02 02302 PHARMACY RESI DENCY	244, 946	481	0	20, 943	266, 370	23. 02
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	13, 303, 648	367, 329	0	2, 854, 961	16, 525, 938	30.00
31. 00 03100 NTENSI VE CARE UNI T	4, 549, 502	70, 513	0	821, 760	5, 441, 775	
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF	0	0	0	0	0	34. 00 40. 00
41. 00 04100 SUBPROVI DER - 1 FF	1, 127, 974	48, 099	0	218, 585	1, 394, 658	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NURSERY	739, 919	4, 771	0	0	744, 690	1
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0	0	0	0	0	44. 00 45. 00
45. 01 04510 I CF/MR	Ö	0	0	Ö	0	45. 01
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	14, 065, 129	97, 275	0	392, 944	14, 555, 348	50.00
50. 00 05000 0FERATING ROOM 50. 01 05001 SURGERY CENTER	14,065,129	91, 215	0	392, 944	14, 555, 546	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	110, 625	79, 950	0	0	190, 575	1
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 060, 913 4, 693, 436	0 74, 096	0	0 722, 540	1, 060, 913 5, 490, 072	53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 332, 343	74,070	0	230, 728		55.00
56. 00 05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 05700 CT SCAN	533, 650	2, 650	0	109, 112	645, 412	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	866, 405 0	4, 824 0	0	67, 586 0	938, 815 0	58. 00 59. 00
60. 00 06000 LABORATORY	5, 464, 899	60, 335	0	8, 690	5, 533, 924	ı
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0				0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	463, 856	0	0	0	0 463, 856	62. 00 63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	Ö	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 340, 473	34, 333	0	296, 169		
66. 00 06600 PHYSI CAL THERAPY	1, 952, 819	45, 857 20, 419	0	362, 038	2, 360, 714	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	1, 181, 820 163, 718	30, 418 0	0	276, 843 39, 855	1, 489, 081 203, 573	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 217, 103	41, 182	Ö	448, 744	2, 707, 029	
70. 00 07000 ELECTROENCEPHALOGRAPHY	507, 526	56, 006	0	100, 764	664, 296	70. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0	0	0	6, 954, 048 4, 933, 346	1
73.00 07300 DRUGS CHARGED TO PATTENTS	4, 933, 346 22, 674, 909	0	0	0	4, 933, 346 22, 674, 909	1
74. 00 07400 RENAL DIALYSIS	0	Ö	Ö	ő	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	O	0	0	0	75. 00
76. 00 03190 CHEMOTHERAPY	1, 047, 676	O	0	216, 663	1, 264, 339	J 76.00

			10	06/30/2016	Date/lime Pre 11/22/2016 3:	
		CAPI TAL REI	LATED COSTS		11/22/2010 3.	25 piii
Cost Center Description	Net Expenses	NEW BLDG &	NEW BLDG &	EMPLOYEE	Subtotal	
	for Cost Allocation	FLXT	FLXT	BENEFITS DEPARTMENT		
	(from Wkst A			DEPARTMENT		
	col . 7)					
	0	1. 00	1. 01	4. 00	4A	
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0	1	0	0	89. 00 90. 00
90. 00 09000 CLINIC 90. 01 09001 ANDERSON CENTER OP CLINIC	718, 667	16, 835	· ·	157, 830	893, 332	
91. 00 09100 EMERGENCY	4, 044, 817	108, 246		868, 935	5, 021, 998	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,011,011			333, 133	0	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0			0	0	
95. 00 09500 AMBULANCE SERVICES	0	Ĭ		0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	-	0	0	
99. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	1	0	0	
99. 10 09910 CORF	0	0	-	0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	o	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0			0		105.00
106.00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION	0	0		0		106. 00 107. 00
108.00 10800 LUNG ACQUISITION	0	0	· ·	0		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0	· ·	ő		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	o	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		0		0	0	114. 00 115. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE	0) 0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	172, 497, 011	1, 809, 561	1 4	13, 075, 417	170, 698, 094	
NONREI MBURSABLE COST CENTERS	112/11/1011	1,700,7001	<u> </u>	10/0/0/11/	1,0,0,0,0,	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 052	0	0		190. 00
191. 00 19100 RESEARCH	141, 985			27, 818	169, 803	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	4, 485, 287	8, 797		797, 757	5, 291, 841	
193. 00 19300 NONPALD WORKERS 194. 00 07950 FOUNDATION	235, 221	0 3, 059	·	31, 821	270, 101	193. 00
194. 02 07951 CHI LDREN' S CLINI C	377, 318	3,039		65, 726	443, 044	
194. 04 07952 HEALTH RESOURCE CENTER	70, 575	2, 660	·	16, 412	89, 647	
194. 05 07953 ADOLESCENT RESIDENTIAL	1, 206, 241	48, 536	0	264, 909	1, 519, 686	194. 05
194.07 07954 COMMUNITY BENEFIT/MISSION	465, 684	13, 684		77, 767	557, 135	
194. 10 07955 DME	4, 869, 048			374, 090	5, 287, 812	
194. 12 07956 MED ONE/TWO	-4, 601	0	-	0	· ·	194. 12
194. 13 07957 UNUSED SPACE 194. 14 07958 ADVERTSISING AND MARKETING	1, 054, 617	0 12, 155		0	1, 066, 772	194. 13
194. 15 07959 PHYSI CLANS RECRUITING	25, 175	12, 133		0	25, 175	
194. 16 07960 MOB	-50, 027	0		O	-50, 027	
194. 17 07961 ASB	2, 455	0	0	0		194. 17
194. 18 07962 MAB	434	0	0	0		194. 18
200.00 Cross Foot Adjustments		_				200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	185, 376, 423	0 1, 952, 178	0	0 14, 731, 717	0 185, 376, 423	201. 00
202.00 TOTAL (Suil TITIES TTO-201)	100, 370, 423	1, 702, 1/0	١	14, /31, /1/	100, 370, 423	1202.00

Provi der CCN: 150088

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2015 | Part |
| To 06/30/2016 | Date/Time Prepared: | 11/22/2016 3: 25 pm

BUILDON STREAM BUIL					, '		11/22/2016 3:	
		Cost Center Description			OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
GENERAL SERVICE COST CENTRS - 18 06 A FIXT 1 01 01 0100 PROCES REST TO SERVICE STATE 4 .00 0000 PROCES RESTET TO REPARTENT 5 .00 0000 PROCES RESTET TO REPARTENT 6 .00 0000 PROCES RESTET TO REPARTENT 7 .00 0000 PROCES RESTET TO REPARTENT 7 .00 0000 PROCES RESTET TO REPARTENT 7 .00 0000 PROCESS RESTET TO REPARTENT 1 .00 0000 PROCESS RESTET TO RESPONSE 1 .00							9. 00	
1.01 0.0000 PART CAP FELL COSTS-PELDG & FIX		GENERAL SERVICE COST CENTERS	3.33	3.00				
4 00 00000 DEPROYER FRAFFITS DEPARTMENT								1
5.00								ł
0.0000 DOGODO MAIN HEAVANCE & REPAILS 2,391,506 10,416,216 1,017,92 5,00 1,017,92 1,000 1,017,92 1,000 1,017,92 1,000 1,017,92 1,000 1,017,92 1,000 1,017,92 1,000 1,017,92 1,000 1,017,92 1,000 1,017,92 1,000 1,			12 575 763					ł
0.00700 0.0700				10, 416, 214				•
0.000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000000			0	C C	o			1
10.00 01000 DETERMY 294, 441 88-7, 764 0 0 0 0 10.00	8.00	00800 LAUNDRY & LINEN SERVICE	179, 011	238, 311	0	1, 017, 962		8. 00
11.00 01000 (AFETERIA 4 474.466 0 0 0 6 61.467 111.00 12.00 12.00 12.00 13.00 MIRST MA ABON NISTATION 356.87 147.87 47 0 0 0 3.322 13.00 13.00 MIRST MA ABON NISTATION 356.87 147.87 47 0 0 0 3.322 13.00 13.00 MIRST MA ABON NISTATION 356.87 147.87 47 157.86 0 0 44.99 17.09 18.00 18.0						1, 060		ı
12.00 01.00 IMA INTERNACE OF PERSONNEL 0		I I		842, 764	0	0		•
13.00 01300 MURSING ADMINISTRATION 3.56, 857 147, 874 0 0 4, 999 20, 928 14.00 15.00 01500 PHARMACY LESS SUPPLY 188, 738 480, 195 0 0 0 0 0 11.909 15.00						0		•
14.00 1400 CENTRAL SERVICES & SUPPLY 188, 738 480, 195 0 44, 999 20, 928 14.00 15.00			_	147 874		0	-	•
16.00 10-00 NEDICAL RECORDS & LIBRARY 461,724 157,865 0 0 6,641 10.00 17.00 170.00					1	_		•
17. 00 0 1700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 17. 00 19. 00	15. 00				1	0		15. 00
10, 00 1000 1000 1000 1000 1000 10			461, 724	157, 865	0	0		1
20. 00 2000 MURSING SCHOOL 0 0 0 0 0 0 20. 00			0	C	0	0		•
21.00 02100 BAT SERVICES-SALANY & FININGES APPRVD 0 0 0 0 0 0 0 22.00 0220 BAT SERVICES-SOTHER PROM COSTS APPRVD 4 2,379 3,936 0 0 0 0 23.00 0230 02300 PARAMEP ED PROM 4 2,379 3,936 0 0 0 0 23.00 0230 02300 0			0		0	0		1
22.00 02000 RAS SERVI CES-OTHER PROM COSTS APPRVID 0		1	0			0		
23.00 02300 PARAMED ED PRICM			0	Ċ	ól ő	0		
23.02 0.2302 PHARMARY RESIDENCY 79, 387 3, 028 0 0 0 0 23, 028			42, 379	3, 936	o o	0	0	
INPATI ENT ROUTI NE SERVICE COST CENTERS 1,925,291 2,312,266 0 377,439 1,411,174 30 0.0 31.00 03100 ADULTS & PEDIATRICS 2,121,266 0 377,439 1,411,174 30 0.0 31.00 31.00 ADULTS & PEDIATRICS 2,121,266 0 377,439 1,411,74 30 0.0 31.00 32.00	23. 01	02301 SCH OF RADIOLOGY	63, 339			0	0	23. 01
30.00 03000 ADULTS & PEDIATRICS	23. 02		79, 387	3, 028	0	0	0	23. 02
31 00 03100 INTENSI VE CARE UNIT	20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 005 001	2 212 277		277 420	1 411 174	20.00
32.00 03200 03200 03200 03200 032.00 032.00 032.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 033.00 030.00 030.00 040.00					1	,		1
33. 00 03300 BURN INTERSIVE CARE UNIT 0 0 0 0 0 0 0 33. 00 40. 00 04000 SURGICAL INTERSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 33. 00 40. 00 04000 SURGICAL INTERSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				443, 603		124, 373		1
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 34. 00			0		ol o	0	-	1
14.10			0	C	0	0		34.00
42.00 04200 SUBPROVIDER	40.00		0	C	0	0		40. 00
43.00 04300 NURSERY 221, 943 30, 035 0 17, 984 83, 780 43, 00 44. 00 44.00 SAI LLED NURSI NG FACILITY 0 0 0 0 0 0 0 44. 00 44. 00 44.00 50.00 50.00 NURSI NG FACILITY 0 0 0 0 0 0 0 0 45. 01			415, 656	302, 771	0	45, 786		•
44. 00 04400 SKILLED NURSING FACILITY			0	20.025	0	17.004		•
45.00 04500 NURSI NG FACILITY			221, 943	30, 035		17, 984		•
45. 01 04510 1CF/MR			0			0		•
ANCIL LARY SERVICE COST CENTERS 50.00 50			0	Ċ		0		ı
50.00			0	C	0	0	0	•
50.01 050.00 05								
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 52.00			4, 337, 989	612, 325	0	77, 888		•
52. 00 05200 DELI VERY ROOM & LABOR ROOM 56, 798 503, 267 0 1, 313 12,557 52. 00			0		0	0		1
53.00 05300 ANESTHESI OLOGY 316, 188 0 0 0 0 0 53.00			56 798	503 267	7	1 313		
54. 00 05400 RADI OLOGY-THERAPEUTI C 1,636, 228 466, 419 0 80, 204 141,516 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 763, 882 0 0 18,031 11,627 55. 00 55. 00 05600 RADI OLOGY-THERAPEUTI C 763, 882 0 0 0 0 0 57. 00 05700 CT SCAN 192, 355 16, 683 0 0 0 0 57. 00 58. 00 05800 MADIETI C RESONANCE I MAGI NG (MRI) 279, 799 30, 368 0 0 0 0 6, 644 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 60. 01 06000 LABORATORY 1, 649, 298 379, 796 0 0 0 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61. 000 62. 00 06200 MOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 138, 245 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 498, 007 216, 118 0 0 3, 322 65. 00 66. 00 06600 RESPIRATORY THERAPY 478, 007 216, 118 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 443, 797 191, 473 0 0 0 0 0 68. 00 06600 SPECH PATHOLOGY 60, 672 0 0 0 0 0 69. 00 06600 SPECH PATHOLOGY 60, 672 0 0 0 0 0 69. 00 06600 SPECH PATHOLOGY 60, 672 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 806, 787 259, 233 0 202 55, 809 69, 90 69. 00 0700 0CCUPATI ONAL THERAPY 197, 983 352, 547 0 1, 196 45, 843 70, 90 70. 00 0700 ELECTROCARDI OLOGY 806, 787 259, 233 0 202 55, 809 69, 90 70. 00 0700 0 0 0 0 0 0 0				303, 207	ol ö	0		1
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 56. 00				466, 419	0	80, 204	141, 516	•
57. 00 05700 CT SCAN 192, 355 16, 683 0 0 0 0 57. 00	55. 00	05500 RADI OLOGY-THERAPEUTI C		C	o	18, 031	11, 627	55. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 279,799 30,368 0 0 0 6,644 58.00				C	0	0		
59,00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00						0	-	ı
60. 00 06000 LABORATORY 1, 649, 298 379, 796 0 0 0 113, 612 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 138, 245 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 498, 007 216, 118 0 0 3, 322 65. 00 06500 RESPI RATORY THERAPY 498, 007 216, 118 0 0 3, 322 65. 00 06600 PHYSI CAL THERAPY 703, 573 288, 662 0 12, 656 44, 847 66. 00 67. 00 06600 PHYSI CAL THERAPY 443, 797 191, 473 0 0 0 67. 00 69. 00 06900 ELECTROCARDI OLOGY 806, 787 259, 233 0 2022 55, 809 69. 00 69. 00 06900 ELECTROCARDI OLOGY 806, 787 259, 233 0 2022 55, 809 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2, 072, 543 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 072, 543 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 6, 757, 922 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 00 07400 RENAL DI ALYSI S 0 0 0 0 77. 00 08900 EDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 90. 01 09000 CLINIC 0 0 0 0 90. 01 09000 CLINIC 0 0 0 90. 01 09000 CLINIC 0 0 0 90. 01 09001 ANDERSON CENTER OP CLINIC 266, 243 105, 970 0 90. 01 09001 ANDERSON CENTER OP CLINIC 266, 243 105, 970 0 90. 01 09001 ANDERSON CENTER OP CLINIC 266, 243 105, 970 0 90. 01 09001 ANDERSON CENTER OP CLINIC 266, 243 105, 970 0 90. 01 09001 ANDERSON CENTER OP CLINIC 266, 243 105, 970 0 0 0 90. 01 09001 ANDERSON CENTER OP CLINIC 266, 243 105, 970 0 90. 01 09001 ANDERSON CENTER OP CLINIC			279, 799	30, 368	0	0		1
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 60. 01 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 138, 245 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 498, 007 216, 118 0 0 0 3, 322 66. 00 06600 PHYSI CAL THERAPY 703, 573 288, 662 0 12, 656 44, 847 66. 00 67. 00 06700 OCCUPATIONAL THERAPY 443, 797 191, 473 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 60, 672 0 0 0 0 0 69. 00 06900 ELECTROCARDIOLOGY 806, 787 259, 233 0 202 55, 809 70. 00 07000 ELECTROENCEPHALOGRAPHY 197, 983 352, 547 0 1, 196 45, 843 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 2, 072, 543 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENT 1, 470, 305 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07400 RENAL DI ALYSI S 0 0 0 0 76. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 76. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 90. 01 09000 CLINIC 266, 243 105, 970 0 0 0 90. 01 09001 ANDERSON CENTER OP CLINIC 266, 243 105, 970 0 10 0 0 0 0 0 0 10 0 0 0 0 11 00 0 0 0 12 00 0 0 13 00 0 0 14 00 0 0 15 00 0 0 16 00 0 0 17 00 0 0 18 00 0 0 18 00 0 0 19 00 0 0 18		1	1 640 209	270 706		0		1
61. 00		1	1, 049, 290	3/9, /90		0		
62. 00					ή	J		1
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 498,007 216, 118 0 0 3, 322 65. 00 66. 00 06600 PHYSI CAL THERAPY 703,573 288,662 0 12,656 44,847 66. 00 67. 00 0 0 0 0 0 0 0 0 0			0	C	0	0	0	ł
65. 00	63.00		138, 245	C	o	0	0	63. 00
66. 00 06600 PHYSI CAL THERAPY 703, 573 288, 662 0 12, 656 44, 847 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 443, 797 191, 473 0 0 0 67. 00 68. 00 68. 00 06800 SPEECH PATHOLOGY 60, 672 0 0 0 0 0 0 68. 00 06900 ELECTROCARDI OLOGY 806, 787 259, 233 0 202 55, 809 69. 00 07. 00 0			0	C	0	0		1
67. 00 06700 OCCUPATI ONAL THERAPY 043,797 191,473 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 60,672 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 806,787 259,233 0 202 55,809 69. 00 07000 ELECTROENCEPHALOGRAPHY 197,983 352,547 0 1,196 45,843 70. 00 71. 00 71. 00 71. 00 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 2,072,543 0 0 0 0 0 0 71. 00 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 6,757,922 0 0 0 0 0 73. 00 74. 00 74. 00 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 75. 00 03190 CHEMOTHERAPY 376,816 0 0 26,017 0 76. 00 0 0 0 0 0 0 0 0 0						0		1
68. 00 06800 SPEECH PATHOLOGY 60, 672 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 806, 787 259, 233 0 202 55, 809 69. 00 70. 00 07000 ELECTROCARDI OLOGY 197, 983 352, 547 0 1, 196 45, 843 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 2, 072, 543 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 1, 470, 305 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 6, 757, 922 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 76. 00 03190 CHEMOTHERAPY 376, 816 0 0 26, 017 0 76. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 79. 00 09900 CLI NI C 0 0 0 0 790. 01 09001 ANDERSON CENTER OP CLI NI C 266, 243 105, 970 0 0 0 70. 00 0 0 0 0 70. 00 09000 CNI NIC CENTER OP CLI NI C 266, 243 105, 970 0 0 70. 00 09000 00000 000000 000000000					1	12, 656		1
69. 00 06900 ELECTROCARDI OLOGY 800, 787 259, 233 0 202 55, 809 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 197, 983 352, 547 0 1, 196 45, 843 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2, 072, 543 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 1, 470, 305 0 0 0 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 6, 757, 922 0 0 0 0 0 0 73. 00 74. 00 74. 00 74. 00 75.				191, 4/3		0		1
70. 00 07000 ELECTROENCEPHALOGRAPHY 197, 983 352, 547 0 1, 196 45, 843 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 2, 072, 543 0 0 0 0 0 0 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENT 1, 470, 305 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 6, 757, 922 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 75. 00 75. 00 03190 CHEMOTHERAPY 376, 816 0 0 0 26, 017 0 76. 00 00 00 00 00 00 00 00				250 233		202		1
71. 00					1			•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 1,470,305 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 6,757,922 0 0 0 0 0 0 73. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 0				C	ol o	0		1
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74. 00 0 75. 00 0 0 0 75. 00 0 0 0 0 0 0 0 0 0	72.00	07200 IMPL. DEV. CHARGED TO PATIENT		C	o	0	0	72. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 00 03190 CHEMOTHERAPY 376, 816 0 0 26, 017 0 76. 00 0 0 0 0 0 0 0 0 0			6, 757, 922	C	0	0		
76. 00 03190 CHEMOTHERAPY 076. 00 0 0 26, 017 0 76. 00			0	C	0	0		1
OUTPATIENT SERVICE COST CENTERS			0	C	0	0		•
88. 00	76.00		3/6, 816	C	η <u></u> Ο	26, 017	0	j 76.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 90. 00 90. 01 09001 ANDERSON CENTER OP CLINIC 266, 243 105, 970 0 0 90. 01	88 NN		0	r) 0	n	n	88.00
90. 00 09000 CLI NI C				Č	o o	0		1
		09000 CLI NI C	0	C	0	0	0	1
91. 00 09100 EMERGENCY 1, 496, 726 681, 387 0 154, 701 342, 828 91. 00						0		
	91. 00	U9 TUU EMERGENCY	1, 496, 726	681, 387	<u>'l</u> 0	154, 701	342, 828	J 91.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150088

			T	o 06/30/2016	Date/Time Pre 11/22/2016 3:	
Cost Center Description	ADMI NI STRATI VE I	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	23 ()111
0001 0011101 20001 1 211 011	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	110002112211110	
	5. 00	6. 00	7. 00	8. 00	9. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o o	0	0	0	0	97. 00
99. 00 09900 CMHC	o o	0	١	0	0	99.00
99. 10 09910 CORF	Ŏ	0	١	0	0	99. 10
100. 00 10000 &R SERVICES-NOT APPRVD PRGM		0	١	0	_	100.00
101. 00 10100 HOME HEALTH AGENCY		0	0	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	0	<u> </u>	0	1101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	O	0	0		0	105. 00
106. 00 10600 HEART ACQUISITION		0		-		106.00
107. 00 10700 LI VER ACQUI SI TI ON		0	0	0	0	
108. 00 10800 LUNG ACQUISITION		0	0	0	_	107.00
109. 00 10900 PANCREAS ACQUISITION		0	0	0		109.00
		0	0	0		1109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	U		
111. 00 11100 I SLET ACQUI SI TI ON	ų į	U	0	U	U	111.00
113. 00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	38, 184, 841	9, 518, 467	0	984, 069	3, 437, 247	1118. 00
NONREI MBURSABLE COST CENTERS			_		_	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 698	56, 982	0	0		190. 00
191. 00 19100 RESEARCH	50, 607	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 577, 149	55, 377	0	30, 777	-	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 FOUNDATI ON	80, 499	19, 256	0	0		194. 00
194. 02 07951 CHI LDREN' S CLINI C	132, 042	0	0	1, 155		194. 02
194.04 07952 HEALTH RESOURCE CENTER	26, 718	16, 743	0	0		194. 04
194. 05 07953 ADOLESCENT RESI DENTI AL	452, 918	305, 527	0	0		194. 05
194.07 07954 COMMUNITY BENEFIT/MISSION	166, 045	86, 138	0	0		194. 07
194. 10 07955 DME	1, 575, 948	281, 214	0	0		194. 10
194.12 07956 MED ONE/TWO	0	0	0	1, 371	0	194. 12
194. 13 07957 UNUSED SPACE	0	0	0	0	0	194. 13
194.14 07958 ADVERTSISING AND MARKETING	317, 934	76, 510	0	0	3, 322	194. 14
194. 15 07959 PHYSI CLANS RECRUITING	7, 503	0	0	0	0	194. 15
194. 16 07960 MOB	0	0	0	0	3, 322	194. 16
194. 17 07961 ASB	732	0	0	0	3, 986	194. 17
194. 18 07962 MAB	129	0	0	590	2, 658	194. 18
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	o	0	201.00
202.00 TOTAL (sum lines 118-201)	42, 575, 763	10, 416, 214	O	1, 017, 962		
						•

Provi der CCN: 150088 | Peri od: From 07/01/2015

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2015 | Part |
| To 06/30/2016 | Date/Time Prepared: | 11/22/2016 3: 25 pm

SEPTION CONTINUES CONTIN					ļ		11/22/2016 3:	
		Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL		CENTRAL SERVICES &	
Children Sample Dost Dentities 1			10.00	44.00			SUPPLY	
0.000 MORE CAP REL COSTS - SELECT 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
4.00 0.0000 PART PART TO PARTANETY		00100 NEW CAP REL COSTS-BLDG & FIXT						1
0.000 0.000 AMM INTERNAT OF A CREERIAL		1 1						1
0.000 0.000 MINTERNANCE & REPAIR		1 1						1
B. DO DOSIDIL AUMBRY & LINEN STRYLCE								1
0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000	7.00							7. 00
10.00 01000 DETARY		i i						
11.00 0 1000 (AFETERIA 0 2.127,908 11.00		1 1	1 722 170					1
12.00 01200 MAINTENANCE OF PERSONNEL 0 0 0 1,733,770 12.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 35,055 0 0,733,770 1.00		1 1	1 ' ' 1	2 127 908	3			
13.00 0.300 NURSIN KO ADMINI STRATION 0 28,355 0 1,733,779 1.00				2, 127, 700	ol o			1
15.00 01500 PHARMACY 0 119, 334 0 0 42, 185 15.00 17.00	13.00	1 1	o	28, 355	5 0	1, 733, 779		
16. 00 01-000 MIDICAL, RECORDS & LIBRARY 0 47, 220 0 0 0 10. 00 17. 00 170.		1 1	0		1	0		1
17.00 01700 01700 01700 0 0 0 0 0 0 0 17.00		1 1	0		1	0		
19 00 0900 MONENINS ICL AN ANESTHEIR ISLS 0 0 0 0 0 0 22 00 220 00		1 1		47, 220		0		1
20. 00 02000 NURSIN S SCHOOL 0 0 0 0 0 0 20. 00 0 21. 00 0 0 0 0 0 0 0 0 0			o o	(0		
22.00 02200 BAT SERVICES-OTHEE PROM OSTS APPRVD 0		02000 NURSI NG SCHOOL	o	(0	0	0	20. 00
23.00 02300 PARAMED ED PREM 0 5,617 0 0 10 22.00			0	(0	0	Ŭ	
23.01 02301 SCH OF FADD IOLOGY 0 8, 136 0 0 0 23. 07 123. 07 230. 07 120			0	(5	7	0	_	1
23. Q2 PIARMACY RESIDENCY Q				•	•	0		
30.00		1 1	o o	•	•	0		
31.00 03100 INTERSI VE CARE UNIT								
32.00 03200 COROMARY CARE UNIT 0 0 0 0 0 0 0 32.00		1 1	1		•			
33.00 03300 BURR I NIFENSIVE CARE UNIT			297, 625	160, 154	1 0	242, 251		
34. 00 03400 SUBRICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0		1 1		(0		1
40.00 04000 SUBPROVI DER - I PF 0 0 0 0 0 0 40.00			o	(0	_	1
42.00 04200 04200 04400 05400 0 0 0 0 0 0 0 0 0	40.00	04000 SUBPROVI DER - I PF	o	(0	0	0	40. 00
43. 00 04300 NURSERY 44. 00 1400 SKILLED NURSI NG FACILITY		1 1	123, 378	42, 357	7 0	64, 069		1
44. 00 04400 SKILLEN NURSING FACILITY 0 0 0 0 0 0 0 0 45. 00 45. 01 04510 ICF/MR 0 0 0 0 0 0 0 0 45. 01 45. 01 04510 ICF/MR 0 0 0 0 0 0 0 0 0 45. 01 46. 00 10460 ONTHER IN CAPE 0 0 0 0 0 0 0 0 0 45. 01 ANCILLARY SERVICE COST CENTERS		1 1	0	27 201	0	0	_	1
45. 00 04500 NURSI NG FACILITY		1 1	39, 951	27, 30		41, 297		
40.00 04.00 04.00 04.00 0 0 0 0 0 0 0 0 0				(0		1
ANCILLARY SERVICE COST CENTERS S0.00	45. 01	04510 I CF/MR	o	(0	0	0	45. 01
50.00	46. 00		0	(0	0	0	46. 00
50. 01 05.001 SURGERY CENTER 0 0 0 0 0 50. 01	50.00		1 0	73 263	al o	110 910	65/ 688	50.00
51.00 05100 RECOVERY ROOM 6.00 0 0 0 0 0 0 51.00					1	0		
53. 00 05300 ANESTHESI OLOGY	51.00		o	(0	0	-	
54.00 05400 RADI OLOCY-DI AGNOSTI C 0 164, 471 0 248, 781 129, 710 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 42, 039 0 63, 588 18, 370 55.00 55.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0			5, 973		1	6, 175		
55.00 05500 RADI OLOGY-THERAPEUTI C 0 42,039 0 63,588 18,370 55.00		1 1	0	,	1 °	0		
56.00 05400 RADI OI SOTOPE 0 0 0 0 0 56.00					1		'	1
57.00 05700 CT SCAN 0 22,559 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 11,567 0 0 1,715 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 60.00 06000 LABORATORY 0 2,153 0 0 140,000 60.01 06001 BLOD LABORATORY 0 0 0 0 0 61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 63.00 06300 BLODD STORIN G, PROCESSI NG & TRANS. 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 56,026 0 0 41,782 65.00 66.00 06600 PHYSI CAL THERAPY 0 45,776 0 0 424 67.00 68.00 06800 SPEECH PATHOLOGY 0 81,191 0 45,979 69.00 69.00 06900 ELECTROCARDI OLOGY 0 81,191 0 0 45,979 69.00 70.00 07000 LECTROENCEPHAL OGRAPHY 0 20,290 0 0 2,177 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0 0 75.00 07300 REIGN CHARGED TO PATI ENT 0 0 0 0 0 0 76.00 07500 ASC (NON-DI STI NCT PART) 0 45,261 0 0 0 36,543 88.00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00 09000 CLINI C 0 0 0 0 0 99.00					1			
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59.00			o	22, 559	9 0	0	0	
60. 00 06000 LABORATORY 0 2, 153 0 0 140,000 60. 00 60. 00 60. 01 60. 01 BLOOD LABORATORY 0 0 0 0 0 0 60. 01 61. 00 61. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 63. 00 63. 00 63. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 65. 00 65. 00 66. 00 65. 00 66. 00		1 1	0	11, 567	7 0	0		1
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	0	0.153	0	0		1
61. 00					1	0		
63. 00		l l			1	J		
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 56, 026 0 0 41, 782 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 70, 759 0 0 7, 196 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 45, 776 0 0 424 67. 00 67. 00 06800 SPEECH PATHOLOGY 0 6, 043 0 0 30, 229 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 81, 191 0 0 45, 979 69. 00 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 20, 290 0 0 2, 177 70. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 1MPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 74. 00 74. 00 74. 00 75. 00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 45, 261 0 0 36, 543 76. 00 00 00 00 00 00 00 00		1 1	o	(0	0	0	
65. 00 06500 RESPIRATORY THERAPY 0 56, 026 0 0 41, 782 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 70, 759 0 0 77, 196 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 45, 776 0 0 424 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 60, 00 0 30, 229 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 81, 191 0 0 45, 979 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 20, 290 0 0 0 2, 177 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 74. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 45, 261 0 0 0 36, 543 76. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 0 0 0 89. 00 90. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	(0	0	0	1
66. 00			0	E(02/	0	0	0	
67. 00 06700 OCCUPATIONAL THERAPY 0 45,776 0 0 424 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 68. 00 06900 ELECTROCARDIOLOGY 0 81, 191 0 0 45, 979 69. 00 07000 ELECTROCARDIOLOGY 0 81, 191 0 0 45, 979 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 20, 290 0 0 2, 177 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0 73. 00 74. 00 075. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 75. 00 075. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1			1	0		
69. 00 06900 ELECTROCARDI OLOGY 0 81, 191 0 0 45, 979 69. 00 70. 00 70. 00 70. 00 70. 00 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 0			o		1	0		1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 20, 290 0 0 2, 177 70. 00 71. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71. 00 72. 00 72. 00 MPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 74. 00 74. 00 74. 00 74. 00 75. 00	68. 00	06800 SPEECH PATHOLOGY	o		1	0	30, 229	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75.			0		1	0		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 72. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 00		1 1	0	20, 290	0	0		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 74. 00 74. 00 75. 00 0 0 0 0 0 0 0 74. 00 75. 00 0 0 0 0 0 0 0 0 0				(0		
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74. 00 0 0 0 0 0 0 0 0 0				(_	1
76. 00 03190 CHEMOTHERAPY 0 45, 261 0 0 36, 543 76. 00 0 0 17PATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 9000 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00		1 1		C	o 0	0		
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 0 0 90.00		1 1 7	0	(0	0	_	ı
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00	76. 00] 0	45, 261	1] 0	0	36, 543	76. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 90. 00	88 00			(n	n	88 00
90. 00 09000 CLI NI C 0 0 0 0 0 90. 00				(1 "	_		
90. 01 09001 ANDERSON CENTER OP CLINIC 0 35, 489 0 0 0 90. 01		09000 CLI NI C	0	(0	0	_	
	90. 01	09001 ANDERSON CENTER OP CLINIC	0	35, 489	9 0	0	0	90. 01

ONAL HOSPITA

Provider CCN: 150088
Period:
From 07/01/2015
To 06/30/2016
Worksheet B
From 07/01/2015
Part I
To 06/30/2016
Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			Τ	o 06/30/2016	Date/Time Pre 11/22/2016 3:	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	10.00	11. 00	12.00	13.00	14.00	
91. 00 09100 EMERGENCY	0	181, 161		274, 026	92, 166	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	1	1 1	0	
95. 00 09500 AMBULANCE SERVI CES	0	0		0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0	70.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	1 /// 00
99. 00 09900 CMHC	0	0		0	0	
99. 10 09910 CORF	0	0			0	1 , , ,
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	1			100.00
101. 00 10100 HOME HEALTH AGENCY	0	0) () 0	0	101. 00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION	O	0		ol ol		105. 00
106. 00 10600 HEART ACQUISITION		0	1	1		106. 00
107. 00 10700 LIVER ACQUISITION		0				107. 00
108. 00 10800 LUNG ACQUISITION		0				108. 00
109. 00 10900 PANCREAS ACQUISITION		0				109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		0				110. 00
111. 00 11100 SLET ACQUISITION		0				111. 00
113. 00 11300 NTEREST EXPENSE		· ·		1	Ü	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0		ol	0	115. 00
116. 00 11600 HOSPI CE	O	0) (o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 600, 489	1, 798, 431		1, 733, 779	1, 397, 474	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0		190. 00
191. 00 19100 RESEARCH	0	4, 965		0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	108, 135	6	0		192. 00
193. 00 19300 NONPAI D WORKERS	0	0)	0		193. 00
194. 00 07950 FOUNDATI ON	0	6, 013		0		194. 00
194. 02 07951 CHI LDREN' S CLI NI C	0	16, 183		0	•	194. 02
194. 04 07952 HEALTH RESOURCE CENTER	0	3, 849	•	0		194. 04
194. 05 07953 ADOLESCENT RESIDENTIAL	132, 681	59, 566	1			194. 05
194. 07 07954 COMMUNITY BENEFIT/MISSION	0	26, 404	1			194. 07
194. 10 07955 DME 194. 12 07956 MED_ONE/TWO	0	104, 362	1			194. 10 194. 12
194. 12 07956 MED ONE/TWO 194. 13 07957 UNUSED SPACE		0				194. 12
194. 13 07957 UNUSED SPACE 194. 14 07958 ADVERTSISING AND MARKETING		0				194. 13
194. 15 07959 PHYSI CLANS RECRUITING		0				194. 15
194. 16 07960 MOB		0				194. 16
194. 17 07961 ASB		0				194. 17
194. 18 07962 MAB		0				194. 18
200.00 Cross Foot Adjustments		O]	· ·	200.00
201.00 Negative Cost Centers	O	0) (ol ol	0	201. 00
202.00 TOTAL (sum lines 118-201)	1, 733, 170	2, 127, 908	s c	1, 733, 779	1, 403, 192	202.00
	•		•	•		•

 ONAL HOSPITA
 In Lieu of Form CMS-2552-10

 Provider CCN: 150088
 Period: From 07/01/2015 From 07/01/2015 To 06/30/2016 Date/Time Prepared: 11/22/2014 3: 35 pm
 Worksheet B Part I Date/Time Prepared: 11/22/2014 3: 35 pm

				1	0 06/30/2016	Date/lime Pre	
	Cost Center Description	PHARMACY		SOCIAL SERVICE		NURSING SCHOOL	, , , , , , , , , , , , , , , , , , ,
			RECORDS & LI BRARY		ANESTHETI STS		
		15. 00	16. 00	17. 00	19. 00	20.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 4. 00	OO101 NEW CAP REL COSTS-BLDG & FLXT OO400 EMPLOYEE BENEFLTS DEPARTMENT						1. 01 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00	01500 PHARMACY	5, 946, 726					15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	2, 222, 684				16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		17. 00 19. 00
20. 00	02000 NURSING SCHOOL	0	0		0	0	20.00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	o	0				21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	O	0	0			22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0			23. 00
23. 01	02301 SCH OF RADI OLOGY	0	0	0			23. 01
23. 02	O2302 PHARMACY RESI DENCY	0	0	0			23. 02
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	8, 163	105, 587	0	0	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	4, 572	52, 161				31.00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40.00	04000 SUBPROVIDER - I PF	0	0	0	0	0	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	157	10, 901	0	0	0	41. 00 42. 00
43. 00	04300 NURSERY	303	3, 453		0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	Ö	0	Ö	44. 00
45.00	04500 NURSING FACILITY	О	0	0	0	0	45. 00
45. 01	04510 CF/MR	0	0	0	0	0	45. 01
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	12, 312	372, 954	0	0	0	50.00
50. 01	05001 SURGERY CENTER	0	0 0	ĺ			50. 01
51.00	05100 RECOVERY ROOM	O	0	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	45	12, 955	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	32, 409	0	0	0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	1, 600	154, 517	0	0	0	54.00
55. 00 56. 00	O5500 RADI OLOGY-THERAPEUTI C O5600 RADI OI SOTOPE	60	97, 229 0		0	0	55. 00 56. 00
57. 00		17, 213	50, 429	·	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	14, 920	13, 830		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	784	221, 992	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	,	0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	9, 214		0	0	63.00
64. 00	06400 NTRAVENOUS THERAPY	o	0,214		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	133	55, 115	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	110	25, 080	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	20, 898	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	2, 537	0	0	0	68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	421 19	88, 571 18, 200		0	0	69. 00 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65, 123		0	0	70.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	l ol	47, 141	0	0	ő	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 866, 413	457, 811	0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76. 00	03190 CHEMOTHERAPY OUTPATI ENT SERVI CE COST CENTERS	0	10, 562	0	0	0	76. 00
88. 00		O	Ω	0	n	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	Ö	0	ő	89.00
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
90. 01	09001 ANDERSON CENTER OP CLINIC	0	6, 680	0	0	0	90. 01

Provi der CCN: 150088

			11	0 06/30/2016	11/22/2016 3:	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSING SCHOOL	25 piii
		RECORDS &		ANESTHETI STS		
		LI BRARY				
	15. 00	16. 00	17. 00	19. 00	20.00	
91. 00 09100 EMERGENCY	4, 014	231, 965	0	0	0	, 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS			1 0	0	1 0	105 00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION	0	0		0	_	105. 00 106. 00
107. 00 10700 LI VER ACQUI SI TI ON		0	0	0		106.00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION		0	0	0		107.00
109. 00 10900 PANCREAS ACQUISITION		0	0	0	l .	109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		0	0	0	l .	110.00
111. 00 11100 SLET ACQUISITION		0		0	l .	111.00
113. 00 11300 NTEREST EXPENSE		O		0		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	1		•			114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0	0	0	0	115. 00
116. 00 11600 H0SPI CE	0	0	o o	0	l .	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 931, 239	2, 167, 314	_	0	l .	118. 00
NONREI MBURSABLE COST CENTERS			•		•	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	2	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	12, 692	13, 862	0	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194. 00 07950 FOUNDATI ON	0	0	0	0		194. 00
194. 02 07951 CHI LDREN' S CLI NI C	2, 793	2, 226	0	0		194. 02
194.04 07952 HEALTH RESOURCE CENTER	0	0	0	0		194. 04
194. 05 07953 ADOLESCENT RESI DENTI AL	0	7, 448		0		194. 05
194. 07 07954 COMMUNITY BENEFIT/MISSION	0	0	0	0		194. 07
194. 10 07955 DME	0	31, 834		0		194. 10
194. 12 07956 MED ONE/TWO	0	0	0	0	l .	194. 12
194. 13 07957 UNUSED SPACE	0	0	0	0		194. 13
194. 14 07958 ADVERTSISING AND MARKETING	0	0	0	0		194. 14
194. 15 07959 PHYSI CLANS RECRUITING 194. 16 07960 MOB		0		0		194. 15 194. 16
194. 16 07960 MOB 194. 17 07961 ASB		0		0		194. 16
194. 17 07961 ASB 194. 18 07962 MAB		0		0	l .	194. 17
200.00 Cross Foot Adjustments	١	U	i o	0		200. 00
201.00 Negative Cost Centers		0	n	0	l .	201. 00
202.00 TOTAL (sum lines 118-201)	5, 946, 726	2, 222, 684		0		202.00
202.00 101/1E (30m 11103 110 201)	0, 710, 720	2, 222, 004	1		1	1202.00

						11/22/2016 3:	25 pm
		INTERNS &	RESI DENTS				
0+ 0	Santan Baraniatian	CEDVI CEC CALAD	CEDVI CEC OTHER	DADAMED ED	COLL OF	DUADMACY	
Cost C	Center Description	SERVICES-SALAR Y & FRINGES	PRGM COSTS	PARAMED ED PRGM	SCH OF RADI OLOGY	PHARMACY RESI DENCY	
		21. 00	22. 00	23. 00	23. 01	23. 02	
GENERAL SERV	/ICE COST CENTERS	21.00	22.00	23.00	23.01	23.02	
	AP REL COSTS-BLDG & FLXT						1.00
	AP REL COSTS-BLDG & FIXT						1. 01
	EE BENEFITS DEPARTMENT						4.00
	STRATIVE & GENERAL						5. 00
	NANCE & REPAIRS						6. 00
	TON OF PLANT						7. 00
	RY & LINEN SERVICE						8. 00
9.00 00900 HOUSEK							9. 00
10. 00 01000 DI ETAR							10.00
11.00 01100 CAFETE	RI A						11. 00
	NANCE OF PERSONNEL						12.00
13. 00 01300 NURSI N	IG ADMINISTRATION						13. 00
14. 00 01400 CENTRA	L SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMA	CY						15. 00
16. 00 01600 MEDI CA	L RECORDS & LIBRARY						16. 00
17. 00 01700 SOCI AL	. SERVICE						17. 00
19. 00 01900 NONPHY	SICIAN ANESTHETISTS						19. 00
20. 00 02000 NURSI N	IG SCHOOL						20.00
21.00 02100 I &R SE	RVICES-SALARY & FRINGES APPRVD	0					21. 00
22. 00 02200 1 &R SE	RVICES-OTHER PRGM COSTS APPRVD		0				22. 00
23. 00 02300 PARAME	D ED PRGM			194, 137			23. 00
23. 01 02301 SCH 0F	RADI OLOGY				287, 328		23. 01
23. 02 02302 PHARMA	CY RESIDENCY					360, 170	23. 02
INPATIENT RO	OUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS	& PEDIATRICS	0	0	0	0	0	30. 00
31. 00 03100 I NTENS	SIVE CARE UNIT	0	0	0	0	0	31.00
32. 00 03200 CORONA	ARY CARE UNIT	0	0	0	0	0	32. 00
33. 00 03300 BURN I	NTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00 03400 SURGI 0	CAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 04000 SUBPRO	VIDER - IPF	0	0	0	0	0	40.00
41. 00 04100 SUBPRO	VIDER - IRF	0	0	0	0	0	41.00
42. 00 04200 SUBPRO	IVI DER	0	0	0	0	0	42.00
43.00 04300 NURSER	RY	0	0	0	0	0	43.00
44. 00 04400 SKI LLE	D NURSING FACILITY	0	0	0	0	0	44.00
45. 00 04500 NURSI N	IG FACILITY	0	0	0	0	0	45. 00
45.01 04510 I CF/MR	2	0	0	0	0	0	45. 01
46. 00 04600 OTHER	LONG TERM CARE	0	0	0	O	0	46.00
ANCI LLARY SE	ERVICE COST CENTERS						1
50. 00 05000 OPERAT	ING ROOM	0	0	0	0	0	50.00
50. 01 05001 SURGER	RY CENTER	0	0	0	O	0	50. 01
51. 00 05100 RECOVE	RY ROOM	0	0	0	0	0	51.00
52. 00 05200 DELIVE	RY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTH	IESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OL	.OGY-DI AGNOSTI C	0	0	0	202, 932	0	54.00
55. 00 05500 RADI OL	OGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 05600 RADI 0I	SOTOPE	0	0	0	0	0	56. 00
57.00 05700 CT SCA	١N	0	0	0	66, 232	0	57. 00
58. 00 05800 MAGNET	IC RESONANCE IMAGING (MRI)	0	0	0	18, 164	0	58. 00
	C CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORA	TORY	0	0	0	0	0	60.00
60. 01 06001 BL00D	LABORATORY	0	0	0	0	0	60. 01
61.00 06100 PBP CL	INICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE	BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00 06300 BL00D	STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 06400 I NTRAV	ENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPIR	RATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSI C	CAL THERAPY	0	0	0	0	0	66.00
67. 00 06700 OCCUPA	ITI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH	I PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTR		0	0	0	o	0	1
	ROENCEPHALOGRAPHY	0	0	0	o	0	
71. 00 07100 MEDI CA	L SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
	CHARGED TO PATIENTS	0	0	o	o	360, 170	1
74.00 07400 RENAL		0	0	0	o	0	1
	ION-DISTINCT PART)	0	0	o	o	0	75. 00
76.00 03190 CHEMOT		0	0	0	0	0	76. 00
	SERVICE COST CENTERS				<u> </u>]
	HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERA	LLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00 09000 CLINIC	,	0	0	0	О	0	90.00
				<u>'</u>			

| Peri od: | Worksheet B | From 07/01/2015 | Part | | To 06/30/2016 | Date/Time Prepared: | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150088

			10	06/30/2016	Date/IIme Pre 11/22/2016 3:	
	INTERNS &	RESI DENTS			11/22/2010 3.	25 piii
Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	SCH OF	PHARMACY	
	Y & FRINGES	PRGM COSTS	PRGM	RADI OLOGY	RESI DENCY	
	21.00	22. 00	23. 00	23. 01	23. 02	
90.01 09001 ANDERSON CENTER OP CLINIC	0	0	0	0	0	
91. 00 09100 EMERGENCY	0	0	194, 137	0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS	1	al		اء		
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	1 ,,, 00
99. 00 09900 CMHC	0	0	0	0	0	1 , , , , , ,
99. 10 09910 CORF	0	0	0	0	0	1
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	U		100.00
101. 00 10100 HOME HEALTH AGENCY	J U	U	U	0	0	101. 00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON	0	O	0	O		105. 00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
107. 00 10700 ETVER ACQUISITION 108. 00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION		0	0	0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		0	0	0		110, 00
111. 00 11100 I SLET ACQUI SI TI ON		0	0	0		111.00
113. 00 11300 NTEREST EXPENSE		ď	O	o _l	O	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0	0	0	0	115. 00
116. 00 11600 HOSPI CE		0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)		o	194, 137	287, 328	360, 170	
NONREI MBURSABLE COST CENTERS	<u> </u>	<u> </u>	174, 137	207, 320	300, 170	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	ol	0	0	0	190. 00
191. 00 19100 RESEARCH	ol	o	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	o	0	0		192. 00
193. 00 19300 NONPALD WORKERS	o	o	0	0		193. 00
194. 00 07950 FOUNDATI ON	o	o	0	0		194. 00
194. 02 07951 CHI LDREN' S CLINIC	o	o	0	o	0	194. 02
194. 04 07952 HEALTH RESOURCE CENTER	o	o	0	0		194. 04
194. 05 07953 ADOLESCENT RESIDENTIAL	o	o	0	0	0	194. 05
194. 07 07954 COMMUNITY BENEFIT/MISSION	o	o	0	0	0	194. 07
194. 10 07955 DME	o	o	0	o	0	194. 10
194. 12 07956 MED ONE/TWO	o	o	0	o	0	194. 12
194. 13 07957 UNUSED SPACE	o	o	0	O	0	194. 13
194.14 07958 ADVERTSISING AND MARKETING	o	o	0	0	0	194. 14
194. 15 07959 PHYSI CLANS RECRULTING	o	o	0	0	0	194. 15
194. 16 07960 MOB	0	o	0	o	0	194. 16
194. 17 07961 ASB	0	o	0	o	0	194. 17
194. 18 07962 MAB	0	o	0	o	0	194. 18
200.00 Cross Foot Adjustments	0	o	0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	o	O	194, 137	287, 328	360, 170	202. 00

Provi der CCN: 150088

			-	To 06/30/2016 Date/Time Pro	
Cost Center Description	Subtotal	Intern &	Total	117 227 2010 3	. 25 piii
		Residents Cost & Post			
		Stepdown			
		Adjustments			
CENEDAL SEDVICE COST CENTEDS	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & FLXT					1.00
1.01 00101 NEW CAP REL COSTS-BLDG & FIXT					1. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5. 00
6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT					6. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10. 00
11. 00 01100 CAFETERI A					11.00
12.00 O1200 MAINTENANCE OF PERSONNEL 13.00 O1300 NURSING ADMINISTRATION					12. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 01700 SOCI AL SERVI CE					17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS 20. 00 02000 NURSI NG SCHOOL					19. 00 20. 00
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD					21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD					22. 00
23.00 02300 PARAMED ED PRGM					23. 00
23. 01 02301 SCH OF RADI OLOGY					23. 01 23. 02
23. 02 02302 PHARMACY RESI DENCY I NPATI ENT ROUTI NE SERVI CE COST CENTERS					23.02
30. 00 03000 ADULTS & PEDIATRICS	28, 005, 455	0	28, 005, 45	5	30.00
31.00 03100 INTENSIVE CARE UNIT	8, 779, 414	0	8, 779, 41	4	31.00
32. 00 03200 CORONARY CARE UNIT	C	1 1	(32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT			())	33. 00 34. 00
40. 00 04000 SUBPROVI DER - 1 PF			,		40.00
41. 00 04100 SUBPROVI DER - RF	2, 610, 604	Ō	2, 610, 60	4	41. 00
42. 00 04200 SUBPROVI DER	C	0	(D	42. 00
43. 00 04300 NURSERY	1, 219, 286		1, 219, 28	5	43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY			() J	44. 00 45. 00
45. 01 04510 I CF/MR		1			45. 01
46.00 O4600 OTHER LONG TERM CARE	c	0	(46. 00
ANCILLARY SERVICE COST CENTERS	04 000 405	- 0	04 000 40	-	
50.00 05000 OPERATING ROOM 50.01 05001 SURGERY CENTER	21, 338, 105	1	21, 338, 10))	50. 00 50. 01
51. 00 05100 RECOVERY ROOM					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	795, 018	B o	795, 01	3	52. 00
53. 00 05300 ANESTHESI OLOGY	1, 409, 510	0	1, 409, 510		53. 00
54. 00 05400 RADI OLOGY -DI AGNOSTI C	8, 716, 450		8, 716, 450		54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	3, 577, 897	1	3, 577, 89	7	55. 00 56. 00
57. 00 05700 CT SCAN	1, 010, 883	1	1, 010, 88		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 315, 822	0	1, 315, 82	2	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.044.556		0.044.55		59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	8, 041, 559		8, 041, 55	7 	60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			,		61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	d	o			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	611, 315	1	611, 31	5	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	2 541 476		0 541 47		64. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 541, 478 3, 513, 597	1	2, 541, 478 3, 513, 59		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 191, 449	1	2, 191, 44		67. 00
68.00 06800 SPEECH PATHOLOGY	303, 054	1	303, 05		68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 045, 222	1	4, 045, 22		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 302, 551	1	1, 302, 55		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	9, 091, 714 6, 450, 792	1	9, 091, 71, 6, 450, 79;		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	36, 117, 225	1	36, 117, 22		73. 00
74.00 07400 RENAL DIALYSIS		o	(74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0			75. 00
76. 00 03190 CHEMOTHERAPY OUTPATIENT SERVICE COST CENTERS	1, 759, 538	8 0	1, 759, 53	3	76. 00
88. 00 08800 RURAL HEALTH CLINIC		ol	(ol	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
-					

Provi der CCN: 150088

			''	11/22/2016	3: 25 pm
Cost Center Description	Subtotal	Intern &	Total		
	R€	esidents Cost			
		& Post			
		Stepdown Adjustments			
	24. 00	25. 00	26. 00		
90. 00 09000 CLI NI C	0	0	0		90.00
90. 01 09001 ANDERSON CENTER OP CLINIC	1, 307, 714	O	1, 307, 714		90. 01
91. 00 09100 EMERGENCY	8, 675, 109	0	8, 675, 109		91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0		97. 00
99. 00 09900 CMHC 99. 10 09910 CORF	0	O O	0		99. 00 99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	ol Ol	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	0		101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0		106.00
107. 00 10700 LIVER ACQUISITION	o	o	0		107. 00
108.00 10800 LUNG ACQUISITION	O	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	O	O	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0		115. 00
116. 00 11600 HOSPI CE	1/4 720 7/1	0	1/4 700 7/1		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	164, 730, 761	0	164, 730, 761		118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	68, 732	0	68, 732		190. 00
191. 00 19100 RESEARCH	225, 377	0	225, 377		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	7, 128, 065	Ö	7, 128, 065		192.00
193. 00 19300 NONPAI D WORKERS	0	0	0		193. 00
194. 00 07950 FOUNDATI ON	378, 527	O	378, 527		194.00
194. 02 07951 CHI LDREN' S CLI NI C	645, 265	0	645, 265		194. 02
194.04 07952 HEALTH RESOURCE CENTER	137, 013	O	137, 013		194. 04
194. 05 07953 ADOLESCENT RESI DENTI AL	2, 477, 826	0	2, 477, 826		194. 05
194. 07 07954 COMMUNITY BENEFIT/MISSION	842, 100	0	842, 100		194. 07
194. 10 07955 DME	7, 284, 492	0	7, 284, 492		194. 10
194. 12 07956 MED ONE/TWO	-3, 230	0	-3, 230		194. 12
194. 13 07957 UNUSED SPACE	0	0	0		194. 13
194. 14 07958 ADVERTSISING AND MARKETING	1, 464, 538	0	1, 464, 538		194. 14
194. 15 07959 PHYSICIANS RECRUITING 194. 16 07960 MOB	32, 678	0	32, 678		194. 15
194. 16 07960 MOB 194. 17 07961 ASB	-46, 705 7, 173	0	-46, 705 7, 173		194. 16 194. 17
194. 17 07961 ASB 194. 18 07962 MAB	3, 811	0	3, 811		194. 17
200.00 Cross Foot Adjustments	3,011	ol	3, 011 N		200. 00
201.00 Negative Cost Centers	ol Ol	o	n		201. 00
202.00 TOTAL (sum lines 118-201)	185, 376, 423	o	185, 376, 423		202. 00
		-		'	

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150088

				To	06/30/2016	Date/Time Pre 11/22/2016 3:	pared: 25 pm
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs	1 00	1 01	2.4	4.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	1. 01	2A	4. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 NEW CAP REL COSTS-BLDG & FLXT	2 771	20. 700	0	22 550	22 550	1. 01
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	2, 771 3, 333, 749	29, 788 0	0	32, 559 3, 333, 749	32, 559 7, 673	4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	45, 259	268, 136	Ö	313, 395	225	6. 00
7.00	00700 OPERATION OF PLANT	o	0	0	o	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	1, 359	37, 859		39, 218	0	8.00
9. 00 10. 00	01000 DI ETARY	3, 811 2, 330	47, 988 133, 883	1	51, 799 136, 213	12	9. 00 10. 00
11. 00	01100 CAFETERI A	2, 731	0	ő	2, 731	14	11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	O	0	0	O	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	178, 147	23, 491	0	201, 638	370	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	47, 419 459, 409	76, 285 22, 698	1	123, 704 482, 107	250 1, 631	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 957	25, 079	1	31, 036	420	16. 00
17. 00	01700 SOCIAL SERVICE	o	0	0	o	0	17. 00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 21. 00	02000 NURSI NG SCHOOL 02100 L&R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	o o	0	0	ő	0	22. 00
23. 00	02300 PARAMED ED PRGM	O	625		625	56	23. 00
23. 01	02301 SCH OF RADI OLOGY	0	529	1	529	88	23. 01
23. 02	02302 PHARMACY RESIDENCY I NPATIENT ROUTINE SERVICE COST CENTERS	0	481	0	481	46	23. 02
30. 00	03000 ADULTS & PEDIATRICS	192, 574	367, 329	0	559, 903	6, 311	30. 00
31. 00	03100 INTENSIVE CARE UNIT	260, 894	70, 513	0	331, 407	1, 816	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	o o	0	0	ő	0	40. 00
41.00	04100 SUBPROVI DER - I RF	23, 704	48, 099	0	71, 803	483	41. 00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	9, 608	4, 771	0	14, 379	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY		0	0	0	0	45.00
45. 01	04510 I CF/MR	0	0	0	0	0	45. 01
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	2, 169, 994	97, 275	0	2, 267, 269	869	50.00
50. 01	05001 SURGERY CENTER	0	0	ő	0	0	50. 01
51. 00	05100 RECOVERY ROOM	0	0	0	o	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	73, 190	79, 950	0	153, 140	0	52.00
53. 00 54. 00		774, 211	74, 096	0	848, 307	0 1, 597	
55. 00	1 1	605, 013	74, 070	0	605, 013	510	
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	3, 312	2, 650	I	5, 962	241	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	451, 715 0	4, 824 0	0	456, 539 0	149 0	58. 00 59. 00
60.00	06000 LABORATORY	21, 616	60, 335	Ö	81, 951	19	60.00
60. 01	06001 BLOOD LABORATORY	o	0	0	o	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0		61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62. 00 63. 00
64. 00	06400 NTRAVENOUS THERAPY	o o	0	0	o	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	52, 744	34, 333	0	87, 077	655	65. 00
66. 00	06600 PHYSI CAL THERAPY	221, 485	45, 857	1	267, 342	800	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	707 2, 356	30, 418 0		31, 125 2, 356	612 88	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	249, 503	41, 182	-	290, 685	992	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	49, 151	56, 006	1	105, 157	223	70. 00
71. 00		0	0	0	0	0	71. 00
72. 00 73. 00	1	0	0	0	0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS		0		0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	o	o	0	75. 00
76. 00		70, 844	0	0	70, 844	479	76. 00
90 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		^		ما	0	88. 00
00.00	OGOOO NORME TIEMETTI GETIVI G	0	0	0	0	0	1 00.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150088

				10	00/30/2010	11/22/2016 3:	
			CAPI TAL REI	ATED COSTS		1172272010 01	
Cost Ce	nter Description	Directly	NEW BLDG &	NEW BLDG &	Subtotal	EMPLOYEE	
		Assigned New	FLXT	FLXT		BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	1. 01	2A	4. 00	
	LY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90. 00 09000 CLI NI C		0	0	0	0	0	90. 00
90. 01 09001 ANDERSO	N CENTER OP CLINIC	2, 209	16, 835	0	19, 044	349	90. 01
91. 00 09100 EMERGEN	CY	29, 954	108, 246	0	138, 200	1, 921	91. 00
	TION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REI MBUR	SABLE COST CENTERS						
	OGRAM DIALYSIS	0	0		0	0	94.00
95. 00 09500 AMBULAN		0	0	0	0	0	95.00
	MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
	MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
99.00 09900 CMHC		0	0	0	0	0	99. 00
99. 10 09910 CORF		0	0	0	0	0	99. 10
100.00 10000 I &R SER	VICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HE	ALTH AGENCY	0	0	0	0	0	101. 00
	SE COST CENTERS						
105. 00 10500 KI DNEY		0	0		0		105. 00
106.00 10600 HEART A		0	0		0		106. 00
107. 00 10700 LIVER A	CQUI SI TI ON	0	0	0	0	0	107. 00
108.00 10800 LUNG AC		0	0	0	0	0	108. 00
109. 00 10900 PANCREA		0	0	0	0		109. 00
110. 00 11000 I NTESTI		0	0	0	0		110. 00
111. 00 11100 I SLET A		0	0	0	0	0	111. 00
113. 00 11300 I NTERES							113. 00
114. 00 11400 UTI LI ZA							114. 00
	ORY SURGICAL CENTER (D.P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE		0	0	0	0		116. 00
	LS (SUM OF LINES 1-117)	9, 347, 726	1, 809, 561	0	11, 157, 287	28, 899	118. 00
	LE COST CENTERS						
1 1	LOWER, COFFEE SHOP & CANTEEN	0	9, 052		9, 052		190. 00
191. 00 19100 RESEARC		25, 784	0		25, 784		191. 00
	ANS' PRIVATE OFFICES	127, 058	8, 797	0	135, 855		192. 00
193. 00 19300 NONPALD		0	0	0	0		193. 00
194. 00 07950 FOUNDAT		121	3, 059		3, 180		194. 00
194. 02 07951 CHI LDRE		9, 209	0		9, 209		194. 02
194. 04 07952 HEALTH		0	2, 660		2, 660		194. 04
194. 05 07953 ADOLESC		3, 708	48, 536		52, 244		194. 05
194. 07 07954 COMMUNI	TY BENEFIT/MISSION	17, 814	13, 684		31, 498		194. 07
194. 10 07955 DME		82, 124	44, 674		126, 798		194. 10
194. 12 07956 MED ONE		0	0		0		194. 12
194. 13 07957 UNUSED		0	0	١	0		194. 13
194. 14 07958 ADVERTS		0	12, 155		12, 155		194. 14
194. 15 07959 PHYSI CI	ANS RECRUITING	0	0	· -	0		194. 15
194. 16 07960 MOB		0	0	· -	0		194. 16
194. 17 07961 ASB		3, 595	0	0	3, 595		194. 17
194. 18 07962 MAB		0	0	0	0	0	194. 18
	oot Adjustments				0		200. 00
	e Cost Centers	_	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	9, 617, 139	1, 952, 178	0	11, 569, 317	32, 559	202. 00

Provi der CCN: 150088

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	11/22/2016 3: HOUSEKEEPI NG	
oost conten bescription	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
GENERAL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP REL COSTS-BLDG & FIXT						1. 01
4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT 5.00 OO500 ADMINISTRATIVE & GENERAL	3, 341, 422					4. 00 5. 00
6. 00 00600 MAINTENANCE & REPAIRS	187, 696	501, 316				6.00
7.00 00700 OPERATION OF PLANT	0	0	0			7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	14, 049	11, 470	1	64, 737		8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	58, 386 16, 045	14, 538 40, 561		67	124, 790 0	9. 00 10. 00
11. 00 01100 CAFETERI A	37, 237	40, 501		0	2, 164	1
12. 00 01200 MAINTENANCE OF PERSONNEL	0	0	Ö	0	0	12. 00
13.00 O1300 NURSING ADMINISTRATION	28, 007	7, 117	1	0	117	1
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	14, 812 101, 402	23, 111 7, 022		2, 862	737 421	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	36, 237	7, 022 7, 598		0	234	1
17. 00 01700 SOCIAL SERVICE	0	0	Ö	0	0	17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19. 00
20.00 02000 NURSI NG SCHOOL 21.00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	20.00
22. 00 02200 &R SERVI CES-SALARY & FRINGES APPRVD		0		0	0	22.00
23. 00 02300 PARAMED ED PRGM	3, 326	189	Ō	0	0	23. 00
23. 01 02301 SCH OF RADI OLOGY	4, 971	160	1	0	0	23. 01
23. 02 02302 PHARMACY RESIDENCY I NPATIENT ROUTINE SERVICE COST CENTERS	6, 230	146	0	0	0	23. 02
30. 00 03000 ADULTS & PEDIATRICS	386, 542	111, 287	· 0	24, 003	49, 700	30.00
31. 00 03100 INTENSIVE CARE UNIT	127, 283	21, 362			11, 349	1
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF	0	0		0	0	34. 00 40. 00
41. 00 04100 SUBPROVI DER - RF	32, 621	14, 572	e o	2, 912	7, 277	1
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NURSERY	17, 418	1, 446	0	1, 144	2, 951	
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0	0	0	0	0	44. 00 45. 00
45. 01 04510 I CF/MR	o o	0	o o	0	0	45. 01
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	340, 450	29, 470	0	4, 953	18, 684	50.00
50. 01 05001 SURGERY CENTER	340, 430	29, 470	1	.,	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	4, 458	24, 221	0	83	442	1
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C	24, 815 128, 413	22, 448	0	5, 101	0 4. 984	53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	59, 950	22, 440		1, 147	4, 784	
56. 00 05600 RADI OI SOTOPE	0	0	0	0	0	
57. 00 05700 CT SCAN	15, 096	803	1	0	0	
58.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON	21, 959	1, 462	0	_	234	58. 00 59. 00
60. 00 06000 LABORATORY	129, 438	18, 279	1	_	4, 001	1
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	10, 850	0		0	0	62. 00 63. 00
64. 00 06400 I NTRAVENOUS THERAPY	10, 630	0	o o	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	39, 084	10, 401	0	0	117	65. 00
66. 00 06600 PHYSI CAL THERAPY	55, 217	13, 893			1, 579	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	34, 830 4, 762	9, 215	0	0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	63, 317	12, 476	Ö	13	1, 966	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	15, 538	16, 968	1	76	1, 615	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	71. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENT 73.00 O7300 DRUGS CHARGED TO PATIENTS	115, 391 530, 400	0	0	0	0	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	530, 400	0		0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	Ö	0	o o	o o	Ö	75. 00
76. 00 03190 CHEMOTHERAPY	29, 573	0	0	1, 655	0	76. 00
88. 00 O8800 RURAL HEALTH CLINIC				0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
90. 00 09000 CLI NI C	o	0	Ō	0	0	90. 00
90. 01 09001 ANDERSON CENTER OP CLINIC	20, 895	5, 100	1	0	12.074	90. 01
91. 00 09100 EMERGENCY	117, 465	32, 794	0	9, 838	12, 074	91.00

Heal th Financial Systems

ST VINCENT ANDERSON REGIONAL HOSPITA

In Lieu of Form CMS-2552-10

Provider CCN: 150088

Period:
From 07/01/2015
To 06/30/2016

Part II
Date/Time Prepared:
11/22/2016 3: 25 pm

Cost Center Description

ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPING

& GENERAL REPAIRS PLANT LINEN SERVICE

5.00 6.00 7.00 8.00 9.00

ADMINISTRATIVE NAINTRANNICE & OPERATION OF LAWNRY & HOUSEKEEPING REPAIR NO						11/22/2016 3:	25 pm
22.00 09200 08SERVATION BEDS (NON-DISTINCT PART)	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
92.00							
OTHER REIMBURSABLE COST CENTERS		5. 00	6. 00	7. 00	8. 00	9. 00	
94.00 00400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00 95.00 09500 ABBULANCE SERVI CES 0 0 0 0 0 0 95.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 97.00 97.00 09700 00400 0040 00 0 0 0 0							92. 00
95. 00 095.00 AMBILLANCE SERVICES 0 0 0 0 0 95. 00 96. 00 096.00 097.00 097.00 097.00 099.00 090.00							
99. 00 09000 DURABLE MEDI CAL EQUI P-ENTED 0 0 0 0 0 0 0 0 0		0	0	C	0	0	94. 00
97. 00 09700 DURBALE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 0 0		0	0	C	0	0	95. 00
99. 00 09900 CMHC 99. 10 09910 CORF 100. 00 10000 LAR SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96.00
99.10 09910 00PF 0 0 0 0 0 0 0 0 0	97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97.00
100.00 100.00 100.00 100.00 100.00 0 0 0 0 0 100.00 101.00	99. 00 09900 CMHC	o	0		0	0	99. 00
101.00 10100 NOBE HEALTH AGENCY 0 0 0 0 0 101.00	99. 10 09910 CORF	o	0		0	0	99. 10
101.00 10100 NOBE HEALTH AGENCY 0 0 0 0 0 101.00	100.00 10000 L&R SERVICES-NOT APPRVD PRGM	o	0		0	0	100.00
SPECIAL PURPOSE COST CENTERS		o	0		0		
105. 00 10500 KI DNEY ACQUISITION		<u> </u>					1.01.00
106.00 10600 IEART ACQUISITION			0		0	n	105 00
107.00 10700 LIVER ACQUISITION		-	0	1			
108.00 10800 LUNG ACQUISITION			0		0		
109. 00 10900 ANCREAS ACQUISITION		0	0		0		
110.00 11000 NTESTI NAL ACQUI SI TI ON		0	0		0		
111.00 11100 1SLET ACQUISITION 0 0 0 0 111.00 113.00 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 114.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 0 0 0 115.00 11		0	0		0		
113. 00 11300 INTEREST EXPENSE		0	0		0		
114. 00 11400 UTILLIZATI ON REVIEW-SNF	· · · · · · · · · · · · · · · · · · ·	U U	0		0	U	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 0 115. 00							
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) 2, 996, 818 458, 109 0 62, 582 121, 055 118. 00							
118. 00 SUBTOTALS (SUM OF LINES 1-117) 2, 996, 818 458, 109 0 62, 582 121, 055 118. 00		0	0		0		
NONREI MBURSABLE COST CENTERS 190. 00 1900.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 212 2,742 0 0 0 0 190.00 1910.00 RESEARCH 3,972 0 0 0 0 1910.00 1920.00 1920.00 1920.00 1920.00 1920.00 1920.00 1930.00		0	0	0	0		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 212 2,742 0 0 0 0 0 191. 00 191. 00 19100 RESEARCH 3,972 0 0 0 0 0 191. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 194. 00 0795. FOUNDATI ON 6,318 927 0 0 0 94 194. 00 194. 00 194. 02 07951 CHI LDREN'S CLI NI C 10,363 0 0 0 73 1,521 194. 02 194. 04 07952 HEALTH RESOURCE CENTER 2,097 806 0 0 0 194. 04 194. 05 07953 ADOLESCENT RESI DENTI AL 35,545 14,705 0 0 0 0 194. 05 194. 07 07954 COMMUNI TY BENEFI T/MI SSI ON 13,031 4,146 0 0 0 225 194. 07 194. 10 194. 12 10 194. 12 10 194. 12 10 194. 12 10 194. 12 10 194. 12 10 194. 12 10 194. 13 07956 MED ONE/TWO 0 0 0 0 0 194. 12 194. 13 07958 ADVERTSI SI NG AND MARKETI NG 24,952 3,682 0 0 0 117 194. 14 194. 15 10 1959 PHYSI CI ANS RECRUI TI NG 589 0 0 0 0 0 117 194. 16 194. 17 107961 ASB 57 0 0 0 0 0 140 194. 17 194. 18 194. 18 07962 MAB 10 0 0 38 94 194. 18 194. 18 07960 MAB 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2, 996, 818	458, 109	C	62, 582	121, 055	118. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 193. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 123, 776							
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 0 193.00 194.00 07950 FOUNDATION 194.00 07950 FOUNDATION 194.02 07951 CHILDREN'S CLINIC 194.04 07952 HEALTH RESOURCE CENTER 2,097 806 0 0 0 194.04 194.05 07953 ADOLESCENT RESIDENTIAL 35,545 14,705 0 0 0 194.05 194.10 07955 DME 123,682 13,534 0 0 117 194.10 194.12 07956 MED ONE/TWO 0 0 0 87 0 194.12 194.13 07957 UNUSED SPACE 0 0 0 0 194.13 194.14 07958 ADVERTSISING AND MARKETING 24,952 3,682 0 0 117 194.14 194.15 07959 PHYSICIANS RECRUITING 589 0 0 0 194.15 194.16 07960 MOB 0 0 0 0 0 194.15 194.18 07960 MB 10 07961 ASB 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2, 742		0		
193. 00 19300 19300 19300 19300 19300 19300 19300 194. 10 194. 10 19			0	·	0		
194. 00 07950 FOUNDATION 6, 318 927 0 0 94 194. 00 194. 02 194. 02 07951 CHI LDREN'S CLINIC 10, 363 0 0 0 73 1, 521 194. 02 194. 04 07952 HEALTH RESOURCE CENTER 2, 097 806 0 0 0 194. 04 194. 05 07953 ADOLESCENT RESI DENTI AL 35, 545 14, 705 0 0 0 194. 05 194. 07 07954 COMMUNI TY BENEFI T/MI SSI ON 13, 031 4, 146 0 0 0 225 194. 07 194. 10 07955 DME 123, 682 13, 534 0 0 0 117 194. 10 194. 12 07956 MED ONE/TWO 0 0 0 87 0 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 24, 952 3, 682 0 0 0 117 194. 14 194. 15 07959 PHYSI CI ANS RECRUI TI NG 589 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		123, 776	2, 665	0	1, 957		
194. 02 07951 CHI LDREN'S CLINIC 10, 363 0 0 73 1, 521 194. 02 194. 04 07952 HEALTH RESOURCE CENTER 2, 097 806 0 0 0 194. 04 194. 05 07953 ADOLESCENT RESI DENTI AL 35, 545 14, 705 0 0 0 194. 05 194. 07 07954 COMMUNI TY BENEFI T/MI SSI ON 13, 031 4, 146 0 0 0 225 194. 07 194. 10 07955 DME 123, 682 13, 534 0 0 0 117 194. 10 194. 12 07956 MED ONE/TWO 0 0 0 87 0 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 87 0 194. 13 194. 14 10 194. 15 07959 PHYSI CI ANS RECRUI TI NG 589 0 0 0 117 194. 14 194. 15 194. 16 07960 MOB 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	C	0		
194. 04 07952 HEALTH RESOURCE CENTER 2,097 806 0 0 194. 04 194. 05 194. 05 194. 07 194. 07 194. 07 194. 07 194. 07 194. 10 194			927	[C	0		
194. 05 07953 ADOLESCENT RESIDENTIAL 35, 545 14, 705 0 0 0 194. 05 194. 07 07954 COMMUNI TY BENEFIT/MI SSI ON 13, 031 4, 146 0 0 225 194. 07 194. 10 07955 DME 123, 682 13, 534 0 0 117 194. 10 194. 12 07956 MED ONE/TWO 0 0 87 0 194. 13 07957 UNUSED SPACE 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 24, 952 3, 682 0 0 117 194. 14 194. 15 07959 PHYSI CI ANS RECRUI TI NG 589 0 0 0 117 194. 15 194. 16 07960 MOB 0 0 0 0 0 117 194. 15 194. 16 07960 MOB 579 DASB 579 0 0 0 0 117 194. 16 194. 17 194. 18 07962 MAB 579 0 0 0 38 94 194. 17 194. 18 07962 MAB 570 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		10, 363	0	C	73		
194. 07 07954 COMMUNI TY BENEFI T/MI SSI ON 13, 031 4, 146 0 0 225 194. 07 194. 10 07955 DME 123, 682 13, 534 0 0 117 194. 10 194. 12 07956 MED ONE/TWO 0 0 0 0 87 0 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 24, 952 3, 682 0 0 0 117 194. 15 194. 16 07959 PHYSI CI ANS RECRUI TI NG 589 0 0 0 0 0 117 194. 15 194. 17 07961 ASB 0 0 0 0 0 117 194. 15 194. 18 07962 MAB 57 0 0 0 38 94 194. 18 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td>2, 097</td> <td></td> <td></td> <td>0</td> <td>0</td> <td>194. 04</td>		2, 097			0	0	194. 04
194. 10 07955 DME 123, 682 13, 534 0 0 117 194. 10 194. 12 07956 MED ONE/TWO 0 0 0 87 0 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSISING AND MARKETING 24, 952 3, 682 0 0 177 194. 14 194. 15 07959 PHYSI CI ANS RECRUITING 589 0 0 0 177 194. 15 194. 16 07960 MOB 0 0 0 0 0 117 194. 16 194. 17 07961 ASB 57 0 0 0 140 194. 17 194. 18 07962 MAB 10 0 0 38 94 194. 18 07962 MAB 10 0 0 0 38 94 194. 18 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 05 07953 ADOLESCENT RESIDENTIAL	35, 545	14, 705	C	0	0	194. 05
194. 12 07956 MED ONE/TWO 0 0 0 87 0 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 24, 952 3, 682 0 0 0 117 194. 14 194. 15 07959 PHYSI CI ANS RECRUI TI NG 589 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 0 117 194. 16 194. 17 07961 ASB 57 0 0 0 140 194. 17 194. 18 07962 MAB 10 0 0 38 94 194. 18 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194.07 07954 COMMUNITY BENEFIT/MISSION	13, 031	4, 146	C	0	225	194. 07
194. 13 07957 UNUSED SPACE 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 24, 952 3, 682 0 0 117 194. 14 194. 15 07959 PHYSI CI ANS RECRUI TI NG 589 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 0 117 194. 16 194. 17 07961 ASB 57 0 0 0 140 194. 17 194. 18 07962 MAB 10 0 0 38 94 194. 18 200. 00 Cross Foot Adjustments 0 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 10 07955 DME	123, 682	13, 534	C	0	117	194. 10
194. 14 07958 ADVERTSI SI NG AND MARKETI NG 24, 952 3, 682 0 0 117 194. 14 194. 15 07959 PHYSI CI ANS RECRUI TI NG 589 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 0 117 194. 15 194. 17 07961 ASB 57 0 0 0 140 194. 17 194. 18 07962 MAB 10 0 38 94 194. 18 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0	194.12 07956 MED ONE/TWO	o	0	C	87	0	194. 12
194. 15 07959 PHYSI CI ANS RECRUITING 589 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 117 194. 16 194. 17 07961 ASB 57 0 0 0 0 140 194. 17 194. 18 07962 MAB 10 0 0 38 94 194. 18 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00	194. 13 07957 UNUSED SPACE	o	0	l c	0	0	194. 13
194. 15 07959 PHYSI CI ANS RECRUITING 589 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 117 194. 16 194. 17 07961 ASB 57 0 0 0 0 140 194. 17 194. 18 07962 MAB 10 0 0 38 94 194. 18 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00	194.14 07958 ADVERTSLSING AND MARKETING	24, 952	3. 682	l c	0	117	194, 14
194. 16 07960 MOB 0 0 0 117 194. 16 194. 17 07961 ASB 57 0 0 0 140 194. 17 194. 18 07962 MAB 10 0 0 38 94 194. 18 200. 00 Cross Foot Adjustments 200. 00 Negative Cost Centers 0 0 0 0 0 201. 00			0		0	0	194, 15
194. 17 07961 ASB 57 0 0 0 140 194. 17 194. 18 07962 200. 00 201. 00 Negati ve Cost Centers 57 0 0 0 0 0 140 194. 17 194. 18 07962 0 0 0 0 0 0 0 0 0			0	0	0		
194. 18 07962 MAB 10 0 0 38 94 194. 18 200. 00 201. 00 Negative Cost Centers 0 0 0 0 201. 00		57	0		0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	· ·		0	١	38		
201.00 Negative Cost Centers 0 0 0 0 0 201.00		"	O			/ -	
			0		0	n	
202. 00 101AL (30 11163 110-201) 3,341,422 301,310 0 04,737 124,790 202.00		3 3/1 /22	501 214		64 727		
	202.00 TOTAL (30111 TITIES TTO 201)	3, 571, 422	301, 310	1	04, 737	124, 770	1202.00

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST VINCENT ANDERSON REGIONAL HOSPITA Provi der CCN: 150088

				Т	0 06/30/2016	Date/Time Pre 11/22/2016 3:	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL	20 pm
		10.00	11. 00	12.00	13. 00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00 1. 01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6. 00
7. 00 8. 00	00700 OPERATION OF PLANT						7. 00 8. 00
9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY	192, 831					10. 00
11. 00	01100 CAFETERI A	0	42, 146				11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	1			12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	562	•		1// 170	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	694 2, 364	•	_	166, 170 4, 996	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	935			0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0		0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	1	_	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	_	0	20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	0	111		0	1	23. 00
23. 01	02301 SCH OF RADI OLOGY	O	161			0	23. 01
23. 02	02302 PHARMACY RESIDENCY	0	226	0	0	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	126, 118	8, 938 3, 172		· ·	8, 512 8, 095	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	33, 114	3, 172			0,095	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	o	0		_	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	-		0	40. 00
41. 00	04100 SUBPROVI DER - I RF	13, 727	839		-,	503	41. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	4, 445	0 541	0	_	0 1, 012	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	4, 445	0	0		1,012	44. 00
45. 00	04500 NURSING FACILITY	O	0	Ö	_	0	45. 00
45. 01	04510 I CF/MR	0	0	0	0	0	45. 01
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	1, 451	0	15, 200	77, 528	50. 00
50. 00	05001 SURGERY CENTER	0	1, 431	1	· ·	77, 320	50. 00
51.00	05100 RECOVERY ROOM	0	0	0		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	665	81	0	847	151	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 55. 00	05400 RADI OLOGY - DI AGNOSTI C	0	3, 258			15, 361	54.00
56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	833	0	8, 722 0	2, 175 0	
57. 00	05700 CT SCAN	O	447	Ö	Ö	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	229	0	0	203	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		_	0	59. 00
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	0	43 0			16, 579	60.00
60. 01 61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	U	U	0	0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	О	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0			0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0	1, 110		_	4, 948	•
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	1, 401 907			852 50	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	120			3, 580	68. 00
69. 00	06900 ELECTROCARDI OLOGY		1, 608	1		5, 445	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	402		0	258	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	_	0	71. 00
72.00	07200 DRUCS CHARGED TO PATIENT	0	0	0	_	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0	0		0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0			0	75. 00
76. 00	03190 CHEMOTHERAPY	o	896	•		4, 328	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0			0	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		0	0		0	89. 00 90. 00
90. 00	09001 ANDERSON CENTER OP CLINIC		703			0	
-	t t						

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150088

Cost Center Description				1	To 06/30/2016	Date/Time Pre 11/22/2016 3:	
91 .00 09100 EMERGENCY 0 3,588 0 37,586 10,915 91.00 92.00 95.00 99.200 095.62NTI ON BEDS (NON-DISTINCT PART) 92.00 97.00	Cost Center Description	DI ETARY	CAFETERI A			CENTRAL SERVI CES &	
97.00 O9100 DMERCENCY O 3, 588 O 37, 586 10, 915 91.00 O OTHER REINBURSABLE COST CENTERS O O O O O O O O O		10, 00	11. 00	12.00	13.00		
92.00	91. 00 09100 EMERGENCY						91. 00
94.0 00400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0 94.00 95.00 09600 00400 ABBULANCE SERVICES 0 0 0 0 0 0 0 0 0	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					•	92.00
95.00 095.00 ADBILLANCE SERVICES 0 0 0 0 0 0 0 0 0	OTHER REIMBURSABLE COST CENTERS	<u> </u>			<u> </u>		
99. 00 096.00 DURABLE MEDI CAL EQUI P-ENTED 0 0 0 0 0 0 0 0 0	94.00 09400 HOME PROGRAM DIALYSIS	0	0	(0	0	94. 00
97. 00 09700 DURBALE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 0 0	95. 00 09500 AMBULANCE SERVICES	o	0		ol ol	0	95. 00
99. 00 09900 CMHC 99. 10 09910 CORF 99. 10 09910 CORF 100. 00 10000 I AR SERVICES-NOT APPRVD PRGM 0	96.00 09600 DURABLE MEDICAL EQUIP-RENTED	O	0	(o	0	96. 00
99.10 09910 00PF 0 0 0 0 0 0 0 0 0	97.00 09700 DURABLE MEDICAL EQUIP-SOLD	O	0	(o o	0	97. 00
100.00 10000 LAR SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 100.00	99. 00 09900 CMHC	O	0	(o o	0	99. 00
101.00 10100 NOBE HEALTH AGENCY 0	99. 10 09910 CORF	0	0	(0	0	99. 10
SPECIAL PURPOSE COST CENTERS	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	(0	0	100. 00
105.00 10500 KLDNEY ACQUISITION	101.00 10100 HOME HEALTH AGENCY	0	0	(0	0	101. 00
106.00 10600 HEART ACQUISITION	SPECIAL PURPOSE COST CENTERS						
107.00 10700 LIVER ACQUISITION		0	0	(0		
108.00 108.00 108.00 109.00 1		0	0	(0		
109. 00 10900 PANCREAS ACQUISITION		0	0	(0		
110.00 11000 NTESTI NAL ACQUI SITION		0	0	(0		
111. 00 11100 1SLET ACQUISITION 0 0 0 0 111. 00 113. 00 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILI ZATI ON REVIEW-SNF 114. 00 115.		0	0	(0		
113. 00 11300 INTEREST EXPENSE		0	0	(0		
114, 00 11400 UTILLIZATI ON REVIEW-SNF		0	0	(0	0	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)							
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) 178,069 35,620 0 237,811 165,492 18. 00							
118.00 SUBTOTALS (SUM OF LINES 1-117) 178,069 35,620 0 237,811 165,492 118.00 NONRE IMBURSABLE COST CENTERS 0 0 0 0 0 0 190.00 191.00 191.00 191.00 191.00 191.00 191.00 191.00 192.		0	0	(이		1
NONRE MBURSABLE COST CENTERS 190. 00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 98 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 2, 142 0 0 122 192.00 193.00 193.00 193.00 NONPAI D WORKERS 0 0 0 0 0 193.00 194.00 195.00 FOUNDATI ON 0 119 0 0 0 194.00 194.00 195.00 190.00 190.00 190.00 194.00 195.00 190.00 190.00 190.00 194.00 195.00 190.00 190.00 194.00 194.00 194.00 194.00 194.00 195.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00		0	0	1	7		
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 98 0 0 0 191. 00 1910 RESEARCH 0 98 0 0 0 191. 00 1910 RESEARCH 0 98 0 0 0 191. 00 1920 RESEARCH 0 98 0 0 0 191. 00 1920 RESEARCH 0 192. 00 1920 RESEARCH 0 1920 RESEARCH 1920		178, 069	35, 620	() 237, 811	165, 492	1118. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 193. 00 19300 NONPAI D WORKERS 194. 00 07950 FOUNDATI ON 194. 00 07950 FOUNDATI ON 194. 02 07951 CHI LDREN' S CLI NI C 194. 04 07952 HEALTH RESOURCE CENTER 194. 05 07953 ADOLESCENT RESI DENTI AL 194. 07 07954 COMMUNI TY BENEFI T/MI SSI ON 194. 10 07955 DME 194. 10 07955 DME 194. 12 07956 MED ONE/TWO 194. 13 07957 UNUSED SPACE 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 194. 15 07959 PHYSI CI ANS RECRUI TI NG 194. 16 07960 MOB 195. 00 194. 17 07961 ASB 194. 17 07961 ASB 194. 18 07962 194. 18 07962 194. 18 07962 194. 18 07962 194. 18 07962 194. 18 07962 194. 18 07965 194. 19 07961 ASB 194. 19 07961 ASB 194. 19 07962 194. 18 07962 195. 00 196. 196. 197. 198. 198. 198. 198. 198. 198. 198. 198				l (0	100 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 2,142 0 0 122 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 193.00 194.00 07950 FOUNDATION 0 119 0 0 0 194.00 194.00 194.02 07951 CHILDREN'S CLINIC 0 321 0 0 549 194.02 194.04 07952 HEALTH RESOURCE CENTER 0 76 0 0 71 194.04 194.05 1950 FOUNDATION 0 144.762 1,180 0 0 194.05 194.07 1950 FOUNDATION 0 194.07 194.07 194.10 1955 DME 0 194.07 194.10 1955 DME 0 194.07 194.10 194.12 1950 FOUNDATION 0 194.13 1950 FOUNDATION 0 194.13 194.14 194.15 19795 PHYSICIANS RECRUITING 0 0 0 194.15 194.16 19796 MBB 0 0 0 0 0 0 194.15 194.18 107961 ASB 0 0 0 0 0 0 194.17 194.18 107962 MBB 0 0 0 0 0 0 0 194.17 194.18 107962 MBB 1807962			-	1	1		
193. 00 19300 19300 19300 19300 19300 194. 10 194. 10				1			
194. 00 07950 FOUNDATION 0 119 0 0 0 194. 00 194. 00 194. 02 194. 04 07952 194. 04 07952 194. 04 07952 194. 05 07953 194. 07 07954 194. 07 07954 194. 07 07954 194. 07			•				
194. 02 07951 CHI LDREN'S CLINIC 0 321 0 0 549 194. 02 194. 04 07952 HEALTH RESOURCE CENTER 0 76 0 0 77 194. 04 194. 05 07953 ADOLESCENT RESI DENTI AL 14, 762 1, 180 0 0 0 194. 05 194. 07 07954 COMMUNI TY BENEFI T/MI SSI ON 0 523 0 0 0 194. 07 194. 10 07955 DME 0 2, 067 0 0 0 0 194. 10 07955 DME 0 2, 067 0 0 0 0 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 194. 12 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 0 0 0 0 194. 13 194. 14 07958 PHYSI CI ANS RECRUI TI NG 0 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 0 0 0 194. 15 194. 18 07962 MAB 0 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-	1			
194. 04 07952 HEALTH RESOURCE CENTER 0 76 0 0 7 194. 04 194. 05 07953 ADOLESCENT RESIDENTIAL 14,762 1,180 0 0 194. 05 194. 07 07954 COMMUNI TY BENEFIT/MISSION 0 523 0 0 0 194. 10 194. 12 07956 MED ONE/TWO 0 0 0 0 194. 10 194. 12 07956 MED ONE/TWO 0 0 0 0 0 194. 13 07957 UNUSED SPACE 0 0 0 0 194. 13 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 0 0 0 0 194. 14 194. 15 07959 PHYSI CI ANS RECRUITI NG 0 0 0 0 194. 15 194. 16 07960 MOB ASB 0 0 0 0 0 194. 17 194. 18 07962 MAB 0 0 0 0 0 194. 17 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 One of the content of the conten						-	
194. 05 07953 ADOLESCENT RESIDENTIAL 14,762 1,180 0 0 194. 05 194. 07 194. 10							
194. 07 07954 COMMUNITY BENEFIT/MISSION 0 523 0 0 0 194. 07 194. 10 07955 DME 0 0 0 0 194. 10 194. 12 07956 DME 0 0 0 0 0 0 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSISING AND MARKETING 0 0 0 0 0 194. 13 194. 14 07958 DYST CIANS RECRUITING 0 0 0 0 0 194. 15 07969 PHYSI CIANS RECRUITING 0 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 0 0 0 194. 17 07961 ASB 0 0 0 0 0 0 194. 17 194. 18 07962 MAB 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		14 762		1			
194. 10 07955 DME 0 2, 067 0 0 0 194. 10 194. 12 07956 MED ONE/TWO 0 0 0 0 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSISING AND MARKETING 0 0 0 0 194. 14 194. 15 07959 PHYSI CI ANS RECRUITING 0 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 0 0 194. 15 194. 17 07961 ASB 0 0 0 0 0 0 194. 17 194. 18 07962 MAB 0 0 0 0 0 0 194. 17 194. 18 07962 MAB 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		14, 702					
194. 12 07956 MED ONE/TWO 0 0 0 0 194. 12 194. 13 07957 UNUSED SPACE 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSI SI NG AND MARKETI NG 0 0 0 0 194. 14 194. 15 07959 PHYSI CI ANS RECRUI TI NG 0 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 0 0 0 194. 16 194. 17 07961 ASB 0 0 0 0 0 0 0 194. 16 194. 17 07961 ASB 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1			
194. 13 07957 UNUSED SPACE 0 0 0 0 0 194. 13 194. 14 07958 ADVERTSISING AND MARKETING 0 0 0 0 194. 14 194. 15 07959 PHYSICIANS RECRUITING 0 0 0 0 0 194. 15 194. 16 194. 17 07961 ASB 0 0 0 0 0 0 194. 16 194. 17 07961 MAB 0 0 0 0 0 0 194. 18 07962 MAB 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 0 194. 18 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2,007				
194. 14 07958 ADVERTSISING AND MARKETING 194. 15 07959 PHYSICIANS RECRUITING 194. 16 07960 MOB 194. 17 07961 ASB 194. 18 07962 MAB 200. 00 Cross Foot Adjustments Negative Cost Centers 0 0 0 0 0 194. 14 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 0 0 194. 16 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0				
194. 15 07959 PHYSI CI ANS RECRUI TI NG 194. 16 07960 MOB 194. 17 07961 ASB 0 0 0 0 0 0 194. 16 194. 18 07962 MAB 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 194. 17			0				
194. 16 07960 MOB 0 0 0 0 194. 16 194. 17 07961 ASB 0 0 0 0 0 194. 17 194. 18 07962 MAB 0 0 0 0 0 194. 18 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 201. 00	· · ·		0				
194. 17 07961 ASB 0 0 0 0 0 194. 17 194. 18 07962 MAB 0 0 0 0 0 194. 18 200. 00 0 0 194. 18 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l ol	0		ol ol		
194. 18 07962 MAB 0 0 0 0 194. 18 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00		o	0		ol ol	0	194, 17
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			0		ol ol		
201.00 Negative Cost Centers 0 0 0 0 201.00							200.00
			0		ol ol	0	201. 00
	202.00 TOTAL (sum lines 118-201)	192, 831	42, 146	(237, 811	166, 170	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150088

						11/22/2016 3:	25 pm
	Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	
		15. 00	16. 00	17. 00	19. 00	20.00	
	GENERAL SERVICE COST CENTERS	13.00	10.00	17.00	17.00	20.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-BLDG & FIXT						1. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING			•			9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	500 042					14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	599, 943	76, 460			•	15. 00 16. 00
	01700 SOCIAL SERVICE	0	70, 400	0			17. 00
	01900 NONPHYSICIAN ANESTHETISTS	o	0	Ö	0		19. 00
	02000 NURSI NG SCHOOL	0	0	0)	0	1
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	0			21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22. 00
	02300 PARAMED ED PRGM	0	0	0			23. 00
23. 01 23. 02	O2301 SCH OF RADI OLOGY O2302 PHARMACY RESI DENCY	0	0				23. 01 23. 02
23. 02	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		<u></u>	1		23.02
30.00	03000 ADULTS & PEDI ATRI CS	824	3, 640	0)		30.00
	03100 INTENSIVE CARE UNIT	461	1, 798	0			31. 00
	03200 CORONARY CARE UNIT	0	0	0			32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0			33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0				34. 00 40. 00
41. 00	04100 SUBPROVI DER – T PF	16	376	_			41.00
42. 00	04200 SUBPROVI DER	0	0				42. 00
43.00	04300 NURSERY	31	119	0)		43.00
44.00	04400 SKILLED NURSING FACILITY	O	0	0)		44. 00
45. 00	04500 NURSING FACILITY	0	0				45. 00
45. 01 46. 00	O4510 CF/MR O4600 OTHER LONG TERM CARE	0	0				45. 01 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	ı o	0	1 0	1		40.00
50.00	05000 OPERATING ROOM	1, 242	12, 857	0)		50.00
50. 01	05001 SURGERY CENTER	0	0	•			50. 01
51. 00	05100 RECOVERY ROOM	0	0	_			51.00
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	5	447	i			52. 00 53. 00
54. 00	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 161	1, 117 5, 327	l .			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	6	3, 352	l .			55. 00
56.00	05600 RADI OI SOTOPE	0	0	l .)		56. 00
57.00	05700 CT SCAN	1, 737	1, 738	0)		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 505	477	1			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	7 (52	_			59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	79 0	7, 653 0	1			60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	٩	0				61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	0)		62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	318	0)		63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0			64. 00
65. 00	06500 RESPI RATORY THERAPY	13	1, 900	1			65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	11	865 720	1			66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	87	1			68. 00
69. 00	06900 ELECTROCARDI OLOGY	43	3, 053	1			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	2	627	0)		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 245	1			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	1, 625				72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	591, 840	15, 619 0	1			73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0	•			75.00
76. 00	03190 CHEMOTHERAPY	0	364	_			76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0	0	0			89. 00 90. 00
90. 00	09001 ANDERSON CENTER OP CLINIC	0	230				90.00
		, -1			1	•	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2015 | Part II |
| To 06/30/2016 | Date/Time Prepared: | 11/22/2016 3: 25 pm

				0 00, 00, 20.0	11/22/2016 3:	25 pm
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSING SCHOOL	
		RECORDS &		ANESTHETI STS		
		LI BRARY				
	15. 00	16.00	17. 00	19. 00	20.00	
91. 00 09100 EMERGENCY	405	7, 997	C			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	C			94.00
95. 00 09500 AMBULANCE SERVICES	0	0	ol c			95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0				96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0				97. 00
99. 00 09900 CMHC	ol	0				99.00
99. 10 09910 CORF	ol	0				99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	0	i d			101.00
SPECIAL PURPOSE COST CENTERS		-	-			1
105. 00 10500 KIDNEY ACQUISITION	0	0	0			105. 00
106. 00 10600 HEART ACQUI SI TI ON	l ol	0	1			106.00
107. 00 10700 LI VER ACQUI SI TI ON		0				107. 00
108. 00 10800 LUNG ACQUISITION		0				108.00
109. 00 10900 PANCREAS ACQUISITION		0				109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON		0				110, 00
111. 00 11100 SLET ACQUISITION		0				111.00
113. 00 11300 NTEREST EXPENSE	١	0	1			113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0				115. 00
	0	0				116. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	F00 201	74 EE1	1			118.00
NONREI MBURSABLE COST CENTERS	598, 381	74, 551)[1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	C			190. 00
191. 00 19100 RESEARCH	0	0	1			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 280	478	1			191.00
193. 00 19300 NONPALD WORKERS	1, 280	4/0				193. 00
		0				1
194. 00 07950 FOUNDATION	0	77				194. 00 194. 02
194. 02 07951 CHI LDREN' S CLINI C	282	77				
194. 04 07952 HEALTH RESOURCE CENTER	0	0				194. 04
194. 05 07953 ADOLESCENT RESIDENTIAL	0	257				194. 05
194. 07 07954 COMMUNITY BENEFIT/MISSION	0	4 007				194. 07
194. 10 07955 DME	0	1, 097				194. 10
194. 12 07956 MED ONE/TWO	0	0				194. 12
194. 13 07957 UNUSED SPACE	0	0	1			194. 13
194.14 07958 ADVERTSISING AND MARKETING	0	0	0			194. 14
194. 15 07959 PHYSI CI ANS RECRUI TI NG	0	0	0			194. 15
194. 16 07960 MOB	0	0	l c			194. 16
194. 17 07961 ASB	0	0	l c			194. 17
194. 18 07962 MAB	0	0) C			194. 18
200.00 Cross Foot Adjustments				C		200. 00
201.00 Negative Cost Centers	0	0) C	C		201. 00
202.00 TOTAL (sum lines 118-201)	599, 943	76, 460) c	[C) 0	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150088 | Period:

Peri od: Worksheet B From 07/01/2015 Part II To 06/30/2016 Date/Time Prepared:

11/22/2016 3:25 pm INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED SCH OF **PHARMACY** Y & FRINGES PRGM COSTS PRGM RADI OLOGY RESI DENCY 21.00 22.00 23.00 23.01 23.02 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT 1.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 19. 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 02000 NURSI NG SCHOOL 20.00 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23 00 4 308 23 00 23.01 02301 SCH OF RADIOLOGY 5, 909 23.01 02302 PHARMACY RESIDENCY 7, 129 23.02 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 32.00 03300 BURN INTENSIVE CARE UNIT 33 00 33 00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 40.00 40.00 41.00 04100 SUBPROVIDER - IRF 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 45.00 04500 NURSING FACILITY 45.00 04510 | CF/MR 45.01 45.01 04600 OTHER LONG TERM CARE 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05001 SURGERY CENTER 50.01 50.01 51.00 05100 RECOVERY ROOM 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 56.00 57 00 05700 CT SCAN 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 60.00 60.00 60.01 06001 BLOOD LABORATORY 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 70 00 07000 FLECTROENCEPHALOGRAPHY 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 07400 RENAL DIALYSIS 74 00 74 00 75.00 07500 ASC (NON-DISTINCT PART) 75.00 03190 CHEMOTHERAPY 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88.00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90. 00 09000 CLINIC 90.00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150088 Peri od: Worksheet B From 07/01/2015 Part II 06/30/2016 Date/Time Prepared: 11/22/2016 3:25 pm INTERNS & RESIDENTS SERVI CES-SALAR SERVI CES-OTHER PARAMED ED SCH OF PHARMACY Cost Center Description RADI OLOGY Y & FRINGES PRGM COSTS PRGM RESI DENCY 23.02 23.00 21.00 22.00 23.01 90. 01 09001 ANDERSON CENTER OP CLINIC 90.01 91. 00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 92.00 92.00 94.00 09400 HOME PROGRAM DIALYSIS 94.00 09500 AMBULANCE SERVICES 95.00 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 99. 00 09900 CMHC 99.00 99. 10 09910 CORF 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY 100.00 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 106.00 10600 HEART ACQUISITION 105.00 106. 00 107.00 10700 LIVER ACQUISITION 107.00 108.00 10800 LUNG ACQUISITION 108.00 109. 00 10900 PANCREAS ACQUISITION 109. 00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION 111.00 113. 00 11300 | INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115. 00 116. 00 11600 HOSPI CE 116. 00 118.00 0 118.00 SUBTOTALS (SUM OF LINES 1-117) O NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 191. 00 19100 RESEARCH 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 00 193. 00 19300 NONPALD WORKERS 193.00 194. 00 07950 FOUNDATI ON 194.00 194. 02 07951 CHILDREN' S CLINIC 194. 02 194. 04 07952 HEALTH RESOURCE CENTER 194. 04 194. 05 07953 ADOLESCENT RESIDENTIAL 194. 05 194. 07 07954 COMMUNITY BENEFIT/MISSION 194. 07 194. 10 07955 DME 194. 10 194. 12 07956 MED ONE/TWO 194. 12 194. 13 07957 UNUSED SPACE 194. 13 194. 14 07958 ADVERTSISING AND MARKETING 194. 14 194. 15 07959 PHYSI CLANS RECRUITING 194. 15 194. 16 194. 16 07960 MOB 194. 17 07961 ASB 194. 17 194. 18 07962 MAB 194. 18 200.00 5, 909 7, 129 200. 00 Cross Foot Adjustments 4, 308 201.00 Negative Cost Centers 0 201.00

4, 308

5, 909

7, 129 202. 00

202.00

TOTAL (sum lines 118-201)

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150088

				To 06/30/2016 Date/Time Pro	
Cost Center Description	Subtotal	Intern &	Total	11/22/2016 3:	. 25 piii
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS	24.00	25.00	20.00		
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					1. 01 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5. 00
6.00 00600 MAINTENANCE & REPAIRS					6. 00
7. 00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING					8. 00 9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11. 00
12. 00 O1200 MAI NTENANCE OF PERSONNEL 13. 00 O1300 NURSI NG ADMI NI STRATI ON					12.00
13. 00 O1300 NURSI NG ADMINI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00 01500 PHARMACY					15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16. 00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS					17. 00 19. 00
20. 00 02000 NURSI NG SCHOOL					20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD					21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD					22. 00
23. 00 02300 PARAMED ED PRGM 23. 01 02301 SCH OF RADI OLOGY					23. 00 23. 01
23. 02 02302 PHARMACY RESI DENCY					23. 02
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	1, 379, 430	1	1, 379, 43		30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	581, 008	1	581, 00	0	31. 00 32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	C			o	33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	C	o o		0	34.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	153, 917		153, 9°	0	40. 00 41. 00
42. 00 04200 SUBPROVI DER	155, 417	1	155, 7	0	42.00
43. 00 04300 NURSERY	49, 150	o	49, 15	50	43. 00
44. 00 04400 SKILLED NURSING FACILITY	C	1 1		0	44. 00
45. 00 04500 NURSING FACILITY 45. 01 04510 CF/MR	C	1		0 0	45. 00 45. 01
46.00 O4600 OTHER LONG TERM CARE	C			0	46. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM 50. 01 05001 SURGERY CENTER	2, 769, 973 C	1	2, 769, 97	73 0	50. 00 50. 01
51. 00 05100 RECOVERY ROOM		1		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	184, 540	o	184, 54	40	52. 00
53. 00 05300 ANESTHESI OLOGY	25, 932		25, 93		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 069, 081 682, 117		1, 069, 08 682, 1		54. 00 55. 00
56. 00 05600 RADI OI SOTOPE	002,117	1	002, 1	Ö	56.00
57. 00 05700 CT SCAN	26, 024	1	26, 02		57. 00
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 O5900 CARDIAC CATHETERIZATION	482, 757	1	482, 7	57	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	258, 042	1	258, 04	42	59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	230, 512		200, 0	O	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	11 140		11 1	0	62.00
64. 00 06400 INTRAVENOUS THERAPY	11, 168		11, 10	0	63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	145, 305		145, 30	05	65. 00
66. 00 06600 PHYSI CAL THERAPY	342, 765	1	342, 70		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	77, 459	1	77, 45		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	10, 993 379, 598	1	10, 99 379, 59		68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	140, 866	0	140, 86	66	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	164, 900	1	164, 90		71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENT 73.00 O7300 DRUGS CHARGED TO PATIENTS	117, 016 1, 137, 859	1	117, 0° 1, 137, 8!		72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	1, 137, 639	1	1, 137, 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	C	o o		0	75. 00
76. 00 03190 CHEMOTHERAPY	108, 139		108, 13	39	76. 00
88. 00 08800 RURAL HEALTH CLINIC	С	ol ol		0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C	1		o	89. 00

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150088

			T	o 06/30/2016	Date/Time Prepared: 11/22/2016 3: 25 pm
Cost Center Description	Subtotal	Intern &	Total		11/22/2010 3.23 piii
		esi dents Cost			
		& Post			
		Stepdown			
		Adjustments			
00.00.000000000000000000000000000000000	24. 00	25. 00	26. 00		00.00
90. 00 09000 CLINIC 90. 01 09001 ANDERSON CENTER OP CLINIC	0 46, 321	0	44 221		90.00
91. 00 09100 EMERGENCY		O O	46, 321		90.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	372, 783	o	372, 783		92.00
OTHER REIMBURSABLE COST CENTERS		U U			92.00
94. 00 09400 HOME PROGRAM DIALYSIS	ol	0	C		94. 00
95. 00 09500 AMBULANCE SERVICES	Ö	o	C		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	O	O	C		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	O	o	C		97. 00
99. 00 09900 CMHC	0	О	C		99. 00
99. 10 09910 CORF	0	0	C		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	C		101. 00
SPECIAL PURPOSE COST CENTERS					
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	C		105. 00
106. 00 10600 HEART ACQUI SITI ON	0	0	0		106.00
107. 00 10700 LIVER ACQUISITION	0	0	0		107. 00 108. 00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION	0	0	0		108.00
110. 00 11000 NTESTINAL ACQUISITION	0	0	0		110, 00
111. 00 11100 SLET ACQUISITION	0	0			111.00
113. 00 11300 NTEREST EXPENSE	o _l	ď			113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C		115. 00
116. 00 11600 H0SPI CE	o	o	C		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	10, 717, 143	O	10, 717, 143		118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12, 006	0	12, 006		190. 00
191. 00 19100 RESEARCH	29, 915	0	29, 915		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	271, 348	0	271, 348		192. 00
193. 00 19300 NONPAI D WORKERS	0	0	0		193. 00
194. 00 07950 FOUNDATION	10, 708	0	10, 708		194. 00
194. 02 07951 CHILDREN' S CLINIC 194. 04 07952 HEALTH RESOURCE CENTER	22, 540	0	22, 540		194. 02 194. 04
194. 05 07953 ADOLESCENT RESIDENTIAL	5, 682 119, 279	0	5, 682 119, 279		194. 04
194. 07 07954 COMMUNITY BENEFIT/MISSION	49, 595	0	49, 595		194. 03
194. 10 07955 DME	268, 122	0	268, 122		194. 07
194. 12 07956 MED ONE/TWO	87	0	200, 122		194. 10
194. 13 07957 UNUSED SPACE	0	0	07		194. 13
194. 14 07958 ADVERTSISING AND MARKETING	40, 906	o	40, 906		194. 14
194. 15 07959 PHYSI CI ANS RECRUI TI NG	589	0	589		194. 15
194. 16 07960 MOB	117	ol	117		194. 16
194. 17 07961 ASB	3, 792	O	3, 792		194. 17
194. 18 07962 MAB	142	o	142		194. 18
200.00 Cross Foot Adjustments	17, 346	o	17, 346		200. 00
201.00 Negative Cost Centers	O	O	C		201. 00
202.00 TOTAL (sum lines 118-201)	11, 569, 317	O	11, 569, 317		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150088 Peri od: Worksheet B-1 From 07/01/2015 06/30/2016 Date/Time Prepared: 11/22/2016 3:25 pm CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW BLDG & **EMPLOYEE** Reconciliation ADMINISTRATIVE FIXT BENEFITS & GENERAL FIXT (SOUARE (ACCUM. COST) (SQUARE DEPARTMENT FEET) FEET) (GROSS SALARI ES) 1.00 1. 01 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 405 869 1 00 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT 1.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 6, 193 58, 251, 442 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 0 13, 732, 610 -42, 575, 763 142 855 288 5 00 6.00 00600 MAINTENANCE & REPAIRS 55, 747 0 401, 715 8,024,608 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 7,871 0 0 600, 640 8.00 8.00 0 00900 HOUSEKEEPI NG 9 00 9.977 2, 496, 198 0 9 00 10.00 01000 DI ETARY 27,835 21, 250 0 685, 965 10.00 01100 CAFETERI A 11.00 0 24, 904 1, 591, 985 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 1, 197, 371 01300 NURSING ADMINISTRATION 4.884 13.00 Ω 661, 776 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 15,860 0 446, 537 0 0 0 633, 277 14.00 01500 PHARMACY 15.00 4,719 2, 918, 296 4, 335, 281 15.00 01600 MEDICAL RECORDS & LIBRARY 5, 214 0 752, 200 1, 549, 231 16,00 16,00 17 00 01700 SOCIAL SERVICE 0 C 0 17 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 19.00 0 0 20.00 02000 NURSING SCHOOL 0 0 O 20.00 0 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 0 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 Ω Λ 0 22.00 02300 PARAMED ED PRGM 130 0 142, 195 23.00 0 100, 294 23.00 02301 SCH OF RADIOLOGY 110 156, 559 212, 523 23.01 23.01 02302 PHARMACY RESIDENCY 100 0 82, 812 266, 370 23.02 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 76. 370 11, 288, 936 16, 525, 938 30.00 o 31.00 03100 INTENSIVE CARE UNIT 14,660 0 3, 249, 362 5, 441, 775 31.00 03200 CORONARY CARE UNIT 0 32.00 0 0 C 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.00 04000 SUBPROVIDER - IPF 40 00 Ω \cap Λ 40 00 04100 SUBPROVI DER - I RF 41.00 10,000 864, 318 1, 394, 658 41.00 04200 SUBPROVI DER 0 42.00 0 0 0 42.00 0 04300 NURSERY 992 744, 690 43.00 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 0 Λ 44.00 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 45. 01 04510 | CF/MR 0 0 0 0 45.01 04600 OTHER LONG TERM CARE 0 46 00 0 0 0 0 46 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 224 n 1, 553, 759 0 14, 555, 348 50.00 05001 SURGERY CENTER 50.01 0 0 50.01 0 0 0 05100 RECOVERY ROOM 0 51 00 0 0 51 00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 16,622 0 0 0 190, 575 52.00 05300 ANESTHESI OLOGY 0 1, 060, 913 53.00 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 15.405 0 2, 857, 029 5, 490, 072 54.00 05500 RADI OLOGY-THERAPEUTI C 2, 563, 071 55 00 0 Ω 912, 334 55 00 56.00 05600 RADI OI SOTOPE 0 0 56.00 57.00 05700 CT SCAN 551 431.444 645, 412 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 938, 815 58.00 1.003 58.00 267, 244 05900 CARDIAC CATHETERIZATION 59 00 C 0 59 00 0 60.00 06000 LABORATORY 12,544 34, 363 5, 533, 924 60.00 0 60.01 06001 BLOOD LABORATORY 0 C 60 01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61 00 61 00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 Λ 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0 463, 856 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 0 0 0 06500 RESPIRATORY THERAPY 1, 171, 097 1, 670, 975 65.00 7.138 0 65 00 06600 PHYSI CAL THERAPY 9,534 1, 431, 553 0 0 0 2, 360, 714 66.00 66.00 06700 OCCUPATIONAL THERAPY 1, 094, 677 67 00 6, 324 1, 489, 081 67.00 06800 SPEECH PATHOLOGY 68.00 157, 592 203, 573 68.00 69 00 06900 ELECTROCARDI OLOGY 8.562 1, 774, 399 2, 707, 029 69 00 07000 ELECTROENCEPHALOGRAPHY 398, 435 664, 296 70.00 11,644 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 0 6, 954, 048 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 4. 933, 346 72.00 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 22, 674, 909 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 o 75.00 75.00 0 C O 76. 00 03190 CHEMOTHERAPY 0 0 856, 716 1, 264, 339 76. 00

Heal th Finan	cial Systems ST VI	NCENT ANDERSON	REGIONAL HOSP	'I TA	In Lie	eu of Form CMS-:	<u> 2552-10</u>
COST ALLOCAT	ION - STATISTICAL BASIS		Provi der	F	Period: From 07/01/2015 To 06/30/2016		pared:
		CAPITAL REL	ATED COSTS			1172272010 3.	25 piii
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	1. 01	4.00	5A	5. 00	
	TIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0	0	(0	0	
	FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0	0			0	89. 00 90. 00
	ANDERSON CENTER OP CLINIC	3, 500	0	624, 083		893, 332	1
	EMERGENCY	22, 505	0	1			1
	OBSERVATION BEDS (NON-DISTINCT PART)	·					92. 00
	REIMBURSABLE COST CENTERS						
	HOME PROGRAM DIALYSIS	0	0		-		
	AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED	0	0	(0	0	
	DURABLE MEDICAL EQUIP-SOLD	0	0			0	1
99.00 09900		Ö	0		Ö	Ō	1
99. 10 09910	CORF	O	0		0	0	99. 10
	I &R SERVICES-NOT APPRVD PRGM	0	0		-	l .	100.00
	HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0	(0	0	101. 00
	KIDNEY ACQUISITION	ام	0		0	0	105. 00
	HEART ACQUISITION	Ö	0			l .	106. 00
	LIVER ACQUISITION	o	0	(0	0	107. 00
	LUNG ACQUISITION	0	0	(0	l .	108. 00
	PANCREAS ACQUISITION	0	0		0		109. 00
	INTESTINAL ACQUISITION ISLET ACQUISITION	0	0				110. 00 111. 00
	INTEREST EXPENSE	١	O				113. 00
	UTILIZATION REVIEW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D.P.)	0	0	(0		115. 00
116. 00 11600		0	0		0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) MBURSABLE COST CENTERS	376, 218	0	51, 702, 19	-42, 575, 763	128, 122, 331]118. 00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 882	0		0	9. 052	190. 00
191. 00 19100		0	0	1			1
	PHYSICIANS' PRIVATE OFFICES	1, 829	0	3, 154, 449	0	5, 291, 841	
	NONPAI D WORKERS	0	0	1	0		193. 00
194. 00 07950	FOUNDATION CHILDREN'S CLINIC	636	0	125, 824 259, 891		270, 101 443, 044	
	HEALTH RESOURCE CENTER	553	0	64, 895			194. 02
	ADOLESCENT RESIDENTIAL	10, 091	0	1		1, 519, 686	
	COMMUNITY BENEFIT/MISSION	2, 845	0			557, 135	194. 07
194. 10 07955		9, 288	0				
194. 12 07956		0	0				194. 12
	UNUSED SPACE ADVERTSISING AND MARKETING	2, 527	0		0	1, 066, 772	194. 13
	PHYSICIANS RECRUITING	2, 327	0				194. 15
194. 16 07960	MOB	Ö	0		50, 027		194. 16
194. 17 07961		0	0	(0		194. 17
194. 18 07962		0	0	(0	434	194. 18
200.00	Cross Foot Adjustments						200. 00 201. 00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 952, 178	0	14, 731, 717	7	42, 575, 763	1
	Part I)	,,,,,,,,,,	Ö				
203. 00	Unit cost multiplier (Wkst. B, Part I)	4. 809872	0. 000000			0. 298034	
204. 00	Cost to be allocated (per Wkst. B,			32, 559	9	3, 341, 422	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part			0. 000559		0. 023390	205 00
203.00				0.00055		0.023390	200.00
'		. '		•	•	•	•

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150088

Peri od: Worksheet B-1 From 07/01/2015 To 06/30/2016 Date/Ti me Prepared:

11/22/2016 3:25 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY REPAIRS PLANT LINEN SERVICE (HOURS OF (PATIENT (SQUARE (SQUARE (POUNDS OF SERVICE) DAYS) LAUNDRY) FFFT) FEET) 9. 00 10.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT 1.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 6.00 00600 MAINTENANCE & REPAIRS 344, 029 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 7.871 977. 927 8.00 9.00 00900 HOUSEKEEPI NG 9,977 1,018 53, 331 9.00 01000 DI ETARY 35, 400 10.00 10.00 27.835 01100 CAFETERI A 0 925 11.00 Λ 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 4.884 50 13.00 01400 CENTRAL SERVICES & SUPPLY 15,860 14.00 43.229 315 14.00 0 01500 PHARMACY 15.00 4,819 C 180 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 5, 214 0 100 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 0 19 00 0 02000 NURSI NG SCHOOL 20.00 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 0 21.00 21.00 0 0 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 0 02300 PARAMED ED PRGM 0 0 Ω 23 00 23 00 130 0 23.01 02301 SCH OF RADIOLOGY 110 0 0 0 0 23.01 02302 PHARMACY RESIDENCY 0 0 23.02 23.02 100 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 76, 370 362, 594 21, 240 23, 153 30.00 03100 INTENSIVE CARE UNIT 119, 693 4, 850 6, 079 31.00 14,660 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 Ω 0 33 00 0 0 33 00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.00 04000 SUBPROVIDER - IPF 0 40.00 40.00 0 04100 SUBPROVI DER - I RF 41.00 10,000 43, 985 3. 110 2,520 41.00 04200 SUBPROVI DER 0 42.00 Ω C 0 42.00 43.00 04300 NURSERY 992 0 17, 277 1, 261 816 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 45.00 04500 NURSING FACILITY 0 0 0 45.00 0 0 04510 | CF/MR 0 45.01 0 C 0 0 45.01 04600 OTHER LONG TERM CARE 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 7, 985 50.00 20, 224 50.00 74,825 0 50.01 05001 SURGERY CENTER r Λ 50.01 51.00 05100 RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 189 122 52.00 16,622 1, 261 05300 ANESTHESI OLOGY 53.00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 405 0 77,050 2.130 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 17, 322 175 0 55.00 05600 RADI OI SOTOPE 56.00 0 0 0 56.00 05700 CT SCAN 57 00 551 C 0 0 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 1,003 100 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 59.00 06000 LABORATORY 60.00 12,544 0 0 1,710 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS 63.00 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 7, 138 50 0 65.00 06600 PHYSI CAL THERAPY 675 66.00 9.534 12, 158 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 6, 324 C 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 8,562 194 840 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 1, 149 690 70 00 11,644 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 C 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 0 0 73.00 07400 RENAL DIALYSIS O 74 00 Ω 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 C 0 0 0 75.00 03190 CHEMOTHERAPY 24, 994 76.00 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 88 00 88.00 08800 RURAL HEALTH CLINIC 0 Ω 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 90. 00 09000 CLINIC 0 0 0 90.00 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 ST VINCENT ANDERSON REGIONAL HOSPITA Provi der CCN: 150088 Peri od: From 07/01/2015 To 06/30/2016 Worksheet B-1 To 06/30/2016 Date/Time Prepared: 11/22/2016 3: 25 pm

CENTRAL PHARMACY Cost Center Description CAFETERIA MAINTENANCE OF NURSING

	Cost Center Description	CAFETERI A (TOTAL HOURS)	(NUMBER HOUSED)	ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (SPD SUPPLI ES)	PHARMACY (DRUG EXPENSE)	
	GENERAL SERVICE COST CENTERS	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00 1. 01 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 19. 00 20. 00 21. 00 22. 00 23. 00 23. 01 23. 02	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02300 PARAMED ED PRGM 02301 SCH OF RADIOLOGY	1, 284, 937 0 17, 122 21, 168 72, 060 28, 514 0 0 0 0 0 0 0 3, 392 4, 913 6, 875	0 0 0 0 0 0 0 0	692, 142 0 0 0 0 0 0 0 0 0	6, 608, 556 198, 677 0 0 0 0 0 0 47 0	22, 986, 199 0 0 0 0 0 0 0 0	1. 00 1. 01 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 23. 01 23. 02
30. 00 31. 00 32. 00 33. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	272, 570 96, 709 0 0 0 25, 577 0 16, 486	0 0 0 0 0 0	96, 709 0 0 0 0 0 25, 577 0 16, 486 0 0	338, 506 321, 923 0 0 0 0 19, 989 0 40, 265 0 0	31, 553 17, 671 0 0 0 0 607 0 1, 170 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00
50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 67. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00	05000 OPERATING ROOM 05001 SURGERY CENTER 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05500 RADI OLOGY-THERAPEUTI C 05600 LABORATORY 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY 067000 CCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03190 CHEMOTHERAPY	44, 240 0 2, 465 0 99, 316 25, 385 0 13, 622 6, 985 0 1, 300 0 0 0 0 0 0 0 0 0 0 0 0		0 0 2, 465 0 99, 316 25, 385 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 083, 361 0 0 6, 020 0 610, 887 86, 518 0 0 8, 075 0 659, 352 0 0 196, 778 33, 890 1, 996 142, 367 216, 547 10, 251 0 0 0 0	47, 591 0 0 175 0 6, 184 231 0 66, 534 57, 672 0 3, 030 0 0 0 0 0 1, 629 74 0 0 22, 675, 760 0	55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00
88. 00 89. 00	1 1	C		1	0	0	

Provider CCN: 150088

Peri od:

COST ALLOCATION - STATISTICAL BASIS

From 07/01/2015 06/30/2016 Date/Time Prepared: 11/22/2016 3:25 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL ADMI NI STRATI ON SERVICES & (DRUG (TOTAL HOURS) (NUMBER **SUPPLY** EXPENSE) HOUSED) (DI RECT (SPD SUPPLI ES) NRSING HRS) 12.00 15.00 11.00 13.00 14.00 90. 00 09000 CLINIC 90.00 09001 ANDERSON CENTER OP CLINIC 90. 01 21, 430 0 90.01 91.00 09100 EMERGENCY 109, 394 109, 394 434, 071 15, 516 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 0 0 0 0 0 09500 AMBULANCE SERVICES 95.00 95.00 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 99.00 109900 CMHC 0 0 99.00 0 09910 CORE 0 99.10 99. 10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 106.00 0 0 0 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 0 108, 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 o O 0 111.00 C 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 Ω 0 116,00 118.00 SUBTOTALS (SUM OF LINES 1-117) 1,085,983 692, 142 6, 581, 624 22, 926, 338 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 6 191.00 191. 00 19100 RESEARCH 2 998 0 Ω 192.00 19200 PHYSICIANS' PRIVATE OFFICES 65, 297 0 0 4,832 49, 058 192. 00 193. 00 19300 NONPALD WORKERS 0 193.00 0 194. 00 07950 FOUNDATI ON 3.631 0 0 0 194.00 194. 02 07951 CHILDREN' S CLINIC 9,772 0 10, 796 194. 02 Ω 21, 836 194. 04 07952 HEALTH RESOURCE CENTER 2, 324 0 194. 04 262 194. 05 07953 ADOLESCENT RESIDENTIAL 0 194. 05 35, 969 0 0 194. 07 07954 COMMUNITY BENEFIT/MISSION 15, 944 0 0 194. 07 2 194. 10 07955 DME 0 1 194. 10 63.019 194. 12 07956 MED ONE/TWO 0 0 194. 12 0 194. 13 07957 UNUSED SPACE 0 0 194. 13 0 194. 14 0 194. 14 07958 ADVERTSISING AND MARKETING 0 194. 15 07959 PHYSI CLANS RECRUITING 0 0 0 0 194. 15 194. 16 07960 MOB 0 0 0 0 194. 16 194. 17 07961 ASB 0 194, 17 0 0 0 0 194. 18 07962 MAB C 0 194. 18 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 2, 127, 908 1, 733, 779 1, 403, 192 5, 946, 726 202. 00 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 1.656041 0.000000 2.504947 0. 212330 0. 258709 203. 00 599, 943 204. 00 204.00 Cost to be allocated (per Wkst. B, 42, 146 237, 811 166, 170 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.032800 0.000000 0.343587 0.025145 0.026100 205.00 Π

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150088
Period:
From 07/01/2015
To 06/30/2016
Date/Time Prepared:
1/1/22/2016 3: 25 pm

					0 06/30/2016	11/22/2016 3:	
						I NTERNS & RESI DENTS	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG SCHOOL	SERVI CES-SALAR	
	, , , , , , , , , , , , , , , , , , ,	RECORDS &		ANESTHETI STS		Y & FRINGES	
		LI BRARY	(TIME	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		(DEPT. REVENUE)	SPENT)	TI ME)	TI ME)	TIME)	
		16. 00	17. 00	19. 00	20.00	21. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT					I	1. 00
1. 00	00101 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	(22 270 0F/					15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	633, 270, 054	j 0				17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	C	o	C)		19. 00
20.00	02000 NURSI NG SCHOOL	C	0		0		20.00
21. 00 22. 00	O2100 I &R SERVI CES-SALARY & FRINGES APPRVD O2200 I &R SERVI CES-OTHER PRGM COSTS APPRVD					0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM		Ö				23. 00
23. 01	02301 SCH OF RADIOLOGY	C	0				23. 01
23. 02	02302 PHARMACY RESIDENCY INPATIENT ROUTINE SERVICE COST CENTERS	C	0				23. 02
30. 00	03000 ADULTS & PEDIATRICS	30, 081, 632	. 0	0	0	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	14, 860, 613		C	0	0	31. 00
32.00	03200 CORONARY CARE UNIT	C	0	C		0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT		0	C		0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF		Ö	ď		Ö	40.00
41. 00	04100 SUBPROVI DER - I RF	3, 105, 712	. 0	C	0	0	41. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	983, 892	0	C	0	0	42. 00 43. 00
44. 00	04400 SKI LLED NURSI NG FACI LI TY	903, 092			0	0	44.00
45. 00	04500 NURSING FACILITY	C	o	C	0	0	45. 00
45. 01	04510 I CF/MR	C	0			-	45. 01
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS		0	C	0	0	46. 00
50.00	05000 OPERATING ROOM	106, 254, 834	. 0	C	0	0	50. 00
50. 01	05001 SURGERY CENTER	C	0	C		0	50. 01
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	3, 690, 913		C		0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	9, 233, 379	_	1		1	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	44, 021, 867	1				54. 00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	27, 700, 671	0	C		0	55. 00 56. 00
57. 00	05700 CT SCAN	14, 367, 104				0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 940, 053		C	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	(2.245.725	0	O	0		59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	63, 245, 725			0	0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C		0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	2, 624, 960	0	C		0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	15, 702, 272		Ö		0	65.00
66.00	06600 PHYSI CAL THERAPY	7, 145, 375	0	C	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	5, 953, 976	1	C		0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	722, 892 25, 233, 986	l	C	_	0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	5, 185, 302		Č		ő	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	18, 553, 516	l	C		-	71.00
72. 00 73. 00	O7200 IMPL. DEV. CHARGED TO PATIENT O7300 DRUGS CHARGED TO PATIENTS	13, 430, 360 130, 457, 322	l	0	_	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	130, 437, 322	0	o c		•	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	C	0	C			75. 00
76. 00	03190 CHEMOTHERAPY	3, 009, 190	0	C	0	0	76. 00

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150088 | Period: From 07/01/2015 | To 06/30/2016 | Date/Time Prepared:

			r	To 06/30/2016		pared:
					11/22/2016 3: INTERNS &	25 piii
					RESI DENTS	
Cost Center Description	MEDI CAL	SOCIAL SERVICE		NURSI NG SCHOOL		
	RECORDS & LI BRARY	(TIME	ANESTHETI STS (ASSI GNED	(ASSI GNED	Y & FRINGES (ASSIGNED	
	(DEPT.	SPENT)	TIME)	TIME)	TIME)	
	REVENUE)	J. 2,	, , , , , ,	, , , , ,	,	
[4	16. 00	17. 00	19. 00	20. 00	21. 00	
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC		0			0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0) 	89.00
90. 00 09000 CLINI C		0			0	90.00
90. 01 09001 ANDERSON CENTER OP CLINIC	1, 903, 139	0	C	0	0	90. 01
91. 00 09100 EMERGENCY	66, 086, 802	0	C	0	0	91. 00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
94. 00 OTHER REI MBURSABLE COST CENTERS 94. 00 O9400 HOME PROGRAM DI ALYSI S	0	0		0	0	94. 00
95. 00 09500 AMBULANCE SERVICES					0	1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	d	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97. 00
99. 00 09900 CMHC	0	0		0	0	
99.10 09910 CORF 100.00 10000 L&R SERVICES-NOT APPRVD PRGM	0	0		0	0	99. 10 100. 00
101. 00 10100 HOME HEALTH AGENCY		0				101.00
SPECIAL PURPOSE COST CENTERS				,		
105.00 10500 KIDNEY ACQUISITION	0		l .	0		105. 00
106. 00 10600 HEART ACQUISITION	0	0		0		106. 00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION	0	0		0		107. 00 108. 00
109. 00 10900 PANCREAS ACQUISITION		0				109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	Ö	d	o o		110.00
111.00 11100 ISLET ACQUISITION	0	0	C	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)]		0	114. 00 115. 00
116. 00 11600 HOSPI CE		0				116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	617, 495, 487	Ö		o o		118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		-		190. 00
191. 00 19100 RESEARCH	2 040 104	0		0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	3, 949, 184	0				192. 00 193. 00
194. 00 07950 FOUNDATION		Ö		o o		194. 00
194. 02 07951 CHI LDREN' S CLINIC	634, 117	0) c	0	0	194. 02
194. 04 07952 HEALTH RESOURCE CENTER	0	0	C	0		194. 04
194. 05 07953 ADOLESCENT RESIDENTIAL	2, 121, 875	0		0		194. 05
194.07 07954 COMMUNITY BENEFIT/MISSION 194.10 07955 DME	9, 069, 391	0				194. 07 194. 10
194. 12 07956 MED ONE/TWO	0	Ö		o o		194. 12
194. 13 07957 UNUSED SPACE	0	0	o c	0	0	194. 13
194.14 07958 ADVERTSISING AND MARKETING	0	0	C	0		194. 14
194. 15 07959 PHYSI CI ANS RECRUI TI NG	0	0		0		194. 15
194. 16 07960 MOB 194. 17 07961 ASB		0) 0	194. 16 194. 17
194. 18 07962 MAB		0				194. 17
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	2, 222, 684	0	C	0	0	202. 00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	0. 003510	0. 000000	0. 000000	0. 000000	0. 000000	203 00
204.00 Cost to be allocated (per Wkst. B,	76, 460	l .	0.00000	0.00000		203. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000121	0. 000000	0. 000000	0. 000000	0. 000000	205. 00
1)	I	I	I		l	I

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150088 Peri od: Worksheet B-1 From 07/01/2015 06/30/2016 Date/Time Prepared: 11/22/2016 3:25 pm INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED SCH OF **PHARMACY** PRGM COSTS RADI OLOGY **PRGM** RESI DENCY (ASSI GNED (PARA MED) (PARA MED) (PARA MED) TIME) 22.00 23.00 23.01 23.02 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-BLDG & FIXT 1.01 1.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16,00 01700 SOCIAL SERVICE 17.00 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 02000 NURSING SCHOOL 20.00 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22 00 0 22 00 23.00 02300 PARAMED ED PRGM 100 23.00 02301 SCH OF RADIOLOGY 23.01 62, 329, 024 23.01 02302 PHARMACY RESIDENCY 23.02 100 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 0 31.00 32.00 03200 CORONARY CARE UNIT 000000000 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 0 0 0 0 40.00 0 41 00 C 41 00 04200 SUBPROVI DER 0 42.00 C 42.00 04300 NURSERY 0 43.00 0 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 44.00 45.00 04500 NURSING FACILITY 0 45.00 45.01 04510 I CF/MR 0 0 0 0 45.01 04600 OTHER LONG TERM CARE 0 0 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 50.01 05001 SURGERY CENTER 000000000000 0 50.01 0 0 0 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 44, 021, 867 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55 00 55 00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 14, 367, 104 0 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 3, 940, 053 58.00 05900 CARDIAC CATHETERIZATION 59 00 Ω 0 59 00 60.00 06000 LABORATORY C 0 0 60.00 06001 BLOOD LABORATORY 0 0 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0000000000000 Ω 0 0 62 00 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 Ω 69 00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 o 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 100 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 75 00 07500 ASC (NON-DISTINCT PART) 0 0 0 75 00 03190 CHEMOTHERAPY 0 0 76.00 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00

CUST ALLUCATION -	STATISTICAL BASIS		Provider		From 07/01/2015 To 06/30/2016	Date/Time Prepared: 11/22/2016 3:25 pm
Cost (Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS (ASSI GNED TI ME) 22.00	PARAMED ED PRGM (PARA MED)	SCH OF RADI OLOGY (PARA MED)	PHARMACY RESI DENCY (PARA MED)	
89. 00 08900 FEDERA	ALLY QUALIFIED HEALTH CENTER	22.00	23.00		0 0	89. 00
90. 00 09000 CLINI		0	0	,	0 0	90. 00
	SON CENTER OP CLINIC	0	0		0 0	90. 01
91. 00 09100 EMERGE		0	100	1	0	91. 00
	VATION BEDS (NON-DISTINCT PART) URSABLE COST CENTERS					92. 00
	PROGRAM DI ALYSI S	0	0	1	0 0	94. 00
1 1	ANCE SERVICES	O	0		0 0	95. 00
96. 00 09600 DURABL	LE MEDICAL EQUIP-RENTED	0	0)	0 0	96.00
	LE MEDICAL EQUIP-SOLD	0	0		0 0	97. 00
99. 00 09900 CMHC		0	0		0	99.00
99. 10 09910 CORF	ERVICES-NOT APPRVD PRGM	0	0		0 0	99. 10 100. 00
101. 00 10100 HOME H			0		0 0	101.00
	POSE COST CENTERS		-			
105. 00 10500 KI DNE		0	0		0 0	
106. 00 10600 HEART		0	0	1	0	106. 00
107. 00 10700 LI VER 108. 00 10800 LUNG A		0	0		0	107. 00 108. 00
109. 00 10900 PANCRE		0	0		0 0	109. 00
110. 00 11000 I NTEST		O	0	,	0 0	110.00
111. 00 11100 I SLET	ACQUI SI TI ON	0	0		0 0	111. 00
113. 00 11300 I NTERE						113. 00
114. 00 11400 UTI LI Z						114.00
116. 00 11600 AMBULA	ATORY SURGICAL CENTER (D. P.)	0	0		0 0	115. 00 116. 00
1	TALS (SUM OF LINES 1-117)	0	100	1	-	118. 00
	ABLE COST CENTERS	,				
	FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	
191. 00 19100 RESEAF		0	0		0	191. 00
193. 00 19300 NONPAI	CLANS' PRIVATE OFFICES	0	0		0 0	192. 00 193. 00
194. 00 07950 FOUNDA			0		0 0	194. 00
194. 02 07951 CHI LDF		0	0		0 0	194. 02
194. 04 07952 HEALTH		0	0		0 0	194. 04
194. 05 07953 ADOLES		0	0	1	0	194. 05
194. 07 07954 COMMUN 194. 10 07955 DME	NITY BENEFIT/MISSION	0	0		0	194. 07 194. 10
194. 12 07956 MED ON	NF/TWO		0		0 0	194. 12
194. 13 07957 UNUSED		0	0		0 0	194. 13
194. 14 07958 ADVERT	TSISING AND MARKETING	0	0		0 0	194. 14
194. 15 07959 PHYSI (CLANS RECRUITING	0	0		0	194. 15
194. 16 07960 MOB 194. 17 07961 ASB		0	0		0 0	194. 16 194. 17
194. 17 07961 ASB			0		0 0	194. 17
1 1	Foot Adjustments		· ·			200. 00
1 1	ive Cost Centers					201. 00
202.00 Cost 1 Part I	to be allocated (per Wkst. B, I)	0	194, 137	287, 32	8 360, 170	202. 00
	cost multiplier (Wkst. B, Part I)	0. 000000	1, 941. 370000	1		
204.00 Cost 1	to be allocated (per Wkst. B,	0	4, 308	5, 90	9 7, 129	204. 00
	cost multiplier (Wkst. B, Part	0. 000000	43. 080000	0. 00009	5 71. 290000	205. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150088

				1	0 06/30/2016	Date/lime Pre 11/22/2016 3:	
			Titl	e XVIII	Hospi tal	PPS	
				o .	Costs	-	
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col.	Auj .		Di Sai i Owance		
		26)					
	LABORT FAIT DOUT HE OFFICE OF COST OFFITTED	1.00	2.00	3. 00	4. 00	5. 00	
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	28, 005, 455	1	28, 005, 455	5, 402	28, 010, 857	30.00
31. 00	03100 NTENSI VE CARE UNI T	8, 779, 414		8, 779, 414		8, 779, 414	1
32. 00	03200 CORONARY CARE UNIT	0		0	0	0	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0		0	0	0	34.00
40. 00 41. 00	04100 SUBPROVIDER - TPF	2, 610, 604		2, 610, 604	5, 136	2, 615, 740	40. 00 41. 00
42. 00	04200 SUBPROVI DER	2,010,001		0	0, 100	2, 010, 710	1
43.00	04300 NURSERY	1, 219, 286		1, 219, 286	0	1, 219, 286	
44. 00	04400 SKILLED NURSING FACILITY	0		0	0	0	1
45. 00 45. 01	04500 NURSING FACILITY 04510 ICF/MR	0		0	0	0	45. 00 45. 01
46. 00	04600 OTHER LONG TERM CARE				0	0	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	21, 338, 105		21, 338, 105			1
50. 01 51. 00	05001 SURGERY CENTER 05100 RECOVERY ROOM			0	_	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	795, 018		795, 018		795, 018	
53.00	05300 ANESTHESI OLOGY	1, 409, 510		1, 409, 510		1, 409, 510	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 716, 450	l .	8, 716, 450		8, 716, 450	
55. 00	05500 RADI OLOGY-THERAPEUTI C	3, 577, 897		3, 577, 897	5, 333	3, 583, 230	1
56. 00 57. 00	05600	1, 010, 883		1, 010, 883	0	0 1, 010, 883	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 315, 822		1, 315, 822		1, 315, 822	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60.00	06000 LABORATORY	8, 041, 559		8, 041, 559	49, 746	8, 091, 305	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	611, 315		611, 315	0	611, 315	1
64. 00	06400 I NTRAVENOUS THERAPY	0		0	0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	2, 541, 478	l .			2, 593, 426	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 513, 597 2, 191, 449	l .	3, 513, 597 2, 191, 449		3, 513, 597 2, 191, 449	
68. 00	06800 SPEECH PATHOLOGY	303, 054		303, 054		303, 054	1
69. 00	06900 ELECTROCARDI OLOGY	4, 045, 222		4, 045, 222		4, 045, 222	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 302, 551		1, 302, 551	· ·	1, 310, 093	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	9, 091, 714 6, 450, 792		9, 091, 714 6, 450, 792		9, 091, 714 6, 450, 792	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	36, 117, 225	l .	36, 117, 225		36, 117, 225	1
74. 00	07400 RENAL DIALYSIS	0		0	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0		0	0	0	
76.00	O3190 CHEMOTHERAPY OUTPATIENT SERVICE COST CENTERS	1, 759, 538		1, 759, 538	0	1, 759, 538	76.00
88. 00	08800 RURAL HEALTH CLINIC	0		0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
90.00	09000 CLINIC	0		0	0	0	
90. 01 91. 00	09001 ANDERSON CENTER OP CLINIC 09100 EMERGENCY	1, 307, 714 8, 675, 109		1, 307, 714 8, 675, 109		1, 307, 714 8, 675, 109	1
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 162, 601		1, 162, 601		1, 162, 601	1
	OTHER REIMBURSABLE COST CENTERS					, , , , , , , , , , , , , , , , , , , ,	
94.00	I I	0		0		0	1
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0		0	0	0	
	09700 DURABLE MEDICAL EQUIP-RENTED			0	0	0	1
99. 00		0		Ö		0	1
	09910 CORF	0		0		0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0		0			100.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS			0		0	101. 00
105.00	10500 KIDNEY ACQUISITION	0		0		0	105. 00
106.00	10600 HEART ACQUISITION	0		0		0	106. 00
	10700 LIVER ACQUISITION	0		0			107. 00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION						108. 00 109. 00
	11000 NTESTINAL ACQUISITION			0			1109.00
111.00	11100 ISLET ACQUISITION			O			111. 00
	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF	<u> </u>	l	l			114. 00

Health Financial Systems	ST VINCENT ANDERSON	REGIONAL HOSP	I TA	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 07/01/2015	Worksheet C Part I	
				To 06/30/2016		pared: 25 pm
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			O	0	115. 00
116. 00 11600 H0SPI CE	0			O	0	116. 00
200.00 Subtotal (see instructions)	165, 893, 362	0	165, 893, 362	2 125, 107	166, 018, 469	200. 00
201.00 Less Observation Beds	1, 162, 601		1, 162, 60°	1	1, 162, 601	201. 00
202.00 Total (see instructions)	164, 730, 761	0	164, 730, 76	1 125, 107	164, 855, 868	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150088

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 07/01/2015	Part
To 06/30/2016	Date/Time Prepared:
11/22/2016 3: 25 pm	

		T: +1	e XVIII	0 06/30/2016	11/22/2016 3:	
		Charges	e xviii	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	+ col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
INDATIENT DOUTING CEDVICE COCT CENTERS	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	24, 850, 184		24, 850, 184			30. 00
31. 00 03100 NTENSI VE CARE UNIT	14, 886, 212		14, 886, 212			31. 00
32. 00 03200 CORONARY CARE UNIT	0		1 1, 555, 212			32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0		d			33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00 04000 SUBPROVI DER - 1 PF	0		(c			40. 00
41. 00 04100 SUBPROVI DER - I RF	3, 105, 712		3, 105, 712			41. 00
42. 00 04200 SUBPROVI DER	0		0			42.00
43. 00 04300 NURSERY	983, 892		983, 892			43. 00 44. 00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0					45. 00
45. 01 04510 CF/MR	0					45. 01
46.00 O4600 OTHER LONG TERM CARE	o					46. 00
ANCILLARY SERVICE COST CENTERS	,		•			
50.00 05000 OPERATING ROOM	22, 842, 635	83, 412, 199	106, 254, 834		0.000000	50. 00
50. 01 05001 SURGERY CENTER	0	0	1		0. 000000	50. 01
51. 00 05100 RECOVERY ROOM	0	(02.740	2 (00 010	0.000000	0.000000	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	3, 007, 165 1, 848, 960	683, 748 9, 384, 419			0. 000000 0. 000000	52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	7, 693, 108	36, 328, 759			0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	893, 555	26, 807, 116			0. 000000	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0), c	0. 000000	0. 000000	56. 00
57. 00 05700 CT SCAN	3, 245, 433	11, 121, 671	14, 367, 104	0. 070361	0. 000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	810, 564	3, 129, 489	3, 940, 053		0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0.00000	0. 000000	59. 00
60. 00 06000 LABORATORY	23, 227, 795	40, 017, 930	63, 245, 725		0. 000000	60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0. 000000 0. 000000	0. 000000 0. 000000	60. 01 61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0. 000000	0. 000000	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 083, 646	1, 541, 314	2, 624, 960		0. 000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0) -, , ,	0. 000000	0. 000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	14, 687, 089	1, 015, 183	15, 702, 272	0. 161854	0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	27, 750	7, 117, 625			0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 371, 122	667, 242			0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 087	721, 805			0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	6, 451, 988 281, 852	15, 034, 670 4, 656, 842			0. 000000 0. 000000	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 382, 888	11, 170, 628			0. 000000	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	6, 651, 822	6, 778, 538			0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	32, 732, 324	97, 724, 998			0.000000	73. 00
74.00 07400 RENAL DIALYSIS	0	0) c		0.000000	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0) C	0. 000000	0. 000000	75. 00
76. 00 03190 CHEMOTHERAPY	96, 270	2, 912, 920	3, 009, 190	0. 584721	0. 000000	76. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 09000 CLI NI C	o	0		0. 000000	0. 000000	90.00
90.01 09001 ANDERSON CENTER OP CLINIC	0	1, 902, 744	1, 902, 744	0. 687278	0. 000000	90. 01
91. 00 09100 EMERGENCY	13, 198, 565	52, 528, 634			0.000000	91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	180, 446	4, 006, 010	4, 186, 456	0. 277705	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS			J	0.000000	0.000000	04.00
94. 00 09400 HOME PROGRAM DI ALYSIS 95. 00 09500 AMBULANCE SERVICES	0 0	0		0. 000000 0. 000000	0. 000000 0. 000000	94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0. 000000	0. 000000	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0. 000000	0. 000000	97. 00
99. 00 09900 CMHC	0	0	ol c			99. 00
99. 10 09910 CORF	0	0) c			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0) C			100. 00
101. 00 10100 HOME HEALTH AGENCY	0	0) <u> </u>			101. 00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION	ol		V C			105. 00
106.00 10600 HEART ACQUISITION	0	0				105.00
107. 00 10700 LI VER ACQUI SI TI ON		0				107. 00
108. 00 10800 LUNG ACQUISITION		n				108. 00
109. 00 10900 PANCREAS ACQUISITION		0) c			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0) c			110. 00
111. 00 11100 SLET ACQUI SITI ON	0	0) C			111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0				114. 00 115. 00
30 TI 300 MIDDENTONT SONOTONE CENTER (D.T.)	<u>ı</u>	0	1	1		1. 13. 00

Health Financial Systems	ST VINCENT ANDERSON	REGIONAL HOSP	I TA	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Peri od:	Worksheet C	
				From 07/01/2015	Part I	
				Γo 06/30/2016	Date/Time Pre	epared:
					11/22/2016 3:	25 pm
		Ti tl	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
116. 00 11600 HOSPI CE	0	0	(D		116. 00
200.00 Subtotal (see instructions)	195, 542, 064	418, 664, 484	614, 206, 548	3		200.00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	195, 542, 064	418, 664, 484	614, 206, 548	3		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 07/01/2015 | Part | To 06/30/2016 | Date/Time Prepared: | 11/22/2016 3: 25 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES ST VINCENT ANDERSON REGIONAL HOSPITA
Provider CCN: 150088

		Title XVIII	Hospi tal	71/22/2016 3: 25 pm PPS
Cost Center Description	PPS Inpatient	THE ATTE	поэрг саг	11.0
, , , , , , , , , , , , , , , , , , ,	Ratio			
	11. 00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				20.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT				30.00
32. 00 03200 CORONARY CARE UNIT				32.00
33. 00 03300 BURN INTENSIVE CARE UNIT				33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T				34.00
40. 00 04000 SUBPROVI DER - 1 PF				40.00
41.00 04100 SUBPROVI DER - I RF				41.00
42. 00 04200 SUBPROVI DER				42. 00
43. 00 04300 NURSERY				43. 00
44. 00 04400 SKILLED NURSING FACILITY				44.00
45. 00 04500 NURSING FACILITY				45. 00
45. 01 04510 CF/MR 46. 00 04600 OTHER LONG TERM CARE				45. 01 46. 00
ANCI LLARY SERVI CE COST CENTERS				46.00
50. 00 05000 OPERATI NG ROOM	0. 200820			50.00
50. 01 05001 SURGERY CENTER	0. 000000			50. 01
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 215399			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 125475			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 198003			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 129355			55. 00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	0.000000			56. 00 57. 00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 070361 0. 333960			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 127934			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 232885			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 165162			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 491730			66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0. 362921 0. 419224			67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 419224			69. 00
70. 00 07000 ELECTROCARD OLOGT	0. 265271			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 490026			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 480314			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 276851			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 00 03190 CHEMOTHERAPY	0. 584721			76. 00
OUTPATIENT SERVICE COST CENTERS				99.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				88. 00 89. 00
90. 00 09000 CLINI C	0. 000000			90.00
90. 01 09001 ANDERSON CENTER OP CLINIC	0. 687278			90. 01
91. 00 09100 EMERGENCY	0. 131987			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 277705			92. 00
OTHER REIMBURSABLE COST CENTERS				
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000			94.00
95. 00 09500 AMBULANCE SERVI CES	0.000000			95. 00
96. 00 O9600 DURABLE MEDICAL EQUIP-RENTED 97. 00 O9700 DURABLE MEDICAL EQUIP-SOLD	0. 000000 0. 000000			96. 00 97. 00
99. 00 09900 CMHC	0.000000			99.00
99. 10 09910 CORF				99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM				100. 00
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS	'			
105. 00 10500 KIDNEY ACQUISITION				105. 00
106.00 10600 HEART ACQUISITION				106. 00
107.00 10700 LIVER ACQUISITION				107. 00
108. 00 10800 LUNG ACQUISITION				108. 00
109. 00 10900 PANCREAS ACQUISITION				109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON				110.00
111.00 11100 I SLET ACQUI SI TI ON				111.00
113. 00 11300 INTEREST_EXPENSE 114. 00 11400 UTI LI ZATI ON_REVI EW-SNF				113. 00 114. 00
114.00 11400 011 LIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115.00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200. 00
	<u> </u>			1

Health Financial Systems	ST VINCENT ANDERSON RE	EGIONAL HOSPITA	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 150088	Peri od:	Worksheet C	
			From 07/01/2015		
			To 06/30/2016	Date/Time Pre	pared:
				11/22/2016 3:	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems ST VINCENT ANDERSON REGIONAL HOSPITA In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150088 Peri od: Worksheet C From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/22/2016 3:25 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 28, 005, 455 28, 005, 455 5.402 28, 010, 857 03100 INTENSIVE CARE UNIT 8, 779, 414 8, 779, 414 8, 779, 414 31.00 32.00 03200 CORONARY CARE UNIT 0 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 Λ 04000 SUBPROVI DER - I PF 40.00 04100 SUBPROVI DER - I RF 2, 610, 604 2, 610, 604 2, 615, 740 41.00 5.136 04200 SUBPROVI DER 42.00 Λ 43.00 04300 NURSERY 1, 219, 286 1, 219, 286 0 1, 219, 286 44.00 04400 SKILLED NURSING FACILITY 0 o 04500 NURSING FACILITY 45.00 0 0 0 04510 LCF/MR 45.01 0 0 0 0 04600 OTHER LONG TERM CARE 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 21, 338, 105 21 338 105 21 338 105 0 50.01 05001 SURGERY CENTER \cap 0 Λ 05100 RECOVERY ROOM 0 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 795, 018 795, 018 0 795, 018 1, 409, 510 0 1, 409, 510 05300 ANESTHESI OLOGY 1 409 510 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 716, 450 8, 716, 450 0 8, 716, 450 55.00 05500 RADI OLOGY-THERAPEUTI C 3, 577, 897 3, 577, 897 5, 333 3, 583, 230 56 00 05600 RADI OI SOTOPE C 0 57.00 05700 CT SCAN 1,010,883 1,010,883 0 1,010,883 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 315, 822 0 58.00 1, 315, 822 1, 315, 822 05900 CARDIAC CATHETERIZATION 59.00 0 8, 041, 559 60 00 06000 LABORATORY 8.041.559 49, 746 8, 091, 305 60.01 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 0 0 0

Health Financial Systems	ST VINCENT ANDERSON	N REGIONAL HOSP	I TA	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	1	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Pre 11/22/2016 3:	pared: 25 pm
		Ti t	le 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	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) C)	(O	0	115. 00
116. 00 11600 HOSPI CE)		o	0	116. 00
200.00 Subtotal (see instructions)	165, 893, 362	. 0	165, 893, 362	2 125, 107	166, 018, 469	200. 00
201.00 Less Observation Beds	1, 162, 601		1, 162, 60°	1	1, 162, 601	201. 00
202.00 Total (see instructions)	164, 730, 761	0	164, 730, 76	1 125, 107		

In Lieu of Form CMS-2552-10
Worksheet C
Part I
30/2016 Date/Time Prepared:
11/22/2016 3:25 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES ST VINCENT ANDERSON REGIONAL HOSPITA Provi der CCN: 150088 Peri od: From 07/01/2015 To 06/30/2016 Cost Title XIX Hospi tal

		Charges		поэрг саг		
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpati ent	
	6. 00	7. 00	8. 00	9. 00	Rati o 10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	24, 850, 184		24, 850, 184			30. 00
31.00 03100 INTENSIVE CARE UNIT	14, 886, 212		14, 886, 212			31. 00
32. 00 03200 CORONARY CARE UNIT	0		0			32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		0			33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0		0			34.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	2 105 712		2 105 712			40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	3, 105, 712		3, 105, 712			41. 00 42. 00
43. 00 04300 NURSERY	983, 892		983, 892			43.00
44. 00 04400 SKI LLED NURSING FACILITY	703, 072		703, 072			44. 00
45. 00 04500 NURSI NG FACILITY	o		l o			45. 00
45. 01 04510 I CF/MR	0		0			45. 01
46.00 O4600 OTHER LONG TERM CARE	0		0			46. 00
ANCILLARY SERVICE COST CENTERS			T			
50. 00 05000 OPERATING ROOM	22, 842, 635	83, 412, 199	106, 254, 834		0.000000	50.00
50. 01 05001 SURGERY CENTER 51. 00 05100 RECOVERY ROOM	0	0		0.000000	0.000000	50. 01
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 007, 165	683, 748	3, 690, 913	0. 000000 0. 215399	0. 000000 0. 000000	51. 00 52. 00
53. 00 05200 DELIVERT ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	1, 848, 960	9, 384, 419			0. 000000	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	7, 693, 108	36, 328, 759			0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	893, 555	26, 807, 116	27, 700, 671	0. 129163	0. 000000	55. 00
56. 00 05600 RADI OI SOTOPE	0	0	27,700,07	0. 000000	0. 000000	56.00
57. 00 05700 CT SCAN	3, 245, 433	11, 121, 671	14, 367, 104		0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	810, 564	3, 129, 489	3, 940, 053	0. 333960	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0. 000000	0. 000000	59. 00
60. 00 06000 LABORATORY	23, 227, 795	40, 017, 930	63, 245, 725		0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0. 000000	0. 000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0. 000000	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1 000 (4(1 541 214	0 (24 0(0	0.000000	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	1, 083, 646	1, 541, 314	2, 624, 960		0.000000	63. 00 64. 00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	14, 687, 089	1, 015, 183	15, 702, 272	0. 000000 0. 161854	0. 000000 0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	27, 750	7, 117, 625			0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 371, 122	667, 242			0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 087	721, 805			0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 451, 988	15, 034, 670	1		0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	281, 852	4, 656, 842			0. 000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 382, 888	11, 170, 628			0. 000000	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	6, 651, 822	6, 778, 538	1		0. 000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	32, 732, 324	97, 724, 998	130, 457, 322		0. 000000	73. 00
74. 00 07400 RENAL DIALYSIS	0	0		0.000000	0. 000000 0. 000000	74.00
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03190 CHEMOTHERAPY	96, 270	2, 912, 920	3, 009, 190	0. 000000 0. 584721	0. 000000	75. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	70, 270	2, 712, 720	3,007,170	0. 304721	0.000000	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0. 000000	0. 000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	O	0			0. 000000	
90. 00 09000 CLI NI C	0	0	0	0. 000000	0.000000	
90.01 09001 ANDERSON CENTER OP CLINIC	0	1, 902, 744	1, 902, 744	0. 687278	0. 000000	90. 01
91. 00 09100 EMERGENCY	13, 198, 565	52, 528, 634			0. 000000	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	180, 446	4, 006, 010	4, 186, 456	0. 277705	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS			1			
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0.000000	0.000000	94.00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0. 000000 0. 000000	0. 000000 0. 000000	95. 00 96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0	0		0. 000000	0. 000000	97.00
99. 00 09900 CMHC	0	0		0.000000	0.00000	99.00
99. 10 09910 CORF	Ö	0	i o			99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	O	0	Ö			100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0			101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0			105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0			106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0			107. 00
108.00 10800 LUNG ACQUISITION	0	0	9			108.00
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION		0				109. 00 110. 00
111. 00 1100 TNTESTINAL ACQUISITION		0				111.00
113. 00 11300 NTEREST EXPENSE	"	O				113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115. 00
				'		

Health Fina	ncial Systems	ST VINCENT ANDERSON	I REGI	ONAL HOSP	I TA	In Lie	u of Form CMS-	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES			Provi der	CCN: 150088	Peri od: From 07/01/2015	Worksheet C Part I	
						To 06/30/2016	Date/Time Pre 11/22/2016 3:	epared: 25 pm
				Ti t	le XIX	Hospi tal	Cost	
			Charges					
	Cost Center Description	Inpatient	0u†	tpati ent	Total (col.	6 Cost or Other	TEFRA	
					+ col. 7)	Ratio	I npati ent	
							Ratio	
		6. 00		7. 00	8. 00	9. 00	10.00	
116. 00 11600	HOSPI CE	C		0		0		116. 00
200. 00	Subtotal (see instructions)	195, 542, 064	4	18, 664, 484	614, 206, 54	8		200. 00
201.00	Less Observation Beds							201.00
202. 00	Total (see instructions)	195, 542, 064	41	18, 664, 484	614, 206, 54	8		202. 00

In Lieu of Form CMS-2552-10
Worksheet C
Part I
30/2016 Date/Time Prepared:
11/22/2016 3: 25 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES ST VINCENT ANDERSON REGIONAL HOSPITA
Provider CCN: 150088 Peri od: From 07/01/2015 To 06/30/2016

		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient		·	
	Ratio			
LNDATI ENT DOUTLNE CEDVI CE COCT CENTEDO	11. 00			
30. 00 O3000 ADULTS & PEDIATRICS				30.00
31. 00 03100 NTENSI VE CARE UNI T				31.00
32. 00 03200 CORONARY CARE UNIT				32. 00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
40. 00 04000 SUBPROVI DER - I PF				40. 00
41. 00 04100 SUBPROVI DER - I RF				41. 00
42. 00 04200 SUBPROVI DER				42. 00
43. 00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44. 00
45. 00 04500 NURSI NG FACILITY				45. 00
45. 01 04510 I CF/MR				45. 01
46. 00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS				46. 00
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
50. 01 05001 SURGERY CENTER	0. 000000			50. 01
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
57.00 05700 CT SCAN	0. 000000			57.00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000			59.00
60. 00 06000 LABORATORY	0.000000			60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY	0. 000000 0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00 07400 RENAL DI ALYSI S	0.000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03190 CHEMOTHERAPY	0. 000000 0. 000000			75. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	0.000000			78.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 ANDERSON CENTER OP CLINIC	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000			94. 00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
99. 00 09900 CMHC 99. 10 09910 CORF				99. 00 99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM				100.00
101. 00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				101:00
105. 00 10500 KIDNEY ACQUISITION				105. 00
106. 00 10600 HEART ACQUI SI TI ON				106. 00
107. 00 10700 LI VER ACQUI SI TI ON				107. 00
108. 00 10800 LUNG ACQUI SI TI ON				108. 00
109.00 10900 PANCREAS ACQUISITION				109. 00
110.00 11000 INTESTINAL ACQUISITION				110. 00
111.00 11100 ISLET ACQUISITION				111. 00
113. 00 11300 I NTEREST EXPENSE				113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200. 00

Health Financial Systems	ST VINCENT ANDERSON RE	EGIONAL HOSPITA	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150088	Peri od:	Worksheet C	
			From 07/01/2015	Part I	
			To 06/30/2016	Date/Time Pre	pared:
			10 00, 00, 2010	11/22/2016 3:	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202. 00

Health Financial Systems	ST VINCENT ANDERSON REG	ONAL HOS	SPI TA	In Lieu	u of Form CMS-2552-10
				T	

Health Financial Systems S	T VINCENT ANDERSON	REGIONAL HOSP	I TA	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	TAL COSTS		<u> </u>	Period: From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 3:	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•	•	•	<u>'</u>	•	
30. 00 ADULTS & PEDIATRICS	1, 379, 430		.,,		58. 66	
31.00 INTENSIVE CARE UNIT	581, 008		581, 008	6, 079	95. 58	
32. 00 CORONARY CARE UNIT	0		(0	0.00	
33.00 BURN INTENSIVE CARE UNIT	0			0	0.00	1
34.00 SURGICAL INTENSIVE CARE UNIT	0		(0	0.00	1
40. 00 SUBPROVI DER - I PF	0	0		0	0.00	
41. 00 SUBPROVI DER - I RF	153, 917	0	153, 91	7 2, 520	61. 08	
42. 00 SUBPROVI DER	0	0		0	0.00	
43. 00 NURSERY	49, 150		49, 150	816	60. 23	
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
45.00 NURSING FACILITY	0			0	0.00	
45. 01 I CF/MR	0			0		45. 01
200.00 Total (lines 30-199)	2, 163, 505		2, 163, 50	32, 930		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS		T	,			
30. 00 ADULTS & PEDI ATRI CS	9, 621	564, 368				30. 00
31.00 INTENSIVE CARE UNIT	3, 513					31. 00
32. 00 CORONARY CARE UNIT	0	0				32. 00
33.00 BURN INTENSIVE CARE UNIT	0	0				33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0)			34. 00
40. 00 SUBPROVI DER - I PF	0	0)			40. 00
41. 00 SUBPROVI DER - I RF	1, 189	72, 624				41. 00
42. 00 SUBPROVI DER	0	0)			42. 00
43. 00 NURSERY	0	0)			43. 00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
45.00 NURSING FACILITY	0	0				45. 00
45. 01 I CF/MR	0	0				45. 01
200.00 Total (lines 30-199)	14, 323	972, 765				200. 00

	INCENT ANDERSON	I REGIONAL HOSP	I TA	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150088	Peri od: From 07/01/2015 To 06/30/2016		pared: 25 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	2, 769, 973	106, 254, 834	0. 0260	9, 229, 257	240, 598	50.00
50. 01 05001 SURGERY CENTER	0					
51. 00 05100 RECOVERY ROOM	0		I			
52. 00 05200 DELI VERY ROOM & LABOR ROOM	184, 540	1	1		o o	
53. 00 05300 ANESTHESI OLOGY	25, 932				1, 798	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 069, 081		1		1	
55. 00 05500 RADI OLOGY-THERAPEUTI C	682, 117		1		13, 356	
56. 00 05600 RADI OI SOTOPE	0		0. 00000		0	1
57. 00 05700 CT SCAN	26, 024	14, 367, 104	1			
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	482, 757				1	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0. 00000		0	
60. 00 06000 LABORATORY	258, 042	63, 245, 725	1			
60. 01 06001 BLOOD LABORATORY	0		0. 00000		0	1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	00	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	11, 168	2, 624, 960	1			
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	1
65. 00 06500 RESPIRATORY THERAPY	145, 305	15, 702, 272			66, 506	65.00
66. 00 06600 PHYSI CAL THERAPY	342, 765		1		0	1
67. 00 06700 OCCUPATI ONAL THERAPY	77, 459				22, 969	
68. 00 06800 SPEECH PATHOLOGY	10, 993				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	379, 598	21, 486, 658			70, 720	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	140, 866				3, 049	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	164, 900	18, 553, 516	0. 00888	4, 419, 401	39, 280	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	117, 016	13, 430, 360	0. 0087 ⁻	13 3, 274, 581	28, 531	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 137, 859	130, 457, 322	0.00872	15, 628, 974	136, 316	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	0.00000	00	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	00	0	75. 00
76. 00 03190 CHEMOTHERAPY	108, 139	3, 009, 190	0. 03593	36 12, 316	443	76. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0					
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1			1	
90. 00 09000 CLI NI C	0	1	1 0.0000		1	
90. 01 09001 ANDERSON CENTER OP CLINIC	46, 321				0	
91. 00 09100 EMERGENCY	372, 783					•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	57, 253	4, 186, 456	0. 0136	76 153, 876	2, 104	92.00
OTHER REIMBURSABLE COST CENTERS		1				
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	00	0	
95. 00 09500 AMBULANCE SERVICES				20	_	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	1 0	1 0	0. 00000	JU 0	0	97.00
200.00 Total (lines 50-199)	8, 610, 891	570, 380, 548	i .	71, 069, 456	838, 894	200 00

Health Financial Systems ST	VINCENT ANDERSON	REGIONAL HOSP	I TA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I	PASS THROUGH COST		<u> </u>	Period: From 07/01/2015 Fo 06/30/2016	Date/Time Pre 11/22/2016 3:	pared: 25 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	o	0))	0	31.00
32. 00 03200 CORONARY CARE UNIT	o o	0		<u>, </u>	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	o o	0		<u></u>	0	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0		2	0	34.00
1	0	0				
40. 00 04000 SUBPROVI DER - 1 PF	0	0	1	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	') 0	0	41. 00
42. 00 04200 SUBPROVI DER	0	0		0	0	42. 00
43. 00 04300 NURSERY	0	0)	O	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0)	O	0	44. 00
45.00 04500 NURSING FACILITY	0	0))	0	45.00
45. 01 04510 I CF/MR	O	0))	0	45. 01
200.00 Total (lines 30-199)	0	0))	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpatient	Inpati ent		
'	Days	5 ÷ col. 6)	Program Days	Program		
	,-			Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	23, 515	0.00	9, 62	1 0		30.00
31.00 03100 INTENSIVE CARE UNIT	6, 079	0.00				31.00
32. 00 03200 CORONARY CARE UNIT	0	0.00				32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	Ŏ	0.00		0		33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0.00		0		34.00
40. 00 04000 SUBPROVI DER - I PF		0.00				40.00
	2 520		1			
41. 00 04100 SUBPROVI DER - I RF	2, 520	0.00		0		41.00
42. 00 04200 SUBPROVI DER	0	0.00		0		42.00
43. 00 04300 NURSERY	816	0.00		0		43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0.00		0		44. 00
45.00 04500 NURSING FACILITY	0	0.00		0		45. 00
45. 01 04510 I CF/MR	0	0.00	1	0		45. 01
200.00 Total (lines 30-199)	32, 930		14, 32	3 0		200. 00

Health Financial Systems ST VINCENT ANDERSON FAPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 150088 THROUGH COSTS

						''	00/30/2010	11/22/2016 3:	
				Ti tl	e XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi no	School	Allied	Heal th	All Other	Total Cost	
	·	Anestheti st	`				Medi cal	(sum of col 1	
		Cost					Education Cost	through col.	
								4)	
		1.00	2.	00	3.	00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS								
50. 00	05000 OPERATI NG ROOM	0		0		0	0	0	50. 00
50. 01	05001 SURGERY CENTER	0		0		0	0	0	50. 01
51. 00	05100 RECOVERY ROOM	0		0		0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0)	0		0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0)	0		0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0)	0		202, 932	0	202, 932	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0)	0		0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0		0		0	0	0	56. 00
57. 00	05700 CT SCAN	0)	0		66, 232	0	66, 232	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0)	0		18, 164	0	18, 164	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0)	0		0	0	0	59. 00
60.00	06000 LABORATORY	0)	0		0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0		0		0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY								61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0		0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0		0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		0		0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0		0		0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0)	0		0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0)	0		0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		0		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0		0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0		0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0		0		0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		0		360, 170	0	360, 170	73. 00
74. 00	07400 RENAL DI ALYSI S	0		0		0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0		0	0	0	75. 00
76. 00	03190 CHEMOTHERAPY	0)	0		0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	_	.1	_		_			
88. 00	08800 RURAL HEALTH CLINIC	0		0	1	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0)	0		0	0	0	89. 00
90.00	09000 CLI NI C	0)	0		0	0	0	90. 00
90. 01	09001 ANDERSON CENTER OP CLINIC	0)	0		0	0	0	90. 01
91.00	09100 EMERGENCY	0	2	0		194, 137	0	194, 137	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0)	0		0	0	0	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS		J		ı	0	0	0	04.00
94. 00 95. 00	09400 HOME PROGRAM DI ALYSI S	0	'	0		0	0	0	94.00
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED			^		0	0	0	95. 00 96. 00
96.00	09700 DURABLE MEDICAL EQUIP-RENTED		(0		0	0	0	96. 00 97. 00
200.00			(0	1	841, 635	ū	841, 635	
200.00) 10tal (111163 30-177)	1	1	U	I	0-1, 030	0	041,033	200.00

Health Financial Systems ST VINCENT ANDERSON REGIONAL HOSPITA In Lieu of Form CMS-2552-1							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF			CCN: 150088	Peri od:	Worksheet D		
THROUGH COSTS				From 07/01/2015	Part IV		
				Го 06/30/2016	Date/Time Pre 11/22/2016 3:	pared: 25 nm	
		Ti tl	e XVIII	Hospi tal	PPS	20 piii	
Cost Center Description	Total	Total Charges		Outpati ent	Inpati ent		
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program		
	Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges		
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.			
	4)			7)			
	6. 00	7. 00	8. 00	9. 00	10. 00		
ANCILLARY SERVICE COST CENTERS		40/ 05/ 00/	0.00000	0.00000	0 000 057	F0 00	
50. 00 05000 OPERATING ROOM	0				9, 229, 257	50.00	
50. 01 05001 SURGERY CENTER	0	· ·			0	50. 01	
51. 00 05100 RECOVERY ROOM	0	0			0	51.00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-, ,			770 001	52.00	
53. 00 05300 ANESTHESI OLOGY	0	,			779, 001		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	202, 932				3, 433, 420	1	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0				542, 384		
56. 00 05600 RADI 0I SOTOPE	0	1	0.00000		0		
57. 00 05700 CT SCAN	66, 232				1, 633, 453		
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	18, 164	1			338, 675		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0. 00000		0		
60. 00 06000 LABORATORY	0				11, 900, 796	60.00	
60. 01 06001 BLOOD LABORATORY	0	0	0. 000000	0. 000000	0	60. 01	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 000000		0	62. 00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	2, 624, 960			569, 299		
64.00 06400 I NTRAVENOUS THERAPY	0		0. 000000		0		
65. 00 06500 RESPI RATORY THERAPY	0				7, 186, 689		
66. 00 06600 PHYSI CAL THERAPY	0				0	66. 00	
67. 00 06700 OCCUPATI ONAL THERAPY	0				1, 790, 546		
68. 00 06800 SPEECH PATHOLOGY	0	,			0	68. 00	
69. 00 06900 ELECTROCARDI OLOGY	0				4, 002, 967	69. 00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				106, 911		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	, ,			4, 419, 401		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0				3, 274, 581	72. 00	
73.00 07300 DRUGS CHARGED TO PATIENTS	360, 170	1			15, 628, 974		
74. 00 07400 RENAL DI ALYSI S	0				0	74. 00	
75.00 07500 ASC (NON-DISTINCT PART)	0		0. 000000		0	75. 00	
76. 00 03190 CHEMOTHERAPY	0	3, 009, 190	0. 00000	0. 000000	12, 316	76. 00	
OUTPATIENT SERVICE COST CENTERS	T	Г	T	T			
88.00 08800 RURAL HEALTH CLINIC	0	1			0		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1			0	89. 00	
90. 00 09000 CLI NI C	0	1			0	90. 00	
90. 01 09001 ANDERSON CENTER OP CLINIC	0				0	90. 01	
91. 00 09100 EMERGENCY	194, 137				6, 066, 910		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4, 186, 456	0. 00000	0. 000000	153, 876	92. 00	
OTHER REIMBURSABLE COST CENTERS	_	-		0.005	_		
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0. 000000	0. 000000	0		
95. 00 09500 AMBULANCE SERVI CES						95. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0		
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000	0. 000000	0	97. 00	
200.00 Total (lines 50-199)	841, 635	570, 380, 548	l		71, 069, 456	200. 00	

Peri od: Worksheet D
From 07/01/2015 Part IV
To 06/30/2016 Date/Time Prepared: 11/22/2016 3: 25 pm THROUGH COSTS

						11/22/2016 3: 25 pm	1
				e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	ŭ	Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS						_
	05000 OPERATING ROOM	l ol	28, 321, 318		ol	50. 0	20
	05000 SURGERY CENTER		20, 321, 310	1	0	50.0	
	l		0				
51.00	05100 RECOVERY ROOM	0	0.700	1	0	51. 0	
	05200 DELIVERY ROOM & LABOR ROOM	0	2, 732	l .	0	52. 0	
53.00	05300 ANESTHESI OLOGY	0	2, 279, 819		0	53. 0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	15, 828	10, 550, 833	48, 63	9	54.0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	12, 574, 277		0	55.0)0
56.00	05600 RADI OI SOTOPE	0	0		0	56.0	00
57.00	05700 CT SCAN	7, 530	3, 378, 750	15, 57	6	57. 0	00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 561	1, 061, 150	4, 89	2	58. 0	00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	o	59. 0	
60.00	06000 LABORATORY	0	6, 847, 199		ō	60.0	
60. 01	06001 BLOOD LABORATORY		0,017,177	1	o	60. 0	
			C				
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					61. 0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0)	l .	0	62. 0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	606, 971		0	63. 0	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	64.0	
65.00	06500 RESPI RATORY THERAPY	0	533, 203		0	65. 0)0
66. 00	06600 PHYSI CAL THERAPY	0	131, 374		0	66. 0)0
67.00	06700 OCCUPATI ONAL THERAPY	0	2, 284		0	67. 0	00
68. 00	06800 SPEECH PATHOLOGY	0	171, 579		0	68. 0	00
69.00	06900 ELECTROCARDI OLOGY	o	6, 997, 217		ol	69. 0	00
	07000 ELECTROENCEPHALOGRAPHY	0	1, 085, 040	1	0	70. 0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 109, 314	1	ō	71. 0	
	07200 I MPL. DEV. CHARGED TO PATIENT		2, 466, 698	1	o o	72. 0	
	07300 DRUGS CHARGED TO PATIENTS	43, 152	44, 927, 955	i		73. 0	
		1					
	07400 RENAL DI ALYSI S	0	0	1	0	74. 0	
	07500 ASC (NON-DISTINCT PART)	0	0	l .	0	75. 0	
76. 00	03190 CHEMOTHERAPY	0	1, 447, 744		0	76. 0)0
	OUTPATIENT SERVICE COST CENTERS				_		
	08800 RURAL HEALTH CLINIC	0	0)	0	88. 0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)	0	89. 0)0
90.00	09000 CLI NI C	0	0)	0	90. 0	00
90. 01	09001 ANDERSON CENTER OP CLINIC	0	363, 516	,	o	90. 0	J1
	09100 EMERGENCY	17, 922	12, 693, 314	1	6	91. 0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 371, 303		ō	92. 0	
,2.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	1, 371, 303	1	~	/2.0	
94. 00	09400 HOME PROGRAM DIALYSIS		0	1	0	94. 0	20
		١	U	1	٦		
	09500 AMBULANCE SERVICES		_			95. 0	
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	1	U	96. 0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	1	O ₁	97. 0	
200.00	Total (lines 50-199)	85, 993	140, 923, 590	230, 64	9	200. 0	JO

APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Pre 11/22/2016 3:	pared: 25 pm
			Ti tl	e XVIII	Hospi tal	PPS	
	·			Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
	ANOLI LADV. CEDVI CE COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
EO 00	ANCI LLARY SERVI CE COST CENTERS	0.200020	20 221 210	I	0 0	F 407 407	FO 00
50.00	05000 OPERATI NG ROOM 05001 SURGERY CENTER	0. 200820 0. 000000			0 0		50.00
50. 01	1 1		1			0	50. 01
51.00	05100 RECOVERY ROOM	0.000000	1		0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 215399			0	588	52.00
53.00	05300 ANESTHESI OLOGY	0. 125475	1		0	286, 060	53.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0. 198003			0	2, 089, 097	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 129163			0	1, 624, 131	55.00
56. 00	05600 RADI OI SOTOPE	0.000000		•	0 0	0	56.00
57. 00	05700 CT SCAN	0. 070361			0	237, 732	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 333960		•	0	354, 382	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			0	0	59. 00
60.00	06000 LABORATORY	0. 127148				870, 608	1
60. 01	06001 BLOOD LABORATORY	0. 000000	1	1	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	ł	1	0	_	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	1	1	0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 232885		1	0	141, 354	
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	ł .		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 161854		1	0	86, 301	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 491730			0	64, 601	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 362921		l .	0	829	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 419224			0	71, 930	1
69. 00	06900 ELECTROCARDI OLOGY	0. 188267			0	1, 317, 345	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 263744			0	286, 173	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 490026		•	0	1, 523, 645	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 480314		•	0	1, 184, 790	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 276851			0 58, 258		
74. 00	07400 RENAL DIALYSIS	0. 000000	1		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000			0	_	75. 00
76. 00	03190 CHEMOTHERAPY	0. 584721	1, 447, 744		0 0	846, 526	76. 00
	OUTPATIENT SERVICE COST CENTERS			1		_	
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	1			0	89. 00
90. 00	09000 CLI NI C	0. 000000			0	0	90.00
90. 01	09001 ANDERSON CENTER OP CLINIC	0. 687278			0	249, 837	90. 01
91. 00	09100 EMERGENCY	0. 131987		•	0		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 277705	1, 371, 303		0 0	380, 818	92. 00
	OTHER REIMBURSABLE COST CENTERS			1			
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000			0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000	1	1	0		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000		1	0	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	ł		0	0	97. 00
200.00			140, 923, 590	1, 02	58, 258	31, 417, 935	1
201.00	1				0		201. 00
000 5	Only Charges		440 000 555		E 50 5==	04 447 655	000 00
202. 00	Net Charges (line 200 +/- line 201)	1	140, 923, 590	1, 02	5 58, 258	31, 417, 935	J202. 00

In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 150088 Peri od: Worksheet D From 07/01/2015 Part V 06/30/2016 Date/Time Prepared: 11/22/2016 3:25 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 50.01 05001 SURGERY CENTER 0000000000 0 50.01 51. 00 05100 RECOVERY ROOM 0 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 57.00 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58 00 58 00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 60.00 06000 LABORATORY 130 0 60.00 06001 BLOOD LABORATORY 00000000000000000 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 72.00 0 72.00 73.00 16, 129 73.00 74.00 07400 RENAL DIALYSIS 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 03190 CHEMOTHERAPY 76.00 0 76.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 90.00 09000 CLI NI C 0 90.00 0 90.01 09001 ANDERSON CENTER OP CLINIC 0 90.01 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 09500 AMBULANCE SERVICES 95.00 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 96.00

0

0

16, 129

16, 129

130

130

97.00

200.00

201 00

202.00

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

200.00

201.00

	57.	LNOENT ANDERCON	L DEGLOVAL LIGED			G. F	0550 40
		INCENT ANDERSON				eu of Form CMS-2	2552-10
APPORT	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		CCN: 150088 CCN: 15T088	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Pre 11/22/2016 3:	
			Ti tl	e XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col		column 4)	
		Part II, col.	8)	2)	. onal goo	l 551 G 1)	
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50.00	05000 OPERATI NG ROOM	2, 769, 973	106, 254, 834	0. 02606	9 7, 130	186	50.00
50. 01	05001 SURGERY CENTER	2,707,770	l .	0. 00000		0	
51. 00	05100 RECOVERY ROOM			0. 00000		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	184, 540	_			0	1
53. 00	05300 ANESTHESI OLOGY	25, 932				0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 069, 081		0. 02428			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	682, 117		0. 02420		0	55.00
56. 00	05600 RADI OLOGI - THERAPEUTI C	002, 117		0.00000		0	
	05700 CT SCAN	_	_				1
57. 00		26, 024		1		l e	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	482, 757				l	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	250.043	_	0.00000		0	
60.00	06000 LABORATORY	258, 042	63, 245, 725			1, 119	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000	0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000		0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	11, 168	2, 624, 960	•		l	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	64. 00
65.00	06500 RESPI RATORY THERAPY	145, 305				1, 618	1
66. 00	06600 PHYSI CAL THERAPY	342, 765				0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	77, 459				i .	67. 00
68. 00	06800 SPEECH PATHOLOGY	10, 993				0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	379, 598				183	
70. 00	07000 ELECTROENCEPHALOGRAPHY	140, 866					70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	164, 900					
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	117, 016				l	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 137, 859	130, 457, 322	0. 00872		3, 901	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0. 00000		0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0. 00000		0	75. 00
76. 00	03190 CHEMOTHERAPY	108, 139	3, 009, 190	0. 03593	6 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
	08800 RURAL HEALTH CLINIC	0					
00 00	08000 FEDERALLY OHALLELED HEALTH CENTER			0 00000	0	Ι	80 00

0

0

46, 321

372, 783

8, 553, 638

1, 902, 744 65, 727, 199

4, 186, 456

570, 380, 548

0.000000

0.000000

0.024344

0.005672

0.000000

0.000000

0.000000

0.000000

0

0

0 92.00

0

Ωl

23, 425 200. 00

0 0 0

0

0

2, 184, 032

89.00

90.00

90. 01

91.00

94.00 0

95.00

96.00

97.00

89.00

90. 01

91.00

92.00

94.00

200.00

90. 00 09000 CLINIC

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

09001 ANDERSON CENTER OP CLINIC

09400 HOME PROGRAM DIALYSIS

96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD

Total (lines 50-199)

H	Health Financial Systems	ST VINCENT ANDERSON REG	IONAL HOSP	I TA	In Lieu of Form CMS-2552-10		
7	APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der	CCN: 150088	Peri od:	Worksheet D	
-	THROUGH COSTS				From 07/01/2015		
			Component	t CCN: 15T088	To 06/30/2016		
_						11/22/2016 3: 2	25 pm_
			Ti tl	e XVIII	Subprovi der -	PPS	
					I RF		
	Cost Center Description	Non Physician Nurs	ing School	Allied Healt	h All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	

			11 11	e xviii	I RF	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health		Total Cost	
	cost center bescription	Anesthetist	Nul 31 lig 3cliool	Airred flearth	Medi cal	(sum of col 1	
		Cost			Education Cost	`	
		0031			Ludcati on cost	4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	C	0	0	50.00
50. 01	05001 SURGERY CENTER	o	0	l c	0	0	50. 01
51.00	05100 RECOVERY ROOM	o	0	l c	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0	l c	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	202, 932	0	202, 932	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55.00
56.00	05600 RADI OI SOTOPE	o	0	l c	0	0	56.00
57.00	05700 CT SCAN	o	0	66, 232	0	66, 232	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	18, 164	0	18, 164	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0		0	0	59.00
60.00	06000 LABORATORY	o	0	l c	0	0	60.00
60. 01	06001 BLOOD LABORATORY	o	0	l c	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	l c	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0	l c	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	o	0	l c	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	o	0	l c	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	o	0	l c	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	o	0	l c	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	o	0	l c	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	o	0	l c	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	l c	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	C	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	o	0	C	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	360, 170	0	360, 170	73.00
74.00	07400 RENAL DIALYSIS	0	0	C	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	75.00
76.00	03190 CHEMOTHERAPY	0	0	C	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	89.00
90.00	09000 CLI NI C	0	0	C	0	0	90.00
90. 01	09001 ANDERSON CENTER OP CLINIC	0	0	C	0	0	90. 01
91.00	09100 EMERGENCY	o	0	194, 137	0	194, 137	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94.00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
200.00	Total (lines 50-199)	0	0	841, 635	0	841, 635	200. 00

APP0R1	Financial Systems ST V TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	INCENT ANDERSON RVICE OTHER PAS	S Provi der	CCN: 150088 F	In Lie Period: From 07/01/2015 To 06/30/2016	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 11/22/2016 3:	
			Ti tl	e XVIII	Subprovi der - I RF	PPS	<u> </u>
	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	(col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS	_					
50. 00 50. 01	O5000 OPERATING ROOM O5001 SURGERY CENTER	0				7, 130 0	50. 00 50. 01
51.00	05100 RECOVERY ROOM	0	0	0. 000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 690, 913	0.000000	0. 000000	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	11, 233, 379	0. 000000	0.000000	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	202, 932	44, 021, 867	0. 004610	0. 004610	24, 034	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	27, 700, 671	0.000000	0.000000	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0. 000000	0.000000	0	56. 00
57.00	05700 CT SCAN	66, 232	14, 367, 104	0. 004610	0. 004610	18, 700	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	18, 164	3, 940, 053	0. 004610	0. 004610	2, 850	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0. 000000	0.000000	0	59. 00
60.00	06000 LABORATORY	0	63, 245, 725	0.000000	0.000000	274, 337	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0. 000000	0.000000	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 000000	0.000000	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	2, 624, 960	0. 000000	0.000000	2, 025	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0. 000000	0.000000	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	15, 702, 272	0.000000	0.000000	174, 837	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	7, 145, 375	0.000000	0.000000	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	6, 038, 364	0.000000	0.000000	1, 155, 800	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	722, 892	0.000000	0.000000	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0			0.000000	10, 361	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	4, 938, 694	0.000000	0.000000	1, 193	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18, 553, 516	0.000000	0.000000	62, 483	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	13, 430, 360			3, 036	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	360, 170	130, 457, 322	0. 00276	0. 002761	447, 246	73. 00
74.00	07400 RENAL DIALYSIS	0		0.00000		0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75. 00
76. 00	O3190 CHEMOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	3, 009, 190	0.000000	0. 000000	0	76. 00
88. 00	08800 RURAL HEALTH CLINIC	0		0. 000000	0.000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			1		0	89. 00
90. 00	09000 CLINIC		_	1		0	90.00
90. 00	09001 ANDERSON CENTER OP CLINIC		1 ~	1		0	90. 00
91. 00	09100 EMERGENCY	194, 137	1 .,,,,,,,			0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	174, 137		1		0	92 00

0.000000

0.000000

0. 000000 0. 000000

0.000000

0.000000

0.000000

0. 000000

4, 186, 456

570, 380, 548

0

841, 635

94.00 0

95.00

96.00 0

97.00 0

0 92.00

2, 184, 032 200. 00

200.00

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
94. 00 09400 HOME PROGRAM DIALYSIS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

Total (lines 50-199)

Health Financial Systems	ST VINCENT ANDERSON REGI	ONAL HOSPITA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150088	Peri od: From 07/01/2015	Worksheet D
Inkough COSTS		Component CCN: 15T088		Date/Time Prepared: 11/22/2016 3:25 pm
		Title XVIII	Subprovi der -	PPS

		Ti tl	le XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent	IKF		
oost content boson per on	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8	g	Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	(0	0		50. 00
50. 01 05001 SURGERY CENTER	0	(0	0		50. 01
51.00 05100 RECOVERY ROOM	0	(0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(O	0		52. 00
53. 00 05300 ANESTHESI OLOGY	0	(O	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	111	(O	0		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(0	0		55. 00
56. 00 05600 RADI OI SOTOPE	0	(0	0		56. 00
57. 00 05700 CT SCAN	86	(0	0		57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	13	(0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(0		59.00
60. 00 06000 LABORATORY	0	()	0		60.00
60. 01 06001 BLOOD LABORATORY	0	(9	O		60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		,				61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(2			62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0	(3			63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	0	(3			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	(2	0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(0		67. 00
68. 00 06800 SPEECH PATHOLOGY		(0		68. 00
69. 00 06900 ELECTROCARDI OLOGY		(0		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	(0		70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		Č	ก	0		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	(0		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 235	(0		73. 00
74. 00 07400 RENAL DI ALYSI S	0	(0		74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	o	(0		75. 00
76. 00 03190 CHEMOTHERAPY	o	(0		76.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u>'</u>		
88.00 08800 RURAL HEALTH CLINIC	0	()	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	(o	0		89. 00
90. 00 09000 CLI NI C	0	(O	0		90.00
90.01 09001 ANDERSON CENTER OP CLINIC	0	(O	0		90. 01
91. 00 09100 EMERGENCY	0	(O O	0		91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(O	0		92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	(0	0		94. 00
95. 00 09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	(9	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	(0		97. 00
200.00 Total (lines 50-199)	1, 445	(0	0		200. 00

Health Financial Systems	ST VINCENT ANDERSON REGI	ONAL HOSPITA	In Lieu of Form CMS-2552-10
ADDODILONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Dravi dan CCN, 150000 Dani adı	Workshoot D

Period: From 07/01/2015 To 06/30/2016 Part V Date/Time Prepared: Component CCN: 15T088 11/22/2016 3:25 pm Title XVIII Subprovi der -**PPS IRF** Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost PPS Services Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 200820 0 50.00 50. 01 05001 SURGERY CENTER 0.000000 0 0 50.01 0 0 05100 RECOVERY ROOM 0.000000 51 00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 215399 0 0 52.00 05300 ANESTHESI OLOGY 0 0 53.00 0.125475 53.00 05400 RADI OLOGY-DI AGNOSTI C 0. 198003 0 54.00 0 54.00 0 0 55 00 05500 RADI OLOGY-THERAPEUTI C 0.129163 Ω 0 55 00 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.070361 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.333960 0 0 58.00 0 59 00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 06000 LABORATORY 0.127148 60.00 60.00 0 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 0.000000 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 232885 0 0 63.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 0 65.00 0.161854 Λ 65.00 06600 PHYSI CAL THERAPY 0.491730 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.362921 67.00 68.00 06800 SPEECH PATHOLOGY 0.419224 0 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0.188267 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0.263744 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.490026 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 72.00 0.480314 C 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 276851 0 73.00 0 07400 RENAL DIALYSIS 0 74.00 0.000000 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75 00 0.000000 Ω 0 75 00 03190 CHEMOTHERAPY 0 76.00 0. 584721 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89 00 89 00 0 90.00 09000 CLI NI C 0.000000 0 0 0 0 90.00 90.01 09001 ANDERSON CENTER OP CLINIC 0.687278 0 0 0 90.01 0 91.00 09100 EMERGENCY 0.131987 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 277705 0 92.00 92.00 0 0 0 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0. 000000 94.00 94.00 0 09500 AMBULANCE SERVICES 0.000000 0 95.00 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 0 97.00 0 0 200.00 Subtotal (see instructions) 0 200. 00 0 0 201.00 Less PBP Clinic Lab. Services-Program 201.00

0 202.00

0

Only Charges

Net Charges (line 200 +/- line 201)

Health Financial Systems	ST VINCENT ANDERSON REG	IONAL HOSPITA	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150088 Component CCN: 15T088	From 07/01/2015	

			Ti tl	e XVIII	Subprovi der -	PPS	25 piii
		Cost	ts		l RF		
	Cost Center Description	Cost	Cost				
	, , , , , , , , , , , , , , , , , , ,	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANOLLI ADV CEDVICE COCT CENTEDS	6. 00	7. 00				
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	l ol	0				50.00
50. 00	05001 SURGERY CENTER		0				50.00
51. 00	05100 RECOVERY ROOM		0				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0				52. 00
53. 00	05300 ANESTHESI OLOGY		0				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	0				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	O	0				55. 00
56.00	05600 RADI OI SOTOPE	0	0				56. 00
57.00	05700 CT SCAN	O	0				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	0	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	_				61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00	06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	0	0				66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		0				68.00
69. 00	06900 ELECTROCARDI OLOGY		0				69.00
	07000 ELECTROENCEPHALOGRAPHY		0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0				71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	o	0				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	O	0				73. 00
	07400 RENAL DI ALYSI S	O	0				74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76. 00	03190 CHEMOTHERAPY	0	0				76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
	09000 CLINIC	0	0				90.00
90. 01	09001 ANDERSON CENTER OP CLINIC	0	0				90. 01
91. 00 92. 00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	l 0	0	L			92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95.00	09500 AMBULANCE SERVICES		0				95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0				96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0				97. 00
200.00		o	0				200.00
201.00		o	_				201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	0	0				202. 00

Heal th	Financial Systems	ST VINCENT ANDERSON RE	GIONAL HOSPITA	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 150088	Peri od:	Worksheet D-1	
				From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 3:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS					
1.00	.00 Inpatient days (including private room days and swing-bed days, excluding newborn)					1. 00
2.00	2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 23,					2. 00
3.00	Private room days (excluding swing-bed	d and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00

NAME TERT CALL PROVIDER COMPONENTS 1.00		III e XVIII Hospital	PPS	
PART ALL PROVIDER COMPONENTS Inpattent days (including private room days, excluding swing-bed days, excluding newborn) 23, 515 21, 10, 10, 10, 10, 10, 10, 10, 10, 10, 1		Cost Center Description	1 00	
MPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS	1.00	
1.00 Impatient days (including private room days, excluding saing-bed and newborn days) 22,516 2,516 2,00 Private room days (coulding saing-bed and observation bed days). If you have only private room days (coulding saing-bed and observation bed days). If you have only private room days (coulding saing-bed and between the private room days) through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 2,530 4,60 7,00 7				
private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Seel - private room days (excluding swing-bed and observation bed days). 5.01 Total swing-bed SWF type inpatient days (including private room days) through December 31 of the cost reporting period (in cell ender year, enter 0 on this line). 7.00 Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (in cell cell ender year, enter 0 on this line). 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (in cell ender year, enter 0 on this line). 8.00 Lotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (in cell ender year, enter 0 on this line). 9.00 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newtorn days). 10.00 Swing-bed SWF type inpatient days applicable to the lite XVIII only (including private room days). 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (in cell ender year, enter 0 on this line). 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (in cell ender year, enter 0 on this line). 10.00 Swing-bed SWF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (in cell ender year, enter 0 on this line). 10.00 Swing-bed SWF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (including private room days). 10.00 Swing-bed SWF type inpatient days applicable to title XVII only (including private room days). 10.00 Total anvaled SWF type inpatient days applicable to services after December	1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23, 515	1.0
do not complete this line. 1. Ose Seni-private room days (excluding swing-bed and observation bod days) 1. Ose Seni-private room days (excluding private room days) 1. Ose Seni-private room days (excluding private room days) 1. Ose Seni-private room days (excluding private room days) 1. Ose Seni-private room days (excluding private room days) 1. Ose Seni-private room days (excluding private room days) 1. Ose Seni-private room days (excluding private room days) 1. Ose Seni-private room days (excluding private room days) 1. Ose Seni-private room days (excluding swing-bed and room days) 1. Ose Seni-private room days (excluding private room days) 1. Ose Seni-private room days (excluding swing-bed and room days) 1. Ose Seni-private room days (excluding private room days) 1. Ose Seni-private room days (excluding swing-bed and room days) 1. Ose Seni-private room days (excluding swing-bed and room days) 1. Ose Seni-private room days (excluding swing-bed and room days) 1. Ose Seni-private room days (excluding swing-bed such through Becember 31 of the cost reporting period (excellent room) 1. Ose Seni-private room days (excluding swing-bed such through Becember 31 of the cost reporting period (excellent room) 1. Ose Seni-private room days (excluding swing-bed such room days) 1. Ose Seni-private room days (excluding swing-bed such room days) 1. Ose Seni-private room days (excluding swing-bed such room days) 1. Ose Seni-private room days (excluding swing-bed such room days) 1. Ose Seni-private room days (excluding swing-bed such room days) 1. Ose Seni-private room days (excluding swing-bed such room days) 1. Ose Seni-private room days (excluding swing-bed says) 1. Ose Seni-private room days (excluding swing-bed say	2.00		23, 515	2. 0
Seei - pri vale room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (in claindary year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (in claindary year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (in claindary year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days) Total inpatient days applicable to the Intervitions) Total inpatient days including private room days applicable to the Program (excluding private room days) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Swing-bed SNF type inpatient days applicable to taltites V or XIX only (including private room days) Swing-bed NF type inpatient days applicable to taltites V or XIX only (including private room days) Swing-bed NF type inpatient days applicable to taltites V or XIX only (including private room days) Swing-bed NF type inpatient days applicable to taltites V or XIX only (including private room days) Swing-bed NF type inpatient days applicable to services through December 31 of the cost Total annexery days (title V or XIX only) Swing-bed December 31 of the cost reporting period (inclaindary period reporting period Total specific of rate for swing-bed SNF services applicable to services through December 31 of the cost Toporting period Total specific directors applicable to SNF services applicable to services after December 31 of the cost reporting period (line 6 on the proper ting period (line 6 on t	3.00		0	3. 0
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period of total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. Total inpatient days including private room days applicable to the Program (excluding swing-bed and membran days) 8. Total swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 8. Total swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 8. Total swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 9. Total swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 9. Total nursery days (title V or XIX only) 9. Total increase and the cost reporting period (if calendar year, enter 0 on this line) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (title V or XIX only) 9. Total nursery days (ti	4 00		22 520	4.0
reporting period. 1.00 Total siming-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 2.00 Total siming-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period. 3.00 Total inpatient days including private room days) after December 31 of the cost reporting period. 3.00 Total inpatient days including private room days) after December 31 of the cost reporting period. 3.00 Total inpatient days including private room days) after December 31 of the cost reporting period (see instructions). 3.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after SNIII only (including private room days). 3.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after SNIII only SNIII only (including private room days). 3.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after SNIII only SNIII only (including private room days). 3.00 SNIII only SNIII only SNIII only (including private room days). 3.00 SNIII only SNIII only SNIII only (including private room days). 3.00 SNIII only SNIII only SNIII only (including private room days). 3.00 SNIII only SNIII only SNIII only SNIII only (including private room days). 3.00 SNIII only SNII				
10 10 10 10 10 10 10 10	5.00		U	3.0
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 9, 621 9, 60 10, 6	6 00		0	6. 0
1.00 Iotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (intering period (intering period)	0.00		· ·	0.0
reporting period Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days including private room days applicable to title XVIII only (including private room days) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total Program (excluding private room days) Total Swing-bed NR 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) Total Program (excluding private room days) Total Swing-bed NR type inpatient days applicable to titles V or XIX only (including private room days) Total Activate of the cost reporting period (if calendar year, enter 0 on this line) Total Calendary or Program (excluding swing-bed days) Total Calendary or Program (excluding swing-bed day	7.00		0	7. 0
reporting period (if callendar year, énter 0 on this line) 10.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if callendar year, enter 0 on this line) 12.00 Swing-bed WF type inpatient days applicable to title XVII only (including private room days) after becember 31 of the cost reporting period (if callendar year, enter 0 on this line) 13.01 SMF type-bed WF type inpatient days applicable to title XVII only (including private room days) 13.02 SMF type-bed WF type inpatient days applicable to title XVIII only (including private room days) 13.03 SMF type-bed WF type inpatient days applicable to XIX only (including private room days) 13.04 SMF type-bed WF type inpatient days applicable to title XVIII only (including private room days) 13.05 SMF type-bed Cost applicable to title XVIII only (including private room days) 13.06 SMF type-bed Cost applicable to title XVIII only (including private room days) 13.07 SMF type-bed Cost applicable to SMF services applicable to services through December 31 of the cost reporting period (including type-bed Cost applicable to SMF type services after December 31 of the cost reporting period (including type-bed Cost applicable to SMF type services after December 31 of the cost reporting period (including type-bed Cost applicable to SMF type services through December 31 of the cost reporting period (line 6 x X III including type-bed Cost applicable to SMF type services through December 31 of the cost reporting period (line 6 x X III including type-bed Cost applicable to SMF type services after December 31 of the cost reporting period (line 6 x X III including type-bed Cost applicable to NF type services after				
7. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 7. Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 8. Through December 31 of the cost reporting period (see instructions) 8. Swing-bed SMF 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) 8. Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 8. Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 8. Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9. Carried Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9. Carried Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9. Carried Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9. Carried Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9. Carried Swing-bed Swing-	8.00		0	8. 0
newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 13.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Total nursery days (title V or XIX only) 16.00 Total nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 SWing-Bed DAUJSMENT 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 X III in 18) 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 X III in 18) 21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 X III in 18) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 X III in 18) 23.00 Swing-bed c	0.00		0 (21	0.0
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 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) 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 (if calendar year, enter 0 on this line) 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) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Total nursery days (title V or XIX only) 17.00 New York (title V or XIX only) 18.00 SWING-BED ADUSTWENT 18.00 Experiment of the cost reporting period (if calendar year, enter 0 on this line) 19.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 19.01 Experiment of the cost reporting period (if the cost reporting peri	9.00		9, 621	9.00
through December' 31 of the cost reporting period (see instructions) 1.00 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) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.10 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.11 August 1.12 Au	10 00		0	10 00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 8 x line 17) 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x line 18) 21.01 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x line 20) 22.02 Swing-bed cost applicable to NF type service after Decemb			Ü	
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 of after December 31 of the cost reporting period (if calendar year, enter 0 on this line) of 13.0 swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of 15.0 on Total nursery days (title V or XIX only) of 15.0 on Total nursery days (t	11.00		0	11.00
through December 31 of the cost reporting period after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (locare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (locare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line of X line 17) 15.00 Total general inpatient routine service cost (see instructions) 16.01 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of X line 18) 17.02 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of X line 19) 18.03 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of X line 19) 18.04 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0) 18.05 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0) 18.06 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0) 28.07 Swing-bed cost applicable to NF type services after Dec				
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.0	12. 00		0	12.00
after December'31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (acare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (acare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (acare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (acare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (acare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (acare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 17. Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 18. Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 18. Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 18. Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 18. On Total swing-bed cost (see instructions) 28. On Total swing-bed cost (see instructions) 29. On Total swing-bed cost (see instructions) 29. On Total swing-bed cost (see charges (excluding swing-bed charges) 29. On Total swing-bed cost (see instructions) 29. On Total swing-bed cost (see instructions) 29. On Total swing-bed cost (see instructions) 2	12 00		0	12 0
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.0 15.0	13.00		U	13.00
15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Notes of the Cost	14.00		0	14.00
SWING BED ADJUSTMENT 1. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 1. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 lawdicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 lawdicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 lawdicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 lawdicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 lawdicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 lawdicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 0.00 lawdicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 0.00 lawdicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 0.00 lawdicaid rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.00 lawdicaid rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.00 lawdicaid rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.00 lawdicaid rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.00 lawdicaid rate for swing-bed cost (line 20 lawdicaid rate for swing-bed cost reporting period (line 8.00 lawdicaid rate for swing-bed cost (line 20 lawdicaid rate for swing-bed cost reporting period (line 8.00 lawdicaid rate for swing-bed cost (line 20 lawdicaid rate for swing-bed cost reporting period (line 8.00 lawdicaid rate for swing-bed cost (line 20 lawdicaid rate for swing-bed cost reporting period (line 8.00 lawdicaid rate for s	15.00		0	15.00
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17.00	16.00		0	16.00
reporting period 19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (21. 00 Total general inpatient routine service cost (see instructions) (28. 010, 857 ct.) (28. 0	47.00		2.22	
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.	17.00		0.00	17.00
reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period reporting states and reporting report	18 00		0.00	18 00
19.00 Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 28,010,857 21.00 21.00 22.00 23.00 24.00 25.00	10.00		0.00	10.0
20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.01 Of total swing-bed cost (see instructions) 29.00 Private room charges (excluding swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 31.00 Average per diem private room charge differential (line 34 x line 31) 31.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 34 x line 31) 31.00 Average per diem private room cost differential (line 34 x line 31) 31.00 Average per diem private room cost differential (line 34 x line 31) 31.00 Average per diem private room cost differential (line 34 x line 31) 31.00 Average per diem private room cost differential (line 34 x line 31) 31.00 Average per diem private room cost differential (line 34 x line 31) 31.00 Average per diem private room cost differential (line 34 x line 31) 31.00 Average per diem private room cost differential (l	19.00		0.00	19.00
reporting period Total general inpatient routine service cost (see instructions) 22.00 Now ing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Now ing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Now ing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Now ing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Now ing-bed cost (see instructions) Now ing-bed cost (see instruct				
21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.01 Decension of the cost reporting period (line 8 x line 20) 28.00 Private ROOM DIFFERENTIAL ADJUSTMENT 28.00 Semi-private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average per diem private room per diem charge (line 29 + line 3) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Private room cost differential (line 32 x line 31) 36.00 Private room cost differential (line 32 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28 x line 31) 38.00 Average per diem private room cost differential (line 32 x line 35) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 P	20. 00		0. 00	20.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.0 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28,010,857 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.0 29.00 Private room charges (excluding swing-bed charges) 0 29.0 30.00 Semi-private room charges (excluding swing-bed charges) 0 29.0 30.00 Semi-private room charges (excluding swing-bed charges) 0 29.0 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0 0.000001 31.00 Average perivate room per diem charge (line 29 + line 3) 0 0.000001 32.00 Average peridiem private room cost differential (line 30 x line 4) 0 0.00 33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0 0.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0 0.00 37.00 Private room cost differential adjustment (line 3 x line 35) 0 0 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1, 191.19 38.0 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 191.19 39.00 1, 40.00 40.00	21 00		20 010 057	21 0
5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.010, 857 29.00 Private ROOM DIFFERENTIAL ADJUSTMENT 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 31.00 Average semi-private room per diem charge (line 29 + line 3) 32.00 Average per diem private room charges differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Private room cost differential adjustment (line 3 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 31.00 Application (line 29 minus line 36) 32.01 PROSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 33.00 Adjusted general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.0 x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (line 21 minus line 26) 28,010,857 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 Average private room per diem charge (line 29 ± line 3) 0.000000 31.00 Average per diem private room per diem charge (line 30 ± line 4) 0.000 32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Private room cost differential djustment (line 3 x line 35) 0 36.00 Private room cost differential djustment (line 3 x line 35) 0 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857 37.00 PROSPAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,191.19 38.00 Program general inpatient routine service cost (line 9 x line 38) 11,460,439 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	22.00		G	22.0
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.01 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.010.857 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average periodem private room periodem charge (line 30 ÷ line 4) 30.00 Average periodem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x line 31) 30.00 Average periodem private room cost differential (line 3 x	23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
7 x line 19) 25.00 26.00 27.00 26.00 27.00 27.00 28.00 29.00 29.00 20		· · · · · · · · · · · · · · · · · · ·		
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRI VATE ROOM DIFFERENTI AL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28, 010, 857) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	24. 00		0	24.00
x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 34 x line 33) (see instructions) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38	25 00		0	25 00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.010,857 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	23.00		O	25.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) 38.00 Ajusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.0 29.00 29.0 29.00 29.0 29.00 29.0 29.00 29.0 29.00 29.0 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 20.00	26.00		0	26.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28, 010, 857) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.0 29.0 29.0 29.0 30.0	27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	28, 010, 857	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00				
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 00000000000000000000000000000000			-	
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00			-	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		i , , , , , , , , , , , , , , , , , , ,		
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28,010,857) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,		
35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28, 010, 857) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 28, 010, 857 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 191. 19 38. 00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	36.00		-	36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 191.19 38.00 Program general inpatient routine service cost (line 9 x line 38) 11, 460, 439 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		28, 010, 857	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 191.19 38.00 Program general inpatient routine service cost (line 9 x line 38) 11, 460, 439 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 191.19 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1, 191.19 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 191.19 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 191.19 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 191.19 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 191.19 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 11, 460, 439 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 11,460,439 39.0	38 00		1 101 10	38 0
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.0				
		· · · · · · · · · · · · · · · · · · ·		
			11, 460, 439	41.0

02.00	interage private reem per arem enarge (interage)	0.00	02.0
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.0
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.0
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	28, 010, 857	37.0
	27 minus line 36)		l
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		l
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		I
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 191. 19	38.0
39. 00	Program general inpatient routine service cost (line 9 x line 38)	11, 460, 439	39.0
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.0
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	11, 460, 439	41.0

COMPUT	Financial Systems ST VI ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150088	Peri od:	Worksheet D-1	
					From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 3:	pared:
	Coat Contan Decerintian	Total	Ti tl Total	e XVIII	Hospi tal	PPS Program Cost	
	Cost Center Description	Total Inpatient Cost	Inpatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
				col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0		ıj 0. t	0	0	42.00
43.00	INTENSIVE CARE UNIT	8, 779, 414	6, 079	1, 444. 2	22 3, 513	5, 073, 545	43. 00
44. 00	CORONARY CARE UNIT	0		1		0	
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0				0	
	OTHER SPECIAL CARE (SPECIFY)	0		0.0	0	0	47.00
.,,	Cost Center Description						171 00
10.00						1.00	10.00
	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)		16, 119, 096 32, 653, 080	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sun	n of Parts I and	900, 141	50. 00
51. 00		atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	924, 887	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				1, 825, 028	52. 00
	Total Program inpatient operating cost exclu	ding capital re	elated, non-phy	sician anesth	netist, and	30, 828, 052	
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	
57. 00 58. 00	Difference between adjusted inpatient operati	ing cost and ta	irget amount (I	ine 56 minus	line 53)	0	
59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endina 1996. u	updated and co	ompounded by the	0.00	
	market basket	0 .		•			
	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	
	which operating costs (line 53) are less than	n expected cost					
(2.00	amount (line 56), otherwise enter zero (see i	nstructions)					(2.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymo	ent (see instri	ıctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						00.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	n period (See	0	65. 00
00.00	instructions)(title XVIII only)				,		00.00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after [December 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili)		70. 00
71. 00	Adjusted general inpatient routine service co	-					71. 00
72.00	Program routine service cost (line 9 x line		Z11	25,			72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine servi						73.00
75. 00	Capital -related cost allocated to inpatient Capital -related cost allocated to inpatient 26, line 45)	•	,		Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minus		rouldor roos	le)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	,		*.	nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service costs for compa			. (, ,		81.00
82. 00	Inpatient routine service cost limitation (li	ne 9 x line 81	* .				82. 00
	Reasonable inpatient routine service costs (ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see ing Utilization review - physician compensation		nns)				84. 00 85. 00
	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87.00	Total observation bed days (see instructions)					976	87. 00

976 87.00 1,191.19 88.00 1,162,601 89.00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	ST VINCENT ANDERSO	N REGIONAL HOSP	I TA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 07/01/2015	Worksheet D-1	
				To 06/30/2016	Date/Time Pre 11/22/2016 3:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROU	IGH COST					
90.00 Capital -related cost	1, 379, 430	28, 010, 857	0. 04924	6 1, 162, 601	57, 253	90. 00
91.00 Nursing School cost	(28, 010, 857	0.00000	0 1, 162, 601	0	91. 00
92.00 Allied health cost	(28, 010, 857	0.00000	0 1, 162, 601	0	92. 00
93.00 All other Medical Education		28, 010, 857	0. 00000	1, 162, 601	0	93. 00

Health Financial Systems	ST VINCENT ANDERSON REGI	ONAL HOSPITA	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150088	Peri od: From 07/01/2015	Worksheet D-1
		Component CCN: 15T088	To 06/30/2016	Date/Time Prepared: 11/22/2016 3:25 pm
		Title XVIII	Subprovi der -	PPS

		TI LIE AVIII	I RF	FF3	
	Cost Center Description			4 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			2, 520	1.00
2.00	Inpatient days (including private room days, excluding swing-bed			2, 520	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	. IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		2, 520	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5.00
	reporting period	daya) after December 3	11 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember 3	of the cost	U	6. 00
7.00	Total swing-bed NF type inpatient days (including private room of	days) through December	31 of the cost	0	7.00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room or reporting period (if calendar year, enter 0 on this line)	days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 189	9. 00
	newborn days)	0 1			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, ento	er 0 on this line)	augo, artor	· ·	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX of	only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year			O	13.00
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed d	lays)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of	the cost	0. 00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of t	he cost	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	e cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			2, 615, 740	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	0	22. 00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reportin	g period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ne 21 minus line 26)		2, 615, 740	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed a Private room charges (excluding swing-bed charges)	and observation bed cha	irges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus	: line 33)(see instruct	ions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	1 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	2, 615, 740	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i	nstructi ons)		1, 037. 99	
39.00	Program general inpatient routine service cost (line 9 x line 3)	•		1, 234, 170	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		0 1, 234, 170	40. 00 41. 00
00	1.22. 1.23. dail gollo. dr. 1.1.pd. 1.3.1. 1.0d. 1110 301 1100 3031 (11110 37 1		ı	., 201, 170	00

C()MPITI	Financial Systems ST VINCENT A ATION OF INPATIENT OPERATING COST	NDERSON REC	Provi der CCI		Peri od:	u of Form CMS-2 Worksheet D-1	
- Omi 01	S. S. HEATEN SERVING COST		Component Co	F	from 07/01/2015 o 06/30/2016	Date/Time Pre	pared:
			Title >	(VIII	Subprovi der -	11/22/2016 3: 2 PPS	∠o µM
	Cost Center Description Tot Inpatie		Total A atient Days Die	verage Per em (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.(00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43. 00	INTENSIVE CARE UNIT	0	0	0. 00	0	0	43.00
44. 00	CORONARY CARE UNIT	O	o	0. 00		0	1
45. 00	BURN INTENSIVE CARE UNIT	0	0	0.00		0	
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0.00	0	0	46. 00 47. 00
17.00	Cost Center Description		 				17.00
	-					1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, Total Program inpatient costs (sum of lines 41 throu					650, 532	
49.00	PASS THROUGH COST ADJUSTMENTS	gii 46) (See	THSTI UCTIONS)			1, 884, 702	1 49.00
50. 00	Pass through costs applicable to Program inpatient r	outine serv	vices (from Wk	st. D, sum	of Parts I and	72, 624	50.00
	III)						
51. 00	Pass through costs applicable to Program inpatient a and IV)	ncillary s	ervices (from	Wkst. D, su	m of Parts II	24, 870	51.00
52. 00	Total Program excludable cost (sum of lines 50 and 5	1)				97, 494	52.00
53. 00	Total Program inpatient operating cost excluding cap	ital relate	ed, non-physic	cian anesthe	tist, and	1, 787, 208	53.00
	medical education costs (line 49 minus line 52)						-
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0	
57. 00 58. 00	Difference between adjusted inpatient operating cost Bonus payment (see instructions)	and targe	t amount (line	e 56 minus I	ine 53)	0	
59.00	Lesser of lines 53/54 or 55 from the cost reporting	period endi	na 1996. upda	ated and com	pounded by the	0. 00	
	market basket	,	g, -p		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
60.00	Lesser of lines 53/54 or 55 from prior year cost rep					0.00	
61. 00	If line 53/54 is less than the lower of lines 55, 59 which operating costs (line 53) are less than expect					0	61.00
	amount (line 56), otherwise enter zero (see instruct		11100 01 X 00)	,	the target		
62.00	Relief payment (see instructions)		`			0	
63. 00	Allowable Inpatient cost plus incentive payment (see PROGRAM INPATIENT ROUTINE SWING BED COST	instructio	ons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine costs throu	gh December	r 31 of the co	st reportir	g period (See	0	64.00
	instructions)(title XVIII only)					_	
65. 00	Medicare swing-bed SNF inpatient routine costs after instructions)(title XVIII only)	December :	31 of the cost	reporting	period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routine costs	(line 64 p	olus line 65)(title XVIII	only). For	0	66.00
	CAH (see instructions)		·	•	<i>3</i> .		
67. 00	Title V or XIX swing-bed NF inpatient routine costs	through Dec	cember 31 of t	the cost rep	orting period	١	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs	after Dece	mber 31 of the	e cost repor	tina period	o	68.00
	(line 13 x line 20)			•	J 1		
69. 00	Total title V or XIX swing-bed NF inpatient routine	•				0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING F. Skilled nursing facility/other nursing facility/ICF/						70.00
71. 00	Adjusted general inpatient routine service cost per						71.00
72.00	Program routine service cost (line 9 x line 71)	D (1)		25)			72.00
73. 00 74. 00	Medically necessary private room cost applicable to Total Program general inpatient routine service cost			35)			73.00
75. 00	Capital -related cost allocated to inpatient routine		,	ksheet B, Pa	rt II, column		75. 00
	26, line 45)						
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)						76.00
78. 00	Inpatient routine service cost (line 74 minus line 7	7)					78.00
79. 00	Aggregate charges to beneficiaries for excess costs						79. 00
80. 00 81. 00	Total Program routine service costs for comparison t	o the cost	limitation (I	ine 78 minu	s line 79)		80.00
	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x	line 81)					82.00
83. 00	Reasonable inpatient routine service costs (see inst	,					83. 00
84. 00	Program inpatient ancillary services (see instruction						84. 00
85. 00	Utilization review - physician compensation (see ins Total Program inpatient operating costs (sum of line		ah 85)				85. 00 86. 00
86 00			gii 00 <i>)</i>				1 30.00
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUG	n CU31					
87. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (li					0	87. 00 88. 00

Health Financial Systems ST	VINCENT ANDERSON	REGIONAL HOSP	I TA	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 07/01/2015 To 06/30/2016		
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
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	153, 917	2, 615, 740	0. 05884	3 0	0	90.00
91.00 Nursing School cost	C	2, 615, 740	0.00000	0	0	91.00
92.00 Allied health cost	C	2, 615, 740	0.00000	0	0	92.00
93.00 All other Medical Education	c	2, 615, 740	0. 00000	0 0	0	93. 00

Health Financial Systems	ST VINCENT	ANDERSON REG	IONAL HOSPITA	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der CCN: 150088	Peri od: From 07/01/2015	Worksheet D-1	
				To 06/30/2016	Date/Time Pre 11/22/2016 3:	
			Title XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						1
1.00 Inpatient days (including private ro	Inpatient days (including private room days and swing-bed days, excluding newborn)					1.00
2.00 Inpatient days (including private ro	Inpatient days (including private room days, excluding swing-bed and newborn days)					

	litie XIX Hospital	COST	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23, 515	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	23, 515 0	2. 00 3. 00
4. 00	do not complete this line.	22, 539	4. 00
5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	22, 539	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	873	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00 15. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	816 685	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	28, 005, 455 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 28, 005, 455	26. 00 27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33. 00	Average semi-private room per diem charge (line 3) ÷ line 4)	0. 00	33.00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	28, 005, 455	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 190. 96 1, 039, 708	38. 00 39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 039, 708	41.00

111 #6-	Figure 1 Contains	INCENT ANDEDCOM	DECLONAL HOCE	1 TA	1 1	ou of Farm CNC (2552 40	
	Financial Systems ST V ATION OF INPATIENT OPERATING COST	INCENT ANDERSON		CCN: 150088	Period:	eu of Form CMS-2 Worksheet D-1		
COMITOT	ATTON OF THE ATTENT OF ENATITIES COST		Trovider	CCN. 130000	From 07/01/2015 To 06/30/2016		pared:	
				le XIX	Hospi tal	Cost		
	Cost Center Description	Total	Total	Average Per		Program Cost		
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)		
		1.00	2. 00	3.00	4. 00	5. 00		
42. 00	NURSERY (title V & XIX only)	1, 219, 286					42. 00	
	Intensive Care Type Inpatient Hospital Units							
43. 00	INTENSIVE CARE UNIT	8, 779, 414	6, 079					
44. 00	CORONARY CARE UNIT	0	0 0				1	
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0						
	OTHER SPECIAL CARE (SPECIFY)			0.0			47. 00	
	Cost Center Description	'		•				
						1. 00		
48. 00	Program inpatient ancillary service cost (Wk			>		3, 848, 896	1	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	ins)		5, 951, 139	49. 00	
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	ı Wkst. D. sum	of Parts I and	0	50.00	
	[111)		·					
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51.00	
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00	
	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	ا		
	medical education costs (line 49 minus line		, . , . , . , . , . , . , . , .					
	TARGET AMOUNT AND LIMIT COMPUTATION							
	Program di scharges					0		
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1	
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	٥	1	
		0	58. 00					
59. 00	0 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the							
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report ur	dated by the m	arkat haskat		0.00	60.00	
	If line 53/54 is less than the lower of line				the amount by	0.00	1	
	which operating costs (line 53) are less tha							
	amount (line 56), otherwise enter zero (see	instructions)				_		
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym		0					
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistro	ictrons)			0	03.00	
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reporti	ng period (See	0	64. 00	
	instructions)(title XVIII only)							
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	Lonly) For	0	66. 00	
00.00	CAH (see instructions)		0. p. do	, (1. 1. 0 , , , , ,			00.00	
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	porting period	0	67. 00	
68. 00	(line 12 x line 19)	o costs ofter	locombor 21 cf	the cost ress	rting period	0	60 00	
00.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs ditel L	ecember 31 01	the cost repo	i triig perrou		68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)		0	69. 00	
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facil	-					70.00	
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		THE 70 ÷ TIME	۷)			71. 00 72. 00	
73. 00	Medically necessary private room cost applic		ı (line 14 x li	ne 35)			73. 00	
74.00	Total Program general inpatient routine serv		74. 00					
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	lorksheet B, F	art II, column		75. 00	
74 00	26, line 45)	no 2)					76. 00	
76. 00 77. 00							77.00	
78. 00							78. 00	
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)						79. 00	
80.00	, ,						80. 00 81. 00	
81. 00 82. 00								
83. 00								
84. 00								
85.00	Utilization review - physician compensation	•					85.00	
86. 00	Total Program inpatient operating costs (sum		rough 85)				86.00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					976	87. 00	
	, and the second	,				,,,,,		

976 87.00 1,190.96 88.00 1,162,377 89.00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems ST	VINCENT ANDERSON	REGIONAL HOSP	I TA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 07/01/2015	Worksheet D-1	
				To 06/30/2016	Date/Time Pre 11/22/2016 3:	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	SH COST					
90.00 Capital-related cost	1, 379, 430	28, 005, 455	0. 04925	6 1, 162, 377	57, 254	90. 00
91.00 Nursing School cost	C	28, 005, 455	0. 000000	0 1, 162, 377	0	91. 00
92.00 Allied health cost	C	28, 005, 455	0. 000000	0 1, 162, 377	0	92. 00
93.00 All other Medical Education	c	28, 005, 455	0. 000000	0 1, 162, 377	0	93. 00

Health Financial Systems	ST VINCENT ANDERSON REGIONA	L HOSPITA	In Lie	u of Form CMS-2552-10

Health Financial Systems ST VINCENT ANDERSON REGI	ONAL HOSP	PI TA	In Li∈	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150088	Peri od:	Worksheet D-3	
			From 07/01/2015		
			To 06/30/2016		
	Ti +I	e XVIII	Hospi tal	11/22/2016 3: 2 PPS	25 piii
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 charges		9	
			Charges	(col . 1 x col .	
		1 00	2.00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			10, 573, 135		30.00
31. 00 03100 I NTENSI VE CARE UNI T			9, 289, 075		31.00
			9, 209, 073		•
1 1			0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33.00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - I PF			0		40. 00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
42. 00 04200 SUBPROVI DER			0		42. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM		0. 20082			50. 00
50. 01 05001 SURGERY CENTER		0.00000	0 0	0	50. 01
51. 00 05100 RECOVERY ROOM		0.00000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 21539	99 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 12547	779, 001	97, 745	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19800	3, 433, 420	679, 827	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12935	542, 384	70, 160	55. 00
56. 00 05600 RADI 0I SOTOPE		0.00000		0	56. 00
57. 00 05700 CT SCAN		0. 07036		114, 931	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 33396			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59.00
60. 00 06000 LABORATORY		0. 12793			60.00
60. 01 06000 BLOOD LABORATORY		0. 00000		1, 322, 310	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61. 00
		1		_	•
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		122 501	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 23288			63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 16516			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 49173		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 36292			67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 41922		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 18826			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 26527		28, 360	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 49002	4, 419, 401	2, 165, 621	71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENT		0. 48031	3, 274, 581	1, 572, 827	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27685	15, 628, 974	4, 326, 897	73. 00
74. 00 07400 RENAL DIALYSIS		0.00000	0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)		0.00000	00	0	75. 00
76. 00 03190 CHEMOTHERAPY		0. 58472	12, 316	7, 201	76. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	00	0	89. 00
90. 00 09000 CLI NI C		0.00000	00	0	90.00
90. 01 09001 ANDERSON CENTER OP CLINIC		0. 68727		0	90. 01
91. 00 09100 EMERGENCY		0. 13198		800, 753	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 27770			92.00
OTHER REI MBURSABLE COST CENTERS		0.2///	1007070	12/102	/2.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	00	0	94. 00
95. 00 09500 AMBULANCE SERVI CES		0.00000			95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.00000	00	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		0	97.00
200.00 Total (sum of lines 50-94 and 96-98)		0.00000	71, 069, 456		1
201.00 Less PBP Clinic Laboratory Services-Program only charges (ling 61)		/ 1, 009, 450	10, 119, 090	200.00
202.00 Net Charges (Line 200 minus Line 201)	11110 01)		71, 069, 456		201.00
202.00 Net onalyes (Title 200 IIII Hus Title 201)		1	/ 1, 007, 430	I .	1202.00

Health Financial Systems	ST VINCENT	ANDERSON	REGI (ONAL HOSP	I TA			In Lie	u of Form CMS-2552	-10
INPATIENT ANCILLARY SERVICE COST APPORTIONME	TV			Provi der	CCN:			od: 07/01/2015	Worksheet D-3	
				Component	CCN	: 15T088	То	06/30/2016	Date/Time Prepare	

		Component	CCN: 15T088	To 06/30/2016	Date/Time Pre 11/22/2016 3:	
		Titl€	e XVIII	Subprovider -	PPS	
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col.	
		-	1 00	2.00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1. 00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDI ATRI CS			0		30.00
	03100 I NTENSI VE CARE UNI T			0		31.00
	03200 CORONARY CARE UNIT			0		32. 00
33.00	03300 BURN INTENSIVE CARE UNIT			0		33. 00
	03400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
	04000 SUBPROVI DER - I PF			0		40. 00
	04100 SUBPROVI DER - I RF			1, 425, 859		41. 00
	04200 SUBPROVI DER			0		42. 00
43. 00	04300 NURSERY					43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS		0.20002	0 7, 130	1 422	50.00
	05000 OPERATI NG ROOM 05001 SURGERY CENTER		0. 20082 0. 00000		1, 432	1
	05100 RECOVERY ROOM	1	0. 00000		0	1
	05200 DELIVERY ROOM & LABOR ROOM		0. 21539		0	1
	05300 ANESTHESI OLOGY		0. 12547		Ö	
	05400 RADI OLOGY-DI AGNOSTI C		0. 19800		4, 759	1
	05500 RADI OLOGY-THERAPEUTI C		0. 12935		0	1
	05600 RADI OI SOTOPE		0.00000		Ō	56. 00
	05700 CT SCAN		0. 07036		1, 316	1
	05800 MAGNETIC RESONANCE I MAGING (MRI)	İ	0. 33396			1
59. 00	05900 CARDI AC CATHETERI ZATI ON	İ	0.00000	0 0	0	59. 00
60.00	06000 LABORATORY		0. 12793	4 274, 337	35, 097	60.00
60. 01	06001 BL00D LABORATORY		0.00000	0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000	0	0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	0	0	62. 00
	06300 BLOOD STORING, PROCESSING & TRANS.		0. 23288		472	1
	06400 I NTRAVENOUS THERAPY		0.00000		0	64. 00
	06500 RESPI RATORY THERAPY		0. 16516		1	1
	06600 PHYSI CAL THERAPY		0. 49173		0	66. 00
	06700 OCCUPATI ONAL THERAPY		0. 36292		419, 464	1
	06800 SPEECH PATHOLOGY		0. 41922		1 051	
	06900 ELECTROCARDI OLOGY	+	0. 18826		1, 951	1
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26527 0. 49002		316 30, 618	1
	07100 MEDICAL SUPPLIES CHARGED TO PATTENTS 07200 IMPL. DEV. CHARGED TO PATIENT		0. 48031			1
	07300 DRUGS CHARGED TO PATIENTS		0. 27685			73. 00
	07400 RENAL DI ALYSI S		0. 00000		0	1
	07500 ASC (NON-DISTINCT PART)		0. 00000		Ö	1
	03190 CHEMOTHERAPY		0. 58472		0	1
	OUTPATIENT SERVICE COST CENTERS				<u>'</u>	1
88. 00	08800 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
	09000 CLI NI C		0.00000		0	
	09001 ANDERSON CENTER OP CLINIC		0. 68727		0	
	09100 EMERGENCY	1	0. 13198		l .	
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 27770	5 0	0	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS		0.0000			04.00
	09400 HOME PROGRAM DI ALYSI S		0.00000	0	0	
	09500 AMBULANCE SERVICES		0 00000		_	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD		0. 00000 0. 00000		0	
200.00			0.00000	2, 184, 032	1	1
200.00		ine 61)		2, 104, U32	030, 332	201. 00
202.00		31)		2, 184, 032		202. 00
50	1 22 2 3-2 (2-2 20.)			_,, 502	ı	,

Health Financial Systems	ST VINCENT ANDERSON REGIONA	L HOSPITA	In Lie	u of Form CMS-2552-10

Health Financial Systems ST VINCENT ANDERSON REGI	ONAL HOSP	PI TA	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150088	Peri od:	Worksheet D-3	
			From 07/01/2015	D-+- /T: D	
			To 06/30/2016	Date/Time Pre 11/22/2016 3:	
	Ti t	le XIX	Hospi tal	Cost	25 piii
Cost Center Description		Ratio of Cos		Inpati ent	
oost contor bescriptron		To Charges	Program	Program Costs	
		l .c c.ia. gcc	Charges	(col. 1 x col.	
			onal goo	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			11, 298, 464		30.00
31.00 03100 INTENSIVE CARE UNIT			2, 061, 048		31.00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 20082	.0 3, 516, 777	706, 239	50.00
50. 01 05001 SURGERY CENTER		0.00000	0 0	0	50. 01
51.00 05100 RECOVERY ROOM		0.00000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 21539	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 12547	75 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19800	1, 054, 954	208, 884	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12916	84, 966	10, 974	55. 00
56. 00 05600 RADI 0I SOTOPE		0.00000	0 0	0	56. 00
57. 00 05700 CT SCAN		0. 07036	389, 702	27, 420	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 33396	0 107, 210	35, 804	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	0 0	0	59. 00
60. 00 06000 LABORATORY		0. 12714	8 3, 721, 427	473, 172	60.00
60. 01 06001 BL00D LABORATORY		0.00000	0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000	0 0	0	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	0 0	0	62. 00
63.00 O6300 BLOOD STORING, PROCESSING & TRANS.		0. 23288	85 0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	0 0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 16185		339, 358	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 49173		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 36292		37, 009	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 41922		222	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 18826		151, 757	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 26374		7, 766	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 49002		l	71. 00
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENT		0. 48031		1	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 27685			73. 00
74. 00 07400 RENAL DI ALYSI S		0.00000		0	74.00
75. 00 O7500 ASC (NON-DISTINCT PART)		0.00000		0	75. 00
76. 00 03190 CHEMOTHERAPY		0. 58472	21 399	233	76. 00
OUTPATIENT SERVICE COST CENTERS		0.0000	20		00.00
88. 00 08800 RURAL HEALTH CLINIC		0.00000			
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER		0.00000		1	89. 00
90. 00 09000 CLI NI C		0.00000		0	90.00
90. 01 09001 ANDERSON CENTER OP CLINIC		0. 68727		0	90. 01
91. 00 09100 EMERGENCY		0. 13198		322, 869	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 27770	05 0	0	92. 00
OTHER REI MBURSABLE COST CENTERS		1 0 0000	10		04.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	0	0	94.00
95. 00 09500 AMBULANCE SERVICES		0.0000	20	_	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.00000		0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.00000			97.00
200.00 Total (sum of lines 50-94 and 96-98) 201.00 Less PBP Clinic Laboratory Services-Program only charges (lino 41)		19, 744, 324	3, 848, 896	200.00
202.00 Net Charges (line 200 minus line 201)	11110 01)		19, 744, 324		201.00
202.00 Net Glarges (True 200 IIII Hus True 201)		1	17, 144, 324	I	1202.00

Health Financial Systems	ST VINCENT	ANDERSON REG	ONAL HOSPI	TA		In Lie	u of Form (CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	-		Provi der	CCN:	150088		Worksheet	D-3
			Component	CCN	: 15T088	07/01/2015 06/30/2016		Prepared:

		Component	CCN: 15T088	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 3:	
		Ti tl	e XIX	Subprovi der - I RF	Cost	25 μιι
	Cost Center Description	1	Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	LNDATIENT DOUTINE CEDAL OF COCT CENTEDS		1. 00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS			0		30. 00
31. 00	03100 INTENSI VE CARE UNI T			0		31.00
32. 00	03200 CORONARY CARE UNIT			0		32.00
33. 00	03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00	03400 SURGI CAL INTENSIVE CARE UNIT			0		34.00
40. 00	04000 SUBPROVI DER			422 000		40.00
41. 00	04100 SUBPROVI DER			433, 998		41.00
42. 00	04200 SUBPROVI DER			0		42. 00
43. 00	04300 NURSERY			0		43. 00
F0 00	ANCI LLARY SERVI CE COST CENTERS		0.0000	20		F0 00
50.00	05000 OPERATI NG ROOM		0. 20082		0	50.00
50. 01	05001 SURGERY CENTER		0.00000		0	50. 01
51.00	05100 RECOVERY ROOM		0.00000		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 21539		0	52. 00
53. 00	05300 ANESTHESI OLOGY		0. 12547		0	53. 00
54. 00	05400 RADI OLOGY -DI AGNOSTI C		0. 19800		2, 271	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 12916		0	55. 00
56. 00	05600 RADI OI SOTOPE		0.00000		0	56.00
57. 00	05700 CT SCAN		0.07036		1, 119	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 33396		317	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59. 00
60.00	06000 LABORATORY		0. 12714		13, 501	60.00
60. 01	06001 BLOOD LABORATORY		0. 00000		0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 23288		0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY		0.00000		0	64. 00
65. 00	06500 RESPI RATORY THERAPY		0. 16185		7, 894	65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 49173		0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY		0. 36292		166, 793	67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 41922		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 18826		868	69. 00
	07000 ELECTROENCEPHALOGRAPHY		0. 26374		315	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 49002		139	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 48031		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS		0. 27685		48, 261	73. 00
	07400 RENAL DI ALYSI S		0.00000		0	74. 00
	07500 ASC (NON-DISTINCT PART)		0.00000		0	75. 00
76. 00	03190 CHEMOTHERAPY		0. 58472	21 0	0	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS		0.0000	20 0	0	00.00
88. 00	08800 RURAL HEALTH CLINIC		0.00000			
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	, 0	Ĭ	07.00
	09000 CLI NI C		0.00000		0	
	09001 ANDERSON CENTER OP CLINIC		0. 68727		0	90. 01
	09100 EMERGENCY		0. 13198		0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 27770	05 0	0	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS	1	0.0000	20	^	04.00
	09400 HOME PROGRAM DI ALYSI S		0. 00000	00	0	
	09500 AMBULANCE SERVI CES		0 0000	20	_	95. 00
	09600 DURABLE MEDICAL EQUI P-RENTED		0.00000		0	
	09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		0	97. 00
200.00		Line (1)		823, 271	241, 478	
201.00		i i ne 61)		000 071		201. 00
202. 00		ļ		823, 271	I	202. 00

Health Financial Systems	ST VINCENT ANDERSON REGIONAL HOSPITA	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150088	From 07/01/2015 Part A To 06/30/2016 Date/Time Prepared:
		From 07/01/2015 Part A

			10 06/30/2016	11/22/2016 3:3	
		Title XVIII	Hospi tal	PPS	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin instructions)	g prior to October 1 (see	0 4, 792, 965	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurrin instructions)	g on or after October	1 (see	13, 704, 025	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	di scharges occurri ng	prior to October	0	1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	di scharges occurri ng	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			1, 936, 088	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0	2. 01
3.00	Managed Care Simulated Payments			0	3.00
4. 00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	ing period (see instru	ctions)	119. 33	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most	recent cost reporting	period endina on	0.00	5. 00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet th			0. 00	6. 00
7. 00	for new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified un			0.00	7.00
7. 00	ACA Section 5503 reduction amount to the IME cap as specified u	ınder 42 CFR §412.105(f		0.00	7. 00
8. 00	If the cost report straddles July 1, 2011 then see instructions Adjustment (increase or decrease) to the FTE count for allopath affiliated programs in accordance with 42 CFR 413.75(b), 413.79 1998), and 67 FR 50069 (August 1, 2002).	ic and osteopathic pro		0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slot the cost report straddles July 1, 2011, see instructions.	s under section 5503 o	f the ACA. If	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slot lunder section 5506 of ACA. (see instructions)	s from a closed teachi	ng hospital	0.00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8, 8,01 and 8,02) (see	0. 00	9. 00
10. 00 11. 00	<pre>instructions) FTE count for allopathic and osteopathic programs in the curren FTE count for residents in dental and podiatric programs.</pre>	it year from your recor	ds	0. 00 0. 00	10. 00 11. 00
12. 00	Current year allowable FTE (see instructions)				12.00
13. 00	Total allowable FTE count for the prior year.			0. 00	ı
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	tember 30, 1997,	0. 00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0. 00	15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16. 00
17.00	Adjustment for residents displaced by program or hospital closu	ire		0.00	17. 00
18.00	Adjusted rolling average FTE count				18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	1
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	n 422 of the MMA		0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen		ec. 412.105	0.00	23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the Lo	wer of line 23 or line	24 (see	0.00	1
26. 00	instructions) Resident to bed ratio (divide Line 25 by Line 4)			0. 000000	26. 00
	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000	27.00
27. 00					
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 00 29. 01
20.00	Disproportionate Share Adjustment Descentage of SSL registers nations days to Medicare Part A nat	iont days (ass instance	tions)	A 47	20 00
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	rent days (see instruc	LI UIIS)	4. 47	30.00
31. 00	Percentage of Medicaid patient days (see instructions)			26. 06	
32.00	Sum of lines 30 and 31			30. 53	1
33.00	Allowable disproportionate share percentage (see instructions)			14. 40	1
34.00	Disproportionate share adjustment (see instructions)		I	665, 892	J 34. UU

CALCUI	Financial Systems ST VINCENT ANDERSON RELATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150088	Peri od: From 07/01/2015	u of Form CMS-2 Worksheet E Part A	
			To 06/30/2016	Date/Time Prep 11/22/2016 3:2	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment				
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		7, 647, 644, 885 0. 000196905	6, 406, 145, 534 0. 000199669	35. 00 35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, ento (see instructions)	er zero on this line)	1, 505, 860	1, 279, 110	
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amount of the uncompensated care (sum of columns 1 and 2 on line 35.0).	3)	379, 560 1, 337, 145	957, 585	35. 03 36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges on Worksheet S-3, Part I excluding of		0		40. 00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	83, 684 an 685. (see	0		41. 00
41. 01	instructions) Total ESRD Medicare covered and paid discharges excluding MS-lan 685. (see instructions)	DRGs 652, 682, 683, 684	0		41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quality Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68: instructions)		0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided lays)		0. 000000		44. 00
45. 00 46. 00	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41.		0.00		45. 00 46. 00
47. 00	Subtotal (see instructions)	. 01)	22, 436, 115		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sr only. (see instructions)	mall rural hospitals	0		48. 00
	John y. (See Thistructions)			Amount	
49. 00	Total payment for inpatient operating costs (see instructions))		1. 00 22, 436, 115	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	d Pt. II, as applicable)		1, 618, 072	50.00
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lin			0	51. 00 52. 00
53. 00	Nursing and Allied Health Managed Care payment	ne 47 see mistraetrons).		19, 357	
54.00	Special add-on payments for new technologies			0	54. 00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 64	· ·		0	55.00
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see intro Routine service other pass through costs (from Wkst. D, Pt. I)		hrough 35)	0	56. 00 57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.		ili ougii 55).	85, 993	
59. 00	Total (sum of amounts on lines 49 through 58)	,		24, 159, 537	59. 00
60.00	Primary payer payments			8, 361	
61. 00 62. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	Tine 60)		24, 151, 176 2, 250, 948	
63.00	Coinsurance billed to program beneficiaries			123, 277	63. 00
64. 00	Allowable bad debts (see instructions)			149, 076	
65.00	Adjusted reimbursable bad debts (see instructions)			96, 899	65. 00
66.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		87, 595	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	annliaghla ta MC DDCa (a	aa imatmuatiana)	21, 873, 850	
60 00	Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).	• •		0	68. 00 69. 00
68. 00 69. 00	outries payments reconcilitation (same of fines 70, 70 and 70).	(101 301 300 That do thon	3)	0	70. 00
68. 00 69. 00 70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70. 50
69. 00 70. 00 70. 50	RURAL DEMONSTRATION PROJECT				
69. 00 70. 00 70. 50 70. 88	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment			0	70. 88
69. 00 70. 00 70. 50 70. 88 70. 89	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see insti	ructions)		0	70. 89
69. 00 70. 00 70. 50 70. 88	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment	ructi ons)			
69. 00 70. 00 70. 50 70. 88 70. 89 70. 90	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see insti	ructi ons)		0	70. 89 70. 90
69. 00 70. 00 70. 50 70. 88 70. 89 70. 90 70. 91	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	ructi ons)		0 0 0	70. 89 70. 90 70. 91 70. 92 70. 93

	Financial Systems ST VINCENT ANDERSON REC	_		•	eu of Form CMS-	2552-10
CALCUI	LATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150088	Peri od: From 07/01/2015	Worksheet E Part A	
				To 06/30/2016		pared:
					11/22/2016 3:	25 pm
		litl	e XVIII	Hospi tal	PPS	
			FFY	(yyyy) 0	Amount 1.00	
70.06	Low volume adjustment for federal fiscal year (yyyy) (Enter in	col ump 0		0	1.00	70. 96
70. 90	the corresponding federal year for the period prior to 10/1)	cor uniir o		U	0	70.90
70 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 97
, 0. , ,	the corresponding federal year for the period ending on or after			· ·		' ' ' ' '
70. 98		,			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	9 & 70)			21, 502, 519	71. 00
71. 01	Sequestration adjustment (see instructions)				430, 050	71. 01
72.00	Interim payments				20, 873, 083	72. 00
73.00					0	73. 00
74.00					199, 386	1
75. 00		ce with			212, 054	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	\			_	
90.00		ructions)			0	
91. 00 92. 00		a+! ono)			0	
92.00					0	
	The rate used to calculate the time value of money (see instructions)					94.00
	Time value of money for operating expenses (see instructions)	2013)			0.00	
	Time value of money for capital related expenses (see instructi	ons)			o o	
70.00	This varies of money for superior expenses (see this true to	0.10)		Prior to 10/1		70.00
				1. 00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0.000000000	•	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions))		0	0	102. 00
100.00	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100 00
103.00	HRR adjustment factor (see instructions)			0.0000	ı U. 0000	103.00

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

0. 0000 103. 00 0 104. 00

0.0000

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 150088

					'	0 00/00/2010	11/22/2016 3:	
	,				e XVIII	Hospi tal	PPS	-
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0		0	1. 00
1. 01	payments DRG amounts other than outlier	1. 01	4, 792, 965	0	4, 792, 965		4, 792, 965	1. 01
1. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	13, 704, 025	0		13, 704, 025	13, 704, 025	1. 02
1. 02	payments for discharges occurring on or after October	1. 52	13, 73 1, 623	J		10, 701, 623	13, 731, 323	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		O	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	1, 936, 088	0	564, 815	1, 371, 273	1, 936, 088	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adju	3.00	0	0	0	0	0	4. 00
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see instructions)							
7. 00	Indirect Medical Education Adju	27.00	0. 000000	0.000000	0. 000000	0. 000000		7. 00
7.00	(see instructions)	27.00	0.000000	0.000000	0.000000	0.00000		7.00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	O	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	O	0	9. 01
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1440	0. 1440	0. 1440	0. 1440		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34.00	665, 892	0	172, 547	493, 345	665, 892	11. 00
11. 01	Uncompensated care payments	36. 00	1, 337, 145	0	0	1, 321, 117	1, 321, 117	11. 01
40.05	Additional payment for high per		D beneficiary				_	40.05
12.00	Total ESRD additional payment (see instructions)	46. 00	0	0	0		0	
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	22, 436, 115 0	0	5, 530, 327 0	16, 905, 788 0	22, 436, 115 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	22, 436, 115	O	5, 530, 327	16, 905, 788	22, 436, 115	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	1, 618, 072	0	415, 680	1, 202, 392	1, 618, 072	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	О	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from	55. 00 68. 00	0	0	0	0	0	17. 01 17. 02
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation	93. 00	0	0	0	0	0	
	adjustment amount (see instructions)							

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 150088 Peri od: Worksheet E From 07/01/2015 Part A Exhibit 4 06/30/2016 Date/Time Prepared: 11/22/2016 3: 25 pm Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 On/After 10/01 Part A) line Ε, Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 19.00 SUBTOTAL 5, 946, 007 18, 108, 180 24, 054, 187 19. 00 W/S L, line (Amounts from L) 2.00 3.00 4. 00 5. 00 0 1.00 20.00 Capital DRG other than outlier 1 00 383, 303 1, 099, 098 1, 482, 401 20 00 1, 482, 401 20.01 Model 4 BPCI Capital DRG other 1.01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 41, 242 7,961 33, 281 41, 242 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments 22.00 Indirect medical education 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) Indirect medical education 23.00 23.00 6.00 adjustment (see instructions) Allowable disproportionate 24.00 10 00 0.0637 0.0637 0.0637 24.00 0.0637 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 94, 429 24, 416 70, 013 94, 429 25.00 adjustment (see instructions) Total prospective capital 26.00 12.00 1, 618, 072 415, 680 1, 202, 392 1, 618, 072 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2.00 1.00 3.00 4.00 5.00 27.00 Low volume adjustment factor 0.000000 0.000000 27. 00 Low volume adjustment 70.96 28.00 28.00 (transfer amount to Wkst. E, Pt. A, line) Low volume adjustment 70.97 29.00 (transfer amount to Wkst. E, Pt. A. line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

Provider CCN: 150088

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 07/01/2015 Part A Exhibit 5 Date/Time Prepared: 06/30/2016 11/22/2016 3:25 pm Title XVIII Hospi tal Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 4, 792, 965 1.01 1.01 4, 792, 965 4, 792, 965 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1.02 13, 704, 025 13, 704, 025 13, 704, 025 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 1, 936, 088 564, 815 1, 371, 273 1, 936, 088 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 O 2.01 0 **BPCI** Operating outlier reconciliation 3 00 2 01 O 0 0 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 8.01 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 9.00 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 0.1440 0.1440 0.1440 10.00 33.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 665, 892 172, 547 493.345 665, 892 11.00 instructions) 11.01 Uncompensated care payments 36.00 1, 337, 145 445, 213 1, 321, 117 1, 766, 330 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12 00 0 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 22, 436, 115 5, 975, 540 16, 460, 575 22, 436, 115 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 22, 436, 115 5, 975, 540 16, 460, 575 22, 436, 115 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 1, 618, 072 415, 680 1, 202, 392 1, 618, 072 16.00 Special add-on payments for new technologies 17.00 54.00 17.00 Net organ aquisition cost 55.00 0 17.01 17.01 0 0 17.02 Credits received from manufacturers for 68.00 0 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 18.00 amount (see instructions) SUBTOTAL 6, 391, 220 19 00 17 662 967 24, 054, 187 19. 00

Heal th Fina	ncial Systems ST V	NCENT ANDERSON	REGIONAL HOSP	I TA	In Lie	eu of Form CMS-	2552-10
HOSPITAL AC	COUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 3:	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00 Capi	tal DRG other than outlier	1.00	1, 482, 401	383, 30	3 1, 099, 098	1, 482, 401	20.00
20. 01 Mode	el 4 BPCI Capital DRG other than outlier	1. 01	0		o o	0	20. 01
21.00 Capi	tal DRG outlier payments	2.00	41, 242	7, 96	1 33, 281	41, 242	21.00
21. 01 Mode	el 4 BPCI Capital DRG outlier payments	2. 01	0		o	0	21. 01
	rect medical education percentage (see ructions)	5. 00	0.0000	0.000	0. 0000		22. 00
23. 00 I ndi	rect medical education adjustment (see ructions)	6. 00	0		0 0	0	23. 00
24. 00 Allo	wable disproportionate share percentage instructions)	10. 00	0. 0637	0. 063	7 0. 0637		24. 00
25. 00 Di sp	proportionate share adjustment (see ructions)	11.00	94, 429	24, 41	6 70, 013	94, 429	25. 00
26. 00 Tota	ndetrons) Il prospective capital payments (see ructions)	12.00	1, 618, 072	415, 68	0 1, 202, 392	1, 618, 072	26. 00
	. 40.11.01.07	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
	volume adjustment prior to October 1	70. 96	l o		ol	0	28. 00
	volume adjustment on or after October 1	70. 97	0		0	0	
	payment adjustment (see instructions)	70. 93	19, 867	11, 08	4 8, 783	19, 867	30.00
30. 01 HVBP	payment adjustment for HSP bonus ent (see instructions)	70. 90	0	,	0 0	0	1
	adjustment (see instructions)	70. 94	-391, 198	-71, 89	5 -319, 303	-391, 198	31.00
31. 01 HRR	adjustment for HSP bonus payment (see ructions)	70. 91	0	, , , ,	0 0	0	1
, ,,,,,						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
	Reduction Program adjustment (see ructions)	70. 99			0 0	0	32.00
	sfer HAC Reduction Program adjustment to . E, Pt. A.		N				100. 00

Health Financial Systems	ST VINCENT ANDERSON REGIONAL HOSPITA	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150	088 Peri od:

			To 06/30/2016	Date/Time Pre 11/22/2016 3:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			16, 259	1. 00
2. 00	Medical and other services reimbursed under OPPS (see instructi	ons)		31, 187, 286	2.00
3. 00 4. 00	PPS payments Outlier payment (see instructions)			26, 619, 020 64, 329	3. 00 4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 406	5.00
6. 00	Line 2 times line 5			12, 662, 038	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		230, 649	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 16, 259	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			10, 237	11.00
	Reasonabl e charges				
12. 00	Ancillary service charges	2		59, 283	1
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			59, 283	14. 00
15. 00	Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)		Ü		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)	: £ ; 10 - ;	11) (59, 283	1
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT line 18 exceeds II	ne II) (see	43, 024	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)		, ,		
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		16, 259	
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 8 and 9)	CTI ONS)		0 26, 913, 998	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			20, 913, 990	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			5, 512, 225	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	21, 418, 032	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	e 30)		0	29.00
30. 00	Subtotal (sum of lines 27 through 29)			21, 418, 032	
31.00	Primary payer payments			3, 822	31. 00
32. 00	Subtotal (line 30 minus line 31)			21, 414, 210	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		0	22.00
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 587, 741	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			382, 032	
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		414, 022	1
37.00	Subtotal (see instructions)			21, 796, 242	
38. 00	MSP-LCC reconciliation amount from PS&R			-76	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Prioneer ACO demonstration payment adjustment (see instructions)	d daylaga (aga i natrua	ti ana)	0	39. 50
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	d devices (see instruc	tions)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)			21, 796, 318	40.00
40. 01	Sequestration adjustment (see instructions)			435, 926	•
41.00	Interim payments			21, 270, 265	•
42.00	Tentative settlement (for contractors use only)			0	42. 00
43.00	Balance due provider/program (see instructions)			90, 127	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e 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
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00	The rate used to calculate the Time Value of Money			0.00	l
	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)		ا	0	94.00

Health Financial Systems	ST VINCENT ANDERSON REG	IONAL HOSPITA	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150088		Worksheet E
			From 07/01/2015	
		Component CCN: 15T088	To 06/30/2016	
				11/22/2016 3:25 pm
		Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I RF	PPS	
			110	1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			0	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2. 00
3. 00 4. 00	PPS payments Outlier payment (see instructions)			0	3. 00 4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00
6.00	Line 2 times line 5	,		0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 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	8. 00 9. 00
10.00	Organ acquisitions	, cor. 13, 11110 200		0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	
47.00	had such payment been made in accordance with 42 CFR §413.13(e)		-		47.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)	1611 44 111	10) (
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		0	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 8 and 9)	ctions)		0	23. 00 24. 00
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				21.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 231 (see	0	26. 00 27. 00
27.00	instructions)	us the sum of filles 22	and 20] (300	O	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0	29. 00 30. 00
31. 00	Primary payer payments			0	31. 00
32. 00	Subtotal (line 30 minus line 31)			0	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE: Composite rate ESRD (from Wkst. I-5, line 11)	S)		0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	36.00
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	d devices (see instruc	tions)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)			0	40. 00
40. 01	Sequestration adjustment (see instructions)			0	40. 01
41.00	Interim payments			0	41. 00
42. 00 43. 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0	42. 00 43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92. 00	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
, 1. 00	1.0ta. (dail of 11100 /1 did 70)		I	O ₁	71.00

Health Financial Systems ST VINCENTAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 ST VINCENT ANDERSON REGIONAL HOSPITA Peri od: Worksheet E-1
From 07/01/2015 Part I
To 06/30/2016 Date/Time Prepared: 11/22/2016 3: 25 pm Provi der CCN: 150088 Title XVIII Hospi tal Inpatient Part A Part B

		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	1.00	20, 764, 183	3.00	21, 270, 265	1. 00
2. 00	Interim payments payable on individual bills, either		20, 704, 103		21, 270, 203	2. 00
2.00	submitted or to be submitted to the contractor for		o o			2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/11/2016	108, 900		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		o	3. 51
3.52			0		o	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		108, 900		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		20, 873, 083		21, 270, 265	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 04	Program to Provider					F 04
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01 5. 02
5. 02 5. 03			0			5. 02 5. 03
5. 03	Provider to Program		U		U	5. 03
5. 50	TENTATI VE TO PROGRAM		O		0	5. 50
5. 51	TENTATI VE TO TROOKAW		0			5. 51
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
3. 77	5. 50-5. 98)		ı		Ĭ	5. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		199, 386		90, 127	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		21, 072, 469		21, 360, 392	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00

 ONAL HOSPITA
 In Lieu of Form CMS-2552-10

 Provider CCN: 150088
 Period: From 07/01/2015 | From 07/01/2015 | Part I
 Worksheet E-1 Part I

 Component CCN: 157088
 To 06/30/2016 | Date/Time Prepared: 11/22/2016 3: 25 pm

 Heal th
 Financial
 Systems
 ST_VINCENT
 ANDERSON
 REGIONAL HOSPITA

 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 Provider CCN:

		Ti tl	e XVIII	Subprovider - IRF	PPS	<u> </u>
		I npati en	Inpatient Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 828, 17	8	0	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,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 01	ADJUSTIMENTS TO FROVIDER			o	0	3. 01
3. 03				o	l o	3. 03
3. 04				Ö	o	3. 04
3.05				О	0	3. 05
	Provider to Program			_		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51 3. 52				0	0	3. 51 3. 52
3. 52				0		3. 52
3. 54				Ö	l ől	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	Ö	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 828, 17	8	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			_1	_	
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01 5. 02
5. 02 5. 03				0		5. 02 5. 03
5.05	Provider to Program			<u> </u>	0	3.03
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
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 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		11, 29	8	0	6. 01
6.02	SETTLEMENT TO PROGRAM			o	0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 839, 47		0	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
				1		

Heal th	Financial Systems ST VINCENT ANDERSON REG	I ONAL HOSPITA	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150088	Peri od: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	70 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1. 00
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2. 00
3.00	0 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, 8-1	2		28, 618	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			614, 206, 548	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir			18, 398, 763	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cer line 168	tified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			905, 440	8. 00
9.00	Sequestration adjustment amount (see instructions)			18, 109	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		887, 331	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			989, 115	30.00
31.00	Other Adjustment (specify)			0	31.00
22 00	Palance due provider (line 0 (or line 10) minus line 30 and lin	o 21) (coo i notruoti en	a)	101 704	22 00

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

989, 115 30. 00 0 31. 00 -101, 784 32. 00

Health Financial Systems	ST VINCENT ANDERSON REG	ONAL HOSPITA	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150088		Worksheet E-3
			From 07/01/2015	
		Component CCN: 15T088	10 06/30/2016	
				11/22/2016 3:25 pm
		Title XVIII	Subprovi der -	PPS
			I RF	

2.00 Medicare SSI ratio (IRF PPS only) (see instructions) 0.0248	1. 00
PART III - MEDICARE PART A SERVICES - IRF PPS 1.00 Net Federal PPS Payment (see instructions) 1,782,363 2.00 Medicare SSI ratio (IRF PPS only) (see instructions) 0.0248	1. 00
1.00Net Federal PPS Payment (see instructions)1,782,3632.00Medicare SSI ratio (IRF PPS only) (see instructions)0.0248	1. 00
2.00 Medicare SSI ratio (IRF PPS only) (see instructions) 0.0248	1. 00
3.00 Inpatient Rehabilitation LIP Payments (see instructions) 98,208	2.00
	4. 00
	5. 00
to November 15, 2004 (see instructions)	5.00
	5. 01
program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.0.
CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	
6.00 New Teaching program adjustment. (see instructions) 0.00	6.00
7.00 Current year's unweighted FTE count of L&R excluding FTEs in the new program growth period of a "new 0.00	7.00
teaching program" (see instructions)	
	8.00
teaching program" (see instructions)	
	9. 00
10.00 Average Daily Census (see instructions) 6.885246 1	
11.00 Teaching Adjustment Factor (see instructions) 0.000000 1	
	2. 00
	3.00
	4.00
	5.00
	6. 00
17.00 Subtotal (see instructions) 1,896,095 1	
	8. 00
	9. 00
	20. 00
	21. 00
	22. 00
	23. 00
	24. 00
	25. 00
	26. 00
	27. 00
	28. 00
	29. 00
	30. 00
	31. 00
	31. 50
	31. 99
	32. 00
	32. 01
	3.00
	34. 00
	35. 00
	36. 00
§115. 2	
TO BE COMPLETED BY CONTRACTOR	
	0.00
	1.00
	2.00
53.00 Time Value of Money (see instructions) 0 5	3. 00

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

Provi der CCN: 150088

Peri od: From 07/01/2015 To 06/30/2016 Date/Ti me Prepared: 11/22/2016 3: 25 pm

					11/22/2016 3:	25 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	19, 073	0	0		
2.00	Temporary investments	0	0	0		2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	84, 963, 560	0	0	0	4. 00
5.00	Other recei vable	4, 147, 711	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-56, 600, 823	0	0	0	6. 00
7.00	Inventory	4, 149, 229	0	0	0	7. 00
8.00	Prepai d expenses	764, 768	1	0	0	8. 00
9. 00	Other current assets	0	0	0	0	
10. 00	Due from other funds	0	0	0	Ō	10.00
11. 00	Total current assets (sum of lines 1-10)	37, 443, 518	ō	0	l	11. 00
11.00	FIXED ASSETS	07, 110, 010	'L			11.00
12. 00	Land	5, 292, 602	. 0	0	0	12. 00
13. 00	Land improvements	1, 539, 559		0	1	13. 00
14. 00	Accumul ated depreciation	-1, 425, 872	1	0		14. 00
15. 00	Bui I di ngs	96, 049, 052	1	0	l	15. 00
16. 00	Accumul ated depreciation	-58, 445, 934	1	0	0	
17. 00	Leasehold improvements	-30, 443, 934	0	0	0	17. 00
18. 00	· '	0		0	0	1
	Accumulated depreciation	0	0	0		18.00
19.00	Fi xed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	49, 569, 492	1	0	0	23. 00
24. 00	Accumul ated depreciation	-39, 413, 440	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumul ated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	53, 165, 459	0	0	0	30.00
	OTHER ASSETS					1
31.00	Investments	54, 591, 483	4, 287, 390	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33.00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	760, 122	0	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	55, 351, 605	1	0	Ö	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	145, 960, 582		0		36. 00
00.00	CURRENT LIABILITIES	1 10, 700, 002	1, 207, 070			00.00
37. 00	Accounts payable	4, 908, 113	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	8, 788, 010	1	0	l	38.00
39. 00	Payroll taxes payable	0, 700, 010	1	0	0	
40. 00	Notes and Loans payable (short term)	E 220 424		0	0	
	Deferred income	5, 220, 626		0	0	1
41. 00		0	1	U	0	41.00
42.00	Accel erated payments	0				42.00
43. 00	Due to other funds	1 040 470		0	0	43.00
44.00	Other current liabilities	1, 849, 478		0	0	1
45. 00	Total current liabilities (sum of lines 37 thru 44)	20, 766, 227	0	0	0	45. 00
47.55	LONG TERM LIABILITIES	44 000 ==:	I =	=		4, 55
46. 00	Mortgage payable	14, 820, 781	l .	0	1	
47. 00	Notes payable	0	0	0	1	
48. 00	Unsecured Loans	0	0	_		1
49. 00	Other long term liabilities	1, 107, 370	1	0	1	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	15, 928, 151	0	0	1	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	36, 694, 378	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	109, 266, 204				52. 00
53.00	Specific purpose fund		4, 287, 390			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				Ō	58. 00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	109, 266, 204	4, 287, 390	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	145, 960, 582			l	
	59)					

15.00

16.00

17.00

18.00

19.00

Health Financial Systems In Lieu of Form CMS-2552-10 ST VINCENT ANDERSON REGIONAL HOSPITA STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 150088 Peri od: Worksheet G-1 From 07/01/2015 06/30/2016 Date/Time Prepared: 11/22/2016 3:25 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 5. 00 2 00 4 00 1.00 Fund balances at beginning of period 106, 788, 507 4, 462, 325 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 23, 552, 421 2.00 3.00 Total (sum of line 1 and line 2) 130, 340, 928 4, 462, 325 3.00 4.00 DONATI ONS 475, 552 4.00 5.00 INVESTMENT INCOME 00000 0 0 5.00 6.00 TRANSFER TO AFFILIATES 0 6.00 7.00 OTHER 0 0 7.00 8.00 0 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 475, 552 10.00 Subtotal (line 3 plus line 10) 130, 340, 928 4, 937, 877 11 00 11.00 12.00 REIMBURSEMENT RESTRICTED 564, 094 0 12.00 13.00 TRANSFER TO AFFILIATES 21, 074, 724 86, 393 13.00 14.00 UNREALI ZED LOSS 14.00 0 0 0 15.00 15.00 0 0 16.00 0 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 21, 074, 724 650, 487 18.00 Fund balance at end of period per balance 19.00 109, 266, 204 4, 287, 390 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 DONATI ONS 4.00 5.00 INVESTMENT INCOME 0 5.00 TRANSFER TO AFFILIATES 0 6.00 6.00 7.00 OTHER 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 REIMBURSEMENT RESTRICTED 12.00 TRANSFER TO AFFILIATES 13.00 13.00 14.00 UNREALI ZED LOSS 0 14.00

0

0

0

15.00 16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

 ONAL HOSPITA
 In Lieu of Form CMS-2552-10

 Provider CCN: 150088
 Period: From 07/01/2015 Parts I & II

 From 07/01/2015
 Parts I & II

 06/20/2015
 Perpagased: Perpagased: Period: Peri
 Heal th Financial
 Systems
 ST VIN

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

DART PATIENT REVENUES 1.00 2.00 3.00				To	06/30/2016	Date/Time Pre 11/22/2016 3:	
PART 1 - PATIENT REVENUES Central Inpatient, Routine, Services		Cost Center Description		Inpatient	Outpati ent		ZO piii
General Inpatient Routine Services 27,847,036 27,847,036 0.0				1.00	2. 00	3. 00	
1.00 Intensive Care Unit							
SUBPROVIDER 0 0 0 0 0 0 0 0 0		General Inpatient Routine Services					
SUBPROVIDER - IRF				27, 847, 036			
4. 00 SUBPROVIDER				0		-	
Solid Soli				3, 102, 508			
Swing bed = NF Swin				0		-	
SKILLED NINSING FACILITY				0		-	
8.00 NURSING FACILITY				0			
8. 01 ICF/MR 0 0 0 0 0 0 0 0 0				0			
9.00 OTHER LONG TERM CARE 10.00 Total general inpatient care services (sum of lines 1-9) 10.00 Total general inpatient care services (sum of lines 1-9) 11.00 Intensive Care Type Inpatient Hospital Services 11.00 COROMARY CARE UNIT 12.00 COROMARY CARE UNIT 13.00 SURGICAL INTENSIVE CARE UNIT 14.336, 250				0			
10.0 Total general inpatient care services (sum of lines 1-9) 30,949,544 30,949,544 10.0				0		0	
Intensive Care Type Inpati ent Hospital Services				20 040 544		20 040 544	
11.00 INTENSIVE CARE UNIT 14, 336, 250 14, 336, 250 12.00	10.00			30, 949, 544		30, 949, 544	10.00
12. 00 CORONARY CARE UNIT	11 00			14 226 250		14 226 250	11 00
13.00 BURN INTENSIVE CARE UNIT 0 0 0 13.00 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 0 14.00 15.00 Total intensive care type inpatient hospital services (sum of lines 14.336,250 14.336,250 15.00 17.00 Total intensive care type inpatient hospital services (sum of lines 14.336,250 14.336,250 15.00 17.00 Total inpatient routine care services (sum of lines 10 and 16) 45.285,774 45.285,774 47.00 18.00 Ancillary services 140,978,361 383,012,699 523,991,060 18.00 19.00 Outpatient services 13,558,167 52,528,634 66,086,801 19.00 19.00 Outpatient services 0 0 0 0 0 10.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 20.00 OWNER HEALTH AGENCY 0 0 0 0 0 0 24.00 CMHC COMP HEALTH AGENCY 0 0 0 0 0 0 25.00 AMBULANCE SERVICES 0 0 0 0 0 0 0 26.00 HOSPICE 0 0 0 0 0 0 0 27.00 OWNER HEALTH AGENCY 0 0 0 0 0 0 28.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 0 0 29.00 G-3, line 1) PART III - OPERATING EXPENSES 0 0 0 31.00 30.00 ADD (SPECIFY) 0 0 0 0 0 0 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00							
14. 00 SURGICAL INTENSIVE CARE UNIT 0THER SPECIAL CARE (SPECIFY) 15.00 0THER SPECIAL CARE (SPECIFY) 16.00 17.00 TOTAL Intensive care type inpatient hospital services (sum of lines 10 and 16) 14, 336, 250 16.00 17.10 17.10 Total inpatient routine care services (sum of lines 10 and 16) 45, 285, 794 17. 00 18. 00 Ancillary services 140, 978, 361 383, 012, 699 523, 991, 060 18. 00 19. 00 Untpatient services 133, 558, 167 52, 528, 634 66, 086, 801 19. 00 00 Untpatient services 133, 558, 167 52, 528, 634 66, 086, 801 19. 00 00 00 00 00 00 00 00 00 00 00 00 00				-		-	
15. 00 OTHER SPECIAL CARE (SPECIFY) 16. 00 Total intensive care type inpatient hospital services (sum of lines 114, 336, 250 11-00 11-15) 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 18. 00 Ancillary services 19. 00 Outpatient services 19. 00 Outpatient services 19. 00 Outpatient services 10. 00 FEDERALLY QUALIFIED HEALTH CENTER 10. 00 Outpatient Agency 10. 00 Outpatient				-		-	
16. 00 Total intensive care type inpatient hospital services (sum of lines 11, 336, 250 14, 336, 250 17, 00 17, 10 18, 10 18, 10 18, 10 19, 10						O	
11-15 17-15 1			i nes	14 336 250		14 336 250	
17. 00 Total inpatient routine care services (sum of lines 10 and 16) 45, 285, 794 45, 285, 794 17. 00 140, 978, 361 383, 012, 699 523, 991, 060 18. 00 00 00 00 00 00 00 00	10.00	, , , , , , , , , , , , , , , , , , , ,		. 1, 000, 200		, 000, 200	10.00
18.00 Ancillary services 140, 978, 361 383, 012, 699 523, 991, 060 18.00 19.00 Outpatient services 13,558, 167 52,528, 634 66,086,801 19.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 21.00 22.00 OMDME HEALTH AGENCY 0 0 0 22.00 23.00 AMBULANCE SERVICES 0 0 0 0 24.00 24.00 COMP (CORF 0 0 0 0 0 24.00 25.00 AMBULANCE SERVICES 0 0 0 0 24.00 26.00 OSPICIAL CENTER (D.P.) 0 0 0 25.00 27.01 ADOLESCENT SERVICES 1 0 1 26.00 27.01 ADOLESCENT SERVICES 2,011,619 0 2.011,619 20.00 28.00 ADD (SPECIFY) 0 0 0 0 20.00 31.00 32.00 33.00 34.00 33.00 34.00 35.00 36.00 37.00 35.00 36.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00 38.00 39.00 40.00 0 0 0 40.00 40.00 0 40.00 Total deductions (sum of lines 37-41) 41.00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer	17. 00	,		45, 285, 794		45, 285, 794	17. 00
19,00 Outpatient services 13,558,167 52,528,634 66,086,801 19,00 20.00 RURAL HEALTH CLINIC 0 0 0 21.00 22.00 EDEMALLY QUALIFIED HEALTH CENTER 0 0 0 22.00 22.00 22.00 MMBULANCE SERVICES 0 0 0 23.00 24.00		,			383, 012, 699		
21. 00 FEDERALLY QUALIFIED HEALTH CENTER	19. 00					66, 086, 801	19. 00
22.00 HOME HEALTH AGENCY 23.00 AMBULANCE SERVICES 0 0 0 0 23.00 24.10 COMPC 24.10 CORF 0 0 0 0 24.10 25.00 HOME HEALTH AGENCY 26.00 HOME HEALTH AGENCY 27.01 ADDIESTERVICES 2 0 0 0 0 0 24.10 27.01 ADDIESTERVICES 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00	RURAL HEALTH CLINIC		0	0	0	20. 00
23. 00	21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	O	0	21. 00
24. 00 CMHC CORF	22. 00	HOME HEALTH AGENCY			0	0	22. 00
24. 10 25. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20	23.00	AMBULANCE SERVICES		0	0	0	23. 00
25. 00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 25. 00 26. 00 HOSPICE 1 0 1 26. 00 27. 01 ADOLESCENT SERVICES 2,011,619 0 2,011,619 28. 00 G-3, line 1) PART II - OPERATING EXPENSES 29. 00 30. 00 31. 00 31. 00 31. 00 32. 00 33. 00 32. 00 33. 00 34. 00 35. 00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 38. 00 39. 00 39. 00 30. 00 39. 00 31. 00 30. 00 31. 00 30. 00 32. 00 30. 00 33. 00 30. 00 34. 00 35. 00 35. 00 36. 00 37. 00 36. 00 38. 00 39. 00 39. 00 0 0 39. 00 0 30. 00 30. 00 0 3	24.00	CMHC			0	0	24. 00
26. 00				0	0	0	
27. 00 27. 01 28. 00 27. 01 28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 201, 833, 942) 29. 00 30. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 195, 485, 225) 27. 00 2, 011, 619 0, 2, 01 0, 33, 00 0, 34, 00 0, 34, 00 0, 34, 00 0, 34, 00 0, 34, 00 0, 34, 00 0, 34, 00 0, 34, 00 0, 34, 00 0, 34, 00 0, 34, 00 0, 34, 00				0	0	0	
27. 01 ADDLESCENT SERVICES Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 201, 833, 942 435, 541, 333 637, 375, 275 28. 00 201, 833, 942 435, 541, 333 637, 375, 275 28. 00 29. 00 29. 00 31. 00 32. 00 32. 00 32. 00 32. 00 33. 00 32. 00 33. 00		HOSPI CE		1	0	1	
28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. G-3, line 1) PART II - OPERATING EXPENSES 29. 00 Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) Debug Total additions (sum of lines 30-35) DEDUCT (SPECIFY) Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 201, 833, 942				0	0	-	
G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) O 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) O 36.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer D 195, 485, 225 29.00 39.00 0 30.00 30.00 31.00 0 31.00 0 32.00 33.00 34.00 35.00 0 36.00 0 36.00 0 37.00 38.00 39.00 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer D 195, 485, 225 29.00 30.00 30.00 30.00 31.00 32.00 32.00 33.00 32.00 33.00 33.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41)					0		
PART II - OPERATING EXPENSES 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 40. 00	28. 00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	o Wkst.	201, 833, 942	435, 541, 333	637, 375, 275	28. 00
29. 00 Operating expenses (per Wkst. A, column 3, line 200) 195, 485, 225 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 Total additions (sum of lines 30-35) 0 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 0 42. 00 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 195, 485, 225 43. 00 30. 00 30. 00 31. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 00							
30.00 ADD (SPECIFY) 0 30.00 31.00 32.00 33	20.00				105 405 225		20.00
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 195, 485, 225 31.00 32.00 33.00 33.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 43.00 43.00 44.00				0	195, 485, 225		
32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 32.00 33.00 34.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 195, 485, 225 43.00		ADD (SPECIFF)					
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 0 33.00 34.00 35.00 36.00 37.00 38.00 0 0 0 0 0 0 40.00 41.00 42.00 195, 485, 225							
34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 34.00 0 35.00 0 36.00 0 37.00 0 38.00 0 0 39.00 0 40.00 0 41.00 0 42.00 195, 485, 225				-			
35. 00 36. 00 36. 00 Total additions (sum of lines 30-35) 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 35. 00 36. 00 37. 00 38. 00 0 0 0 0 41. 00 42. 00 195, 485, 225 43. 00				-			
36. 00 Total additions (sum of lines 30-35)				١			
37. 00 DEDUCT (SPECIFY) 0 37. 00 38. 00 39. 00 40. 00 40. 00 41. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225 43. 00 195, 485, 225		Total additions (sum of lines 30-35)			0		
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 195, 485, 225 43.00				0	J		
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 195, 485, 225 43.00				l 0			
40.00				l			
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 195, 485, 225 43.00				Ö			
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 195, 485, 225 43.00				0			41. 00
	42.00	Total deductions (sum of lines 37-41)			O		42. 00
to Wkst. G-3, line 4)	43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		195, 485, 225		43.00
		to Wkst. G-3, line 4)					

Health Financial Systems ST VINCENT ANDERSON RE	u of Form CMS-2	2552-10		
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 150088 Period:			Worksheet G-3	
		From 07/01/2015	5	
		To 06/30/2016	Date/Time Pre 11/22/2016 3:	
			11/22/2010 3.	25 piii
			1. 00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		637, 375, 275	1. 00
2.00 Less contractual allowances and discounts on patients' account	ts		419, 695, 869	2. 00
3.00 Net patient revenues (line 1 minus line 2)			217, 679, 406	3. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 4	13)		195, 485, 225	4. 00
5.00 Net income from service to patients (line 3 minus line 4)			22, 194, 181	5. 00
OTHER I NCOME				
6.00 Contributions, donations, bequests, etc			0	6. 00
7.00 Income from investments			-1, 599, 048	1
· ·	0 Revenues from telephone and other miscellaneous communication services			8. 00
9.00 Revenue from television and radio service	ON Revenue from television and radio service			9. 00
	10.00 Purchase discounts			10.00
11.00 Rebates and refunds of expenses			0	11. 00
12.00 Parking Lot receipts			0	12. 00
13.00 Revenue from Laundry and Linen service			0 650, 024	13. 00
	00 Revenue from meals sold to employees and guests			1
	00 Revenue from rental of living quarters			15. 00
	00 Revenue from sale of medical and surgical supplies to other than patients			16. 00
	0 Revenue from sale of drugs to other than patients			17. 00
				18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			19. 00
	00 Revenue from gifts, flowers, coffee shops, and canteen			20. 00
	00 Rental of vending machines			21. 00
00 Rental of hospital space			0	22. 00
23.00 Governmental appropriations			0	23. 00
24. 00 MAB/MOB/ASC			714, 230	1
24. 01 GRANTS			435, 989	1
24. 02 DME			195, 841	ı
24. 03 OTHER MISC INCOME			468, 332	ı
24. 04 MEDI CARE EHR			440, 593	24. 04

24. 05 25. 00

26.00

27.00

1, 358, 240

0 28.00 23,552,421 29.00

23, 552, 421

24.05 25.00 Total other income (sum of lines 6-24)

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

Total (line 5 plus line 25)

26.00

27.00

Hool +h	Financial Systems ST VINCENT ANDERSON DEC	LONAL HOSDITA	In Lie	u of Form CMS 1	DEED 10
	Financial Systems ST VINCENT ANDERSON REG ATION OF CAPITAL PAYMENT	Provider CCN: 150088	Period: From 07/01/2015 To 06/30/2016		pared:
		Title XVIII	Haani tal	11/22/2016 3: PPS	25 pm
		little XVIII	Hospi tal	PPS PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD		I		
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier				1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			41, 242	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			70.53	
3. 00 4. 00	Total inpatient days divided by number of days in the cost repo Number of interns & residents (see instructions)	orting period (see inst	ructions)	78. 52 0. 00	3. 00 4. 00
5.00	Indirect medical education percentage (see instructions)			0.00	
6.00	Indirect medical education adjustment (multiply line 5 by the s	um of lines 1 and 1 01	columns 1 and	0.00	
0.00	1.01) (see instructions)	idiii or rrries r drid r. or	, cor anno i ana	· ·	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A pat 30) (see instructions)	ient days (Worksheet E	, part A line	4. 47	7. 00
8. 00	Percentage of Medicaid patient days to total days (see instruct	i ons)		26.06	8.00
9.00	Sum of lines 7 and 8			30. 53	1
10.00	Allowable disproportionate share percentage (see instructions)			6. 37	10.00
11.00	Disproportionate share adjustment (see instructions)			94, 429	11. 00
12. 00	00 Total prospective capital payments (see instructions)			1, 618, 072	12. 00
	DART III DAVMENT UNDER DEACONARIE COCT			1. 00	
1 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1 1 00
1. 00 2. 00	Program inpatient ancillary capital cost (see instructions)			0	
3. 00	3			0	
4. 00				0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		1		
1.00	Program inpatient capital costs (see instructions)	(!+		0	
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstances	(see instructions)		0	
4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6.00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00	
7. 00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0	
8.00	Capital minimum payment level (line 5 plus line 7)	•	ĺ	0	8. 00
9.00				0	9. 00
10.00				0	10.00
11. 00				0	11. 00
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital paym	ments (line 10 plus lin	۵ 11)	0	12. 00
13. 00				0	13. 00
14. 00				0	
1 1. 00	(if line 12 is negative, enter the amount on this line)				
15. 00				0	15. 00
	O Current year operating and capital costs (see instructions)			0	16. 00
17. 00	00 Current year exception offset amount (see instructions) 0 17				