Health Financial Systems	ST. VINCENT WILLIAMSPORT	T HOSPI TAL	In Lieu	of Form CMS-2552-10
This report is required by law (42 USC				
payments made since the beginning of the		1 2 1	0,	OMB NO. 0938-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPL AND SETTLEMENT SUMMARY	X COST REPORT CERTIFICATION	Provider CCN: 151307	From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/22/2016 12:45 pm
PART I - COST REPORT STATUS				
Provider 1. [X] Electronically fi			Date: 11/22/20	16 Time: 12:45 pm
use only 2. [ ] Manually submitte				
3. [ 0 ]If this is an ame 4. [ F ]Medicare Utilizat	nded report enter the number of on. Enter "F" for full or "L" f	times the provider re or low.	esubmitted this co	st report
Contractor use only 5. [ 1 ]Cost Report Statu (1) As Submitted (2) Settled without Au (3) Settled with Audit (4) Reopened (5) Amended	s 6. Date Received: 7. Contractor No. dit 8. [ N ]Initial Report for t 9. [ N ]Final Report for thi	11.C his Provider CCN 12.[		r Code: 4 umn 1 is 4: Enter es reopened = 0-9.
PART II - CERTIFICATION				
MISREPRESENTATION OR FALSIFICATION OF A ADMINISTRATIVE ACTION, FINE AND/OR IMPR PROVIDED OR PROCURED THROUGH THE PAYMEN ADMINISTRATIVE ACTION, FINES AND/OR IMP CERTIFICATION BY OFFICI	SONMENT UNDER FEDERAL LAW. FURT DIRECTLY OR INDIRECTLY OF A KIC	THERMORE, IF SERVICES CKBACK OR WERE OTHERW	IDENTIFIED IN THI	S REPORT WERE
electronically filed or manuall Expenses prepared by ST. VINCEN 07/01/2015 and ending 06/30/201 correct, complete and prepared instructions, except as noted.	ad the above certification stater y submitted cost report and the I WILLIAMSPORT HOSPITAL (151307 5 and to the best of my knowledge from the books and records of the I further certify that I am fami es, and that the services identi- egulations.	Balance Sheet and Sta ) for the cost repor e and belief, this re e provider in accorda iliar with the laws a	tement of Revenue ting period begin port and statemen ince with applicab ind regulations re	and ning t are true, le garding the
	(Si gned)			
	()	Officer or Adminis	strator of Provide	er(s)
	Ti t	le		
	Dat	e		

			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	49, 701	-288, 798	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	7, 689	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		114, 064		0	10.00
10.01	RURAL HEALTH CLINIC II	0		74, 843		0	10.01
200.00	Total	0	57, 390	-99, 891	0	0	200.00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Prov	ider CCN:	: 151307	Period: From 07/01 To 06/30	/2015 /2016	Part I	eet S-2	
	1					10 00/30		11/22/2		
	1.00	2.00		3.00			4.00			
0	Hospital and Hospital Health Care Co Street: 412 NORTH MONROE	PO Box:								1.
0	City: WILLIAMSPORT	State: IN	Zin Cod	e: 47993	Coun	ty: WARREN				2.
-		Component Name	CCN	CBSA	Provi der		Payme	ent Syst	em (P,	
			Number	Number	Туре	Certified		, 0, or		
					-		V	XVIII		-
	Uponital and Uponital Decod Company	1.00	2.00	3.00	4.00	5.00	6.00	0 7.00	8.00	
D	Hospital and Hospital-Based Componen Hospital	ST. VINCENT	151307	99915	1	07/01/1966	5 N	0	0	3
,		WILLIAMSPORT HOSPITAL	131307	77713	'	0770171700				J .
)	Subprovider - IPF									4
)	Subprovider - IRF									5
C	Subprovider - (Other)									6.
)	Swing Beds - SNF	ST. VINCENT	15Z307	99915		02/01/1988	3 N	0	N	7
	Swing Dada NE	WILLIAMSPORT SWING BEDS								8.
) )	Swing Beds - NF Hospital-Based SNF									9.
	Hospi tal -Based NF									10
	Hospi tal -Based OLTC			1	1					11.
00	Hospital-Based HHA									12.
	Separately Certified ASC									13.
	Hospi tal -Based Hospi ce		450000	00015						14
	Hospital -Based Health Clinic - RHC	NORTH CLINIC SOUTH CLINIC	153993 153994	99915 99915		05/06/2001		0	N N	15
1	Hospital-Based Health Clinic - RHC	SUUTE CLINIC	103994	CI 444		00/01/200				15
00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17.
	Renal Dialysis									18.
00	Other					-				19.
						From 1.00		Tc 2. (		-
00	Cost Reporting Period (mm/dd/yyyy)					07/01/2		2.0		20.
						6		00/00	2010	20.
JÜ	Type of Control (see instructions)					0				21.
	Inpatient PPS Information									21.
	Inpatient PPS Information Does this facility qualify and is it					: N		N	1	1
	Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord	ance with 42 CFR §412.10	16? In co	olumn 1,	enter "Y"	N N		N	1	1
	Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil	ance with 42 CFR §412.10 ity subject to 42 CFR Se	16? In co ection §47	olumn 1,	enter "Y"	N N		N	1	1
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					To 06	/01/2015 /30/2016	Date 11/2	e/Tin 22/20	ne Pre 016 10	
		In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medic HMO d			her cai d	
		paid days	eligible	Medi cai d	Medi cai d		ays		ays	
			unpai d	paid days	eligible				5	
		1.00	days	0.00	unpai d		-			
5.00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	<u>5.0</u>	0	6.	00	25.
	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.							6		20.
						/Rural S .00	Date	2.00		
5.00	Enter your standard geographic classification (not wa		at the beg	ginning of t			2		-	26.
7.00	cost reporting period. Enter "1" for urban or "2" for		at the end	l of the cos	+		2			27.
7.00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	r "2" for r	ural. If an	policable.	L		2			27.
	enter the effective date of the geographic reclassifi	cation in	column 2.							
5.00	If this is a sole community hospital (SCH), enter the	e number of	periods SC	CH status in		(	C			35.
	effect in the cost reporting period.				Begi	nni ng:	E	indi n	q:	
					1	. 00		2.00	0	
6.00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb	er					36.
7.00	If this is a Medicare dependent hospital (MDH), enter		r of period	ds MDH statu	s	(	o			37.
	is in effect in the cost reporting period.									
7. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)					Ν				37.
3. 00	If line 37 is 1, enter the beginning and ending dates	s of MDH st	atus. Ifli	ne 37 is						38.
	greater than 1, subscript this line for the number of	f periods i	n excess of	one and						
	enter subsequent dates.					Y/N		Y/N		
						. 00		2.00		
9.00	Does this facility qualify for the inpatient hospital					N		Ν		39.
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage red									
	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	or "N" for	no. (see i	nstructions						
$\cap \cap \cap$	Is this hospital subject to the HAC program reduction									
0.00	"N" for no in column 1 for discharges prior to Octob					Ν		Ν		40.
J. UU	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for y			Ν		N		40.
		per 1. Ente	r "Y" for y			V			XI X	40.
	no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for y						XI X 3. 00	40.
	no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital	per 1. Ente (see inst	r "Y" for y ructions)	yes or "N" f	or	V 1.0	0 2.			
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5. 00 6. 00 7. 00 8. 00 7. 00 8. 00 9. 00 9. 00 9. 00	no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA	ber 1. Ente (see inst (see inst t for disp eption for t. L, Pt. I tal? Enter " approved G beriod duri r yes or "N th of this (", complet bursement f complete W s, complete costs for for yes or Y/N	r "Y" for y ructions) roportionat extraordina II and Wkst r "Y for yes Y" for yes ME programs ng which re " for no ir cost report e Worksheet cable. or physicia kst. D-5. Wkst. D-2, a program t "N" for no IME	ves or "N" f te share in ary circumst t. L-1, Pt. es or "N" for or "N" for s? Enter "Y esidents in n column 1. ting period? t E-4. If co ans' service Pt. I. that meets t b. (see inst Direct GM	accordanc ances I through r no. no. " for yes approved I f columr Enter " I umn 2 is s as he ructions) E	V           1.0           re         N           N           N           Y"           N	0 2.	N N N N N N N N	3.00 N N N S GME	45. 46. 47. 48. 56. 57. 58. 59. 60.
5. 00 6. 00 7. 00 8. 00 7. 00 8. 00 9. 00 0. 00	no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reint defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yee Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	ber 1. Ente (see inst (see inst t for disp eption for t. L, Pt. I tal? Enter " approved G beriod duri r yes or "N th of this (", complet bursement f complete W s, complete costs for for yes or Y/N	r "Y" for y ructions) roportionat extraordina II and Wkst r "Y for yes Y" for yes ME programs ng which re " for no ir cost report e Worksheet cable. or physicia kst. D-5. Wkst. D-2, a program t "N" for no IME	ves or "N" f te share in ary circumst t. L-1, Pt. es or "N" for or "N" for s? Enter "Y esidents in n column 1. ting period? t E-4. If co ans' service Pt. I. that meets t b. (see inst Direct GM	accordanc ances I through r no. no. " for yes approved I f columr Enter " I umn 2 is s as he ructions) E	V           1.0           1.0           ie           N	0 2.	N N N N N N N N	3.00 N N N S GME	45. 46. 47. 48. 56. 57. 58. 59.
5. 00 6. 00 7. 00 8. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00	no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care	ber 1. Ente (see inst (see inst t for disp eption for t. L, Pt. I tal? Enter " approved G beriod duri r yes or "N th of this (", complet bursement f complete W s, complete costs for for yes or Y/N	r "Y" for y ructions) roportionat extraordina II and Wkst r "Y for yes Y" for yes ME programs ng which re " for no ir cost report e Worksheet cable. or physicia kst. D-5. Wkst. D-2, a program t "N" for no IME	ves or "N" f te share in ary circumst t. L-1, Pt. es or "N" for or "N" for s? Enter "Y esidents in n column 1. ting period? t E-4. If co ans' service Pt. I. that meets t Direct GM 3.00	accordanc ances I through r no. no. " for yes approved I f columr Enter " I umn 2 is s as he ructions) E	V           1.0           1.0           ie           N	0 2.	N N N N N N N N	3.00 N N N S GME	45. 46. 47. 48. 56. 57. 58. 59. 60.
5. 00 6. 00 7. 00 8. 00 6. 00 7. 00 8. 00 9. 00 0. 00	no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes, Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	ber 1. Ente (see inst (see inst t for disp eption for t. L, Pt. I tal? Enter " approved G beriod duri r yes or "N th of this (", complet bursement f complete W s, complete costs for for yes or Y/N	r "Y" for y ructions) roportional extraordina II and Wkst r "Y for ye Y" for yes ME programs ME programs mg which re " for no ir cost report e Worksheet cable. or physicia kst. D-2, wkst. D-2, a program t "N" for no IME 2.00	ves or "N" f te share in ary circumst t. L-1, Pt. es or "N" for or "N" for s? Enter "Y esidents in n column 1. ting period? t E-4. If co ans' service Pt. I. that meets t Direct GM 3.00	accordances ances I through r no. no. " for yes approved If columr Enter " I umn 2 is s as he ructions) E	V           1.0           1.0           ie           N	0 2.	N N N N N N N N	3.00 N N N S GME	45. 46. 47. 48. 56. 57. 58. 59. 60.

HOSPITAL AND HO	OSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA				Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Pre 11/22/2016 10	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
FTE coun and prim	e current year total unwe t (excluding OB/GYN, gene ary care FTEs added under ee instructions)	eral surgery FTEs,		0.00	0.	00		61.02
and/or g	e base line FTE count for eneral surgery residents, ing compliance with the 7 ions)	which is used for		0.00	0.	oc		61.03
51.04 Enter the surgery	e number of unweighted pr allopathic and/or osteopa cost reporting period.(se	athic FTEs in the		0.00	0.	00		61.04
61.05 Enter the and/or g primary	e difference between the eneral surgery FTEs and t care and/or general surge	baseline primary the current year's ery FTE counts (line		0.00	0.	00		61.05
61.06 Enter the used for	nus line 61.03). (see ins e amount of ACA §5503 awa cap relief and/or FTEs 1 general surgery. (see ins	ard that is being that are nonprimary		0.00	0.	00		61.06
			Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
special t for each column 1 program FTE unweight FTE unwei 51.20 Of the F program resident instruct enter in 3, the II	TEs in line 61.05, specif y, if any, and the number new program. (see instru- code, enter in column 3, ed count and enter in col ighted count. TEs in line 61.05, specif special ty, if any, and th s for each expanded progr ions) Enter in column 1, column 2, the program co ME FTE unweighted count a t GME FTE unweighted court	F of FTE residents Justions) Enter in F in column 2, the the IME FTE Jumn 4, direct GME Fy each expanded the number of FTE Fram. (see the program name, Jode, enter in column and enter in column				0.00		61. 10
							1.00	
	isions Affecting the Heal e number of FTE residents					riod for which	0.00	62.00
your hos 52.01 Enter th	pital received HRSA PCRE e number of FTE residents n this cost reporting per	funding (see instructs that rotated from a	ti ons) Teachi	ng Health Cent	er (THC) int			62.01
	Hospitals that Claim Res facility trained resider				st roporting	pariod? Entor	N	42 00
	yes or "N" for no in colu						IN	63.00
					Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section	5504 of the ACA Base Yea	r FTF Residents in No	nprovi	der Settings	1.00 This base yea	2.00 ur is vour cost r	3.00	
period t	<u>hat begins on or after Ju</u>	uly 1, 2009 and befor	<u>e June</u>	<u>30, 2010.</u>				
in the b resident settings resident	column 1, if line 63 is ase year period, the numb FTEs attributable to rot . Enter in column 2 the FTEs that trained in you mn 1 divided by (column 2	per of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	all nor non-pr columr	ry care nprovider rimary care n 3 the ratio	0.	00 0. 00	0. 000000	64.00
		Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEsin	Ratio (col. 3/ (col. 3 + col. 4))	,

OSPITAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENIIFICATION D	ATA PLOVIDE		eriod: .om 07/01/2		Workshee Part I	1 3-2	
			To		2016	Date/Tim 11/22/20		
	Program Name	Program Code	Unwei ghted	Unwei ght		Ratio (co		25 0
	, i i i i i i i i i i i i i i i i i i i	U U	FTĔs	FTES i		(col. 3 +	col .	
			Nonprovi der	Hospi ta	1	4))		
	1.00	2.00	Si te 3. 00	4.00		5.00		
.00 Enter in column 1, if line 63	1.00	2.00	0.00		0.00		00000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3								
divided by (column 3 + column 4)). (see instructions)								
			Unweighted FTEs	Unweight FTEs in		Ratio (co (col. 1 +		
			Nonprovi der	Hospita		(201. 1 +	COI .	
			Site			_,,		
			1.00	2.00		3.00		
Section 5504 of the ACA Current beginning on or after July 1, 2		n Nonprovider Settir	ngsEffective fo	or cost rep	portir	ng period	s	
FTEs attributable to rotations	unweighted non-prima occurring in all nonp	provider settings.	0.00		0. 00	0. 0	00000	66.
	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column	provider settings. ary care resident 3 the ratio of	Unweighted FTEs Nonprovider	Unweight FTEs i Hospita	ed F	0.0 Ratio (co (col. 3 + 4))	1.3/	66. (
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see ir Program Name	provider settings. ary care resident 3 the ratio of <u>astructions</u> ) Program Code	Unweighted FTEs Nonprovider Site	Unweight FTEs i Hospita	ed F	Ratio (co (col. 3 + 4))	I. 3/ col.	66. 9
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see ir	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider	Unweight FTEs in Hospita 4.00	ed F	Ratio (co (col. 3 + 4)) 5.00	I. 3/ col.	
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see ir Program Name 1.00	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweight FTEs in Hospita 4.00	ed F n ( 1	Ratio (co (col. 3 + 4)) 5.00	I. 3/ col.	
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1 divided by (column 1) Description 2 FTEs that trained in your hospi (column 1 divided by (column 1) Description 2 FTE resident with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see ir Program Name 1.00	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweight FTEs in Hospita 4.00	ed F n ( 1	Ratio (co (col. 3 + 4)) 5.00 0.0	I. 3/ col.	
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1</li> <li>OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)</li> </ul>	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see ir Program Name 1.00	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweight FTEs in Hospita 4.00	ed F n ( 1	Ratio (co (col. 3 + 4)) 5.00 0.0	I. 3/ col.	
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1 	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see ir Program Name 1.00	provider settings. ary care resident 3 the ratio of astructions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ght FTEs i Hospi ta 4.00	ed F n ( 1	Ratio (co (col. 3 + 4)) 5.00 0.0	I. 3/ col.	67.1
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1.00Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 divided by (column 3 + column 4)). (see instructions).00Inpatient Psychiatric Facility Enter "Y" for yes or "N" for m	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see ir Program Name 1.00 1.00	(1PF), or does it cor	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ght FTEs i I Hospi ta 4.00	1. 00	Ratio (co (col. 3 + 4)) 5.00 0.0	1. 3/ col. 000000	67.0
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospid (column 1 divided by (column 1)</li> <li>OD Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 3 the resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 divided by (column 3 + column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</li> <li>Inpatient Psychiatric Facility 200 Is this facility an Inpatient P Enter "Y" for yes or "N" for not 1f line 70 yes: Column 1: Did the recent cost report filed on or 42 CFR 412.424(d)(1)(iii)(c)) C program in accordance with 42 C Column 3: If column 2 is Y, ind (see instructions)</li> </ul>	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see ir Program Name 1.00 1.00 1.00	(IPF), or does it cor approved GME teaching 2004? Enter "Y" for cility train resident )(D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 0.00	Unwei ght FTEs i Hospi ta 4.00	1. 00	Ratio (co (col. 3 + 4)) 5.00 0.0	I. 3/ col.	67.0
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1</li> <li>OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 3 divided by (column 1 divided by (column 3 di</li></ul>	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see ir Program Name 1.00 1.00 PPS sychiatric Facility ( o. he facility have an a before November 15, 2 olumn 2: Did this fac FR 412.424 (d)(1)(iii i cate which program 5	(IPF), or does it cor approved GME teaching 2004? Enter "Y" for cility train resident )(D)? Enter "Y" for cear began during thi	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ght FTEs i Hospi ta 4.00	1. 00	Ratio (co (col. 3 + 4)) 5.00 0.0	1. 3/ col. 000000	

Health Financial Systems         ST. VINCENT WILLIA           HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 151307 F	In Lie Period: From 07/01/2015 To 06/30/2016	u of Form CMS Worksheet S- Part I Date/Time Pr	-2 Tepared:
				11/22/2016	10:23 am
Long Term Care Hospital PPS				1.00	-
<ul> <li>80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes</li> <li>81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.</li> </ul>			period? Enter	N N	80.00 81.00
TEFRA Providers         85.00       Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)       86.00         B6.00       Did this facility establish a new Other subprovider (exclude)         C442.40(f)(1)(i)       Facility establish a new Other subprovider (exclude)				N	85.00 86.00
<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital a "subclause (II)" LTCH classified under set for yes or "N" for no.</pre>	ection 1886(d)	(1)(B)(iv)(II)	? Enter "Y"	N	87.00
for yes or "N" for no.			V	XI X	
Title V and XIX Services			1.00	2.00	_
90.00 Does this facility have title V and/or XIX inpatient hospita	al services? Er	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through t			Ν	N	91.00
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du	ual certificati			Y	92.00
93.00 Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XLX reduce capital cost? Enter "Y" for yes,	and "N" for no	o in the	N	N	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0.00	95.00
applicable column. 97.00   f line 96 is "Y", enter the reduction percentage in the app			0.00	N O OO	96.00 97.00
Rural Providers		1.	0.00	0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (C/ $106.00$ ] f this facility qualifies as a CAH, has it elected the all-		nod of payment	Y N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 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 instr	ructions) If	Ν		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee schee	dul e? See 42	Ν		108. 00
	Physi cal	Occupational	Speech	Respi ratory	'
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1.00 Y	2.00 N	3.00 N	4.00 N	109.00
for yes or "N" for no for each therapy.					-
				1.00	-
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for	Ν	110.00
			1.00	0 2.00 3.00	)
Miscellaneous Cost Reporting Information					
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider	. If column 2 i nt for long ter	s "E", enter rm care (inclu	in column des	0	115.00
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu no.			"N" for Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	f the policy	is 1		118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		84,04	5 0		0118.01

Heal th Financial Systems ST. VINCENT WILLIAN			eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151	307 Period: From 07/01/2015 To 06/30/2016		repared:
		1.00	2.00	_
118.02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 DO NOT USE THIS LINE		N	2.00	118.02
120.00 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 qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes alifies for the Outpa	s or tient	N	120.00
121.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.	ntable devices charge	d to Y		121.00
122.00 Does the cost report contain state health or similar taxes? I 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	122.00
125.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N" for no.	lf N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en		date		126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter		date		127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter		date		128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter		ate in		129.00
column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare certified pancreas transplant center, e				130.00
date in column 1 and termination date, if applicable, in colu 131.00 f this is a Medicare certified intestinal transplant center,	umn 2.			131.00
date in column 1 and termination date, if applicable, in colu 132.00 f this is a Medicare certified islet transplant center, enter	umn 2.			132.00
in column 1 and termination date, if applicable, in column 2 133.00 If this is a Medicare certified other transplant center, enter				133.00
in column 1 and termination date, if applicable, in column 2. 134.00 f this is an organ procurement organization (0P0), enter the				134.00
and termination date, if applicable, in column 2. All Providers				_
140.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y are claimed, enter in column 2 the home office chain number.	yes, and home office of		15H046	140. 00
1.00 2.00		3.00 the name and address	of the	
home office and enter the home office contractor name and co 141.00 Name: ST. VINCENT HEALTH Contractor's Name: WPS	ntractor number.	tractor's Number: 081		141.00
142.00[Street: 10330 N. MERIDIAN ST. SUITE 420 PO Box: 143.00[City: INDIANAPOLIS State: IN		Code: 462		142.00 143.00
				_
144.00 Are provider based physicians' costs included in Worksheet A	?		1.00 Y	144.00
		1.00	2.00	_
145.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in o no, does the dialysis facility include Medicare utilization to period? Enter "Y" for yes or "N" for no in column 2.	column 1. If column 1	is N		145.00
146.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 19 yes, enter the approval date (mm/dd/yyyy) in column 2.				146.00
			1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yet 148.00 Was there a change in the order of allocation? Enter "Y" for			N N	147.00 148.00
149.00 Was there a change to the simplified cost finding method? En	ter "Y" for yes or "N		N	149.00
	Part A         Part           1.00         2.0	3.00	Title XIX 4.00	
Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each component				
155.00Hospital 156.00Subprovider - IPF	N N N N	N	N N	155.00
157.00 Subprovider - IRF	N N		N	157.00
158. 00 SUBPROVI DER 159. 00 SNF			1	158.00
	N	N	N	
160. OOHOME HEALTH AGENCY 161. OO CMHC	N N N N	N	N N N	159.00 160.00 161.00

Health Financial Systems	ST. VINCENT W	ILLIAMSPORT HOSPITAL			In Lie	u of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider C	CN: 15130	From O	7/01/2015	Worksheet S Part I Date/Time P 11/22/2016	- repared:
						1.00	_
Multicampus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one or more campus	es in di	fferent CB	SAs?	N	165.00
	Name	County	State		CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.1	00 166. 00
lead the laformation Tachnology (III	T) inconting in the Ar	noni con Docovery and	Daimuna	tmont Act		1.00	-
Health Information Technology (HI 167.00Is this provider a meaningful user						N	167.00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	⊃5 is "Y") and is a me	eaningful user (line			the		0168.00
168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or	"N" for no. (see in	structic	ons)		Y	168. 01
169.00 If this provider is a meaningful u transition factor. (see instruction		and is not a CAH (I	ine 105				00169.00
					gi nni ng	Endi ng	_
					1.00	2.00	170.00
170.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy)	beginning date and end	ling date for the rep	orting				170.00
						1.00	-
171.00 If line 167 is "Y", does this prov Medicare cost plans reported on WM (see instructions)						N	171.00

IOSPI T	Financial Systems ST. VINCENT WILLIA	Provi der	CCN: 151307	Period: From 07/01/2015 To 06/30/2016 Y/N	Worksheet S- Part II Date/Time Pr 11/22/2016 1 Date	epared:
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	esponses. Ente			
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			Ν		1.0
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare F	Program2 If	1.00 N	2.00	3.00	2.0
. 00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includir	nn 3, "V" for	N			3.0
	contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board				
			Y/N	Туре	Date	
	Einancial Data and Poports		1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	For Compiled,	N			4.0
. 00	Are the cost report total expenses and total revenues diffe		N			5. C
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Logal Oper	
				1.00	Legal Oper. 2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	N		6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		l during the	N N		7. 0 8. 0
. 00	Are costs claimed for Interns and Residents in an approved	0	al education	Ν		9.0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c		he current	Ν		10.0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.0
					Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			st reporting	Y N	12. 0 13. 0
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	<sup>°</sup> yes, see ins	tructions.	N	14. (
5.00	Did total beds available change from the prior cost reporti		<u>yes, see inst</u> t A		N t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	10/04/2016	Y	10/04/2016	16.0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		Ν		17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		Ν		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19. C

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... f Eo m CMS 2552 10

Heal th	Financial Systems SI. VINCENI WILLI	AMSPORT HOSPIT	AL	In Lie	u of Form CMS	-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet S- Part II Date/Time Pr 11/22/2016 1	epared:		
		Descr	ription	Y/N	Y/N			
			0	1.00	3.00			
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	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 (EXC	EPT CHILDRENS	HOSPI TALS)					
	Capital Related Cost							
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			Ν	22.00		
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ng the cost	Ν	23.00				
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	orting period?	Ν	24.00				
25.00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	lfyes, see	Ν	25.00		
26.00	Were assets subject to Sec.2314 of DEFRA acquired during t instructions.	he cost report	ing period? If	yes, see	Ν	26.00		
27.00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? If	yes, submit	Ν	27.00		
	Interest Expense							
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into du	ring the cost	reporti ng	Ν	28.00		
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Re	serve Fund)	Ν	29.00		
30.00	Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes,	see	Ν	30.00		
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes,	see	Ν	31.00		
	Purchased Services			ļ				
32.00	Have changes or new agreements occurred in patient care se	rvi ces furni sh	ed through con	tractual	N	32.00		
	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap	ructions.	Ū.		Ν	33.00		
	no, see instructions. Provider-Based Physicians	P P	3	Jan 199		_		
34 00	Are services furnished at the provider facility under an a	rrangement wit	h provider-bas	ed physicians?	Y	34.00		
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	0	•		N	35.00		
35.00	physicians during the cost reporting period? If yes, see i		ints with the p			35.00		
				Y/N 1.00	Date 2.00			
	Home Office Costs			1.00	2.00			
36.00	Were home office costs claimed on the cost report?			Y		36.00		
	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	home office?	Y		37.00		
38.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en	fice different	from that of	N		38.00		
39. 00	If line 36 is yes, did the provider render services to oth see instructions.			Ν		39.00		
40.00	If line 36 is yes, did the provider render services to the	e home office?	lf yes, see	Ν		40.00		
	i nstructi ons.							
	Cast Doport Proparar Contact Information	1	. 00	2.	00			
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JILL		HILL		41.00		
	respectively.							
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT H	EALTH			42.00		
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3175833519		JI LL. HI LL@STVI I	NCENT. ORG	43.00		

Heal th	Financial Systems	ST. VINCENT WILLIA	AMSPORT H	IOSPI TA	L		In Lieu	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Pro	ovi der	CCN: 151307	Peri		Worksheet S-2	
						To	07/01/2015 06/30/2016		pared: :23 am
						_			
				3.	00				
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the t		REI MBURSI	EMENT I	MANAGER				41.00
	held by the cost report preparer in colum	ins 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the co	st report							42.00
	preparer.								
43.00	Enter the telephone number and email addr	ess of the cost							43.00
	report preparer in columns 1 and 2, respe	cti vel y.							

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA		Provi der	CCN: 151307		eriod: com 07/01/2015 o 06/30/2016	Worksheet Part I Date/Time 11/22/2016	Pre	pared:
								I/P Days /		25 am
								<u>Visits / Tr</u>	'i ps	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V		
		Line Number 1.00		2.00	Available 3.00		4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00		16		56	45,048.00	5.00	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 I PF Subprovider									3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF								0	4.00 5.00
5.00 6.00	Hospital Adults & Peds. Swing Bed NF Hospital Adults & Peds. Swing Bed NF								0	5.00 6.00
7.00	Total Adults and Peds. (exclude observation			16	5,8	56	45, 048. 00		0	7.00
7.00	beds) (see instructions)			10	0,0	00	10, 010.00		Ŭ	7.00
8.00	INTENSIVE CARE UNIT									8.00
9.00	CORONARY CARE UNI T									9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13.00	NURSERY	43.00							0	13.00
14.00	Total (see instructions)			16	5, 8	56	45,048.00		0	14.00
15.00 16.00	CAH visits SUBPROVIDER - IPF								0	15. 00 16. 00
17.00	SUBPROVIDER - IPF SUBPROVIDER - IRF									16.00
18.00	SUBPROVI DER									18.00
19.00	SKILLED NURSING FACILITY									19.00
20.00	NURSING FACILITY									20.00
21.00	OTHER LONG TERM CARE								1	21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)									23.00
24.00	HOSPICE									24.00
24.10	HOSPICE (non-distinct part)	30.00								24.10
25.00	CMHC - CMHC								~	25.00
26.00	RURAL HEALTH CLINIC	88. 00 88. 01							0	26.00
26. 01 26. 25	RURAL HEALTH CLINIC II FEDERALLY QUALIFIED HEALTH CENTER	88.01							0	26. 01 26. 25
20.25	Total (sum of lines 14-26)			16						20.25
28.00	Observation Bed Days			10					o	28.00
29.00	Ambul ance Trips								Ŭ	29.00
30.00	Employee discount days (see instruction)									30.00
31.00	Employee discount days - IRF									31.00
32.00	Labor & delivery days (see instructions)			0		0				32.00
32.01	Total ancillary labor & delivery room									32.01
~~ ~-	outpatient days (see instructions)									
33.00	LTCH non-covered days									33.00

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC			F	Period: From 07/01/2015 Fo 06/30/2016	Worksheet S-3 Part I Date/Time Pre 11/22/2016 10	pared
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 384	29	1, 877	7		1.0
. 00	HMO and other (see instructions)	171	100				2.0
. 00	HMO IPF Subprovider	0	0				3.0
. 00	HMO IRF Subprovider	0	0				4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	494	0	554	1		5.0
. 00	Hospital Adults & Peds. Swing Bed NF		0	12	2		6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 878	29	2, 443	3		7.0
. 00	INTENSIVE CARE UNIT						8. (
00	CORONARY CARE UNIT						9.
0.00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)		0				12.
3.00	NURSERY	1 070	0	-		110 70	13.
1.00 5.00	Total (see instructions)	1,878	29			112.78	14. 15.
b. 00	CAH visits SUBPROVIDER - IPF	27, 619	1, 376	74, 495			15.
. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF						10.
. 00	SUBPROVIDER - TRF						17.
. 00	SKILLED NURSING FACILITY						10.
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21.
. 00	HOME HEALTH AGENCY						22.
. 00	AMBULATORY SURGICAL CENTER (D. P. )						23.
. 00	HOSPICE						24.
. 10	HOSPICE (non-distinct part)	0	0		)		24.
. 00	СМНС – СМНС						25.
. 00	RURAL HEALTH CLINIC	3, 379	332	16, 519	0.00	14.92	26.
. 01	RURAL HEALTH CLINIC II	5, 168	184	12, 215	0.00	16. 52	26.
. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.
. 00	Total (sum of lines 14-26)				0.00	144.22	27.
. 00	Observation Bed Days		0	663	3		28.
. 00	Ambul ance Trips	446					29.
. 00	Employee discount days (see instruction)			0			30.
. 00	Employee discount days - IRF			0			31.
2.00	Labor & delivery days (see instructions)	0	0	0			32.
2. 01	Total ancillary labor & delivery room			(			32.
	outpatient days (see instructions)			1			1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	CCN: 151307	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part I Date/Time Pre 11/22/2016 10	pared:
	Full Time Equivalents		Di s	charges		
Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
<ol> <li>Hospital Adults &amp; Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)</li> <li>HMO and other (see instructions)</li> <li>HMO 1 PF Subprovider</li> <li>HMO 1 RF Subprovider</li> <li>HMO 1 RF Subprovider</li> <li>O Hospital Adults &amp; Peds. Swing Bed SNF</li> <li>Hospital Adults &amp; Peds. Swing Bed SNF</li> <li>O Hospital Adults and Peds. (exclude observation beds) (see instructions)</li> <li>O Total Adults and Peds. (exclude observation beds) (see instructions)</li> <li>O CORONARY CARE UNIT</li> <li>O BURN INTENSIVE CARE UNIT</li> <li>O UTHER SPECIAL CARE (SPECIFY)</li> <li>O OTHER SPECIAL CARE (SPECIFY)</li> <li>O CAH visits</li> <li>O SUBPROVIDER - IPF</li> <li>O SUBPROVIDER - IRF</li> </ol>		<u>12.00</u> 0	41	8 10  1 33 0 0	<u>15.00</u> 575	15.00 16.00 17.00 18.00 19.00 20.00
<ul> <li>21.00 OTHER LONG TERM CARE</li> <li>22.00 HOME HEALTH AGENCY</li> <li>23.00 AMBULATORY SURGICAL CENTER (D.P.)</li> <li>24.00 HOSPICE</li> <li>24.10 HOSPICE (non-distinct part)</li> <li>25.00 CMHC - CMHC</li> <li>26.01 RURAL HEALTH CLINIC II</li> <li>26.25 FEDERALLY QUALIFIED HEALTH CENTER</li> <li>27.00 Total (sum of lines 14-26)</li> <li>28.00 Observation Bed Days</li> <li>29.00 Ambulance Trips</li> <li>30.00 Employee discount days (see instruction)</li> <li>31.00 Employee discount days (see instructions)</li> <li>32.01 Total ancillary labor &amp; delivery room outpatient days (see instructions)</li> <li>33.00 LTCH non-covered days</li> </ul>	0. 00 0. 00 0. 00					21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00

Heal th	Financial Systems ST.	VINCENT WILLIAMS	PORT HOSPITA	AL.	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFI			CCN: 151307	Peri od:	Worksheet S-8	
STATI S	ITI CAL DATA		Component	CCN: 153993	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 10	
					Rural Health <u>Clinic (RHC) I</u>	Cost	
					1.	00	
1 00	Clinic Address and Identification						1 00
1.00	Street		Ci	tv	1731 RINGER LA State	ZIP Code	1.00
	· · · · · · · · · · · · · · · · · · ·		1.	00	2.00	3.00	
2.00	City, State, ZIP Code, County	WIL	LI AMSPORT		IN	47993	2.00
						1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urbar	ı			0	3.00
					Grant Award 1.00	Date 2.00	
	Source of Federal Funds						
4.00 5.00 6.00 7.00 8.00 9.00 9.01 9.02	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac Health Services for the Homeless (Section 340 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	t)					4.00 5.00 6.00 7.00 8.00 9.00 9.01 9.02
9.03 9.04 9.05 9.06 9.07 9.08 9.09 9.10							9.03 9.04 9.05 9.06 9.07 9.08 9.09 9.10
10.00	Does this facility operate as other than an R	HC or EOHC2 Enter	· "Y" for ve	s or "N" for	1.00 N	2.00	10.00
	no in column 1. If yes, indicate number of ot subscripts of line 11 the type of other opera	her operations ir	n column 2. (	Enter in			10.00
		Sunday			onday	Tuesday	
		from 1.00	to 2.00	from 3.00	to 4.00	from 5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:00	19:00	07:00	11.00
					1.00	2.00	
12.00 13.00	Have you received an approval for an exception Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report. numbers below.	in CMS Pub. 100- mn 1. If yes, ent	-04, chapter ter in colum	9, section n 2 the	N N	0	12.00 13.00
					der name	CCN number	
14 00	Provider name, CCN number				1. 00	2.00	14.00
14.00		Y/N	V	XVIII	XIX	Total Visits	14.00
15.00		1.00	2.00	3.00	4.00	5.00	15.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

Health Financial Systems ST.	VINCENT WILLI	AMSPORT HOSPIT	AL	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	IED HEALTH CEN	TER Provi der	CCN: 151307	Period:	Worksheet S-8	}
STATI STI CAL DATA		Componen	t CCN: 153993	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 10	epared: ):23 am
				Rural Health	Cost	
				Clinic (RHC) I		
		Со	unty			
		4	00			
2.00 City, State, ZIP Code, County		WARREN				2.00
	Tuesday	Wedr	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 Clinic	19:00	07:00	19: 00	07:00	19: 00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 Cl i ni c	07: 00	19:00				11.00

<sup>11/22/2016 10:23</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20160630 \28950-16.mcrx

Heal th	Financial Systems ST.	VINCENT WILLIAMSF	PORT HOSPITA	AL.	In Lie	eu of Form CMS-	2552-10
	AL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFI	ED HEALTH CENTER	Provi der	CCN: 151307	Period:	Worksheet S-8	3
STATES	TICAL DATA		Component	CCN: 153994	From 07/01/2015 To 06/30/2016	Date/Time Pre	
					Rural Health	11/22/2016 10 Cost	):23 am
					<u>Clinic (RHC) II</u>		
					1	00	-
	Clinic Address and Identification					00	
1.00	Street		0.		440 W. SONGER		1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County	VEE	DERSBURG			47987	2.00
						1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urban	1			1.00	3.00
	· · · · · · · · · · · · · · · · · · ·				Grant Award	Date	
	Source of Federal Funds				1.00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)			0	J	4.00
5.00	Migrant Health Center (Section 329(d), PHS Ac				0		5.00
6.00 7.00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	(d), PHS Act)			0		6.00 7.00
7.00 8.00	Look-Alikes				0		8.00
9.00	OTHER (SPECI FY)				0		9.00
9.01					0		9.01
9.02					0		9.02 9.03
9.03 9.04					0	,	9.03
9.05					0	,	9.05
9.06					0		9.06
9.07 9.08					0		9.07 9.08
9.08 9.09					0		9.08
9.10					0		9.10
					1.00	2.00	
10.00	Does this facility operate as other than an R	HC or FQHC? Enter	"Y" for ye	s or "N" for	N	2.00	10.00
	no in column 1. If yes, indicate number of ot	her operations in	ı column 2. (	Enter in			
	subscripts of line 11 the type of other opera	<u>ition(s) and the o</u> Sunday			onday	Tuesday	
	·	from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) Clinic			08:00	17:00	08:00	111 00
11.00	CITIE			08.00	17.00	08.00	11.00
					1.00	2.00	
	Have you received an approval for an exception				N		12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu				N	C	13.00
	number of providers included in this report.						
	numbers below.						
					<u>der name</u> 1.00	CCN number 2.00	
14.00	Provider name, CCN number					2100	14.00
		Y/N	V	XVIII	XI X	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
	GME cost? Enter "Y" for yes or "N" for no in						
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)	I		I	I	I	I

Health Financial Systems ST.	. VINCENT WILLI	AMSPORT HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIE	FIED HEALTH CEN	TER Provi de	er CCN: 151307	Period:	Worksheet S-8	}
STATI STI CAL DATA		Compone	ent CCN: 153994	From 07/01/2015 To 06/30/2016		epared: ):23 am
				Rural Health	Cost	
				<u>Clinic (RHC) II</u>		
			ounty			
			4.00			
2.00 City, State, ZIP Code, County		FOUNTAI N				2.00
	Tuesday	We	dnesday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 Clinic	17:00	08: 00	17:00	08:00	17:00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)					•	
11. 00 Cl i ni c	08: 00	16: 30				11.00

<sup>11/22/2016 10:23</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20160630 \28950-16.mcrx

Heal th	Financial Systems ST. VINCENT WILLIAMSPOR	T HOSPITA	L	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151307	Peri od:	Worksheet S-1	0
				From 07/01/2015		
				To 06/30/2016		
					11/22/2016 10	23 80
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by li	ne 202 columr	1.8)	0. 272103	1.00
	Medicaid (see instructions for each line)			)		
2.00	Net revenue from Medicaid				416, 361	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p	payments i	from Medicaid	1?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from N				0	5.00
6.00	Medi cai d charges				14, 605, 152	6.00
7.00	Medicaid cost (line 1 times line 6)				3, 974, 106	7.00
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minu	us sum of lir	nes 2 and 5; if	3, 557, 745	8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instructio	ons for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP				0	9.00
10.00	Stand-alone SCHIP charges				0	10.00
	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				-	
	Net revenue from state or local indigent care program (Not includ					13.00
14.00	Charges for patients covered under state or local indigent care p	program (I	Not included	in lines 6 or	0	14.00
15 00	10) State on least indigent core program cost (line 1 times line 14)				0	15 00
	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indig	ant cara	program (Lir	o 15 minus lino		15.00
10.00	13; if < zero then enter zero)	Jent Care	program (III		0	10.00
	Uncompensated care (see instructions for each line)				<u>I</u>	
17.00	Private grants, donations, or endowment income restricted to func	ding chari	tv care		0	17.00
18.00	Government grants, appropriations or transfers for support of hos				0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local			ns (sum of lines	3, 557, 745	19.00
	8, 12 and 16)	5	1 3			
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (a		2, 259, 73	607, 900	2, 867, 638	20.00
01 00	charges excluding non-reimbursable cost centers) for the entire f		(14.0)	1/5 411	700 000	21 00
21.00	Cost of initial obligation of patients approved for charity care times line 20)	(line i	614, 88	31 165, 411	780, 292	21.00
22, 00	Partial payment by patients approved for charity care		142, 65	57 52, 261	194, 918	22.00
	Cost of charity care (line 21 minus line 22)		472, 22			
23.00	Cost of charty care (The 21 minus The 22)		472, 24	113,130	565, 574	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient of	avs bevoi	nd a length o	of stay limit	N 1.00	24.00
21.00	imposed on patients covered by Medicaid or other indigent care pr		la a rongen e	i stay mint		21.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent		ogram's lengt	h of stay limit	0	25.00
	Total bad debt expense for the entire hospital complex (see instr		5		2, 144, 644	
	Medicare bad debts for the entire hospital complex (see instructi				442, 829	
	Non-Medicare and non-reimbursable Medicare bad debt expense (line		s line 27)		1, 701, 815	
	Cost of non-Medicare and non-reimbursable Medicare bad debt exper			28)	463, 069	
	Cost of uncompensated care (line 23 column 3 plus line 29)	<b>、</b>			1, 048, 443	
	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			4, 606, 188	

Heal th	Financial Systems ST.	VINCENT WILLIAM	SPORT HOSPITA	AL.	In Lie	u of Form CMS-:	2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O			CCN: 151307	Peri od:	Worksheet A	
					From 07/01/2015 To 06/30/2016	Date/Time Pre	narod
					10 00/30/2010	11/22/2016 10	:23 am
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		160, 309	160, 30	9 -2,222	158, 087	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		790, 057			790, 057	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		0		0 0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	139, 626	2, 258, 881	2, 398, 50		2, 398, 507	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 899, 275	2, 029, 428			3, 930, 925	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0		0 0	0	6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	822, 607	822, 60	7 0	822, 607 0	7.00 8.00
9.00	00900 HOUSEKEEPING	0	163, 709	163, 70	9 0	163, 709	9.00
10.00	01000 DI ETARY	0	21, 205	21, 20		21, 205	10.00
11.00	01100 CAFETERIA	0	0		0 0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	12.00
13.00	01300 NURSING ADMINISTRATION	152, 581	7, 966			160, 547	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	37, 837	21, 268			59, 105	14.00
15.00	01500 PHARMACY	168, 778	430, 723			599, 501	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	140, 426	62, 710	203, 13	6 0	203, 136	16.00
17.00 19.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	17.00 19.00
20.00	02000 NURSI NG SCHOOL	0	0			0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	Ő	0		0 0	0	22.00
23.00	02300 PARAMED ED PRGM	0	0		0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 123, 577	259, 367	1, 382, 94		1, 371, 531	30.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	E0E 202	207 101	002 57	2 21 020	700 (24	
50.00 53.00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	505, 392 0	297, 181 0	802, 57	3 -21, 939 0 0	780, 634 0	50.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	555, 185	501, 916			1, 057, 101	
60.00	06000 LABORATORY	23, 492	1, 020, 460			1, 043, 952	60.00
65.00	06500 RESPI RATORY THERAPY	19, 981	24, 241	44, 22		44, 222	
66.00	06600 PHYSI CAL THERAPY	203, 559	104, 227	307, 78	6 -1, 200	306, 586	66.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	12, 649			67, 780	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	57, 969			57, 969	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	73.00
88.00	08800 RURAL HEALTH CLINIC	909, 337	408, 374	1, 317, 71	1 148, 915	1, 466, 626	88.00
88.01	08801 RURAL HEALTH CLINIC II	1, 127, 711	293, 632				88.01
91.00	09100 EMERGENCY	803, 069	1, 070, 862				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	408, 700	35, 020	443, 72	0 0	443, 720	95.00
	SPECIAL PURPOSE COST CENTERS		10.071.7	40	-1	10	
118.00		8, 218, 526	10, 854, 761	19, 073, 28	7 0	19, 073, 287	118.00
102 00	NONREI MBURSABLE COST CENTERS		0				102 00
	19300 NONPALD WORKERS 19301 ORTHO CLINIC	0 282, 996	0 49, 448		0 0 4 0		193.00
	19301 ORTHO CEINIC	282, 998	49, 448 34				193.01
	07950 MARKETI NG	7, 343	1, 851				193.02
200.00		8, 508, 865	10, 906, 094				
					1		

Health Financial Sy	ystems	ST. VINCENT WILLIAMSPOR	T HOSPI TAL	
RECLASSIFICATION A	AND ADJUSTMENTS OF TRIAL	BALANCE OF EXPENSES	Provider CCN: 151307	Peri od:

In Lieu of Form CMS-2552-10 Worksheet A

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	CCN: 151307	Period: From 07/01/2015	Worksheet A
				To 06/30/2016	Date/Time Prepare 11/22/2016 10:23
Cost Center Description	Adjustments	Net Expenses			
	(See A-8) 6.00	For Allocation 7.00			
GENERAL SERVICE COST CENTERS	0.00	1.00			
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	-122, 701	35, 38	6		1.
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	C	790, 05	7		2.
3.00 00300 OTHER CAPITAL RELATED COSTS	0		ol		3.
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	853, 752	3, 252, 25	9		4.
5. 00 00500 ADMI NI STRATI VE & GENERAL	247,032				5.
0.00 00600 MAI NTENANCE & REPAI RS	C		ol		6.
00700 OPERATION OF PLANT	-11, 738	8 810, 86	9		7.
. 00 00800 LAUNDRY & LINEN SERVICE	C		ol		8.
. 00 00900 HOUSEKEEPI NG	C	163, 70	9		9.
0. 00 01000 DI ETARY	-6, 774	14, 43	1		10.
1. 00 01100 CAFETERI A	0		o		11.
2.00 01200 MAINTENANCE OF PERSONNEL					12.
3. 00 01300 NURSI NG ADMI NI STRATI ON	-395	160, 15	2		13.
4. 00 01400 CENTRAL SERVICES & SUPPLY					14.
5. 00 01500 PHARMACY	-164		1		15.
6. 00 01600 MEDICAL RECORDS & LIBRARY	-7, 245				16.
7. 00 01700 SOCIAL SERVICE	,,210		ol		17.
9. 00 01900 NONPHYSICIAN ANESTHETISTS			0		19.
0. 00 02000 NURSI NG SCHOOL					20.
1.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD			0		21.
2. 00 02200 I & SERVICES-OTHER PRGM COSTS APPRVD			0		22.
3. 00 02300 PARAMED ED PRGM					23.
INPATIENT ROUTINE SERVICE COST CENTERS		1	0		20.
0. 00 03000 ADULTS & PEDI ATRI CS	-760	1, 370, 77	1		30.
3. 00 04300 NURSERY	C		0		43.
ANCI LLARY SERVICE COST CENTERS		1	<u> </u>		101
0. 00 05000 OPERATI NG ROOM	-218, 256	562, 37	8		50.
3. 00 05300 ANESTHESI OLOGY	C		ol		53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	-145, 747		-		54.
D. 00 06000 LABORATORY	-1, 555				60.
5. 00 06500 RESPI RATORY THERAPY	-225				65.
5. 00 06600 PHYSI CAL THERAPY	-10, 039				66.
3. 00 06800 SPEECH PATHOLOGY					68.
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					71.
2. 00 07200 I MPL. DEV. CHARGED TO PATIENT					72.
3. 00 07300 DRUGS CHARGED TO PATIENTS			0		73.
OUTPATIENT SERVICE COST CENTERS		1	<u> </u>		, 0.
8. 00 08800 RURAL HEALTH CLINIC	-28, 860	1, 437, 76	6		88.
8. 01 08801 RURAL HEALTH CLINIC II	-126, 142		1		88.
1. 00 09100 EMERGENCY	-665		1		91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	000	1,032,00	<b>'</b>		92.
OTHER REIMBURSABLE COST CENTERS					/2.
5. 00 09500 AMBULANCE SERVICES	-225	443, 49	5		95.
SPECIAL PURPOSE COST CENTERS	220	<u>, , , , , , , , , , , , , , , , , , , </u>	5		/3.
18.00 SUBTOTALS (SUM OF LINES 1-117)	419, 293	19, 492, 58	n		118.
NONREI MBURSABLE COST CENTERS	417,273	17,472,00	<u> </u>		110.
93. 00 19300 NONPAI D WORKERS	C		0		193.
93. 01 19301 ORTHO CLINIC	-69				193.
93. 02 19303 COMMUNITY MED CLINIC	-09				193.
93. 02 19303 COMMONTRY MED CLINIC 94. 00 07950 MARKETI NG	68, 302	-			193.
200.00 TOTAL (SUM OF LINES 118-199)	487, 526				200.
.00.00   10TAL (30M OF LINES 110-199)	407, 320	17, 902, 48			1200.

Heal th	Financial Systems	ST.	VINCENT WILLI	AMSPORT HOSPIT	AL	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 151307	Period: From 07/01/2015	Worksheet A-	6
						To 06/30/2016	Date/Time Pr 11/22/2016 1	epared: <u>0:23 am</u>
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
-	A - INTEREST							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 222				1.00
2.00		0.00	0	0				2.00
	TOTALS			2,222				
	B - RHC RECLASS 1				1			1
1.00	RURAL HEALTH CLINIC	88.00	148, 915	0				1.00
	TOTALS		148, 915	0				1
	C - MEDI CAL SUPPLI ES							1
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	55, 131				1.00
	PATI ENTS							
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
	TOTALS		o	55, 131	1			
500.00	Grand Total: Increases		148, 915	57, 353				500.00

Heal th	Financial Systems	ST.	VINCENT WILLIA	AMSPORT HOSPIT	AL	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 151307	Period:	Worksheet A-	6
						From 07/01/2015 To 06/30/2016	Date/Time Pr 11/22/2016 1	epared: <u>0:23 am</u>
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A – INTEREST							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	2, 222	1	1		1.00
	FIXT							
2.00		0.00	0	0	1	1		2.00
	TOTALS		0	2, 222				
	B - RHC RECLASS 1							
1.00	RURAL HEALTH CLINIC II	88.01	148, 915	0		0		1.00
	TOTALS		148, 915	o		7		
	C - MEDICAL SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	11, 413		0		1.00
2.00	OPERATING ROOM	50.00	0	21, 939		0		2.00
3.00	PHYSICAL THERAPY	66.00	0	1, 200		o		3.00
4.00	EMERGENCY	91.00	0	20, 579		o		4.00
	TOTALS		o	55, 131		7		
500.00	Grand Total: Decreases		148, 915	57, 353				500.00

Heal th Financia	I S	Systems		
RECONCI LI ATI ON	0F	CAPI TAL	COSTS	CENTERS

In Lieu of Form CMS-2552-10 Worksheet A-7

RECONC	TELATION OF CALTAL COSTS CENTERS		Trovider	CCN. 131307	From 07/01/2015 To 06/30/2016		
				Acqui si ti on	S		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	174, 050	0		0 0	0	1.00
2.00	Land Improvements	106, 181	0		0 0	0	2.00
3.00	Buildings and Fixtures	7, 904, 951	0		0 0	30, 777	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	5, 158, 174	54, 804		0 54, 804	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13, 343, 356	54, 804		0 54, 804	30, 777	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	13, 343, 356	54, 804		0 54, 804	30, 777	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	174, 050	0				1.00
2.00	Land Improvements	106, 181	0				2.00
3.00	Buildings and Fixtures	7, 874, 174	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5, 212, 978	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	13, 367, 383	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	13, 367, 383	0				10.00

Heal th	Financial Systems ST	. VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 07/01/2015 To 06/30/2016		pared:
			SL	JMMARY OF CAPI	ΓAL	11/22/2010 10	25 am
	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 WO	RKSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	17, 144	0	124, 923	8 8, 473	9, 769	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	443, 203	346, 539	(	315	0	2.00
3.00	Total (sum of lines 1-2)	460, 347	346, 539	124, 923	8, 788	9, 769	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	160, 309				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	790, 057				2.00
3.00	Total (sum of lines 1-2)	0	950, 366	.			3.00

Health Financial	Systems ST	. VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
RECONCI LI ATI ON	OF CAPI TAL COSTS CENTERS		Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet A-7 Part III Date/Time Prep 11/22/2016 10:	pared:
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cos	t Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	- RECONCILIATION OF CAPITAL COSTS C		-			-	
	REL COSTS-BLDG & FIXT	8, 154, 405		8, 154, 40		0	1.00
	REL COSTS-MVBLE EQUIP	5, 212, 978		5, 212, 97		0	2.00
3.00 Total (su	um of lines 1-2)	13, 367, 383		13, 367, 38		0	3.00
		ALLUCA	TION OF OTHER (	APITAL	SUMMARY O	F CAPITAL	
Cos	t Center Description	Taxes	Other Capi tal -Rel ate		f Depreciation	Lease	
		6.00	d Costs 7.00	through 7) 8.00	9.00	10.00	
PART III	- RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	7.00	10.00	
	REL COSTS-BLDG & FLXT	0	0		0 17, 144	0	1.00
	REL COSTS-MVBLE EQUIP	0			0 443, 203	346, 539	2.00
	um of lines 1-2)	0	0		0 460, 347	346, 539	3.00
<b>`</b> ``			SL	JMMARY OF CAPI			
Cos	t Center Description	Interest	Insurance (see instructions)		Other ) Capital -Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III	- RECONCILIATION OF CAPITAL COSTS C						
	REL COSTS-BLDG & FIXT	0	8, 473	9, 76	9 0	35, 386	1.00
		1					
2.00 NEW CAP F	REL COSTS-MVBLE EQUIP	0	315		0 0	790, 057	2.00

Heal th	Fi nanci	al	Systems
AD JUST	MENTS TO	) F)	(PENSES

## ST VINCENT WILLIAMSPORT HOSPITAL

Heal th	Financial Systems	ST.	VINCENT WILLI	AMSPORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUSTI	IENTS TO EXPENSES				Period: From 07/01/2015 To 06/30/2016	Worksheet A-8 Date/Time Pre 11/22/2016 10	pared:
				Expense Classification of To/From Which the Amount is		11/22/2010 10	20 0
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	1.00
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-113, 776	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	Ínvestment income - other (chapter 2)	В	-2, 060	ADMI NI STRATI VE & GENERAL	5.00	0	3.00
. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
o. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		C		0.00	0	7.00
3. 00	Television and radio service (chapter 21)		0		0.00	0	8.00
0.00 0.00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	-352, 705		0.00	0 0	9. 00 10. 00
	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.00
	Related organization transactions (chapter 10)	A-8-1	1, 487, 505		0.00	0	
4.00	Laundry and linen service Cafeteria-employees and guests		0		0.00 0.00 0.00	0 0 0	13.00 14.00 15.00
	Rental of quarters to employee and others Sale of medical and surgical		C		0.00	0	16.00
7 00	supplies to other than patients				0.00		17 00
	Sale of drugs to other than patients		U		0.00	0	
	Sale of medical records and abstracts		U		0.00	0	
	Nursing school (tuition, fees, books, etc.)		U		0.00	0	19.00
	Vending machines Income from imposition of interest, finance or penalty		0		0.00 0.00	0 0	
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		O		0.00	0	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	C	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of	A-8-3	-9, 728	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114.00		25.00
6. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
7. 00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE	2.00	0	27.00
	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C O	*** Cost Center Deleted ***	0. 00 67. 00	0	29.00 30.00
0. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	O	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		C	)	0.00	0	32.00

ADJUSTMENTS TO EXPENSES Provider CCN: 151307 Period: Work From 07/01/2015	sheet A-8
Erom 07/01/2015	
	/Time Prepared:
	2/2016 10:23 am
Expense Classification on Worksheet A	
To/From Which the Amount is to be Adjusted	
Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst.	A-7 Ref.
	5.00
33. 00 CHARLTABLE CONTRIBUTIONS A -1, 876 ADMINI STRATIVE & GENERAL 5. 00	0 33.00
34.00 ALCOHOL EXPENSE A -34ADMI NI STRATI VE & GENERAL 5.00	0 34.00
35.00 0.00	0 35.00
36. 00 LOBBYI NG A -882 ADMI NI STRATI VE & GENERAL 5. 00	0 36.00
37. 00 PROVIDER TAX A -378, 715 ADMINI STRATI VE & GENERAL 5. 00	0 37.00
38. 00 MISC SURGERY REVENUE B -1 OPERATING ROOM 50. 00	0 38.00
39. 00 CREDENTIALING B -5, 800 ADMINISTRATIVE & GENERAL 5. 00	0 39.00
40. 00 MISC PLANT OP REVENUE B -100 OPERATION OF PLANT 7. 00	0 40.00
41. 00 FOOD SERVICES B -6, 774 DI ETARY 10. 00	0 41.00
41. 01 PHARMACY SERVICES B -52 PHARMACY 15. 00	0 41.01
42. 00 MED. RECORD COPY REVENUE B -7, 245 MEDI CAL RECORDS & LI BRARY 16. 00	0 42.00
43. 00 MI SC RADI OLOGY REVENUE B -49 RADI OLOGY-DI AGNOSTI C 54. 00	0 43.00
43. 01 MI SC. VACCI NE REVENUE B -112 PHARMACY 15. 00	0 43.01
43. 02 MISC. EMERGENCY REVENUE B -25EMERGENCY 91. 00	0 43.02
45. 00 I NCENTI VE ACCRUAL ADJUSTMENT A -238, 648 ADMI NI STRATI VE & GENERAL 5. 00	0 45.00
45. 01 I NCENTI VE ACCRUAL ADJUSTMENT A 273, 034 EMPLOYEE BENEFI TS DEPARTMENT 4. 00	0 45.01
45. 02 N CLINIC NON-RHC SALARY A -28, 635 RURAL HEALTH CLINIC 88. 00	0 45.02
45.03 S CLINIC NON-RHC SALARY A -125,796 RURAL HEALTH CLINIC II 88.01 50.00 TOTAL (sum of lines 1 thru 49) 487,526	0 45.03 50.00
50.00 TOTAL (sum of lines 1 thru 49) 487,526 (Transfer to Worksheet A,	50.00
column 6, line 200.)	

column 6, line 200.) 

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

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

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

STATEME OFFICE	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO				
OFFI CE	COSTS	RELATED ORGANIZATIONS AND THE	ME Provider CCN: 151307	Peri od:	Worksheet A-8	-1
	00313			From 07/01/2015		
				To 06/30/2016	Date/Time Pre 11/22/2016 10	
	Line No.	Cost Center	Expense Items	Amount of	Amount	. 23 dili
	Line No.	cost center		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:				o Er ti me b	
1.00		ADMINISTRATIVE & GENERAL	НО	1, 866, 705	991, 456	1.00
2.00	194.00	MARKETI NG	но	68, 302	0	2.00
3.00	193. 02	COMMUNITY MED CLINIC	SVH CHARGEBACKS	34	34	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT		301,605	301, 605	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	1, 341, 962	1, 341, 962	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	SVH CHARGEBACKS	47, 182	47, 182	4.01
4.02	15.00	PHARMACY	SVH CHARGEBACKS	5,075	5,075	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACKS	124, 344	124, 344	4.03
4.04	30.00		SVH CHARGEBACKS	32, 680	32, 680	4.04
4.05		OPERATING ROOM	SVH CHARGEBACKS	7,720	7,720	4.05
4.06	54.00	RADI OLOGY-DI AGNOSTI C	SVH CHARGEBACKS	20, 632	20, 632	4.06
4.07			SVH CHARGEBACKS	7, 520	7, 520	4.07
4.08		RURAL HEALTH CLINIC	SVH CHARGEBACKS	116, 551	116, 551	4.08
4.09	88. 01	RURAL HEALTH CLINIC II	SVH CHARGEBACKS	124, 087	124,087	4.09
4.10	91.00	EMERGENCY	SVH CHARGEBACKS	119	119	4.10
4.11	193. 01	ORTHO CLINIC	SVH CHARGEBACKS	15, 492	15, 492	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	1, 376, 256	1, 113, 768	4.12
4.13	1.00	NEW CAP REL COSTS-BLDG & FIX	ASCENSION INTEREST	113, 776	122, 701	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	2,060	2, 222	4.14
4.15		OPERATION OF PLANT	TRIMEDX	203, 948	215, 586	4.15
4.16	30.00	ADULTS & PEDIATRICS	TRIMEDX	13, 321	14, 081	4.16
4.17	50.00	OPERATING ROOM	TRIMEDX	41, 174	43, 524	4.17
4.18	54.00	RADI OLOGY-DI AGNOSTI C	TRIMEDX	163, 544	172, 877	4. 18
4.19		LABORATORY	TRIMEDX	27, 247	28, 802	4.19
4.20	65.00	RESPI RATORY THERAPY	TRIMEDX	3, 936	4, 161	4.20
4.21	66.00	PHYSI CAL THERAPY	TRIMEDX	5, 450	5, 761	4.21
4.22	88.00	RURAL HEALTH CLINIC	TRIMEDX	3, 936	4, 161	4.22
4.23	88. 01	RURAL HEALTH CLINIC II	TRIMEDX	6, 055	6, 401	4.23
4.24		EMERGENCY	TRIMEDX	11, 201	11, 841	4.24
4.25	95.00	AMBULANCE SERVICES	TRIMEDX	3, 936	4, 161	4.25
4.26	193. 01	ORTHO CLINIC	TRIMEDX	1, 211	1, 280	4.26
4.27	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION - PENSION	363, 067	44, 837	4.27
4.28	0.00			0	0	4. 28
5.00	0		0	6, 420, 128	4, 932, 623	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.

nus not	been posted to norksheet h,		it unromable sh		or this purt.		
				Related Organization(s) and/	or Home Office		
						1	
						1	
	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 RELATED 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	G	SVH	100.00 ST. VINCENT HEALTH	100.00	6.00
7.00	G	ASCENSI ON	100.00 ASCENSI ON	100.00	7.00
8.00	A	TRI MEDX	100. 00 TRI MEDX	100.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	HOME OFFICE			100.00
	non-financial) specify:				

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

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

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

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

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

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

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

Heal th	Financial Syst	ems	ST.	VINCENT WILLIAMS	PORT HOSPI TAL	In Lie	u of Form CMS	-2552-10
STATEN	MENT OF COSTS OF	SERVICES FROM	RELATED ORGANIZ	ATIONS AND HOME	Provider CCN: 151307	Peri od:	Worksheet A-	8-1
OFFICE	COSTS					From 07/01/2015 To 06/30/2016	Date/Time Pr	onarod
						10 00/30/2010	11/22/2016 1	
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED A	S A RESULT OF TRA	NSACTIONS WITH RELATED (	ORGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO	STS:						
1.00	875, 249	0						1.00
2.00	68, 302	0						2.00
3.00	0	0 0						3.00
3.01	0	0						3. 01
4.00	0	0 0						4.00
4.01	0	0 0						4.01
4.02	0	0						4.02
1 02								1 02

	001. 3)			
	6.00	7.00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	875, 249	0		1.00
2.00	68, 302	0		2.00
3.00	0	0		3.00
3.01	0	0		3. 01
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	262, 488			4. 12
4.13	-8, 925			4.13
4.14	-162	0		4.14
4.15	-11, 638			4.15
4.16	-760			4. 16
4.17	-2, 350			4.17
4.18	-9, 333			4. 18
4.19	-1, 555	0		4. 19
4.20	-225	0		4.20
4.21	-311	0		4. 21
4.22	-225	0		4. 22
4.23	-346			4.23
4.24	-640	0		4.24
4.25	-225	0		4.25
4.26	-69			4.26
4.27	318, 230	0		4.27
4.28	0	0		4.28
5.00	1, 487, 505			5.00
* The	amounts on line	es 1-4 (and sub	scripts 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

1103 110	been posted to worksheet A,	cordinins i and/or z, the amount arrowable should be that cated in cordinin 4 of this part.	
	Rel ated Organi zati on(s)		
	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

rer mour	sement under title XVIII.	
6.00	ADMI NI STRATI ON	6.00
7.00	ADMI NI STRATI ON	7.00
8.00	TECHNOLOGY MGNT	8.00
9.00		9.00
10.00		10.00
100.00		100.00
(4) 11		

(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.

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

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

Health Financial Systems

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

PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der		Period:	Worksheet A-8	3-2
						From 07/01/2015 To 06/30/2016	5 5 Date/Time Pre	nared
						10 00/30/2010	11/22/2016 10	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
	1.00						Hours	
1.00	1.00	2.00	3.00	4.00	5.00	6.00	7.00	1.00
1.00		ADMI NI STRATI VE & GENERAL	40	40	(	۳ ۱	Ŭ	1.00
2.00 3.00		NURSI NG ADMI NI STRATI ON	395	395	0		0	2.00
3.00 4.00		OPERATING ROOM	215, 905	215, 905			0	3.00
4.00 5.00		RADI OLOGY-DI AGNOSTI C EMERGENCY	136, 365 875, 009		875, 009		0	4.00 5.00
5.00 6.00	0.00		875,009	0	875,009		0	5.00 6.00
7.00	0.00		0	0			0	7.00
7.00 8.00	0.00		0	0			0	8.00
9.00	0.00		0	0			0	9,00
10.00	0.00		0	0			0	10.00
200.00	0.00		1, 227, 714	352, 705	875,009		0	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	WRSt. A EINC #	I denti fi er		Unadjusted RCE			of Malpractice	
			2	Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	(	0 0	0 0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	(	0 0	0	2.00
3.00		OPERATING ROOM	0	0	(	0 0	0 0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	(	0 0	0 0	4.00
5.00		EMERGENCY	0	0	(	0	0	5.00
6.00	0.00		0	0	(	0 0	0	6.00
7.00	0.00		0	0	(	0 0	0 0	7.00
8.00	0.00		0	0	(	0 0	0 0	8.00
9.00	0.00		0	0	(	0	0	9.00
10.00	0.00		0	0	(	0	0	
200.00			0	0	(		0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMINISTRATIVE & GENERAL	0	0	(			1.00
2.00		NURSI NG ADMI NI STRATI ON	0	0	0	395		2.00
3.00		OPERATING ROOM	0	0	(	215, 905		3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	136, 365		4.00
5.00	91.00	EMERGENCY	0	0	(	0 0		5.00
6.00	0.00		0	0	(	0 0		6.00
7.00	0.00		0	0	(	0 0		7.00
8.00	0.00		0	0	(	0 0		8.00
9.00	0.00		0	0	(	0 0		9.00
10.00	0.00		0	0	(	0 0		10.00
200.00			0	0	(	352, 705		200.00

	Financial Systems ST. IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provider CCN: 1	From To	d: 07/01/2015 06/30/2016 cal Therapy	Worksheet A-8- Parts I-VI Date/Time Prep 11/22/2016 10: Cost	pared:
					-	1.00	
	PART I - GENERAL INFORMATION					1.00	
1.00 2.00 3.00 4.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy	sor or therapist assistant was o	was on provider si			52 780 0 0	2.00
5.00 6.00	nor therapist was on provider site (see instr Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther instructions)	rvisors or thera apy assistants (	include only visits	made by the		0 138	5. 00 6. 00
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile					5. 21 0. 00	7.00 8.00
0.00		Supervi sors	Therapists Assi	stants	Ai des	Trai nees	0.00
0.00		1.00		. 00	4.00	5.00	0.00
9.00 10.00 11.00	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	0. 00 0. 00 0. 00	0.00 0.00 0.00	1, 535. 00 51. 76 25. 88	0. 00 0. 00	0. 00 0. 00	9.00 10.00 11.00
12. 00 12. 01	one-half of column 3, line 10) Number of travel hours (provider site) Number of travel hours (offsite)	0	0 0	0			12. 00 12. 01
13. 00 13. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0 0	0 0	0 0			13.00 13.01
					-	1.00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	line 10)				0	14.00
15.00	Therapists (column 2, line 9 times column 2,					0	15.00
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 ar others)		atory therapy or li	nes 14-16 fo	r all	79, 452 79, 452	
18.00	Aides (column 4, line 9 times column 4, line					0	18.00
19.00 20.00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	or respiratory t therapy or col line 2, make r	umns 1-3 for physic	al therapy, s	speech path		19.00 20.00
21.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,	ainees (line 17 line 9 for all	others)	olumns 1 and	2, line 9	0.00	21.00
22.00 23.00	Weighted allowance excluding aides and trained	es (line 2 time	es line 21)			0 79, 452	
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPUTATIO	N - PROVIDER	SI TE	79,432	23.00
	Standard Travel Allowance						
24.00 25.00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					0	24.00 25.00
26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for all oth	ers)		0	
27.00	Standard travel expense (line 7 times line 3	for respiratory	therapy or sum of	lines 3 and	4 for all	0	27.00
28. 00	others) Total standard travel allowance and standard 27)	travel expense	at the provider sit	e (sum of li	nes 26 and	0	28.00
	Optional Travel Allowance and Optional Travel	Expense			I		
29.00	Therapists (column 2, line 10 times the sum of Assistants (column 2, line 10 times column 2)		2, line 12 )			0	1
30.00 31.00	Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or		and 30 for all oth	ers)		0	
32.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)				um of	0	1
33.00	Standard travel allowance and standard travel					0	33.00
34.00 35.00	Optional travel allowance and standard travel Optional travel allowance and optional travel		,			0	34.00 35.00
33.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense			- SERVICES	OUTSIDE PRO		35.00
36.00	Therapists (line 5 times column 2, line 11)					0	
37.00	Assistants (line 6 times column 3, line 11)					3, 571	1
38.00 39.00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	of lines 5 and	6)			3, 571 719	
27.00	Optional Travel Allowance and Optional Travel		· -/			717	
40.00	Therapists (sum of columns 1 and 2, line 12.0	01 times column	2, line 10)			0	
41.00	Assistants (column 3, line 12.01 times column	n 3, line 10)				0	1
42.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	n of columps 1 ?	line 13 01)			0	
<u>43 NN</u>				ho following	three line		
43.00	Total Travel Allowance and Travel Expense - C	TTSI TE Servi ces	; complete one of t	ne rorrowing	three Trhe	S 44, 45,	
43.00 44.00	lotal Iravel Allowance and Iravel Expense - C or 46, as appropriate. Standard travel allowance and standard travel		•				44.00

	COST DETERMINATION FOR THERAPY SERVICES PLIERS	FURNI SHED BY	Provi der	CCN: 151307	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8 Parts I-VI Date/Time Pre 11/22/2016 10	pared:
					Physical Therapy	Cost	
						1.00	
5.00 Optic	onal travel allowance and optional travel	expense (sum of	lines 42 and	d 43 - see ir	istructions)	0	46.00
			Assi stants	Ai des	Trai nees	Total	
DADT		1.00	2.00	3.00	4.00	5.00	
	V - OVERTIME COMPUTATION	0.00	0.00	0.0		0.00	47.00
	ime hours worked during reporting od (if column 5, line 47, is zero or	0.00	0.00	0.0	0.00	0.00	47.0
	to or greater than 2,080, do not						
	ete lines 48-55 and enter zero in each						
	n of line 56)						
3.00 Overt	ime rate (see instructions)	0.00	0.00	0.0	0.00		48.0
	overtime (including base and overtime	0. 00	0.00	0.0	0. 00		49.0
	vance) (multiply line 47 times line 48)						
	LATION OF LIMIT						
	entage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.0
	de the hours in each column on line 47 ne total overtime worked - column 5,						
line							
	cation of provider's standard work year	0.00	0.00	0. (	0.00	0.00	51.0
	one full-time employee times the	01 00	0100	010	0100	0100	
	entages on line 50) (see instructions)						
DETER	MINATION OF OVERTIME ALLOWANCE						
	sted hourly salary equivalency amount	0. 00	51.76	0.0	0.00		52.0
	instructions)						
	time cost limitation (line 51 times line	0	0		0 0		53.0
52) 4.00  Maxim	num quartima cast (antar the laccor of	0	0		0 0		54.0
	num overtime cost (enter the lesser of 49 or line 53)	0	0		0		54.0
	on of overtime already included in	0	0		0 0		55.0
	y computation at the AHSEA (multiply	Ű	Ũ		0		00.0
	47 times line 52)						
5.00 Overt	ime allowance (line 54 minus line 55 -	O	0		0 0	0	56.0
	egative enter zero) ( Enter in column 5						
	sum of columns 1, 3, and 4 for						
	ratory therapy and columns 1 through 3						
	all others.)						
for a							
for a						1 00	
	VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	DJUSTMENT			1.00	
Part		ND EXCESS COST A	DJUSTMENT			1.00	57.0
Part ' 7.00 Salar 8.00 Trave	VI - COMPUTATION OF THERAPY LIMITATION A y equivalency amount (from line 23) allowance and expense - provider site	(from lines 33,	34, or 35))				
Part . 00 Sal ar . 00 Trave . 00 Trave	VI - COMPUTATION OF THERAPY LIMITATION A y equivalency amount (from line 23) allowance and expense - provider site allowance and expense - Offsite servic	(from lines 33,	34, or 35))	)		79, 452	58. 0 59. 0
Part 1 . 00 Salar . 00 Trave . 00 Trave . 00 Overt	VI - COMPUTATION OF THERAPY LIMITATION A y equivalency amount (from line 23) el allowance and expense - provider site allowance and expense - Offsite servic time allowance (from column 5, line 56)	(from lines 33,	34, or 35))	)		79, 452 0	58.0 59.0 60.0
Part 1 . 00 Sal ar . 00 Trave . 00 Trave . 00 Overt . 00 Equip	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite servic time allowance (from column 5, line 56) poment cost (see instructions)	(from lines 33,	34, or 35))	)		79, 452 0 0 0 0	58.0 59.0 60.0
Part 1 2.00 Sal ar 3.00 Trave 2.00 Trave 0.00 Overt .00 Equip 2.00 Suppl	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite servic cime allowance (from column 5, line 56) ment cost (see instructions) ies (see instructions)	(from lines 33,	34, or 35))	)		79, 452 0 0 0 0 0 0	58.0 59.0 60.0 61.0 62.0
Part . 00 Sal ar . 00 Trave . 00 Trave . 00 Overt . 00 Equip . 00 Suppl . 00 Total	VI - COMPUTATION OF THERAPY LIMITATION A y equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite servic time allowance (from column 5, line 56) ment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62)	(from lines 33, es (from lines 4	34, or 35))	)		79, 452 0 0 0 0 0 79, 452	58. ( 59. ( 60. ( 61. ( 62. ( 63. (
Part         Part           .00         Salar           .00         Trave           .00         Trave           .00         Quert           .00         Suppl           .00         Total           .00         Total	VI - COMPUTATION OF THERAPY LIMITATION A y equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite servic time allowance (from column 5, line 56) ment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from	(from lines 33, ces (from lines 4 n your records)	34, or 35)) 4, 45, or 46;	)		79, 452 0 0 0 0 0 79, 452 89, 180	58. ( 59. ( 60. ( 61. ( 62. ( 63. ( 64. (
Part           .00         Salar           .00         Trave           .00         Trave           .00         Trave           .00         Supprise           .00         Supprise           .00         Supplie           .00         Supplie           .00         Total           .00         Excess	VI - COMPUTATION OF THERAPY LIMITATION A y equivalency amount (from line 23) al allowance and expense - provider site allowance and expense - Offsite servic time allowance (from column 5, line 56) ment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from so over limitation (line 64 minus line 65	(from lines 33, ces (from lines 4 n your records)	34, or 35)) 4, 45, or 46;	)		79, 452 0 0 0 0 0 79, 452	58. ( 59. ( 60. ( 61. ( 62. ( 63. ( 64. (
Part           .00         Sal ar           .00         Trave           .00         Trave           .00         Overt           .00         Suppl           .00         Total           .00         Suppl           .00         Total           .00         Total           .00         Exces           LINE         LINE	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite servic time allowance (from column 5, line 56) ment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from so over limitation (line 64 minus line 65 33 CALCULATION	(from lines 33, ces (from lines 4 n your records) 3 - if negative,	34, or 35)) 4, 45, or 46) <u>enter zero)</u>			79, 452 0 0 0 0 79, 452 89, 180 9, 728	58.0 59.0 60.0 61.0 62.0 63.0 64.0 65.0
Part           7.00         Salar           8.00         Trave           0.00         Trave           0.00         Overt           0.00         Overt           0.00         Suppl           0.00         Total           0.00         Total           0.00         Exces           LINE         LINE	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite servic time allowance (from column 5, line 56) oment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from so over limitation (line 64 minus line 63 33 CALCULATION 26 = line 24 for respiratory therapy or	(from lines 33, ces (from lines 4 n your records) <u>3 - if negative,</u> sum of lines 24	34, or 35)) 4, 45, or 46) enter zero) and 25 for al	I others	others	79, 452 0 0 0 0 79, 452 89, 180 9, 728	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0
Part           .00         Sal ar           .00         Trave           .00         Trave           .00         Trave           .00         Overt           .00         Equip           .00         Suppl           .00         Total           .00         Excess           LINE         0.00           0.00         Line	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite servic time allowance (from column 5, line 56) oment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from ss over limitation (line 64 minus line 63 33 CALCULATION 26 = line 24 for respiratory therapy or 27 = line 7 times line 3 for respiratory	(from lines 33, ces (from lines 4 n your records) <u>3 - if negative,</u> sum of lines 24	34, or 35)) 4, 45, or 46) enter zero) and 25 for al	I others	others	79, 452 0 0 0 0 79, 452 89, 180 9, 728 0 0	58. C 59. C 60. C 61. C 62. C 63. C 64. C 65. C 100. C
Part 1 .00 Salar .00 Trave .00 Trave .00 Equip .00 Suppl .00 Total .00 Total .00 Excess LINE 0.00 Line 0.01 Line 0.02 Line	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite servic ime allowance (from column 5, line 56) oment cost (see instructions) iles (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from ss over limitation (line 64 minus line 63 33 CALCULATION 26 = line 24 for respiratory therapy or 27 = line 7 times line 3 for respiratory 33 = line 28 = sum of lines 26 and 27	(from lines 33, ces (from lines 4 n your records) <u>3 - if negative,</u> sum of lines 24	34, or 35)) 4, 45, or 46) enter zero) and 25 for al	I others	others	79, 452 0 0 0 0 79, 452 89, 180 9, 728 0 0	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0
Part           .00         Salar           .00         Trave           .00         Trave           .00         Vert           .00         Suppl           .00         Total           .00         Total           .00         Exces           LINE         Line           0.01         Line           LINE         LINE	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite servic cime allowance (from column 5, line 56) ment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from as over limitation (line 64 minus line 63 as CALCULATION 26 = line 24 for respiratory therapy or 27 = line 7 times line 3 for respiratory 33 = line 28 = sum of lines 26 and 27 34 CALCULATION	(from lines 33, ces (from lines 4 n your records) 3 - if negative, sum of lines 24 / therapy or sum	34, or 35)) 4, 45, or 46; enter zero) and 25 for al of lines 3 au	I others nd 4 for all		79, 452 0 0 0 0 79, 452 89, 180 9, 728 0 0 0 0	58. C 59. C 60. C 61. C 62. C 63. C 64. C 65. C 100. C 100. C
Part 0 .00 Sal ar .00 Trave .00 Trave .00 Equip .00 Suppl .00 Suppl .00 Total .00 Total .00 Exces LI NE 0.00 Li ne 0.02 Li ne 1. NO Li ne	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite servic ime allowance (from column 5, line 56) oment cost (see instructions) iles (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from ss over limitation (line 64 minus line 63 33 CALCULATION 26 = line 24 for respiratory therapy or 27 = line 7 times line 3 for respiratory 33 = line 28 = sum of lines 26 and 27	(from lines 33, ces (from lines 4 n your records) 3 - if negative, sum of lines 24 / therapy or sum	34, or 35)) 4, 45, or 46; enter zero) and 25 for al of lines 3 an of lines 3 an	I others nd 4 for all nd 4 for all		79, 452 0 0 0 0 0 79, 452 89, 180 9, 728 0 0 0 0 0 0	58. C 59. C 60. C 61. C 62. C 63. C 64. C 65. C 100. C
Part           .00         Sal ar           .00         Trave           .00         Trave           .00         Trave           .00         Overt           .00         Suppl           .00         Suppl           .00         Total           .00         Exces           LINE         0.00           Line         LINE           1.00         Line           1.00         Line	VI - COMPUTATION OF THERAPY LIMITATION A y equivalency amount (from line 23) al allowance and expense - provider site allowance and expense - Offsite service ime allowance (from column 5, line 56) ment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from so over limitation (line 64 minus line 63 33 CALCULATION 26 = line 24 for respiratory therapy or 27 = line 7 times line 3 for respiratory 33 = line 28 = sum of lines 26 and 27 34 CALCULATION 27 = line 7 times line 3 for respiratory	(from lines 33, ces (from lines 4 n your records) 3 - if negative, sum of lines 24 / therapy or sum	34, or 35)) 4, 45, or 46; enter zero) and 25 for al of lines 3 an of lines 3 an	I others nd 4 for all nd 4 for all		79, 452 0 0 0 0 0 79, 452 89, 180 9, 728 0 0 0 0 0 0 0	58. ( 59. ( 60. ( 61. ( 62. ( 63. ( 64. ( 65. ( 100. ( 100. ( 100. ( 100. ( 101. (
Part           .00         Sal ar           .00         Trave           .00         Trave           .00         Trave           .00         Overt           .00         Equip           .00         Suppl           .00         Total           .00         Exces           .00         LINE           0.00         Line           .01         Line           1.00         Line           1.01         Line           1.02         Line	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite service sime allowance (from column 5, line 56) oment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from ss over limitation (line 64 minus line 63 33 CALCULATION 26 = line 24 for respiratory therapy or 27 = line 7 times line 3 for respiratory 33 = line 28 = sum of lines 26 and 27 34 CALCULATION 27 = line 7 times line 3 for respiratory 31 = line 29 for respiratory therapy or 34 = sum of lines 27 and 31 35 CALCULATION	(from lines 33, es (from lines 4 h your records) 3 - if negative, sum of lines 24 / therapy or sum sum of lines 29	34, or 35)) 4, 45, or 46; enter zero) and 25 for al of lines 3 an of lines 3 an and 30 for al	I others nd 4 for all nd 4 for all I others		79, 452 0 0 0 0 0 79, 452 89, 180 9, 728 0 0 0 0 0 0 0	58. ( 59. ( 60. ( 61. ( 62. ( 63. ( 64. ( 65. ( 100. ( 100. ( 100. ( 101. ( 101. (
Part           00         Sal ar           00         Trave           00         Trave           00         Trave           00         Overt           00         Equip           00         Suppl           00         Total           00         Total           00         Excess           LINE         LINE           0.00         Line           1.00         Line           1.00         Line           1.01         Line           1.02 <tdline< td=""></tdline<>	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite service time allowance (from column 5, line 56) oment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from so over limitation (line 64 minus line 63 33 CALCULATION 26 = line 24 for respiratory therapy or 27 = line 7 times line 3 for respiratory 33 = line 28 = sum of lines 26 and 27 34 CALCULATION 27 = line 7 times line 3 for respiratory 31 = line 29 for respiratory therapy or 34 = sum of lines 27 and 31	(from lines 33, es (from lines 4 h your records) 3 - if negative, sum of lines 24 / therapy or sum sum of lines 29	34, or 35)) 4, 45, or 46; enter zero) and 25 for al of lines 3 an of lines 3 an and 30 for al	I others nd 4 for all nd 4 for all I others		79, 452 0 0 0 0 79, 452 89, 180 9, 728 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58. ( 59. ( 60. ( 61. ( 62. ( 63. ( 64. ( 65. ( 100. ( 100. ( 101. ( 101. ( 101. ( 101. ( 101. (
Part           00         Salar           00         Trave           00         Trave           00         Vert           00         Suppl           00         Suppl           00         Total           00         Total           00         Total           00         Excess           0.00         Line           0.00         Line           1.01         Line           1.02         Line           1.02         Line           2.00         Line           2.00         Line	VI - COMPUTATION OF THERAPY LIMITATION A ry equivalency amount (from line 23) el allowance and expense - provider site el allowance and expense - Offsite service sime allowance (from column 5, line 56) oment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (from ss over limitation (line 64 minus line 63 33 CALCULATION 26 = line 24 for respiratory therapy or 27 = line 7 times line 3 for respiratory 33 = line 28 = sum of lines 26 and 27 34 CALCULATION 27 = line 7 times line 3 for respiratory 31 = line 29 for respiratory therapy or 34 = sum of lines 27 and 31 35 CALCULATION	(from lines 33, ces (from lines 4 h your records) 3 - if negative, sum of lines 24 / therapy or sum sum of lines 29 sum of lines 29	34, or 35)) 4, 45, or 46 enter zero) and 25 for al of lines 3 an of lines 3 an and 30 for al and 30 for al	I others nd 4 for all nd 4 for all I others	others	79, 452 0 0 0 0 79, 452 89, 180 9, 728 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58. ( 59. ( 60. ( 61. ( 62. ( 63. ( 64. ( 65. ( 100. ( 100. ( 101. ( 101. (

In Lieu of Form CMS-2552-10 Worksheet B

CUST	ALLOCATION - GENERAL SERVICE CUSIS		Provider		rom 07/01/2015 o 06/30/2016	Part I Date/Time Pre 11/22/2016 10	pared: 23 am
			CAPI TAL REI	LATED COSTS		11/22/2010 10	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	35, 386	35, 386				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	790, 057		790, 057			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 252, 259	0		3, 252, 259		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 177, 957	3, 787	84, 558		5,004,352	5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.00
7.00	00700 OPERATION OF PLANT	810, 869	5, 090	113, 639	0	929, 598	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	143	3, 189	0	3, 332	8.00
9.00	00900 HOUSEKEEPI NG	163, 709	35	790	0	164, 534	9.00
10.00	01000 DI ETARY	14, 431	0	0	0	14, 431	10.00
11.00	01100 CAFETERI A	0	0		0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		-	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	160, 152	379			228, 283	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	59, 105	0			73, 808	
15.00	01500 PHARMACY	599, 337	0	-		664, 924	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	195, 891	1, 218			278, 862	•
17.00	01700 SOCIAL SERVICE	0	0	-	-	0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		-	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 23.00	02200 I & SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	0	0		-	0	22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	0	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	1, 370, 771	4, 336	96, 813	436, 619	1, 908, 539	30.00
43.00	04300 NURSERY	0	0			0	43.00
	ANCI LLARY SERVI CE COST CENTERS				-	-	
50.00	05000 OPERATI NG ROOM	562, 378	2, 974	66, 410	196, 394	828, 156	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	911, 354	2, 027	45, 255	215, 743	1, 174, 379	54.00
60.00	06000 LABORATORY	1,042,397	1, 015	22, 658	9, 129	1, 075, 199	60.00
65.00	06500 RESPI RATORY THERAPY	43, 997	615	13, 729	7, 765	66, 106	65.00
66.00	06600 PHYSI CAL THERAPY	296, 547	1, 390	31, 041	79, 102	408, 080	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	-	-	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	67, 780	382			76, 682	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	57, 969	0	-	-	57, 969	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	323	7, 214	0	7, 537	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	1 407 7//	2 110	(0.422	411 004	1 001 540	00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	1, 437, 766 1, 146, 286	3, 110			1, 921, 542	
91.00	09100 EMERGENCY	1, 146, 286	4, 470 1, 756			1, 630, 918 2, 205, 709	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,002,007	1,750	39, 190	312,070	2,203,709	
92.00	OTHER REIMBURSABLE COST CENTERS					0	92.00
95 00	09500 AMBULANCE SERVICES	443, 495	1, 994	44, 527	158, 820	648, 836	95.00
70.00	SPECIAL PURPOSE COST CENTERS	110,170		11,027	100, 020	010,000	70.00
118.00		19, 492, 580	35, 044	782, 419	3, 139, 435	19, 371, 776	118.00
	NONREI MBURSABLE COST CENTERS						
193.00	19300 NONPALD WORKERS	0	0	0	0	0	193.00
193.01	19301 ORTHO CLINIC	332, 375	337	7, 532	109, 971	450, 215	193. 01
193.02	19303 COMMUNITY MED CLINIC	34	0		0		193. 02
	07950 MARKETI NG	77, 496	5	106	2, 853		194.00
200.00							200. 00
201.00			0	0	-		201.00
202.00	TOTAL (sum lines 118-201)	19, 902, 485	35, 386	790, 057	3, 252, 259	19, 902, 485	202.00

COST ALLOCATION - ÉENERAL SERVICE COSTS         Provider CDL: 151307         Provider CDL: 151307	Health Financial Systems S	T. VINCENT WILLIA	MSPORT HOSPITA	۱L	In Lie	u of Form CMS-	2552-10
Cost Center Description         ADMINISTRATIVE         Intervance a (Christal, REPails)         OPERATION OF PLANT         LAMBRY a LINEN SERVICE, OST CENTERS           1:00         DO100 (HF) CAP REL COST -BLO & FLYT         5.00         6.00         7.00         8.00         9.00           1:00         DO400 (HF) CAP REL COST -BLO & FLYT         2.00         0.00         0.00         9.00         2.00           0:00 COSO (ANNINISTRATIVE & GENERAL         5.004, 352         0         5.00         5.00         5.00           0:00 COSO (ANNINISTRATIVE & GENERAL         5.004, 352         0         7.00         7.00         7.00         8.00         9.00         5.00           0:00 COSO (ANNINISTRATIVE & GENERAL         5.004, 352         0         0         7.00         7.00         7.00         7.00         8.00         9.00	COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	rom 07/01/2015	Part I	naradi
LUMURY 5         Cost Center Description         ADMINISTRATIVE SCHEPARES         OPENATE SCHEPARES         OPENATE OPANT         ULMER SCHEPARES         OPENATE ULMER SCHEPARES         ULMER SCHEPARES         OUSSECEPTING           100         DOTOD VER CAP REL COSTS -BLDC A FIYT         5.00         5.00         7.00         8.00         9.00         4.00           2.00         DOSOD VER CAP REL COSTS -BLDC A FIYT         0.00					0 00/30/2010		
ENERAL SERVICE COST CENTERS         5.00         6.00         7.00         8.00         9.00           1.00         ODTOO INEW CAP REL COSTS-BUDGE & FIXT         1.00         0.00	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &		20 0
CHNERAL SERVICE COST CHIES         1.00           100         001000 (MPK (APR FLE COST-SHUDG & FIXT         2.00           2.00         00200 (NEW (APR FLE COST-SHUDG & FIXT         4.00           2.01         00200 (NEW (APR FLE COST-SHUDG & FIXT         5.004,352           0.00         00400 (AUM INTENNES A EPRAIRS         5.004,352         6.00           0.00         00500 (AUM INTENNES A EPRAIRS         5.004,352         7.00           0.00         00500 (AUM INTENNES A EPRAIRS         6.00         7.00           0.00         00500 (AUM INTENNES A EPRAIRS         6.00         7.00           0.00         00500 (AUM INTENNES A EPRAIRS         6.00         7.00           0.00         0000 (CHETERIA         0         0         0.00         0.011.00           10.00         01000 (CHETERIA         0         0         0.00         0.011.00         10.00           10.00         01400 (CHETERIA         0         0         0         0.011.00         10.011.00         10.011.00         10.00         10.011.00         10.00         10.00         10.011.00         10.00         10.011.00         10.00         10.00         10.011.00         10.00         10.00         10.00         10.00         10.00         10.00		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
1:00         00100 NWI GA REL         COSTS-WILE SERVER         1.00           0:00         00400 LMPLOYE BENEFITS DEPARTINENT         5.004.352         5.00           0:00         00500 MAIN ISTRATY RE COSTS-WILE SENVERT         5.004.352         6.00           0:00         00500 MAIN ISTRATY RE GENERAL         5.004.352         6.00           0:00         00500 MAIN ISTRATY RE GENERAL         5.004.352         6.00           0:00         00500 MAIN ISTRATY RE GENERAL         5.004.352         6.00           0:00         00500 MAIN ISTRATY RE LORD FEAST         0         0         0.00           0:00         00500 MISS INAR PAR         0.00         0         0.00		5.00	6.00	7.00	8.00	9.00	
2. 00         00200 PMP CAP FEL COSTS-MUBLE FOLIP         2. 00           4.00         04500 PMPUYCE ENCHES IS DEPARTMENT         5.004, 352           5. 00         06500 ADMI NITENACE & GENERAL         5.004, 352           6. 00         06500 ADMI NITENACE & GENERAL         5.004, 352           6. 00         06500 ADMI NITENACE & GENERAL         5.004, 352           6. 00         06500 ADMI NITENACE & GENERAL         5.004, 352           6. 00         06500 ADMI NITENACE         1.119           0. 00         00500 ADMI NITENACE         1.119           0. 00         01500 ADMI NITENACE         1.119           0. 00         0.00 INESIN GAIM NITENACE         0.00           12.00         01300 ADMI NITENACE         PERSONNEL           0.00         0.00 INESIN GAIM NITENACE         PERSONNEL           0.00         0.00 INESIN GAIM NITENACE         PERSONNEL           0.00         0.00 NINESIN GAIM NITENACE         PERSONNEL           0.00         0.1200 PMAMACY         2.23, 351         0         0           11.00         0.1400 PMAMACY         23, 351         0         0         0           12.00         0.100 ADMI NETANACE NICE         9.00         0         0         0         0							
4. 00         004000         EVPLOYEE         EVPLOYEE         6.00         00500         AMN IN STRAT IVE & GENERAL         5.00         5.00         6.00         00500         AMN IN STRAT IVE & GENERAL         5.00         5.00         6.00         00500         AMN IN STRAT IVE & GENERAL         5.00         7.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
5. 00         00500 ADM IN TENART & & GENERAL         5. 00, 352         5. 00         5. 00         5. 00         5. 00         5. 00         5. 00         5. 00         5. 00         5. 00         5. 00         5. 00         5. 00         7. 00         0. 00000 (DERATION OF PLANT         33.2, 257         0         1, 241, 855         7. 00         0. 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>							1
6. 00         000000 MM INTENNANCE & REPARTS         0		5 004 050					
2. 00         00700 OPEARTION OF PLANT         312, 257         0         1, 241, 855         .         7, 00           80.00         00800 LAUNDRY & LINEN SERVICE         1, 119         0         2, 320         0         222, 122         8, 00           9, 00         00100 CAFETERI A         0         0         0         0         0         0         10, 00         11, 00           12, 00         1200 MINTENARCE OF PERSONNEL         0         0         0         0         11, 00           13, 00         01300 NURSING AMINISTRATION         76, 681         0         24, 886         0         3, 196         13, 00           14, 00         0140 CENTRAL SERVICES & SUPPLY         24, 792         0         0         0         14, 00           00         01500 PHARMACY         223, 351         0         0         0         0         0         17, 70           17, 00         01300 NARHING SCHALL SERVICE         0         0         0         0         0         0         0         0         0         0         0         0         17, 70         17, 70         17, 70         17, 70         17, 70         17, 70         12, 941         12, 941         1, 93, 70         0         <			0				1
B. 00         000000 LAUNDRY & LINEN SERVICE         1,119         0         9,371         13,822         8,00           0.00         000000 HUSEKKEPING         55,268         0,230         0         222,129         9,00           10.00         01000 DIETARY         4,847         0         0         0         0         10.00           11.00         01100 CAFETERIA         0         0         0         0         11.00         110.00           12.00         01300 MAINTENNACE OF PERSONNEL         0         0         0         14.00         14.00         14.00         0         0         0         14.00         0         0         0         15.00         150.00         150.00         160.00         10.271         16.00         17.00         170.00         10.021         16.00         17.00         10.021         18.587 (CES-SALARY & FRINCES APRVD         0         0         0         0         0         0         0         0         0         0         0         0         22.00         22.01         22.01         22.00         22.01         22.01         22.01         22.01         22.01         22.01         22.01         22.01         22.01         22.01         22.01         <		-			-		1
9. 00         000000         PUSEKEEPI NG         55, 266         0         2. 320         0         0         222, 122         9. 00           11. 00         01100         CARETERI A         6         0			0				1
10.00         01000         01000         01000         01000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         00000         00000         00000         00000         00000         00000         00000         00000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         0000000         0000000         0000000         0000000         00000000         00000000000000000         000000000000000000000000000000000000			0			222 122	
11.00         01100         0APTERIA         0			0				1
12 00         01200 MAINESINA CLOP PERSONNEL         0         0         0         0         12.00           13.00         01300 NURSING ADMINISTRATION         76.681         0         24.856         0         31.00           14.00         01400 CENTRAL SERVICES & SUPPLY         24.792         0         0         0         0         0         13.00           15.00         01500 NEDICAL RECORDS & LIBRARY         23.351         0         0         0         0         0         0         16.00         17.00         170.00			0	-	-		•
13.00       01300 NURSING ADMINISTRATION       76.661       0       24.856       0       3.106       13.00         14.00       01400 CENTRAL SERVICES & SUPPLY       223.351       0       0       0       16.00         15.00       01500 PHARMACY       223.351       0       0       0       16.00       16.00         16.00       01700 SOCI.AL SERVICES & LIBRARY       93.671       0       79.878       0       0       10.0271       16.00         19.00       01700 SOCI.AL SERVICES SALARY & FRINGES APPRVD       0       0       0       0       0       0       22.00         22.00       18.8 SERVICES - SALARY & FRINGES APPRVD       0       0       0       0       0       0       0       0       0       0       22.00         23.00       02300 NARPHSICIC ES-OTHER PRGM COSTS APPRVD       0		-	0		0		
14.00       0 <td></td> <td>0</td> <td>0</td> <td>24 856</td> <td>0</td> <td>-</td> <td>1</td>		0	0	24 856	0	-	1
15.00       01500       PHARMACY       223.351       0       0       0       0       15.00         16.00       01600       MEDI CAL RECORDS & LIBRARY       93.671       0       79.878       0       10.271       16.00         17.00       001700       SOCIAL SERVICE       0			0	21,000	0		1
16.00       01600       MEDICAL       RECORDS & LIBRARY       93,671       0       79,876       0       10,2211       16.00         17.00       01700       SOCIAL_SERVICE       0       0       0       0       0       17.00         17.00       01700       NORD SOCIAL_SERVICES       0 <td></td> <td></td> <td>0</td> <td>(</td> <td>0</td> <td></td> <td>1</td>			0	(	0		1
17:00       O1700       SOCIAL SERVICE       0 <td></td> <td></td> <td>0</td> <td>79, 878</td> <td>3 0</td> <td></td> <td>1</td>			0	79, 878	3 0		1
20:00         DOD         DOD         O         O         O         O         O         D			0				1
121:00         D21:00         L&R         SERVICES-SALARY & FRINCES APPRVD         0 <td></td> <td>0</td> <td>0</td> <td>C</td> <td>0</td> <td>0</td> <td>1</td>		0	0	C	0	0	1
22.00         02200         PAR SERVICES-OTHER PROM COSTS APPRVD         0         0         0         0         0         0         22.00           1MPATI ENT ROUTINE SERVICE COST CENTERS         0         0         0         0         0         0         0         0         0         23.00           1MPATI ENT ROUTINE SERVICE COST CENTERS         0         0         0         0         0         0         0         0         0         0         43.00           30.00         05000 OPECATI ENG ROOM         278, 182         0         195, 143         2, 073         25, 092         50.00           51.00         05300 ANESTHESI OLOGY         0         0         0         0         0         0         53.00           53.00         05300 ANESTHESI OLOGY         361.165         06.580         0         85.61         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         66.00         68.50         65.00         68.00         68.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         72.02         72.00	20. 00 02000 NURSI NG SCHOOL	0	0	(	0 0	0	20.00
23.00         DRAMED         ED         PROM         O         O         O         O         23.00           INPATIENT ROUTINE SERVICE COST CENTERS	21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	(	0 0	0	21.00
INPATI ENT         ROUTI NE SERVI CE         COST         CENTERS           30.00         03000         ADULTS & PEDI ATRI CS         641,088         0         284,481         6,496         36,579         43.00           43.00         04300         NURSERY         0         0         0         0         0         0         43.00           ANCILLARY SERVICE COST CENTERS         0         0         0         0         0         0         0         0         0         0         43.00           ANCILLARY SERVICE COST CENTERS         0         195,143         2.073         25.022         50.00         53.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         53.00         0         53.00         0         53.00         <	22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	(	0 0	0	22.00
30.00       00	23.00 02300 PARAMED ED PRGM	0	0	(	0 0	0	23.00
43.00       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
ANCILLARY SERVICE COST CENTERS         -         -           50.00         DEPRATI NG ROOM         276, 182         0         195, 143         2, 073         25, 092         53.00           53.00         DS300 ANESTHESI OLOGY         0 <td></td> <td>641, 088</td> <td></td> <td></td> <td>6, 496</td> <td>36, 579</td> <td>30.00</td>		641, 088			6, 496	36, 579	30.00
50.00         05000         OPERATING ROOM         278, 182         0         195, 143         2, 073         25, 092         50.00           53.00         05300         ANESTHESI OLOGY         0		0	0	(	00	0	43.00
53.00         05300         ANESTHESI OLOGY         0         0         0         0         0         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         394,480         0         132,981         691         17,099         54.00           06.00         0.000         LABORATORY         361,165         0         66.580         0         8.561         60.00           06.00         0.6600         PECIAL         DERAPIA         0         5,187         65.00           06.00         0.6600         PECIAL         DPHYSI CAL         THERAPY         137,076         0         91,212         1,382         11,728         66.00           0.00         0							
54.00       05400       RADI OLOGY - DI AGNOSTI C       394,480       0       132,981       691       17,099       54.00         60.00       06000       LABORATORY       361,165       0       66,580       0       8,561       60.00         65.00       05500       RSEPI RATORY THERAPY       22,205       0       40,341       0       5,187       65.00         66.00       06600       PHYSI CAL THERAPY       137,076       0       91,212       1,382       11,728       66.00         68.00       OB600       SPECH PATHOLOGY       0       0       0       0       0       68.00         71.00       OTIOM MEDI CAL SUPPLIES CHARGED TO PATIENTS       25,758       0       25,034       0       3,219       71.00         72.00       07300       DRUGS CHARGED TO PATIENTS       2,532       0       21,197       0       2,726       73.00         00       0       0       3315       37,710       88.01       0       3315       37,710       88.01         88.01       0800       RURAL HEALTH CLINIC C       645,456       0       0       315       37,710       88.01         91.00       DREGENCY       740,904       115,176							1
60.00         06000         LABORATORY         361,165         0         66,580         0         8,561         60.00           65.00         06500         RESPIRATORY THERAPY         22,205         0         40,341         0         5,187         65.00           66.00         06600         RESPIRATORY THERAPY         137,076         0         91,212         1,382         11,728         60.00           68.00         06800         SPEECH PATHOLOGY         0         0         0         0         68.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         25,758         0         25,034         0         3,219         71.00           72.00         07300         DRUGS CHARGED TO PATIENT         2,532         0         21,197         0         2,726         73.00           00TPATIENT SERVICE COST CENTERS		-	0		-		•
65.00       06500       RESPI RATORY THERAPY       22, 205       0       40, 341       0       5, 187       65.00         66.00       06600       PHYSI CAL THERAPY       137, 076       0       91, 212       1, 382       11, 728       66.00         68.00       OREGO PHYSI CAL THERAPY       0 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td>1</td></t<>			0				1
66.00       06600       PHYSICAL THERAPY       137,076       0       91,212       1,382       11,728       66.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       25,758       0       25,034       0       3,219       71.00         72.00       07200   MPL. DEV. CHARGED TO PATIENT       19,472       0       0       0       72.00         07300   DRUGS CHARGED TO PATIENTS       2,532       0       21,197       0       2,726       73.00         0UTPATIENT SERVICE COST CENTERS       0       0       0       315       37,710       88.00         88.00       088001       RURAL HEALTH CLINIC II       547,834       0       0       315       37,710       88.01         91.00       09100       EMERGENCY       740,904       0       115,176       2,073       14,810       91.00         92.00       OSEGNATION BEDS (NON-DISTINCT PART)       740,904       0       115,176       2,073       14,810       91.00         92.00       OSEGNATION BEDS (NON-DISTINCT PART)       0       130,839       415       16,824       95.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>1</td>			0				1
68.00         06800         SPEECH         PATHOLOGY         0         0         0         0         0         68.00           71.00         V7100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         25,758         0         25,034         0         3,219         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENT         19,472         0         0         0         272.00           73.00         ORUGS CHARGED TO PATIENTS         2,532         0         21,197         0         2,726           0UTPATIENT SERVICE COST CENTERS         0         0         377         26,234         88.00           88.01         08801 RURAL HEALTH CLINIC II         547,834         0         0         315         37,710         88.01           91.00         DERGENCY         740,904         0         115,176         2,073         14,810         91.00           92.00         OBSERVATION BEDS (NON-DISTINCT PART)         740,904         0         115,176         2,073         14,810         91.00           92.00         OBSERVATION BEDS (NON-DISTINCT PART)         740,904         130,839         415         6.824         95.00           95.00         OPSOO AMBULANCE SERVICES         217,947			0				1
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       25,758       0       25,034       0       3,219       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       19,472       0       0       0       72.00         73.00       D7300       DRUGS CHARGED TO PATIENTS       2,532       0       21,197       0       2,726         0UTPATIENT SERVICE COST CENTERS			0				1
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       19,472       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       2,532       0       21,197       0       2,726       73.00         0UTPATIENT SERVICE COST CENTERS       0       0       317       26,234       88.00       0800       RURAL HEALTH CLINIC II       645,456       0       0       315       37,710       88.01         98.00       0800 RURAL HEALTH CLINIC II       547,834       0       0       315       37,710       88.01         91.00       09100       EMERGENCY       740,904       0       115,176       2,073       14,810       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       740,904       0       130,839       415       16,824       95.00         95.00       09500       AMBULANCE SERVICES       217,947       0       130,839       415       16,824       95.00         118.00       SUBTOTALS (SUM OF LINES 1-117)       4,826,085       0       1,219,409       13,822       219,236       118.00         193.00       19300       NORPAID WORKERS       0       0       0       0       193.02       <		-	0	-	-		
73. 00       OT300       DRUGS CHARGED TO PATIENTS       2,532       0       21,197       0       2,726       73. 00         OUTPATIENT SERVICE COST CENTERS			-				1
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         645,456         0         0         377         26,234         88.00           88.01         08801         RURAL HEALTH CLINIC II         547,834         0         0         315         37,710         88.01           91.00         09100         EMERGENCY         740,904         0         115,176         2,073         14,810         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         740,904         0         115,176         2,073         14,810         91.00           0THER REI MBURSABLE COST CENTERS         0         0         130,839         415         16,824         95.00           95.00         09500         AMBULANCE SERVICES         217,947         0         130,839         415         16,824         95.00           SPECIAL PURPOSE COST CENTERS         0         0         1,219,409         13,822         219,236         118.00           NONREI MBURSABLE COST CENTERS         0         0         0         0         193.00         193.00         193.00         0,846         193.01           193.01         19300         NONPAID WORKERS         0			-	-	-		•
88.00       08800       RURAL HEALTH CLINIC       645,456       0       0       377       26,234       88.00         88.01       08801       RURAL HEALTH CLINIC II       547,834       0       0       315       37,710       88.01         91.00       09200       DBSERVATION BEDS (NON-DISTINCT PART)       740,904       0       115,176       2,073       14,810       91.00         92.00       09200       DBSERVATION BEDS (NON-DISTINCT PART)       92.00       95.00       95.00 <td></td> <td>2,002</td> <td></td> <td>21,177</td> <td></td> <td>2,720</td> <td>/ 0/ 00</td>		2,002		21,177		2,720	/ 0/ 00
88.01       08801       RURAL HEALTH CLINIC II       547,834       0       0       315       37,710       88.01         91.00       09100       EMERGENCY       740,904       0       115,176       2,073       14,810       91.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART)       0       130,839       415       16,824       95.00         0       09500       AMBULANCE SERVI CES       217,947       0       130,839       415       16,824       95.00         SPECI AL PURPOSE COST CENTERS       118.00       SUBTOTALS (SUM OF LINES 1-117)       4,826,085       0       1,219,409       13,822       219,236       118.00         NONREI MBURSABLE COST CENTERS       0       0       0       0       0       193.00       19300       NONPAI D WORKERS       0       0       0       193.00       193.00       193.00       193.00       193.00       193.00       0       0       0       193.02       193.02       193.02       2,846       193.01         193.02       19303       COMMUNI TY MED CLINIC       11       0       0       0       193.02       193.02       193.02       193.02       193.02       193.02       0       193.02       <		645, 456	0	(	377	26, 234	88.00
91.00       09100       EMERGENCY       740,904       0       115,176       2,073       14,810       91.00       92.00         92.00       0BSERVATI ON BEDS (NON-DI STI NCT PART)       0       130,839       415       16.20       92.00         0THER REIMBURSABLE COST CENTERS       0       130,839       415       16.24       95.00         SPECIAL PURPOSE COST CENTERS       0       1,219,409       13,822       219,236       118.00         NONREI MBURSABLE COST CENTERS       0       0       0       0       193.00       0       0       193.00       0       0       193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00       193.00       2,846       193.01       193.02       193.00       2,846       193.01       193.02       193.02       193.00       0       0       0       0       193.02       193.02       193.02       193.02       193.02       193.02       193.02       193.02       0       0       0       0       193.02       193.02       0       193.02       193.02       193.02       193.02       193.02       193.02       193.02       193.02       193.02       0       0       0       193.02			0	C			1
OTHER         REI MBURSABLE         COST         CENTERS         95.00         Op500         AMBULANCE         SERVI CES         217,947         0         130,839         415         16,824         95.00         95.00           SPECI AL         PURPOSE         COST         CENTERS         118.00         SUBTOTALS         SUBTOTALS         SUM OF         LINES         1-117)         4,826,085         0         1,219,409         13,822         219,236         118.00           NONREI MBURSABLE         COST         CENTERS           193.00         19300         NONPAI D         WORKERS         0         0         0         193.00         193.00         2,846         193.01           193.01         19301         ORTHO         CLI NI C         151,229         0         22,134         0         2,846         193.02           193.02         19303         COMMUNI TY         MED CLI NI C         11         0         0         0         193.02           194.00         07950         MARKETI NG         27,027         0         312         0         40         194.00           200.00         Cross Foot Adj ustments         0         0         0         0         00			0	115, 176			1
95.00         09500         AMBULANCE         SERVICES         217,947         0         130,839         415         16,824         95.00           SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         4,826,085         0         1,219,409         13,822         219,236         118.00           NONREI MBURSABLE COST CENTERS           193.00         19300         NONPAI D WORKERS         0         0         0         0         193.00         193.01         0RTHO CLINIC         151,229         0         22,134         0         2,846         193.01         193.01         193.02         193.03         COMMUNI TY MED CLINIC         11         0         0         0         193.01         193.04         193.01         0         193.01         193.01         0         193.01         193.01         0         193.01         0         193.01         0         193.01         193.01         0         193.01         193.01         193.01         193.01         193.01         193.01         193.01         193.01         193.01         193.01         193.01         193.01         193.01         193.01         193.02         193.03         193.03         193.03         193.01 <td>92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						1
SPECIAL PURPOSE COST CENTERS           118. 00         SUBTOTALS (SUM OF LINES 1-117)         4,826,085         0         1,219,409         13,822         219,236         118.00           NONREI MBURSABLE COST CENTERS         0         0         0         0         0         193.00         193.00         193.01         193.01         000000000000000000000000000000000000	OTHER REIMBURSABLE COST CENTERS						1
I18.00         SUBTOTALS (SUM OF LINES 1-117)         4,826,085         0         1,219,409         13,822         219,236         118.00           NONREI MBURSABLE COST CENTERS         0         0         0         0         0         193.00         19300         NONPAI D WORKERS         0         0         0         0         193.00         193.00         193.00         193.00         193.00         193.00         193.00         193.00         0         0         0         193.00         193.00         193.00         193.00         2,846         193.01         193.01         0         2,846         193.01         193.02         193.02         193.03         COMMUNI TY MED CLINIC         11         0         0         0         193.02         1	95. 00 09500 AMBULANCE SERVICES	217, 947	0	130, 839	9 415	16, 824	95.00
NONRE I MBURSABLE COST CENTERS           193.00         19300         NONPAI D WORKERS         0         0         0         193.00           193.01         19300         NONPAI D WORKERS         0         0         0         0         193.00           193.01         19301         ORTHO CLINIC         151,229         0         22,134         0         2,846         193.01           193.02         19303         COMMUNITY MED CLINIC         11         0         0         0         193.02           194.00         07950         MARKETI NG         27,027         0         312         0         401         194.00           200.00         Cross Foot Adj ustments         0         0         0         0         200.00           201.00         Negative Cost Centers         0         0         0         0         0         201.00							
193.00       19300       NONPAI D WORKERS       0       0       0       193.00         193.01       19301       ORTHO CLINIC       151,229       0       22,134       0       2,846       193.01         193.02       19303       COMMUNITY MED CLINIC       11       0       0       0       193.02         194.00       07950       MARKETING       27,027       0       312       0       104		4, 826, 085	0	1, 219, 409	13, 822	219, 236	118.00
193.01       19301       ORTHO CLINIC       151,229       0       22,134       0       2,846       193.01         193.02       19303       COMMUNITY MED CLINIC       11       0       0       0       193.02         194.00       07950       MARKETING       27,027       0       312       0       40       194.00         200.00       Cross Foot Adjustments       0       0       0       0       0       200.00							
193.02       19303       COMMUNITY MED CLINIC       11       0       0       0       193.02         194.00       07950       MARKETING       27,027       0       312       0       40       194.00         200.00       Cross Foot Adjustments       200.00       200.00       0       0       0       201.00			0	(	0 0		•
194.00         07950         MARKETI NG         27,027         0         312         0         40         194.00           200.00         Cross Foot Adjustments         200.00 <td></td> <td>1 1</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		1 1	0				
200.00         Cross Foot Adjustments         200.00			0		-		
201.00         Negative Cost Centers         0 </td <td></td> <td>27,027</td> <td>0</td> <td>312</td> <td>2 0</td> <td>40</td> <td></td>		27,027	0	312	2 0	40	
			-			-	
202. 00   101AL (Sum Lines 118-201)   5,004,352  0  1,241,855  13,822  222,122 202.00							
	202.00   TUTAL (SUII TITIES TID-201)	5,004,352	0	1, 241, 855	ין וא, 822	222, 122	1202. UU

<u>Heal th Financia</u>	al Systems ST.	VINCENT WILLIAM	ASPORT HOSPIT	AL	In Lie	u of Form CMS-	2552-10
COST ALLOCATIO	N - GENERAL SERVICE COSTS		Provi der		Period: From 07/01/2015	Worksheet B Part I	
					To 06/30/2016	Date/Time Pre	
Co	st Center Description	DI ETARY	CAFETERI A	MAINTENANCE C	F NURSI NG	11/22/2016 10 CENTRAL	:23 am
		51217411	0/11/21/21/11/1	PERSONNEL	ADMI NI STRATI ON	SERVICES &	
		10.00	11 00	12.00	12.00	SUPPLY	
GENERAL	SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
	W CAP REL COSTS-BLDG & FIXT						1.00
	W CAP REL COSTS-MVBLE EQUIP						2.00
	PLOYEE BENEFITS DEPARTMENT						4.00
	MINISTRATIVE & GENERAL						5.00
	INTENANCE & REPAIRS ERATION OF PLANT						6.00 7.00
	UNDRY & LINEN SERVICE						8.00
	USEKEEPI NG						9.00
10.00 01000 DI		19, 278					10.00
11.00 01100 CA		0	(	D			11.00
	INTENANCE OF PERSONNEL	0	(		0 222 014		12.00
1 1	RSING ADMINISTRATION NTRAL SERVICES & SUPPLY	0	(		0 333, 016 0 0	98, 600	13.00
15. 00 01500 PH		0	(		0 0	98, 000 0	
	DICAL RECORDS & LIBRARY	Ő	(		0 0	0	
1 1	CIAL SERVICE	0	(	b	0 0	0	17.00
	NPHYSICIAN ANESTHETISTS	0	(		0 0	0	19.00
	RSING SCHOOL	0	(	D	0 0	0	20.00
	R SERVICES-SALARY & FRINGES APPRVD	0	(	D	0 0	0	21.00
	R SERVICES-OTHER PRGM COSTS APPRVD	0	(		0 0	0	
	RAMED ED PRGM IT ROUTINE SERVICE COST CENTERS	U	(	J	0 0	0	23.00
	ULTS & PEDIATRICS	19, 278	(	b	0 159, 104	0	30.00
43.00 04300 NU		0	(		0 0	0	43.00
	RY SERVICE COST CENTERS	<b></b>					
	ERATING ROOM	0	(	D D	0 44, 395	0	
	ESTHESI OLOGY DI OLOGY-DI AGNOSTI C	0	(		0 0	0	
60. 00 06000 LA		0	(		0 7, 104	0	
	SPI RATORY THERAPY	0	(		0 3, 559	0	
	YSI CAL THERAPY	0	(		0 22, 148	0	
68.00 06800 SP	EECH PATHOLOGY	0	(	D	0 0	0	68.00
	DICAL SUPPLIES CHARGED TO PATIENTS	0	(	D	0 0	53, 146	•
	PL. DEV. CHARGED TO PATIENT	0	(	D	0 0	45, 454	•
	UGS CHARGED TO PATIENTS INT SERVICE COST CENTERS	0	(	<u>ار</u>	0 0	0	73.00
	RAL HEALTH CLINIC	0	(		0 0	0	88.00
1 1	RAL HEALTH CLINIC II	0	(		0 0	0	
91.00 09100 EM		0	(		0 96, 706	0	
	SERVATION BEDS (NON-DISTINCT PART)						92.00
	I MBURSABLE COST CENTERS	L		1	1		
	BULANCE SERVICES	0	(	<u>ו</u>	0 0	0	95.00
	PURPOSE COST CENTERS BTOTALS (SUM OF LINES 1-117)	19, 278			0 333, 016	003 80	118.00
	SURSABLE COST CENTERS	17,270		J	0 333, 010	70,000	110.00
193.00 19300 NO		0	(		0 0	0	193.00
193. 01 19301 OR		0	(		0 0		193. 01
	MMUNITY MED CLINIC	0	(		0 0		193. 02
194.0007950 MA		0	(	U	0 0	0	194.00
	oss Foot Adjustments gative Cost Centers	_	ſ		0 0	0	200. 00 201. 00
	TAL (sum lines 118-201)	19, 278	(	) )	0 333, 016		201.00
10		1,270		-1	- 000,010	,0,000	1-02.00

	Financial Systems ST. LLOCATION - GENERAL SERVICE COSTS	VINCENT WILLIA		CCN: 151307	Peri od:	eu of Form CMS- Worksheet B	2002 10
					From 07/01/2019 To 06/30/2010	5 Part I 5 Date/Time Pre	
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVIO	CE NONPHYSI CI AN	11/22/2016 10 NURSI NG SCHOOL	): 23 am
			RECORDS &		ANESTHETI STS		- 
		15.00	LI BRARY	17.00	10.00	20.00	
	GENERAL SERVICE COST CENTERS	15.00	16.00	17.00	19.00	20.00	-
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
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	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY	888, 275					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	462, 682	2			16.00
17.00	01700 SOCIAL SERVICE	0	C		0		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	C		0	C	19.00
20.00	02000 NURSI NG SCHOOL	0	C	D	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	C	D	0		21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	C		0		22.00
23.00	02300 PARAMED ED PRGM	0	C	)	0		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDIATRICS	0	32, 591			0 0	
43.00	04300 NURSERY	0	C		0	0 0	43.00
	ANCI LLARY SERVICE COST CENTERS				-		
50.00	05000 OPERATING ROOM	0	29, 878	3	-		
53.00	05300 ANESTHESI OLOGY	0	110 402		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	118, 482		0		
60.00		0	89, 604		0		
65.00		0	10, 224	1	0	0	
66.00	06600 PHYSI CAL THERAPY	0	12, 359		0		
68.00 71.00	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0		
73.00	07300 DRUGS CHARGED TO PATIENTS	888, 275			0		
75.00	OUTPATIENT SERVICE COST CENTERS	000,275	C	<u>/</u>	U I	J	/ /3.00
88.00	08800 RURAL HEALTH CLINIC	0	19, 772		0	o lc	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	17, 340	1	-		
91.00	09100 EMERGENCY	0	118, 843	1	-		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ŭ	110,010		0		92.00
,2.00	OTHER REIMBURSABLE COST CENTERS	1 1		1			1 /2/ 00
95.00	09500 AMBULANCE SERVI CES	0	13, 589	)	0	0 0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		888, 275	462, 682	2	0	0 0	118.00
	NONREI MBURSABLE COST CENTERS						
	19300 NONPALD WORKERS	0	C	)	0		193.00
193.01	19301 ORTHO CLINIC	0	C		0		193.01
	19303 COMMUNITY MED CLINIC	0	C	)	0		193. 02
193.02			0				194.00
193.02 194.00	07950 MARKETI NG	0	Ĺ	2	0		
193.02 194.00 200.00	Cross Foot Adjustments	0	Ĺ	)		o o	200.00
193.02 194.00	Cross Foot Adjustments Negative Cost Centers	0	c		0		

In Lieu of Form CMS-2552-10 Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151307	Peri od:	Worksheet B	
				From 07/01/2015 To 06/30/2016		narodi
				10 06/30/2016	Date/Time Prep 11/22/2016 10:	23 am
	INTERNS & R	RESIDENTS				20 4
Cost Center Description	SERVI CES-SALARS	ERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
	Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
					& Post	
					Stepdown	
					Adjustments	
	21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FI>	(T					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUI						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	F I I					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  01100  CAFETERI A						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE						17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS						19.00
20.00 02000 NURSI NG SCHOOL						20.00
21.00 02100 I &R SERVICES-SALARY & FRINGE						21.00
22.00 02200 I &R SERVICES-OTHER PRGM COST	IS APPRVD	0				22.00
23.00 02300 PARAMED ED PRGM				0	L	23.00
I NPATI ENT ROUTI NE SERVI CE COST CEI				0 000 454		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 3, 088, 156		30.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	0		0 1, 402, 919	0	50.00
53. 00 05300 OPERATING ROOM 53. 00 05300 ANESTHESI OLOGY	0	0		0 1, 402, 919	1	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				53.00 54.00
60. 00 06000 LABORATORY	0	0		0 1, 838, 112 0 1, 608, 213		60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 1, 008, 213		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 683, 985		66.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 003, 783	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO		0		0 183, 839		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIEN		0		0 122, 895		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0		0 922, 267	0	73.00
OUTPATIENT SERVICE COST CENTERS		0		722,201		75.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 2, 613, 381	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II	o	0		0 2, 234, 117		88.01
91. 00 09100 EMERGENCY	o	0		0 3, 294, 221		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTIN	-	Ű		0,2,1,221	0	92.00
OTHER REI MBURSABLE COST CENTERS						12100
95. 00 09500 AMBULANCE SERVICES	0	0		0 1, 028, 450	0	95.00
SPECIAL PURPOSE COST CENTERS		-		.,	-	
118.00 SUBTOTALS (SUM OF LINES 1-11	17) 0	0		0 19, 168, 177	0	118.00
NONREI MBURSABLE COST CENTERS						
193. 00 19300 NONPAI D WORKERS	0	0		0 0	0	193.00
193. 01 19301 ORTHO CLINIC	0	0		0 626, 424		193.01
193.02 19303 COMMUNITY MED CLINIC	0	0		0 45	0	193. 02
194.0007950 MARKETI NG	O	0		0 107, 839		194.00
200.00 Cross Foot Adjustments	0	0		0 0	0	200. 00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	0	0		0 19, 902, 485		202.00

In Lieu of Form CMS-2552-10

LOCATION - GENERAL SERVICE COSTS Cost Center Description	Total	Provider CCN: 151307	Peri od:         Worksheet B           From 07/01/2015         Part I           To         06/30/2016         Date/Time Pre           11/22/2016         10	pared:
	Total		To 06/30/2016 Date/Time Pre	pared:
	Total			spareu.
	Total			
			1172272010 10	<u>. 25 ui</u>
	26.00			
GENERAL SERVICE COST CENTERS	20100		· · · · · · · · · · · · · · · · · · ·	
00100 NEW CAP REL COSTS-BLDG & FIXT				1 1.0
00200 NEW CAP REL COSTS-MVBLE EQUIP				2.0
00400 EMPLOYEE BENEFITS DEPARTMENT				4.0
00500 ADMINI STRATI VE & GENERAL				5.0
				6.0
				7.0
				8.0
				9.0
				10.0
				11.0
				12.0
				13.0
				14.0
				15.0
				16.0
				17.0
01900 NONPHYSICIAN ANESTHETISTS				19.0
02000 NURSI NG SCHOOL				20.0
02100 I&R SERVICES-SALARY & FRINGES APPRVD				21.0
				22. (
02300 PARAMED ED PRGM				23. (
	I			
03000 ADULTS & PEDIATRICS	3, 088, 156			7 зо. с
	0			43. C
	· · · ·			
	1, 402, 919			7 50. C
	0			53.0
	1, 838, 112			54.0
				60.0
				65.0
				66. (
				68.0
	-			71. (
				72.
				73. (
	722,207			_ / J. '
	2 613 381			88. (
				88.0
	3, 294, 221			91.0
				92. (
	1 000 450			
	1,028,450			95.0
	10.1(0.177			1
	19, 168, 177			118.0
				4
	-			193.0
	626, 424			193. 0
19303 COMMUNITY MED CLINIC	45			193. (
07950 MARKETI NG	107, 839			194. (
Cross Foot Adjustments	0			200. 0
Negative Cost Centers	o			201.0
TOTAL (sum lines 118-201)	19, 902, 485			202.0
	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 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 02200 I&R SERVICES-SALARY & FRINGES APPRVD 02200 J&R SERVICES-OTHER PRGM COSTS APPRVD 02200 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 04300 NURSERY ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 06600 LABORATORY 06500 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 19300 NONPAID WORKERS 19301 ONTHO CLINIC 19303 COMMUNITY MED CLINIC 07950 MARKETING Cross FOOT ADJ USTMENTS Negative Cost Centers 07500 MARUSABLE COST CENTERS 07500 MARUSABL	006000MAI NTENANCE & REPAI RS007000OPERATION OF PLANT00800LAUNDRY & LINEN SERVICE00900HOUSEKEEPI NG01100DI ETARY01100DI ETARY01100NURSI NG ADMI NI STRATI ON01400CENTRAL SERVICES & SUPPLY01500PHARMACY01600MEDI CAL RECORDS & LI BRARY01700SOCI AL SERVICES & SUPPLY01700NURSI NG SCHOOL02000NURSI NG SCHOOL021001I & SERVICES-SALARY & FRI NGES APPRVD022001I & SERVICES-SALARY & FRI NGES APPRVD022001I & SERVICES-SALARY & FRI NGES APPRVD023000ADULTS & PEDI ATRI CS03000ADULTS & PEDI ATRI CS03000ADULTS & PEDI ATRI CS04300NURSERY05000OPERATI NG ROOM05300ANESTHESI OLOGY0005500PESTI RATORY THERAPY140014, 602, 91906500RESPI RATORY THERAPY147, 62206600PHYSI CAL THERAPY07100MEDI CAL SUPPLI ES CHARGED TO PATI ENT07200INPL. DEV. CHARGED TO PATI ENT07200INPL. DEV. CHARGED TO PATI ENT07200INPL. DEV. CHARGED TO PATI ENT07200RURAL HEALTH CLINIC TI07200ANGULACE SERVICES07200INPL. DEV. CHARGED TO PATI ENTS07200MARAL HEALTH CLINIC TI07200ANGUS CONT CENTERS09500ANBULANCE SERVICE COST CENTERS09500ANBULANCE SERVICE COST	00600         MAI NTEVNANCE & REPAIRS           00700         OPERATION OF PLANT           00800         LAUNDRY & LINEN SERVICE           00900         HOUSEKEEPING           01000         DETARY           01100         CAFETERIA           01200 MAINTENANCE OF PERSONNEL           01300         NURSI NG ADMINISTRATION           01400         CENTRAL SERVICES & SUPPLY           01500         PHARMACY           01600         MEDICAL SERVICE           01700         SCIAL SERVICE           01700         SCIAL SERVICE           01200         INRSING SCHOOL           022000         PARAMACY           012000         IAR SERVICES-SALARY & FRINGES APPRVD           02300         PARAMED ED PRGM           INPATI ENT ROUTI NE SERVICE         3, 088, 156           03000         ADULTS & PEDI ATRICS         3, 088, 156           03000         ADULTS & PEDI ATRICS         1, 402, 919           05300         ANESTHESI OLGEY         0           05400         RESPITING ROOM         1, 402, 919           05300         ANESTHESI OLGEY         0           05400         RESPITING ROOM         1, 402, 919           05500         GESPI	000000         MUN INTENANCE & REPAIRS

Heal th	Fina	nci a	al S	yste	ms		
		OF	CADI	TAI	DEL	ATED	0

13.00       01300       NURSING ADMINISTRATION       0       379       8, 459       8, 838       0         14.00       01400       CENTRAL SERVICES & SUPPLY       0       0       0       0       0       0         15.00       01500       PHARMACY       0       1, 218       27, 184       28, 402       0         17.00       10700       SCIAL SERVICE       0       0       0       0       0       0         19.00       01900       NORINESING SCHOOL       0 <th></th> <th>TION OF CAPITAL RELATED COSTS</th> <th>VINCENT WILLIA</th> <th></th> <th>CCN: 151307 F</th> <th>Period: From 07/01/2015 To 06/30/2016</th> <th></th> <th>pared:</th>		TION OF CAPITAL RELATED COSTS	VINCENT WILLIA		CCN: 151307 F	Period: From 07/01/2015 To 06/30/2016		pared:
Jerken Keiner Kein Keiner Keiner Keiner Keiner Keiner Keiner Keiner Ke				CAPI TAL REI	ATED COSTS			
O         1.00         2.00         2.4         4.00           6 DERERAL SERVICE COST CENTERS         0         0.0000 NEW CAP REL COSTS-BLIDG & FLXT         0		Cost Center Description	Assigned New Capital			Subtotal	<b>BENEFITS</b>	
1.00         00100 NEW CAP REL COSTS-BLDG & FIXT         0				1.00	2.00	2A	4.00	
2.00         00200 NEW CAP REL COSTS-WREE EQUIP         0		GENERAL SERVICE COST CENTERS						
4. 00         00400         EMPLOYEE         EEMEFITS         DEPARTMENT         0         <								1.00
5.00         00500         ADM IN STRATI VE & GENERAL         337,055         3,787         84,558         425,400         0           6.00         00600         MAI NETANCE & REPARES         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>2.00</td>								2.00
6.00         OGGOO MAINTENANCE & REPAIRS         O <th< td=""><td></td><td></td><td>0</td><td>0</td><td>C</td><td>0 0</td><td></td><td></td></th<>			0	0	C	0 0		
7.00         OPTOR         OPERATION OF PLANT         0         5.090         113,639         118,729         0           8.00         008000         LAUNDRY & LINEN SERVICE         0         143         3,189         3,332         0           0.00         00900         HOUSEKEEPING         0         35         790         825         0           10.00         1000 CAFETERIA         0 </td <td></td> <td></td> <td>337,055</td> <td>3, 787</td> <td>84, 558</td> <td>425, 400</td> <td></td> <td></td>			337,055	3, 787	84, 558	425, 400		
8. 00         ODBOOL         LAUNDRY & LINEN SERVICE         0         143         3, 189         3, 332         0           9.00         OPOOL         ODOL         0			0	0		0		
9. 00         00000 HOUSEKEEPING         0         55         790         825         0           01000         01000         DITAPY         0			0				-	
10.00         D1CTARY         0         0         0         0         0           11.00         D1100         CAFETERIA         0<			0				0	
11.00         0100         CAFETERIA         0         0         0         0         0           12.00         01200         MAINTENANCE OF PERSONNEL         0			0	35	/90	825	0	9.00
12.00         01200         MAI NTENANCE OF PERSONNEL         0			0	0				
13:00       01300       NURSING ADMINISTRATION       0       379       8,459       8,838       0         14:00       01400       CENTRAL SERVICES & SUPPLY       0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>-</td> <td>1</td>			0	0			-	1
14.00       01400       CENTRAL SERVICES & SUPPLY       0			0	370	8 450	8 8 8 8	-	1
15.00         01500         PHARMACY         0         0         0         0         0         0           16.00         MEDI CAL RECORDS & LI BRARY         0         1, 218         27, 184         28, 402         0           17.00         01700 SOCI AL SERVI CE         0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>0,407</td><td>0,000</td><td>-</td><td></td></t<>			0	0	0,407	0,000	-	
16.00         01600         MEDI CAL         RECORDS & LI BRARY         0         1, 218         27, 184         28, 402         0           07.00         01700         SOCI AL         SERVI CE         0			0	0		0	-	
17.00       O1700       SOCI AL SERVICE       0       0       0       0         19.00       ONONPHYSI CI AN ANESTHETI STS       0       0       0       0       0         019.00       ORONPHYSI CI AN ANESTHETI STS       0       0       0       0       0       0         02000       NURSI KG SCHOOL       0       0       0       0       0       0       0         21.00       02200 1 & SERVI CES-SALARY & FRI NGES APPRVD       0       0       0       0       0       0         23.00       02300 PARAMED ED PRGM       0       0       0       0       0       0       0       0         10.00       03000 ADULTS & PEDI ATRI CS       0       4,336       96,813       101,149       0       <			0	1, 218	27, 184	28, 402	0	
19:00       001900       NONPHYSICLAN ANESTHETISTS       0			0	0	C	0	0	1
21.00       02100       1&R       SERVI CES-SALARY & FRI NGES APPRVD       0       0       0       0         22.00       02200       1AR       SERVI CES-OTHER PROM COSTS APPRVD       0       0       0       0       0         23.00       02300       PARAMED ED PROM       0       0       0       0       0       0       0         30.00       03000       ADULTS & PEDI ATRI CS       0       4,336       96,813       101,149       0         43.00       04300       NURSERY       0       0       0       0       0       0         43.00       OS000       ARCTLLARY SERVICE COST CENTERS       0       4,336       96,813       101,149       0         43.00       05300       OPERATING ROOM       0       2,974       66,410       69,384       0			0	0	c c	0 0	0	19.00
22.00         02200   &R SERVI CES-OTHER PRGM COSTS APPRVD         0	20.00	02000 NURSING SCHOOL	0	0	c	0 0	0	20.00
23.00         PARAMED ED PRGM         0         0         0         0         0         0           INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         ADULTS & PEDI ATRI CS         0         4,336         96,813         101,149         0           ANCI LLARY SERVI CE COST CENTERS           50.00         0000 PERATI NG ROM         0         2,974         66,410         69,384         0	21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	c	0 0	0	21.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS         Image: Cost of the service cost centers           30. 00         03000 ADULTS & PEDI ATRI CS         0         4, 336         96, 813         101, 149         0           43. 00         04300 NURSERY         0         0         0         0         0         0           ANCI LLARY SERVI CE COST CENTERS         0         0         0         0         0         0         0         0           50. 00         05300 ANESTHESI 0LOGY         0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td>C</td><td>0 0</td><td>0</td><td>22.00</td></td<>			0	0	C	0 0	0	22.00
30.00       03000       ADULTS & PEDIATRICS       0       4,336       96,813       101,149       0         43.00       04300       NURSERY       0       0       0       0       0       0         ANCILLARY SERVICE COST CENTERS         Source Cost Centers         50.00       05000       OPERATING ROM       0       2,974       66,410       69,384       0         53.00       05300       ANESTHESI OLOGY       0       0       0       0       0         64.00       06400       LABORATORY       0       1,015       22,658       23,673       0         65.00       06500       RESPI RATORY THERAPY       0       615       13,729       14,344       0         66.00       06600       PHYSI CAL THERAPY       0       1,390       31,041       32,431       0         66.00       06600       SPECH PATHOLOGY       0       0       0       0       0         71.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       382       8,520       8,902       0         72.00       OT200       IMPL       DEV. CHARGED TO PATIENTS       0       323       7,214	H		0	0	C	0 0	0	23.00
43.00         Od300         NURSERY         O         O         O         O         O           ANCILLARY SERVICE COST CENTERS	-		-1				-	
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROOM         0         2,974         66,410         69,384         0           53.00         05300         ANESTHESI OLOGY         0         <								
50.00       05000       OPERATING ROOM       0       2,974       66,410       69,384       0         53.00       05000       ANESTHESI OLOGY       0       0       0       0       0         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       2,027       45,255       47,282       0         60.00       06000       LABORATORY       0       1,015       22,658       23,673       0         65.00       06500       RESPI RATORY THERAPY       0       615       13,729       14,344       0         66.00       06600       PHYSI CAL THERAPY       0       1,390       31,041       32,431       0         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       382       8,520       8,902       0         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       323       7,214       7,537       0         00       0       0       0       323       7,214       7,537       0         0173.00       DRIGS CHARGED TO PATI ENTS       0       3,110			0	0	l (		0	43.00
53.00       05300       ANESTHESI OLOGY       0       0       0       0       0       0         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       2,027       45,255       47,282       0         60.00       06000       LABORATORY       0       1,015       22,658       23,673       0         65.00       06500       RESPI RATORY THERAPY       0       615       13,729       14,344       0         66.00       06600       PHYSI CAL       THERAPY       0       1,390       31,041       32,431       0         68.00       06800 SPEECH PATHOLOGY       0       0       0       0       0       0         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       382       8,520       8,902       0         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       323       7,214       7,537       0         00TPATI ENT SERVICE COST CENTERS       0       3,110       69,432       72,542       0         88.00       08800       RURAL HEALTH CLINI C       0       3,110       69,432       72,542       0         91.00       09100       EMERGENCY       <			0	2 074	66 /10	60 201	0	50.00
54.00       05400       RADI OLOGY - DI AGNOSTI C       0       2,027       45,255       47,282       0         60.00       06000       LABORATORY       0       1,015       22,658       23,673       0         65.00       06500       RESPI RATORY THERAPY       0       615       13,729       14,344       0         66.00       06600       PHYSI CAL THERAPY       0       1,390       31,041       32,431       0         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0         71.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       382       8,520       8,902       0         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENT       0       0       0       0         07300       DRUGS CHARGED TO PATI ENTS       0       323       7,214       7,537       0         00TPATI ENT SERVICE COST CENTERS			0	2, 774	00,410	09,304		
60.00       06000       LABORATORY       0       1,015       22,658       23,673       0         65.00       06500       RESPI RATORY THERAPY       0       615       13,729       14,344       0         66.00       06600       PHYSI CAL THERAPY       0       1,390       31,041       32,431       0         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       382       8,520       8,902       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       323       7,214       7,537       0         00TPATI ENT SERVICE COST CENTERS       0       3,110       69,432       72,542       0         88.00       08800       RURAL HEALTH CLINIC       0       3,110       69,432       72,542       0         88.01       08801       RURAL HEALTH CLINIC II       0       4,470       99,805       104,275       0         91.00       09100       EMERGENCY       0       1,756       39,196       40,952       0         92.00       0BSERVATI ON BEDS (NON-DI STINCT PART)       0       0			0	2 027	45 255	47 282		1
65.00       06500       RESPI RATORY THERAPY       0       615       13, 729       14, 344       0         66.00       06600       PHYSI CAL THERAPY       0       1, 390       31, 041       32, 431       0         68.00       06600       SPEECH PATHOLOGY       0       0       0       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       382       8, 520       8, 902       0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       323       7, 214       7, 537       0         00       07300       DRUGS CHARGED TO PATIENTS       0       3, 110       69, 432       72, 542       0         88.00       08800       RURAL HEALTH CLINIC       0       3, 110       69, 432       72, 542       0         88.01       08801       RURAL HEALTH CLINIC II       0       4, 470       99, 805       104, 275       0         91.00       09100       EMERGENCY       0       1, 756       39, 196       40, 952       0         0       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       0       0       0       0         0       09500       AMBULANCE SERVI CES			0					1
66.00       06600       PHYSI CAL THERAPY       0       1,390       31,041       32,431       0         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       382       8,520       8,902       0         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       0       0       0       0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       323       7,214       7,537       0         001700       0800       RURAL HEALTH CLINIC       0       3,110       69,432       72,542       0         88.00       08800       RURAL HEALTH CLINIC II       0       4,470       99,805       104,275       0         91.00       09100       EMERGENCY       0       1,756       39,196       40,952       0         92.00       09200       OBSERVATION BEDS (NON-DI STINCT PART)       0       1,994       44,527       46,521       0			0					
68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       382       8, 520       8, 902       0         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENT       0       0       0       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       323       7, 214       7, 537       0         0UTPATI ENT SERVI CE COST CENTERS       0       3, 110       69, 432       72, 542       0         88.00       08800       RURAL HEALTH CLINI C       0       3, 110       69, 432       72, 542       0         91.00       09100       EMERGENCY       0       1, 756       39, 196       40, 952       0         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       0       0         0       09200       AMBULANCE SERVI CES       0       1, 994       44, 527       46, 521       0			0				0	66.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       0       0       0       0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       323       7,214       7,537       0         0UTPATIENT SERVICE COST CENTERS       0       3,110       69,432       72,542       0         88.00       08800       RURAL HEALTH CLINIC       0       3,110       69,432       72,542       0         88.01       08801       RURAL HEALTH CLINIC       0       4,470       99,805       104,275       0         91.00       09100       EMERGENCY       0       1,756       39,196       40,952       0         92.00       0BSERVATION BEDS (NON-DISTINCT PART)       0       0       0       0         0THER REI MBURSABLE COST CENTERS       0       1,994       44,527       46,521       0	68.00	06800 SPEECH PATHOLOGY	0	0	c	0 0	0	68.00
73.00         07300         DRUGS CHARGED TO PATIENTS         0         323         7, 214         7, 537         0           OUTPATIENT SERVICE COST CENTERS         0         323         7, 214         7, 537         0           88.00         08800         RURAL HEALTH CLINIC         0         3, 110         69, 432         72, 542         0           88.01         08801         RURAL HEALTH CLINIC II         0         4, 470         99, 805         104, 275         0           91.00         OP100         EMERGENCY         0         1, 756         39, 196         40, 952         0           92.00         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         0         0           0THER REI MBURSABLE COST CENTERS         0         1, 994         44, 527         46, 521         0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	382	8, 520	8, 902	0	71.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         3,110         69,432         72,542         0           88.01         08801         RURAL HEALTH CLINIC II         0         4,470         99,805         104,275         0           91.00         09100         EMERGENCY         0         1,756         39,196         40,952         0           92.00         09SERVATION BEDS (NON-DISTINCT PART)         0         0         0         0           0THER REIMBURSABLE COST CENTERS         0         1,994         44,527         46,521         0			0	0	C	0 0	0	72.00
88.00       08800       RURAL HEALTH CLINIC       0       3,110       69,432       72,542       0         88.01       08801       RURAL HEALTH CLINIC II       0       4,470       99,805       104,275       0         91.00       09100       EMERGENCY       0       1,756       39,196       40,952       0         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       0       1,994       44,527       46,521       0			0	323	7, 214	7, 537	0	73.00
88.01         08801         RURAL HEALTH CLINICII         0         4,470         99,805         104,275         0           91.00         09100         EMERGENCY         0         1,756         39,196         40,952         0           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         1         0         0           0THER         REI MBURSABLE         COST CENTERS         0         1,994         44,527         46,521         0			-1				_	
91. 00         09100         EMERGENCY         0         1,756         39,196         40,952         0           92. 00         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         1,756         39,196         40,952         0           0THER REI MBURSABLE COST CENTERS         0         1,994         44,527         46,521         0			0					
92.00         O9200         OBSERVATI ON         BEDS         (NON-DI STINCT PART)         0           OTHER         REI MBURSABLE         COST         CENTERS         0         1,994         44,527         46,521         0			0					
OTHER REI MBURSABLE COST CENTERS           95.00         09500         AMBULANCE SERVI CES         0         1,994         44,527         46,521         0			0	1, 756	39, 196		-	
95.00 09500 AMBULANCE SERVICES 0 1,994 44,527 46,521 0	Г					0		92.00
			0	1 994	44 527	46 521	0	95.00
SPECIAL PURPOSE COST CENTERS				.,,,,	11/02/	10/021		,0,00
	-		337, 055	35, 044	782, 419	1, 154, 518	0	118.00
NONREI MBURSABLE COST CENTERS	Ī	NONREI MBURSABLE COST CENTERS						
			0			0 0		193.00
			0	337	7, 532	2 7, 869		193. 01
			0	0	-	0 0		193. 02
			0	5	106	111	0	194.00
				-	-	0	-	200.00
			227 055	0				201.00
202.00 TOTAL (sum lines 118-201) 337,055 35,386 790,057 1,162,498 02	202.00	TUTAL (SUM TIMES TIG-201)	337,055	30, 380	/90,057	1, 102, 498	0	202.00

Heal th	Fi nanc	ial S	Syste	ems	
ALLOCA	TION OF	CAP	I TAL	RELATED	COSTS

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

ALLOC	ATION OF CAPITAL RELATED COSTS			CCN: 151307	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Pre 11/22/2016 10	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS		1		T		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	425, 400					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	(	D			6.00
7.00	00700 OPERATION OF PLANT	26, 544					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	95					8.00
9.00	00900 HOUSEKEEPI NG	4, 698				5, 794	
10.00	01000 DI ETARY	412			0 0	0	
11.00	01100 CAFETERI A	0			0 0	0	
12.00	01200 MAINTENANCE OF PERSONNEL	0	-		0 0	0	
13.00	01300 NURSING ADMINISTRATION	6, 518				83	
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 108			0 0	0	
15.00	01500 PHARMACY	18, 986			0 0	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	7,963	0			268	
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	
19.00		0	0		0 0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	(		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0 0	0	22.00
23.00	02300 PARAMED ED PRGM	0	(	)	0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	-		-			
30.00	03000 ADULTS & PEDI ATRI CS	54, 496			8 2, 127	954	30.00
43.00	04300 NURSERY	0	(		0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS	1	I		T		
50.00	05000 OPERATI NG ROOM	23, 647	0		8 678	655	
53.00	05300 ANESTHESI OLOGY	0			0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	33, 533				446	
60.00	06000 LABORATORY	30, 701	(	7,78	9 0	223	60.00
65.00	06500 RESPI RATORY THERAPY	1, 888	(	4, 71	9 0	135	65.00
66.00	06600 PHYSI CAL THERAPY	11, 652	(	10, 67	0 452	306	66.00
68.00	06800 SPEECH PATHOLOGY	0	(		0 0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 190	(	2, 92	9 0	84	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 655	(		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	215	(	2,48	0 0	71	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	54, 868			0 123	684	
88. 01	08801 RURAL HEALTH CLINIC II	46, 569	0		0 103	985	88.01
91.00	09100 EMERGENCY	62, 982	0	13, 47	3 678	386	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	1	1	1	1		
95.00	09500 AMBULANCE SERVICES	18, 527	(	) 15, 30	6 136	439	95.00
	SPECIAL PURPOSE COST CENTERS		-				
118.00	NONREI MBURSABLE COST CENTERS	410, 247	(	142, 64	7 4, 523	5, 719	118.00
	19300 NONPAI D WORKERS	0			0 0		193.00
193. O	1 19301 ORTHO CLINIC	12, 855	0	2, 58	9 0		193. 01
	2 19303 COMMUNITY MED CLINIC	1	(	)	0 0		193. 02
194.00	07950 MARKETI NG	2, 297	(	3	7 0	1	194.00
200.00	Cross Foot Adjustments						200. 00
201.00	D Negative Cost Centers	0	(		0 0		201.00
202.00	D TOTAL (sum lines 118-201)	425, 400	(	145, 27	3 4, 523	5, 794	202.00

Heal th	Financial Systems ST.	VINCENT WILLIAM	ASPORT HOSPIT	AL	In Lie	eu of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	CCN: 151307	Period: From 07/01/2015 To 06/30/2016		
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE PERSONNEL	OF NURSING ADMINISTRATION	CENTRAL	
		10.00	11.00	12.00	13.00	14.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
$\begin{array}{c} 1, 00\\ 2, 00\\ 4, 00\\ 5, 00\\ 6, 00\\ 7, 00\\ 8, 00\\ 9, 00\\ 10, 00\\ 11, 00\\ 12, 00\\ 12, 00\\ 13, 00\\ 14, 00\\ 15, 00\\ 16, 00\\ 17, 00\\ 19, 00\\ 20, 00\\ 21, 00\\ \end{array}$	00100NEW CAP REL COSTS-BLDG & FIXT00200NEW CAP REL COSTS-MVBLE EQUIP00400EMPLOYEE BENEFITS DEPARTMENT00500ADMINI STRATIVE & GENERAL00600MAI NTENANCE & REPAIRS00700OPERATION OF PLANT00800LAUNDRY & LINEN SERVICE00900HOUSEKEEPING01000DI ETARY01100CAFETERIA01200MAI NTENANCE OF PERSONNEL01300NURSI NG ADMINI STRATION01400CENTRAL SERVICES & SUPPLY01500PHARMACY01600MEDI CAL RECORDS & LI BRARY01700SOCI AL SERVICE01900NONPHYSI CI AN ANESTHETI STS02000NURSI NG SCHOOL02100I & R SERVICES-SALARY & FRINGES APPRVD	412 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 18,347 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		15.00 16.00 17.00 19.00 20.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	C		0 0		
23.00	02300 PARAMED ED PRGM	0	0	)	0 0	) C	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	412	0	1	0 8, 766	b C	30.00
43.00	04300 NURSERY	0	(		0 0		1
50.00	ANCI LLARY SERVI CE COST CENTERS			1	0 2,446	bl C	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0 2,440		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0		
60.00	06000 LABORATORY	0	C		0 391	c c	60.00
65.00	06500 RESPI RATORY THERAPY	0	C		0 196	b C	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 1, 220	) C	66.00
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	) C	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	1, 136	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	(		0 0	972	1
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	l	)	0 0	) C	73.00
88.00	08800 RURAL HEALTH CLINIC	0	(	1	0 0		88.00
88.01	08801 RURAL HEALTH CLINIC II	0	(		0 0	-	
91.00	09100 EMERGENCY	0	(		0 5, 328		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REI MBURSABLE COST CENTERS	· · ·		•	!		1
95.00	09500 AMBULANCE SERVI CES	0	C	)	0 0	) C	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	412			0 18, 347	2.108	118.00
	NONREI MBURSABLE COST CENTERS					1	
	19300 NONPAI D WORKERS	0	C		0 0		193.00
	19301 ORTHO CLINIC	0	C		0 0		193. 01
	2 19303 COMMUNITY MED CLINIC	0	C		0 0		193.02
	07950 MARKETI NG	0	C		0 0	ך C	194.00
200.00							200.00
201.00 202.00		412			0 18, 347		201.00 202.00
202.00		412	Ĺ	<b>'</b> I	y 10, 347	2,100	202.00

Heal th	Fi nar	ici al	Syste	ems		
				DEL	ATED	C

Heal th	Financial Systems ST.	VINCENT WILLIA	MSPO	RT HOSPITA	AL	In Li€	eu of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS			Provi der		Period: From 07/01/2015	Worksheet B Part II	
						To 06/30/2016	Date/Time Prep 11/22/2016 10:	pared:
	Cost Center Description	PHARMACY	М	EDI CAL	SOCIAL SERVIC	E NONPHYSI CI AN		25 am
				CORDS &		ANESTHET I STS		
		15.00		I BRARY	17.00	10.00		
	GENERAL SERVICE COST CENTERS	15.00		16.00	17.00	19.00	20.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT							1.00
2.00	00200 NEW CAP REL COSTS DEDG & TTAT							2.00
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							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	01100 CAFETERI A							11.00
	01200 MAINTENANCE OF PERSONNEL							12.00
	01300 NURSI NG ADMI NI STRATI ON							13.00
	01400 CENTRAL SERVICES & SUPPLY							14.00
	01500 PHARMACY	18, 986						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0		45, 977	<u></u>			16.00
	01700 SOCIAL SERVICE	0		0	)	0		17.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0		0	)	0 0		19.00
	02000 NURSI NG SCHOOL	0		0		0	0	20.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD	0		0		0		21.00 22.00
22.00	02300 PARAMED ED PRGM	0		0		0		22.00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		0	/	0	1	23.00
30.00	03000 ADULTS & PEDI ATRI CS	0		3, 239		0		30, 00
	04300 NURSERY	0		0		0		43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0		2, 969		0		50.00
53.00	05300 ANESTHESI OLOGY	0		0		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		11, 775		0		54.00
60.00	06000 LABORATORY	0		8, 905		0		60.00
65.00	06500 RESPI RATORY THERAPY	0		1, 016		0		65.00
66.00	06600 PHYSI CAL THERAPY	0		1, 228		0		66.00
68.00	06800 SPEECH PATHOLOGY	0		0		0		68.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0		0		0		71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	18, 986		0		0		72.00 73.00
73.00	OUTPATIENT SERVICE COST CENTERS	10, 900		0	/		<u> </u>	73.00
88.00	08800 RURAL HEALTH CLINIC	0		1, 965	1	0	1	88.00
88.01	08801 RURAL HEALTH CLINIC II	0		1, 723		0		88.01
91.00	09100 EMERGENCY	Ő		11, 807		0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVI CES	0		1, 350	)	0		95.00
	SPECIAL PURPOSE COST CENTERS	r				- T		
118.00		18, 986		45, 977		0 0	0	118.00
	NONREI MBURSABLE COST CENTERS				1	_1		
	19300 NONPAI D WORKERS	0		0		0		193.00
	19301 ORTHO CLINIC	0		0		0		193.01
	19303 COMMUNITY MED CLINIC	0		0		0		193.02
194.00 200.00	07950 MARKETING Cross Foot Adjustments	0		0		0		194.00
200.00		_		0		0 0		200. 00 201. 00
201.00		0 18, 986		45, 977				201.00
202.00		10, 200		-J, 711	I	ч U		202.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			CCN: 151307 F	Period:	Worksheet B	
				rom 07/01/2015	Part II	aarad.
			1	o 06/30/2016	Date/Time Pre 11/22/2016 10	23 am
	INTERNS &	RESI DENTS				
Cost Center Description		SERVI CES-OTHER		Subtotal	Intern &	
	Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
					& Post	
					Stepdown	
	21.00	22.00	23.00	24.00	Adjustments 25.00	
GENERAL SERVICE COST CENTERS	21.00	22.00	23.00	24.00	23.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & 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 01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY						14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00 01700 SOCIAL SERVICE						17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS						19.00
20. 00 02000 NURSI NG SCHOOL						20.00
21.00 02100 I & SERVICES-SALARY & FRINGES APPRVD	0					21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		0	)			22.00
23.00 02300 PARAMED ED PRGM			0	)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS	_	-				
30. 00 03000 ADULTS & PEDI ATRI CS				204, 421	0	30.00
43. 00 04300 NURSERY				0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	1		1		-	
50. 00 05000 OPERATING ROOM				122, 607	0	50.00
53. 00 05300 ANESTHESI OLOGY				0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C				108, 818	0	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY				71, 682	0	60. 00 65. 00
66. 00 06600 PHYSICAL THERAPY				22, 298 57, 959	0	66.00
68. 00 06800 SPEECH PATHOLOGY				57, 757	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				15, 241	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT				2, 627	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS				29, 289	0	73.00
OUTPATIENT SERVICE COST CENTERS	1	1				
88.00 08800 RURAL HEALTH CLINIC				130, 182	0	88.00
88.01 08801 RURAL HEALTH CLINIC II				153, 655	0	88. 01
91.00 09100 EMERGENCY				135, 606	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	1			
95. 00 09500 AMBULANCE SERVICES				82, 279	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	0	1, 136, 664	0	118.00
NONREI MBURSABLE COST CENTERS	T			2		102 00
193. 00 19300 NONPALD WORKERS				0		193.00 192.01
193. 01 19301 ORTHO CLINIC 193. 02 19303 COMMUNITY MED CLINIC				23, 387		193. 01 193. 02
194. 00 07950 MARKETI NG				2, 446		193.02 194.00
200.00 Cross Foot Adjustments	0	0	, c	) 2, 440		200.00
201.00 Negative Cost Centers	0	0		0		200.00
202.00 TOTAL (sum lines 118-201)	0	0				202.00

Provider CCN: 151307

In Lieu of Form CMS-2552-10 Period: Worksheet B From 07/01/2015 Part II

			1/2015   Part II 0/2016   Date/Time Prepared: 11/22/2016 10:23 am
	Cost Center Description	Total	11/22/2010 10.23 am
		26.00	
-	GENERAL SERVICE COST CENTERS		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 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		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	01200 MAINTENANCE OF PERSONNEL		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		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS		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 SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300 PARAMED ED PRGM		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000 ADULTS & PEDIATRICS	204, 421	30.00
43.00	04300 NURSERY	0	43.00
	ANCILLARY SERVICE COST CENTERS		
50.00	05000 OPERATING ROOM	122, 607	50.00
53.00	05300 ANESTHESI OLOGY	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	108, 818	54.00
60.00	06000 LABORATORY	71, 682	60.00
65.00	06500 RESPI RATORY THERAPY	22, 298	65.00
66.00	06600 PHYSI CAL THERAPY	57, 959	66.00
68.00	06800 SPEECH PATHOLOGY	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 241	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2, 627	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	29, 289	 73.00
	OUTPATIENT SERVICE COST CENTERS		
88.00	08800 RURAL HEALTH CLINIC	130, 182	88.00
88. 01	08801 RURAL HEALTH CLINIC II	153, 655	88.01
91.00	09100 EMERGENCY	135, 606	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		 92.00
	OTHER REIMBURSABLE COST CENTERS		
95.00	09500 AMBULANCE SERVICES	82, 279	95.00
	SPECIAL PURPOSE COST CENTERS		
118.00		1, 136, 664	 118.00
	NONREI MBURSABLE COST CENTERS		
	19300 NONPALD WORKERS	0	193.00
	19301 ORTHO CLINIC	23, 387	193. 01
	2 19303 COMMUNITY MED CLINIC	1	193. 02
	07950 MARKETI NG	2, 446	194.00
200.00	Cross Foot Adjustments	0	200. 00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	1, 162, 498	202.00

	5	VINCENT WILLIA			In Lie	u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2015	Worksheet B-1	
					To 06/30/2016		
		CAPI TAL REL	ATED COSTS			11/22/2016 10:	:23 am
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		FIXT (SQUARE	EQUI P (SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	52,024			1		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		52, 024				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	8, 369, 239	2		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	5, 568	5, 568	1, 899, 275	-5, 004, 352		5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	0	0	, i	0	6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	7, 483 210	7, 483 210		0	929, 598	7.00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	52	210 52			3, 332 164, 534	9.00
	01000 DI ETARY	0	0	(	0	14, 431	10.00
	01100 CAFETERIA	0	0	C	0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	C	0 0	0	12.00
	01300 NURSING ADMINISTRATION	557	557	152, 581		228, 283	
	01400 CENTRAL SERVICES & SUPPLY	0	0	37, 837		73, 808	•
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	168, 778		664, 924	15.00
	01700 SOCIAL SERVICE	1, 790	1, 790	140, 426		278, 862 0	16.00 17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	0			0	19.00
	02000 NURSI NG SCHOOL	0	0		0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	C	) 0	0	21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	C	-	0	22.00
	02300 PARAMED ED PRGM	0	0		0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	6, 375	6, 375	1, 123, 577	7 0	1, 908, 539	30.00
	03000 ADDETS & PEDIATRICS 04300 NURSERY	0,375	6, 375 0				43.00
10.00	ANCI LLARY SERVI CE COST CENTERS		0				10.00
50.00	05000 OPERATING ROOM	4, 373	4, 373	505, 392	2 0	828, 156	50.00
	05300 ANESTHESI OLOGY	0	0	C	0 0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 980	2, 980			1, 174, 379	
		1, 492	1, 492			1, 075, 199	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	904 2, 044	904 2, 044			66, 106 408, 080	
	06800 SPEECH PATHOLOGY	2,044	2,044	203, 335		408, 080	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	561	561		, i	76, 682	•
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	0 0	57, 969	•
	07300 DRUGS CHARGED TO PATIENTS	475	475		0 0	7, 537	73.00
	OUTPATIENT SERVICE COST CENTERS	]					
	08800 RURAL HEALTH CLINIC	4, 572 6, 572	4, 572 6, 572				
	08801 RURAL HEALTH CLINIC II 09100 EMERGENCY	0, 572 2, 581	6, 572 2, 581				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 301	2, 501	000,000	Ŭ	2,203,707	92.00
	OTHER REIMBURSABLE COST CENTERS	L			11		1
	09500 AMBULANCE SERVICES	2, 932	2, 932	408, 700	0 0	648, 836	95.00
	SPECIAL PURPOSE COST CENTERS				1		
118.00		51, 521	51, 521	8, 078, 900	-5, 004, 352	14, 367, 424	118.00
102 00	NONREI MBURSABLE COST CENTERS	0	0			0	102 00
	19300 NONPALD WORKERS 19301 ORTHO CLINIC	0 496	0 496				193.00 193.01
	19303 COMMUNITY MED CLINIC	430	490 0	202, 990			193.02
	07950 MARKETI NG	7	7	7, 343	3 0	80, 460	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00		35, 386	790, 057	3, 252, 259	1	5, 004, 352	202.00
202 00	Part I)	0 40010/	15 10/005	0 200505	,	0.335005	202 00
203.00 204.00		0. 680186	15. 186395	0. 388597		0. 335905 425, 400	
207.00					1	+23, 400	207.00
	Part II)				1	۱	
205.00				0. 000000	)	0. 028554	205.00

DST A	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet B-1 Date/Time Pre 11/22/2016 10	epar
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG E (SQUARE FEET)	DI ETARY (MEALS SERVED)	
	OFNERAL CERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	_
00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		[				.
00 00 00 00 00 00 00	00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 0 0 0 0	27, 829 210 52	83, 89	0 38, 711		
00	01000 DI ETARY	0	0		0 0	100	
. 00	01100 CAFETERI A	0	C		0 0	0	
. 00	01200 MAINTENANCE OF PERSONNEL	0				0	
. 00 . 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	557		0 557 0 0	0	
. 00	01500 PHARMACY	0			0 0	0	
. 00	01600 MEDICAL RECORDS & LIBRARY	0	1, 790		0 1, 790	0	
. 00	01700 SOCIAL SERVICE	0	.,,,,,	1	0 0	0	
. 00	01900 NONPHYSICIAN ANESTHETISTS	0	C	)	0 0	0	
. 00	02000 NURSI NG SCHOOL	0	C		0 0	0	2
. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	C		0 0	0	2
. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	C		0 0	0	
00	02300 PARAMED ED PRGM	0	0		0 0	0	2
00	INPATIENT ROUTINE SERVICE COST CENTERS		6 275	20.42	0 4 275	100	1 2
. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	0			9 6, 375 0 0	100 0	
. 00	ANCI LLARY SERVICE COST CENTERS			1	<u>v</u>	0	1 7
00	05000 OPERATING ROOM	0	4, 373	12, 58	3 4, 373	0	5
00	05300 ANESTHESI OLOGY	0	C		0 0	0	5
00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 980	4, 19	4 2, 980	0	5
00	06000 LABORATORY	0	1, 492	1	0 1, 492	0	
00	06500 RESPI RATORY THERAPY	0	904	1	0 904	0	
00	06600 PHYSI CAL THERAPY	0	2,044			0	
00	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	561		0 0 0 561	0	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	001		0 561 0 0	0	
. 00	07300 DRUGS CHARGED TO PATIENTS	0	475		0 475	0	
	OUTPATIENT SERVICE COST CENTERS			•	-		
. 00	08800 RURAL HEALTH CLINIC	0	C	2, 28	6 4, 572	0	8
. 01	08801 RURAL HEALTH CLINIC II	0	C	.,,,,		0	
00	09100 EMERGENCY	0	2, 581	12, 58	4 2, 581	0	
. 00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS		<u> </u>				9
00	09500 AMBULANCE SERVICES	0	2, 932	2, 51	7 2, 932	0	9
00	SPECIAL PURPOSE COST CENTERS		2,702	2,01			ĺ
8.00		0	27, 326	83, 89	1 38, 208	100	11
	NONREI MBURSABLE COST CENTERS	1	1	1			
	19300 NONPAI D WORKERS	0	-		0 0		19
	19301 ORTHO CLINIC	0	496	1	0 496		19
	19303 COMMUNITY MED CLINIC	0			0 0		19
4. UC D. OC	07950 MARKETING Cross Foot Adjustments	0	'		/	0	20
1. OC							200
2.00		0	1, 241, 855	13, 82	2 222, 122	19, 278	
	Part I)		., 2 , 000			17,270	
3.00		0. 000000	44. 624492	0. 16476	1 5. 737956	192. 780000	20
4.00		0	145, 273			412	
	Part II)	1					1
5.00		0. 000000	5. 220202	0. 05391		4. 120000	

Heal th Financial	Systems
COST ALLOCATION	- STATISTICAL BASIS

Heal th	Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL	In Lieu	u of Form CMS-:	2552-10
	LOCATION - STATISTICAL BASIS			CCN: 151307 P	eriod:	Worksheet B-1	
				F	rom 07/01/2015 o 06/30/2016	Date/Time Pre 11/22/2016 10	
	Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	20 am
		(MEALS		ADMI NI STRATI ON		(COSTED	
		SERVED)	(NUMBER		SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT	(DIRECT COSTS)		
				NRSING HRS)			
		11.00	12.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS	1		1			
1	DO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	DO2OO NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 0	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	DO5OO ADMINISTRATIVE & GENERAL						5.00
	DO6OO MAI NTENANCE & REPAI RS						6.00
	DO700 OPERATION OF PLANT						7.00
	DO800 LAUNDRY & LINEN SERVICE						8.00
9.00	DO900 HOUSEKEEPI NG						9.00
10.00	D1000 DI ETARY						10.00
11.00 (	01100 CAFETERI A	0					11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0				12.00
13.00 (	01300 NURSI NG ADMI NI STRATI ON	0	0	98, 349			13.00
14.00 (	01400 CENTRAL SERVICES & SUPPLY	0	0	0 0	125, 749		14.00
15.00 (	D1500 PHARMACY	0	0	0 0	0	100	15.00
16.00 (	D1600 MEDICAL RECORDS & LIBRARY	0	0	0 0	0	0	16.00
17.00 (	D1700 SOCIAL SERVICE	0	0	0 0	0	0	17.00
19.00 (	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	D2000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	D2200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0 0	0	0	22.00
23.00 0	D2300 PARAMED ED PRGM	0	0	0	0	0	23.00
I	NPATIENT ROUTINE SERVICE COST CENTERS				•		1
30.00	03000 ADULTS & PEDIATRICS	0	0	46, 988	0	0	30.00
43.00 0	04300 NURSERY	0	0	0 0	0	0	43.00
ŀ	ANCILLARY SERVICE COST CENTERS						
50.00	D5000 OPERATING ROOM	0	0	) 13, 111	0	0	50.00
53.00 (	05300 ANESTHESI OLOGY	0	0	0 0	0	0	53.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	0	0	0 0	0	0	54.00
60.00 (	D6000 LABORATORY	0	0	2, 098	0	0	60.00
65.00 (	06500 RESPI RATORY THERAPY	0	0	1, 051	0	0	65.00
66.00 (	D6600 PHYSI CAL THERAPY	0	0	6, 541	0	0	66.00
68.00 (	06800 SPEECH PATHOLOGY	0	0	0 0	0	0	68.00
71.00 (	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0 0	67, 780	0	71.00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0 0	57, 969	0	72.00
73.00	D7300 DRUGS CHARGED TO PATIENTS	0	0	0 0	0	100	73.00
C	DUTPATIENT SERVICE COST CENTERS			_			
88.00 (	08800 RURAL HEALTH CLINIC	0	0	0 0	0	0	88.00
88.01 (	08801 RURAL HEALTH CLINIC II	0	0	0 0	0	0	88.01
91.00 (	D9100 EMERGENCY	0	0	28, 560	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
C	THER REIMBURSABLE COST CENTERS						
95.00 (	09500 AMBULANCE SERVI CES	0	0	0 0	0	0	95.00
<u> </u>	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	98, 349	125, 749	100	118.00
1	NONREIMBURSABLE COST CENTERS						
193.00	19300 NONPAI D WORKERS	0	0	0 0	0	0	193.00
193.01	19301 ORTHO CLINIC	0	0	0 0	0	0	193. 01
193.02	19303 COMMUNITY MED CLINIC	0	0	0 0	0	0	193. 02
194.000	07950 MARKETI NG	0	0	0 0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	0	0	333, 016	98, 600	888, 275	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	3. 386064	0. 784102	8, 882. 750000	
204.00	Cost to be allocated (per Wkst. B,	0	0	18, 347	2, 108	18, 986	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 186550	0. 016764	189.860000	205.00
	11)		l				

Heal th	Fi nanci al	Systems	
COST A			B

In Lieu of Form CMS-2552-10

	VINCENT WILLI	AMSPORT HOSPITA	AL	In Lie	u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
				rom 07/01/2015 0 06/30/2016	Date/Time Pre	pared:
					11/22/2016 10	
					INTERNS &	
					RESI DENTS	
Cost Center Description	MEDICAL	SOCI AL SERVI CE		NURSING SCHOOL		
	RECORDS &	(71.115	ANESTHETI STS	(100101)55	Y & FRINGES	
	LIBRARY	(TIME	(ASSI GNED	(ASSI GNED	(ASSI GNED	
	(GROSS	SPENT)	TIME)	TIME)	TIME)	
	CHARGES)	17.00	10.00	20,00	21.00	
GENERAL SERVICE COST CENTERS	16.00	17.00	19.00	20.00	21.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	[		1		[	1.00
2.00 00200 NEW CAP REL COSTS-BEDG & TTXT						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & 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 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						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						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	65, 317, 028					16.00
17.00 01700 SOCIAL SERVICE	0	o c				17.00
19.00 01900 NONPHYSI CLAN ANESTHETI STS	0	) O	c			19.00
20. 00 02000 NURSI NG SCHOOL	0	o c		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	o c			0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	c c				22.00
23.00 02300 PARAMED ED PRGM	0	c c				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					•	
30. 00 03000 ADULTS & PEDIATRICS	4, 600, 676	C	C	0	0	30.00
43. 00 04300 NURSERY	0	0	c c	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 217, 716	0	C	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0 0	C	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 725, 264	0	C	0	0	54.00
60. 00 06000 LABORATORY	12, 648, 762		C	0	0	
65. 00 06500 RESPI RATORY THERAPY	1, 443, 318		C	0	0	
66. 00 06600 PHYSI CAL THERAPY	1, 744, 685		C	0	0	
68.00 06800 SPEECH PATHOLOGY	0	0 0	C	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C C	C	0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	-		-	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0 0	C	0	0	73.00
OUTPATIENT SERVICE COST CENTERS		-	-	-	-	
88. 00 08800 RURAL HEALTH CLINIC	2, 791, 097					
88. 01 08801 RURAL HEALTH CLINIC II	2, 447, 822					
91.00 09100 EMERGENCY	16, 779, 406	C	C	0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
	1 010 202			0	0	
95. 00 09500 AMBULANCE SERVICES	1, 918, 282	0	C	0	0	95.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)	65, 317, 028	C	C	0	0	1110 00
NONREIMBURSABLE COST CENTERS	03, 317, 020		<u>ı</u> U	0	0	118.00
193. 00 19300 NONPAID WORKERS	0	C	C	0	0	193.00
193. 01 19300 NORPALD WORKERS 193. 01 19301 ORTHO CLI NI C				-		193.00
193. 02 19303 COMMUNITY MED CLINIC				0		193.01
194. 00 07950 MARKETI NG						194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	462, 682			0	0	202.00
Part I)	402,002					202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 007084	0. 000000	0. 000000	0.000000	0. 000000	203.00
204.00 Cost to be allocated (per Wkst. B,	45, 977		0.00000	0.00000		204.00
Part II)			Ĭ			
205.00 Unit cost multiplier (Wkst. B, Part	0. 000704	0. 000000	0. 000000	0.000000	0. 000000	205.00

Heal th	Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPIT	AL	In Lieu	of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 151307		Worksheet B-1	
					From 07/01/2015 To 06/30/2016	Data /Tima Draw	oorod.
						Date/Time Prep 11/22/2016 10:	
		INTERNS &			-1 -		
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	PARAMED ED				
		PRGM COSTS	PRGM				
		(ASSI GNED	(ASSI GNED				
		TIME)	TIME)	-			
		22.00	23.00				
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-BEDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATI ON OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERIA						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE						17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS						19.00
20.00	02000 NURSING SCHOOL						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	0					22.00
23.00	02300 PARAMED ED PRGM		(	D			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0		D			30.00
43.00	04300 NURSERY	0	(	ס			43.00
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	0					50.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0					53.00 54.00
	06000 LABORATORY	0	(				54.00 60.00
	06500 RESPI RATORY THERAPY	0	(				65.00
	06600 PHYSI CAL THERAPY	0					66. 00
	06800 SPEECH PATHOLOGY	0	(				68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0					72.00
	07300 DRUGS CHARGED TO PATIENTS	0					73.00
	OUTPATIENT SERVICE COST CENTERS			-			
88.00	08800 RURAL HEALTH CLINIC	0	(	D			88.00
88.01	08801 RURAL HEALTH CLINIC II	0	(	D			88. 01
	09100 EMERGENCY	0	(	D			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS			-			
95.00	09500 AMBULANCE SERVI CES	0	(	D			95.00
	SPECIAL PURPOSE COST CENTERS			-			
118.00		0	(	0			118.00
102 00	NONREI MBURSABLE COST CENTERS 19300 NONPAI D WORKERS			2			193.00
		0					
	19301 ORTHO CLINIC	0					193.01
	19303 COMMUNITY MED CLINIC	0					193.02
200.00	07950 MARKETING	0	(				194.00
200.00							200. 00 201. 00
201.00		0	(				201.00 202.00
202.00	Part I)		(				202.00
203.00		0. 000000	0.00000				203. 00
203.00		0.00000	0.00000				203.00
204.00	Part II)			]			201.00
205.00		0. 000000	0.00000	b			205.00

Heal th	Fi nan	ici a	I Syst	ems			
COMPLIT		OF	PATIO	0F	27200	ΤO	C

Health Financial Systems	SI. VINCENI WILLI.	AMSPORT HOSPITA	AL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			F	Period: From 07/01/2015 Fo 06/30/2016	11/22/2016 10	
		Titl	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B, Part I, col.	Adj.		Di sal I owance		
	26)					
	1.00	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	3, 088, 156		3, 088, 156	5 0	0	30.00
43. 00 04300 NURSERY	0,000,100		0,000,100	0 0	0	
ANCI LLARY SERVI CE COST CENTERS			· · · · ·			
50. 00 05000 OPERATI NG ROOM	1, 402, 919		1, 402, 919	9 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 838, 112		1, 838, 112	2 0	0	54.00
60. 00 06000 LABORATORY	1, 608, 213		1, 608, 213	3 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	147, 622	0	147, 622	2 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	683, 985	C	683, 985	5 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0 0	(	0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	183, 839		183, 839	9 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	122, 895		122, 895		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	922, 267		922, 26	7 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	2, 613, 381		2, 613, 381		0	00.00
88.01 08801 RURAL HEALTH CLINIC II	2, 234, 117		2, 234, 117		0	
91.00 09100 EMERGENCY	3, 294, 221		3, 294, 22		0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	661, 402		661, 402	2	0	92.00
OTHER REI MBURSABLE COST CENTERS	1 000 150	1	1 000 151			1 05 00
95. 00 09500 AMBULANCE SERVICES	1, 028, 450		1, 028, 450		0	1 /0.00
200.00 Subtotal (see instructions)	19, 829, 579		19, 829, 579			200.00
201.00Less Observation Beds202.00Total (see instructions)	661, 402 19, 168, 177		661, 402 19, 168, 17			201.00 202.00
zuz. uu   Tutai (see fiistructions)	19, 108, 177	'  C	η 19, 108, 17,	7 0	0	1202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			-	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Pre 11/22/2016 10	
		Ti tl	e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	+ col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 611, 780		3, 611, 780	C		30.00
43.00 04300 NURSERY	0		(	0		43.00
ANCI LLARY SERVI CE COST CENTERS				I		
50. 00 05000 OPERATI NG ROOM	180, 226	4,037,490	4, 217, 716		0.000000	
53. 00 05300 ANESTHESI OLOGY	0	0	(	0. 000000	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	769, 215	15, 956, 049	16, 725, 26		0.00000	
60. 00 06000 LABORATORY	1, 056, 114	11, 592, 648	12, 648, 762		0.00000	
65. 00 06500 RESPI RATORY THERAPY	719, 079	724, 239	1, 443, 318		0.000000	
66. 00 06600 PHYSI CAL THERAPY	413, 486	1, 331, 199	1, 744, 68		0.00000	
68.00 06800 SPEECH PATHOLOGY	0	0	(	0. 000000	0.000000	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	472, 059	822, 200	1, 294, 259		0.00000	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	15, 829	355, 100	370, 929		0.00000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 460, 341	2,001,933	3, 462, 274	4 0. 266376	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS		0 704 007	0 704 00	-		
88. 00 08800 RURAL HEALTH CLINIC	0	2, 791, 097	2, 791, 09			88.00
88. 01 08801 RURAL HEALTH CLINIC II		2, 447, 822	2, 447, 822		0,000000	88.01
91.00 09100 EMERGENCY	253, 967	16, 525, 439			0.000000	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	67, 350	921, 546	988, 890	6 0. 668829	0.000000	92.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	ol	1, 918, 282	1, 918, 282	2 0. 536131	0. 000000	95.00
	0 9, 019, 446					
200.00Subtotal (see instructions)201.00Less Observation Beds	9, 019, 446	61, 425, 044	70, 444, 490	J		200.00
				1		1201.UU

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 151307         Period: From 07/01/2015         Worksheet C Part I Date/Time Prepared: 11/22/2016 10:23 am           Cost Center Description         PPS Inpatient Ratio         Title XVIII         Hospital         Cost           INPATIENT ROUTINE SERVICE COST CENTERS         0.00         03000 ADULTS & PEDIATRICS         30.00         43.00           ACCILLARY SERVICE COST CENTERS         0.0000000         50.00         50.00         50.00         50.00           50.00         05000 OPERATING ROOM         0.000000         53.00         50.00         54.00         66.00           65.00         065000 RESPIRATORY         0.000000         54.00         0.000000         54.00         66.00         66.00           66.00         066000 PHYSICAL THERAPY         0.000000         65.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         71.00         72.00         73.00 <td< th=""><th>Health Financial Systems ST.</th><th>VINCENT WILLIA</th><th>AMSPORT HOSPITAL</th><th>In Lie</th><th>u of Form CMS-255</th><th>52-10</th></td<>	Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITAL	In Lie	u of Form CMS-255	52-10
Cost Center Description         PPS Inpatient Ratio         PPS Inpatient Ratio         Number Streps           0.00         0000 ADULTS & PEDIATRICS         30.00         30.00         30.00           0.3000 ADULTS & PEDIATRICS         30.00         30.00         30.00           ANCILLARY SERVICE COST CENTERS         43.00           0.000 OFERTING ROOM         0.000000         53.00           053.00 OS300 ANDESTHESIOLOGY         0.000000         53.00           54.00 OS400 RADIOLOGY DI AGNOSTIC         0.000000         65.00           66.00 O6600 LABORATORY         0.000000         65.00           66.00 O6600 PHYSICAL THERAPY         0.000000         66.00           66.00 O6600 SPEECH PATHOLOGY         0.000000         66.00           71.00         07100 MEDICAL SUPPLIES CHARGED TO PATIENT         0.000000         68.00           71.00         07100 MEDICAL SUPPLIES CHARGED TO PATIENT         0.000000         71.00           72.00         07200 INPL. DEV. CHARGED TO PATIENT         0.000000         73.00           73.00         07300 DRUGS CHARGED TO PATIENT         0.000000         73.00           09100 EMERGENCY         0.000000         92.00         92.00         92.00         92.00           092000 OBSERVATION BEDS (NON-DISTINCT PART)	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 07/01/2015 To 06/30/2016	Part I Date/Time Prepar 11/22/2016 10:23	
Ratio         11.00           30.00         03000 ADULTS & PEDI ATRI CS         30.00           43.00         04300 NURSERY         43.00           ANCI LLARY SERVICE COST CENTERS         50.00           50.00         05000 OPERATI NG ROOM         0.000000           53.00         05300 ANESTHESI OLOGY         0.000000           54.00         05000 OPERATI NG ROOM         0.000000           60.00         06000 LABORATORY         0.000000           60.00         6600 PHYSI CAL THERAPY         0.000000           66.00         06600 PHYSI CAL THERAPY         0.000000           68.00         06800 SPEECH PATHOLOGY         0.000000           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.000000           73.00         07300 DRUGS CHARGED TO PATI ENT         0.000000           73.00         07300 DRUGS CHARGED TO PATI ENTS         0.000000           73.00         07300 DRUGS CHARGED TO PATI ENT         0.000000			Title XVIII	Hospi tal	Cost	
INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00           03000 ADULTS & PEDIATRI CS         30.00           43.00         04300 NURSERY         43.00           ANCI LLARY SERVI CE COST CENTERS         50.00           50.00         05000 OPERATI NG ROOM         0.000000           53.00         05300 ANESTHESI OLOGY         0.000000           54.00         054000 LABORATORY         0.000000           65.00         065000 RESPI RATORY THERAPY         0.000000           66.00         06600 PHYSI CAL THERAPY         0.000000           66.00         06600 SPEECH PATHOLOGY         0.000000           71.00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.000000           72.00         07200 IMPL. DEV. CHARGED TO PATI ENTS         0.000000           73.00         07300 DRUGS CHARGED TO PATI ENT         0.000000           73.00         07300 DRUGS CHARGED TO PATI ENTS         0.000000           73.00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000           72.00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000           72.00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000           72.00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000	Cost Center Description	PPS Inpatient				
INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00           30.00         03000 ADULTS & PEDI ATRI CS         30.00           43.00         04300 NURSERY         43.00           ANCI LLARY SERVI CE COST CENTERS         50.00         055000 OPERATI NG ROM         0.000000           53.00         05400 RABI OLOGY         0.000000         53.00           54.00         05400 RABI OLOGY         0.000000         53.00           65.00         06500 RESPI RATORY         0.000000         65.00           66.00         06600 LABORATORY         0.000000         65.00           65.00         06500 RESPI RATORY THERAPY         0.000000         66.00           66.00         06600 PHYSI CAL THERAPY         0.000000         66.00           71.00         07100 MEDI CAL SUPLI ES CHARGED TO PATI ENTS         0.000000         71.00           72.00         07200 IMPL. DEV. CHARGED TO PATI ENTS         0.000000         73.00           007300 DRUGS CHARGED TO PATI ENTS         0.000000         73.00           000000 ORUGAL HEALTH CLINI C         88.00         88.00           88.01         08801 RURAL HEALTH CLINI C         88.00           92.00         09200 OBSERVATI ON BEDS (MON-DI STINCT PART)         0.000000           00         09						
30.00         03000         ADULTS & PEDIATRICS         30.00           43.00         04300         NURSERY         43.00           ANCILLARY SERVICE COST CENTERS         50.00         05000         PERATING ROOM         0.000000           53.00         05300         ANESTHESI OLOGY         0.000000         53.00           54.00         05400         RADIOLGY -DI AGNOSTI C         0.000000         64.00           60.00         06000         LABORATORY         0.000000         65.00           66.00         06500         RESPI RATORY THERAPY         0.000000         65.00           66.00         06600         PHYSI CAL THERAPY         0.000000         66.00           66.00         06600         SPECH PATHOLOGY         0.000000         67.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.000000         71.00           72.00         73.00         07300         RURAL HEALTH CLINIC         72.00           73.00         08801         RURAL HEALTH CLINIC         88.00           88.01         08801         RURAL HEALTH CLINIC         88.00           92.00         09200         DIBERVATION BEDS (NON-DI STINCT PART)         0.0000000         92.00		11.00				
43.00       04300       NURSERY       43.00         ANCI LLARY SERVICE COST CENTERS       50.00       05000       OPERATING ROOM       0.000000       50.00         53.00       05300       ANESTHESI OLGGY       0.000000       53.00       50.00         54.00       05400       RADI OLGGY-DI AGNOSTI C       0.000000       60.00       60.00         65.00       06500       RSPI RATORY       0.000000       60.00       60.00         65.00       06500       RSPI RATORY THERAPY       0.000000       66.00       66.00         66.00       06600       SPEICH PATHOLOGY       0.000000       68.00       68.00         71.00       MDICLAL SUPPLIES CHARGED TO PATIENTS       0.000000       71.00       72.00         72.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       72.00         00170ATIENT SERVICE COST CENTERS       0.000000       73.00       73.00         88.00       08801       RURAL HEALTH CLINIC II       88.00       88.00         92.00       092500       RURAL HEALTH CLINIC TART)       0.000000       91.00       91.00         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART)       0.000000       92.00       92.00         0						
ANCILLARY SERVICE COST CENTERS           50:00         05000         OPERATING ROOM         0.000000         53.00           53:00         05300         ANESTHESI OLOGY         0.000000         53.00           54:00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         54.00           60:00         06000         LABORATORY         0.000000         60.00           65:00         06500         RESPI RATORY THERAPY         0.000000         65.00           66:00         06600         PHYSI CAL THERAPY         0.000000         66.00           66:00         06600         PHYSI CAL THERAPY         0.000000         66.00           68:00         06800         SPEECH PATHOLOGY         0.000000         68.00           71:00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.000000         71.00           72:00         07200         IMUL. DEV. CHARGED TO PATIENT         0.000000         72.00           73:00         0TUPATIENT SERVICE COST CENTERS         0.000000         72.00         72.00           73:00         0B801 RURAL HEALTH CLINIC 11         0.000000         92.00         95.00         09200 OBSERVATION BEDS (NON-DI STINCT PART)         0.0000000         92.00         95.00						
50.00         05000         OPERATING ROOM         0.000000         53.00           53.00         05300         ANESTHESI 0LOGY         0.000000         53.00           54.00         05400         RADI 0LOGY-DI AGNOSTI C         0.000000         54.00           60.00         LABORATORY         0.000000         60.00         60.00           65.00         06500         RESPI RATORY THERAPY         0.000000         65.00           66.00         06600         PHYSI CAL THERAPY         0.000000         66.00           68.00         06800         SPECH PATHOLOGY         0.000000         68.00           71.00         OT100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.000000         71.00           72.00         07200         IMPL.         DEV. CHARGED TO PATIENTS         0.000000         71.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         73.00         73.00           01000         09100         EMERGENCY         0.000000         90.00         91.00           91.00         09200         OBSERVATION BEDS (NON-DI STINCT PART)         0.000000         92.00         92.00           021.00         OHERGENCY         0.000000         92.00         9					43	3.00
53.00       05300       ANESTHESI OLOGY       0.000000       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       54.00         60.00       LABORATORY       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       65.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       72.00         72.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       73.00         001704TI ENT SERVICE COST CENTERS       0.000000       73.00       72.00         0100       09100       EMERGENCY       0.000000       91.00         91.00       09100       BERGENCY       0.000000       91.00         92.00       09500       AMBULANCE SERVICES       0.000000       92.00         01100       09500       AMBULANCE SERVICES       0.000000       95.00         0201.00       Less Observati on Beds       0.000000 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
54.00         05400         RADIOLOGY-DIAGNOSTIC         0.000000         54.00           60.00         06000         LABORATORY         0.000000         60.00           65.00         06500         RESPIRATORY THERAPY         0.000000         65.00           66.00         06600         PHYSICAL THERAPY         0.000000         66.00           68.00         064800         SPEECH PATHOLOGY         0.000000         66.00           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 PATIENT         0.000000         73.00         73.00           010TPATIENT SERVICE COST CENTERS         0.000000         73.00         09100         EMERGENCY         0.000000         88.00           91.00         09100         EMERGENCY         0.000000         91.00         91.00           92.00         095ERVATION BEDS (NON-DISTINCT PART)         0.000000         91.00         92.00           92.00         095ERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00         95.00           09500         AMBULANCE SERVIC						
60.00       06000       LABORATORY       0.000000       60.00         65.00       06500       RESPIRATORY THERAPY       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         71.00       07100       MEDI CAL 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         0UTPATIENT SERVICE COST CENTERS       0.000000       73.00       73.00         008800       RURAL HEALTH CLINIC       88.00       88.01         91.00       09100       EMERGENCY       0.000000       91.00         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       0.000000       91.00         95.00       09500       AMBULANCE SERVICES       0.000000       95.00         000000       Subtotal (see instructions)       0.000000       95.00       200.00         201.00       Less Observation Beds       0.000000       201.00       201.00						
65.00       06500       RESPIRATORY THERAPY       0.000000       65.00         66.00       06600       PHYSICAL THERAPY       0.000000       66.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         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       DTAGES CHARGED TO PATIENTS       0.000000       73.00         0UTPATIENT SERVICE COST CENTERS       0.000000       88.00         88.00       08800       RURAL HEALTH CLINIC       88.01         91.00       09200       OBSERVATION BEDS (NON-DI STINCT PART)       0.000000       91.00         92.00       OPSEOR AMBULANCE SERVICES       0.000000       95.00       95.00       95.00         00500       AMBULANCE SERVICES       0.000000       95.00       200.00       201.00						
66.00       06600       PHYSICAL THERAPY       0.00000       66.00         68.00       06800       SPECH PATHOLOGY       0.000000       68.00         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 PATIENT       0.000000       72.00         001TPATIENT SERVICE COST CENTERS       0.000000       73.00         88.00       08800       RURAL HEALTH CLINIC       88.00         88.01       08801       RURAL HEALTH CLINIC 11       88.01         91.00       09100       EMERGENCY       0.000000       91.00         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       0.000000       92.00         0THER REIMBURSABLE COST CENTERS       0.000000       95.00       95.00         00500       AMBULANCE SERVICES       0.000000       95.00       95.00         200.00       Subtotal (see instructions)       0.000000       95.00       95.00         201.00       Less Observation Beds       0.000000       201.00       201.00						
68.00       06800       SPECH PATHOLOGY       0.00000       68.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.000000       71.00         72.00       07300       DRUGS CHARGED TO PATIENT       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENT       0.000000       72.00         0UTPATIENT SERVICE COST CENTERS       0.000000       73.00						
71.00       07100       MEDI CAL 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         0UTPATIENT SERVICE COST CENTERS       0.000000       73.00         88.00       08800       RURAL HEALTH CLINIC       88.00         88.01       08801       RURAL HEALTH CLINIC TI       88.01         91.00       09100       EMERGENCY       0.000000       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.000000       91.00         95.00       09500       AMBULANCE SERVICES       0.000000       95.00         00000       Subtotal (see instructions)       0.000000       95.00       200.00         201.00       Less Observation Beds       0.000000       201.00       201.00		0. 000000				
72.00         07200         IMPL. DEV. CHARGED TO PATIENT         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         73.00           0UTPATIENT SERVICE COST CENTERS         88.00         08800         RURAL HEALTH CLINIC         88.00           88.01         08801         RURAL HEALTH CLINIC II         88.01         91.00         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.000000         91.00           95.00         09500         AMBULANCE SERVICES         0.000000         95.00           200.00         Subtotal (see instructions)         0.000000         95.00         200.00           201.00         Less Observation Beds         0.000000         201.00         201.00	68.00 06800 SPEECH PATHOLOGY	0. 000000			68	8.00
73.00         07300         DRUGS CHARGED TO PATIENTS         0.00000         73.00           0UTPATIENT SERVICE COST CENTERS         00000         88.00         08800         RURAL HEALTH CLINIC         88.00         88.01           88.01         08801         RURAL HEALTH CLINIC II         88.01         91.00         91.00         91.00         92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0.000000         91.00         91.00         91.00         92.00         95.00 <td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td> <td>0. 000000</td> <td></td> <td></td> <td>7'</td> <td>1.00</td>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			7'	1.00
OUTPATIENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         88.00           88.01         08801         RURAL HEALTH CLINIC         88.00           91.00         09100         EMERGENCY         0.000000         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           07HER REIMBURSABLE COST CENTERS         95.00         9500         AMBULANCE SERVICES         0.000000           200.00         Subtotal (see instructions)         200.00         201.00         201.00         201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72	2.00
88.00         08800         RURAL HEALTH CLINIC         88.00           88.01         08801         RURAL HEALTH CLINIC II         88.01           91.00         09100         EMERGENCY         0.000000         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           0THER REIMBURSABLE COST CENTERS         0.000000         95.00         95.00         0.000000         95.00           200.00         Subtotal (see instructions)         0.000000         201.00         201.00         201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			7:	3.00
88.01         08801         RURAL HEALTH CLINICII         88.01           91.00         09100         EMERGENCY         0.000000           92.00         09SERVATION BEDS (NON-DISTINCT PART)         0.000000           0THER         REIMBURSABLE COST CENTERS         95.00           95.00         09500         AMBULANCE SERVICES         0.000000           200.00         Subtotal (see instructions)         200.00         201.00	OUTPATIENT SERVICE COST CENTERS					
91.00         09100         EMERGENCY         0.00000         91.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           0THER         REIMBURSABLE COST CENTERS         0.000000         95.00           95.00         09500         AMBULANCE SERVICES         0.000000         95.00           200.00         Subtotal (see instructions)         200.00         201.00         201.00	88.00 08800 RURAL HEALTH CLINIC				88	8.00
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           0THER         REIMBURSABLE COST CENTERS         0.000000         95.00           95.00         09500         AMBULANCE SERVICES         0.000000         95.00           200.00         Subtotal (see instructions)         200.00         201.00         201.00	88.01 08801 RURAL HEALTH CLINIC II				88	8. 01
OTHER REI MBURSABLE COST CENTERS         95. 00       09500         AMBULANCE SERVICES       0.000000         200. 00       Subtotal (see instructions)         201. 00       Less Observation Beds	91. 00 09100 EMERGENCY	0. 000000			9'	1.00
95. 00         09500         AMBULANCE SERVICES         0.000000         95. 00           200. 00         Subtotal (see instructions)         200. 00         200. 00         201. 00         2	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92	2.00
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00						
201.00 Less Observation Beds 201.00	95. 00 09500 AMBULANCE SERVICES	0.000000				
202.00   Total (see instructions)   202.00	201.00 Less Observation Beds				20	1.00
	202.00  Total (see instructions)				202	2.00

Heal th Financial	Systems			
COMPLITATION OF R	ATLO OF	COSTS	TO	CHAR

COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 07/01/2015 To 06/30/2016		
		_	Tit	le XIX	Hospi tal	Cost	-
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,		Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	PATIENT ROUTINE SERVICE COST CENTERS		1	1			
	000 ADULTS & PEDIATRICS	3, 088, 156		3, 088, 15		3, 088, 156	•
	300 NURSERY	0			0 0	0	43.00
	CILLARY SERVICE COST CENTERS						-
	000 OPERATING ROOM	1, 402, 919		1, 402, 91	9 0	1, 402, 919	
	300 ANESTHESI OLOGY	0			0 0	0	53.00
	400 RADI OLOGY-DI AGNOSTI C	1, 838, 112		1, 838, 11		1, 838, 112	•
		1, 608, 213		1, 608, 21		1, 608, 213	•
	500 RESPIRATORY THERAPY	147, 622		147, 62		147, 622	
	600 PHYSI CAL THERAPY	683, 985	0	683, 98	0 0	683, 985	
	800 SPEECH PATHOLOGY	102.020	0		0	0	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENT	183, 839 122, 895		183, 83 122, 89		183, 839 122, 895	•
	300 DRUGS CHARGED TO PATIENTS	922, 267				922, 267	
	TPATIENT SERVICE COST CENTERS	922, 207		922, 26	07 0	922, 207	/3.00
	800 RURAL HEALTH CLINIC	2, 613, 381		2, 613, 38	1 0	2, 613, 381	88.00
	801 RURAL HEALTH CLINIC II	2, 234, 117		2, 234, 11		2, 234, 117	
	100 EMERGENCY	3, 294, 221		3, 294, 22		3, 294, 221	•
	200 OBSERVATION BEDS (NON-DISTINCT PART)	661, 402		661, 40		661, 402	
	HER REIMBURSABLE COST CENTERS	001,102	1	001,10	· •	001, 102	1 2.00
	500 AMBULANCE SERVICES	1, 028, 450		1, 028, 45	0 0	1, 028, 450	95.00
200.00	Subtotal (see instructions)	19, 829, 579				19, 829, 579	
201.00	Less Observation Beds	661, 402		661, 40		661, 402	
202.00	Total (see instructions)	19, 168, 177					

COMPUTATIO	N OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Pre 11/22/2016 10	pared: 23 am
			Tit	le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	+ col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	ATIENT ROUTINE SERVICE COST CENTERS	11					
	00 ADULTS & PEDIATRICS	3, 611, 780		3, 611, 78	iO		30.00
	00 NURSERY	0		L	0		43.00
	I LLARY SERVICE COST CENTERS				r		4
	OO OPERATING ROOM	180, 226	4,037,490			0.00000	
	00 ANESTHESI OLOGY	0	0		0 0. 000000	0.000000	
	00 RADI OLOGY-DI AGNOSTI C	769, 215	15, 956, 049			0.00000	
	00 LABORATORY	1, 056, 114	11, 592, 648			0.00000	
	00 RESPI RATORY THERAPY	719, 079	724, 239			0.000000	
	00 PHYSI CAL THERAPY	413, 486	1, 331, 199	1, 744, 68		0.00000	
	00 SPEECH PATHOLOGY	0	0	1	0 0. 000000	0.000000	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	472, 059	822, 200			0.00000	•
	00 IMPL. DEV. CHARGED TO PATIENT	15, 829	355, 100			0.00000	
	DO DRUGS CHARGED TO PATIENTS	1, 460, 341	2,001,933	3, 462, 27	4 0. 266376	0.00000	73.00
	PATIENT SERVICE COST CENTERS	1 1			T		
	DO RURAL HEALTH CLINIC	0	2, 791, 097			0.000000	
	01 RURAL HEALTH CLINIC II	0	2, 447, 822			0.00000	
	DO EMERGENCY	253, 967	16, 525, 439			0.00000	
	00 OBSERVATION BEDS (NON-DISTINCT PART)	67,350	921, 546	988, 89	0. 668829	0.00000	92.00
	ER REIMBURSABLE COST CENTERS						
	00 AMBULANCE SERVI CES	0	1, 918, 282			0.000000	
200.00	Subtotal (see instructions)	9, 019, 446	61, 425, 044	70, 444, 49	0		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	9, 019, 446	61, 425, 044	70, 444, 49	'O		202.00

In Lieu of Form CMS-2552-10

near th Financial Systems 31.	. VINCENT WILLIAMS	SPURI HUSPITAL	III LIEU	U UI FUIII CM3-2	.552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151307	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prep 11/22/2016 10:	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
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
OUTPATIENT SERVICE COST CENTERS	· ·				
88.00 08800 RURAL HEALTH CLINIC	0. 000000				88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				88. 01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	· ·				
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
	1			'	

	VINCENT WILLIA	AMSPORT HOSPITA	AL .	In Lie	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	TIOS NET OF	Provi der		Peri od:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 07/01/2015 To 06/30/2016		nared
				10 00/ 30/ 2010	11/22/2016 10	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part			Reduction	
	I, col. 26)	II col. 26)		-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1 100 010	100 (07	1 000 01			
50. 00 05000 OPERATING ROOM	1, 402, 919	122, 607	1, 280, 31	12 0	-	50.00
53. 00 05300 ANESTHESI OLOGY	0	100.010	1 700 00	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 838, 112				0	54.00
	1, 608, 213				0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	147, 622				0	65.00 66.00
66. 00 06600 PHYSI CAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	683, 985	57, 959				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	183, 839	-		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	122, 895				0	72.00
73. 00 07200 TMPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS	922, 267					73.00
OUTPATIENT SERVICE COST CENTERS	922, 207	27,207	072, 71	0 0	0	73.00
88. 00 08800 RURAL HEALTH CLINIC	2, 613, 381	130, 182	2, 483, 19	99 0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II	2, 234, 117				0	88.01
91. 00 09100 EMERGENCY	3, 294, 221				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	661, 402				-	92.00
OTHER REIMBURSABLE COST CENTERS						
95, 00 09500 AMBULANCE SERVICES	1,028,450	82, 279	946, 17	71 0	0	95.00
200.00 Subtotal (sum of lines 50 thru 199)	16, 741, 423				0	200.00
201.00 Less Observation Beds	661, 402					201.00
202.00 Total (line 200 minus line 201)	16, 080, 021	932, 243	15, 147, 77	78 0	0	202.00
			-			

	VINCENT WILLI	AMSPORT HOSPITA	\L	In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provi der	CCN: 151307	Period:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 07/01/2015 To 06/30/2016		narod
				10 00/ 30/ 2010	11/22/2016 10	): 23 am
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Total Charges				
		(Worksheet C,				
	Operating Cost			6		
	Reduction	8)	/ col. 7)	_		
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS	1 100 010		0.000/			
50. 00 05000 OPERATING ROOM	1, 402, 919	4, 217, 716				50.00
53. 00 05300 ANESTHESI OLOGY	0		0.0000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 838, 112					54.00
	1, 608, 213					60.00
65. 00 06500 RESPI RATORY THERAPY	147, 622					65.00
66.00 06600 PHYSI CAL THERAPY	683, 985					66.00
68.00 06800 SPEECH PATHOLOGY	0		010000			68.00 71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	183, 839					72.00
72.00 07200 TMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	122, 895 922, 267					73.00
OUTPATIENT SERVICE COST CENTERS	922, 207	3, 462, 274	0.2003	/0		/3.00
88.00 08800 RURAL HEALTH CLINIC	2, 613, 381	2, 791, 097	0. 9363	00		88.00
88. 01 08801 RURAL HEALTH CLINIC II	2, 013, 381					88.00
91. 00 09100 EMERGENCY	3, 294, 221					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	661, 402					92.00
OTHER REIMBURSABLE COST CENTERS	001,402	900, 090	0.0000	- 7		72.00
95. 00 09500 AMBULANCE SERVICES	1, 028, 450	1, 918, 282	0. 5361	31		95.00
200.00 Subtotal (sum of lines 50 thru 199)	16, 741, 423					200.00
201.00 Less Observation Beds	661, 402					200.00
202.00 Total (line 200 minus line 201)	16, 080, 021					202.00
			1	1		1

Health Financial Systems         ST. VINCENT WILLIAMSPORT HOSPITAL         In Lieu						2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS			Period: From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 10	pared: :23 am
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1	1	-	- F		
50.00 05000 OPERATING ROOM	122, 607	4, 217, 716	0. 02907	0 142, 595	4, 145	
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	108, 818	16, 725, 264	0.00650	399, 460	2, 599	54.00
60. 00 06000 LABORATORY	71, 682	12, 648, 762	0.00566	699, 718	3, 965	60.00
65. 00 06500 RESPI RATORY THERAPY	22, 298	1, 443, 318	0. 01544	9 548, 420	8, 473	65.00
66. 00 06600 PHYSI CAL THERAPY	57, 959	1, 744, 685	0. 03322	155, 431	5, 163	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 241	1, 294, 259	0. 01177	6 276, 272	3, 253	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2,627	370, 929	0. 00708	14, 471	102	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	29, 289	3, 462, 274	0. 00845	i9 782, 737	6, 621	73.00
OUTPATIENT SERVICE COST CENTERS			·			1
88.00 08800 RURAL HEALTH CLINIC	130, 182	2, 791, 097	0. 04664	2 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	153, 655	2, 447, 822	0.06277	2 0	0	88. 01
91.00 09100 EMERGENCY	135, 606	16, 779, 406	0. 00808	783	6	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	43, 782	988, 896	0.04427	4 1, 300	58	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	893, 746	64, 914, 428		3, 021, 187	34, 385	200. 00

Health Financial Systems	ST.	VINCENT WILLIA	AMSPORT HOSPI	AL	In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	NT ANCILLARY SEF	RVICE OTHER PAS	S Provi der	- CCN: 151307	Peri od:	Worksheet D	
THROUGH COSTS					From 07/01/2015		
					To 06/30/2016	Date/Time Pre 11/22/2016 10	
			Tit	le XVIII	Hospi tal	Cost	. 20 um
Cost Center Description		Non Physician	Nursing Schoo	I Allied Heal	th All Other	Total Cost	
		Anestheti st	-		Medi cal	(sum of col 1	
		Cost			Education Cost	t through col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTER	S						
50.00 05000 OPERATING ROOM		0		0	0 (	0 0	50.00
53. 00 05300 ANESTHESI OLOGY		0		0	0 (	0 0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0		0	0 (	0 0	54.00
60. 00 06000 LABORATORY		0		0	0 (	0 0	60.00
65. 00 06500 RESPI RATORY THERAPY		0		0	0 (	0 0	65.00
66. 00 06600 PHYSI CAL THERAPY		0		0	0 (	0 0	66.00
68.00 06800 SPEECH PATHOLOGY		0		0	0 (	0 0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGE	D TO PATIENTS	0		0	0 (	0 0	71.00
72.00 07200 I MPL. DEV. CHARGED TO P.	ATI ENT	0		0	0 (	0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIEN	ΓS	0		0	0 (	0 0	73.00
OUTPATIENT SERVICE COST CENTE	RS		_				
88.00 08800 RURAL HEALTH CLINIC		0		0	0 (	0 0	88.00
88.01 08801 RURAL HEALTH CLINIC II		0		0	0 (	0 0	88.01
91.00 09100 EMERGENCY		0		0	0 (	0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-D	STINCT PART)	0		0	0 (	0 0	92.00
OTHER REIMBURSABLE COST CENTE	RS						
95.00 09500 AMBULANCE SERVICES							95.00
200.00   Total (lines 50-199)		0		0	0 0	0 0	200. 00

Health Financia	al Systems	ST. VINCENT WILLI	AMSPORT HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT	OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PAS	S Provi der		Period:	Worksheet D	
THROUGH COSTS					From 07/01/2015		
					To 06/30/2016	Date/Time Pre 11/22/2016 10	
			Ti †I	e XVIII	Hospi tal	Cost	. 20 am
Со	st Center Description	Total	Total Charges			I npati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col	to Charges	Charges	
		col. 2, 3 and		7)	(col. 6 ÷ col.	Ũ	
		4)			7)		
		6.00	7.00	8.00	9.00	10.00	
	RY SERVICE COST CENTERS			-			
	ERATING ROOM	0	4, 217, 716				1
53.00 05300 AN	ESTHESI OLOGY	0	0	0. 00000	0. 000000	0	53.00
54.00 05400 RA	DI OLOGY-DI AGNOSTI C	0	16, 725, 264	0.00000	0. 000000	399, 460	54.00
60.00 06000 LA	BORATORY	0	12, 648, 762	0. 00000	0. 000000	699, 718	60.00
65.00 06500 RE	SPI RATORY THERAPY	0	1, 443, 318	0. 00000	0. 000000	548, 420	65.00
66.00 06600 PH	YSI CAL THERAPY	0	1, 744, 685	0. 00000	0. 000000	155, 431	66.00
68.00 06800 SP	EECH PATHOLOGY	0	0	0. 00000	0. 000000	0	68.00
71.00 07100 ME	DICAL SUPPLIES CHARGED TO PATIENT	S O	1, 294, 259	0.00000	0. 000000	276, 272	71.00
72.00 07200 IM	PL. DEV. CHARGED TO PATIENT	0	370, 929	0.00000	0. 000000	14, 471	72.00
73.00 07300 DR	UGS CHARGED TO PATIENTS	0	3, 462, 274	0.00000	0. 000000	782, 737	73.00
OUTPATI E	ENT SERVICE COST CENTERS			_	_		
88.00 08800 RU	RAL HEALTH CLINIC	0	2, 791, 097	0.00000	0. 000000	0	88.00
88.01 08801 RU	RAL HEALTH CLINIC II	0	2, 447, 822	0. 00000	0. 000000	0	88.01
91.00 09100 EM	ERGENCY	0	16, 779, 406	0.00000	0. 000000	783	91.00
92.00 09200 OB	SERVATION BEDS (NON-DISTINCT PART	) 0	988, 896	0.00000	0.00000	1, 300	92.00
OTHER RE	IMBURSABLE COST CENTERS			_			
95.00 09500 AM	BULANCE SERVICES						95.00
200. 00 To	tal (lines 50-199)	0	64, 914, 428	3		3, 021, 187	200. 00

Health Financial Systems ST.	VINCENT WILLIAMSPORT HOSPITAL		AL	In Lie	u of Form CMS-2552-	-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der	CCN: 151307	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2015		-1
				To 06/30/2016	Date/Time Prepared 11/22/2016 10:23 a	u: am
		Ti tl	e XVIII	Hospi tal	Cost	<u></u>
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS	-			<b>F</b>		
50.00 05000 OPERATI NG ROOM	0	C		0	50.0	
53. 00 05300 ANESTHESI OLOGY	0	C		0	53.0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C	D	0	54.0	
60. 00 06000 LABORATORY	0	C	D	0	60.0	
65. 00 06500 RESPI RATORY THERAPY	0	C	D	0	65.0	
66. 00 06600 PHYSI CAL THERAPY	0	C		0	66. (	
68.00 06800 SPEECH PATHOLOGY	0	C	D	0	68.0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0	71.0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0	72.0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0	73. 0	00
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 RURAL HEALTH CLINIC	0	C		0	88. 0	
88.01 08801 RURAL HEALTH CLINIC II	0	C		0	88. 0	
91. 00 09100 EMERGENCY	0	C		0	91.0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	)	0	92.0	00
OTHER REI MBURSABLE COST CENTERS	· · · · · ·		1			
95. 00 09500 AMBULANCE SERVICES					95.0	
200.00  Total (lines 50-199)	0	C	)	0	200. 0	00

Health Financial Systems ST.	VINCENT WILLI	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 07/01/2015 To 06/30/2016		
		Ti tl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0. 332625		1, 477, 83	6 0	0	00.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 109900	0	5, 285, 37	2 0	0	54.00
60. 00 06000 LABORATORY	0. 127144	. 0	5, 327, 64	8 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 102280	0	625, 40	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 392039	0	571, 84	0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 142042	0	351, 06	3 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 331317	0	150, 83	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 266376	0	682, 81	9 52, 699	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0. 000000	)			0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	88.01
91.00 09100 EMERGENCY	0. 196325	0	4, 338, 37	4 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 668829	0	465, 09	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	0. 536131			0		95.00
200.00 Subtotal (see instructions)		0	19, 276, 27	2 52, 699	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	19, 276, 27	2 52, 699	0	202.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	L	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 151307	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Pre 11/22/2016 10	
		Title	e XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	491, 565					50.00
53. 00 05300 ANESTHESI OLOGY	0	-				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	580, 862					54.00
60. 00 06000 LABORATORY	677, 378					60.00
65. 00 06500 RESPI RATORY THERAPY	63, 966					65.00
66. 00 06600 PHYSI CAL THERAPY	224, 184	0				66.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	49, 866					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	49, 973					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	181, 887	14, 038				73.00
OUTPATIENT SERVICE COST CENTERS	1	1				
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0				88. 01
91.00 09100 EMERGENCY	851, 731					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	311,066	0				92.00
OTHER REIMBURSABLE COST CENTERS	1	1				_
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	3, 482, 478	14, 038				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	3, 482, 478	14, 038				202.00

Health Financial Systems ST.	VINCENT WILLI	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST			Period: From 07/01/2015 Fo 06/30/2016		norodi
		Component	L CCN: 15Z307	10 06/30/2016	11/22/2016 10	
		Ti tl	e XVIII S	wing Beds - SNF		<u> </u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.000/05		1			
50. 00 05000 OPERATING ROOM	0. 332625			0	0	
53. 00 05300 ANESTHESI OLOGY	0.00000			0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 109900			0	0	
60. 00 06000 LABORATORY	0. 127144			0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 102280			0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 392039			0 0	0	00.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			0 0	0	00.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 142042			0 0	0	1 1 1 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 331317			0 0	0	1 2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 266376	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					-	
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	00.0.
91. 00 09100 EMERGENCY	0. 196325			0 0	0	1 1 1 0 0
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 668829	0	(	0 0	0	92.00
0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	0 52(121	1	1			
	0. 536131	0			0	95.00
200.00 Subtotal (see instructions)		0		0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program			(	0 0		201.00
Only Charges 202.00 Net Charges (line 200 +/- line 201)					^	202.00
202.00   INEL CHALVES (ITTHE 200 +/ - ITTHE 201)	I	1 0	1	ט וי	0	1202.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 151307	Period: From 07/01/2015	Worksheet D Part V	
		Component	CCN: 15Z307	To 06/30/2016	Date/Time Pre 11/22/2016 10	epared: ):23 am
		Ti tl	e XVIII	Swing Beds - SNF	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00  05400  RADI OLOGY-DI AGNOSTI C						54.00
60. 00 06000 LABORATORY		0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY		0				66.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS	-	-	1			
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0				88.01
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0					95.00
200.00 Subtotal (see instructions)	0	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	0	0				202.00

Health Financial Systems ST.	VINCENT WILLIAMSPORT HOSPITAL In Lieu of Form CMS				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 07/01/2015		
				To 06/30/2016	Date/Time Pre 11/22/2016 10	pared:
		т: +	le XIX	Hospi tal	Cost	<u>23 alli</u>
Cost Costos Decesistion	Carrital					
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capital	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col	•		
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	204, 421	36, 690	167, 73	2, 540	66.04	30.00
43.00 NURSERY	0			0 0	0.00	43.00
200.00 Total (lines 30-199)	204, 421		167, 73	2, 540		200.00
Cost Center Description	Inpati ent	Inpati ent				
·	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6,00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	29	1, 915				30.00
43. 00 NURSERY	27	1, 713				43.00
	1 20	1 015				1
200.00 Total (lines 30-199)	29	1, 915	1			200.00

Health Financial Systems ST.	VINCENT WILLI	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		CCN: 151307	Period: From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 10	pared: :23 am
			le XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		1	1			
50.00 O5000 OPERATING ROOM	122, 607	4, 217, 716			0	00.00
53. 00 05300 ANESTHESI OLOGY	0	C	0.0000		0	00.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	108, 818					
60. 00 06000 LABORATORY	71, 682					
65. 00 06500 RESPI RATORY THERAPY	22, 298					
66. 00 06600 PHYSI CAL THERAPY	57, 959	1, 744, 685			107	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 241		0.0117	6, 286	74	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 627	370, 929	0.00708	32 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	29, 289	3, 462, 274	0.00845	59 24, 831	210	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	130, 182	2, 791, 097	0. 04664	12 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	153, 655	2, 447, 822	0.0627	72 0	0	88.01
91.00 09100 EMERGENCY	135, 606	16, 779, 406	0.00808	32, 154	260	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	43, 782	988, 896	0.0442	74 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50-199)	893, 746	64, 914, 428		124, 175	1, 081	200.00

Health Financial Systems ST.	VINCENT WILLI	AMSPORT HOSPITA	4L	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provi der		Period: From 07/01/2015 To 06/30/2016	Date/Time Pre	pared:
		Tit	le XIX	Hospi tal	11/22/2016 10 Cost	<u>:23 am</u>
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cos	Swing-Bed Adjustment t Amount (see	Total Costs (sum of cols. 1 through 3,	
	1.00	2.00	3.00	instructions) 4.00	minus col. 4) 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	) C		0 0	0	30.00
43. 00 04300 NURSERY	0	) C	)	0	0	
200.00 Total (lines 30-199)	0	) C	)	0	0	200.00
Cost Center Description		Per Diem (col.	1 1	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	1	
INPATIENT ROUTINE SERVICE COST CENTERS	-	•				
30. 00 03000 ADULTS & PEDI ATRI CS	2, 540	0.00	2	9 0	1	30.00
43. 00 04300 NURSERY	0	0.00		0 0	i l	43.00
200.00   Total (lines 30-199)	2, 540		2	9 0	1	200.00

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider	CCN: 151307	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2015		nored.
				To 06/30/2016	Date/Time Pre 11/22/2016 10	·23 am
		Tit	le XIX	Hospi tal	Cost	20 4
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				- 1		
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88. 01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems ST	. VINCENT WILLI	AMSPORT HOSE	I TAL	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi d	er CCN: 151307	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2015		
				To 06/30/2016	Date/Time Pre 11/22/2016 10	
			Title XIX	Hospi tal	Cost	. 20 am
Cost Center Description	Total		es Ratio of Co		Inpati ent	
	Outpati ent	(from Wkst.				
	Cost (sum of	Part I, co			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	Ŭ	
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	4, 217,	0.000	0.00000	0	50.00
53. 00 05300 ANESTHESI OLOGY	0		0 0.0000			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	16, 725,	264 0.0000	0.00000	23, 945	54.00
60. 00 06000 LABORATORY	0	12, 648,	0. 0000	0.00000	25, 266	60.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 443,	0.000	0.00000	8, 469	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 744,	0.000	0.00000	3, 224	66.00
68.00 06800 SPEECH PATHOLOGY	0		0 0.0000	0.00000	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 294,	0.000	0.00000	6, 286	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	370,	0.000	0.00000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 462,	0.0000	0.00000	24, 831	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	2, 791,	0.000	0.00000	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	2,447,	322 0.0000	0.00000	0	88.01
91.00 09100 EMERGENCY	0	16, 779,	0.000	0.00000	32, 154	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	988,	396 0.0000	0.00000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50-199)	0	64, 914,	128		124, 175	200.00

Health Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL	In Lie	u of Form CMS-25	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der	CCN: 151307	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2015 To 06/30/2016		anad.
				To 06/30/2016	Date/Time Prepa 11/22/2016 10:2	areu: 23 am
·		Ti t	le XIX	Hospi tal	Cost	Lo un
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS				<b>F</b>		
50. 00 05000 OPERATI NG ROOM	0	C		0		50.00
53. 00 05300 ANESTHESI OLOGY	0	C		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
60. 00 06000 LABORATORY	0	C		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C		0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	C		0		88. 01
91. 00 09100 EMERGENCY	0	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00   Total (lines 50-199)	0	C		0	2	00.00

11/22/2016 10:23 am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20160630 \28950-16.mcrx

	Financial Systems ST. VINCENT WILLIAMS ATION OF INPATIENT OPERATING COST	Provi der CCN: 151307	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 10	
		Title XVIII	Hospi tal	Cost	. 23 6
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s. excluding newborn)		3, 106	1.
. 00 . 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day do not complete this line.	bed and newborn days)	rivate room days,	2, 540 0	2. 3.
. 00 . 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	1, 877 277	4. 5.
. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	277	6.
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	<sup>-</sup> 31 of the cost	6	7.
.00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	6	8.
. 00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	g swing-bed and	1, 384	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct	nly (including private i tions)	room days)	247	10.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, et	nly (including private i	room days) after	247	11.
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		te room days)	0	12
8. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar ye			0	13
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	
	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost		17
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18
0. 00	Medicaid rate for swing-bed NF services applicable to service: reporting period	s through December 31 of	f the cost	134.09	19
0. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	the cost	134.09	20
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December 5 x line 17)		ting period (line	3, 088, 156 0	
3. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23
1. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	805	24
5. 00	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting	g period (line 8	805	25
7.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		554, 275 2, 533, 881	26 27
8. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	narges)	0	28 29
0. 00	Semi -private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	ctions)	0.00	
	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 2, 533, 881	36 37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			007 50	
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			997. 59 1, 380, 665	
	Medically necessary private room cost applicable to the Progra			1, 360, 665	40
	Total Program general inpatient routine service cost (line 39	•		1, 380, 665	

Heal th	Financial Systems ST.	VINCENT WILLIAM	ISPORT HOSPI TA	L	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 07/01/2015		
					To 06/30/2016	11/22/2016 10	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Costlr	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
42.00	NUDSERV (title V & VIX only)	1.00	2.00	3.00	4.00 0 0	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		0	0.0		0	42.00
43.00 44.00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.00 44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00 47.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.00 47.00
47.00	Cost Center Description	<u> </u>				1.00	47.00
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1.00 550,885	48.00
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(se	ee instructio	ns)		1, 931, 550	49.00
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sum	of Parts I and	0	50.00
51,00	III) Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst D si	m of Parts II	0	51.00
	and IV)	5				_	
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-phy:	sician anesth	etist, and	0	52.00 53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	
55.00 56.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
57.00	Difference between adjusted inpatient operat	ing cost and tar	get amount (l	ine 56 minus	line 53)	0	57.00
58.00 59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	portina period e	ndina 1996, u	pdated and co	mpounded by the	0.00	58.00 59.00
	market basket	01	Ū I				
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60.00 61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	ber 31 of the	cost reporti	ng period (See	246, 405	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reporting	period (See	246, 405	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	492, 810	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through I	December 31 o	f the cost re	porting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost reno	rting period	0	68.00
	(line 13 x line 20)				ting period		
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU	· · · ·		· ·		0	69.00
70.00 71.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	ity/ICF/IID rout	ine service c	ost (line 37)			70.00
72.00	Program routine service cost (line 9 x line		ne /o ÷ i i ne .	2)			72.00
73.00 74.00	Medically necessary private room cost applic. Total Program general inpatient routine serv			ne 35)			73.00 74.00
75.00	Capital-related cost allocated to inpatient			orksheet B, Pa	art II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ li						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.00
79.00	Aggregate charges to beneficiaries for exces	s costs (from pro		· · ·			79.00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		st limitation	(line 78 min	us line 79)		80.00 81.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82.00
83.00 84.00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		)				83.00 84.00
85.00	Utilization review - physician compensation	(see instruction					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ough 85)				86.00
87.00	Total observation bed days (see instructions	)				663	1
88.00 89.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		line 2)			997.59 661,402	1
		/				, , , , , , , , , , , , , , , , , , , ,	•

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 10	pared: 23 am
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	204, 421	3, 088, 156	0.06619	5 661, 402	43, 782	90.00
91.00 Nursing School cost	0	3, 088, 156	0.00000	0 661, 402	0	91.00
92.00 Allied health cost	0	3, 088, 156	0.00000	0 661, 402	0	92.00
93.00 All other Medical Education	0	3, 088, 156	0.00000	0 661, 402	0	93.00

ST.	VI NCENT	WI LLI AMSPORT	HOSPI TAL

	Financial Systems ST. VINCENT WILLIAMSPO ATION OF INPATIENT OPERATING COST	ORT HOSPITAL Provider CCN: 151307	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2015 To 06/30/2016	Date/Time Prep 11/22/2016 10:	
	· · · · · · · · · · · · · · · · · · ·	Title XIX	Hospi tal	Cost	. 25 ai
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		3, 106	1. C
2.00 3.00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days do not complete this line.		rivate room days,	2, 540 0	2. C 3. C
. 00 . 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	1, 877 277	4. ( 5. (
. 00	reporting period Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	277	6. (
. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	6	7.0
3. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	6	8. (
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	g swing-bed and	29	9. (
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi	ons)	5.	0	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent	er 0 on this line)		0	
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		5.	0	
	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program	ar, enter O on this lin	ne)	0	
	Total nursery days (title V or XIX only)	r (excluding swing-bed	uays)	0	
6. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.
7.00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 d	of the cost		17.
8. 00	reporting period Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost		18.
9. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	f the cost	134.09	19.
0. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	the cost	134.09	20.
1. 00 2. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 5 x line 17)		ing period (line	3, 088, 156 0	
3. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reportin	ng period (line 6	0	23.
4.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	805	24.
	Swing-bed cost applicable to NF type services after December 31 x line 20) $$	of the cost reporting	g period (line 8		25.
6. 00 7. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		554, 275 2, 533, 881	26. 27.
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	narges)	0	28. 29.
	Semi -private room charges (excluding swing bed charges)			0	30.
1.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
	Average per diem private room charge differential (line 32 minu	ıs line 33)(see instruc	ctions)	0.00	
5.00	Average per diem private room cost differential (line 34 x line		-	0.00	35.
5.00	Private room cost differential adjustment (line 3 x line 35)	d privato room cost di	fforontial (line	0 2 522 991	36.
7.00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	u private room cost di	rierential (IThe	2, 533, 881	37.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
	Adjusted general inpatient routine service cost per diem (see i	-		997.59	
9.00 0.00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	-		28, 930 0	39. 40.
U. UU	Imedicarly necessary private room cost appricable to the Program	i (iiiie i4 X iiiie 35)		0	40.

	h Financial Systems ST. VINCENT WILLIAMSPORT HOSPI TATION OF INPATIENT OPERATING COST Provide	r CCN: 151307	Period:	u of Form CMS-: Worksheet D-1	
			From 07/01/2015		
			To 06/30/2016	Date/Time Pre 11/22/2016 10	
		tle XIX	Hospi tal	Cost	
	Cost Center Description Total Total Total Inpatient Cost Inpatient Day	Average Per		Program Cost (col. 3 x col.	
		col . 2)		4)	
	1.00 2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)     0       Intensive Care Type Inpatient Hospital Units	0 0.	00 0	0	42.00
43.00					43.00
44.00	CORONARY CARE UNI T				44.00
45.00					45.00
46.00 47.00					46.00
17100	Cost Center Description				
40.00				1.00	10.00
48.00 49.00	5 1 5	ons)		21, 794 50, 724	
49.00	PASS THROUGH COST ADJUSTMENTS	0113)		50,724	47.00
50.00	Pass through costs applicable to Program inpatient routine services (fro	om Wkst. D, sur	m of Parts I and	0	50.00
51 00	III) Pass through costs applicable to Program inpatient ancillary services (1	From Wkst D	cum of Parts II	0	51 00
51.00	and IV)	IUM WKSL. D, S	Sull VI Faits II	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)			0	
53.00		nysician anestl	netist, and	0	53.00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION				
54.00				0	54.00
55.00	5 1 5			0.00	
56.00 57.00	5	line 56 minus	line 53)	0	
58.00			TTHE 55)	0	
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996,	updated and co	ompounded by the	0.00	59.00
40.00	market basket	markat backat		0.00	60.00
60.00 61.00			the amount by	0.00	
	which operating costs (line 53) are less than expected costs (lines 54 >				
42 00	amount (line 56), otherwise enter zero (see instructions)			0	62.00
62.00 63.00				0	
	PROGRAM INPATIENT ROUTINE SWING BED COST				
64.00		ne cost reporti	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the	cost reporting	n period (See	0	65.00
00.00	instructions)(title XVIII only)			0	
66.00	5 1	65)(title XVI	ll only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31	of the cost re	eporting period	0	67.00
07100	(line 12 x line 19)		opor tring por roa	0	
68.00	5 1	ີ the cost repo	orting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + lin	ne 68)		0	69.00
07100	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/III				
70.00	5 5 5		)		70.00
71.00 72.00	3 3 1	e 2)			71.00
73.00	5	ine 35)			73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73	3)			74.00
75.00		Worksheet B, I	Part II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00					77.00
78.00					78.00
79.00 80.00			nus line 79)		79.00
81.00	5				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00 84.00					83.00 84.00
84.00 85.00	5 1 5				84.00
86.00					86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				07.0
87.00				663 997.59	
88.00					

Health Financial Systems ST.	VINCENT WILLIA	AMSPORT HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 10	pared: :23 am
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	204, 421	3, 088, 156	0.06619	5 661, 402	43, 782	90.00
91.00 Nursing School cost	0	3, 088, 156	0.00000	0 661, 402	0	91.00
92.00 Allied health cost	0	3, 088, 156	0.00000	0 661, 402	0	92.00
93.00 All other Medical Education	0	3, 088, 156	0.00000	0 661, 402	0	93.00

Health Financial Systems	ST. VINCENT WILLIAMSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Period:	Worksheet D-3	
			From 07/01/2015 To 06/30/2016	Date/Time Pre	narodi
			10 00/30/2010	11/22/2016 10	
	Titl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1 005 004		
30. 00 03000 ADULTS & PEDI ATRI CS			1, 935, 326		30.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS		0.000/0	- 440 505	47.404	50.00
		0. 33262		47, 431	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 10990		43, 901	
		0. 12714			1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 10228 0. 39203		56, 092	1
				60, 935	
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	· C	0. 00000 0. 14204		0 39, 242	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	3	0. 14204		4, 794	1
73. 00 07300 DRUGS CHARGED TO PATIENT		0. 33131			
OUTPATIENT SERVICE COST CENTERS		0.20037	0 702,737	200, 302	/3.00
88.00 08800 RURAL HEALTH CLINIC		0.00000	n	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II		0.00000		0	
91. 00 09100 EMERGENCY		0. 19632		154	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	)	0. 66882			
OTHER REIMBURSABLE COST CENTERS	/	0.00002	,	007	72.00
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98	)		3, 021, 187	550, 885	
201.00 Less PBP Clinic Laboratory Services			0,021,107	000,000	201.00
202.00 Net Charges (line 200 minus line 20	5 5 5 5 7		3, 021, 187		202.00
	<i>,</i>	1	-, -= -, -0,	1	

Health Financial Systems	ST. VINCENT WILLIAMSPORT HOSP	I TAL	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIC	ONMENT Provi de		Period:	Worksheet D-3	
	Compon		From 07/01/2015 To 06/30/2016	Date/Time Pre	narod
	Compon	ent CON. 152507	10 00/30/2010	11/22/2016 10	
	Ti	tle XVIII S	wing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
INPATIENT ROUTINE SERVICE COST CEN		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	IIERS		0		30.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 33262	5 37, 631	12, 517	50.00
53.00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0.109900	74, 244	8, 159	54.00
60. 00 06000 LABORATORY		0. 12714	4 127, 953	16, 268	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 102280	0 144, 068	14, 735	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 39203		67, 788	
68.00 06800 SPEECH PATHOLOGY		0.00000	0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO I		0. 142042		11, 845	
72.00 07200 IMPL. DEV. CHARGED TO PATIEN	Т	0. 33131		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 266370	6 225, 086	59, 958	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	88.00
88.01 08801 RURAL HEALTH CLINIC II 91.00 09100 EMERGENCY		0.00000		0	88.01 91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTING		0. 19632		0	91.00
OTHER REIMBURSABLE COST CENTERS	CI PART)	0.00002	9 0	0	92.00
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and	d 96-98)		865, 284	191, 270	
	ervices-Program only charges (line 61		000, 204		200.00
202.00 Net Charges (line 200 minus l			865, 284		202.00
	/	I		I	

Health Financial Systems ST. V	INCENT WILLIAMSPORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN:		eriod:	Worksheet D-3	
			rom 07/01/2015 0 06/30/2016	Date/Time Pre	nared
			0 00/ 30/ 2010	11/22/2016 10	
	Title X	I X	Hospi tal	Cost	
Cost Center Description		o of Cost	Inpati ent	Inpati ent	
	То	Charges		Program Costs	
			Charges	(col. 1 x col.	
		1 00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			46, 831		30.00
43. 00 04300 NURSERY			40,031		43.00
ANCI LLARY SERVICE COST CENTERS			<u> </u>		45.00
50. 00 05000 OPERATING ROOM		0. 332625	0	0	50.00
53. 00 05300 ANESTHESI OLOGY		0.000000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.109900	23, 945	2, 632	54.00
60. 00 06000 LABORATORY		0. 127144	25, 266	3, 212	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 102280	8, 469	866	65.00
66. 00 06600 PHYSI CAL THERAPY		0.392039	3, 224	1, 264	66.00
68.00 06800 SPEECH PATHOLOGY		0.000000		0	00.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.142042		893	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.331317		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 266376	24, 831	6, 614	73.00
OUTPATIENT SERVICE COST CENTERS		0.00/000			00.00
88.00 08800 RURAL HEALTH CLINIC 88.01 08801 RURAL HEALTH CLINIC II		0.936328 0.912696		0	00.00
91. 00 09100 EMERGENCY		0. 912696		6, 313	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 190325		0, 313	
OTHER REI MBURSABLE COST CENTERS		0.000027	<u> </u>	0	72.00
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98)			124, 175	21, 794	
201.00 Less PBP Clinic Laboratory Services-Progra	am only charges (line 61)		0	21,771	201.00
202.00 Net Charges (line 200 minus line 201)			124, 175		202.00
	l				

 
 Health Financial Systems
 ST. VINCENT WILLIAMSPORT HOSPITAL
 In Lieu of Form CMS-252-10

 CALCULATION OF REIMBURSEMENT SETTLEMENT
 Provider CCN: 151307
 Period: From 07/01/2015
 Worksheet E Part B

			From 07/01/2015 To 06/30/2016		
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	`		3, 496, 516	
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		0	
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 instructions)	ons)		0.000	•
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	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 3, 496, 516	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			3, 490, 510	1 11.00
	Reasonable charges				1
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	
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	ment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for pa			0	
	had such payment been made in accordance with 42 CFR §413.13(e)			-	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds l	ne 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)			0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	nstructions)		3, 531, 481	21.00
	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see instruct	ctions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			42, 431	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for (	CAH, see instructions	)	2, 768, 775	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu	us the sum of lines 2	2 and 23] (see	720, 275	27.00
20.00	instructions)	5. 50)		0	20.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line ESRD direct medical education costs (from Wkst. E-4, line 36)	9 50)		0	
30.00	Subtotal (sum of lines 27 through 29)			720, 275	
31.00	Primary payer payments			4	31.00
32.00	Subtotal (line 30 minus line 31)			720, 271	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)			
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
34.00 35.00	, ,			651, 841 423, 697	1
	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		426, 497	
	Subtotal (see instructions)	,		1, 143, 968	
38.00				0	•
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	d dovices (see instru	ations)	0	39.50
39. 98 39. 99	Partial or full credits received from manufacturers for replaced RECOVERY OF ACCELERATED DEPRECIATION		. (1 0115)	0	39.98 39.99
40.00	Subtotal (see instructions)			1, 143, 968	•
40.01	Sequestration adjustment (see instructions)			22, 879	1
41.00	Interim payments			1, 409, 887	41.00
42.00	Tentative settlement (for contractors use only)			0	•
43.00	Balance due provider/program (see instructions)		-h	-288, 798	1
44.00	Protested amounts (nonallowable cost report items) in accordance \$115.2	e with two Pub. 15-2,	chapter I,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	•
	5				92.00
93.00	Time Value of Money (see instructions)				93.00
	Total (sum of lines 91 and 93)			^	94.00

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151307	Period: From 07/01/2015 To 06/30/2016		parec 23 a
		Ti tl	e XVIII	Hospi tal	Cost	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 414, 2	66 0	1, 409, 887 0	1.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER	01/08/2016	70, 0	00	0	3.
02				0	0	3.
03				0	0	3.
04 05				0	0	3. 3.
55	Provider to Program			0	0	3
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		70, 0	00	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 484, 2	66	1, 409, 887	4
_	TO BE COMPLETED BY CONTRACTOR	1				_
0	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5
)1	TENTATI VE TO PROVIDER		[	0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program	1				
50	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0	5 5
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
)0	5.50-5.98) Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
)1	SETTLEMENT TO PROVIDER		49, 7		0	6
)2 )0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		1, 533, 9	0 67	288, 798 1, 121, 089	6
.0			1, 555, 9	Contractor	NPR Date	/
				Number	(Mo/Day/Yr)	
			)	1.00	2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			eriod: rom 07/01/2015 o 06/30/2016	Date/Time Pre	pared
					11/22/2016 10	:23 a
			e XVIII Sw t Part A	ving Beds - SNF	Cost	1
		Inpatren	I PARLA	Par	ιв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		635, 182		0	
00	Interim payments payable on individual bills, either		0		0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	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					
01	ADJUSTMENTS TO PROVIDER	01/08/2016	31, 600		0	3.
02		01/00/2010	0		0	
03			0		0	
04			0		0	
05			0		0	3.
- 0	Provider to Program	1		1	0	
50 51	ADJUSTMENTS TO PROGRAM		0		0	
52			0		0	
53			0		0	
54			0		0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		31, 600		0	3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		666, 782		0	4.
00	(transfer to Wkst. E or Wkst. E-3, line and column as		000, 782		0	4.
	appropri ate)					
	TO BE COMPLÉTED BY CONTRACTOR					]
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	1				1
01	TENTATI VE TO PROVI DER		0		0	5
02			0		0	
)3			0		0	5
-0	Provider to Program TENTATIVE TO PROGRAM		0		0	5
50 51	IENTATIVE TO PROGRAM		0		0	
52			0		0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines		0		0	
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6.
01	the cost report. (1) SETTLEMENT TO PROVIDER		7, 689		0	6.
01	SETTLEMENT TO PROVIDER		7, 089		0	
02	Total Medicare program liability (see instructions)		674, 471		0	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	Name of Contractor	(	)	1.00	2.00	8.

Heal th	Financial Systems ST. VINCENT WILLIAMSPO	ORT HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151307	Peri od:	Worksheet E-2	
			From 07/01/2015		
		Component CCN: 15Z307	To 06/30/2016	Date/Time Pre 11/22/2016 10	
		Title XVIII	Swing Beds - SNF		. 25 am
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		497, 738	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		193, 183	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst				
4.00	Per diem cost for interns and residents not in approved teachin	g program (see		0.00	4.00
F 00	instructions)		101	0	F 00
5.00	Program days		494	0	5.00
6.00	Interns and residents not in approved teaching program (see ins			0	6.00
7.00	Utilization review - physician compensation - SNF optional meth	lod only	00,001	0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		690, 921	0	8.00
9.00	Primary payer payments (see instructions)		(00, 021	0	9.00 10.00
10.00	Subtotal (line 8 minus line 9)	hla ta nhuciaian	690, 921	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applica professional services)	ble to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)		690, 921	0	12.00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	2, 685	0	13.00
4.4.00	for physician professional services)			0	4.4.00
14.00	80% of Part B costs (line 12 x 80%)		(00.00)	0	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14	)	688, 236	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00 16.50
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	
16.55	410A RURAL DEMONSTRATION PROJECT		0	0	16.55
17.00 17.01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	17.00 17.01
17.01	Allowable bad debts for dual eligible beneficiaries (see instru	ations)	0	0	17.01
	Total (see instructions)	ctrons)	688, 236	0	18.00
19.00 19.01	Sequestration adjustment (see instructions)		13, 765	0	19.00
20,00	Interim payments		666, 782	0	20.00
20.00	Tentative settlement (for contractor use only)		000, 782	0	20.00
21.00	Balance due provider/program (line 19 minus lines 19.01, 20, an	d 21)	7,689	0	21.00
22.00	Protested amounts (nonallowable cost report items) in accordance		7,009	0	22.00
z3. 00	chapter 1, §115.2	e with GWS FUD. 13-2,	0	0	23.00
	1		1		

	Financial Systems ST. VINCENT WILL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151307	Peri od:	u of Form CMS-: Worksheet E-3	
ALCUL	ATTON OF REFINDORSEMENT SETTLEMENT	FIOVIDEI CCN. 151507	From 07/01/2015	Part V	
			To 06/30/2016	Date/Time Pre	
		T: 11 - M(111		11/22/2016 10	: 23
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDI	CARE PART A SERVICES - COST	REIMBURSEMENT		
00	Inpatient services			1, 931, 550	
00	Nursing and Allied Health Managed Care payment (see instr	ructions)		0	
00	Organ acqui si ti on			0	
00	Subtotal (sum of lines 1 through 3)			1, 931, 550	
00	Primary payer payments			0	5.
00	Total cost (line 4 less line 5). For CAH (see instruction	is)		1, 950, 866	6
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable charges				1 _
00	Routine service charges			0	
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
0. 00	Total reasonable charges			0	10
00	Customary charges	for an and for an iteration			1
	Aggregate amount actually collected from patients liable	1 5	9	0	
. 00	Amounts that would have been realized from patients liabl		n a charge basis	0	12
. 00	had such payment been made in accordance with 42 CFR 413. Ratio of line 11 to line 12 (not to exceed 1.000000)	13(e)		0. 000000	13
				0.00000	
. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complet	o only if line 14 exceeds li	no 6) (soo	0	1
5.00	instructions)	e only if the 14 exceeds if	lie 0) (See	0	10
5.00	Excess of reasonable cost over customary charges (complet	e only if line 6 exceeds lin	e 14) (see	0	16
. 00	instructions)		0 11) (300	0	'
7.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
3. 00	Direct graduate medical education payments (from Workshee	et E-4, line 49)		0	1 18
	Cost of covered services (sum of lines 6, 17 and 18)			1, 950, 866	19
0. 00	Deductibles (exclude professional component)			396, 144	20
. 00	Excess reasonable cost (from line 16)			0	21
. 00	Subtotal (line 19 minus line 20 and 21)			1, 554, 722	22
. 00	Coinsurance			8, 582	23
. 00	Subtotal (line 22 minus line 23)			1, 546, 140	24
	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		29, 434	25
. 00	Adjusted reimbursable bad debts (see instructions)	· · ·		19, 132	26
. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		5, 933	27
	Subtotal (sum of lines 24 and 25, or line 26)			1, 565, 272	28
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
. 50	Pioneer ACO demonstration payment adjustment (see instruc	ctions)		0	29
. 99	Recovery of Accel erated Depreciation			0	29
0. 00	Subtotal (see instructions)			1, 565, 272	30
0. 01	Sequestration adjustment (see instructions)			31, 305	30
. 00	Interim payments			1, 484, 266	31
2.00	Tentative settlement (for contractor use only)			0	32
3. 00	Balance due provider/program (line 30 minus lines 30.01,	31, and 32)		49, 701	33
	Protested amounts (nonallowable cost report items) in acc			0	34

	Financial Systems ST. VINCENT WILLIAMSPOR ATION OF REIMBURSEMENT SETTLEMENT	RT HOSPITAL Provider CCN: 151307	In Lie Period:	u of Form CMS-2 Worksheet E-3	
CALCOL			From 07/01/2015 To 06/30/2016	Part VII Date/Time Pre	pared:
		Title XIX	Hospi tal	11/22/2016 10 Cost	:23 am
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR X	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		50, 724		1.00
1.00 2.00	Inpatient hospital/SNF/NF services Medical and other services		50, 724	0	
3.00	Organ acquisition (certified transplant centers only)		0	0	3.00
	Subtotal (sum of lines 1, 2 and 3)		50, 724	0	
5.00	Inpatient primary payer payments		0		5.00
	Outpatient primary payer payments			0	
	Subtotal (line 4 less sum of lines 5 and 6)		50, 724	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
	Routi ne servi ce charges		171,006		8.00
	Ancillary service charges		124, 175	0	
	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		0		11.00
	Total reasonable charges (sum of lines 8 through 11)		295, 181	0	12.00
	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for s	arvi cos on a charge	0	0	13.00
13.00	basis	services on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for p	avment for services o	n 0	0	14.00
	a charge basis had such payment been made in accordance with 42				
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.00000	
	Total customary charges (see instructions)		295, 181	0	
17.00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	If line 16 exceeds	244, 457	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	- 0	0	18.00
. 0. 00	16) (see instructions)			0	
	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instruc	-	0	0	
	Cost of covered services (enter the lesser of line 4 or line 16)		50, 724	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co Other than outlier payments	mpleted for PPS provid	oers.	0	22.00
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		50, 724	0	29.00
	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		50, 724	0	
32.00	Deducti bl es		0	0	32.00
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	50, 724	0	35.00 36.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		50, 724	0	
	Subtotal (line $36 \pm 1$ ine $37$ )		50, 724	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		50, 724	0	
	Interim payments		50, 724	0	
	Balance due provider/program (line 40 minus line 41)	with CMC Dub 15 0	0	0	
43.00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	WILLIUMS PUD 15-2,	0	0	43.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl		F	Period: From 07/01/2015 O 06/30/2016	Worksheet G Date/Time Pre	epare
		Company Frind			11/22/2016 10	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	34, 936, 330		0	C	) 1.
00	Temporary investments	0			C	
00	Notes receivable	0			C	
00	Accounts receivable	5, 815, 341	0		C	
00	Other receivable	158, 430	0	0 0	C	) 5
00	Allowances for uncollectible notes and accounts receivable	-3, 549, 501	(	0 0	C	
00	Inventory	276, 109		-	C	
00	Prepaid expenses	30, 963			C	
00	Other current assets	-376, 796			C	
. 00 . 00	Due from other funds Total current assets (sum of lines 1-10)	236, 671 37, 527, 547			C	
. 00	FIXED ASSETS	57, 527, 547			L. L.	4 ''
. 00	Land	174, 050		0	C	12
. 00	Land improvements	106, 181			C	
. 00	Accumulated depreciation	-94, 182			C	
. 00	Bui I di ngs	7, 874, 174			C	
. 00	Accumulated depreciation	-4, 455, 901	(		C	
. 00	Leasehold improvements	0			C	
. 00	Accumulated depreciation	1 202 7/0			C	
0. 00 0. 00	Fixed equipment Accumulated depreciation	1, 382, 769 -769, 704		-	C	
. 00	Automobiles and trucks	51, 450			C	
. 00	Accumulated depreciation	-51, 450			C	
. 00	Major movable equipment	3, 778, 759			C	
. 00	Accumulated depreciation	-3, 256, 189	0	0 0	C	24
. 00	Minor equipment depreciable	0	(	0 0	C	25
. 00	Accumulated depreciation	0	0		C	
. 00	HIT designated Assets	0	(		C	
. 00	Accumulated depreciation	0	(		C	
0. 00 0. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	4, 739, 957			C	
. 00	OTHER ASSETS	4, 737, 737			C.	1 30
. 00	Investments	251, 935	(	0	C	31
. 00	Deposits on Leases	0			C	
. 00	Due from owners/officers	0	0	0 0	C	33
. 00	Other assets	246, 674			C	
. 00	Total other assets (sum of lines 31-34)	498, 609			C	
. 00	Total assets (sum of lines 11, 30, and 35)	42, 766, 113	420, 296	0	C	<u>)</u> 36
~~~	CURRENT LI ABI LI TI ES	250, 10/				1
. 00	Accounts payable Salaries, wages, and fees payable	350, 186 1, 266, 355			C	
. 00	Payroll taxes payable	1, 200, 355			C	
	Notes and Loans payable (short term)	52, 235			C	
. 00	Deferred income	0		0	C	
. 00	Accelerated payments	0				42
. 00	Due to other funds	-119, 750	(	0 0	C	43
. 00	Other current liabilities	894, 615			C	
. 00	Total current liabilities (sum of lines 37 thru 44)	2, 443, 641	(	0 0	C	<u>)</u> 45
00	LONG TERM LIABILITIES	0				
00 . 00	Mortgage payable Notes payable	0		-	C	
. 00	Unsecured Loans	3, 932, 246			C	
. 00	Other long term liabilities	137, 560		-	C	
. 00	Total long term liabilities (sum of lines 46 thru 49)	4, 069, 806			C	
. 00	Total liabilities (sum of lines 45 and 50)	6, 513, 447		0	C	
	CAPI TAL ACCOUNTS					
00	General fund balance	36, 252, 666				52
. 00	Specific purpose fund		420, 296			53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00 . 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance					55
. 00	Plant fund balance - invested in plant			0	C	
. 00	Plant fund balance - reserve for plant improvement,				C	
	replacement, and expansion					
00	Total fund balances (sum of lines 52 thru 58)	36, 252, 666	420, 296	0	C	
0. 00 0. 00	Total liabilities and fund balances (sum of lines 51 and		420, 296		C	60

		VINCENT WILLIA				Lieu of Form CMS-	
STATEM	ENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 151307	Period: From 07/01/2 To 06/30/2		epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		38, 271, 647		420,	296	1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29)		2, 192, 291		420	204	2.00
3.00 4.00	Total (sum of line 1 and line 2)	0	40, 463, 938		420,	296	
5.00		0			0		
6.00		0			0		
7.00		0			0	C	
8.00		0			0	C	8.00
9.00		0			0	C	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		40, 463, 938		420,		11.00
12.00	DEFERRED PENSION COSTS	745, 208			0	C	
13.00 14.00	GRANT TRANSFER TO RP	2 466 064			0		
14.00	TRANSFER TO RP	3, 466, 064			0		
16.00		0			0		
17.00		0			0		
18.00	Total deductions (sum of lines 12-17)		4, 211, 272			0	18.00
19.00	Fund balance at end of period per balance		36, 252, 666		420,	296	19.00
	sheet (line 11 minus line 18)			<b>F</b> 1			
		Endowment Fund	Pl ant	Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	6.00 0	7.00	8.00	0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)	0	7.00	8.00	-		2.00
2.00 3.00	5 5 1			8.00	0		2.00 3.00
2.00 3.00 4.00	Net income (loss) (from Wkst. G-3, line 29)	0	7.00	8.00	-		2.00 3.00 4.00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 29)	0		8.00	-		2.00 3.00 4.00 5.00
2.00 3.00 4.00 5.00 6.00	Net income (loss) (from Wkst. G-3, line 29)	0		8.00	-		2.00 3.00 4.00 5.00 6.00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 29)	0		8.00	-		2.00 3.00 4.00 5.00
2.00 3.00 4.00 5.00 6.00 7.00	Net income (loss) (from Wkst. G-3, line 29)	0		8.00	-		2.00 3.00 4.00 5.00 6.00 7.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9)	0		8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00 \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0		8.00	0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) DEFERRED PENSION COSTS	0		8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00 \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) DEFERRED PENSION COSTS GRANT	0		8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) DEFERRED PENSION COSTS	0		8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) DEFERRED PENSION COSTS GRANT	0		8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) DEFERRED PENSION COSTS GRANT	0		8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) DEFERRED PENSION COSTS GRANT TRANSFER TO RP	0		8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) DEFERRED PENSION COSTS GRANT	0		8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00

	Financial Systems ST. VINCENT WILLIAM: IENT OF PATIENT REVENUES AND OPERATING EXPENSES		CCN: 151307	Per	i od:	u of Form CMS-2 Worksheet G-2	
					07/01/2015 06/30/2016	Parts I & II Date/Time Pre 11/22/2016 10	pared:
	Cost Center Description		I npati ent		Outpatient	Total	23 am
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		3, 854, 1	00		3, 854, 100	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE		0.054.4	~~		0.054.400	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		3, 854, 1	00		3, 854, 100	10.0
11 00	Intensive Care Type Inpatient Hospital Services						111 00
11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T						11.00
12.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00		lines		0		0	16.00
10.00	11-15)	111105		Ŭ		0	10.00
17.00		5)	3, 854, 1	00		3, 854, 100	17.00
18.00	Ancillary services	,	5, 053, 9		37, 027, 828	42,081,732	
19.00	Outpati ent servi ces			0	17, 757, 954	17, 757, 954	
20.00	RURAL HEALTH CLINIC			0	2, 791, 097	2, 791, 097	20.00
20.01	RURAL HEALTH CLINIC II			0	2, 447, 822	2, 447, 822	20.0
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES			0	1, 918, 282	1, 918, 282	23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00							26.00
27.00	DI ETARY			0	357	357	
27.01	ORTHO CLINIC			0	934, 823	934, 823	
27.02				0	0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	8, 908, 0	004	62, 878, 163	71, 786, 167	28.00
	G-3, line 1) PART II - OPERATING EXPENSES						-
29.00	Operating expenses (per Wkst. A, column 3, line 200)		1	- T	19, 414, 959		29.00
30.00	operating expenses (per wkst. A, corumn s, time 200)			0	19, 414, 939		30.00
31.00				0			31.0
32.00				0			32.0
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)			Ũ	0		36.00
37.00	DEDUCT (SPECIFY)			0	-		37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer			19, 414, 959		43.00
	to Wkst. G-3, line 4)		1				1

Health Financial Systems

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ST. VINCENT WILLIAMSPO	ORT HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEN	IENT OF REVENUES AND EXPENSES	Provider CCN: 151307	Peri od:	Worksheet G-3	
			From 07/01/2015		
			To 06/30/2016	Date/Time Pre	
			L .	11/22/2016 10	:23 am
1 00				1.00	1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			71, 786, 167	1.00
2.00	Less contractual allowances and discounts on patients' accounts	5		49, 685, 498	2.00
3.00	Net patient revenues (line 1 minus line 2)			22, 100, 669	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		19, 414, 959	4.00
5.00	Net income from service to patients (line 3 minus line 4)			2, 685, 710	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			170, 765	7.00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
14.00				0	
	Revenue from rental of living quarters				15.00
16.00	Revenue from sale of medical and surgical supplies to other that	in patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			7, 245	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	AMBULANCE SUBSI DY			302, 001	24.00
24.01	CREDENTIALING			5, 800	24.01
24.02	CLINICAL INCENTIVE			39, 200	24.02
24.03	RENTAL INCOME - ENT CLINIC			36, 289	24.03
24.04	OTHER MISC INCOME			112	24.04
24.05	OTHER MI SC PHARMACY			52	24.05
24.06	OTHER MISC - ORTHO CLINIC			902	24.06
24.07	OTHER MISC FOOD SVCS			6, 774	24.07
24.08	OTHER MISC - RADIOLOGY			49	24.08
24.09	OTHER MI SC - NORTH			52	24.09
24.10	OTHER MISC - SOUTH			22, 969	24.10
24.10	OTHER MISC ER			22, 707	24.10
24.11	OTHER MISC - PT			21, 210	
24.12	OTHER MISC - PT				
				59, 918	
24.14	OTHER PLANT MAINT			100	24.14
24.15				0	24.15
25.00	Total other income (sum of lines 6-24)			673, 463	25.00
26.00	Total (line 5 plus line 25)			3, 359, 173	26.00
27.00	OTHER MISC - TRANS & STATS			0	27.00
27.01	UNREALIZED INV LOSS			1, 166, 882	
27.02				0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)			1, 166, 882	
29.00	Net income (or loss) for the period (line 26 minus line 28)			2, 192, 291	29.00

Heal th	Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	u of Form CMS-:	2552-10
ANALYS	IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE	RALLY QUALIFIED	) Provi der	CCN: 151307	Peri od:	Worksheet M-1	
	CENTER COSTS				From 07/01/2015		
			Component	CCN: 153993	To 06/30/2016		
					Rural Health	11/22/2016 10 Cost	: 23 811
					Clinic (RHC) I	COST	
		Compensati on	Other Costs	Total (col	1 Recl assi fi cati	Recl assi fi ed	
		oomponsation	00010	+ col. 2	ons	Trial Balance	
					0110	$(col \cdot 3 + col \cdot$	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	349, 695	C	349, 6	95 148, 915	498, 610	1.00
2.00	Physician Assistant	0	C		0 0	0	2.00
3.00	Nurse Practitioner	190, 489	C	190, 4	39 0	190, 489	3.00
4.00	Visiting Nurse	0	C		0 0	0	4.00
5.00	Other Nurse	170, 476	C	170, 4	76 0	170, 476	5.00
6.00	Clinical Psychologist	0	C		0 0	0	6.00
7.00	Clinical Social Worker	0	C		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	198, 677	0	198, 6	77 0	198, 677	9.00
10.00	Subtotal (sum of lines 1 through 9)	909, 337	0	909, 3		1, 058, 252	10.00
11.00	Physician Services Under Agreement	0	0	,0,,0	0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	13, 556	13, 5	56 0	13, 556	
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	C		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	394, 818	394, 8	18 0	394, 818	
20.00	Allowable GME Costs	0	0		0 0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	408, 374	408, 3	74 0	408, 374	21.00
22.00	Total Cost of Health Care Services (sum of	909, 337	408, 374			1, 466, 626	1
	lines 10, 14, and 21)			, - ,			
	COSTS OTHER THAN RHC/FQHC SERVICS						1
23.00	Pharmacy	0	C		0 0	0	23.00
24.00	Dental	0	C		0 0	0	24.00
25.00	Optometry	0	C		0 0	0	25.00
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs	0	0		0 0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	C		0 0	0	29.00
30.00	Administrative Costs	0	C		0 0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	C		0 0	0	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	909, 337	408, 374	1, 317, 7	11 148, 915	1, 466, 626	32.00
	and 31)						

Heal th	Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE	RALLY QUALIFIED	Provi der	CCN: 151307	Peri od:	Worksheet M-1	1
HEALTH	CENTER COSTS		Component	CCN: 153993	From 07/01/2015 To 06/30/2016	Date/Time Pre	
						11/22/2016 10	D:23 am
					Rural Health Clinic (RHC) I	Cost	
		Adjustments	Net Expenses			1	
			for Allocation				
		(	(col. 5 + col.				
		( 00	6)				
		6.00	7.00				
1 00	FACILITY HEALTH CARE STAFF COSTS	20 (25	440.075				1 1 00
1.00	Physician	-28, 635	469, 975 0				1.00
2.00	Physician Assistant Nurse Practitioner	0	190, 489				3.00
4.00	Visiting Nurse	0	190, 469				4.00
4.00 5.00	Other Nurse	0	170, 476				5.00
6.00	Clinical Psychologist	0	170, 470				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	198, 677				9.00
10.00	Subtotal (sum of lines 1 through 9)	-28,635	1, 029, 617				10.00
11.00	Physician Services Under Agreement	-20, 033	1, 02 7, 017				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	13, 556				15.00
	Transportation (Health Care Staff)	0	0	1			16.00
	Depreciation-Medical Equipment	0	0				17.00
	Professional Liability Insurance	0	0				18.00
	Other Health Care Costs	-225	394, 593				19.00
20.00	Allowable GME Costs	0	0				20.00
21.00	Subtotal (sum of lines 15 through 20)	-225	408, 149				21.00
22.00	Total Cost of Health Care Services (sum of	-28, 860	1, 437, 766				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs	0	0				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
	through 27) FACILITY OVERHEAD						-
29.00	Facility Costs	0	0				29.00
	Administrative Costs	0	0				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	0				31.00
51.00	30)	0	0				51.00
~~ ~~	Total facility costs (sum of lines 22, 28	-28,860	1, 437, 766				32.00
32.00							

Heal th	Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE			CCN: 151307	Peri od:	Worksheet M-1	
HEALTH	I CENTER COSTS				From 07/01/2015		
			Component	CCN: 153994	To 06/30/2016		
					Divised the state	11/22/2016 10	:23 am
					Rural Health	Cost	
		Compensation	Other Costs	Total (col	<u>Clinic (RHC) II</u> 1 Reclassificati	Reclassi fi ed	
		compensation	Uther Costs	+ col. 2	ons	Trial Balance	
				+ (01. 2)	0113	$(col \cdot 3 + col \cdot$	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	0.00	1.00	0.00	
1.00	Physi ci an	605, 877	0	605, 8	-148, 915	456, 962	1.00
2.00	Physician Assistant	000,011	0	000,0	0 0	0	2.00
3.00	Nurse Practitioner	94, 340	0	94, 34	10 0	94, 340	
4.00	Visiting Nurse	0	0	, , , , 0	0 0	0	4.00
5.00	Other Nurse	201, 452	0	201, 4	52 0	201, 452	
6.00	Clinical Psychologist	201, 102	0	201, 10	0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0			0	8.00
9.00	Other Facility Health Care Staff Costs	226, 042	0	226. 04	12 0	226, 042	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 127, 711	0	1, 127, 7		978, 796	10.00
11.00	Physician Services Under Agreement	0	0	1, 127, 7	0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	6, 622	6, 62	22 0	6, 622	
16.00	Transportation (Health Care Staff)	0	0, 022	0,0.	0 0	0,022	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	287, 010	287, 0 <sup>-</sup>	10 0	287, 010	
20.00	Allowable GME Costs	0	207,010	20170	0 0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	293, 632	293, 63	32 0	293, 632	
22.00	Total Cost of Health Care Services (sum of	1, 127, 711	293, 632				
22100	lines 10, 14, and 21)	.,,,	2,0,002	., .2., 0	10, 10, 10	1, 2, 2, 120	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs	0	0		0 0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)						
	FACILITY OVERHEAD						1
29.00	Facility Costs	0	0		0 0	0	29.00
30.00	Administrative Costs	0	0		0 0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	0		0 0	0	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 127, 711	293, 632	1, 421, 34	43 –148, 915	1, 272, 428	32.00
	and 31)						

Heal th	Financial Systems ST.	VINCENT WILLIA	MSPORT HOSPITA	AL.	In Lie	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE	RALLY QUALIFIED	Provi der	CCN: 151307	Peri od:	Worksheet M-1	1
HEALTH	CENTER COSTS		Component	CCN: 153994	From 07/01/2015 To 06/30/2016	Date/Time Pre	
					Rural Health	11/22/2016 10 Cost	J. 23 dili
					Clinic (RHC) II	COST	
		Adjustments	Net Expenses			I	
		- 1	for Allocation				
		(	(col. 5 + col.				
			6)				
		6.00	7.00				
1 00	FACILITY HEALTH CARE STAFF COSTS	405 70/	004 4//				1 1 00
1.00	Physician	-125, 796	331, 166				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	94, 340				3.00
4.00 5.00	Visiting Nurse	0	201 452				4.00
6.00	Other Nurse Clinical Psychologist	0	201, 452 0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	226, 042				9.00
10.00	Subtotal (sum of lines 1 through 9)	-125, 796	853,000				10.00
11.00	Physician Services Under Agreement	-123, 790	033,000				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	6, 622				15.00
	Transportation (Health Care Staff)	0	0	1			16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
19.00	Other Health Care Costs	-346	286, 664				19.00
20.00	Allowable GME Costs	0	0				20.00
21.00	Subtotal (sum of lines 15 through 20)	-346	293, 286				21.00
22.00	Total Cost of Health Care Services (sum of	-126, 142	1, 146, 286				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS	1		1			_
	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0	1			25.00
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs	0	0				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
	through 27) FACILITY OVERHEAD			1			
29.00	Facility Costs	0	0				29.00
30.00	Admini strati ve Costs	0	0				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	0				31.00
200	30)	0	0				
32.00	Total facility costs (sum of lines 22, 28	-126, 142	1, 146, 286				32.00
	and 31)			1			1

	Financial Systems ST. TION OF OVERHEAD TO RHC/FOHC SERVICES	VINCENT WILLIA			In Lie Period:	u of Form CMS-2 Worksheet M-2	
ALLOOF	THON OF OVERHEAD TO KNOT CHO SERVICES		riovidei	0011. 191307	From 07/01/2015	WOLKSHEET W Z	
			Component	CCN: 153993	To 06/30/2016	Date/Time Pre 11/22/2016 10	
					Rural Health	Cost	
		Number of FTE	Total Visits	Productivity	Clinic (RHC)   / Minimum Visits	Greater of	
		Personnel			(col. 1 x col.		
		i ei sonner			3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VI SI TS AND PRODUCTI VI TY						
	Posi ti ons						1
1.00	Physi ci an	2.46	11, 661	4, 20	10, 332		1.00
2.00	Physician Assistant	0.00	0	2, 10	0 0		2.00
3.00	Nurse Practitioner	1. 62	4, 858	2, 10	3, 402		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.08	16, 519		13, 734	16, 519	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	4.08	16, 519			16, 519	8.00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9.00
						1, 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O RHC/FQHC SERV	'I CES				
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			1, 437, 766	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			1, 437, 766	12.00
13.00	3.00 Ratio of RHC/FQHC services (line 10 divided by line 12)						13.00
14.00	4.00 Total facility overhead - (from Wkst. M-1, col. 7, line 31)						14.00
15.00	5.00 Parent provider overhead allocated to facility (see instructions)						15.00
16.00	Total overhead (sum of lines 14 and 15)					1, 175, 615	
17.00	Allowable GME overhead (see instructions)					0	
	Subtotal (see instructions)					1, 175, 615	
19.00	Overhead applicable to RHC/FQHC services (li					1, 175, 615	
20.00	Total allowable cost of RHC/FQHC services (s	um of lines 10	and 19)			2, 613, 381	20.00

ALLOCA	Financial Systems ST. ATION OF OVERHEAD TO RHC/FQHC SERVICES	VINCENT WILLIA			Peri od:	u of Form CMS-2 Worksheet M-2	
					From 07/01/2015		
			Component	CCN: 153994		11/22/2016 10	
					Rural Health Clinic (RHC) II	Cost	
		Number of FTE	Total Visits		Minimum Visits	Greater of	
		Personnel			(col. 1 x col.		
		i ei sonner			3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VI SI TS AND PRODUCTI VI TY						
	Posi ti ons	1	-				
1.00	Physi ci an	1. 27					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	0. 95					3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 22			7, 329		
5.00	Visiting Nurse	0.00				0	1 0.00
5.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
2 00	only)	2.00	10.015			10 015	
8.00	Total FTEs and Visits (sum of lines 4	2. 22	12, 215			12, 215	8.00
9.00	through 7) Physician Services Under Agreements		0			0	9.00
9.00	Physicial services under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O RHC/FQHC SERV	'I CES				
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			1, 146, 286	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			1, 146, 286	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided	by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, c					0	14.00
15.00							15.00
16.00	Total overhead (sum of lines 14 and 15)					1, 087, 831	
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					1, 087, 831	
19.00	Overhead applicable to RHC/FQHC services (li		·			1, 087, 831	
20.00	Total allowable cost of RHC/FQHC services (s	um of lines 10	and 19)			2, 234, 117	20.00

ALCULA	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151307	Period:	Worksheet M-3	
		Component CCN: 153993	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 10	
		Title XVIII	Rural Health Clinic (RHC) l	Cost	. 20
				1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			1.00	
00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lir	ne 20)		2, 613, 381	1.
	Cost of vaccines and their administration (from Wkst. M-4, lir			132, 134	2
00	Total allowable cost excluding vaccine (line 1 minus line 2)			2, 481, 247	3
00	Total Visits (from Wkst. M-2, column 5, line 8)			16, 519	4
00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5
00	Total adjusted visits (line 4 plus line 5)			16, 519	6
00	Adjusted cost per visit (line 3 divided by line 6)			150. 21	7
			Cal cul ati on	of Limit (1)	
			Prior to	On on After	
			January 1	January 1	
00	Dam visit normant limit (from CNC Dub 100 04 -bard 0, 000		1.00	2.00	
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	80. 44 150. 21	81.32	8
	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		150.21	150. 21	9
	Program covered visits excluding mental health services (from	contractor records)	0	3, 379	1 10
	Program cost excluding costs for mental health services (line		0	507, 560	
	Program covered visits for mental health services (from contra		0	007,000	12
	Program covered cost from mental health services (line 9 x lin		0	0	13
	Limit adjustment for mental health services (see instructions)		0	0	14
. 00	Graduate Medical Education Pass Through Cost (see instructions	5)		0	15
. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *		507, 560	16
. 01	Total program charges (see instructions) (from contractor's red	cords)		526, 739	
	Total program preventive charges (see instructions)(from provi			79, 862	
	Total program preventive costs ((line 16.02/line 16.01) times	-		76, 954	
b. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	3 and 18) times .80)		298, 270	16
. 05	Total program cost (see instructions)			375, 224	16
. 00	Primary payer amounts			85	17
. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		57, 768	18
. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		77, 834	19
. 00	Net Medicare cost excluding vaccines (see instructions)			375, 139	20
. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		44, 272	21
	Total reimbursable Program cost (line 20 plus line 21)			419, 411	
	Allowable bad debts (see instructions)			0	23
	Adjusted reimbursable bad debts (see instructions)			0	23
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	->		0	25
	Pioneer ACO demonstration payment adjustment (see instructions	5)		0 410 411	
	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			419, 411 8, 388	
	Interim payments			8, 388 296, 959	
	Tentative settlement (for contractor use only)			296, 959	21
	Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		114, 064	20
	Protested amounts (nonallowable cost report items) in accordar			0	30
	chapter I, §115.2			Ű	1 22

	Financial Systems ST. VINCENT WILLIAMS ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FOHC SERVICES	Provi der CCN: 151307	Peri od:	u of Form CMS-2 Worksheet M-3	
ALCOL			From 07/01/2015	worksneet w-5	
		Component CCN: 153994	To 06/30/2016	Date/Time Pre	
		Title XVIII	Rural Health	11/22/2016 10: Cost	:23 am
			Clinic (RHC) II	0031	
			-	1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES		I		
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lin			2, 234, 117	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, lin	ne 15)		99, 138	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2, 134, 979	3.00
1.00	Total Visits (from Wkst. M-2, column 5, line 8)			12, 215	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, l	line 9)		0	5.00
5.00	Total adjusted visits (line 4 plus line 5)			12, 215	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	174.78 of limit (1)	7.00
			carculation		
			Prior to	On on After	
			January 1	January 1	
			1.00	2.00	
3.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		174. 78	174. 78	9.00
10.00	Program covered visits excluding mental health services (from	contractor records)	0	5, 168	10.0
11.00	Program cost excluding costs for mental health services (line		0	903, 263	
12.00	Program covered visits for mental health services (from contra		0	0	12.00
13.00			0	13.00	
14.00	Limit adjustment for mental health services (see instructions)	)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction	s)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			903, 263	•
16.01			671, 139		
16.02				3, 074	
16.03	Total program preventive costs ((line 16.02/line 16.01) times			4, 137	16.0
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03) (Titles V and XIX see instructions.)	3 and 18) times .80)		665, 544	16. 04
16.05	Total program cost (see instructions)			669, 681	16. 05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		67, 196	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		120, 205	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			669, 681	20.0
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		61, 528	
22.00	Total reimbursable Program cost (line 20 plus line 21)	/		731, 209	
23.00	Allowable bad debts (see instructions)			0	23.0
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23.0
24.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	•
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
26.00	Net reimbursable amount (see instructions)			731, 209	
26.01	Sequestration adjustment (see instructions)			14, 624	
27.00 28.00	Interim payments Tentative settlement (for contractor use only)			641, 742 0	27.00 28.00
28.00	Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		0 74, 843	•
29.00	Protested amounts (nonallowable cost report items) in accorda			74, 843	30.00
	Tracesce anounts (nonarrowable cost report riens) III accorda	noo with owo lub. IJ-II,	1	0	00.00

Heal th	Financial Systems ST. VINCENT WILLIAMSPO	ORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 151307	Period:	Worksheet M-4	
		Component CCN: 153993	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/22/2016 10	
		Title XVIII	Rural Health	Cost	
			Clinic (RHC) I Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 029, 617		1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	health care staff time			2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line		113	923	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fro		34, 406	37, 252	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus		34, 519	38, 175	5.00
6.00	5.00 Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)			1, 437, 766	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	1, 175, 615	1, 175, 615	7.00	
8.00	00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			0. 026552	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li	ne 8)	28, 225	31, 215	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) a lines 5 and 9)	administration (sum of	62, 744	69, 390	10. 00
11.00	Total number of pneumococcal and influenza vaccine injections (	from your records)	50	409	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/		1, 254. 88	169.66	12.00
13.00					13.00
14.00	4.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)			25, 449	14.00
15.00	5.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum			132, 134	15.00
16.00	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)16.00Total Program cost of pneumococcal and influenza vaccine and its (their)administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,line 21)				

Heal th	Financial Systems ST. VINCENT WILLIAMSPO	In Lie	u of Form CMS-2	2552-10	
COMPUT	ATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 151307	Peri od:	Worksheet M-4	
		Component CCN: 153994		Date/Time Prep 11/22/2016 10:	
		Rural Health	Cost		
		Clinic (RHC) II	Influenzo		
			Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst M 1 col 7 line 10)		853,000		1.00
2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of pneumococcal and influenza vaccine staff time to total	boolth core staff time			2.00
2.00	Pneumococcal and influenza vaccine health care staff cost (line		94	396	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fro	,	32, 342		4.00
4.00 5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus		32, 342		5.00
6.00				1, 146, 286	6.00
7.00				1, 087, 831	7.00
8.00					
	00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 0.028297 0.0160 divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li	ne 8)	30, 782	17, 490	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) a	dministration (sum of	63, 218	35, 920	10.00
	lines 5 and 9)				
11.00	Total number of pneumococcal and influenza vaccine injections (	from your records)	47		11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/		1, 345. 06	181.41	
13.00	Number of pneumococcal and influenza vaccine injections adminis beneficiaries	tered to Program	39	50	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (the	ir) administration	52, 457	9, 071	14.00
45 00	(line 12 x line 13)		00,400	45 00	
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			99, 138	15.00
16.00				61, 528	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this a line 21)	mount to Wkst. M-3,			
			1	I	

Health Financial Systems ST. VINCENT WILLIAMSPORT HOSPITAL In Lieu of Form CMS-2552-10							
	IS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICE	S Provider CCN: 151307	Peri od:	Worksheet M-5			
RENDEF	ED TO PROGRAM BENEFICIARIES	Component CCN: 153993	From 07/01/2015 To 06/30/2016	Date/Time Pre	arod		
		component con. 153495	10 00/30/2010	11/22/2016 10:			
			Rural Health	Cost			
			Clinic (RHC) I				
				t B			
			mm/dd/yyyy	Amount			
1 00	Total interim payments paid to provider		1.00	2.00 296.959	1.00		
1.00 2.00	Interim payments payable on individual bills, either submitte	d or to be submitted to		290, 939	2.00		
2.00	the contractor for services rendered in the cost reporting pe			0	2.00		
	"NONE" or enter a zero						
3.00	List separately each retroactive lump sum adjustment amount b	ased on subsequent			3.00		
	revision of the interim rate for the cost reporting period. A	lso show date of each					
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
3.01				0	3.01		
3.02 3.03				0	3. 02 3. 03		
3.03				0	3.03		
3.05				0	3.05		
0.00	Provider to Program				0.00		
3.50				0	3.50		
3.51				0	3.51		
3.52				0	3. 52		
3.53				0	3.53		
3.54		N		0	3.54		
3.99 4.00	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98			-	3.99 4.00		
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 296,959 27)						
	TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk	review. Also show date of	,		5.00		
	each payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
5.01				0	5.01		
5.02 5.03				0	5. 02 5. 03		
5.05	Provider to Program			0	5.05		
5.50				0	5.50		
5.51				0	5.51		
5.52				0	5.52		
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) (				5.99		
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						
6.01	SETTLEMENT TO PROVIDER 114,064				6.01		
6.02	SETTLEMENT TO PROGRAM				6.02		
7.00	Total Medicare program liability (see instructions)		Contractor	411,023 NPR Date	7.00		
			Contractor Number	(Mo/Day/Yr)			
		0	1.00	2.00			
8.00	Name of Contractor				8.00		

Heal th	Financial Systems ST. VINCENT WILLIAMS	PORT HOSPI TAL	In Lie	eu of Form CMS-2	2552-10		
	IS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICE	S Provider CCN: 151307	Peri od:	Worksheet M-5			
RENDER	ED TO PROGRAM BENEFICIARIES	Component CCN: 153994	From 07/01/2015 To 06/30/2016				
			Rural Health	Cost	20 411		
			Clinic (RHC) II				
				rt B			
			mm/dd/yyyy 1.00	Amount 2.00			
1.00	Total interim payments paid to provider		1.00	581, 442	1.00		
2.00	Interim payments payable on individual bills, either submitted the contractor for services rendered in the cost reporting per "NONE" or enter a zero	d or to be submitted to riod. If none, write		0			
3.00	List separately each retroactive lump sum adjustment amount ba revision of the interim rate for the cost reporting period. Al payment. If none, write "NONE" or enter a zero. (1)				3. 00		
	Program to Provider						
3.01			01/08/2016	60, 300	3. 01		
3.02				0	3.02		
3.03 3.04				0	3. 03 3. 04		
3.04 3.05				0	3.04		
3.05	Provider to Program			0	3.05		
3.50				0	3.50		
3.51				0	3. 51		
3.52				0	3. 52		
3.53				0	3.53		
3.54				0	3.54		
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	•		60, 300	3.99 4.00		
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line641,742						
	27) TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk i	review. Also show date of	2		5.00		
	each payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider		1				
5.01				0	5.01		
5.02				0			
5.03	Description to Description			0	5.03		
5.50	Provider to Program		1	0	5.50		
5.50				0	5.50		
5.52				0	5. 52		
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	5.99		
6.00					6.00		
6.01	SETTLEMENT TO PROVIDER 74,84				6.01		
6.02					6. 02		
7.00	Total Medicare program liability (see instructions)			716, 585	7.00		
			Contractor	NPR Date			
		0	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00			
8.00	Name of Contractor	0	1.00	2.00	8.00		
	· I		1				