Heal th Financia	al Systems	ST. VINCENT JENNINGS	HOSPI TAL	In Lieu	u of Form CMS-2552-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	re to report can res	sult in all interim	FORM APPROVED
payments made	since the beginning of the cost	reporting period being d	eemed overpayments	(42_USC_1395g).	OMB NO. 0938-0050
HOSPI TAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX COS SUMMARY	T REPORT CERTIFICATION	Provider CCN: 15130	3 Period: From 07/01/2014 To 06/30/2015	
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed co	ost report		Date: 11/23/20	015 Time: 3:43 pm
use only	2. [] Manually submitted cost	report			
	3. [0] If this is an amended r 4. [F] Medicare Utilization. E			resubmitted this co	ost report
Contractor use only	 (1) As Submitted (2) Settled without Audit 8. 	Date Received: Contractor No. [N]Initial Report for [N]Final Report for th	this Provider CCN 12		
PART II - CERT	I FI CATI ON				
MI SREPRESENTAT	ION OR FALSIFICATION OF ANY INF	ORMATION CONTAINED IN THI	S COST REPORT MAY B	E PUNISHABLE BY CRIN	INAL, CIVIL AND
ADMI NI STRATI VE	ACTION, FINE AND/OR IMPRISONME	NT UNDER FEDERAL LAW. FU	RTHERMORE, IF SERVIO	CES IDENTIFIED IN TH	IIS REPORT WERE
PROVIDED OR PR	OCURED THROUGH THE PAYMENT DIRE	CTLY OR INDIRECTLY OF A K	ICKBACK OR WERE OTHI	ERWISE ILLEGAL, CRIN	INAL, CIVIL AND

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT JENNINGS HOSPITAL (151303) for the cost report and statement of kevenue and and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)

Title

Officer or Administrator of Provider(s)

			Date				
			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	198, 180	210, 558	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	72, 343	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	270, 523	210, 558	0	0	200.00

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

	Financial Systems		NT JENNING			454000					2552-10
HUSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX I	IDENTIFICATION DA	IA	Provi	der CCN		Period: From 07/01, To 06/30,	/2014 /2015	Part I Date/Ti	et S-2 me Prep 2015 8:2	pared:
	1.00		00		3.00			4.00	11/23/2	.013 0.1	
1 00	Hospital and Hospital Health Care Co										1 00
1.00 2.00	Street: 301 HENRY STREET City: NORTH VERNON	PO Box: State: I	N Zi	n Code	e: 47265	Count	ty: JENNINGS	;			1.00 2.00
		Component Na	ame	ĊCN	CBSA	Provi der	Date	Paymer	nt Syst		
			Nu	umber	Number	Туре	Certified	Т, V	0, or		
		1.00		2.00	3.00	4.00	5.00	6. 00	XVIII 7.00	XI X 8.00	
	Hospital and Hospital-Based Componen	t Identification:				1					
3.00	Hospi tal	ST. VINCENT JENN HOSPITAL	INGS 15	51303	99915	1	07/01/1996	N	0	Р	3.00
4.00	Subprovider - IPF	HUSPITAL									4.00
5.00	Subprovider - IRF										5.00
6.00 7.00	Subprovider - (Other) Swing Beds - SNF	ST. VINCENT JENN		5Z303	99915		07/05/1991	N	0	N	6.00 7.00
7.00	Swirig beds - Swi	SWING BED		12303	77713		0770371771				7.00
8.00	Swing Beds - NF										8.00
9. 00 10. 00	Hospi tal -Based SNF Hospi tal -Based NF										9.00 10.00
11.00	Hospi tal -Based OLTC										11.00
	Hospi tal -Based HHA										12.00
	Separately Certified ASC Hospital-Based Hospice										13.00 14.00
	Hospital-Based Health Clinic - RHC										15.00
	Hospital-Based Health Clinic - FQHC										16. 00 17. 00
	Hospital-Based (CMHC) I Renal Dialysis										17.00
19.00	Other										19.00
							From: 1.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2		06/30/		20.00
21.00	Type of Control (see instructions)							2			21.00
22.00	Inpatient PPS Information Does this facility qualify and is it	currently receiv	ing navmen	ts for	dispron	ortionato	N		N		22.00
22.00	share hospital adjustment, in accord	ance with 42 CFR	§412.106?	In co	lumn 1,	enter "Y"					22.00
	for yes or "N" for no. Is this facil				2.06(c)((2) (Pi ckl e					
22. 01	amendment hospital?) In column 2, en Did this hospital receive interim un				s cost r	reporting	N		N		22. 01
	period? Enter in column 1, "Y" for y										
	reporting period occurring prior to for no for the portion of the cost r										
	(see instructions)	eporting period e	ceurring e			.000111.					
22. 02	Is this a newly merged hospital that determined at cost report settlement				1 2		N		N		22.02
	or "N" for no, for the portion of th						5				
	in column 2, "Y" for yes or "N" for						n				
22 03	or after October 1. Did this hospital receive a geograph	ic reclassificati	on from ur	han to	rural a	as a resul	t N		N		22. 03
22.00	of the OMB standards for delineating	statistical area	adopted	by CMS	in FY20)15? Enter					221 00
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column						0				
	cost reporting period occurring on o						e				
	hospital contain at least 100 but no			unted	in accor	dance wit	h				
23.00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me			/or 25	bel ow?	In column		2	N		23.00
	1, enter 1 if date of admission, 2 i	f census days, or	3 if date	of di	scharge.	Is the					
	method of identifying the days in th used in the prior cost reporting per										
			In-State	In-St	tate (Out-of	Out-of M	ledi cai		ther	
			Medicaid paid days	Medio eligi		State edi cai d	State H Medicaid	HMO day		li cai d lays	
			paru uays	unpa			eligible			ays	
				day	/s		unpai d				
24 00	If this provider is an IPPS hospital	enter the	1.00	2.0	0	3.00	4.00	5.00	0	0. 00 0	24.00
24.00	in-state Medicaid paid days in colum			1		0	0			0	24.00
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu	t unpaid days in									
25 00	column 5, and other Medicaid days in If this provider is an IRF, enter th		C		o	0	0		0		25.00
20.00	Medicaid paid days in column 1, the	in-state			Ĭ						20.00
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid day										

			NINGS HOSPITAL		L	n Lieu	of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΑΤΑ	Provi der		eriod: rom 07/01/ p 06/30/	/2014 /2015	Workshe Part I Date/Ti 11/23/2	me Pre	pared:
					Urban/Rur 1.00		Date of 2.C		-
26.00	Enter your standard geographic classification (not wa			jinning of the	1.00	2	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	age) sta r "2" fo	atus at the enc or rural. If ap			2			27.00
35.00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00		Endi 2. C		-
36.00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent date		Subscript line	36 for number				-	36.00
	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	r the n				0			37.00
38.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
					Y/N 1.00		Y/ 2. 0		-
39.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage red	i)? Énte	er in column 1	"Y" for yes	N		<u> </u>		39.00
40. 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	or "N" n adjus ber 1.	for no. (see i tment? Enter "Y Enter "Y" for y	nstructions) (" for yes or	N		Ν		40.00
	no mediani 2, for discharges on or after betober 1.	. (300				V	XVIII	XIX	-
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45.00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	nt for (di sproporti onat	te share in acc	ordance	N	N	N	45.00
46.00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	eption ⁻ t. L, P [.]	for extraordina t. III and Wkst	ary circumstanc L-1, Pt. I t	es hrough	N	N	N	46.00
47.00 48.00	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital paymen				0.	N N	N N	N N	47.00 48.00
56.00	Teaching Hospitals Is this a hospital involved in training residents in or "N" for no.	approv	ed GME programs	s? Enter "Y" f	or yes	N			56.00
	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 mon- 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	ryeso thoftl Y", com I, ifa	r "N" for no ir his cost report plete Worksheet pplicable.	n column 1. If ing period? E E-4. If colum	column 1 inter "Y" in 2 is				57.00
58.00	If line 56 is yes, did this facility elect cost reiml defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' services a	IS	N			58.00
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health					N N			59.00 60.00
	provi der-operated criteria under §413.85? Enter "Y"				tions)		Di rect	GME	00.00
		1.00	2.00	3.00	4.00		5. C		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0. 00	0.00					61.02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.00					61.03
61.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.00					61.04
61.05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0.00					61.05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00					61.06

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	TA	Provi der		Period:	Worksheet S-2	
					rom 07/01/2014 fo 06/30/2015	Date/Time Pre 11/23/2015 8:	
		Progra	n Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.0	00	2.00	3.00	4.00	
 10 Of the FTEs in line 61.05, specify ea specialty, if any, and the number of for each new program. (see instructic column 1, the program name, enter in program code, enter in column 3, the unweighted count and enter in column FTE unweighted count. 10 Of the FTEs in line 61.05, specify ea program specialty, if any, and the nu residents for each expanded program. instructions) Enter in column 1, the enter in column 2, the program code, 3, the IME FTE unweighted count. 	FTE residents ns) Enter in column 2, the IME FTE 4, direct GME ch expanded mber of FTE (see program name, enter in column				0. oc		61. 1
		L					
						1.00	
ACA Provisions Affecting the Health R 2.00 Enter the number of FTE residents that					iod for which	0.00	62.0
your hospital received HRSA PCRE fund	ing (see instruc	tions)					
2.01 Enter the number of FTE residents that during in this cost reporting period Teaching Hospitals that Claim Resider	of HRSA THC prog	jram. (see i	nstruction		your hospital	0.00	62.0
B. 00 Has your facility trained residents i "Y" for yes or "N" for no in column 1	n nonprovider se	ettings duri	ng this co	instructions)		N	63. (
				Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	Hospi tal	2))	
			2	1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE period that begins on or after July 1				This base year	ris your cost r	reporting	
4.00 Enter in column 1, if line 63 is yes, in the base year period, the number of resident FTEs attributable to rotatic settings. Enter in column 2 the numb resident FTEs that trained in your ho of (column 1 divided by (column 1 + column 2)	or your facilit f unweighted nor ns occurring in er of unweightec spital. Enter ir	trained n primary ca all nonprov non-priman column 3 f	residents are /ider ry care the ratio	0.0	0 0. 00	0. 000000	64. C
F	Program Name	Prograi	n Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.	00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 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				0.0	o o. oc	0. 000000	

Health Financial Systems			NT JENNINGS				eu of Form CMS-	
HOSPITAL AND HOSPITAL HEAL	TH CARE COMPL	EX IDENTIFICATION DA	λTA	Provi der	F	eriod: rom 07/01/201 o 06/30/201		pared:
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the	ACA Current	Year FTE Residents in	n Nonprovide	er Setting	1.00 sEffective fe	2.00 pr cost report	3.00 ing periods	
beginning on or afte 66.00 Enter in column 1 th			ry care resi	dent	0.00	. 0. 0	0.000000	66 00
FTEs attributable to Enter in column 2 th	o rotations of Ne number of N	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi	i ngs. dent				
(column 1 divided by	(column 1 +	column 2)). (see ins Program Name	structions) Program	Code	Unweighted	Unweighted	Ratio (col. 3/	
					FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
(7.00 Enter in column 1. t	bo program	1.00	2.0	0	3.00	4.00	5.00	(7.00
67.00 Enter in column 1, t name associated with your primary care pr which you trained re Enter in column 2, t code. Enter in colum number of unweighted care FTE residents a to rotations occurri non-provider setting column 4, the number unweighted primary c resident FTEs that t your hospital. Enter 5, the ratio of (col divided by (column 3 4)). (see instructio	each of ograms in sidents. he program in 3, the primary ittributable ng in all is. Enter in of sare rained in in column umn 3 i + column				0. 00) O. C	0 0. 000000	67.00
						1.0	00 2.00 3.00	-
Inpatient Psychiatri			LDE) an daa	a it cont	ain an IDE aubr			70.00
42 CFR 412.424(d)(1) program in accordanc	"N" for no. mn 1: Did the iled on or be (iii)(c)) Col e with 42 CFI 2 is Y, indic	e facility have an ap efore November 15, 20 Jumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	oproved GME 004? Enter ility train)(D)? Enter	teaching "Y" for y residents "Y" for y	, program in the es or "N" for r in a new teach es or "N" for r	most no. (see ni ng no.	0	70.00
75.00 Is this facility an	Inpatient Rel	nabilitation Facility	y (IRF), or	does it c	ontain an IRF	N	1	75.00
no. Column 2: Did th CFR 412.424 (d)(1)(i	mn 1: Did the g period endi is facility ii)(D)? Enter	e facility have an ap ing on or before Nove train residents in a	ember 15, 20 new teachin for no. Col	04? Enter g program umn 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for with 42	0	76.00
					, , ,		1.00	
Long Term Care Hospi							1	
80.00 Is this a long term 81.00 Is this a LTCH co-lo "Y" for yes and "N"	cated within					period? Enter	N N	80.00 81.00
TEFRA Providers 85.00 Is this a new hospit	al under 42 (CFR Section §413.40(1	f)(1)(i) TEF	RA? Ente	r "Y" for yes o	or "N" for no.	N	85.00
86.00 Did this facility es				it) under	42 CFR Sectior	ı		86.00
§413.40(f)(1)(ii)? 87.00 Is this hospital a " for yes or "N" for n	subclause (I			n 1886(d)	(1)(B)(iv)(II)?	? Enter "Y"	N	87.00
						V 1.00	XI X 2.00	-
Title V and XIX Serv 90.00 Does this facility h		and/or XIX inpationt	hospital so	rvi cos? E	nter "V" for	N	Y	90.00
yes or "N" for no in	the applical	ole column.	·					
91.00 Is this hospital rei full or in part? Ent	er "Y" for ye	es or "N" for no in t	the applicab	le column		N	N	91.00
92.00 Are title XIX NF pat instructions) Enter					ion)? (see		Ν	92.00
93.00 Does this facility o "Y" for yes or "N" f	perate an ICI	F/IID facility for pu			d XIX? Enter	N	N	93.00
94.00 Does title V or XIX applicable column.			or yes, and	"N" for n	o in the	N	Ν	94.00

Health Financial Systems ST. VINCENT JENNINGS				Lieu	u of Form		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	F	Period: From 07/01/2 To 06/30/2		Workshee Part I Date/Tim 11/23/20	ne Pre	pared:
		I	V		XI X		
95.00 If line 94 is "Y", enter the reduction percentage in the application of the provided of the second se			1.00 N	0. 00	2.00 N		95.00 96.00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applica	ble columr	۱.		0. 00		0.00	97.00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-incl	usive meth	nod of payment	Y				105.00 106.00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost rein training programs? Enter "Y" for yes or "N" for no in column 1.	mbursement (see instr	t for I&R ructions) If	N				107.00
yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		0	N				108.00
	hysi cal	Occupational	Speech	۱	Respi ra		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 Y	2.00 Y	3.00 Y		<u>4.00</u> N)	109.00
					1.00)	
110.00 Did this hospital participate in the Rural Community Hospital Den the current cost reporting period? Enter "Y" for yes or "N" for		on project (41	OA Demo)for		N		110. 00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" is yes, enter the method used (A, B, or E only) in column 2. If 3 either "93" percent for short term hospital or "98" percent fo psychiatric, rehabilitation and long term hospitals providers) bu	column 2 i r long ter	s "E", enter m care (inclu	in column des	N		0	115.00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for 117.00 s this facility legally-required to carry malpractice insurance			"N" for	N Y			116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence policy? claim-made. Enter 2 if the policy is occurrence.	Enter 1 i	f the policy	is	2			118. 00
jerdnin made. Enter 2 fr the porrey is occurrence.		Premiums	Losses	5	Insura	nce	
		1.00	2.00		3.00		
118.01 List amounts of malpractice premiums and paid losses:		36, 12		0			118. 01
			1.00		2.00)	
118.02 Are malpractice premiums and paid losses reported in a cost cent. Administrative and General? If yes, submit supporting schedule and amounts contained therein.			N				118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harn §3121 and applicable amendments? (see instructions) Enter in col- "N" for no. Is this a rural hospital with < 100 beds that qualif Hold Harmless provision in ACA §3121 and applicable amendments?	umn 1, "Y" ies for th	' for yes or ne Outpatient	N		Ν		119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantab patients? Enter "Y" for yes or "N" for no.	le devices	s charged to	Y				121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for ye yes, enter certification date(s) (mm/dd/yyyy) below.	s and "N"	for no. If	N				125.00
126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certif	fication date					126. 00
127.00 If this is a Medicare certified heart transplant center, enter t in column 1 and termination date, if applicable, in column 2.	he certifi	cation date					127.00
128.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.							128. 00
129.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.							129.00
130.00 If this is a Medicare certified pancreas transplant center, ente date in column 1 and termination date, if applicable, in column 1	2.						130.00
131.00 If this is a Medicare certified intestinal transplant center, en date in column 1 and termination date, if applicable, in column 1	2.						131.00
132.00 If this is a Medicare certified islet transplant center, enter the in column 1 and termination date, if applicable, in column 2.							132.00
 133.00 If this is a Medicare certified other transplant center, enter the in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (OPO), enter the OP and the production of the product o							133. 00 134. 00
and termination date, if applicable, in column 2.			I				I

Health Financial Systems		JENNI NGS HOS	SPI TAL			In Lie	u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	CIDENTIFICATION DATA	Pro	ovider CC	N: 151303		d: 07/01/2014	Worksheet S-2 Part I	
						06/30/2015	Date/Time Pre	
							11/23/2015 8:	22 am
						1.00	2.00	-
ALL Providers							-	
140.00 Are there any related organization chapter 10? Enter "Y" for yes or "						Y	15H046	140.00
are claimed, enter in column 2 the					515			
1.00		2.00				3.00		
If this facility is part of a chai					e name a	nd address	of the	
home office and enter the home off 141.00Name: ST. VINCENT HEALTH	Contractor name a		r number.		actor's M	lumber: 0810	1	141.00
142.00 Street: 10330 N. MERIDAN ST	PO Box:							142.00
143.00 City: INDIANAPOLIS	State:	IN		Zip Cc	ode:	4629	0	143.00
							1.00	-
144.00 Are provider based physicians' cos	ts included in Worksh	eet A?					Y	144.00
	· · · · · · · · · · · · · · · · · · ·	74 11		_		1.00	2.00	1.45 00
145.00 If costs for renal services are cl inpatient services only? Enter "Y"						N		145.00
no, does the dialysis facility inc					,			
period? Enter "Y" for yes or "N"	for no in column 2.			. 0				
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in	y changed from the pro	eviously fil	ed cost r	report?	1.E	N		146.00
yes, enter the approval date (mm/d		up. 15-2, Ch	apter 40,	94020)	11			
		6	NII 6	-			1.00	147.00
147.00Was there a change in the statisti 148.00Was there a change in the order of							N N	147.00 148.00
149.00 Was there a change to the simplifi					for no.		N	149.00
		Par		Part E	3	Title V	Title XIX	
Does this facility contain a provi	dan that qualifies fo	<u> </u>		2.00	lootion	3.00	4.00	
or charges? Enter "Y" for yes or "								
155.00 Hospi tal		N		N		N	N	155.00
156.00 Subprovider - IPF		N		N		N	N	156.00
157. 00 Subprovi der – IRF 158. 00 SUBPROVI DER		N		Ν		Ν	N	157.00 158.00
159. 00 SNF		N		Ν		N	N	159.00
160.00 HOME HEALTH AGENCY		N		Ν		N	N	160. 00
161.00 CMHC				N		N	N	161.00
							1.00	-
Multicampus							1.00	
165.00 Is this hospital part of a Multica	mpus hospital that ha	s one or mor	e campuse	es in dif	fferent (BSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	Count	V I	State	Zip Code	e CBSA	FTE/Campus	
-	0	1.00		2.00	3.00	4.00	5.00	-
166.00 If line 165 is yes, for each							0.00	166.00
campus enter the name in column								
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)								
							1.00	-
Health Information Technology (HIT) incentive in the Am	eri can Recov	ery and F	Rei nvestr	ment Act		1.00	
167.00 Is this provider a meaningful user							N	167.00
168.00 If this provider is a CAH (line 10			r (line 1	167 is "Y	/"), ente	er the	(168.00
reasonable cost incurred for the H 168.01 f this provider is a CAH and is n			rovider o	ualify f	for a hai	dshi p		168. 01
exception under §413.70(a)(6)(ii)?						P		
169.00 If this provider is a meaningful u	ser (line 167 is "Y")					enter the	0.00	169.00
transition factor. (see instructio	ns)					egi nni ng	Endi ng	
						1. 00	2.00	1
170.00 Enter in columns 1 and 2 the EHR b	eginning date and end	ing date for	the repo	orting				170.00
period respectively (mm/dd/yyyy)								

Health Financial Systems	ST. VINCENT JENNING	S HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provider CCN: 151303	Period: From 07/01/2014 To 06/30/2015		
				11/23/2015 8	22 am
				1.00	
171.00 If line 167 is "Y", does this provid Medicare cost plans reported on Wkst (see instructions)				Ν	171.00

	cial Systems S) HOSPITAL HEALTH CARE REIMBURSEMENT QUE	T. VINCENT JENNINGS HOSPITAL	- - CCN: 151303	Peri od:	Worksheet S-	
STITLE AND	HUSPITAL HEALTH CARE REIMBURSEMENT QUE	STI UNNALKE Provider	~ CCN: 151303	From 07/01/2014 To 06/30/2015	Part II Date/Time Pr	repare
				Y/N	11/23/2015 8 Date	8:22 a
				1.00	2.00	
	al Instruction: Enter Y for all YES resp	ponses. Enter N for all NO r	esponses. Ente	er all dates in	the	
	/yyyy format.					_
	ETED BY ALL HOSPITALS der Organization and Operation					_
	he provider changed ownership immediatel	ly prior to the beginning of	the cost	N		1
repor	ting period? If yes, enter the date of	the change in column 2. (see	· · · · · · · · · · · · · · · · · · ·			
			Y/N	Date	V/I	_
10 Has t'	he provider terminated participation in	the Medicare Program? If		2.00	3.00	2
			IN IN			2
vol un	tary or "I" for involuntary.					
			N			3
relat	ionships? (see instructions)					
						_
Financ	cial Data and Penorts		1.00	2.00	3.00	-
		pared by a Certified Public	Y	Α		4
or "R	" for Reviewed. Submit complete copy or	enter date available in				
						_
			N			5
those	on the fired financial statements? If	yes, submit reconcirration.		Y/N	Legal Oper	
				1.00	2.00	
Appro\	/ed Educational Activities					
		ool? Column 2: If yes, is t	he provider is	s N		6
						_
Approved Educational Activities Y/N Legal Oper. Approved Educational Activities Y/N Eagl operator N S.00 Approved Educational Activities 0.00 2.00 3.00 2.00 <t< td=""></t<>						
			a during the	IN		
			cal education	N		9
			the current	N		10
			proved	N		11
	5 5		proved			· ·
					Y/N	
					1.00	
						_
		d dobte2 lf voccoo instruc	tions		V	112
00 Is the	e provider seeking reimbursement for ba			ost reporting		
00 Is the 00 If lin	e provider seeking reimbursement for bac ne 12 is yes, did the provider's bad del			ost reporting		
00 Is the 00 If lin perioe	e provider seeking reimbursement for bac ne 12 is yes, did the provider's bad del d? If yes, submit copy.	bt collection policy change	during this co		N	13
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Heal th	Financial Systems S	T. VINCENT JEN	INI NGS HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period:	Worksheet S-2	2
					rom 07/01/2014 o 06/30/2015	Part II Date/Time Pro	enared
						11/23/2015 8	22 am
					rt A	Part B	
			iption	Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the		0	1.00 N	2.00	3.00 N	21.00
21.00	provider's records? If yes, see			IN		IN	21.00
	instructions.						
	AND FED DV AAAT DELNDUDGED AND TEEDA HAADI					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	ALS ONLY (EXC	EPT CHILDRENS H	IOSPITALS)			-
22.00	Capital Related Cost Have assets been relifed for Medicare purpose	s? If yes se	e instructions			N	22.00
	Have changes occurred in the Medicare depreci			sals made durin	a the cost	N	23.00
20.00	reporting period? If yes, see instructions.	att off onpolioo	ado to appiare		.g 1110 0001		20100
24.00	Were new leases and/or amendments to existing	g leases enter	ed into during	this cost repo	orting period?	Y	24.00
	If yes, see instructions						
25.00	Have there been new capitalized leases entere instructions.	ed into during	the cost repor	rting period? I	f yes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during t	he cost reporti	ng period?lf	ves see	Ν	26.00
20.00	instructions.	an our during t		ng porrour ri	J00, 000		20.00
27.00	Has the provider's capitalization policy char	nged during th	e cost reportir	ng period?lf y	ves, submit	Ν	27.00
	copy.						_
28.00	Interest Expense	a of oradit o	ntored into dur	ing the east r	ananting	N	1 20 00
28.00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	s of credit e	ntered into dur	ing the cost i	eportring	Ν	28.00
29.00	Did the provider have a funded depreciation a	account and/or	bond funds (De	ebt Service Res	erve Fund)	Ν	29.00
	treated as a funded depreciation account? If	yes, see inst	ructions				
30.00	Has existing debt been replaced prior to its			debt? If yes,	see	Ν	30.00
	instructions.		c.				
31.00	Has debt been recalled before scheduled matur instructions.	rity without i	ssuance of new	debt? If yes,	see	Ν	31.00
	Purchased Services						
32.00	Have changes or new agreements occurred in pa	atient care se	rvi ces furni she	ed through cont	ractual	Y	32.00
	arrangements with suppliers of services? If	yes, see instr	uctions.	0			
33.00	If line 32 is yes, were the requirements of S	Sec. 2135.2 ap	plied pertainir	ng to competiti	ve bidding? If	Y	33.00
	no, see instructions.						-
34 00	Provider-Based Physicians Are services furnished at the provider facili	ty under an a	rrangement with	nrovi der-base	d như si ci ans?	Y	34.00
54.00	If yes, see instructions.	ty under an a	rrangement with				54.00
35.00	If line 34 is yes, were there new agreements	or amended ex	isting agreemer	nts with the pr	ovi der-based	Ν	35.00
	physicians during the cost reporting period?	lf yes, see i	nstructions.				
					Y/N	Date	
	Home Office Costs				1.00	2.00	
36, 00	Were home office costs claimed on the cost re	eport?			Y		36.00
	If line 36 is yes, has a home office cost sta		repared by the	home office?	Ý		37.00
	If yes, see instructions.						
38.00	If line 36 is yes, was the fiscal year end o				Ν		38.00
	the provider? If yes, enter in column 2 the 1						
39.00	If line 36 is yes, did the provider render se see instructions.	ervices to oth	er chain compor	ients? IT yes,	N		39.00
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lf ves see	Ν		40.00
	instructions.			, j,			
			1.	00	2.	00	
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title	/nosition	JI LL		HILL		41.00
41.00	held by the cost report preparer in columns		SILL				41.00
	respecti vel y.	,					
42.00	Enter the employer/company name of the cost i	report	ST. VINCENT HE	ALTH			42.00
40.00	preparer.	с. н				NOENT OSS	10.05
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv		(317) 583-3519	,	JILL. HILL@STVI	NCENT. ORG	43.00
	report preparer in corumns ranu z, respectiv	very.	I		1		П

	Financial Systems S AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE:	<u>T. VI NCENT JENNI</u> STI ONNAI RE	Provi der CCN: 151303	Period: From 07/01/2014	of Form CMS-2552 Worksheet S-2 Part II Date/Time Prepare	ed:
		Part B			<u>11/23/2015 8: 22 a</u>	am
		Date				
		4.00				
	PS&R Data					
16.00	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 instructions)	10/13/2015			16.	6.00
17.00	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 in columns 2 and 4. (see instructions)				17	7.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18	8.00
19. 00	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.				19.	9. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20	0. 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.	1.00
		_	3.00			
	Cost Report Preparer Contact Information		3.00			
	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		EIMBURSEMENT MANAGER		41	1. 00
42.00	Enter the employer/company name of the cost r preparer.	report			42	2. 00
	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv				43	3.00

	Financial Systems S AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	T. VINCENT JENN	Drovi dor	CCN: 151303	Peri od:	Worksheet S-3	2552-10
позет і	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	PLOVE	CCN. 151303	From 07/01/201	4 Part I	
					To 06/30/201	5 Date/Time Pre 11/23/2015 8:	pared:
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2	5 9, 1	25 21, 936.0	0 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 Subprovi der						3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF		0		01 00/ 0	0	
7.00	Total Adults and Peds. (exclude observation		2	5 9, 1	25 21, 936. 0	0 0	7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		2	5 9, 1	25 21, 936.0	0 0	
15.00	CAH visits		-		21,70010	0	
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		2	5			27.00
28.00	Observation Bed Days					0	
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)			C	0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)			1	1	1	1

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	F	eriod: rom 07/01/2014 o 06/30/2015	Worksheet S-3 Part I Date/Time Pre 11/23/2015 8:	parec
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6.00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10. 00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	528	7.00	8.00		10.00	1.0
. 00	8 exclude Swing Bed, Observation Bed and	526	70	914			1. '
	Hospice days) (see instructions for col. 2						
~ ~	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)	112	48				2.
. 00	HMO I PF Subprovi der	0	0				3.
00	HMO I RF Subprovider	0	0				4.
00	Hospital Adults & Peds. Swing Bed SNF	250	0	250			5.
00	Hospital Adults & Peds. Swing Bed NF		0	10			6.
00	Total Adults and Peds. (exclude observation	778	70	1, 174			7.
00	beds) (see instructions)						8
00							8.
	CORONARY CARE UNIT						10
. 00	BURN INTENSIVE CARE UNIT						
. 00	SURGI CAL I NTENSI VE CARE UNI T						11
2.00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12
. 00	Total (see instructions)	778	70	1, 174	0.00	90.32	
. 00	CAH visits	8, 719	2,353	30, 084		90. JZ	14
. 00	SUBPROVIDER - IPF	0, / 19	2, 303	30, 064			16
. 00	SUBPROVIDER - IRF						17
. 00	SUBPROVI DER						18
. 00 . 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY						22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPI CE						24
. 10	HOSPICE (non-distinct part)	0	0	C			24
5.00	CMHC - CMHC	J.	0				25
5.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	
. 25	FEDERALLY QUALIFIED HEALTH CENTER	-		-			26
. 00	Total (sum of lines 14-26)				0.00	90.32	
. 00	Observation Bed Days		0	589			28
. 00	Ambul ance Trips	О	-				29
. 00	Employee discount days (see instruction)	Ŭ.		C			30
. 00	Employee discount days - IRF			C			31
. 00	Labor & delivery days (see instructions)	o	0				32
2. 01	Total ancillary labor & delivery room	Ŭ	0	0			32
	outpatient days (see instructions)						
2 00	LTCH non-covered days	o					33

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151303	Period: From 07/01/2014 To 06/30/2015		
		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	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0		70 26		1. 0
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider				34 21 0 0		2.0 3.0 4.0
5. 00 5. 00 7. 00 8. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						5. 0 6. 0 7. 0 8. 0
 2.00 10.00 11.00 12.00 13.00 	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						9.0 10.0 11.0 12.0 13.0
3.00 4.00 5.00 6.00 7.00 8.00 9.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 25.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0.00	0	1	70 26	339	13. 0 14. 0 15. 0 16. 0 17. 0 18. 0 20. 0 21. 0 22. 0 23. 0 24. 0 24. 1 25. 0
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0.00					26. 0 26. 2 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 32. 0 33. 0

Heal th	Financial Systems ST. VINCENT JENNINGS	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151303	Peri od:	Worksheet S-1	0
				From 07/01/2014		
				To 06/30/2015		
					<u>11/23/2015</u> 8: :	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by Li	ne 202 columr	1.8)	0. 248389	1.00
	Medicaid (see instructions for each line)	acu og i i			01210007	
2.00	Net revenue from Medicaid				64, 150	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	pavments	from Medicaid	1?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from I				0	5.00
6.00	Medicaid charges				11, 999, 032	6.00
7.00	Medicaid cost (line 1 times line 6)				2, 980, 428	7.00
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 min	us sum of lir	nes 2 and 5; if	2, 916, 278	8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruction	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
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 m	inus line 9;	if < zero then	0	12.00
	enter zero)				<u> </u>	
	Other state or local government indigent care program (see instru					
13.00	Net revenue from state or local indigent care program (Not includ				0	
14.00	Charges for patients covered under state or local indigent care p	orogram (Not included	in lines 6 or	0	14.00
15 00	10)					15 00
15.00	State or local indigent care program cost (line 1 times line 14)	ant coro	nrogrom (Lir	a 15 minua lina	0	
16.00	Difference between net revenue and costs for state or local indig 13; if < zero then enter zero)	Jent care	program (III		0	10.00
	Uncompensated care (see instructions for each line)				l	
17.00	Private grants, donations, or endowment income restricted to fund	ding char	itv 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	2, 916, 278	
	8, 12 and 16)				_,,	
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (a		3, 810, 63	35 230, 954	4, 041, 589	20.00
	charges excluding non-reimbursable cost centers) for the entire t					
21.00	Cost of initial obligation of patients approved for charity care	(line 1	946, 52	20 57, 366	1, 003, 886	21.00
~~ ~~	times line 20)					
22.00	Partial payment by patients approved for charity care		044 54	0 0	-	22.00
23.00	Cost of charity care (line 21 minus line 22)		946, 52	20 57, 366	1, 003, 886	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient of	davic hove	nd a longth o	f ctov limit	1.00 N	24.00
24.00	imposed on patients covered by Medicaid or other indigent care p		nu a renyth t	n stay minit		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigen		oaram's Lenat	h of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see insti			an of oray frime	3, 147, 002	
27.00	Medicare bad debts for the entire hospital complex (see instructi				656, 690	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		s line 27)		2, 490, 312	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (rink			28)	618, 566	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			/	1, 622, 452	
	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			4, 538, 730	

		T. VINCENT JENNI	NGS_HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period: From 07/01/2014	Worksheet A	
					o 06/30/2015	Date/Time Pre 11/23/2015 8:	pared:
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	
		our un roo	othor	+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00			4.00	col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		731, 636	731, 636	-15, 648	715, 988	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	307, 239	1, 598, 633			1, 905, 872	
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 181, 516	1, 416, 646			2, 613, 810	
7.00	00700 OPERATION OF PLANT	53, 726	875, 039			928, 765	
8.00	00800 LAUNDRY & LINEN SERVICE	00,720	27, 741	27, 741		27, 741	
9.00	00900 HOUSEKEEPING	0	329, 324			329, 324	
10.00	01000 DI ETARY	0	259, 222			201, 085	
11.00	01100 CAFETERIA	0	207,222			58, 137	
13.00	01300 NURSI NG ADMI NI STRATI ON	70, 778	123, 111	193, 889		193, 889	
14.00	01400 CENTRAL SERVICES & SUPPLY	74, 751	14, 795			89, 546	
15.00	01500 PHARMACY	167, 656	391, 535			559, 191	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	127, 245	25, 875			153, 120	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	127,210	20,070	100, 120	<u> </u>	100, 120	10.00
30, 00	03000 ADULTS & PEDI ATRI CS	885, 017	378, 374	1, 263, 391	-14, 432	1, 248, 959	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	000/01/	0,0,0,1	17200707	11/102	1/210/707	00100
50.00	05000 OPERATI NG ROOM	337, 365	441, 414	778, 779	-53, 913	724, 866	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	791, 847	871, 084			1, 662, 931	
60.00	06000 LABORATORY	0	1, 193, 553			1, 193, 553	
65.00	06500 RESPI RATORY THERAPY	0	5, 253			5, 253	
66.00	06600 PHYSI CAL THERAPY	299	226, 967			225, 677	
67.00	06700 OCCUPATI ONAL THERAPY	0	9, 115			9, 115	
68.00	06800 SPEECH PATHOLOGY	0	1, 869			1, 869	
69.00	06900 ELECTROCARDI OLOGY	0	0			0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 730	4, 730	113, 417	118, 147	
72.00	07200 I MPLANTABLE DEVI CES CHARGED TO	0	48, 898			48, 898	
	PATIENTS						
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
91.00	09100 EMERGENCY	849, 465	894, 461	1, 743, 926	-43, 483	1, 700, 443	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS			_			
118.00	SUBTOTALS (SUM OF LINES 1-117)	4, 846, 904	9, 869, 275	14, 716, 179	9 0	14, 716, 179	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(0 0	0	190.00
191.00	19100 RESEARCH	0	0	(0 0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	-		192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	37, 779	37, 779	9 0	37, 779	194.00
194.02	07952 OUTPATI ENT CLINICS	0	1, 376	1, 376	5 O	1, 376	194.02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0 0	0	194.03
194.04	07955 SPN	0	0	(0 0	0	194.04
200.00	TOTAL (SUM OF LINES 118-199)	4, 846, 904	9, 908, 430	14, 755, 334	1 O	14, 755, 334	200.00

Health Financial Systems	ST. VINCENT JENN	INGS HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet A Date/Time Pr	enared.
				10 00/00/2010	11/23/2015 8	:22 am
Cost Center Description	Adjustments	Net Expenses				
	(See A-8) F	or Allocation				
	6.00	7.00				
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	-267,977	448, 011				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-73, 528	1, 832, 344				4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	871, 335	3, 485, 145				5.00
7.00 00700 OPERATION OF PLANT	-32,270	896, 495				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	27, 741				8.00
9. 00 00900 HOUSEKEEPI NG	-16, 466	312, 858				9.00
10. 00 01000 DI ETARY	-58	201, 027				10.00
11. 00 01100 CAFETERI A	-85,666	-27, 529	1			11.00
13.00 01300 NURSING ADMINISTRATION	0	193, 889	1			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	89, 546				14.00
15. 00 01500 PHARMACY	-2, 343	556, 848				15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-10, 769	142, 351	1			16.00
INPATIENT ROUTINE SERVICE COST CENTERS	-10,709	142, 331				10.00
30. 00 03000 ADULTS & PEDIATRICS	-173, 477	1,075,482				30.00
ANCI LLARY SERVICE COST CENTERS	-1/3,4//	1, 075, 462				
	0	704.044	1			50.00
	-	724, 866	1			
54. 00 05400 RADI OLOGY - DI AGNOSTI C	-117,649	1, 545, 282	•			54.00
	-4, 493	1, 189, 060	•			60.00
65. 00 06500 RESPI RATORY THERAPY	0	5, 253	•			65.00
66. 00 06600 PHYSI CAL THERAPY	0	225, 677				66.00
67.00 06700 OCCUPATIONAL THERAPY	0	9, 115				67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 869	1			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	•			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	118, 147	•			71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	48, 898				72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
91. 00 09100 EMERGENCY	-150,000	1, 550, 443				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	-63, 361	14, 652, 818				118.00
NONREI MBURSABLE COST CENTERS	· · ·					
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0				190.00
191. 00 19100 RESEARCH	0	0				191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	•			192.00
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	37, 779				194.00
194. 02 07952 OUTPATIENT CLINICS	0	1, 376				194.02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	89, 291	89, 291				194.03
194. 04 07955 SPN	07,271	0,2,1	1			194.04
200.00 TOTAL (SUM OF LINES 118-199)	25, 930	14, 781, 264	•			200.00
200.00 101AL (30W 01 LINES 110-177)	23, 930	14,701,204	1			1200.00

Heal th	Financial Systems		ST. VINCENT	JENNI NGS	6 HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS				Provi der	CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet A-	
							To 06/30/2015	Date/Time Pr 11/23/2015 8	:22 am
		Increases							
	Cost Center	Line #	Sal ary	(Other				
	2.00	3.00	4.00		5.00				
	A – CAFETERIA								
1.00	CAFETERI A			0	<u>58, 1</u> 37				1.00
	TOTALS			0	58, 137				
	B – INTEREST								
1.00	ADMI NI STRATI VE & GENERAL	5.00		0	1 <u>5, 6</u> 48				1.00
	TOTALS			0	15, 648				
	C – MEDI CAL SUPPLI ES								_
	MEDICAL SUPPLIES CHARGED TO	71.00		0	113, 417				1.00
	PATI ENTS								
2.00		0.00		0	0				2.00
3.00		0.00		0	0				3.00
4.00	L	0.00		0	0				4.00
	TOTALS			0	113, 417				
500.00	Grand Total: Increases			0	187, 202				500.00

Heal th	Financial Systems	S	ST. VINCENT	JENNI NO	S HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS				Provi der	CCN: 151303	Peri od:	Worksheet A-	6
							From 07/01/2014 To 06/30/2015	Date/Time Pr 11/23/2015 8	epared: :22 am
		Decreases							
	Cost Center	Line #	Sal ary		0ther	Wkst. A-7 Re	f.		
	6.00	7.00	8.00		9.00	10.00			
	A – CAFETERIA								
1.00	DI ETARY	10.00		0	58, 137		0		1.00
	TOTALS			0	58, 137				
	B – INTEREST								
1.00	CAP REL_COSTS-BLDG & FIXT	1.00		0	15, 648		9		1.00
	TOTALS			0	15, 648				
	C – MEDICAL SUPPLIES								
1.00	ADULTS & PEDIATRICS	30.00		0	14, 432		0		1.00
2.00	OPERATING ROOM	50.00		0	53, 913		0		2.00
3.00	PHYSI CAL THERAPY	66.00		0	1, 589		0		3.00
4.00	EMERGENCY	91.00		0	43, 483		0		4.00
	TOTALS			0	113, 417				
500.00	Grand Total: Decreases			0	187, 202				500.00

Heal th	Financial Systems S	T. VINCENT JENN	II NGS_HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151303	Period: From 07/01/2014 To 06/30/2015		pared:
				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 ASSE				- 1		
1.00	Land	127, 944	0		0 0	0	1.00
2.00	Land Improvements	409, 779	0		0 0	0	2.00
3.00	Buildings and Fixtures	13, 701, 092	0		0 0	19, 551	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	968, 285	98, 132		0 98, 132	0	5.00
6.00	Movable Equipment	3, 400, 066	475, 341		0 475, 341	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18, 607, 166	573, 473		0 573, 473	19, 551	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	18, 607, 166	573, 473		0 573, 473	19, 551	10.00
	· · · ·	Ending Balance	Fully				
		Ũ	Depreciated				
			Assets				
		6.00	7.00]			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES					
1.00	Land	127, 944	0				1.00
2.00	Land Improvements	409, 779	0				2.00
3.00	Buildings and Fixtures	13, 681, 541	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	1, 066, 417	0				5.00
6.00	Movable Equipment	3, 875, 407	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	19, 161, 088	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	19, 161, 088	0				10.00

Heal th	Financial Systems S	ST. VINCENT JENI	NINGS HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 07/01/2014 To 06/30/2015		pared: 22 am
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	376, 267	0	330, 96	0 24, 409	0	1.00
3.00	Total (sum of lines 1-2)	376, 267	0	330, 96	0 24, 409	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN					
1.00	CAP REL COSTS-BLDG & FIXT	0	731, 636				1.00
3.00	Total (sum of lines 1–2)	0	731, 636				3.00

Health Financial Systems S	T. VINCENT JEN	NINGS HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period:	Worksheet A-7	
				From 07/01/2014 To 06/30/2015		nared
				10 00/ 30/ 2013	11/23/2015 8:	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col. 2)			
	1.00	2.00	3,00	4, 00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	5.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FLXT	19, 161, 088	0	19, 161, 088	3 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	19, 161, 088		19, 161, 088			3.00
	1 - 1	TION OF OTHER (F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1	1	1	1		
1.00 CAP REL COSTS-BLDG & FIXT	0	-	(160, 927		1.00
3.00 Total (sum of lines 1-2)	0	0		160, 927	0	3.00
		SL	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)		Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)	,	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-	1				
1.00 CAP REL COSTS-BLDG & FIXT	262, 675			0 0	448, 011	1.00
3.00 Total (sum of lines 1-2)	262, 675	24, 409	(0 0	448, 011	3.00

^{11/23/2015 8:22} am Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20150630\28550-15.mcrx

USTI	MENTS TO EXPENSES			Provi der	CCN: 151303	Period: From 07/01/2014	Worksheet A-8	
						To 06/30/2015		
						on Worksheet A s to be Adjusted		
	Cost Center Description		Amount		Center		Wkst. A-7 Ref.	
0	Investment income - CAP REL	1.00 B	<u>2.00</u> -199,692	CAP REL COSTS	.00 -BLDG & FIXT	4.00	5.00	1
0	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	*** Cost Cente	ar Deleted **		0	2
	COSTS-MVBLE EQUIP (chapter 2)	5						
0	Investment income - other (chapter 2)	В	-9, 910	ADMI NI STRATI VE	E & GENERAL	5.00		
0	Trade, quantity, and time discounts (chapter 8)		0			0.00	0	4
0	Refunds and rebates of expenses (chapter 8)		0			0.00	0	5
0	Rental of provider space by		0			0.00	0	6
0	suppliers (chapter 8) Telephone services (pay		0			0.00	0	7
	stations excluded) (chapter 21)							
0	Television and radio service (chapter 21)	А	-4, 484	OPERATION OF F	PLANT	7.00	0	8
0	Parking lot (chapter 21)		0			0.00	0	
00	Provider-based physician adjustment	A-8-2	-440, 236				0	10
00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11
00	Related organization	A-8-1	1,061,620				0	12
00	transactions (chapter 10) Laundry and linen service		0			0.00	0	1:
00 00	Cafeteria-employees and guests Rental of quarters to employee	В	-85,666	CAFETERI A		11.00 0.00		
	and others Sale of medical and surgical		0					
00	supplies to other than		U			0.00	0	16
00	patients Sale of drugs to other than		0			0.00	0	17
00	patients Sale of medical records and	В	-10 769	MEDI CAL RECORI	NS & LIBRARY	16.00	0	18
00	abstracts Nursing school (tuition, fees,		0			0.00		
	books, etc.)		U					
00 00	Vending machines Income from imposition of		0			0.00		
	interest, finance or penalty charges (chapter 21)							
00	Interest expense on Medicare overpayments and borrowings to		0			0.00	0	22
	repay Medicare overpayments							
00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY TH	HERAPY	65.00		23
00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THER	Δργ	66.00		24
00	therapy costs in excess of		Ū					
00	limitation (chapter 14) Utilization review –		0	*** Cost Cente	er Deleted **	* 114.00		25
	physicians' compensation (chapter 21)							
00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS	-BLDG & FIXT	1.00	0	26
00	Depreciation - CAP REL		0	*** Cost Cente	er Deleted **	2.00	0	27
00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Cente	er Deleted *'	.* 19.00		28
00 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL	THERAPY	0.00		29
	therapy costs in excess of							
99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDI	ATRI CS	30.00		30
00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLO	DGY	68.00		31
	pathology costs in excess of limitation (chapter 14)							
00	CAH HIT Adjustment for		0			0.00	0	32
00	Depreciation and Interest PAYROLL INCENTIVE	А	-152, 891	EMPLOYEE BENER	FITS DEPARTME			
01	MI SC REVENUE	В	-952	ADMI NI STRATI VI	E & GENERAL	5.00	0	33

Health Financial Systems	S	T. VINCENT JEN	NINGS HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 07/01/2014		
				To 06/30/2015	Date/Time Pre 11/23/2015 8:	
			Expense Classification on	Worksheet A	1172372013 0.	
			To/From Which the Amount is			
				,		
Cost Center Description	Basis/Code (2)		Cost Center	-	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33. 02 CHARI TABLE EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00		00.02
33.03 AHA & I HA DUES	A		ADMINISTRATIVE & GENERAL	5.00		33.03
33.07 MI SC REVENUE	В	-2, 343	PHARMACY	15.00	0	33.07
33.08 MISC REVENUE	В	-4, 493	LABORATORY	60.00	0	33.08
33.09 PHYSICIAN HOUSEKEEPING	A	-16, 466	HOUSEKEEPI NG	9.00	0	33.09
33.10 PHYSICIAN PLANT OPS	A	-11, 149	OPERATION OF PLANT	7.00	0	33.10
33.11 PHYSICIAN BENEFITS	A	-254	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12 MISC REVENUE	В	-58	DI ETARY	10,00	0	33.12
33. 13 MI SC REVENUE	В	-2,439	ADMI NI STRATI VE & GENERAL	5.00	0	33.13
33. 14 ENTERTAL NMENT	A		EMPLOYEE BENEFITS DEPARTMENT			33.14
33. 15 ENTERTAL MENT	A	-325	ADMINI STRATI VE & GENERAL	5.00	0	33.15
33. 16 ENTERTAI NMENT	A		RADIOLOGY - DIAGNOSTIC	54.00		33.16
33. 17 HOSPITAL PROVIDER TAX	A		ADMI NI STRATI VE & GENERAL	5.00		
33. 18 LATE PENALTY FEE	A		ADULTS & PEDIATRICS	30.00		
33. 19 LATE PENALTY FEE	A		RADIOLOGY - DIAGNOSTIC	54.00		33.19
50.00 TOTAL (sum of lines 1 thru 49)		25, 930				50.00
(Transfer to Worksheet A,		,				
column 6, line 200.)						

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

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

Heal th	Financial Systems	ST. VINCENT JEI	NNI NGS HOSPI TAL	In Li	eu of Form CMS-	2552-10
STATEME OFFI CE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO	ME Provi der CCN: 151303	Period: From 07/01/2014 To 06/30/2015	5 Date/Time Pre	epared:
	I ' NI				11/23/2015 8:	22 am
	Line No.	Cost Center	Expense Items	Amount of	Amount Included in	
				Allowable Cost	Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF				
	HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	69, 780	69, 780	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1, 911, 401	930, 609	2.00
3.00	194.03	OTHER NONREIMBURSABLE COST C	HOME OFFICE	89, 291	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	133, 461	133, 461	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	618, 599	618, 599	4.01
4.02	7.00	OPERATION OF PLANT	SVH CHARGEBACKS	25, 664	25, 664	4.02
4.03	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	350	350	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	SVH CHARGEBACKS	84, 103	84, 103	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACKS	60, 843	60, 843	4.05
4.06	0.00			0	0	4.06
4.07	54.00	RADIOLOGY – DIAGNOSTIC	SVH CHARGEBACKS	22, 134	22, 134	4.07
4.08	0.00			0	0	4.08
4.09		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF-INSURANCE	774, 720	841, 823	4.09
4.10	0.00			0	0	4.10
4.11			ASCENSION INTEREST	247,027		4.11
4.12		ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	12, 259	15, 648	4.12
4.13	0.00			0	0	4.13
4.14		OPERATION OF PLANT	TRIMEDX	416, 683		4.14
4.15		EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	208, 139	61, 188	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4. 18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4. 21
4.22	0.00			0	0	4. 22
5.00	0		0	4, 674, 454	3, 612, 834	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

1103 1101	been posted to norkaneet A,	cordining r and/or 2, the allour	it arrowable 3h		for this part.	
				Related Organization(s) and	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	

B. INTERRELATIONSHIP TO 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.

1 01 110 01					
6.00	G	ST. VINCENT HEA	100.00 ST. VINCENT HEA	100.00	6.00
7.00	В	ST. VINCENT HOS	100.00 ST. VINCENT HOS	100.00	7.00
8.00	G	ASCENSI ON	100.00 ASCENSI ON	100.00	8.00
9.00	A	TRIMEDX	0. 00 TRI MEDX	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.

 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 JENNINGS HOSPITAL	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED	ORGANIZATIONS AND HOME Provider CCN: 15	
OFFICE COSTS		From 07/01/2014 To 06/30/2015 Date/Time Prepared

					10 06/30/2015	11/23/2015 8:22 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			MENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED OF	RGANIZATIONS OR C	LAIMED
	HOME OFFICE CO	STS:				
1.00	0	0				1.00
2.00	980, 792	0				2.00
3.00	89, 291	0				3.00
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	-67, 103					4.09
4.10	0	-				4.10
4.11	-68, 285					4.11
4.12	-3, 389	0				4. 12
4.13	0	0				4.13
4.14	-16, 637	0				4.14
4.15	146, 951	0				4.15
4.16	0	0				4.16
4. 17 4. 18	0	0				4.17
4.18 4.19	0	0				4.18
4. 19 4. 20		0				4. 19
4.20 4.21		0				4.20
4.21		0				4. 2
4.22 5.00	1, 061, 620	0				4. 22
5.00	1,001,020					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.

nas not	been posted to worksheet A,	corumns r ar	1/01 2	, the amount	. arrowabre	Shourd	be thui cated	Th Corumn 4	or this part.	
	Related Organization(s)									
	and/or Home Office									
	Type of Business	1								
	51									
	6.00									

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.

rerinbur		
6.00	ADMI NI STRATI ON	6.00
7.00	HOSPI TAL	7.00
8.00	ADMI NI STRATI ON	8.00
9.00	TECHNOLOGY MGMT	9.00
10.00		10.00
100.00		100.00

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

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

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

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

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

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

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

Health Financial Systems

ST. VINCENT JENNINGS HOSPITAL

In Lieu of Form CMS-2552-10

Hearth	Financial Syste	ans	SI. VINCENI JEI		SPITAL	·	I II LI	eu or Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Pr	ovi der		Period: From 07/01/2014 To 06/30/2015		
							To 06/30/2015	5 Date/Time Pre 11/23/2015 8:	
	Wkst. A Line #	Cost Center/Physician	Total	Profess	i onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Compor		Component		ider Component	
								Hours	
	1.00	2.00	3.00	4.0	0	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	173, 450	1	73, 450	() C	0 0	1.00
2.00	54.00	RADIOLOGY - DIAGNOSTIC	116, 786	1	16, 786	(ol c	0 0	2.00
3.00	91.00	EMERGENCY	597, 235	1	50, 000	447, 235	s c	0 0	3.00
4.00	0.00		0		0			0 0	4.00
5.00	0.00		0		0	(0	
6.00	0.00		0		0	(0	
7.00	0.00		0		Ő	(o o	
8.00	0.00		0		0				1
9.00	0.00				0				9.00
10.00	0.00		0		0				
200.00	0.00		887, 471		40, 236	447, 235			1
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Cost of	Provi der	Physician Cost	
	WKSL. A LINE #	I denti fi er				Memberships &		of Malpractice	
		ruentirrei		Li mi		Continuing	Share of col.		
					ι	Educati on	12	I IISUI ance	
	1.00	2.00	8.00	9.0	0	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0.00		0	12.00			1.00
2.00		RADIOLOGY - DIAGNOSTIC	0		0	(
3.00		EMERGENCY			0				
4.00	0.00		0		0				
4.00 5.00	0.00		0		0				
6.00	0.00		0		0				
7.00	0.00		0		0				
	0.00		0		0				
8.00			0		0			0	
9.00	0.00		0		0	(0	
10.00	0.00		0		0	(0	
200.00			0		0	005		0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjuste		RCE	Adjustment		
		I denti fi er	Component	Limi	τ	Di sal I owance			
			Share of col.						
	1.00	2.00	14 15.00	16. (0	17.00	18.00	-	
1.00		ADULTS & PEDIATRICS	15.00		0	17.00			1.00
		RADIOLOGY - DIAGNOSTIC			0				
2.00			0		0	(2.00
3.00		EMERGENCY	0		0		150,000		3.00
4.00	0.00		0		0				4.00
5.00	0.00		0		0				5.00
6.00	0.00		0		0	(c C		6.00
7.00	0.00		0		0	(C C)	7.00
8.00	0.00		0		0	(C C		8.00
9.00	0.00		0		0	() C		9.00
10.00	0.00		0		0	() C)	10.00
200.00			0		0	(440, 236	0	200.00

001011	DE SUPPLIERS			CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8 Parts I-VI Date/Time Pre 11/23/2015 8:3	pared:
					Physical Therapy		
						1.00	
	PART I – GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			52	1.00
2.00	Line 1 multiplied by 15 hours per week	oon on thoronic	t waa an noovi	dan aita (aa	o instructions)	780 293	
3.00 4.00	Number of unduplicated days in which supervis Number of unduplicated days in which therapy					293 59	3.00
1.00	nor therapist was on provider site (see instr		on provider si		Super vi ser	0,	
5.00	Number of unduplicated offsite visits - super	rvisors or ther	apists (see in	structions)		0	5.00
6.00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the					0	6.00
	instructions)	apist was not	present during	the visit(s	(366		
7.00	Standard travel expense rate					5. 21	7.00
8.00	Optional travel expense rate per mile	Supervicerc	Thoranists	Accietante	Aidoc	0.00	8.00
		Supervi sors 1.00	Therapists 2.00	Assistants 3.00	Ai des 4.00	Trai nees 5.00	
9.00	Total hours worked	0.00	1, 704.00	1, 304.		0.00	9.00
10. 00	AHSEA (see instructions)	0.00	77.54	58.		0.00	10.00
11.00	Standard travel allowance (columns 1 and 2,	38. 77	38.77	29.	08		11.00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12. 01	Number of travel hours (offsite)	0	0		0		12.01
13.00	Number of miles driven (provider site)	0	0		0		13.00
13.01	Number of miles driven (offsite)	0	0		0		13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1,					0	
15.00 16.00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					132, 128 75, 828	
17.00	Subtotal allowance amount (sum of lines 14 ar		ratory therapy	or lines 14	-16 for all	207, 956	
	others)						
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 fo		therapy or lin	es 17 and 18	for all others)	0 207, 956	19.00 20.00
20.00	If the sum of columns 1 and 2 for respiratory						20.00
	occupational therapy, line 9, is greater than	n line 2, make					
21 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by ou	m of columns	1 and 2 Line 0	0.00	1 21 00
21.00	for respiratory therapy or columns 1 thru 3,					0.00	21.00
22. 00	Weighted allowance excluding aides and traine					0	22.00
23.00	Total salary equivalency (see instructions)					207, 956	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVE	L EXPENSE COMP	UTATION - PR	OVIDER SITE		-
24.00	Therapists (line 3 times column 2, line 11)					11, 360	24.00
25.00	Assistants (line 4 times column 3, line 11)					1, 716	
26.00	Subtotal (line 24 for respiratory therapy or					13, 076	
27.00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or s	um of lines	3 and 4 for all	1, 834	27.00
28.00	Total standard travel allowance and standard	travel expense	at the provid	er site (sum	of lines 26 and	14, 910	28.00
	27)	•	•				
20.00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of					0	
29.00 30.00	Assistants (column 3, line 10 times column 3,		ia z, tine iz)			0	29.00 30.00
31.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for a	II others)		0	31.00
32.00	Optional travel expense (line 8 times columns	s 1 and 2, line	13 for respir	atory therap	y or sum of	0	32.00
22.00	columns 1-3, line 13 for all others)	avnanca (lina	20)			14 010	22.00
33.00 34.00	Standard travel allowance and standard travel Optional travel allowance and standard travel			d 31)		14, 910 0	33.00 34.00
35.00	Optional travel allowance and optional travel					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	ANCE AND TRAVEL	EXPENSE COMPU	TATION - SER	VICES OUTSIDE PRO	VIDER SITE	
	Standard Travel Expense						
36.00 37.00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)					0	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sur		id 6)			0	
40.00	Optional Travel Allowance and Optional Travel		0			_	40.0-
40.00	Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column		2, line 10)			0	40.00
41.00	Subtotal (sum of lines 40 and 41)	, , , , , , , , , , , , , , , , , , ,				0	
43.00	Optional travel expense (line 8 times the sur	<u>m of colu</u> mns 1-	<u>3, line 1</u> 3.01)			0	
	Total Travel Allowance and Travel Expense - C			e of the fol	lowing three line	s 44, 45,	
	or 46, as appropriate.		of Linos 20 am	d 20	nstructions)		44.00
11 00		expense (SUM	ULLINES 38 an	u 37 - See I	IISTIUCTIONS)	0	1 44. UC
44.00 45.00	Standard travel allowance and standard travel Optional travel allowance and standard travel						45.00

			Provi der		Period: From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 8:	pared:
					Physical Therapy	Cost	
						1.00	
<u>5.00 0</u>	Optional travel allowance and optional travel						46.00
		Therapi sts	Assistants	Aides	Trai nees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting	0.00	0.00	0.0	0 0.00	0.00	47.00
	period (if column 5, line 47, is zero or	0.00	0.00	0.0	0.00	0.00	47.00
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
	column of line 56)						
8.00 0	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00
9.00 T	Total overtime (including base and overtime	0.00	0.00	0.0	0.00		49.00
г	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT				1		
	Percentage of overtime hours by category	0.00	0.00	0.0	0 0.00	0.00	50.00
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5,						
	line 47)	0.00	0.00	0.0	0 0 00	0.00	E1 00
	Allocation of provider's standard work year for one full-time employee times the	0.00	0.00	0.0	0 0.00	0.00	51.00
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE						
	Adjusted hourly salary equivalency amount	77.54	58.15	0.0	0 0.00		52.00
	(see instructions)				-		
3.00 0	Overtime cost limitation (line 51 times line	0	0		0 0		53.00
5	52)						
4.00 N	Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
	line 49 or line 53)						
	Portion of overtime already included in	0	0		0 0		55.00
	hourly computation at the AHSEA (multiply						
	line 47 times line 52) Duartime allowance (line 54 minus line 55	0	0		0 0	0	56.00
6.00 0	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	0		0 0	0	50.00
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
	Salary equivalency amount (from line 23)	(207, 956	
	Travel allowance and expense - provider site			`		14, 910	
1	Travel allowance and expense - Offsite servic	ces (Trom lines	44, 45, Or 46)		0	
	Overtime allowance (from column 5, line 56)					0	
1	Equipment cost (see instructions)					0	
1	Supplies (see instructions)					-	
	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	vour rocorde)				222, 866 219, 417	
	Excess over limitation (line 64 minus line 63		enter zero)				65.00
	INE 33 CALCULATION	5 - TT negative,	enter zero)			0	05.00
	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	ll others		13, 076	100 0
	Line 27 = line 7 times line 3 for respiratory				others	1, 834	
	Line $33 = 1$ ine $28 = $ sum of lines 26 and 27	,				14, 910	
	INE 34 CALCULATION						
16	Line 27 = line 7 times line 3 for respiratory	/ therapy or sum	n of lines 3 a	nd 4 for all	others	1, 834	101.00
							101.01
01. 00 L	Line 31 = 11he 29 for respiratory therapy or						
01. 00 L 01. 01 L	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31					1, 834	101. 0 ∠
01. 00 L 01. 01 L 01. 02 L						1, 834	101.0.
01.00L 01.01L 01.02L	Line 34 = sum of lines 27 and 31		and 30 for a	II others			101.02
01. 00 L 01. 01 L 01. 02 L L 02. 00 L	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 29			mns 1-3, line	0	

	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	T. VINCENT JENN FURNI SHED BY		1	Period: From 07/01/2014 Fo 06/30/2015 Occupational Therapy	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 11/23/2015 8: Cost	-3 pared:
					-	1.00	
	PART I - GENERAL INFORMATION						
1.00 2.00	Total number of weeks worked (excluding aide: Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			21 315	1.00 2.00
3.00	Number of unduplicated days in which supervis	sor or therapis	t was on provid	der site (see	instructions)	30	3.00
4.00	Number of unduplicated days in which therapy		on provider si	te but neither	supervi sor	0	4.00
5.00	nor therapist was on provider site (see inst		anists (soo in	structions)		0	5.00
6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - there				/ therapy	0	6.00
	assistant and on which supervisor and/or the						
7.00	instructions) Standard travel expense rate					5. 21	7.00
8.00	Optional travel expense rate per mile					0.00	
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	
9.00	Total hours worked	1.00	2.00 83.00	3.00	4.00 0.00	5.00 0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.50	0.00		0.00	
11.00	Standard travel allowance (columns 1 and 2,	36. 75	36.75	0.00	D		11.00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	о	(D		12.00
12.01	Number of travel hours (offsite)	0	0		D		12.01
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0				13.00 13.01
13.01		<u> </u>	V				13.01
	Dept 11 CALADY FOULVALENCY CONDUTATION					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,					6, 101	15.00
16.00	Assistants (column 3, line 9 times column 3,					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and others)	na 15 tor respi	ratory therapy	or lines 14-	16 TOP ALL	6, 101	17.00
18.00	Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, li			47 4 40 4		0	19.00
20. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					6, 101	20.00
	occupational therapy, line 9, is greater than	n line 2, make i					
21.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by cu	n of columns (Land 2 Line 0	73. 51	21.00
21.00	for respiratory therapy or columns 1 thru 3,					75.01	21.00
22.00	Weighted allowance excluding aides and train					23, 156	
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW					23, 156	23.00
	Standard Travel Allowance	VANCE AND TRAVEL	L EXPENSE COMPL	JTATION - PROV	IDER SITE		
24.00						1, 103	
25.00	Assistants (line 4 times column 3, line 11)	oum of Linco D	4 and 25 fam al	(athera)		0	
26.00 27.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				and 4 for all	1, 103 156	
	others)		,				
	Total standard travel allowance and standard	travel expense	at the provid		of lines 26 and		
28.00		thaton onpolico		er site (sum d		1, 259	28. 00
	27) Optional Travel Allowance and Optional Travel	· .		er site (sum d		1, 259	28. 00
28. 00 29. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	Expense of columns 1 and	•	er site (sum d		0	29. 00
28.00 29.00 30.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3	Expense of columns 1 an , line 12)	d 2, line 12)			0	29. 00 30. 00
28.00 29.00 30.00 31.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	Expense of columns 1 an , line 12) sum of lines 2	d 2, line 12) 9 and 30 for al	I others)		0	29. 00 30. 00 31. 00
28.00 29.00 30.00 31.00 32.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	Expense of columns 1 and line 12) sum of lines 2 s 1 and 2, line	d 2, line 12) 9 and 30 for al 13 for respira	I others)		0 0 0 0	29.00 30.00 31.00 32.00
28.00 29.00 30.00 31.00 32.00 33.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line l expense (line	d 2, line 12) 9 and 30 for al 13 for respira 28)	ll others) atory therapy		0 0 0 0 1, 259	29.00 30.00 31.00 32.00 33.00
28.00 29.00 30.00 31.00 32.00 33.00 34.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum of	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and	ll others) atory therapy d 31)		0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00
28.00 29.00 30.00 31.00 32.00 33.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	ll others) atory therapy d 31) d 32)	or sum of	0 0 0 1, 259 0 0	29.00 30.00 31.00 32.00 33.00
28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	ll others) atory therapy d 31) d 32)	or sum of	0 0 0 1, 259 0 0 VI DER_SI TE	29.00 30.00 31.00 32.00 33.00 34.00 35.00
28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Optional travel allowance and optional trave Deart IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	ll others) atory therapy d 31) d 32)	or sum of	0 0 0 1, 259 0 0	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum ANCE AND TRAVEL	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU	ll others) atory therapy d 31) d 32)	or sum of	0 0 0 1, 259 0 0 VI DER_SITE 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00
28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum expense (sum NACE AND TRAVEL	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU	ll others) atory therapy d 31) d 32)	or sum of	0 0 0 1, 259 0 0 VI DER SI TE 0 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum NCE AND TRAVEL m of lines 5 and Expense	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT d 6)	ll others) atory therapy d 31) d 32)	or sum of	0 0 0 1, 259 0 0 VI DER SI TE 0 0 0 0 0	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	Expense Df columns 1 an, line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum NNCE AND TRAVEL m of lines 5 an Expense D1 times column	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT d 6)	ll others) atory therapy d 31) d 32)	or sum of	0 0 0 1, 259 0 0 VI DER SI TE 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum of l expense (sum of expense (sum of	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT d 6) 2, line 10)	ll others) atory therapy d 31) d 32)	or sum of	0 0 0 0 1, 259 0 0 VI DER SI TE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.4 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line 1 expense (line 1 expense (sum of 1 expense (sum of 1 expense (sum of NNCE AND TRAVEL m of lines 5 and Expense D1 times column n 3, line 10) m of columns 1-	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT d 6) 2, line 10) 3, line 13.01)	d 31) d 32) FATION - SERVI	or sum of CES OUTSI DE PRO	0 0 0 0 1, 259 0 0 VI DER SI TE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	Expense of columns 1 and , line 12) sum of lines 2 s 1 and 2, line 1 expense (line 1 expense (sum of 1 expense (sum of 1 expense (sum of NNCE AND TRAVEL m of lines 5 and Expense D1 times column n 3, line 10) m of columns 1-	d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT d 6) 2, line 10) 3, line 13.01)	d 31) d 32) FATION - SERVI	or sum of CES OUTSI DE PRO	0 0 0 0 1, 259 0 0 VI DER SI TE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der		Period: From 07/01/2014 To 06/30/2015 Occupational Therapy		pared:
					merupy		
45 00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see in	structions)	1.00	45.00
	Optional travel allowance and optional travel		of lines 42 an			0	•
		Therapi sts	Assistants	Aides	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0.0	0 0. 00	0. 00	47.00
48.00	Overtime rate (see instructions)	0. 00	0.00				48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0.0	0 0.00		49.00
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0 0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0 0.00	0.00	51.00
F0 00	DETERMINATION OF OVERTIME ALLOWANCE	70.50					50.00
52.00 53.00	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line	73. 50 0	0.00		0 0.00 0 0		52.00 53.00
54.00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
55.00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		o o	0	56.00
		4			- I		
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EVCESS COST				1.00	
	Salary equivalency amount (from line 23)	ND EXCLOSE COST	ADJUSTMENT			23, 156	57.00
62. 00 63. 00 64. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63	i your records)	44, 45, or 46)			59.00 60.00 61.00 62.00
55.00	LINE 33 CALCULATION	- i negati ve				0	05.00
100. 01	100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 100.02 Line 33 = line 28 = sum of lines 26 and 27						
101. 01	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02
102.00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				mns 1-3 line	0	102.00 102.01
	13 for all others Line 35 = sum of lines 31 and 32		тогу тнегару о		mis 1-5, TINE		102. 01

	DE SUPPLIERS	FURNI SHED BY		CN: 151303	Peri od: From 07/01/2014 To 06/30/2015 Speech Pathol og	5 Date/Time Pre 11/23/2015 8:	pared:
					Speech Fathorog		
						1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides	s) (see instruct	i ons)			18	1.00
2.00	Line 1 multiplied by 15 hours per week					270	
3.00	Number of unduplicated days in which supervise					20	
4.00	Number of unduplicated days in which therapy nor therapist was on provider site (see instr		n provider sit	e but neith	ner supervisor	0	4.00
5.00	Number of unduplicated offsite visits - super		pists (see ins	tructions)		0	5.00
6.00	Number of unduplicated offsite visits - thera					0	6.00
	assistant and on which supervisor and/or ther instructions)	apist was not p	oresent during	the visit(s	s)) (see		
7.00	Standard travel expense rate					5. 21	7.00
8.00	Optional travel expense rate per mile					0.00	1
		Supervi sors	Therapists	Assi stants		Trai nees	
9.00	Total hours worked	1.00	2.00	3.00	4.00 00 0.00	5.00 0.00	9.00
7.00 10.00	AHSEA (see instructions)	0.00	70.65		00 0.00		1
11.00	Standard travel allowance (columns 1 and 2,	35.33	35.33		00		11.00
	one-half of column 2, line 10; column 3,						
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	o		0		12.00
12.00	Number of travel hours (offsite)	0	0		0		12.00
13.00	Number of miles driven (provider site)	0	0		0		13.00
13.01	Number of miles driven (offsite)	0	0		0		13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1,					0	
15.00	Therapists (column 2, line 9 times column 2,					2, 543	
16.00 17.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 ar		atory therapy	or lines 1/	1-16 for all	0 2, 543	
17.00	others)		atory therapy	01 111103 1-		2, 545	17.00
18.00	Aides (column 4, line 9 times column 4, line					0	
19.00 20.00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17-19 fo		harany or line	o 17 and 10) fam all athema)	0 2, 543	
20.00	If the sum of columns 1 and 2 for respiratory						20.00
	occupational therapy, line 9, is greater than						
21 00	the amount from line 20. Otherwise complete		all of all all lass as one	-61	- 1	70 (4	1 01 00
21.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,			OT COLUMNS	s I and 2, IIne 9	70.64	21.00
22.00	Weighted allowance excluding aides and traine					19, 073	22.00
23.00	Total salary equivalency (see instructions)					19, 073	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPU	TATION - PF	ROVIDER SITE		-
24 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					707	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	
26.00	Subtotal (line 24 for respiratory therapy or					707	1
27.00	Standard travel expense (line 7 times line 3	for respiratory	therapy or su	m of lines	3 and 4 for all	104	27.00
28.00	others) Total standard travel allowance and standard	travel expense	at the provide	r site (sum	n of lines 26 and	811	28.00
201 00	27)	trator expense	at the provide				20,00
	Optional Travel Allowance and Optional Travel					-	
29.00 30.00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		[2,]ine 12)			0	
31.00	Subtotal (line 29 for respiratory therapy or		and 30 for al	l others)		0	
32.00	Optional travel expense (line 8 times columns				oy or sum of	0	1
~~ ~~	columns 1-3, line 13 for all others)	<i>(</i> 1,1)	22)				
33.00 34.00	Standard travel allowance and standard travel Optional travel allowance and standard travel			21)		811	33.00 34.00
35.00	Optional travel allowance and optional travel					0	
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				RVICES OUTSIDE PR	OVIDER SITE	
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	
37.00 38.00							
39.00	Standard travel expense (line 7 times the sur	<u>n of lines 5 a</u> nd	6)			0	
10 5-	Optional Travel Allowance and Optional Travel		0 11 17				1.0 -
40.00 41.00	Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column		2, line 10)			0	1
41.00	Subtotal (sum of lines 40 and 41)	· 5, THE 10)				0	
43.00	Optional travel expense (line 8 times the sur	<u>n of columns</u> 1-3	8 <u>, line 13.01</u>)			0	
	Total Travel Allowance and Travel Expense - C			of the fol	lowing three lin	es 44, 45,	
44.00	or 46, as appropriate. Standard travel allowance and standard travel	expense (cum a	flines 20 and	39 - 500 -	nstructions)	0	44.00
	Optional travel allowance and standard travel						44.00
45.00							

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8 Parts I-VI Date/Time Prep 11/23/2015 8:2	pared:
	· · · · · · · · · · · · · · · · · · ·				Speech Pathology	Cost	
						1.00	
16.00	Optional travel allowance and optional travel					0	46.00
		Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION		2100	0100		0100	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0.0	0.00	0.00	47. OC
8.00	Overtime rate (see instructions)	0. 00	0.00	0.0	0.00		48.00
9.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00				49.00
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0.00	0.0	0. 00	0.00	50.00
1. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.0	00 0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
2.00	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line	70. 65 0	0.00	0.0	0 0.00		52.00 53.00
3.00 4.00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		53.00
5.00	line 49 or line 53) Portion of overtime already included in	0	0		0 0		55.00
0.00	hourly computation at the AHSEA (multiply line 47 times line 52)	Ŭ	0				
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3	0	0		0 0	0	56.00
	for all others.)						
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EVCESS COST (1.00	
7.00	Salary equivalency amount (from line 23)	ND LACESS COST F				19, 073	57.00
8.00	Travel allowance and expense - provider site	(from lines 33,	34, or 35))			811	
9.00	Travel allowance and expense - Offsite servic	es (from lines 4	14, 45, or 46)		0	59.00
0. 00	Overtime allowance (from column 5, line 56)					0	60.00
1.00	Equipment cost (see instructions)					0	61.00
2.00	Supplies (see instructions)					0	62.00
3.00	Total allowance (sum of lines 57-62)					19, 884	
4.00	Total cost of outside supplier services (from	, , , , , , , , , , , , , , , , , , ,				1, 869	
5.00	Excess over limitation (line 64 minus line 63	- if negative,	enter zero)			0	65.0
~ ~	LINE 33 CALCULATION	6.11 04	1 05 C			707	100.00
	Line 26 = line 24 for respiratory therapy or						100.00
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	therapy or sum	or lines 3 a	nd 4 Tor all	otners		100. 01 100. 02
			of lines 3 a	nd 4 for all	others	104	101.00
00. 02	LINE 34 CALCULATION	therany or sum			others		101.01
00. 02 01. 00	Line 27 = line 7 times line 3 for respiratory			ll others		0	
00. 02 01. 00 01. 01				II others			101. 02
00. 02 01. 00 01. 01 01. 02 02. 00	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines 29 sum of lines 29	and 30 for a and 30 for a	II others		104 0	101. 02 102. 00
00. 02 01. 00 01. 01 01. 02 02. 00	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 29 sum of lines 29	and 30 for a and 30 for a	II others	mns 1-3, line	104 0	101. 02

Heal th	Financial Systems	ST. VINCENT JEN	NI NGS HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151303	Period: From 07/01/2014		
					To 06/30/2015	Date/Time Pre 11/23/2015 8:	pared: 22 am
			CAPI TAL				
	Cost Center Description	Net Expenses	RELATED COSTS BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost		BENEFITS	Subtotui	& GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		<u>col.7)</u>	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS	0	1.00	4.00	4A	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	448, 011	448, 011				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 832, 344	C	1, 832, 34	4		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 485, 145	39, 579	476, 89	4 4, 001, 618	4, 001, 618	5.00
7.00	00700 OPERATION OF PLANT	896, 495	40, 898	21, 68	5 959, 078	355, 430	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	27, 741			0 28, 228	10, 461	
9.00	00900 HOUSEKEEPI NG	312, 858			0 322, 053	119, 351	9.00
10.00	01000 DI ETARY	201, 027			0 205, 561	76, 180	
11.00	01100 CAFETERI A	-27, 529			0 -18, 186	0	
13.00	01300 NURSING ADMINISTRATION	193, 889				82, 835	
14.00	01400 CENTRAL SERVICES & SUPPLY	89, 546				47, 129	
15.00	01500 PHARMACY	556, 848				232, 998	
16.00	01600 MEDICAL RECORDS & LIBRARY	142, 351	35, 481	51, 36	0 229, 192	84, 937	16.00
30, 00	03000 ADULTS & PEDI ATRI CS	1,075,482	42, 032	357, 21	9 1, 474, 733	546, 529	30.00
	ANCILLARY SERVICE COST CENTERS	.,	,		., .,,		
50.00	05000 OPERATING ROOM	724, 866	33, 400	136, 17		331, 474	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	1, 545, 282				701, 152	
60.00	06000 LABORATORY	1, 189, 060			0 1, 200, 349	444, 843	
65.00	06500 RESPI RATORY THERAPY	5, 253			0 5, 253	1, 947	65.00
66.00	06600 PHYSI CAL THERAPY	225, 677		1		105, 350	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	9, 115			0 9, 115 0 1, 869	3, 378 693	
68.00 69.00	06900 ELECTROCARDI OLOGY	1,869			0 1,869	093	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	118, 147			0 118, 147	43, 785	
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	48, 898			0 48, 898	18, 121	
12.00	PATIENTS	10,070			10,070	10,121	/2/00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS		1	1		[
88.00	08800 RURAL HEALTH CLINIC	0	-		0 0	0	
91.00	09100 EMERGENCY	1, 550, 443	27, 035	342, 87		711, 666	1
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECIAL PURPOSE COST CENTERS				0		92.00
118.00		14, 652, 818	351, 526	1, 832, 34	4 14, 556, 333	3, 918, 259	1118.00
	NONREI MBURSABLE COST CENTERS	11/002/010	001/020	1,002,01	1 1,000,000	0, , 10, 20,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2, 318		0 2, 318	859	190.00
	19100 RESEARCH	0	C		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	5, 065		0 5, 065		192.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	37, 779			0 37, 779		194.00
	07952 OUTPATIENT CLINICS	1, 376			0 1, 376		194.02
	07953 OTHER NONREI MBURSABLE COST CENTERS	89, 291			0 89, 291		194.03
	07955 SPN	0	89, 102		0 89, 102	33, 021	194.04
200.00					0	_	200. 00 201. 00
201.00		14, 781, 264	448, 011	1, 832, 34	4 14, 781, 264		
202.00	1 101AE (300111103 110-201)	1 17,701,204	1 440,011	1 1,052,54	17,701,204	1 7,001,010	1202.00

COST	n Financial Systems SALLOCATION - GENERAL SERVICE COSTS	<u>ST. VINCENT JENI</u>		CCN: 151303	Period: From 07/01/2014 To 06/30/2015	u of Form CMS- Worksheet B Part I Date/Time Pre 11/23/2015 8:	pared:
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE			CAFETERI A	
	Γ	7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS		1	1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	1, 314, 508					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 741	40, 430				8.00
9.00	00900 HOUSEKEEPI NG	32, 887	0	474, 2	91		9.00
10.00	01000 DI ETARY	16, 215	0	10, 8	04 308, 760		10.00
11.00	01100 CAFETERI A	33, 414	0		0 0	15, 228	11.00
13.00	01300 NURSING ADMINISTRATION	3, 802	0		0 0	235	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	26, 658	0		0 0	480	14.00
15.00	01500 PHARMACY	15,001	0	10, 3	34 0	533	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	126, 900	0		0 0	785	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		150, 329	6, 452	96, 5	49 308, 760	3, 982	30.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	119, 457	25, 756	50, 8	40 0	1, 782	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	96, 807				3, 417	
60.00	06000 LABORATORY	40, 376				0	
65.00	06500 RESPI RATORY THERAPY	0			0 0	0	
66.00	06600 PHYSI CAL THERAPY	209, 141	690		-	1	
67.00	06700 OCCUPATI ONAL THERAPY	0			0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	-		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	-		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	-		0 0	0	
72.00	PATIENTS	0	0		0	0	12.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	/3.00
88.00	08800 RURAL HEALTH CLINIC	0	0	1	0 0	0	88.00
91.00	09100 EMERGENCY	96, 692				4, 013	
91.00		90, 092	/5/	100, 8	32 0	4, 013	
92.00							92.00
110 0	SPECIAL PURPOSE COST CENTERS	0(0,420	20.021	220.0	71 200 740	15 000	1110 00
118.0		969, 420	38, 921	320, 0	71 308, 760	15, 228	118.00
100.0	NONREI MBURSABLE COST CENTERS	0.001	0	1	0 0		100.00
	D 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN	8, 291	0				190.00
		0			0 0		191.00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	18, 116			0 0		192.00
	07950 OTHER NONREI MBURSABLE COST CENTERS	0					194.00
	2 07952 OUTPATIENT CLINICS	0	.,				194.02
	3 07953 OTHER NONREI MBURSABLE COST CENTERS	0	-		0 0		194.03
	4 07955 SPN	318, 681	0	108, 9	44 0	0	194.04
200.0							200.00
201.0		0 1, 314, 508	0 40, 430		0 0		201.00
202.0					91 308, 760		

Heal th	Financial Systems	ST. VINCENT JENN	INGS HOSPITAL		In Lie	u of Form CMS-	2552-10
	LOCATION - GENERAL SERVICE COSTS			CCN: 151303	Period:	Worksheet B	
					From 07/01/2014	Part I	
					To 06/30/2015	Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<u>11/23/2015 8:</u> Subtotal	
	cost center bescription	ADMI NI STRATI ON	SERVICES &		RECORDS &	Subtotui	
			SUPPLY		LIBRARY		
		13.00	14.00	15.00	16.00	24.00	
(GENERAL SERVICE COST CENTERS			•			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION	310, 392					13.00
	01400 CENTRAL SERVICES & SUPPLY	0	201, 439				14.00
	01500 PHARMACY	0	0				15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 441, 814		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	04.452	11 504	1	0 22.100	2 704 750	20.00
	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	84, 652	11, 584	·	0 23, 189	2, 706, 759	30.00
	05000 OPERATING ROOM	84, 652	43, 276	1	0 50, 529	1, 602, 203	50,00
	05400 RADIOLOGY - DIAGNOSTIC	04, 052	43, 270	1	0 134, 621	2, 864, 517	
	06000 LABORATORY	0	0	1	0 92, 836	1, 789, 786	
	06500 RESPI RATORY THERAPY	0	0		0 72,030	8, 918	
	06600 PHYSI CAL THERAPY	0	1, 276		0 9,932	618, 901	
	06700 OCCUPATI ONAL THERAPY	0	0		0 325	12, 818	
	06800 SPEECH PATHOLOGY	0	0		0 74	2, 636	
	06900 ELECTROCARDI OLOGY	0	0		0 0	2,000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	77, 322		0 0	239, 254	71.00
	07200 IMPLANTABLE DEVICES CHARGED TO	0	33, 077		0 0	100, 096	
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	887, 5	79 0	887, 579	73.00
(DUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0 0	C	88.00
	09100 EMERGENCY	141, 088	34, 904		0 128, 590	3, 138, 690	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	- <u>1</u>					
118.00	SUBTOTALS (SUM OF LINES 1-117)	310, 392	201, 439	887, 5	79 441, 814	13, 972, 157	118.00
	NONREI MBURSABLE COST CENTERS			1			1400.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
	07952 OUTPATIENT CLINICS 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.02
	07953 OTHER NONRETMBURSABLE COST CENTERS	0	0			122, 382	194.03
200.00	Cross Foot Adjustments	0	0		0		200.00
200.00	Negative Cost Centers		0		0		200.00
201.00	TOTAL (sum lines 118-201)	310, 392	201, 439	887, 5	79 441, 814	14, 781, 264	
202.00	1017E (301111103 110-201)	1 510, 572	201, 437	1 007, 5	, , , , , , , , , , , , , , , , , , , ,	17,701,204	1202.00

Health Financial Systems COST ALLOCATION - GENERAL	SERVICE COSTS	ST. VINCENT JENNI	Provider C	CN: 151303	Peri od:	u of Form CMS-2 Worksheet B	
					From 07/01/2014 To 06/30/2015	Part I Date/Time Pre 11/23/2015 8:1	
Cost Center De	scription	Intern & Residents Cost & Post Stepdown Adjustments	Total				
		25.00	26.00				
GENERAL SERVICE COST							
1.00 00100 CAP REL COSTS- 4.00 00400 EMPLOYEE BENEF 5.00 00500 ADMI NI STRATI VE	TS DEPARTMENT						1.00 4.00 5.00
7.00 00700 OPERATION OF F 8.00 00800 LAUNDRY & LINE							7.00
9.00 00900 HOUSEKEEPING	N SERVICE						9.00
10.00 01000 DI ETARY							10.00
11.00 01100 CAFETERIA							11.00
13.00 01300 NURSING ADMINI	STRATI ON						13.00
14.00 01400 CENTRAL SERVIC	ES & SUPPLY						14.00
15.00 01500 PHARMACY							15.00
16.00 01600 MEDICAL RECORD							16.00
I NPATI ENT ROUTI NE SE			2 70/ 750				1 20 00
30. 00 03000 ADULTS & PEDIA		0	2, 706, 759				30.00
ANCI LLARY SERVICE CO 50.00 05000 OPERATING ROOM		0	1, 602, 203				50.00
54.00 05400 RADI OLOGY - DI		0	2, 864, 517				54.00
60. 00 06000 LABORATORY	Adnostric	0	1, 789, 786				60.00
65. 00 06500 RESPI RATORY TH	FRAPY	0	8, 918				65.00
66.00 06600 PHYSI CAL THERA		0	618, 901				66.00
67.00 06700 OCCUPATIONAL T	HERAPY	0	12, 818				67.00
68.00 06800 SPEECH PATHOLC	GY	0	2, 636				68.00
69.00 06900 ELECTROCARDI OL		0	0				69.00
	ES CHARGED TO PATIENTS	0	239, 254				71.00
72.00 07200 I MPLANTABLE DE PATI ENTS	VICES CHARGED TO	0	100, 096				72.00
73.00 07300 DRUGS CHARGED	TO PATIENTS	0	887, 579				73.00
OUTPATIENT SERVICE (COST CENTERS						1
88.00 08800 RURAL HEALTH C	LINIC	0	0				88.00
91.00 09100 EMERGENCY		0	3, 138, 690				91.00
	DS (NON-DISTINCT PART)	0					92.00
SPECIAL PURPOSE COST		-1					
	OF LINES 1-117)	0	13, 972, 157				118.00
NONREI MBURSABLE COST 190. 00 19000 GI FT, FLOWER,		0	11 4(0				190. 00
190.0019000 GFFT, FLOWER, 191.00 19100 RESEARCH	COFFEE SHOP, & CANTEEN	0	11, 468 0				190.00
192. 00 19200 PHYSI CI ANS' PR	IVATE OFFICES	0	25, 058				192.00
194. 00 07950 OTHER NONRELME		0	53, 659				194.00
194. 02 07952 OUTPATI ENT CLI		0	46, 792				194.02
194. 03 07953 OTHER NONRELME		0	122, 382				194.03
194.04 07955 SPN		0	549, 748				194.04
200.00 Cross Foot Adj	ustments	0	0				200.00
201.00 Negative Cost	Centers	0	0				201.00
202.00 TOTAL (sum lin	06 110 201)	0	14, 781, 264				202.00

Heal th	Financial Systems S	T. VINCENT JENI	NINGS HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	FION OF CAPITAL RELATED COSTS				Period: From 07/01/2014 To 06/30/2015		pared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
		0	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
4.00 5.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0 214, 782	0 39, 579	254, 36	0 0 1 0	254, 361	1.00 4.00 5.00
8.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	2, 817 0 119	40, 898 487 9, 195	43, 71 48 9, 31	7 0	22, 593 665 7, 587	
10.00	01000 DI ETARY 01100 CAFETERI A	2,072	4, 534 9, 343	6, 60 9, 34	6 0	4, 842	10.00
14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	3, 081 1, 052 25, 465	1, 063 7, 454 4, 194	4, 14 8, 50 29, 65	6 0	5, 265 2, 996 14, 811	
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	322	35, 481	35, 80	3 <u> </u>	5, 399	16.00
	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	91, 988	42, 032	134, 02	0 0	34, 740	30.00
50.00	05000 OPERATING ROOM	69, 411	33, 400	102, 81			
60.00	05400 RADI OLOGY – DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY	422, 775	27, 067 11, 289	449, 84 11, 28			60.00
66. 00 67. 00	06600 PHYSICAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 085 0	58, 475 0			6, 697 215	66.00 67.00
69. 00 71. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 0 3, 842	0	3, 84	0 0 0 0 2 0 0 0	_/	69.00 71.00
	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			1, 152 0	
	OUTPATIENT SERVICE COST CENTERS	1				1	
91.00 92.00	08800 RURAL HEALTH CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	0 16, 115	0 27, 035	43, 15	0 0 0 0		
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	854, 926	351, 526	1, 206, 45	2 0	249, 063	118.00
191.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH	0	2, 318 0		0 0	0	190.00 191.00
194.00 194.02	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE COST CENTERS 07952 OUTPATIENT CLINICS	0	5, 065 0 0	5, 06 27	0 0	890 32	192. 00 194. 00 194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS 07955 SPN Cross Foot Adjustments	0	0 89, 102	89, 10	0 0 2 0		194. 03 194. 04 200. 00
200.00 201.00 202.00	Negative Cost Centers TOTAL (sum lines 118-201)	855, 202	0 448, 011		0 0		201.00

	n Financial Systems S ATION OF CAPITAL RELATED COSTS	ST. VINCENT JEN		CCN: 151303	Period:	u of Form CMS- Worksheet B	2552-10
ALLOO	ATTON OF CALLINE REEATED COSTS		11001dei	0011. 101000	From 07/01/2014	Part II	
					To 06/30/2015	Date/Time Pre	
	Cast Canton Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	G DI ETARY	11/23/2015 8: CAFETERI A	22 am
	Cost Center Description	PLANT	LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	9.00	10.00	11.00	-
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	66, 308					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	88					8.00
9.00	00900 HOUSEKEEPI NG	1,659			50		9,00
10.00		818					10.00
11.00		1, 686		42	0 12,009	3, 928	
13.00		1,080			0 0	5, 728	1
13.00					0		
		1, 345				124	1
15.00		757				137	
16.00		6, 401	0		0 0	202	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	7.500	100			4 007	
30.00		7, 583	198	3, 7	78 12, 689	1, 027	30.00
	ANCI LLARY SERVICE COST CENTERS						
50.00		6, 026				460	
54.00		4, 883				881	1
60.00		2,037				0	
65.00		0	-		0 0	0	
66.00		10, 550				0	
67.00		0	-		0 0	0	
68.00		0	0		0 0	0	
69.00		0	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
	PATIENTS						
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	C		0 0	0	88.00
91.00	09100 EMERGENCY	4, 877	23	3, 93	38 0	1, 036	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS			_			
118.0	0 SUBTOTALS (SUM OF LINES 1-117)	48, 902	1, 194	12, 52	24 12, 689	3, 928	118.00
	NONREI MBURSABLE COST CENTERS		·	•			1
190.0	0 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	418	0		0 0	0	190.00
191.0	0 19100 RESEARCH	0	C		0 0	0	191.00
192.0	0 19200 PHYSI CLANS' PRI VATE OFFI CES	914	c c		0 0	0	192.00
	007950 OTHER NONREIMBURSABLE COST CENTERS	0	C	-	74 0	0	194.00
194.0	2 07952 OUTPATIENT CLINICS	0	46	1,69	98 0	0	194.02
	3 07953 OTHER NONREI MBURSABLE COST CENTERS				0 0		194.03
	4 07955 SPN	16,074	-	4, 26	64 0		194.04
200.0			Ĭ			0	200.00
200.0	5	0	0		0 0	7 101	200.00
201.0	5	66, 308	1, 240	18, 56	0		202.00
202.0		00,300	1,240	1 10, 30	12,009	11, 029	1202.0

Health Financial Systems	ST. VINCENT JENN	INGS HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			CCN: 151303	Period:	Worksheet B	
				From 07/01/2014	Part II	
				To 06/30/2015	Date/Time Pre 11/23/2015 8:	22 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS			1			
1.00 00100 CAP REL COSTS-BLDG & FIXT					1	1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					1	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT					1	5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE					1	8.00
9.00 00900 HOUSEKEEPING					1	9.00
10. 00 01000 DI ETARY					1	10.00
11. 00 01100 CAFETERI A					1	11.00
13. 00 01300 NURSING ADMINI STRATI ON	9, 662				1	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	12, 971			1	14.00
15. 00 01500 PHARMACY	0	0	45, 7	58	1	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		0 47, 805	1	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 635	746	1	0 2, 510	199, 926	30.00
ANCI LLARY SERVI CE COST CENTERS			•			
50.00 05000 OPERATING ROOM	2, 635	2, 787		0 5, 469	144, 037	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		0 14, 558	516, 120	54.00
60. 00 06000 LABORATORY	0	0		0 10, 047	52, 095	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 186	310	
66. 00 06600 PHYSI CAL THERAPY	0	82		0 1,075	78, 307	
67.00 06700 OCCUPATIONAL THERAPY	0	0		0 35	250	
	0	0		0 8	52	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	4, 978 2, 130		0 0	11, 603 3, 282	
PATIENTS	0	2, 130		0 0	3, 202	/2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	45, 7	58 0	45, 768	3 73.00
OUTPATIENT SERVICE COST CENTERS		0	10, 10	50 01	10,700	, , 0. 00
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	C	88.00
91.00 09100 EMERGENCY	4, 392	2, 248		0 13, 917	118, 815	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	9, 662	12, 971	45, 7	68 47, 805	1, 170, 565	118.00
NONREI MBURSABLE COST CENTERS			1			_
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190. 00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		3 192. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
194. 02 07952 OUTPATIENT CLINICS	0	0		0 0		2 194. 02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS 194.04 07955 SPN	0	0		0 0	2, 103 111, 539	3 194. 03
	0	0				200.00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0				200.00
202.00 TOTAL (sum lines 118-201)	9,662	12, 971	45, 7	68 47,805	1, 303, 213	
202.001 [101/1E (3011111163 110-201)	1 7,002	12, 771	1 45,70	47,000	1, 303, 213	1202.00

	2	ST. VINCENT JENNI			In Lieu of Form CMS	8-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CCN: 1	151303	Period: Worksheet B From 07/01/2014 Part II To 06/30/2015 Date/Time Pr 11/23/2015 B	
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	GENERAL SERVICE COST CENTERS	25.00	26.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY					16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		100.00/			
30.00	03000 ADULTS & PEDIATRICS	0	199, 926			30.00
50.00	ANCILLARY SERVICE COST CENTERS	0	144, 037			50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	516, 120			54.00
60.00	06000 LABORATORY	0	52, 095			60.00
65.00	06500 RESPI RATORY THERAPY	0	310			65.00
66.00	06600 PHYSI CAL THERAPY	0	78, 307			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	250			67.00
68.00	06800 SPEECH PATHOLOGY	0	52			68.00
69.00	06900 ELECTROCARDI OLOGY	0	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 603			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	3, 282			72.00
72 00	PATIENTS	0	45 740			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	45, 768			73.00
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
91.00	09100 EMERGENCY	0	118, 815			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	110,010			92.00
	SPECIAL PURPOSE COST CENTERS	-1 -1				
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1, 170, 565			118.00
	NONREIMBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2, 791			190.00
	19100 RESEARCH	0	0			191.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	6, 098			192.00
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	964			194.00
	07952 OUTPATIENT CLINICS	0	2,052			194.02
	07953 OTHER NONREIMBURSABLE COST CENTERS 07955 SPN	0	2, 103 111, 539			194. 03 194. 04
200. 00		0	0			200.00
200.00		0	7, 101			200.00
201.00		0	1, 303, 213			201.00
0			,			1

OST A	Financial Systems S LOCATION - STATISTICAL BASIS	ST. VINCENT JENN		CCN: 151303 F	Peri od:	Worksheet B-1	2552-
				F	rom 07/01/2014		
					o 06/30/2015	Date/Time Pre 11/23/2015 8:	
		CAPI TAL				11/20/2010 01	
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	Reconciliatior	ADMI NI STRATI VE		
		(SQUARE FEET)	BENEFITS		& GENERAL	PLANT	
			DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
			(GROSS SALARI ES)				
		1.00	4.00	5A	5.00	7.00	<u> </u>
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT	69, 965					1.
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 539, 665				4.
	00500 ADMI NI STRATI VE & GENERAL	6, 181	1, 181, 516			57 007	5.
	00700 OPERATION OF PLANT	6, 387	53, 726			57, 397	
	00800 LAUNDRY & LINEN SERVICE	76	0			76	
	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 436 708	0) 322, 053 205, 561	1, 436 708	
	01100 CAFETERI A	1, 459	0	18, 186		1, 459	
	01300 NURSI NG ADMI NI STRATI ON	1,439	70, 778			1, 459	
	01400 CENTRAL SERVICES & SUPPLY	1, 164	74, 751			1, 164	
	01500 PHARMACY	655	167, 656			655	
	01600 MEDICAL RECORDS & LIBRARY	5, 541	127, 245			5, 541	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	· · · · · ·	•		· · · · · · · · · · · · · · · · · · ·	
	03000 ADULTS & PEDIATRICS	6, 564	885, 017	(1, 474, 733	6, 564	30
	ANCI LLARY SERVICE COST CENTERS	5.01/					1
	05000 OPERATING ROOM	5, 216	337, 365	(5, 216	
	05400 RADI OLOGY – DI AGNOSTI C 06000 LABORATORY	4, 227	791, 847			4, 227	54. 60.
	06500 RESPI RATORY THERAPY	1, 763	0			1, 763 0	
	06600 PHYSI CAL THERAPY	9, 132	299		284, 273	9, 132	
	06700 OCCUPATI ONAL THERAPY	9,132	277			9, 132	
	06800 SPEECH PATHOLOGY	0	0		1, 869	0	
	06900 ELECTROCARDI OLOGY	0	0		0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	118, 147	0	71.
2.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	(48, 898	0	72.
	PATIENTS						
	07300 DRUGS CHARGED TO PATIENTS	0	0	(00	0	73.
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0			0	88.
	09100 EMERGENCY	4, 222	849, 465			4, 222	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,222	047,403		1, 920, 340	4,222	92
	SPECIAL PURPOSE COST CENTERS				11		1 -
18.00		54, 897	4, 539, 665	-3, 983, 432	10, 572, 901	42, 329]118.
	NONREI MBURSABLE COST CENTERS	1			1 1		
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	362	0				190.
	19100 RESEARCH	0	0				191.
	19200 PHYSI CLANS' PRI VATE OFFI CES	791	0				192
	07950 OTHER NONREIMBURSABLE COST CENTERS 07952 OUTPATIENT CLINICS	0	0	(194
		0	0		1, 376		194 194
74.03	07953 OTHER NONREIMBURSABLE COST CENTERS 07955 SPN	12 015	0		89, 291	0 13, 915	
94.04 00.00		13, 915	0		89, 102	13, 915	200
00.00 01.00							200.
01.00	Cost to be allocated (per Wkst. B,	448, 011	1, 832, 344		4, 001, 618	1, 314, 508	
52.00	Part I)	5,011	1,002,044		1,001,010	1, 514, 500	202
03.00	Unit cost multiplier (Wkst. B, Part I)	6. 403359	0. 403630		0. 370595	22. 902033	203
	Cost to be allocated (per Wkst. B,		0		254, 361	66, 308	
04.00							1
04.00 05.00	Part II)		0. 000000		0. 023557	1. 155252	

COST A	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2014	Worksheet B-1 Date/Time Pre	
					To 06/30/2015	11/23/2015 8:	
	Cost Center Description	LAUNDRY & LI NEN SERVI CE (I TEMI ZED	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED	CAFETERI A) (HOURS)	NURSI NG ADMI NI STRATI ON	
		BI LLS)	SERVICE)			(DI RECT NURS. HRS.)	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS			1		1	1
1.00 4.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE	21, 726					8.00
9.00	00900 HOUSEKEEPING	21,720	13, 126				9.00
10.00	01000 DI ETARY	0	299	1	0		10.00
11.00	01100 CAFETERI A	0	0		0 126, 178	İ	11.00
	01300 NURSI NG ADMI NI STRATI ON	0	0)	0 1,944	528	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 3, 976	0	14.00
	01500 PHARMACY	0	286		0 4, 416	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 6, 504	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					_	
30.00	03000 ADULTS & PEDIATRICS	3, 467	2, 672	10	0 32, 994	144	30.00
	ANCILLARY SERVICE COST CENTERS	-		1	-		
50.00	05000 OPERATING ROOM	13, 840		1	0 14, 769		
	05400 RADI OLOGY - DI AGNOSTI C	2,830	866		0 28, 313	0	
	06000 LABORATORY	0	315		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
	06600 PHYSI CAL THERAPY	371	228	1	0 10		66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 0	0	
	06900 ELECTROCARDI OLOGY	0			0 0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	1
	07200 I MPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	1
/2:00	PATIENTS				0	Ĩ	12:00
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
91.00	09100 EMERGENCY	407	2, 785		0 33, 252	240	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	1		1			
118.00		20, 915	8, 858	10	0 126, 178	528	118.00
	NONREI MBURSABLE COST CENTERS	1		1			1.00.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190.00
		0	0		0 0	-	191.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE COST CENTERS	0	U 50		0 0		192.00
	07952 OUTPATIENT CLINICS	811	52 1, 201		0 0		194.00 194.02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0					194.02
	07955 SPN	0	-		0 0		194.03
200.00			0,010		°	Ĭ	200.00
201.00						l	201.00
202.00	- 5	40, 430	474, 291	308, 76	0 15, 228	310, 392	1
203.00	-	1. 860904	36. 133704	3, 087. 60000	0 0. 120687	587.863636	203.00
		1, 240					204.00
204.00	Part II)						

		T. VINCENT JENN			In Lieu of Form CM	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 151303	Period: Worksheet E	8-1
					From 07/01/2014 To 06/30/2015 Date/Time P	repared:
					11/23/2015	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL		
		SERVICES & SUPPLY	(COSTED	RECORDS & LI BRARY		
		(COSTED	REQUIS.)	(TIME SPENT)		
		REQUIS.)			·	
		14.00	15.00	16.00	_	
	GENERAL SERVICE COST CENTERS			•		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
5.00	00500 ADMINI STRATI VE & GENERAL					5.0
7.00	00700 OPERATION OF PLANT					7.0
8.00	00800 LAUNDRY & LINEN SERVICE					8.0
9.00	00900 HOUSEKEEPING					9.0
10.00	01000 DI ETARY					10.0
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION					11.0
14.00	01400 CENTRAL SERVICES & SUPPLY	297, 786				14.0
15.00	01500 PHARMACY	247,780	100			15.0
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		14	16.0
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	9	0	51,002,30		10.0
30.00	03000 ADULTS & PEDIATRICS	17, 125	0	2, 722, 05	55	30. 0
	ANCI LLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	63, 974	0	5, 931, 36	57	50. 0
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	15, 802, 73	30	54.0
60.00	06000 LABORATORY	0	0	10, 897, 49	90	60.0
65.00	06500 RESPI RATORY THERAPY	0	0	201, 71	17	65.0
66.00	06600 PHYSI CAL THERAPY	1, 886	0	1, 165, 86		66.0
67.00	06700 OCCUPATI ONAL THERAPY	0	0	38, 16		67.0
68.00	06800 SPEECH PATHOLOGY	0	0	8, 64		68.0
69.00	06900 ELECTROCARDI OLOGY	0	0		0	69.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	114, 305	0		0	71.0
72.00	07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	48, 898	0		0	72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0	100		0	73.0
73.00	OUTPATIENT SERVICE COST CENTERS	0	100		0	/3.0
88.00	08800 RURAL HEALTH CLINIC	0	0		0	88. 0
91.00	09100 EMERGENCY	51, 598	0			91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	01,070	0			92.0
	SPECIAL PURPOSE COST CENTERS	1 1		I		
118.00	SUBTOTALS (SUM OF LINES 1-117)	297, 786	100	51, 862, 50	04	118. 0
	NONREIMBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0	190. 0
	19100 RESEARCH	0	0		0	191. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192.0
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	194.0
	207952 OUTPATIENT CLINICS	0	0		0	194.0
194.03	07953 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	194.0
	107955 SPN	0	0		0	194.0
200.00						200. 0 201. 0
201.00	5	201, 439	007 570	441, 81		201.0
202.00	Part I)	201, 439	887, 579	441,8	1 - 4	202.0
203.00		0. 676456	8, 875. 790000	0. 00851	19	203.0
203.00		12, 971	45, 768			203.0
	Part II)	, , , , ,	,			
205.00		0. 043558	457. 680000	0. 00092	22	205.0
		1		1		

Health Financial Systems	ST. VINCENT JEN	NINGS_HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 07/01/2014 To 06/30/2015		
		Titl	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	(from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)	2.00	2.00	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	2, 706, 759	1	2, 706, 75	9 0	0	30.00
ANCI LLARY SERVICE COST CENTERS	2,700,734		2,700,75	7 0	0	30.00
50. 00 05000 OPERATING ROOM	1, 602, 203		1, 602, 20	3 0	0	50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 864, 517		2, 864, 51		0	
60. 00 06000 LABORATORY	1, 789, 786		1, 789, 78		0	
65. 00 06500 RESPI RATORY THERAPY	8, 918		8, 91		0	65.00
66. 00 06600 PHYSI CAL THERAPY	618, 901	0	618, 90	1 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 818	0	12, 81	8 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	2, 636	0	2,63	6 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	239, 254		239, 25	4 0	0	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	100, 096		100, 09	6 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	887, 579		887, 57	9 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 0	-	
91. 00 09100 EMERGENCY	3, 138, 690		3, 138, 69		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	909, 021		909, 02		0	
200.00 Subtotal (see instructions)	14, 881, 178		14, 881, 17			200. 00
201.00 Less Observation Beds	909, 021		909, 02			201.00
202.00 Total (see instructions)	13, 972, 157	0	13, 972, 15	7 0	0	202.00

^{11/23/2015 8:22} am Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20150630\28550-15.mcrx

Health Fin	ancial Systems	ST. VINCENT JENN	NINGS HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATIO	ON OF RATIO OF COSTS TO CHARGES			-	Period: From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 8:	
				e XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	ATIENT ROUTINE SERVICE COST CENTERS				-		
	00 ADULTS & PEDIATRICS	1, 834, 181		1, 834, 18	1		30.00
	I LLARY SERVICE COST CENTERS			1			
	OO OPERATING ROOM	14, 842					
	00 RADI OLOGY - DI AGNOSTI C	356, 312					
	00 LABORATORY	545, 175					
	00 RESPI RATORY THERAPY	129, 549					
	00 PHYSI CAL THERAPY	152, 072					
	00 OCCUPATI ONAL THERAPY	23, 598					
	00 SPEECH PATHOLOGY	2, 412				0.00000	
	00 ELECTROCARDI OLOGY	0	C		0 0.000000		
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	207, 470					
72.00 072	00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	9	255, 188	255, 19	7 0. 392230	0. 000000	72.00
73.00 073	00 DRUGS CHARGED TO PATIENTS	879, 711	2, 542, 851	3, 422, 56	2 0. 259332	0.00000	73.00
	PATIENT SERVICE COST CENTERS				_		
	00 RURAL HEALTH CLINIC	0	C		0		88.00
91.00 091	00 EMERGENCY	192, 595	14, 901, 877	15, 094, 47	2 0. 207936		
92.00 092	00 OBSERVATION BEDS (NON-DISTINCT PART)	78, 068	809, 806	887, 87	4 1.023818	0.00000	92.00
200.00	Subtotal (see instructions)	4, 415, 994	51, 835, 054	56, 251, 04	8		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	4, 415, 994	51, 835, 054	56, 251, 04	8		202.00

Health Financial Systems	ST. VINCENT JENNI	NGS HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Pre	pared [.]
			10 00,00,2010	11/23/2015 8:	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	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
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000				72.00
PATIENTS					
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
OUTPATIENT SERVICE COST CENTERS	-1				
88.00 08800 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
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	ST. VINCENT JEN	NINGS HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Pre 11/23/2015 8:	pared: 22 am
		Tit	le XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	2, 706, 759		2, 706, 75	9 0	2, 706, 759	30.00
ANCI LLARY SERVICE COST CENTERS	2,700,707		2,100,10	0	2,700,707	00.00
50. 00 05000 OPERATI NG ROOM	1, 602, 203		1, 602, 20	3 0	1, 602, 203	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	2, 864, 517		2, 864, 51		2, 864, 517	
60. 00 06000 LABORATORY	1, 789, 786		1, 789, 78	6 0	1, 789, 786	60.00
65. 00 06500 RESPI RATORY THERAPY	8, 918	0	8, 91	8 0	8, 918	65.00
66. 00 06600 PHYSI CAL THERAPY	618, 901	0	618, 90	0	618, 901	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 818	0	12, 81	8 0	12, 818	67.00
68.00 06800 SPEECH PATHOLOGY	2, 636	0	2,63	6 0	2, 636	68.00
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	239, 254		239, 25	4 0	239, 254	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	100, 096		100, 09	6 0	100, 096	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	887, 579		887, 57	9 0	887, 579	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	
91. 00 09100 EMERGENCY	3, 138, 690		3, 138, 69		3, 138, 690	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	909, 021		909, 02		909, 021	•
200.00 Subtotal (see instructions)	14, 881, 178	0	14, 881, 17	8 0	14, 881, 178	
201.00 Less Observation Beds	909, 021		909, 02		909, 021	
202.00 Total (see instructions)	13, 972, 157	0	13, 972, 15	7 0	13, 972, 157	202.00

	ST. VINCENT JENN	NINGS HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Pre 11/23/2015 8:	epared: 22 am
	_	Tit	le XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		Cost or Other Ratio	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6,00	7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 834, 181		1, 834, 18	1		30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	14, 842	5, 916, 525	5, 931, 36	7 0. 270124	0. 000000	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	356, 312	15, 446, 418	15, 802, 73	0 0. 181267	0.00000	54.00
60. 00 06000 LABORATORY	545, 175	10, 352, 315	10, 897, 49	0 0. 164238	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	129, 549	72, 168	201, 71	7 0. 044210	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	152, 072	1, 013, 795	1, 165, 86	7 0. 530850	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	23, 598	14, 564	38, 16	2 0. 335884	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	2, 412	6, 232	8, 64	4 0. 304951	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0. 000000	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	207, 470	503, 315	710, 78	5 0. 336605	0.00000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	9	255, 188	255, 19	7 0. 392230	0. 000000	72.00
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	879, 711	2, 542, 851	3, 422, 56	2 0. 259332	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS	0//////	2,012,001	0, 122, 00	0.207002	0.00000	/0.00
88.00 08800 RURAL HEALTH CLINIC	0	0		0.00000	0, 000000	88.00
91. 00 09100 EMERGENCY	192, 595	14, 901, 877	15, 094, 47			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	78, 068	809, 806			0. 000000	
200.00 Subtotal (see instructions)	4, 415, 994	51, 835, 054	56, 251, 04			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	4, 415, 994	51, 835, 054	56, 251, 04	8		202.00

Health Financial Systems	ST. VINCENT JENNI	NGS HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Pre 11/23/2015 8:	pared:
		Title XIX	Hospi tal	PPS	22 0111
Cost Center Description	PPS Inpatient				
'	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 270124				50.00
54.00 05400 RADIOLOGY – DIAGNOSTIC	0. 181267				54.00
60. 00 06000 LABORATORY	0. 164238				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 044210				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 530850				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 335884				67.00
68.00 06800 SPEECH PATHOLOGY	0. 304951				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 336605				71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 392230				72.00
PATIENTS					
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 259332				73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0. 000000				88.00
91.00 09100 EMERGENCY	0. 207936				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1. 023818				92.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	ST. VINCENT JEN	NI NGS_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R REDUCTIONS FOR MEDICALD ONLY	ATIOS NET OF	Provi der	CCN: 151303	Period: From 07/01/2014	Worksheet C Part II	
				To 06/30/2015	Date/Time Pre 11/23/2015 8:	
			le XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
	(Wkst. B, Part	(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	- 1		
50.00 05000 OPERATING ROOM	1, 602, 203				0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	2, 864, 517				0	54.00
60. 00 06000 LABORATORY	1, 789, 786				0	60.00
65. 00 06500 RESPI RATORY THERAPY	8, 918				0	65.00
66. 00 06600 PHYSI CAL THERAPY	618, 901				0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 818			0 8	0	67.00
68.00 06800 SPEECH PATHOLOGY	2,636	52	2, 58	34 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	239, 254	11, 603	227, 65	51 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	100, 096	3, 282	96, 81	4 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	887, 579	45, 768	841, 81	1 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
91.00 09100 EMERGENCY	3, 138, 690	118, 815	3, 019, 87	75 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	909, 021	78, 348	830, 67	0 0	0	92.00
200.00 Subtotal (sum of lines 50 thru 199)	12, 174, 419	1, 048, 987	11, 125, 43	32 0	0	200.00
201.00 Less Observation Beds	909, 021				0	201.00
202.00 Total (line 200 minus line 201)	11, 265, 398	970, 639	10, 294, 75	59 0	0	202.00

11/23/2015 8:22 am Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20150630\28550-15.mcrx

Health Financial Systems	ST. VINCENT JEN	NINGS_HOSPITAL		In Lie	u of Form CMS-2552-	-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F	RATIOS NET OF	Provi der	CCN: 151303	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 07/01/2014 To 06/30/2015	Part II Date/Time Prepared	d.
				10 00/ 30/ 2013	11/23/2015 8: 22 ar	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
	Capital and	(Worksheet C,				
		Part I, column		6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS	1]		
50. 00 05000 OPERATI NG ROOM	1, 602, 203				50.	
54.00 05400 RADI OLOGY - DI AGNOSTI C	2, 864, 517				54.	
60. 00 06000 LABORATORY	1, 789, 786				60.	
65. 00 06500 RESPI RATORY THERAPY	8, 918				65.	
66. 00 06600 PHYSI CAL THERAPY	618, 901				66.	
67.00 06700 OCCUPATI ONAL THERAPY	12, 818				67.	
68.00 06800 SPEECH PATHOLOGY	2, 636				68.	
69. 00 06900 ELECTROCARDI OLOGY	0	, i i i i i i i i i i i i i i i i i i i	0.0000		69.	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	239, 254				71.	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	100, 096	255, 197	0. 39223	30	72.	00
73.00 07300 DRUGS CHARGED TO PATIENTS	887, 579	3, 422, 562	0. 25933	32	73.	. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	00	88.	00
91.00 09100 EMERGENCY	3, 138, 690	15, 094, 472	0. 20793	36	91.	00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	909, 021	887, 874	1. 0238	18	92.	00
200.00 Subtotal (sum of lines 50 thru 199)	12, 174, 419	54, 416, 867			200.	00
201.00 Less Observation Beds	909, 021	0			201.	00
202.00 Total (line 200 minus line 201)	11, 265, 398	54, 416, 867			202.	00

11/23/2015 8:22 am Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20150630\28550-15.mcrx

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL C	COSTS	Provi der		Peri od:	Worksheet D	
				From 07/01/2014 To 06/30/2015	Part II Date/Time Pre 11/23/2015 8:	
			e XVIII	Hospi tal	Cost	
Cost Center Description		Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	rom Wkst. B,		·	. Charges	column 4)	
Pa	art II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				-		
50.00 05000 OPERATI NG ROOM	144, 037					
54.00 05400 RADIOLOGY - DIAGNOSTIC	516, 120	15, 802, 730				54.00
60. 00 06000 LABORATORY	52, 095	10, 897, 490	0. 00478	0 309, 384	1, 479	60.00
65. 00 06500 RESPI RATORY THERAPY	310	201, 717	0. 00153	7 68, 169		65.00
66. 00 06600 PHYSI CAL THERAPY	78, 307	1, 165, 867	0. 06716	6 43, 444	2, 918	66.00
67.00 06700 OCCUPATI ONAL THERAPY	250	38, 162	0.00655	1 8, 353	55	67.00
68.00 06800 SPEECH PATHOLOGY	52	8, 644	0. 00601	6 444	3	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 603	710, 785	0. 01632	4 103, 493	1, 689	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	3, 282	255, 197	0. 01286	1 9	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	45, 768	3, 422, 562	0. 01337	2 416, 381	5, 568	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88.00
91.00 09100 EMERGENCY	118, 815	15, 094, 472	0. 00787	1 9, 117	72	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	78, 348	887, 874	0. 08824	2 13, 244	1, 169	92.00
200.00 Total (lines 50-199)	1, 048, 987	54, 416, 867		1, 072, 797	16, 224	200. 00

	ST. VINCENT JEN			-	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der	CCN: 151303	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2014 To 06/30/2015		norod.
				To 06/30/2015	Date/Time Pre 11/23/2015 8:	
	_		e XVIII	Hospi tal	Cost	
Cost Center Description		Nursing School	Allied Healt		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	+	•				
50.00 05000 OPERATI NG ROOM	C	0		0 0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	C	0		0 0	0	54.00
60. 00 06000 LABORATORY	C	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	C	0 0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	C	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	C	0 0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	C	0 0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	C	0)	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0)	0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	C	0)	0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0 0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	C	0)	0 0	0	88.00
91. 00 09100 EMERGENCY	C	0)	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0		0 0	0	92.00
200.00 Total (lines 50-199)	C	0		0 0	0	200. 00

Health Financial Systems	ST. VINCENT JEN	NINGS_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2014		
				To 06/30/2015	Date/Time Pre 11/23/2015 8:	
		Ti †I	e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges			I npati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		$(col. 5 \div col$		Charges	
	col. 2, 3 and		7)	(col. 6 ÷ col.	5	
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	5, 931, 367	0. 00000	0.000000	14, 842	50.00
54.00 05400 RADIOLOGY – DIAGNOSTIC	0	15, 802, 730	0. 00000	0 0.000000	85, 917	54.00
60. 00 06000 LABORATORY	0	10, 897, 490	0. 00000	0 0.000000	309, 384	60.00
65. 00 06500 RESPI RATORY THERAPY	0	201, 717	0. 00000	0 0.000000	68, 169	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 165, 867	0. 00000	0 0.000000	43, 444	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	38, 162	0. 00000	0 0.000000	8, 353	67.00
68.00 06800 SPEECH PATHOLOGY	0	8, 644	0. 00000	0.000000	444	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C	0. 00000	0.000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	710, 785	0. 00000	0.000000	103, 493	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	255, 197	0. 00000	0.000000	9	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 422, 562	0. 00000	0.000000	416, 381	73.00
OUTPATIENT SERVICE COST CENTERS	- P		-	- F		
88.00 08800 RURAL HEALTH CLINIC	0	C				88.00
91. 00 09100 EMERGENCY	0	15, 094, 472				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	887, 874		0 0. 000000		
200.00 Total (lines 50-199)	0	54, 416, 867	'		1, 072, 797	200. 00

Health Financial Systems	ST. VINCENT JENN	NINGS HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PASS	6 Provider	CCN: 151303	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2014		
				To 06/30/2015	Date/Time Prep 11/23/2015 8:2	Darea: D2 am
		Ti †I	e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8	0	Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	C		0		50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	C	D	0		54.00
60. 00 06000 LABORATORY	0	C	D	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
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	C	D	0		72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
OUTPATIENT SERVICE COST CENTERS			1	1		
88.00 08800 RURAL HEALTH CLINIC	0	C		0		88.00
91.00 09100 EMERGENCY	0	C))	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		92.00
200.00 Total (lines 50-199)	0	C) I	0	:	200.00

Health Financial Systems S	T. VINCENT JEN	NINGS HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Pre 11/23/2015 8:	
		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	
ANCI LLARY SERVI CE COST CENTERS				-		
50.00 05000 OPERATI NG ROOM	0. 270124		1, 847, 92		0	
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 181267		3, 560, 35		0	54.00
60. 00 06000 LABORATORY	0. 164238	0	3, 745, 57	9 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 044210	0	47, 54		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 530850	0	241, 97	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 335884	0	3, 46	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 304951	0	1, 89	2 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 336605	0	154, 34	6 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 392230	0	82, 75	1 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 259332	0	870, 30	6 10, 496	0	73.00
OUTPATIENT SERVICE COST CENTERS			_			
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
91.00 09100 EMERGENCY	0. 207936	0	3, 188, 58	9 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 023818	0	384, 28	3 0	0	92.00
200.00 Subtotal (see instructions)		0	14, 128, 99	6 10, 496	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	14, 128, 99	6 10, 496	0	202.00

Health Financial Systems S	T. VINCENT JEN	NINGS HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Pre 11/23/2015 8:	epared: 22 am
		Titl	e XVIII	Hospi tal	Cost	
	Cos	sts				
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	400.470					50.00
50. 00 05000 OPERATING ROOM	499, 168					50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	645, 375					54.00
	615, 166					60.00
65. 00 06500 RESPIRATORY THERAPY	2, 102					65.00
66. 00 06600 PHYSI CAL THERAPY	128, 450					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 162					67.00
68. 00 06800 SPEECH PATHOLOGY	577	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	51, 954					71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	32, 457	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	225, 698	2, 722				73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
91. 00 09100 EMERGENCY	663, 022	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	393, 436	0				92.00
200.00 Subtotal (see instructions)	3, 258, 567	2, 722				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	3, 258, 567	2, 722				202.00

Health Financial Systems	ST. VINCENT JENI	NINGS HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVI	CES AND VACCINE COST	Provi der		Period:	Worksheet D	
		Component		From 07/01/2014 To 06/30/2015	Part V Date/Time Pre	narod
		component	L CON. 152505	10 00/30/2015	11/23/2015 8:	
		Ti tl	e XVIII S	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 270124			0 0	0	
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 181267			0 0	0	
60. 00 06000 LABORATORY	0. 164238			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 044210			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 530850			0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 335884	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 304951	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT				0 0	0	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 392230	0		0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 259332	0		00	0	73.00
OUTPATIENT SERVICE COST CENTERS	l.					
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
91.00 09100 EMERGENCY	0. 207936			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT I	PART) 1. 023818	0		0 0	0	
200.00 Subtotal (see instructions)		0		0 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Pi	rogram			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 2	201)	0	1	0 0	0	202.00

Health Financial Systems S	T. VINCENT JEN	NINGS HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151303	Peri od:	Worksheet D	
			001 457000	From 07/01/2014	Part V	
		Component	CCN: 15Z303	To 06/30/2015	Date/Time Pre 11/23/2015 8:	
		Ti †I	e XVIII	Swing Beds - SNF		
	Cos	sts		Joining Deus Olli	0031	
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	1					
50.00 05000 OPERATI NG ROOM	0	0				50.00
54.00 05400 RADI OLOGY – DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0				72.00
PATIENTS						
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
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	_	_				
202.00 Net Charges (line 200 +/- line 201)	0	0				202.00

Health Financial Systems	ST. VINCENT JENNINGS HOSPITAL In Lieu of Form CMS					
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period:	Worksheet D	
				From 07/01/2014 To 06/30/2015	Date/Time Pre	pared:
		T: +		lloonitel	11/23/2015 8:	22 am
			Ie XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	199, 926	28, 512	2 171, 41	4 1, 503	114.05	30.00
200.00 Total (lines 30-199)	199, 926		171, 41	4 1, 503		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6,00	7,00	1			
INPATIENT ROUTINE SERVICE COST CENTERS			1		-	
30. 00 ADULTS & PEDI ATRI CS	70	7, 984	ļ			30.00
200.00 Total (lines 30-199)	70					200.00

Health Financial Systems	ST. VINCENT JEN	NINGS_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der		Peri od:	Worksheet D	
				From 07/01/2014 To 06/30/2015		narod
				10 00/30/2015	Date/Time Pre 11/23/2015 8:	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		-	-	- F		
50. 00 05000 OPERATI NG ROOM	144, 037					
54.00 05400 RADIOLOGY - DIAGNOSTIC	516, 120					54.00
60. 00 06000 LABORATORY	52, 095				258	60.00
65. 00 06500 RESPI RATORY THERAPY	310				0	65.00
66. 00 06600 PHYSI CAL THERAPY	78, 307	1, 165, 867	0. 06716	6 1, 804	121	66.00
67.00 06700 OCCUPATIONAL THERAPY	250	38, 162	0. 00655	1 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	52	8, 644	0. 00601	6 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0 0	0. 00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 603	710, 785	0. 01632	4 16, 798	274	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	3, 282	255, 197	0. 01286	0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	45, 768	3, 422, 562	0. 01337	2 71, 459	956	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0 0	0. 00000	0 0	0	88.00
91. 00 09100 EMERGENCY	118, 815	15, 094, 472	0. 00787	1 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	78, 347	887, 874	0. 08824	1 0	0	92.00
200.00 Total (lines 50-199)	1, 048, 986	54, 416, 867	1	184, 242	2, 921	200. 00

Health Financial Systems	ST. VINCENT JENI	NI NGS_HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Pro			Period: From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 8:	pared: 22 am
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied H Cos	t	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.0	0	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	0		0		0 0	0	30.00
200.00 Total (lines 30-199)	0		0		0	0	200. 00
Cost Center Description	Total Patient Days	5 ÷ col	. 6)	Inpatient Program Days	Pass-Through Cost (col. 7 x col. 8)		
	6.00	7.0	0	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	1, 503		0.00		0 0		30.00
200.00 Total (lines 30-199)	1, 503				0 0		200. 00

	ST. VINCENT JEN			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der	CCN: 151303	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2014		
				To 06/30/2015	Date/Time Prep 11/23/2015 8:2	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
54.00 05400 RADIOLOGY – DIAGNOSTIC	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
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
PATIENTS						
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
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
200.00 Total (lines 50-199)	0	0		0 0	0	200.00
	1			1		•

54.00 05400 RADI OLOGY - DI AGNOSTI C 0 15,802,730 0.000000 0.000000 40,177 54.00 60.00 06000 LABORATORY 0 10,897,490 0.000000 0.000000 54,004 60.00 65.00 06500 RESPI RATORY THERAPY 0 201,717 0.000000 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,165,867 0.000000 0.000000 0 65.00 67.00 06700 0CCUPATI ONAL THERAPY 0 38,162 0.000000 0.000000 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 8,644 0.000000 0.000000 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 710,785 0.000000 0.000000 0 69.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED TO 0 255,197 0.000000 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 3,422,562 0.000000 0.000000 71,459 <t< th=""><th>Health Financial Systems</th><th>ST. VINCENT JEN</th><th>NINGS HOSPITAL</th><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></t<>	Health Financial Systems	ST. VINCENT JEN	NINGS HOSPITAL		In Lie	u of Form CMS-2	2552-10
Introduct Cost 3 To 06/30/2015 Date/Time Prepared: 11/23/2015 8: 22 am Cost Center Description Total Outpatient Cost (sum of col. 2, 3 and 4) Total Cost (sum of col. 2, 3 and 4) Total Charges (col. 5 + col. Part I, col. 8) Ratio of Cost to Charges (col. 5 + col. 7) Inpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges (col. 6 + col. 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 60.00 05400 (PRATING ROOM 0 05400 (RADI OLOGY - DI AGNOSTI C 0 5, 931, 367 0.000000 0.000000 0.000000 0.000000 0.000000 50.00 0.000000 60.00 6500 (RSPI RATORY THERAPY 0 10, 897, 490 0.000000 0.000000 0.000000 0.000000 0.000000 65.00 0.000000 0.000000 0.000000 0.66.00 0.000000 66.00 0.000000 67.00 0.000000 67.00 0.000000<		RVICE OTHER PAS	S Provi der				
Anci LLARY SERVICE COST CENTERS Total Octoant Cost (Sum of cost A) Total Charges (Col. 5 + col. 7) Noncomposition (Cost Center Description) Inpatient (From Wkst. C. Cost (Sum of cost Center Description) Inpatient (Sot (Sum of cost (Sum	THROUGH COSTS						narod
Image: control of the star in t					10 00/30/2015		22 am
ANCILLARY SERVICE COST CENTERS Outpatient Cost 2, 3 and 4) (from Wkst. C, Part 1, col. 8) to Charges (col. 5 + col. 7) Ratio of Cost to Charges (col. 6 + col. 7) Program Charges 50.00 05000 OPERATING ROOM 0 5,931,367 0.000000 0.000000 0 50.00 54.00 05400 RADI OLOCY - DI AGNOSTI C 0 15,802,730 0.000000 0.000000 0 50.00 66.00 06500 RESPI RATORY 1HERAPY 0 10,897,490 0.000000 0.000000 66.00 66.00 06600 LABORATORY 0 201,717 0.000000 0.000000 0 65.00 66.00 06600 PHERAPY 0 1,165,867 0.000000 0.000000 0 65.00 66.00 06600 SPEECH PATHOLOGY 0 38,162 0.000000 0.000000 0 67.00 67.00 06700 CUPATHOLOGY 0 0 0.000000 0.000000 0 68.00 68.00 SPEECH PATHOLOGY 0 <		_	Ti t	le XIX	Hospi tal		
ANCI LLARY SERVICE COST CENTERS Cost (sum of col. 2, 3 and 4) Part I, col. 8) (col. 5 + col. 7) Charges (col. 6 + col. 7) 50.00 05000 OPERATI NG ROOM 0 5.931, 367 0.000000 0.000000 0 50.00 54.00 05000 OPERATI NG ROOM 0 5.931, 367 0.000000 0.000000 0 0 5.000 0.000000 0.000000 0 0 5.000 0.000000 0.000000 0 0 0.000000 0.000000 0 0 0.000000 0.000000 0.000000 0 0 0.000000 0.000000 0.000000 0 0 0.000000 0.000000 0 0.000000 0.000000 0.000000 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000	Cost Center Description	Total	Total Charges	Ratio of Cost	t Outpatient	I npati ent	
ANCI LLARY SERVICE COST CENTERS 0 7.00 8.00 9.00 10.00 50.00 05000 OPERATI NG ROOM 0 5.931, 367 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 40, 177 54.00 54.00 05400 RADI OLGGY - DI AGNOSTI C 0 15, 802, 730 0.000000 0.000000 40, 177 54.00 65.00 06500 RESPI RATORY THERAPY 0 10, 897, 490 0.000000 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 165, 867 0.000000 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 1, 165, 867 0.000000 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 8, 644 0.000000 0.000000 68.00 69.00 OG900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 0.000000 68.00 73.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 710, 785 0.0000000 0.000000 72.00		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
4) 7) 6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0 5,931,367 0.000000 0.000000 40,177 54.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 15,802,730 0.000000 0.000000 40,177 54.00 66.00 06000 LABORATORY 0 10,897,490 0.000000 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,165,867 0.000000 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0 38,162 0.000000 0.000000 0 67.00 67.00 06800 SPEECH PATHOLOGY 0 8,644 0.000000 0.000000 69.00 69.00 06900 LECTROCARDI OLOGY 0 0 710,785 0.000000 0.000000 69.00 72.00 O7200 I MPLANTABLE DEVI CES CHARGED TO 0 255, 197 0.0000		Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVICE COST CENTERS 05000 0PERATI NG ROM 0 5,931,367 0.000000 0.000000 0 50.00 54.00 05400 RADI OLOGY DI AGNOSTI C 0 15,802,730 0.000000 0.000000 40,177 54.00 60.00 06000 LABORATORY 0 10,897,490 0.000000 0.000000 65.00 66.00 06600 RESPI RATORY THERAPY 0 201,717 0.000000 0.000000 1,804 66.00 66.00 06600 PHYSI CAL THERAPY 0 38,162 0.000000 0.000000 67.00 67.00 06700 0CCUPATI ONAL THERAPY 0 38,644 0.000000 0.000000 68.00 69.00 066900 ELCTROCARDI OLOGY 0 0 0.000000 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 71.07.785 0.000000 0.000000 0.000000 0 72		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0 5, 931, 367 0.000000 0.000000 0 50.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 15, 802, 730 0.000000 0.000000 40, 177 54.00 60.00 06500 RESPI RATORY 0 10, 897, 490 0.000000 0.000000 0 65.00 66.00 06500 RESPI RATORY THERAPY 0 201, 717 0.000000 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 165, 867 0.000000 0.000000 0 67.00 67.00 06700 0CUPATI ONAL THERAPY 0 38, 162 0.000000 0.000000 0 67.00 68.00 06800 SPECH PATHOLOGY 0 0 8, 644 0.000000 0.000000 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 710, 785 0.0000000 0.000000 0		.,			• /		
50.00 05000 OPERATING ROOM 0 5,931,367 0.000000 0.000000 0 50.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 15,802,730 0.000000 0.000000 40,177 54.00 60.00 06000 LABORATORY 0 10,897,490 0.000000 0.000000 60.00 65.00 06500 RESPI RATORY THERAPY 0 201,717 0.000000 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,165,867 0.000000 0.000000 1,804 66.00 06700 0CCUPATI ONAL THERAPY 0 38,162 0.000000 0.000000 0 67.00 68.00 06900 ELECTROCARDI OLOGY 0 8.644 0.000000 0.000000 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 710,785 0.000000 0.000000 0 69.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 3,422,562 0.000000 0.000000 71,459 73.00		6.00	7.00	8.00	9.00	10.00	
54.00 05400 RADI OLOGY - DI AGNOSTI C 0 15, 802, 730 0.000000 0.000000 40, 177 54.00 60.00 06000 LABORATORY 0 10, 897, 490 0.000000 0.000000 54, 004 60.00 65.00 06500 RESPI RATORY THERAPY 0 201, 717 0.000000 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 165, 867 0.000000 0.000000 0 65.00 67.00 06700 OCCUPATI ONAL THERAPY 0 38, 162 0.000000 0.000000 0 67.00 0 06800 SPEECH PATHOLOGY 0 8, 644 0.000000 0.000000 0 69.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 710, 785 0.000000 0.000000 72.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED TO 0 3, 422, 562 0.000000 0.0000000 72.00 <tr< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr<>							
60.00 06000 LABORATORY 0 10, 897, 490 0.000000 0.000000 54, 004 60. 00 65.00 06500 RESPI RATORY THERAPY 0 201, 717 0.000000 0.000000 0 65. 00 66.00 06600 PHYSI CAL THERAPY 0 1, 165, 867 0.000000 0.000000 1, 804 66. 00 67.00 06700 OCCUPATI ONAL THERAPY 0 38, 162 0.000000 0.000000 0 67. 00 68.00 06800 SPEECH PATHOLOGY 0 8, 644 0.000000 0.000000 0 68. 00 69.00 05900 ELCTROCARDI OLOGY 0 0 0.000000 0.000000 0 69. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 710, 785 0.000000 0.000000 0 72. 00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 255, 197 0.000000 0.000000 71, 459 72. 00 73.00 OTRUGS CHARGED TO PATI ENTS	50.00 05000 OPERATI NG ROOM	0	5, 931, 367	0.00000	0 0.000000	0	50.00
65.00 06500 RESPI RATORY THERAPY 0 201, 717 0.000000 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 165, 867 0.000000 0.000000 1, 804 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 38, 162 0.000000 0.000000 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 8, 644 0.000000 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 0.000000 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 710, 785 0.000000 0.000000 16, 798 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 255, 197 0.000000 0.000000 71, 459 73.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 3, 422, 562 0.000000 0.000000 71, 459 73.00 0 08800 RURAL HEALTH CLINIC 0 0 0.0000000 0.0000000 0	54.00 05400 RADIOLOGY – DIAGNOSTIC	0	15, 802, 730	0. 00000	0 0.000000	40, 177	54.00
66.00 06600 PHYSI CAL THERAPY 0 1, 165, 867 0.000000 0.000000 1, 804 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 38, 162 0.000000 0.000000 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 8, 644 0.000000 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 710, 785 0.000000 0.000000 16, 798 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 255, 197 0.000000 0.000000 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 3, 422, 562 0.000000 0.000000 71, 459 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 0 88.00 91.00 09100 EMERGENCY 0 15, 094, 472 0	60. 00 06000 LABORATORY	0	10, 897, 490	0.00000	0 0.000000	54, 004	60.00
67.00 06700 OCCUPATI ONAL THERAPY 0 38, 162 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 8, 644 0.000000 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 710, 785 0.000000 0.000000 16, 798 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 255, 197 0.000000 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 3, 422, 562 0.000000 0.000000 71, 459 73.00 02030 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 88.00 91.00 09100 EMERGENCY 0 15, 094, 472 0.000000 0.000000 91.00	65. 00 06500 RESPI RATORY THERAPY	0	201, 717	0. 00000	0 0.000000	0	65.00
68.00 06800 SPEECH PATHOLOGY 0 8,644 0.000000 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 0.000000 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 710,785 0.000000 0.000000 16,798 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 255,197 0.000000 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 3,422,562 0.000000 0.000000 71,459 73.00 0UTPATIENT SERVICE COST CENTERS 0 0.000000 0.000000 0.000000 71,459 73.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 0.000000 88.00 91.00 09100 EMERGENCY 0 15,094,472 0.000000 0.000000 0 91.00	66. 00 06600 PHYSI CAL THERAPY	0	1, 165, 867	0. 00000	0 0.000000	1, 804	66.00
69.00 06900 ELECTROCARDIOLOGY 0 0 0.000000 0.000000 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 710,785 0.000000 0.000000 16,798 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 255,197 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 3,422,562 0.000000 0.000000 71,459 73.00 0UTPATIENT SERVICE COST CENTERS 0 0.000000 0.000000 71,459 73.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 88.00 91.00 09100 EMERGENCY 0 15,094,472 0.000000 0.000000 91.00	67.00 06700 OCCUPATI ONAL THERAPY	0	38, 162	0.00000	0 0.000000	0	67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 710,785 0.000000 0.000000 16,798 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 255,197 0.000000 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 3,422,562 0.000000 0.000000 71,459 73.00 00TPATIENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0.000000 71,459 73.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 88.00 91.00 09100 EMERGENCY 0 15,094,472 0.000000 0.000000 91.00	68.00 06800 SPEECH PATHOLOGY	0	8, 644	0. 00000	0 0.000000	0	68.00
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO 0 255, 197 0.000000 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 3, 422, 562 0.000000 0.000000 71, 459 73. 00 0UTPATI ENT SERVICE COST CENTERS 0 0, 000000 0.000000 0.000000 71, 459 73. 00 88. 00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 0 88. 00 91. 00 09100 EMERGENCY 0 15, 094, 472 0.000000 0.000000 0 91. 00	69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0.000000	0	69.00
PATI ENTS PATI ENTS O 3, 422, 562 0.00000 0.000000 71, 459 73. 00 0UTPATI ENT SERVICE COST CENTERS 0 3, 422, 562 0.000000 0.000000 71, 459 73. 00 88. 00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 0 88. 00 91. 00 09100 EMERGENCY 0 15, 094, 472 0.000000 0.000000 0 91. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	710, 785	0. 00000	0.000000	16, 798	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 3, 422, 562 0.000000 0.000000 71, 459 73. 00 0UTPATI ENT SERVICE COST CENTERS 0 0.000000 0.000000 0.000000 0.000000 88. 00 88. 00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 0 88. 00 91. 00 09100 EMERGENCY 0 15,094,472 0.000000 0.000000 0 91. 00	72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	255, 197	0. 00000	0.000000	0	72.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0.000000 0 88.00 91.00 09100 EMERGENCY 0 15,094,472 0.000000 0.000000 0 91.00	PATIENTS						
88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0.000000 0 88.00 91.00 09100 EMERGENCY 0 15,094,472 0.000000 0.000000 0 91.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 422, 562	0. 00000	0.000000	71, 459	73.00
91. 00 09100 EMERGENCY 0 15, 094, 472 0. 000000 0. 000000 0 91. 00	OUTPATIENT SERVICE COST CENTERS						
	88.00 08800 RURAL HEALTH CLINIC	0	0	0. 00000	0.000000	0	88.00
	91. 00 09100 EMERGENCY	0	15, 094, 472	0.00000	0.000000	0	91.00
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	887, 874	0. 00000	0.000000	0	92.00
200.00 Total (lines 50-199) 0 54, 416, 867 184, 242 200.00	200.00 Total (lines 50-199)	0	54, 416, 867			184, 242	200. 00

Health Financial Systems	ST. VINCENT JENN	NINGS HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	6 Provider	CCN: 151303	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2014	Part IV	
				To 06/30/2015	Date/Time Pre 11/23/2015 8:	
		Ti t		Hospi tal	PPS	<u>22 am</u>
Cost Center Description	Inpatient	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			1	- 1		
50.00 05000 OPERATI NG ROOM	0	C	D	0		50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	C	D	0		54.00
60. 00 06000 LABORATORY	0	C	D	0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	C	D	0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C	D	0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C	D	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C	D	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C	D	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	D	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	C		0		72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0		73.00
OUTPATIENT SERVICE COST CENTERS			1	1		
88.00 08800 RURAL HEALTH CLINIC	0	C	D	0		88.00
91. 00 09100 EMERGENCY	0	C))	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C))	0		92.00
200.00 Total (lines 50-199)	0	C) I	0		200. 00

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

 COMPUTATION OF INPATIENT OPERATING COST
 Provider CCN: 151303
 Period:
 Worksheet D-1

COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 151303 Worksheet D-1 From 07/01/2014 То 06/30/2015 Date/Time Prepared: 11/23/2015 8:22 am Title XVIII Hospi tal Cost Cost Center Description 1.00 PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn) 1.00 1,763 1.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 1, 503 2.00 2.00 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, 0 3.00 do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 914 4.00 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost 125 5.00 reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 6.00 125 6.00 reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 7.00 5 7.00 reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 8.00 8.00 5 reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 528 9.00 newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 125 10.00 10.00 through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 11.00 125 11.00 12.00 0 12.00 through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 0 13.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days) 14.00 14.00 0 Total nursery days (title V or XIX only) 15.00 0 15.00 16.00 Nursery days (title V or XIX only) 0 16.00 SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 17.00 17.00 reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 129 14 19.00 reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 129.14 20.00 20 00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 2,706,759 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 22.00 0 22.00 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 0 23.00 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 646 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 646 25.00 x line 20) 26.00 387.127 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2, 319, 632 27.00 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 0 28.00 29.00 Private room charges (excluding swing-bed charges) 29.00 0 30.00 Semi -private room charges (excluding swing-bed charges) 0 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 0.00 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33 00 0 00 33 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34.00 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 2, 319, 632 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 1.543.34 38.00 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 814, 884 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 40.00 0 41.00 Total Program general inpatient routine service cost (line 39 + line 40) 814, 884 41.00

Heal th	Financial Systems	ST. VINCENT JEN	NI NGS_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 07/01/2014	Worksheet D-1	
					o 06/30/2015	Date/Time Pre	pared:
			Ti +I	e XVIII	Hospi tal	11/23/2015 8: Cost	22 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days			(col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)		2100	0100		0100	42.00
	Intensive Care Type Inpatient Hospital Units	5	1	1			
43.00 44.00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	cost center bescription					1.00	
	Program inpatient ancillary service cost (W			_		257, 689	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructio	ons)		1, 072, 573	49.00
50.00	Pass through costs applicable to Program in	patient routine	services (from	n Wkst. D, sum	of Parts I and	0	50.00
							-1 -0
51.00	Pass through costs applicable to Program inp and IV)	patient ancillar	ry services (fr	rom Wkst. D, su	m of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu	5 1	elated, non-phy	vsician anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient opera	ting cost and ta	arget amount (l	ine 56 minus l	ine 53)	0	56.00 57.00
58.00	Bonus payment (see instructions)	ting cost and to			1110 00)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re	eporting period	ending 1996, u	updated and com	pounded by the	0.00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report um	odated by the m	arket basket		0.00	60.00
	If line 53/54 is less than the lower of line				he amount by	0	61.00
	which operating costs (line 53) are less that		ts (lines 54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive payr	ment (see instru	uctions)			0	63.00
(1 00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Door	mbor 21 of the	anot monomic	a partiad (Caa	102_010	(1 00
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through bece		e cost reportir	ig period (see	192, 918	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	per 31 of the c	cost reporting	period (See	192, 918	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line 6	5)(title XVIII	only) For	385, 836	66 00
00.00	CAH (see instructions)				on y). To	303, 030	00.00
67.00	Title V or XIX swing-bed NF inpatient routin	ne costs through	n December 31 c	of the cost rep	orting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	ne costs after [December 31 of	the cost repor	ting period	0	68.00
	(line 13 x line 20)					-	
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service of	cost per diem (I		• •			71.00
72.00 73.00	Program routine service cost (line 9 x line		n (lino 14 v li	po 2E)			72.00 73.00
73.00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.00
75.00	Capital-related cost allocated to inpatient				rt II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76.00
77.00	Program capital -related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minu						78.00
79.00 80.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				ic lino 70)		79.00 80.00
80.00	Inpatient routine service cost per diem limi				5 THE 77)		80.00 81.00
82.00	Inpatient routine service cost limitation (ine 9 x line 8					82.00
83.00 84.00	Reasonable inpatient routine service costs Program inpatient ancillary services (see in	•	าร)				83.00 84.00
	Utilization review - physician compensation		ons)				85.00
	Total Program inpatient operating costs (sur	n of lines 83 th					86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					589	87.00
	Adjusted general inpatient routine cost per		÷line 2)			1, 543. 33	
89.00	Observation bed cost (line 87 x line 88) (se	ee instructions))			909, 021	89.00

Health Financial Systems S	T. VINCENT JE	NNI NGS	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Period: From 07/01/2014	Worksheet D-1	
					To 06/30/2015		pared: 22 am
			Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Rou	tine Cost	column 1 ÷	Total	Observati on	
		(fro	m line 27)	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	199, 92	26	2, 319, 632	0. 08618	909, 021	78, 348	90.00
91.00 Nursing School cost		0	2, 319, 632	0.00000	909, 021	0	91.00
92.00 Allied health cost		0	2, 319, 632	0.00000	909, 021	0	92.00
93.00 All other Medical Education		0	2, 319, 632	0.00000	909, 021	0	93.00

^{11/23/2015 8:22} am Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20150630\28550-15.mcrx

Health Financial Systems

ST.	VI NCENT	JENNI NGS	HOSPI TAL

In Lieu of Form CMS-2552-10

leal th	Financial Systems ST. VINCENT JENNINGS	5 HOSPI TAL	In Lie	u of Form CMS-2	2552-1
	ATION OF INPATIENT OPERATING COST	Provider CCN: 151303	Peri od:	Worksheet D-1	
			From 07/01/2014	Data /Tima Dray	parad
			To 06/30/2015	Date/Time Prep 11/23/2015 8:2	
		Title XIX	Hospi tal	PPS	22 am
	Cost Center Description				
				1.00	
	PART I – ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
	Inpatient days (including private room days and swing-bed days,			1, 763	
	Inpatient days (including private room days, excluding swing-be			1, 503	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pr	rivate room days,	0	3.0
4.00	do not complete this line.	dave)		914	4.0
5.00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		or 21 of the cost	914	5.0
. 00	reporting period	a agas) thi bagn becembe		0	5.0
. 00	Total swing-bed SNF type inpatient days (including private room	davs) after December	31 of the cost	250	6.0
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	5	7.0
	reporting period				
3.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	31 of the cost	5	8.0
	reporting period (if calendar year, enter 0 on this line)			70	
9.00	Total inpatient days including private room days applicable to	the Program (excluding	g swing-bed and	70	9.0
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on	v (including private r	coom days)	0	10.0
. 5. 50	through December 31 of the cost reporting period (see instructi		com dayo)	0	.0.0
11.00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11.0
	December 31 of the cost reporting period (if calendar year, ent				
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	te room days)	0	12.0
0.00	through December 31 of the cost reporting period			0	12.0
3.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13.0
4.00	Medically necessary private room days applicable to the Program			0	14.0
	Total nursery days (title V or XIX only)	(over adding oning boa	uu jo)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				1
7.00	Medicare rate for swing-bed SNF services applicable to services	through December 31 d	of the cost		17.0
	reporting period				
8.00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18.0
9.00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19.0
19.00	reporting period	through becember 31 of	the cost	0.00	17.0
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of 1	he cost	0.00	20.0
	reporting period				
	Total general inpatient routine service cost (see instructions)			2, 706, 759	
2.00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22.0
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	na neriod (line 6	0	23.0
23.00	x line 18)	Tor the cost reportin	ig period (inne o	0	25.0
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.0
	7 x line 19)		51 (
25.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	g period (line 8	0	25. C
	x line 20)			00/ 017	
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ing 21 minus ling 24)		386, 017 2, 320, 742	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The 21 minus Trhe 20)		2, 320, 742	27.0
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)	0	28.0
	Private room charges (excluding swing-bed charges)			0	
0.00	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.00000	31.0
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minu	0.00			
	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0. 00 0	35.0 36.0
	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	2, 320, 742	
7.00	27 minus line 36)	a private room cost u		2, 320, 142	37.0
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			1
	Adjusted general inpatient routine service cost per diem (see i			1, 544. 07	38.0
9.00	Program general inpatient routine service cost (line 9 x line 3	-		108, 085	
		$(lino 14 \times lino 2E)$		0	1 40 0
	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +			108, 085	

MPUT	Financial Systems FATION OF INPATIENT OPERATING COST		Provi der	CCN: 151303	Peri od:	Worksheet D-1	· <u>2552</u> · 1
					From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 8:	
				tle XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Per sDiem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)						42.
~ ~	Intensive Care Type Inpatient Hospital Uni	ts		1			1
. 00	INTENSIVE CARE UNIT						43.
. 00 . 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
. 00	SURGICAL INTENSIVE CARE UNIT						46
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
00	Program inpatient ancillary service cost	(Wkat D 2 col 2	Line 200)			1.00 41,297	7 48.
	Total Program inpatient costs (sum of line			ons)		149, 382	
. 00	PASS THROUGH COST ADJUSTMENTS			01137		117,002	
. 00	Pass through costs applicable to Program i	npatient routine	services (fro	m Wkst. D, sun	of Parts I and	7, 984	1 50.
~~							
. 00	Pass through costs applicable to Program i and IV)	npatient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	2, 921	51
2. 00	Total Program excludable cost (sum of line	es 50 and 51)				10, 905	5 52
3.00	Total Program inpatient operating cost exe		lated, non-ph	ysician anesth	netist, and	138, 477	
	medical education costs (line 49 minus lin	ne 52)		-			
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0. 00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient oper	rating cost and ta	rget amount (line 56 minus	line 53)	C	
. 00	Bonus payment (see instructions)	5	5		,	C	58
. 00	Lesser of lines 53/54 or 55 from the cost	reporting period	endi ng 1996,	updated and co	ompounded by the	0.00) 59
	market basket	an agat rapart up	datad by the	markat baakat		0.00	
). 00 . 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of li				the amount by	0.00	
. 00	which operating costs (line 53) are less						
	amount (line 56), otherwise enter zero (se				5		
	Relief payment (see instructions)					C	
. 00	Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST	ayment (see instru	ctions)			C	0 63
. 00	Medicare swing-bed SNF inpatient routine	costs through Dece	mber 31 of th	e cost reporti	na period (See	C	64
	instructions)(title XVIII only)					_	
5.00	Medicare swing-bed SNF inpatient routine	costs after Decemb	er 31 of the	cost reporting	period (See	C	65
00	instructions)(title XVIII only)		(4	(F) (+: + - \\\/			
b. 00	Total Medicare swing-bed SNF inpatient rou CAH (see instructions)	utine costs (line	64 prus rine	65)(title XVII	i oniy). For	C) 66
. 00	Title V or XIX swing-bed NF inpatient rou	tine costs through	December 31	of the cost re	porting period	C	67
	(line 12 x line 19)				1 J J J J J J J J J J J J J J J J J J J		
3. 00	Title V or XIX swing-bed NF inpatient rou	tine costs after D	ecember 31 of	the cost repo	orting period	C	68
9. 00	(line 13 x line 20)	at routing costs (lino 47 i lin	o 49)		C	40
. 00	Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER			,		U) 69
0. 00	Skilled nursing facility/other nursing fac						70
. 00	Adjusted general inpatient routine service	e cost per diem (l		• •			71
. 00	Program routine service cost (line 9 x lin						72
. 00	Medically necessary private room cost appl						73
. 00 5. 00	Total Program general inpatient routine so Capital-related cost allocated to inpatient			·	Part II column		74
. 50	26, line 45)	LE FORTING SELVICE	55515 (11011		a.e.r., corumit		'
. 00	Per diem capital-related costs (line 75 ÷	line 2)					76
. 00	Program capital-related costs (line 9 x li						77
. 00	Inpatient routine service cost (line 74 mi	,	roulder	de)			78
. 00	Aggregate charges to beneficiaries for exe Total Program routine service costs for co	· · ·			us line 70)		80
. 00	Inpatient routine service costs for co	•			103 TITE /7)		81
. 00	Inpatient routine service cost limitation)				82
. 00	Reasonable inpatient routine service cost	•	•				83
. 00	Program inpatient ancillary services (see		,				84
. 00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (PART IV - COMPUTATION OF OBSERVATION BED F		rougn 85)				86
7.00	Total observation bed days (see instruction					589	87
	Adjusted general inpatient routine cost pe		line 2)			1, 544. 07	
3.00	Thay as too general inpatrient roatine cost p						

Health Financial Systems S	T. VINCENT JI	ENNI NGS	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Period: From 07/01/2014	Worksheet D-1	
					To 06/30/2015		pared: 22 am
			Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Rou	tine Cost	column 1 ÷	Total	Observation	
		(fro	m line 27)	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	199, 9	26	2, 320, 742	0. 08614	909, 457	78, 347	90.00
91.00 Nursing School cost		0	2, 320, 742	0.0000	909, 457	0	91.00
92.00 Allied health cost		0	2, 320, 742	0.0000	909, 457	0	92.00
93.00 All other Medical Education		0	2, 320, 742	0.00000	909, 457	0	93.00

^{11/23/2015 8:22} am Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20150630\28550-15.mcrx

Health Financial Systems ST. VINCENT JENNINGS HOSP	I TAL	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provi	der CCN: 151303	Peri od:	Worksheet D-3	
		From 07/01/2014 To 06/30/2015	Date/Time Pre	narod
		10 00/30/2013	11/23/2015 8:	
	Title XVIII	Hospi tal	Cost	
Cost Center Description	Ratio of Cos	t Inpatient	I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	I		1	
30. 00 03000 ADULTS & PEDI ATRI CS		613, 257		30.00
ANCI LLARY SERVI CE COST CENTERS	0.0704		1	
50.00 O5000 OPERATING ROOM	0. 2701			
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 1812			
	0. 1642			
65. 00 06500 RESPI RATORY THERAPY	0.0442			
66. 00 06600 PHYSI CAL THERAPY	0. 5308			66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0. 3358			
69. 00 06900 ELECTROCARDI OLOGY	0. 3049		135	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 3366		-	
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0. 3922		4 34,030	72.00
73. 00 07200 DRUGS CHARGED TO PATIENTS	0. 3922			73.00
OUTPATIENT SERVICE COST CENTERS	0.2373	32 410, 301	107, 901	75.00
88. 00 08800 RURAL HEALTH CLINIC	0.0000	00	0	88.00
91. 00 09100 EMERGENCY	0. 2079			
92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART)	1. 0238			
200.00 Total (sum of lines 50-94 and 96-98)		1, 072, 797		
201.00 Less PBP Clinic Laboratory Services-Program only charges (line	61)	0		201.00
202.00 Net Charges (line 200 minus line 201)		1, 072, 797		202.00
	·		•	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 151303 Period: To 06/30/2015 To 06/30/2015	Health Financial Systems S	T. VINCENT JENNINGS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
Component CCN: 152303 To 06/30/2015 Date/Time Prepared: 1/23/2015 8:22 am Title XVIII Swing Beds - SNF Cost Inpatient Program Charges Inpatient Prog	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der			Worksheet D-3	
Impact end Title XVIII Swing Beds - SNF Cost Cost Center Description Ratio of Cost Inpatient Program Cost 0 0 0 2.00 3.00 1 30.00 0 0 0 3.00 3.00 ANCI LARY SERVICE COST CENTERS 0 0 30.00 0 <td></td> <td>Component</td> <td></td> <td></td> <td>Data (Tima Dra</td> <td>nored.</td>		Component			Data (Tima Dra	nored.
Title XVIII Swing Beds - SNF Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Program Program Charges Program Program Charges Program Program Charges Inpatient Program Charges Inpatient Program Charges		Component	L CCN: 152303	0 00/30/2015		
To Charges Program Charges (col 1 x col 2) 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0 30.00 ANCILLARY SERVICE COST CENTERS 0 30.00 30.00 50.00 05400 RADIOLOGY - DI AGNOSTIC 0.270124 0 0 50.00 64.00 05400 RADIOLOGY - DI AGNOSTIC 0.181267 18,161 3.292 54.00 65.00 06000 LABORATORY 0.164238 29,660 4.871 60.00 65.00 06500 RESPI RATORY THERAPY 0.530850 94.024 913 66.00 66.00 06000 PYISI CAL THERAPY 0.335884 14,377 4,829 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.3304951 1,968 600 68.00 69.00 06900 ELECTROCARDI OLOGY 0.339230 0 0 72.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.392230 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.392230 0 0 72.00		Ti tl	e XVIII S	wing Beds - SNF		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30.00 30.00 ANCI LLARY SERVI CE COST CENTERS 0 30.00 30.00 30.00 ANCI LLARY SERVI CE COST CENTERS 0 30.00 30.00 30.00 50.00 05000 OPERATI NG ROOM 0.270124 0 0 50.00 54.00 05400 RADI DLOGY - DI AGNOSTI C 0.181267 18.161 3.292 54.00 60.00 CABOO RADI DLOGY - DI AGNOSTI C 0.164238 29,660 4.871 66.00 65.00 06500 RESPI RATORY THERAPY 0.530850 94,024 49,913 66.00 66.00 06600 SPEECH PATHOLOGY 0.335884 14,377 4,829 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.33605 18,436 6,206 71.00 69.00 06800 SPEECH PATHOLOGY 0.044210 2,697 119 65.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.334605 18,436 6,206 71.00 71.00 07100 IMELANTABLE DEVI CES CHARGED TO PATI ENTS 0.392230	Cost Center Description		Ratio of Cost	I npati ent	Inpati ent	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 ANCILLARY SERVICE COST CENTERS 0 30.00 50.00 05000 OPERATING ROM 0.270124 0 0 50.00 05000 DERATING ROM 0.270124 0 0 60.00 05400 RADILOGY - DI AGNOSTIC 0.181267 18.161 3.292 60.00 06500 RESPI RATORY THERAPY 0.164238 29,660 4,871 60.00 06500 RESPI RATORY THERAPY 0.530850 94,024 49,913 61.00 06300 SPEECH PATHOLOGY 0.335884 14,377 4,829 62.00 06900 LECTROCARDI OLOGY - DIANGEY 0.304951 1,968 600 63.00 06800 SPEECH PATHOLOGY 0.335884 14,377 4,829 7.00 64.00 06300 GRUPATIONAL THERAPY 0.3364051 1,968 600 68.00 65.00 06500 PHYSI CAL SUPPLIES CHARGED TO PATIENTS 0.3364051 1,968 600 68.00 69.00 71.00 07100 MEDI CAL SUPPLIES CH			To Charges	Program	Program Costs	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 ANCILLARY SERVICE COST CENTERS 0 30.00 50.00 05000 (PERATING ROOM 0.270124 0 0 50.00 54.00 05400 (PERATING ROOM 0.181267 18,161 3,292 54.00 60.00 06000 LABORATORY 0.184238 29,660 4,871 60.00 66.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 71.00 71.00 71.00 72.00 0 72.00 72.00 0 72.00 72.00 72.00 0 <td></td> <td></td> <td></td> <td>Charges</td> <td>(col. 1 x col.</td> <td></td>				Charges	(col. 1 x col.	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30. 00 30. 00 03000 (ADULTS & PEDI ATRI CS 0 30. 00 ANCI LLARY SERVI CE COST CENTERS 0 0 50. 00 50. 00 05000 (PERATI NG ROM 0. 270124 0 0 50. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0. 181267 18, 161 3, 292 54. 00 60. 00 06000 LABORATORY 0. 164238 29, 660 4, 871 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 044210 2, 697 119 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 335884 14, 377 4, 829 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 334585 94, 024 49, 913 66. 00 68. 00 06800 SPEECH PATHOLOGY 0. 304951 1, 968 600 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 336605 18, 436 6, 206 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 392230 0 0 72. 00 <tr< td=""><td></td><td></td><td></td><td></td><td>2)</td><td></td></tr<>					2)	
30. 00 O3000 ADULTS & PEDIATRICS 0 30. 00 ANCILLARY SERVICE COST CENTERS			1.00	2.00	3.00	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROM 0. 270124 0 0 50. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0. 181267 18, 161 3, 292 54. 00 60.00 06000 LABORATORY 0. 181267 18, 161 3, 292 54. 00 65. 00 06500 RESPI RATORY THERAPY 0. 164238 29, 660 4, 871 60. 00 66. 00 06600 PHYSI CAL THERAPY 0. 530850 94, 024 49, 913 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 335884 14, 377 4, 829 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 304951 1, 968 600 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 335605 18, 436 6, 206 71. 00 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATI ENTS 0. 259332 81, 433 21, 118 73. 00 73. 00 073000 DRUGS CHARGED TO PATI ENTS 0. 200000						
50. 00 05000 0PERATING ROOM 0. 270124 0 0 50. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0. 181267 18, 161 3, 292 54. 00 60. 00 06000 LABORATORY 0. 164238 29, 660 4, 871 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 530850 94, 024 49, 913 66. 00 66. 00 06600 PHYSI CAL THERAPY 0. 530850 94, 024 49, 913 66. 00 67. 00 06700 0CUPATI ONAL THERAPY 0. 335884 14, 377 4, 829 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 304951 1, 968 600 68. 00 69. 00 06900 LECTROCARDI OLOGY 0. 000000 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 336605 18, 436 6, 206 71. 00 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATI ENTS 0. 259332 81, 433 21, 118 73. 00 0171.00 07300 DRUGS CHARGED TO PATI ENTS 0. 200000 0 0 88. 00				0		30.00
54.00 05400 RADI OLOGY - DI AGNOSTI C 0.181267 18,161 3,292 54.00 60.00 06000 LABORATORY 0.164238 29,660 4,871 60.00 65.00 06500 RESPI RATORY THERAPY 0.044210 2,697 119 65.00 66.00 06600 PHYSI CAL THERAPY 0.530850 94,024 49,913 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.33584 14,377 4,829 67.00 68.00 06800 SPEECH PATHOLOGY 0.304951 1,968 600 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.336605 18,436 6,206 71.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED TO PATI ENTS 0.392230 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.259332 81,433 21,118 73.00 92.00 09200 08800 RURAL HEALTH CLINIC 0.000000 0 88.00			1	1		
60.00 06000 LABORATORY 0.164238 29,660 4,871 60.00 65.00 06500 RESPI RATORY THERAPY 0.044210 2,697 119 65.00 66.00 06600 PHYSI CAL THERAPY 0.530850 94,024 49,913 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.335884 14,377 4,829 67.00 68.00 06800 SPEECH PATHOLOGY 0.304951 1,968 600 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.336605 18,436 6,206 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATI ENTS 0.392230 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.259332 81,433 21,118 73.00 01.00 09100 EMERGENCY 0.207936 348 72 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 1.023818 264 270 92.00						
65.00 06500 RESPI RATORY THERAPY 0.044210 2,697 119 65.00 66.00 06600 PHYSI CAL THERAPY 0.530850 94,024 49,913 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.335884 14,377 4,829 67.00 68.00 06800 SPEECH PATHOLOGY 0.304951 1,968 600 68.00 69.00 06900 ELECTROCARDI OLOGY 0.300000 0 69.00 69.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.336605 18,436 6,206 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATI ENTS 0.392230 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.259332 81,433 21,118 73.00 01TPATI ENT SERVICE COST CENTERS 0.200000 0 0 88.00 0.207936 348 72 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 1.023818 264 270 92.00 200.00 UP30 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 <td< td=""><td></td><td></td><td></td><td></td><td>3, 292</td><td></td></td<>					3, 292	
66.00 06600 PHYSI CAL THERAPY 0.530850 94,024 49,913 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.335884 14,377 4,829 67.00 68.00 06800 SPEECH PATHOLOGY 0.304951 1,968 6600 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.336605 18,436 6,206 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATI ENTS 0.392230 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.259332 81,433 21,118 73.00 01741 ENT SERVICE COST CENTERS 0.000000 0 0 88.00 0 91.00 O9100 EMERGENCY 0.207936 348 72 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 1.023818 264 270 92.00 92.00 09200 BSERVATI ON BEDS (NON-DI STINCT PART) 261,368 91,290 200.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
67.00 06700 OCCUPATIONAL THERAPY 0.335884 14,377 4,829 67.00 68.00 06800 SPEECH PATHOLOGY 0.304951 1,968 600 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.336605 18,436 6,206 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 0.392230 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.259332 81,433 21,118 73.00 01700TATIENT SERVICE COST CENTERS 0.200000 0 0 91.00 88.00 08800 RURAL HEALTH CLINIC 0.207936 348 72 91.00 91.00 09100 EMERGENCY 0.207936 348 72 91.00 92.00 9200 0BSERVATION BEDS (NON-DISTINCT PART) 1.023818 264 270 92.00 92.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
68.00 06800 SPEECH PATHOLOGY 0.304951 1,968 600 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.336605 18,436 6,206 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 0.392230 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.259332 81,433 21,118 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 91.00 09100 EMERGENCY 0.207936 348 72 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.023818 264 270 92.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00						
69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.336605 18,436 6,206 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 0.392230 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.259332 81,433 21,118 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 88.00 0800 RURAL HEALTH CLINIC 0.000000 88.00 91.00 09100 EMERGENCY 0.207936 348 72 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.023818 264 270 92.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00			0. 335884	14, 377	4, 829	67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.336605 18,436 6,206 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 0.392230 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.259332 81,433 21,118 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 0 88.00 91.00 09100 EMERGENCY 0.207936 348 72 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.023818 264 270 92.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00			0. 304951	1, 968	600	68.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 0.392230 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.259332 81,433 21,118 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 88.00 08800 RURAL HEALTH CLINIC 0 88.00 91.00 09100 EMERGENCY 0.207936 348 72 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1.023818 264 270 92.00 200.00 Total (sum of lines 50-94 and 96-98) 201.00 201.00 201.00 201.00 201.00					-	
73.00 07300 DRUGS CHARGED TO PATIENTS 0.259332 81,433 21,118 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 0 0 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 91.00 91.00 92.00 09500 BSERVATION BEDS (NON-DISTINCT PART) 1.023818 264 270 92.00 90.00 Total (sum of lines 50-94 and 96-98) 261,368 91,200 201.00 201.00 201.00 201.00 201.00 201.00 0 201.00 201.00 201.00 201.00 0 201.00 0 201.00 0 201.00 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00					6, 206	
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 000000 0 88.00 91.00 09100 EMERGENCY 0.207936 348 72 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 1.023818 264 270 92.00 200.00 Total (sum of lines 50-94 and 96-98) 261,368 91,290 200.00 201.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00	72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	5	0. 392230	0 0	0	72.00
88.00 08800 RURAL HEALTH CLINIC 0 88.00 91.00 09100 EMERGENCY 0.207936 348 72 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 1.023818 264 270 92.00 200.00 Total (sum of lines 50-94 and 96-98) 261,368 91,290 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			0. 259332	81, 433	21, 118	73.00
91.00 09100 EMERGENCY 0.207936 348 72 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 1.023818 264 270 92.00 200.00 Total (sum of lines 50-94 and 96-98) 261,368 91,290 200.00 201.00 0 201.00 0 201.00 0 201.00 1.023818 264 270 92.00 1.023818 264 270 92.00 200.00 201.00 201.00 1.023818 264 270 200.00 201.00 201.00 1.023818 264 270 200.00 201.00						
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 1.023818 264 270 92.00 200.00 Total (sum of lines 50-94 and 96-98) 261,368 91,290 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00						
200.00 Total (sum of lines 50-94 and 96-98) 261, 368 91, 290 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00						
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			1. 023818	3 264		
				261, 368		
202.00 Net Charges (line 200 minus line 201) 261, 368 202.00		ogram only charges (line 61)		0		
	202.00 Net Charges (line 200 minus line 201)			261, 368		202.00

Health Financial Systems ST.	VINCENT JENNINGS HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Pr	ovi der	CCN: 151303	Period:	Worksheet D-3	
				From 07/01/2014 To 06/30/2015	Date/Time Pre	nared
				10 00/ 30/ 2013	11/23/2015 8:	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			1	151, 625		30, 00
ANCI LLARY SERVICE COST CENTERS				151, 025		30.00
50. 00 05000 OPERATING ROOM			0. 27012	4 0	0	50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C			0, 18126			
60. 00 06000 LABORATORY			0. 16423			1
65. 00 06500 RESPI RATORY THERAPY			0. 0442	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 53085	0 1, 804	958	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 33588	4 0	0	67.00
68.00 06800 SPEECH PATHOLOGY			0. 30495		0	68.00
69. 00 06900 ELECTROCARDI OLOGY			0.0000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 33660		5, 654	1
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS			0. 39223		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 25933	2 71, 459	18, 532	73.00
			0.0000			
88.00 08800 RURAL HEALTH CLINIC 91.00 09100 EMERGENCY			0. 00000		0	88.00 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1. 0238		0	91.00
200.00 Total (sum of lines 50-94 and 96-98)			1.0230	184, 242	Ű	
201.00 Less PBP Clinic Laboratory Services-Progra	m only charges (lir	00 61)		104, 242	41,297	200.00
202.00 Net Charges (line 200 minus line 201)	in only charges (111			184, 242		201.00
			I	104, 242	I	202.00

Health Financial Systems	ST. VINCENT JENNINGS	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151303	From 07/01/2014	Worksheet E Part B Date/Time Prepared: 11/22/2015 8:22 am

) 06/30/2015	11/23/2015 8:	
		Title XVIII	Hospi tal	Cost	
					_
DAI				1.00	-
	RT B - MEDICAL AND OTHER HEALTH SERVICES edical and other services (see instructions)			3, 261, 289	1 1
	edical and other services reimbursed under OPPS (see instructi	ons)		3, 201, 209	
	PS payments			0	
	itlier payment (see instructions)			0	
	ter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	
	ne 2 times line 5			0	1 6
0 Su	m of line 3 plus line 4 divided by line 6			0.00	
	ansitional corridor payment (see instructions)			0	8
	cillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	
	gan acquisitions			0	
	tal cost (sum of lines 1 and 10) (see instructions)			3, 261, 289	1
	MPUTATION OF LESSER OF COST OR CHARGES				-
	asonable charges			0	112
	ncillary service charges igan acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	a 60)		0	
	ital reasonable charges (sum of lines 12 and 13)	e 07)		0	
	stomary charges			0	1'
	gregate amount actually collected from patients liable for pa	vment for services on a c	charge basis	0	115
	nounts that would have been realized from patients liable for			0	
ha	d such payment been made in accordance with 42 CFR §413.13(e)		U		
00 Ra	tio of line 15 to line 16 (not to exceed 1.000000)			0.00000	1
	tal customary charges (see instructions)			0	
	ccess of customary charges over reasonable cost (complete only	if line 18 exceeds line	11) (see	0	1
	istructions)		10) (
	ccess of reasonable cost over customary charges (complete only istructions)	IT TIME IT exceeds Time	18) (see	0	20
	esser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		3, 293, 902	2
	iterns and residents (see instructions)			0,270,702	
	ost of physicians' services in a teaching hospital (see instru	ctions)		0	
	tal prospective payment (sum of lines 3, 4, 8 and 9)			0	24
CO	MPUTATION OF REIMBURSEMENT SETTLEMENT				
	eductibles and coinsurance (for CAH, see instructions)			30, 107	
	eductibles and Coinsurance relating to amount on line 24 (for			2, 154, 523	
	btotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22 ar	nd 23] (see	1, 109, 272	2
	istructions) react graduate modical advection novments (from Wkst. E.4. Lin	a EQ)		0	2
	rect graduate medical education payments (from Wkst. E-4, lin RD direct medical education costs (from Wkst. E-4, line 36)	e 50)		0	
	abtotal (sum of lines 27 through 29)			1, 109, 272	
	imary payer payments			469	
	ubtotal (line 30 minus line 31)			1, 108, 803	
	LOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	5)			1
00 Co	mposite rate ESRD (from Wkst. I-5, line 11)			0	
	lowable bad debts (see instructions)			827, 635	
	justed reimbursable bad debts (see instructions)			629, 003	
	lowable bad debts for dual eligible beneficiaries (see instru	ctions)		473, 367	
	Ibtotal (see instructions)			1, 737, 806	
	P-LCC reconciliation amount from PS&R			0	
00 50 Pi	oneer ACO demonstration payment adjustment (see instructions)			0	
	intial or full credits received from manufacturers for replace	d devices (see instructio	ns)	0	
	COVERY OF ACCELERATED DEPRECIATION			0	
	ibtotal (see instructions)			1, 737, 806	
	equestration adjustment (see instructions)			34, 756	
	iterim payments			1, 492, 492	
	entative settlement (for contractors use only)			0	
	I ance due provider/program (see instructions)			210, 558	4
	otested amounts (nonallowable cost report items) in accordanc	e with CMS Pub. 15-2, cha	apter 1,	0	4
	15. 2				
	BE COMPLETED BY CONTRACTOR				4
	iginal outlier amount (see instructions)			0	
	Itlier reconciliation adjustment amount (see instructions)			0	
	e rate used to calculate the Time Value of Money			0.00	
	me Value of Money (see instructions)				9
	otal (sum of lines 91 and 93)			0	9

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151303	Period: From 07/01/2014 To 06/30/2015		pare
		Ti tl	e XVIII	Hospi tal	Cost	
		I npati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		734, 4	72	1, 492, 492	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	1				
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	3
05				0	0	3
- 0	Provider to Program					
50 51	ADJUSTMENTS TO PROGRAM			0	0	3
51 52				0	0	3
52				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		734, 4	72	1, 492, 492	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5
00	desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1)					
	Program to Provider		I			
01	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	5
03				0	0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0	5
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
,,	5. 50-5. 98)			0	0	"
00	Determined net settlement amount (balance due) based on					6
-	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		198, 1	80	210, 558	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		932, 6		1, 703, 050	7
				Contractor	NPR Date	
)	<u>Number</u> 1.00	(Mo/Day/Yr)	
		()	1.00	2.00	8

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			Period: From 07/01/2014 To 06/30/2015		pared:
				Swing Beds - SNF		
		I npati er	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		396, 88		0	1.0
. 00	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			D	0	2.0
. 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)					3.0
	Program to Provider					
. 01	ADJUSTMENTS TO PROVIDER			0	0	
. 02 . 03				0	0	
. 03				0	0	
. 05				0	0	
	Provider to Program					
. 50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52 53				0	0	
. 53				0	0	
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
	3. 50-3. 98)					
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)		396, 88.	2	0	4.0
	TO BE COMPLETED BY CONTRACTOR	1			1	
00	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. (
01	TENTATI VE TO PROVIDER	1		0	0	5.0
02				0	0	
03				0	0	5.0
	Provider to Program	1	1	-	1	
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		72, 34	3	0	
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		469, 22		0	7.
			0	Contractor Number 1.00	NPR Date (Mo/Day/Yr)	
00	Name of Contractor		0	1.00	2.00	8. (

Heal th	Financial Systems ST. VINCENT JENNING	S HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151303	Period: From 07/01/2014	Worksheet E-2	
		Component CCN: 15Z3O3	To 06/30/2015	Date/Time Pre 11/23/2015 8:	
		Title XVIII	Swing Beds - SNF	Cost	
			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)		389, 694	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		92, 203	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 teachir	ng program (see		0.00	4.00
	instructions)			_	
5.00	Program days		250	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	nod only	0	_	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		481, 897	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		481, 897	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applica professional services)	able to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)		481, 897	0	
13.00	Coinsurance billed to program patients (from provider records) for physician professional services)	(excl ude coi nsurance	5, 060	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14	+)	476, 837	0	15.00
16.00			0	0	
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	1	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		2, 691	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		1, 964	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)	1, 947	0	18.00
19.00	Total (see instructions)		478, 801	0	19.00
19.01	Sequestration adjustment (see instructions)		9, 576	0	19.01
20.00	Interim payments		396, 882	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, ar		72, 343	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance chapter 1, $\S115.2$	ce with CMS Pub. 15-2,	0	0	23.00

	I Financial Systems ST. VINCENT JENN ATION OF REIMBURSEMENT SETTLEMENT	II NGS HOSPITAL Provider CCN: 151303	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCOL			From 07/01/2014	Part V	
			To 06/30/2015	Date/Time Pre	
		Title XVIII	Hospi tal	11/23/2015 8: Cost	22 am
		II the Aviii	поѕрітаі	COST	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	RE PART A SERVICES - COST	REIMBURSEMENT		
. 00	Inpatient services			1, 072, 573	
2.00	Nursing and Allied Health Managed Care payment (see instruc	tions)		0	
. 00	Organ acqui si ti on			0	
. 00	Subtotal (sum of lines 1 through 3)			1, 072, 573	
6.00	Primary payer payments			0	
. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 083, 299	6.(
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
. 00	Routine service charges			0	7.0
. 00 3. 00	Ancillary service charges			0	
00 0.00	Organ acquisition charges, net of revenue			0	
0.00	Total reasonable charges			0	
0.00	Customary charges				1.0.
1.00	Aggregate amount actually collected from patients liable for	r payment for services on	a charge basis	0	111.
2.00				0	12.
	had such payment been made in accordance with 42 CFR 413.13	(e)	Ũ		
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13.
4.00	Total customary charges (see instructions)			0	14.
5.00	Excess of customary charges over reasonable cost (complete o	only if line 14 exceeds li	ne 6) (see	0	15.
	instructions)				
6.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lin	e 14) (see	0	16.
7 00	instructions)	-+		0	17
7.00	Cost of physicians' services in a teaching hospital (see in: COMPUTATION OF REIMBURSEMENT SETTLEMENT	structions)		0	17.
8.00	Direct graduate medical education payments (from Worksheet)	E 4 Lipo 40)		0	18.
9.00	Cost of covered services (sum of Lines 6, 17 and 18)	L-4, 1111e 49)		1, 083, 299	
20.00				157, 336	
1.00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			925, 963	
3.00	Coinsurance			0	
4.00	Subtotal (line 22 minus line 23)			925, 963	
5.00	Allowable bad debts (exclude bad debts for professional service)	vices) (see instructions)		33, 846	25.
6. 00	Adjusted reimbursable bad debts (see instructions)			25, 723	26.
7.00	Allowable bad debts for dual eligible beneficiaries (see in:	structions)		12, 656	27.
8.00	Subtotal (sum of lines 24 and 25, or line 26)			951, 686	28.
9.00				0	
9. 50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	
9.99				0	
0.00	Subtotal (see instructions)			951, 686	
0.01				19, 034	
1.00				734, 472	
2.00	Tentative settlement (for contractor use only)			0	
3.00 4.00	Balance due provider/program (line 30 minus lines 30.01, 31,			198, 180	
(A) (A)	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2,	cnapter I,	0	34.

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl			Period: From 07/01/2014	Worksheet G	
inu- t <u>i</u>	ype accounting records, comprete the General Fund cordination	y)		To 06/30/2015	Date/Time Pre 11/23/2015 8:	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	7, 075, 701		0 0	0	1.
00	Temporary investments	7,075,701		0 0	0	
00	Notes receivable			0 0	0	
00	Accounts receivable	5, 548, 332		0 0	0	
00	Other receivable	3, 374		0 0	0	5
00	Allowances for uncollectible notes and accounts receivable	-3, 492, 530		0 0	0	
00	Inventory	158, 906		0 0	0	
00	Prepaid expenses	169, 381		0 0	0	
00	Other current assets Due from other funds	3, 026 -209, 354		° °	0	
00	Total current assets (sum of lines 1-10)	9, 256, 836			0	
00	FIXED ASSETS	7, 230, 030	207, 33		0	1
00	Land	127, 944		0 0	0	12
00	Land improvements	409, 779		0 0	0	
00	Accumulated depreciation	-392, 933		0 0	0	14
	Buildings	13, 681, 541		0 0	0	
	Accumulated depreciation	-5, 799, 504		0 0	0	
	Leasehold improvements	C		0 0	0	
00	Accumulated depreciation	0		0 0	0	
	Fixed equipment	1, 066, 417		0 0	0	
00	Accumulated depreciation	-912, 378		0 0	0	
	Automobiles and trucks Accumulated depreciation				0	
	Major movable equipment	3, 849, 020		0 0	0	
	Accumulated depreciation	-3, 060, 051		0 0	0	
	Minor equipment depreciable	26, 387		0 0	0	
00	Accumul ated depreciation	-61, 328		0 0	0	
	HIT designated Assets	C		0 0	0	
00	Accumulated depreciation	C		0 0	0	28
00	Mi nor equipment-nondepreciable	C		0 0	0	29
00	Total fixed assets (sum of lines 12-29)	8, 934, 894		0 0	0	30
	OTHER ASSETS					
	Investments	C		0 0	0	
00	Deposits on Leases	0		0 0	0	
00	Due from owners/officers	1// 150		0 0	0	
00	Other assets	166, 158			0	
00 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	166, 158 18, 357, 888		0	0	
00	CURRENT LIABILITIES	10, 307, 000	209, 33	4 0	0	30
00	Accounts payable	1, 157, 776		0 0	0	37
	Salaries, wages, and fees payable	592, 200		0 0	0	
	Payroll taxes payable	46, 484		0 0	0	
	Notes and loans payable (short term)	129, 087		0 0	0	
	Deferred income	0		0 0	0	41
00	Accelerated payments	C				42
00	Due to other funds	C		0 0	0	
	Other current liabilities	303, 729		0 0	0	
00	Total current liabilities (sum of lines 37 thru 44)	2, 229, 276		0 0	0	45
	LONG TERM LIABILITIES		1		-	١.,
00	Mortgage payable			0 0	0	
00	Notes payable Unsecured Loans	10, 511, 337		0 0	0	
00	Other long term liabilities	-18, 287		0 0	0	
00	Total long term liabilities (sum of lines 46 thru 49	10, 493, 050		0 0	0	
00	Total liabilites (sum of lines 45 and 50)	12, 722, 326		0 0	0	
	CAPITAL ACCOUNTS	.2, 722, 320		- 0	0	1
00	General fund balance	5, 635, 562				52
00	Specific purpose fund		209, 35	4		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion				-	
. 00 . 00	Total fund balances (sum of lines 52 thru 58)	5, 635, 562			0	
(11)	Total liabilities and fund balances (sum of lines 51 and	18, 357, 888	209, 35	4 0	0	60

STATE	Financial Systems S IENT OF CHANGES IN FUND BALANCES	T. VINCENT JENNI		CCN: 151303	Peri od:	wof Form CMS-2 Worksheet G-1	
					From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 8:	
		General	Fund	Speci al I	Purpose Fund	Endowment Fund	
		1.00	2.00	2 00	4.00	F 00	
1.00	Fund balances at beginning of period	1.00	2.00	3.00	4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1, 375, 567		103, 070		2.00
3.00	Total (sum of line 1 and line 2)		7, 745, 012		185, 898		3.00
4.00	GRANT/DONATI ON	0		66, 54		0	4.00
5.00	INTERCOMPANY TRANSFERS	-1, 785, 262			0	0	5.00
6.00	PENSION ADJ	-329, 341			0	0	6.00
7.00	RELEASED FROM RESTRICTION	5, 153			0	0	7.00
8.00		0			0	0	8.00
9.00		0			0	0	9.00
10.00	Total additions (sum of line 4-9)		-2, 109, 450		66, 541		10.00
11.00	Subtotal (line 3 plus line 10)		5, 635, 562		252, 439		11.00
12.00	RELEASED CAPI TAL	0		5, 15		0	12.00
13.00	GRANT/DONATI ON	0		24, 22		0	13.00
14.00	OTHER RESTRICTED	0		13, 70		0	14.00
15.00	ROUNDING	0			1	0	15.00
16.00		0			0	0	16.00
17.00		0			0	0	17.00
18.00	Total deductions (sum of lines 12-17)				43, 085		18.00
19.00	Fund balance at end of period per balance		5, 635, 562		209, 354		19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
	Sheet (The Thimnus The 18)				_		
1.00	Fund balances at beginning of period	Endowment Fund 6.00	Pl ant 7.00	Fund 8. 00	0		1.00
1.00 2.00		6.00			0		1.00
	Fund balances at beginning of period	6.00			0		
2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	6.00					2.00 3.00
2.00 3.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	7.00				2.00 3.00 4.00
2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION	6.00	7.00				2.00 3.00 4.00 5.00
2.00 3.00 4.00 5.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS	6.00	7.00 0 0 0 0				2.00 3.00 4.00 5.00 6.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ	6.00	7.00 0 0 0				2.00 3.00 4.00 5.00 6.00 7.00 8.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (Ioss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ RELEASED FROM RESTRICTION	6.00	7.00 0 0 0 0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
$\begin{array}{c} 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00 \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ RELEASED FROM RESTRICTION Total additions (sum of line 4-9)	6.00	7.00 0 0 0 0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ RELEASED FROM RESTRICTION Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00	7.00 0 0 0 0 0 0 0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ RELEASED FROM RESTRICTION Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RELEASED CAPITAL	6.00	7.00 0 0 0 0 0 0 0 0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00 \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ RELEASED FROM RESTRICTION Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RELEASED CAPITAL GRANT/DONATION	6.00	7.00 0 0 0 0 0 0 0 0 0 0 0 0		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
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ RELEASED FROM RESTRICTION Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RELEASED CAPITAL GRANT/DONATION OTHER RESTRICTED	6.00	7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ RELEASED FROM RESTRICTION Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RELEASED CAPITAL GRANT/DONATION	6.00	7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ RELEASED FROM RESTRICTION Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RELEASED CAPITAL GRANT/DONATION OTHER RESTRICTED	6.00	7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ RELEASED FROM RESTRICTION Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RELEASED CAPITAL GRANT/DONATION OTHER RESTRICTED ROUNDING	6.00 0 0 0	7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) GRANT/DONATION INTERCOMPANY TRANSFERS PENSION ADJ RELEASED FROM RESTRICTION Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RELEASED CAPITAL GRANT/DONATION OTHER RESTRICTED	6.00	7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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

11/23/2015 8:22 am Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20150630\28550-15.mcrx

STATEN	Financial Systems ST. VINCENT JENNING IENT OF PATIENT REVENUES AND OPERATING EXPENSES		CCN: 151303	Per	i od:	u of Form CMS- Worksheet G-2	
					07/01/2014 06/30/2015	Parts I & II Date/Time Pre 11/23/2015 8:	epared:
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
	General Inpatient Routine Services		1		1		
1.00	Hospi tal		1, 750, 4	93		1, 750, 493	
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVI DER			~			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		1, 750, 4	0.2		1 750 402	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		1, 750, 4	93		1, 750, 493	10.00
11.00	Intensive Care Type Inpatient Hospital Services						11.00
12.00	CORONARY CARE UNIT						12.00
12.00	BURN INTENSIVE CARE UNIT						12.00
14.00	SURGICAL INTENSIVE CARE UNIT						13.00
15.00	OTHER SPECIAL CARE (SPECIFY)						14.00
16.00	Total intensive care type inpatient hospital services (sum of I	ines		0		0	
10.00	11-15)	THES		0		0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		1, 750, 4	03		1, 750, 493	17.00
18.00	Ancillary services		2, 169, 0		35, 407, 959	37, 577, 058	
19.00	Outpati ent servi ces		414, 6		16, 508, 863	16, 923, 498	
20.00	RURAL HEALTH CLINIC			0	0	0, 10, 120, 170	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY				-	-	22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	PHYSI CI AN REVENUE			0	194, 150	194, 150	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	to Wkst.	4, 334, 2	27	52, 110, 972	56, 445, 199	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				14, 755, 334		29.00
30.00				0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00				0			37.00
38.00				0			38.00
				0			39.00
39.00			1	0			40.00
40.00				-			
40. 00 41. 00				0	_		41.00
40.00	Total deductions (sum of lines 37–41) Total operating expenses (sum of lines 29 and 36 minus line 42)			-	0 14, 755, 334		

Health Financial Systems ST. VINCENT JENNINGS HOSPITAL In Lieu of Form CM					2552-10
	IENT OF REVENUES AND EXPENSES	Provi der CCN: 151303	Peri od:	Worksheet G-3	
0 III E			From 07/01/2014		
			To 06/30/2015		
				11/23/2015 8:	22 am
				1.00	
1 00				1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			56, 445, 199	1.00
2.00	Less contractual allowances and discounts on patients' accounts			40, 696, 073	2.00
3.00	Net patient revenues (line 1 minus line 2)	~		15, 749, 126	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		14, 755, 334	4.00
5.00	Net income from service to patients (line 3 minus line 4)			993, 792	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			209, 602	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			85, 666	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other that	an 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			10, 769	18.00
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			311, 855	22.00
23.00	Governmental appropriations			0	23.00
24.00	GAINS AND LOSSES			0	24.00
24.01	ASSETS RELEASED FROM RESTRICTION			0	24.01
24.02	BARBER AND BEAUTY			-5, 020	24.02
24.03	GAIN AND LOSS ON SALE OF ASSETS			952	24.03
24.04				0	24.04
24.05	NET ASSETS RELEASED			37, 932	24.05
24.06	PHARMACY			6, 836	24.06
25.00	Total other income (sum of lines 6-24)			658, 592	25.00
26.00	Total (line 5 plus line 25)			1, 652, 384	26.00
27.00				0	27.00
27.01	UNREALIZED GAINS AND LOSSES			276, 817	27.01
28.00	Total other expenses (sum of line 27 and subscripts)			276, 817	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			1, 375, 567	29.00