Heal th Financia	al Systems ST VINCENT	SETON SPECIAL	ITY HOSPITAL		In Lie	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 a	III interim	FORM APPR	ROVED
payments made	since the beginning of the cost reporting p	period being d	eemed overpayments ((42 USC 1	395g).	OMB NO. C)938-0050
AND SETTLEMENT SUMMARY					d: 07/01/2014	Worksheet Parts I-I	
				То	06/30/2015		e Prepared: 15 2:47 pm
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically filed cost report			Da	ate: 11/25/2	015 Tim	ne: 2:47 pm
use only	2. [] Manually submitted cost report						
	3. [0] If this is an amended report enter 4. [F] Medicare Utilization. Enter "F" fo			resubmi 1	tted this co	ost report	
Contractor use only	5. [1]Cost Report Status 6. Date Receive (1) As Submitted 7. Contractor (2) Settled without Audit 8. [N]Initial (3) Settled with Audit 9. [N] Final	No. al Report for	11	2. [0]If	tor's Vendo	lumn 1 is	

PART II - CERTIFICATION

(4) Reopened (5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST VINCENT SETON SPECIALITY HOSPITAL (152020) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
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Ti t	il e
Dat	e ·

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	97, 199	14	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	97, 199	14	0	0	200. 00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 152020 Peri od: Worksheet S-2 From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/25/2015 11:28 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 8050 TOWNSHIP LINE ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zip Code: 46260 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST VINCENT SETON 152020 26900 2 02/08/2003 Ν 0 3.00 SPECIALITY HOSPITAL Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2014 06/30/2015 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N 22.00 Ν share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 Ν 23 00 2 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2. out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

	Financial Systems ST VINCENT SE AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA			CCN: 152020	Period: From 07/01 To 06/30	/2014	Workshop Part I Date/Ti 11/25/2	eet S-2 me Pre	pared:
					Urban/Ru		Date of	Geogr	
26 00	Enter your standard geographic classification (not wa	age) sta	atus at the bed	inning of th	1. 00	<u> </u>	2. (00	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 enter the effective date of the geographic reclassifi	rural. age) sta "2" fo cation	atus at the end or rural. If ap in column 2.	of the cost		1			27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number	of periods SC	H status in		0			35.00
					Begi nni 1. 00		Endi 2. (-
36. 00	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for numbe		<i>.</i>	2. '	50	36. 00
37. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		umber of period	s MDH status		0			37. 00
38. 00	is in effect in the cost reporting period. If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38. 00
	enter subsequent dates.				Y/N		Y/	'N	
39. 00	Does this facility qualify for the inpatient hospital	pavmer	nt adiustment f	or low volum	e N)	2. (39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ente qui remer or "N"	er in column 1 nts in accordar for no. (see i	"Y" for yes ce with 42 nstructions)					
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. E	Enter "Y" for y			V	XVIII	XIX	40.00
						1. 00		3.00	
45. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for a	di sproporti onat	e share in a	ccordance	N	N	N	45. 00
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete WkstPt. III.	eption f	or extraordina	ry circumsta	nces	N	N	N	46. 00
	Is this a new hospital under 42 CFR §412.300 PPS capils the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47. 00 48. 00
56. 00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	for yes	N			56. 00
57. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or th of th /", comp	"N" for no ir nis cost report olete Worksheet	column 1. I ing period?	f column 1 Enter "Y"				57.00
58. 00	If line 56 is yes, did this facility elect cost reimb	oursemer	nt for physicia	ns' services	as				58. 00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	s, compl costs f	ete Wkst. D-2, for a program t	hat meets th		N N			59. 00 60. 00
	provider-operated criteria under 9413.03: Enter 1	Y/N	IME	Direct GME			Di rec	t GME	
		1.00	2. 00	3. 00	4.0	0	5. (00	
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	li	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 instructions)		0. 00	0.	od				61. 01
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.	00				61. 02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.	00				61. 03
61. 04	instructions) Enter the number of unweighted primary care/or		0. 00	0.	00				61. 04

Heal th	Financial Systems	ST VINCENT SE	ETON SPECIAL	ITY HOSPI	TAL	In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	\TA	Provi der		eri od:	Worksheet S-2	
					F	rom 07/01/2014 o 06/30/2015	Part I Date/Time Pre	nared:
						00/30/2013	11/25/2015 11	
			Program	Name	Program Code	Unweighted IME		
						FTE Count	Direct GME FTE Count	
			1.0	0	2. 00	3.00	4. 00	-
61. 10	Of the FTEs in line 61.05, speci					0. 00		61. 10
	specialty, if any, and the number for each new program. (see instr column 1, the program name, ente	ructions) Enter in						
	program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	the IME FTE						
61. 20	Of the FTEs in line 61.05, speci program specialty, if any, and t	he number of FTE				0. 00	0. 00	61. 20
	residents for each expanded prog							
	instructions) Enter in column 1, enter in column 2, the program of							
	3, the IME FTE unweighted count							
	4, direct GME FTE unweighted cou	ınt.						
							1.00	
	ACA Provisions Affecting the Hea							
62.00	Enter the number of FTE resident your hospital received HRSA PCRE	this cost	reporting peri	od for which	0.00	62.00		
62. 01	Enter the number of FTE resident during in this cost reporting pe	eriod of HRSA THC prog	gram. (see i			your hospital	0.00	62. 01
63. 00	Teaching Hospitals that Claim Re Has your facility trained reside			ng this co	ost reporting p	period? Enter	N	63.00
	"Y" for yes or "N" for no in col	umn 1. If yes, comple	ete lines 64	-67. (see				
					Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
					Nonprovi der	Hospi tal	2))	
					Si te			
	Section 5504 of the ACA Base Yea	or ETE Docidonts in No	opprovi don S	ottings	1.00	2.00	3. 00	
	period that begins on or after J				iiiis base year	is your cost i	epor tring	
64. 00	Enter in column 1, if line 63 is	yes, or your facilit	ty trained r	esi dents	0.00	0.00	0. 000000	64. 00
	in the base year period, the num resident FTEs attributable to ro							
	settings. Enter in column 2 the							
	resident FTEs that trained in yo	our hospital. Enter in	n column 3 t	he ratio				
	of (column 1 divided by (column				Upwai abtad	Upwai abtad	Dotio (ool 2/	
		Program Name	Program	code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
					Nonprovi der	Hospi tal	4))	
		1.00		_	Si te		5.00	
65.00	Enter in column 1, if line 63	1. 00	2.0	0	3. 00	4.00	5. 00 0. 000000	65.00
03.00	is yes, or your facility				0.00	0.00	0.000000	05.00
	trained residents in the base							
	year period, the program name associated with primary care							
	FTEs for each primary care							
	program in which you trained							
	residents. Enter in column 2,							
	the program code, enter in column 3, the number of							
	unweighted primary care FTE							
	residents attributable to							
	rotations occurring in all non-provider settings. Enter in							
	column 4, the number of							
	unweighted primary care							
	resident FTEs that trained in							
	your hospital. Enter in column 5, the ratio of (column 3							
	divided by (column 3 + column							
	4)). (see instructions)							

	L AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA Provi der		Peri od:	Worksheet S-2	2552-
					From 07/01/2014 To 06/30/2015		
				Unwei ghted	Unwei ghted	11/25/2015 11 Ratio (col. 1/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
				Si te	·	-//	
c	Section 5504 of the ACA Current	Year FTF Residents in	n Nonnrovider Setting	1.00	2.00	3.00	
b	oeginning on or after July 1, 20	10					
	Inter in column 1 the number of TEs attributable to rotations o	3 .	3	0.0	0.00	0. 000000	66.
E	Enter in column 2 the number of	unweighted non-primar	y care resident				
	TEs that trained in your hospit column 1 divided by (column 1 +						
		Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1. 00	2.00	Si te 3. 00	4. 00	5. 00	
00 E	nter in column 1, the program	1.00	2.00	0.0			67
	name associated with each of						
	our primary care programs in which you trained residents.						
	inter 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						
С	column 4, the number of						
	unweighted primary care resident FTEs that trained in						
У	our hospital. Enter in column						
	5, the ratio of (column 3 Hivided by (column 3 + column						
	l)). (see instructions)						
					1.00	0 2.00 3.00	
	npatient Psychiatric Facility P					- 1 - 1 - 1 - 1 - 1	
00 I	s this facility an Inpatient Ps	ychiatric Facility (I	PF) or does it cont.	ain an IPF sub	provider? N		70
lF.	inter "Y" for ves or "N" for no		Try, or does it come	arm an irr sac	,p. 011 doi: 1		/ / /
00	nter "Y" for yes or "N" for no f line 70 yes: Column 1: Did th	e facility have an ap	oproved GME teaching	program in the	e most	0	
00 I	fline 70 yes: Column 1: Did the recent cost report filed on or b	e facility have an ap efore November 15, 20	pproved GME teaching 004? Enter "Y" for y	program in the es or "N" for	e most no. (see	0	
00 I r 4	fline 70 yes: Column 1: Did the recent cost report filed on or b 12 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF	e facility have an ap efore November 15, 20 Lumn 2: Did this faci R 412.424 (d)(1)(iii)	oproved GME teaching 204? Enter "Y" for y lity train residents (D)? Enter "Y" for y	program in the es or "N" for in a new teac es or "N" for	e most no. (see ching no.	0	
00 I r 4	fline 70 yes: Column 1: Did the recent cost report filed on or be 12 CFR 412.424(d)(1)(iii)(c)) Coorogram in accordance with 42 CF Column 3: If column 2 is Y, indi-	e facility have an ap efore November 15, 20 Lumn 2: Did this faci R 412.424 (d)(1)(iii)	oproved GME teaching 204? Enter "Y" for y lity train residents (D)? Enter "Y" for y	program in the es or "N" for in a new teac es or "N" for	e most no. (see ching no.	0	
00 I r 4 p C	fline 70 yes: Column 1: Did the recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi- see instructions) npatient Rehabilitation Facilit	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	oproved GME teaching 204? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this	program in the es or "N" for in a new teac es or "N" for cost reportir	e most no. (see ching no. no. g period.	0	71
00 I r 4 p C (I 1 1 1 1 1 1 1 1 1	fline 70 yes: Column 1: Did the cent cost report filed on or be 12 CFR 412.424(d)(1)(iii)(c)) Corogram in accordance with 42 CF column 3: If column 2 is Y, indicate instructions) npatient Rehabilitation Facility the state of the column and the column are reported by the column are reported	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye y PPS habilitation Facility	oproved GME teaching 204? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this	program in the es or "N" for in a new teac es or "N" for cost reportir	e most no. (see ching no.	0	71
00 I r 4 p C C C	fline 70 yes: Column 1: Did the cecent cost report filed on or be 12 CFR 412.424(d)(1)(iii)(c)) Coorogram in accordance with 42 CF column 3: If column 2 is Y, indicate instructions) npatient Rehabilitation Facility sites facility an Inpatient Resubprovider? Enter "Y" for yes of line 75 yes: Column 1: Did the	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program you per shabilitation Facility and "N" for no. e facility have an apefore November 15, 20 for some facility have november 15, 20 for some facility have not some facility hav	opproved GME teaching pools? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this (IRF), or does it copproved GME teaching	program in the es or "N" for in a new teac es or "N" for cost reportir ontain an IRF program in the	e most no. (see chi ng no. g peri od. N	0	71
00 I r 4 p C C C C C C C C C	fline 70 yes: Column 1: Did the recent cost report filed on or by 12 CFR 412. 424(d)(1)(iii)(c)) Courogram in accordance with 42 CF column 3: If column 2 is Y, indicated instructions) npatient Rehabilitation Facility statistically an Inpatient Resulprovider? Enter "Y" for yes of line 75 yes: Column 1: Did the recent cost reporting period end	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program years and "N" for no. e facility have an aping on or before Nove	oproved GME teaching 1004? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this (IRF), or does it coproved GME teaching ember 15, 2004? Enter	program in the es or "N" for in a new teac es or "N" for cost reportir ontain an IRF program in the "Y" for yes o	e most no. (see ching no. g period. N e most or "N" for		71
00 r 4 p C C C C C C C C C	fline 70 yes: Column 1: Did the cent cost report filed on or be 12 CFR 412.424(d)(1)(iii)(c)) Co or ogram in accordance with 42 CF column 3: If column 2 is Y, indicated in the column 2 is Y, indicated in the column 2 is Y, indicated in the column 3: If column 2 is Y, indicated in the column 3: If column 1: The column 1: Did the column 2: Did the column 2: Did this facility column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program years of the program	oproved GME teaching 1004? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this (IRF), or does it copproved GME teaching ember 15, 2004? Enter new teaching program for no. Column 3: If	program in the es or "N" for in a new teac es or "N" for cost reportir ontain an IRF program in the "Y" for yes c in accordance column 2 is Y	e most no. (see ching no. ng period. N e most or "N" for e with 42		71
00 r 4 p C C C C C C C C C	fline 70 yes: Column 1: Did the recent cost report filed on or but 2 CFR 412. 424(d)(1)(iii)(c)) Colorogram in accordance with 42 CF column 3: If column 2 is Y, indicated instructions) Inpatient Rehabilitation Facility is this facility an Inpatient Resubprovider? Enter "Y" for yes for fline 75 yes: Column 1: Did the recent cost reporting period end in Column 2: Did this facility	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program years of the program	oproved GME teaching 1004? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this (IRF), or does it copproved GME teaching ember 15, 2004? Enter new teaching program for no. Column 3: If	program in the es or "N" for in a new teac es or "N" for cost reportir ontain an IRF program in the "Y" for yes c in accordance column 2 is Y	e most no. (see ching no. ng period. N e most or "N" for e with 42		71
00 r r 4 p C C C C C C C C C	fline 70 yes: Column 1: Did the recent cost report filed on or but 2 CFR 412. 424(d)(1)(iii)(c)) Courogram in accordance with 42 CF column 3: If column 2 is Y, indicated instructions) Inpatient Rehabilitation Facilit sthis facility an Inpatient Resubprovider? Enter "Y" for yes of line 75 yes: Column 1: Did the recent cost reporting period end no. Column 2: Did this facility CFR 412. 424 (d)(1)(iii)(D)? Entendicate which program year begans	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program years of the program	oproved GME teaching 1004? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this (IRF), or does it copproved GME teaching ember 15, 2004? Enter new teaching program for no. Column 3: If	program in the es or "N" for in a new teac es or "N" for cost reportir ontain an IRF program in the "Y" for yes c in accordance column 2 is Y	e most no. (see ching no. ng period. N e most or "N" for e with 42		71
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Health Financial Systems ST VINCENT SETON SPECIALITY HOSPI			n Lieu	of Form		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	F	eriod: rom 07/01/ o 06/30/		Workshee Part I Date/Tii		
		V		11/25/20 XI X	015 11	
		1.00		2. 0		
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for napplicable column.		N	0. 00	N	0. 00	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable colum Rural Providers	n.		0. 00		0. 00	97. 00
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-inclusive met for outpatient services? (see instructions)	hod of payment	N N				105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursemen training programs? Enter "Y" for yes or "N" for no in column 1. (see inst yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the p reimbursed. If yes complete Wkst. D-2, Pt. II.	ructions) If	N				107. 00
108.00 is this a rural hospital qualifying for an exception to the CRNA fee sche CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	dul e? See 42	N				108. 00
Physi cal 1.00	Occupati onal 2.00	Speec 3.00		Respira 4.0		
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.	2.00	3.00		4.0	<u> </u>	109. 00
			-	1.0	0	-
110.00 Did this hospital participate in the Rural Community Hospital Demonstration the current cost reporting period? Enter "Y" for yes or "N" for no.	on project (410	OA Demo)fo	r	N		110. 00
			1. 00	2. 00	3. 00	
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no i	n column 1. If	column 1	N	Τ	0	115. 00
is yes, enter the method used (A, B, or E only) in column 2. If column 2 3 either "93" percent for short term hospital or "98" percent for long te psychiatric, rehabilitation and long term hospitals providers) based on t Pub. 15-1, chapter 22, §2208. 1.	is "E", enter i rm care (inclu	n column des				
116.00 is this facility classified as a referral center? Enter "Y" for yes or "N 117.00 is this facility legally-required to carry malpractice insurance? Enter "		'N" for	N Y			116. 00 117. 00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1	if the policy	S	2			118. 00
claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losse	S	Insura	nce	
118.01 List amounts of malpractice premiums and paid losses:	1.00	2.00	0	3. 0		118. 01
The offerst amounts of marpraetree premiums and para resses.	04, 42					110.01
118.02 Are mal practice premiums and paid losses reported in a cost center other	than the	1. 00 N		2. 0	0	118. 02
Administrative and General? If yes, submit supporting schedule listing cand amounts contained therein. 119.00 DO NOT USE THIS LINE		, iv				119. 00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for t	" for yes or	N		N		120. 00
Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device	,	N				121. 00
patients? Enter "Y" for yes or "N" for no. Transplant Center Information						1
125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.	for no. If	N				125. 00
126.00 of this is a Medicare certified kidney transplant center, enter the certific of umn 1 and termination date, if applicable, in column 2.	fication date					126. 00
127.00 If this is a Medicare certified heart transplant center, enter the certifin column 1 and termination date, if applicable, in column 2.	ication date					127. 00
128.00 If this is a Medicare certified liver transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2.	ication date					128. 00
129.00 If this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2.						129. 00
130.00 f this is a Medicare certified pancreas transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2.						130.00
131.00 f this is a Medicare certified intestinal transplant center, enter the c date in column 1 and termination date, if applicable, in column 2.						131. 00
132.00 f this is a Medicare certified islet transplant center, enter the certifing column 1 and termination date, if applicable, in column 2.						132.00
133.00 f this is a Medicare certified other transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2. 134.00 f this is an organ procurement organization (0P0), enter the 0P0 number						133. 00
and termination date, if applicable, in column 2.	corumii i					104.00

Health Financial Systems	ST VINCENT SETON S	PECIALITY HOSPI	TAL		In Lie	u of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 15202			Worksheet S-	-2
					7/01/2014 6/30/2015	Part I Date/Time Pr	repared:
						11/25/2015	11:28 am
					1. 00	2.00	
All Providers						1. =	
140.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	N" for no in column 1. I	f yes, and home	office co		Υ	15H046	140. 00
1.00	2.	00			3. 00		
If this facility is part of a chai				ne name and	d address	of the	
home office and enter the home offi 141.00 Name: ST VINCENT HEALTH	Contractor name and			actor's Nu	mber: 0810)1	141. 00
142.00 Street: 10330 N MERIDIAN STREET	PO Box:						142. 00
143.00 City: INDIANAPOLIS	State: I	N	Zip C	ode:	4629	90 T	143. 00
						1.00	
144.00 Are provider based physicians' cos	sts included in Worksheet	A?				N	144. 00
					1 00	2.00	
145.00 If costs for renal services are cl	aimed on Wkst. A. line 7	4. are the costs	s for		1. 00 Y	2.00	145. 00
inpatient services only? Enter "Y'	for yes or "N" for no i	n column 1. If o	column 1 i				
no, does the dialysis facility inc period? Enter "Y" for yes or "N"		n for this cost	reporti ng				
146.00 Has the cost allocation methodolog		ously filed cost	t report?		N		146. 00
Enter "Y" for yes or "N" for no ir		15-2, chapter 4	40, §4020)	lf			
yes, enter the approval date (mm/c	dd/yyyy) in column 2.						
						1.00	
147.00 Was there a change in the statisti						N	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				for no		N N	148. 00 149. 00
177. 00 mas there a change to the simplifit	ed cost irriding method.	Part A	Part		itle V	Title XIX	117.00
		1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '							
155. 00 Hospi tal	To The For each compo	N N	N N	D. (300 12	N N	N N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157.00 Subprovi der - I RF 158.00 SUBPROVI DER		N	N		N	N	157. 00 158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N		N	N	160. 00
161. 00 CMHC			l N		N	N	161. 00
						1.00	
Mul ti campus				£6+ 0D	CA-2	NI NI	1/5 00
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that nas o	ne or more campu	uses in ai	TTERENT CB	SAS?	N	165. 00
Enter 1 101 years 1 101 1101	Name	County	State	Zip Code	CBSA	FTE/Campus	
1// 00 6 1 2 1/5 2 1/5 2 2 5 2 2 5	0	1. 00	2. 00	3. 00	4. 00	5.00	20144 00
166.00 If line 165 is yes, for each campus enter the name in column						0.0	00 166. 00
0, county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
	·						
Health Information Technology (HI	() incentive in the Ameri	can Recovery and	d Reinvoct	tment Act		1.00	
167.00 Is this provider a meaningful user	under §1886(n)? Enter	"Y" for yes or '	'N" for no).		N	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a meani	ngful user (line	e 167 is "	Y"), enter	the		0168.00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r			oualify	for a hard	shi n		168. 01
exception under §413.70(a)(6)(ii)?					5111 P		100.01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y") and	d is not a CAH ((line 105	is "N"), e	nter the	0.	00169.00
priansition ractor. (see instruction) (S)			Be	gi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	peginning date and ending	date for the re	eporti ng				170. 00
period respectivery (mm/dd/yyyy)				ı		1	ı

Health Financial Systems	u of Form CMS-	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DATA	Provi der CCN: 152020		Worksheet S-2	
			From 07/01/2014		
			To 06/30/2015	Date/Time Pre	
				11/25/2015 11	:28 am
				1. 00	
171.00 If line 167 is "Y", does this pr	ovider have any days for indivi	duals enrolled in secti	on 1876	N	171. 00
Medicare cost plans reported on	Wkst. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes an	nd "N" for no.		
(see instructions)		-			

		NCENT SETON SPECIALI				eu of Form CMS	
HOSPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period: From 07/01/2014 Fo 06/30/2015	Worksheet S- Part II Date/Time Pr 11/25/2015	repared:
					Y/N	Date	11. 20 alli
	General Instruction: Enter Y for all YES resp	anasa Entar N for a	all NO ma	onences Enter	1.00	2.00	
	mm/dd/yyyy format.	onses. Enter N 101 a	aii NO ie	sponses. Enter	arr dates in t	.He	
	COMPLETED BY ALL HOSPITALS						
1. 00	Provider Organization and Operation Has the provider changed ownership immediatel	y prior to the begin	nning of	the cost	N		1.00
	reporting period? If yes, enter the date of t			instructions)	5.1)///I	
				Y/N 1.00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in			N	2.00	0.00	2. 00
	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column 3, '	'V" for				
3. 00	Is the provider involved in business transact			N			3. 00
	contracts, with individuals or entities (e.g.						
	or medical supply companies) that are related officers, medical staff, management personnel						
	of directors through ownership, control, or f						
	relationships? (see instructions)			Y/N	Type	Date	
				1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prep	pared by a Certified	Public	Υ	A		4.00
1. 00	Accountant? Column 2: If yes, enter "A" for	Audited, "C" for Cor	mpiled,		^		1.00
	or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr		ein				
5.00	Are the cost report total expenses and total		from	N			5. 00
	those on the filed financial statements? If y	ves, submit reconcili	ati on.		Y/N	Legal Oper.	
					1. 00	2. 00	
	Approved Educational Activities	-12 0-1 2 15			N.		
6. 00	Column 1: Are costs claimed for nursing school the legal operator of the program?	ooi? Column 2: IT ye	es, is th	ne provider is	N		6. 00
7. 00	Are costs claimed for Allied Health Programs?				N		7. 00
8. 00	Were nursing school and/or allied health procost reporting period? If yes, see instruction		renewed	during the	N		8. 00
	Are costs claimed for Interns and Residents i		ate medic	cal education	N		9. 00
9. 00							
	program in the current cost report? If yes, s	see instructions.		he current	N		10.00
10. 00	Was an approved Intern and Resident GME progr cost reporting period? If yes, see instruction	see instructions. ram initiated or reno ons.	ewed in t		N		10. 00
	Was an approved Intern and Resident GME progr cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center	see instructions. ram initiated or reno ons. rs other than I & R i	ewed in t		N N		10. 00 11. 00
10. 00	Was an approved Intern and Resident GME progr cost reporting period? If yes, see instruction	see instructions. ram initiated or reno ons. rs other than I & R i	ewed in t			Y/N	
10. 00	Was an approved Intern and Resident GME progr cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see	see instructions. ram initiated or reno ons. rs other than I & R i	ewed in t			Y/N 1.00	
10. 00	Was an approved Intern and Resident GME progr cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center	see instructions. ram initiated or renouns. rs other than I & R instructions.	ewed in t	proved			
10. 00 11. 00 12. 00	Was an approved Intern and Resident GME progress reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bactering International Internati	see instructions. ram initiated or renomes. rs other than I & R instructions.	n an App	proved	N	1. 00	11.00
10. 00 11. 00 12. 00 13. 00	Was an approved Intern and Resident GME progress reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bactering International Seeking Research Seeking reimbursement for bactering International Seeking Research Seeking Res	see instructions. cam initiated or renowns. cs other than I & R instructions. I debts? If yes, see of collection policy	n an App	cions.	N st reporting	1. 00 Y N	11. 00 12. 00 13. 00
10. 00 11. 00 12. 00 13. 00	Was an approved Intern and Resident GME progrost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for backing I in e 12 is yes, did the provider's bad deby period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	see instructions. cam initiated or renomes. cs other than I & R instructions. didebts? If yes, see of collection policy	instruct change d	cions. during this cos	N st reporting tructions.	1.00 Y N	11. 00 12. 00 13. 00 14. 00
10. 00 11. 00 12. 00 13. 00	Was an approved Intern and Resident GME progrost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for backing line 12 is yes, did the provider's bad deben period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement	see instructions. cam initiated or renomes. cs other than I & R instructions. didebts? If yes, see of collection policy	instruct change d	cions. Suring this costs yes, see inst	N st reporting tructions.	1. 00 Y N	11. 00 12. 00 13. 00
10. 00 11. 00 12. 00 13. 00 14. 00	Was an approved Intern and Resident GME progrost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for backing I in e 12 is yes, did the provider's bad deby period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	see instructions. cam initiated or renomes. cs other than I & R instructions. didebts? If yes, see of collection policy	instruct change d aived? If	cions. Suring this costs yes, see inst	N st reporting tructions.	1.00 Y N	11. 00 12. 00 13. 00 14. 00
10. 00 11. 00 12. 00 13. 00 14. 00	Was an approved Intern and Resident GME progress reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider of the provider of the provider of the period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the price	see instructions. cam initiated or renomes. cs other than I & R instructions. didebts? If yes, see of collection policy and/or co-payments we or cost reporting per	instruct change d aived? If	croved crions. during this cost yes, see inst yes, see inst Pa	N st reporting tructions.	1.00 Y N N Part B	11. 00 12. 00 13. 00 14. 00
10. 00 11. 00 12. 00 13. 00 14. 00	Was an approved Intern and Resident GME progrost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for backing line 12 is yes, did the provider's bad deben period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priores. PS&R Data	see instructions. Fam initiated or renomes. Fas other than I & R instructions. I debts? If yes, see of collection policy and/or co-payments was or cost reporting per	instruct change d aived? If	oroved ions. during this cost yes, see inst yes, see inst Y/N 1.00	st reporting tructions. ructions. rt A Date 2.00	1.00 Y N N Part B Y/N 3.00	12. 00 13. 00 14. 00
10. 00 11. 00 12. 00 13. 00 14. 00	Was an approved Intern and Resident GME progrost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for backing line 12 is yes, did the provider's bad debe period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,	see instructions. Fam initiated or renomes. Fas other than I & R instructions. I debts? If yes, see of collection policy and/or co-payments was or cost reporting per	instruct change d aived? If	cions. during this cost yes, see inst yes, see inst Pa Y/N	nst reporting tructions. ructions. rt A Date	1.00 Y N N Part B Y/N	11. 00 12. 00 13. 00 14. 00
10. 00 11. 00 12. 00 13. 00 14. 00	Was an approved Intern and Resident GME progress reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider should be seeking reimbursement for back of the provider should be seeking reimbursement for back of the provider should be seeking reimbursement for back of the provider should be seeking reimbursement for back of the provider should be seeking reimbursement for back of the provider should be seeking reimbursement for back of the pask of the provider should be seeking reimbursement for back of the pask of the provider should be seeking reimbursement for back of the provider should be seeking reimburseme	see instructions. Fam initiated or renomes. Fas other than I & R instructions. I debts? If yes, see of collection policy and/or co-payments was or cost reporting per	instruct change d aived? If	oroved ions. during this cost yes, see inst yes, see inst Y/N 1.00	st reporting tructions. ructions. rt A Date 2.00	1.00 Y N N Part B Y/N 3.00	12. 00 13. 00 14. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Was an approved Intern and Resident GME progroost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for backing line 12 is yes, did the provider's bad deby period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	see instructions. Fam initiated or renomes. Fas other than I & R instructions. I debts? If yes, see of collection policy and/or co-payments was or cost reporting per	instruct change d aived? If	oroved ions. during this cost yes, see inst Pa Y/N 1.00	st reporting tructions. ructions. rt A Date 2.00	1.00 Y N N Part B Y/N 3.00	12. 00 13. 00 14. 00 15. 00
11. 00 11. 00 12. 00 13. 00 14. 00	Was an approved Intern and Resident GME progrost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for backing line 12 is yes, did the provider's bad deby period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priodection of the priodection of the provider's periodection of the priodection of the	see instructions. Fam initiated or renomes. Fas other than I & R instructions. I debts? If yes, see of collection policy and/or co-payments was or cost reporting per	instruct change d aived? If	oroved ions. during this cost yes, see inst yes, see inst Y/N 1.00	st reporting tructions. ructions. rt A Date 2.00	1.00 Y N N Part B Y/N 3.00	12. 00 13. 00 14. 00
11. 00 11. 00 12. 00 13. 00 14. 00	Was an approved Intern and Resident GME progroost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for backing line 12 is yes, did the provider's bad deby period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	see instructions. Fam initiated or renomes. Fas other than I & R instructions. I debts? If yes, see of collection policy and/or co-payments was or cost reporting per	instruct change d aived? If	oroved ions. during this cost yes, see inst Pa Y/N 1.00	st reporting tructions. ructions. rt A Date 2.00	1.00 Y N N Part B Y/N 3.00	12. 00 13. 00 14. 00 15. 00
10. 00 11. 00 12. 00 13. 00 14. 00	Was an approved Intern and Resident GME progrost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for backing I in a 12 is yes, did the provider's bad deby period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod total beds available change from the priod 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) Was the cost report prepared using the PS&R Report for totals and the provider's records	see instructions. Fam initiated or renomes. Fas other than I & R instructions. I debts? If yes, see of collection policy and/or co-payments was or cost reporting per	instruct change d aived? If	oroved ions. during this cost yes, see inst Pa Y/N 1.00	st reporting tructions. ructions. rt A Date 2.00	1.00 Y N N Part B Y/N 3.00	12. 00 13. 00 14. 00 15. 00

yes, enter the paid-through date in columns 2 and 4. (see instructions)

18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.

20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:

Health Financial Systems	ST VINCENT SETON SPECIALITY HOSPITAL	In Lieu of Form CMS-

-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Worksheet S-2 Provi der CCN: 152020 Peri od From 07/01/2014 Part II 06/30/2015 Date/Time Prepared: 11/25/2015 11:28 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Υ 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Ν 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Υ 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position RONALD HFLMS 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 | Enter the employer/company name of the cost report ST VINCENT HEALTH 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-583-3234 RONALD. HELMS@STVI NCENT. ORG 43.00 report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 152020 Peri od: Worksheet S-2 From 07/01/2014 To 06/30/2015 Part II Date/Time Prepared: 11/25/2015 11:28 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 10/13/2015 16.00 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) 17.00 Was the cost report prepared using the PS&R 17.00 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) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 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.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position REIMBURSEMENT MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00 report preparer in columns 1 and 2, respectively.

Heal th Financial Systems ST VINCENT SETON SPECIALITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN Provi der CCN: 152020

						То	06/30/2015	Date/Time Pre		
				1				I/P Days / 0/P		- Cilii
								Visits / Trips		
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available		CAH Hours	Title V		
		1.00		2. 00	3. 00		4. 00	5. 00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		74	27, 01	10	0. 00	0	1	1. 00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2									
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)									2. 00
3.00	HMO IPF Subprovider									3. 00
4. 00	HMO IRF Subprovider									4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF							0		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							0		6. 00
7.00	Total Adults and Peds. (exclude observation			74	27, 01	10	0.00	0	7	7. 00
	beds) (see instructions)									
8.00	INTENSIVE CARE UNIT									8. 00
9.00	CORONARY CARE UNIT									9. 00
10.00	BURN INTENSIVE CARE UNIT									0.00
11.00	SURGICAL INTENSIVE CARE UNIT									1. 00
12.00	OTHER SPECIAL CARE (SPECIFY)									2. 00 3. 00
13. 00 14. 00	NURSERY Total (see instructions)			74	27, 01		0. 00	0		4. 00
15. 00	CAH visits			74	27,01	10	0.00	0		4. 00 5. 00
16. 00	SUBPROVI DER - I PF							0		6. 00
17. 00	SUBPROVI DER - I RF									7. 00
18. 00	SUBPROVI DER									8. 00
19.00	SKILLED NURSING FACILITY								19	9. 00
20.00	NURSING FACILITY								20	O. CO
21. 00	OTHER LONG TERM CARE									1. 00
22. 00	HOME HEALTH AGENCY									2. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)									3. 00
24. 00	HOSPI CE	20.00								4. 00
24. 10	HOSPICE (non-distinct part)	30. 00								4. 10 5. 00
25. 00 26. 00	CMHC									5. 00 6. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER									6. 25
27. 00	Total (sum of lines 14-26)			74						7. 00
28. 00	Observation Bed Days			, ,				0		8. 00
29. 00	Ambulance Trips									9. 00
30.00	Employee discount days (see instruction)								30	0. 00
31.00	Employee discount days - IRF								31	1. 00
32.00	Labor & delivery days (see instructions)			0		0			32	2. 00
32. 01	Total ancillary labor & delivery room								32	2. 01
	outpatient days (see instructions)									
33. 00	LTCH non-covered days		l		1				33	3. 00

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

Provi der CCN: 152020

				'	0 00/30/2013	11/25/2015 11	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	20 a
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	13, 615	1, 060	22, 085			1. 00
0.00	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0.000					
2.00	HMO and other (see instructions)	2, 330	0				2.00
3.00	HMO IPF Subprovider	0	U				3. 00 4. 00
4.00	HMO IRF Subprovider	0	0	0			
5.00	Hospital Adults & Peds. Swing Bed SNF	U	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	40 (45	1 0 (0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	13, 615	1, 060	22, 085			7. 00
0.00	beds) (see instructions)						0 00
8. 00 9. 00	INTENSIVE CARE UNIT						8. 00 9. 00
	CORONARY CARE UNIT						•
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	40 (45				050.54	13.00
14. 00	Total (see instructions)	13, 615	1, 060	22, 085	0. 00	250. 51	
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	250. 51	
28. 00	Observation Bed Days		0	0			28. 00
29. 00	Ambulance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30. 00
31.00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	o					33. 00

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 152020

Peri od: Worksheet S-3 From 07/01/2014 Part I To 06/30/2015 Date/Time Prepared:

11/25/2015 11:28 am Full Time Di scharges Equi val ents Title V Title XVIII Title XIX Total All Component Nonpai d Workers Pati ents 12.00 13.00 14.00 11.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 354 22 603 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 64 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 603 14.00 Total (see instructions) 0.00 0 354 22 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 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 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 29.00 29.00 Ambul ance Trips 30 00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions)

33.00 LTCH non-covered days

Heal th	Financial Systems ST VI	NCENT SETON SPEC	CIALITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 152020	Peri od:	Worksheet A	
					From 07/01/2014		
					To 06/30/2015		
						11/25/2015 11	: 28 am
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		951, 849	951, 84	9 -623	951, 226	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		729, 106	729, 10	6 0	729, 106	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	174, 698	3, 873, 103	4, 047, 80	1 0	4, 047, 801	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 930, 608	3, 597, 530	6, 528, 13		6, 528, 761	5. 00
7. 00	00700 OPERATION OF PLANT	205, 844	1, 681, 351	1, 887, 19		1, 887, 195	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	200,011	143, 038	143, 03		143, 038	8. 00
9. 00	00900 HOUSEKEEPING	l o	446, 949	446, 94		446, 949	9. 00
10. 00	01000 DI ETARY		732, 218			732, 218	10.00
13. 00		1 205 200					13.00
	01300 NURSI NG ADMI NI STRATI ON	1, 205, 288	174, 221	1, 379, 50		1, 379, 509	
15. 00	01500 PHARMACY	1, 449, 906	2, 638, 620	4, 088, 52		4, 088, 526	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	121, 849	155, 803	277, 65		277, 652	16. 00
17. 00	01700 SOCIAL SERVICE	136, 739	10, 673	147, 41		147, 412	17. 00
18. 00	01851 PASTORAL CARE	63, 663	499	64, 16	2 0	64, 162	18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 088, 173	3, 289, 596	10, 377, 76	9 -20, 020	10, 357, 749	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	176, 665	301, 762	478, 42	7 -159	478, 268	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	193, 082	88, 305	281, 38	7 -1, 373	280, 014	54.00
54.01	03630 ULTRA SOUND	0	0		0	0	54. 01
57.00	05700 CT SCAN	150, 360	11, 848	162, 20	-556	161, 652	57. 00
60.00	06000 LABORATORY	O	760, 537	760, 53	7 0	760, 537	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	143, 612	143, 61	2 0	143, 612	63. 00
65.00	06500 RESPIRATORY THERAPY	2, 147, 354	447, 142	2, 594, 49		2, 594, 136	65. 00
66. 00	06600 PHYSI CAL THERAPY	420, 249	192, 385	612, 63		612, 634	
67. 00	06700 OCCUPATI ONAL THERAPY	207, 013	52, 721	259, 73		259, 734	67. 00
68. 00	06800 SPEECH PATHOLOGY	151, 079	11, 231	162, 31		162, 310	68. 00
69. 00	06900 ELECTROCARDI OLOGY	131,077	11, 231	102, 31		0	69.00
70. 00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	829	1, 456	2, 28	5	2, 285	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	029	1, 450	2, 20		2, 203	70.00
		0	0		0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	U		0 22 000	-	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	000 404	000 40	22, 989	22, 989	73. 00
74. 00	07400 RENAL DIALYSIS	0	808, 406	808, 40	6 -521	807, 885	74. 00
	SPECIAL PURPOSE COST CENTERS					_	
	11300 I NTEREST EXPENSE		0		0		113. 00
118.00		16, 823, 399	21, 243, 961	38, 067, 36	0	38, 067, 360	118. 00
	NONREI MBURSABLE COST CENTERS	T T					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19100 RESEARCH	0	0		0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192. 00
	19300 NONPALD WORKERS	0	0		0 (C		193. 00
	07950 BIOTERRORISM GRANT	0	24, 583	24, 58	3	24, 583	
194. 01	07951 MARKETI NG	0	0		0 (0		194. 01
200.00	TOTAL (SUM OF LINES 118-199)	16, 823, 399	21, 268, 544	38, 091, 94	3 0	38, 091, 943	200. 00
		·					

 Heal th Financial
 Systems
 ST VINCENT SETON SPECIALITY HOSPITAL

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN
 In Lieu of Form CMS-2552-10 Provi der CCN: 152020

				11/25/2015 1	
	Cost Center Description	Adjustments	Net Expenses		
	· · · · · · · · · · · · · · · · · · ·		or Allocation		
		6.00	7. 00		
-	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-11, 930	939, 296		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	729, 106		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	326, 388	4, 374, 189		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 347, 265	8, 876, 026		5. 00
7.00	00700 OPERATION OF PLANT	-32, 595	1, 854, 600		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	143, 038		8. 00
9.00	00900 HOUSEKEEPI NG	0	446, 949		9. 00
10.00	01000 DI ETARY	-89, 148	643, 070		10.00
13.00	01300 NURSING ADMINISTRATION	0	1, 379, 509		13. 00
15.00	01500 PHARMACY	0	4, 088, 526		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-11, 378	266, 274		16. 00
17.00	01700 SOCIAL SERVICE	-1, 868	145, 544		17. 00
18.00	01851 PASTORAL CARE	0	64, 162		18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	0	10, 357, 749		30. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	478, 268		50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	280, 014		54.00
54. 01	03630 ULTRA SOUND	0	0		54. 01
57.00	05700 CT SCAN	0	161, 652		57.00
60.00	06000 LABORATORY	0	760, 537		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	143, 612		63.00
65.00	06500 RESPI RATORY THERAPY	0	2, 594, 136		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	612, 634		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	259, 734		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	162, 310		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2, 285		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	l .	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	22, 989		73. 00
74. 00	07400 RENAL DIALYSIS	0	807, 885		74. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 NTEREST EXPENSE	0	0		113. 00
118. 00		2, 526, 734	40, 594, 094		118. 00
	NONREI MBURSABLE COST CENTERS				4
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19100 RESEARCH	0	0	l .	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	l .	192. 00
	19300 NONPALD WORKERS	0	0		193. 00
	07950 BIOTERRORISM GRANT	0	24, 583		194. 00
	07951 MARKETI NG	174, 563	174, 563	l .	194. 01
200.00	TOTAL (SUM OF LINES 118-199)	2, 701, 297	40, 793, 240		200. 00

Heal t	h Financial Systems	ST \	VINCENT SETON S	PECIALITY HOSP	I TAL	In Lie	u of Form CMS-	2552-10
RECLA	ASSI FI CATI ONS			Provi der	CCN: 152020	Peri od: From 07/01/2014	Worksheet A-6	5
						To 06/30/2015	Date/Time Pro	
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2.00	2 00	4 00	г оо				

		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4.00	5. 00	
	A - DRUGS CHARGED TO PATIENTS	S			
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	22, 989	1. 00
2.00		0.00	0	0	2. 00
3.00		0.00	0	0	3. 00
4.00		0.00	0	0	4. 00
5.00		0.00	0	0	5. 00
6.00		0.00	0	0	6. 00
	TOTALS		0	22, 989	
	B - INTEREST EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	623	1. 00
	TOTALS		0	623	
500.00	Grand Total: Increases		0	23, 612	500.00

Provi der CCN: 152020 | Peri od: From 07/01/2014 | Worksheet A-6 | Date/Ti me Prepared: 11/25/2015 11: 28 am

						11/25/2015 1	<u>1:28 am</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - DRUGS CHARGED TO PATIENTS	S					
1.00	ADULTS & PEDIATRICS	30.00	0	20, 020	0		1. 00
2.00	OPERATING ROOM	50.00	0	159	0		2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 373	0		3. 00
4.00	CT SCAN	57.00	0	556	0		4. 00
5.00	RESPIRATORY THERAPY	65.00	0	360	0		5. 00
6.00	RENAL DIALYSIS	74.00	0	521	0		6. 00
	TOTALS		0	22, 989			
	B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	623	11		1. 00
	TOTALS		0	623			
500.00	Grand Total: Decreases		0	23, 612			500.00

9.00

Reconciling Items

10.00 Total (line 8 minus line 9)

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 152020 Peri od: Worksheet A-7 From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/25/2015 11:28 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 850, 786 0 1.00 0 2.00 Land Improvements 0 2.00 0 3.00 Buildings and Fixtures 21, 967, 569 40, 428 118, 676 3.00 40, 428 Building Improvements 0 4.00 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 0 0 0 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 22, 818, 355 40, 428 40, 428 118, 676 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 118, 676 22, 818, 355 40, 428 40, 428 10.00 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 850, 786 0 1.00 2.00 Land Improvements 0 2.00 21, 889, 321 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 0 5.00 Movable Equipment 0 0 6.00 6.00 7.00 HIT designated Assets 0 7.00 0 Subtotal (sum of lines 1-7) 8.00 22, 740, 107 0 8.00

22, 740, 107

Health Financial Systems	ST VINCENT SETON SPECIALITY HOSPITAL	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 152020	Peri od: Worksheet A-7

RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 07/01/2014 To 06/30/2015	Worksheet A-7 Part II Date/Time Pre	nared:
					.0 00,00,2010	11/25/2015 11	
	·		Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	786, 974	152, 322	12, 55	3 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	371, 233	312, 874		0 21, 483	8, 381	2. 00
3.00	Total (sum of lines 1-2)	1, 158, 207	465, 196	12, 55	3 21, 483	8, 381	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
14.00 15.00							
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	951, 849				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	15, 135	729, 106				2. 00
3.00	Total (sum of lines 1-2)	15, 135	1, 680, 955				3. 00

2. 00 CAP REL COSTS-MVBLE EQUIP 461, 540 0 461, 540 0. 375686 0	Health Financial Systems ST	VINCENT SETON SE	PECIALITY HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
Cost Center Description Gross Assets Capitalized Leases For Ratio (col. 1 - col. 2) 1.00 2.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2) Cost Center Description Gross Assets Capitalized (col. 1 - col. 2) 3.00 3.00 4.00 5.00 766, 986 0 766, 986 0 766, 986 0 0 766, 986 0 1.228, 526 0 1.228, 526 0 1.228, 526 1.000000	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		From 07/01/2014	Part III Date/Time Pre	pared:
Leases for Ratio instructions		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	Cost Center Description	Gross Assets		for Ratio (col. 1 - col	instructions)	Insurance	
1. 00 CAP REL COSTS-BLDG & FIXT 766, 986 0 766, 986 0.624314 0 2. 00 CAP REL COSTS-MVBLE EQUIP 461, 540 0 461, 540 0.375686 0 3. 00 Total (sum of lines 1-2) 1, 228, 526 0 1, 228, 526 1.000000 0			2.00	3.00	4. 00	5. 00	
2.00 CAP REL COSTS-MVBLE EQUIP 461,540 0 461,540 0.375686 0 3.00 Total (sum of lines 1-2) 1,228,526 0 1,228,526 1.000000 0		· _ · · · · · · · · · · · · · · · · · ·					
3.00 Total (sum of lines 1-2) 1,228,526 0 1,228,526 1.000000 0	1.00 CAP REL COSTS-BLDG & FLXT	766, 986	0	766, 98	6 0. 624314	0	1.00
	2. 00 CAP REL COSTS-MVBLE EQUIP	461, 540	0	461, 54	0. 375686	0	2. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL	3.00 Total (sum of lines 1-2)	1, 228, 526	0	1, 228, 52	1. 000000	0	3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description Taxes Other Total (sum of Depreciation Lease	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
Capi tal -Rel ate col s. 5			Capi tal -Rel ate	col s. 5			
d Costs through 7)			d Costs	through 7)			
6.00 7.00 8.00 9.00 10.00		6.00	7. 00	8. 00	9. 00	10.00	

		ALLOCA	ITON OF OTTICK C	AFITAL	JOIWIWAK I O	I CAFITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	col s. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	0	786, 974	152, 322	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	371, 233	312, 874	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1, 158, 207	465, 196	3. 00
			SU	JMMARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance (see	,		Total (2) (sum	
			instructions)	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	ENTERS					
1. 00	LCAD DEL COCTO DIDO 0 FIVT	Λ	0	1 0	0	939, 296	1. 00
	CAP REL COSTS-BLDG & FLXT			_			
2.00	CAP REL COSTS-MVBLE EQUIP	Ö	21, 483	· ·			2. 00
		0	21, 483 21, 483				2. 00 3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES

				T	o 06/30/2015		pared:
				Expense Classification on	Worksheet A	11/25/2015 11	28 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00	Investment income - CAP REL	1.00 B	2.00	3. 00	4. 00	5. 00	1. 00
1. 00	COSTS-BLDG & FLXT (chapter 2)	В	-9, 211	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	-623	ADMINISTRATIVE & GENERAL	5. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
4.00	di scounts (chapter 8)		0		0.00		4.00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
7.00	stations excluded) (chapter		0		0.00	Ŭ	7.00
8. 00	21) Television and radio service		0		0.00	0	8. 00
	(chapter 21)		_				
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0		0.00	0	9. 00 10. 00
	adj ustment		-				
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12.00	Related organization	A-8-1	3, 261, 991			О	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests		-89, 148	DI ETARY	10.00	0	
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
	patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	-11, 357	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19. 00
20.00	books, etc.)		0		0.00	0	20.00
20. 00 21. 00	Vending machines Income from imposition of	A	-206	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00		
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
20.00	limitation (chapter 14)		2	ADULTS & DEDLATRICS	20.00		30. 99
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		JU. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)	[
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	MI SCELLANEOUS I NCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 01	CHARITABLE DONATIONS	A	-6, 153	ADMINISTRATIVE & GENERAL	5. 00	ı Ol	33. 01

Provi der CCN: 152020 Peri od: Worksheet A-8 From 07/01/2014 To 06/30/2015 Date/Time Prepared:

					0 00/30/2013	11/25/2015 11:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1. 00	2.00	3. 00	4. 00	5. 00	
33. 02	CHARITABLE DONATIONS	A	-1, 868	SOCI AL SERVI CE	17. 00	0	33. 02
33. 03	MISC INCOME	В	-1, 020	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33.04	MISC INCOME	В	-21	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 04
33.05	CORPORATE SPONSORSHIP	A	-415	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	LOBBYING EXPENSE	A	-835	ADMINISTRATIVE & GENERAL	5.00	0	33. 06
33. 07	INCENTIVE COMP. SALARY ACCRUAL	A	-406, 688	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	INCENT COMP. FICA ACCRUAL	A	-29, 095	ADMINISTRATIVE & GENERAL	5.00	0	33. 08
50.00	TOTAL (sum of lines 1 thru 49)		2, 701, 297				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 152020 Peri od: Worksheet A-8-1 From 07/01/2014
To 06/30/2015 Date/Time Prepared: OFFICE COSTS

				To 06/30/2015	Date/lime Pre	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:	EUDI OVEE DENEEL TO DEDARTHENT	luous assues	1	440 755	4 00
1.00		EMPLOYEE BENEFITS DEPARTMENT		0	149, 755	
2.00		ADMINISTRATIVE & GENERAL	HOME OFFICE	4, 943, 417	2, 146, 928	
3.00		MARKETI NG	HOME OFFICE	174, 563	0	3. 00
3. 01			SVH CHARGEBACK	264, 438	264, 438	3. 01
3. 02	II		SVH CHARGEBACK	237, 096	237, 096	
3. 03		l .	SVH CHARGEBACK	104, 219	104, 219	
3.04		l .	SVH CHARGEBACK	25, 644	25, 644	
3. 05			SVH CHARGEBACK	18, 142	18, 142	
3.06			SVH CHARGEBACK	184, 950	184, 950	
3. 07			SVH CHARGEBACK	63, 663	63, 663	
3.08			SVH CHARGEBACK	300	300	3. 08
3.09			SVH CHARGEBACK	107, 493	107, 493	
3. 10		l l	SVH CHARGEBACK	74, 028	74, 028	3. 10
3. 11			SVH CHARGEBACK	150, 360	150, 360	
3. 12			SVH CHARGEBACK	2, 534	2, 534	3. 12
4.00		k	ASCENSION INTEREST	9, 834	12, 553	
4.01			ASCENSION INTEREST	488	623	4. 01
4.02			TRIMEDX	816, 374	848, 969	4. 02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	2, 758, 929	2, 673, 526	4. 03
4.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	PENSI ON	714, 099	323, 359	4. 04
4.05	0.00			0	0	4. 05
5.00	TOTALS (sum of lines 1-4).			10, 650, 571	7, 388, 580	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

6. 00	G	ST VINCENT HEAL	100.00	0.00	6. 00
7.00	G	ASCENSI ON	100.00	0.00	7.00
8.00	A	TRI MEDX	100.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	HOME OFFICE			100.00
	non-financial) specify:				

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

* 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.

4.00

4 01

4.02

4.03

4.04

4.05

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

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

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

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

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

4.00

4 01

4.02

4.03

4.04

4.05

5.00

-2, 719

-32, 595

85, 403

390, 740

3, 261, 991

-135

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0

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COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 152020 Peri od: Worksheet B From 07/01/2014 Part I 06/30/2015 Date/Time Prepared: 11/25/2015 11:28 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 939, 296 939, 296 2.00 00200 CAP REL COSTS-MVBLE EQUIP 729, 106 729, 106 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 374, 189 4, 374, 189 4.00 00500 ADMINISTRATIVE & GENERAL 769, 973 5 00 8, 876, 026 44, 152 34 272 9, 724, 423 5 00 00700 OPERATION OF PLANT 7.00 1,854,600 47,066 36, 534 54,082 1, 992, 282 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 143, 038 7, 683 5, 964 156, 685 8.00 9.00 00900 HOUSEKEEPI NG 446, 949 10, 674 8, 285 o 465, 908 9.00 643, 070 710, 737 01000 DI FTARY 38.096 29, 571 10 00 10.00 0 13.00 01300 NURSING ADMINISTRATION 1, 379, 509 61, 998 48, 124 316, 671 1, 806, 302 13.00 01500 PHARMACY 4, 088, 526 17, 364 380, 941 4, 509, 200 15.00 22, 369 15.00 01600 MEDICAL RECORDS & LIBRARY 10, 163 7, 888 32, 014 16.00 16, 00 266, 274 316, 339 01700 SOCIAL SERVICE 4, 334 35, 926 191, 387 17.00 145, 544 5, 583 17.00 18.00 01851 PASTORAL CARE 64, 162 6, 889 5, 347 16, 726 93, 124 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 10, 357, 749 30.00 635, 135 493, 007 1, 862, 305 13, 348, 196 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 478, 268 6, 737 5, 230 46, 416 50.00 536, 651 54.00 05400 RADI OLOGY-DI AGNOSTI C 280, 014 12, 112 9, 402 50, 729 352, 257 54.00 03630 ULTRA SOUND 54.01 54.01 0 0 05700 CT SCAN 206, 871 57.00 161, 652 3.217 2 497 39, 505 57.00 06000 LABORATORY 760, 537 2,042 765, 210 60.00 2,631 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 143, 612 143, 612 63.00 65.00 06500 RESPIRATORY THERAPY 2, 594, 136 4.769 3.702 564, 185 3, 166, 792 65.00 66.00 06600 PHYSI CAL THERAPY 612, 634 6, 680 5, 186 110, 414 734, 914 66.00 06700 OCCUPATI ONAL THERAPY 259, 734 54, 390 325, 990 67.00 6, 680 5, 186 67.00 213, 837 68.00 06800 SPEECH PATHOLOGY 162, 310 6, 662 5, 171 39, 694 68.00 69.00 06900 ELECTROCARDI OLOGY 0 C 0 0 Ω 69.00 07000 ELECTROENCEPHALOGRAPHY 0 218 70.00 2.285 2,503 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 Ω 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 72 00 0 C 0 Λ 0 73.00 07300 DRUGS CHARGED TO PATIENTS 22, 989 C 0 22, 989 73.00 07400 RENAL DIALYSIS 74.00 807,885 0 0 807, 885 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 40, 594, 094 729, 106 40, 594, 094 118. 00 118.00 939, 296 4, 374, 189 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193. 00 194. 00 07950 BI OTERRORI SM GRANT 0 0 24 583 194 00 24 583 Ω 194. 01 07951 MARKETI NG 174, 563 C 0 0 174, 563 194. 01 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 0 201. 00 40, 793, 240 202. 00 40, 793, 240 4, 374, 189 202.00 TOTAL (sum lines 118-201) 939, 296 729, 106

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST VINCENT SETON SPECIALITY HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 152020

				''	0 00/30/2013	11/25/2015 11	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	'	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	9, 724, 423					5. 00
7.00	00700 OPERATION OF PLANT	623, 576	2, 615, 858				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	49, 042	23, 699	229, 426			8. 00
9.00	00900 HOUSEKEEPI NG	145, 827	32, 922	0	644, 657		9. 00
10.00	01000 DI ETARY	222, 458	117, 504	0	29, 599	1, 080, 298	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	565, 365			48, 170	0	13. 00
15. 00	01500 PHARMACY	1, 411, 362	68, 997		17, 380	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	99, 013			7, 896	0	16. 00
17. 00	01700 SOCIAL SERVICE	59, 903			4, 338	0	17. 00
18. 00	01851 PASTORAL CARE	29, 147			5, 352	0	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	27, 147	21, 240		5, 332		10.00
30. 00	03000 ADULTS & PEDI ATRI CS	4, 177, 940	1, 959, 047	229, 426	493, 472	1, 080, 298	30. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	1, 177, 710	1, 707, 017	227, 120	170, 172	1,000,270	00.00
50. 00	05000 OPERATING ROOM	167, 970	20, 781	0	5, 235	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	110, 255			9, 410	0	
54. 01	03630 ULTRA SOUND	110, 233			0,410	0	
57. 00	05700 CT SCAN	64, 750	-	_	2, 500	0	
60.00	06000 LABORATORY	239, 508		•	2, 044	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	44, 950			2, 044	0	
65. 00	06500 RESPIRATORY THERAPY	991, 193			3, 705	0	65.00
66. 00	06600 PHYSI CAL THERAPY	230, 025			5, 703 5, 190	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	102, 034			5, 190	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	66, 930			5, 190 5, 176	0	68.00
69.00	06900 ELECTROCARDI OLOGY	00, 930	20, 547		3, 176	0	69.00
		702			0	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	783	0	0	U	_	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	7 405	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 195			0	0	
74. 00	07400 RENAL DIALYSIS SPECIAL PURPOSE COST CENTERS	252, 865	0	0	U	0	74. 00
112 00							112 00
	11300 I NTEREST EXPENSE	0 ((0 001	2 /15 050	220 427	/ 4 4 / 5 7	1 000 200	113. 00
118. 00		9, 662, 091	2, 615, 858	229, 426	644, 657	1, 080, 298	1118.00
400.00	NONREI MBURSABLE COST CENTERS						100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	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
	19300 NONPAI D WORKERS	0	0	0	0		193. 00
	07950 BI OTERRORI SM GRANT	7, 694		0	0		194. 00
	07951 MARKETI NG	54, 638	0	0	0	0	194. 01
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	9, 724, 423	2, 615, 858	229, 426	644, 657	1, 080, 298	202.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 152020 Peri od: Worksheet B From 07/01/2014 Part I 06/30/2015 Date/Time Prepared: 11/25/2015 11:28 am OTHER GENERAL SERVI CE SOCIAL SERVICE PASTORAL CARE Cost Center Description NURSI NG **PHARMACY** MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY 13.00 15.00 17.00 18.00 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 2, 611, 066 01300 NURSING ADMINISTRATION 13.00 13 00 01500 PHARMACY 15.00 6,006,939 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 454, 594 16.00 01700 SOCIAL SERVICE 17.00 0 272, 848 17.00 C 01851 PASTORAL CARE 148, 871 18.00 0 0 18 00 Ω INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 1, 881, 203 0 173, 093 272, 848 148, 871 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 36, 145 10.803 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 11, 382 0 0 54.00 0 03630 ULTRA SOUND 54.01 0 0 0 54.01 0 05700 CT SCAN 0 0 57 00 1 684 57 00 0 06000 LABORATORY 60.00 0 0 41,842 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 1, 970 0 0 0 0 0 0 63.00 63.00 0 06500 RESPIRATORY THERAPY 65.00 504, 463 0 108, 228 0 65.00 06600 PHYSI CAL THERAPY 104, 507 0 9. 244 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 52, 418 9,036 0 67.00 06800 SPEECH PATHOLOGY 32, 330 3, 238 68.00 68.00 0 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 0 C 07000 ELECTROENCEPHALOGRAPHY 0 Ω 70.00 70.00 146 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 6,006,939 73, 707 0 73.00 07400 RENAL DIALYSIS 74.00 10, 221 Ω 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 6,006,939 454, 594 148, 871 118. 00 2, 611, 066 272, 848 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 0 191. 00 19100 RESEARCH 0 0 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194. 00 07950 BI OTERRORI SM GRANT 0 0 0 o 0 194.00 194. 01 07951 MARKETI NG 0 194, 01

0

2, 611, 066

C

6,006,939

0

454, 594

0

272, 848

200. 00

0 201.00

148, 871 202. 00

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

					rom 07/01/2014 Part I o 06/30/2015 Date/Time	
	Cost Center Description	Subtotal	Intern &	Total	11/25/2015	5 11:28 am
			Residents Cost			
			& Post			
			Stepdown			
			Adjustments			
	DENERAL CERVILOR COCT CENTERS	24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FLXT	1			T	1.00
	00200 CAP REL COSTS-BLDG & FIXT					2.00
	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
	D1300 NURSING ADMINISTRATION					13. 00
	D1500 PHARMACY					15. 00
	01600 MEDICAL RECORDS & LIBRARY					16.00
	01700 SOCIAL SERVICE					17. 00
	D1851 PASTORAL CARE					18. 00
	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	23, 764, 394	0	23, 764, 394		30.00
Ī	ANCILLARY SERVICE COST CENTERS					
50.00	D5000 OPERATING ROOM	777, 585	0	777, 585		50. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	520, 663	0	520, 663		54.00
54. 01	03630 ULTRA SOUND	0	0	0		54. 01
	D5700 CT SCAN	285, 728	0	285, 728		57. 00
60.00	06000 LABORATORY	1, 056, 718	0	1, 056, 718		60. 00
	06300 BLOOD STORING, PROCESSING & TRANS.	190, 532	0	190, 532		63. 00
	06500 RESPI RATORY THERAPY	4, 789, 091	0	4, 789, 091		65. 00
	D6600 PHYSI CAL THERAPY	1, 104, 486	0	1, 104, 486		66. 00
	06700 OCCUPATI ONAL THERAPY	515, 274	0	515, 274		67. 00
	06800 SPEECH PATHOLOGY	342, 058	0	342, 058		68. 00
	06900 ELECTROCARDI OLOGY	0	0	0		69. 00
	07000 ELECTROENCEPHALOGRAPHY	3, 432	0	3, 432		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	U	0		71.00
	D7200 IMPL. DEV. CHARGED TO PATIENTS D7300 DRUGS CHARGED TO PATIENTS	4 110 020	0	(110 020		72. 00 73. 00
	07400 RENAL DIALYSIS	6, 110, 830 1, 070, 971	0	6, 110, 830 1, 070, 971		74.00
	SPECIAL PURPOSE COST CENTERS	1,070,971	UU	1, 070, 971		74.00
	11300 INTEREST EXPENSE					113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	40, 531, 762	o	40, 531, 762		118.00
	NONREI MBURSABLE COST CENTERS	1070017702	31	10/001/702		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
191.00	19100 RESEARCH	0	0	0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0		192. 00
193.00	19300 NONPALD WORKERS	0	O	0		193. 00
194. 00	D7950 BIOTERRORISM GRANT	32, 277	0	32, 277		194. 00
194. 01	D7951 MARKETI NG	229, 201	0	229, 201		194. 01
200.00	Cross Foot Adjustments	0	0	0		200. 00
201.00	Negative Cost Centers	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	40, 793, 240	0	40, 793, 240		202. 00

From 07/01/2014 Part II 06/30/2015 Date/Time Prepared: 11/25/2015 11:28 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal Assigned New **BENEFITS** Capi tal DEPARTMENT Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 557, 191 44, 152 34, 272 635, 615 0 5.00 00700 OPERATION OF PLANT 47, 066 7 00 36 534 83 600 7 00 0 0 00800 LAUNDRY & LINEN SERVICE 8.00 0 7, 683 5, 964 13, 647 0 8.00 9.00 00900 HOUSEKEEPI NG 0 10, 674 8, 285 18, 959 0 9.00 01000 DI ETARY 0 0 38.096 29. 571 67.667 10.00 10 00 0 01300 NURSING ADMINISTRATION 13.00 61, 998 48, 124 110, 122 0 13.00 15.00 01500 PHARMACY 22, 369 17, 364 39, 733 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 10, 163 7,888 18,051 0 16.00 01700 SOCIAL SERVICE 17.00 4, 334 9 917 17 00 5. 583 0 18.00 01851 PASTORAL CARE 6, 889 5, 347 12, 236 0 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 635, 135 493, 007 1, 128, 142 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 6, 737 5, 230 11, 967 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 12, 112 9, 402 21, 514 54.00 54.01 03630 ULTRA SOUND 54. 01 0000000000000 0 C 05700 CT SCAN 3. 217 2 497 5 714 57.00 57.00 0 60.00 06000 LABORATORY 2, 631 2,042 4,673 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 06500 RESPIRATORY THERAPY 8, 471 65.00 4,769 3.702 0 65.00 06600 PHYSI CAL THERAPY 5, 186 66.00 6,680 11, 866 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 6, 680 5, 186 11,866 0 67.00 06800 SPEECH PATHOLOGY 68.00 5, 171 11, 833 68.00 6, 662 06900 ELECTROCARDI OLOGY 69.00 69.00 C 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY C 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 C Λ 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 729, 106 2, 225, 593 557, 191 939, 296 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 191. 00 191. 00 19100 RESEARCH Λ 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 0 0 o 194. 00 07950 BI OTERRORI SM GRANT 0 0 194.00 194. 01 07951 MARKETI NG 0 194.01 0 0 0 C 200.00 Cross Foot Adjustments 0 200.00 Negative Cost Centers 201.00 0 0 201.00 202 00 TOTAL (sum lines 118-201) 557 191 939, 296 729, 106 2. 225. 593 0 202. 00

Provider CCN: 152020

Peri od:

Health Financial Systems

ST VINCENT SETON SPECIALITY HOSPITAL

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020
Period:
From 07/01/2014
To 06/30/2015
Date/Time Prepared:
11/25/2015 11: 28 am

Cost Center Description

ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPING DIETARY

BEAUTION OF LAUNDRY & HOUSEKEEPING DIETARY

LINEN SERVICE

						11/25/2015 11	:28 am
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	PLANT	LINEN SERVICE			
		5.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	635, 615					5. 00
7.00	00700 OPERATION OF PLANT	40, 758					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 205					8. 00
9.00	00900 HOUSEKEEPI NG	9, 532					9, 00
10.00	01000 DI ETARY	14, 540			· ·		
13. 00	01300 NURSI NG ADMI NI STRATI ON	36, 953			,		13. 00
15. 00	01500 PHARMACY	92, 249					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 472	1				16. 00
17. 00	01700 SOCIAL SERVICE	3, 915					17. 00
18. 00	01851 PASTORAL CARE	1, 905					18.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 703	1,010	0	250	U	10.00
30. 00	03000 ADULTS & PEDIATRICS	273, 088	93, 132	17, 979	23, 007	89, 173	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	273,000	93, 132	17, 979	23,007	09, 1/3	30.00
50. 00	05000 OPERATING ROOM	10, 979	988	0	244	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 206					54.00
54. 00	03630 ULTRA SOUND	7, 200	1, 776	1			54. 00
54. 01	05700 CT SCAN	4 222	-		_	0	57.00
	1	4, 232					
60.00	06000 LABORATORY	15, 655				0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 938			_		63.00
65. 00	06500 RESPIRATORY THERAPY	64, 786					65.00
66. 00	06600 PHYSI CAL THERAPY	15, 035	ł .				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	6, 669					67. 00
68. 00	06800 SPEECH PATHOLOGY	4, 375	ł .	_		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	51	0	0	_	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	470		_		0	73. 00
74. 00	07400 RENAL DI ALYSI S	16, 528	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS	_					
	11300 INTEREST EXPENSE						113. 00
118.00		631, 541	124, 358	17, 979	30, 056	89, 173	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	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	0	0	192. 00
193.00	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00	07950 BI OTERRORI SM GRANT	503	0	0	0	0	194. 00
	07951 MARKETI NG	3, 571	0	0	0	0	194. 01
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118-201)	635, 615	124, 358	17, 979	30, 056	89, 173	202. 00
				•			

Part II

From 07/01/2014 06/30/2015 Date/Time Prepared: 11/25/2015 11:28 am OTHER GENERAL SERVI CE SOCIAL SERVICE PASTORAL CARE Cost Center Description NURSI NG **PHARMACY** MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY 13.00 15.00 17.00 18.00 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 158, 412 13.00 13 00 01500 PHARMACY 15.00 136, 072 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 26, 381 16.00 01700 SOCIAL SERVICE 17.00 0 C 14, 853 17.00 C 01851 PASTORAL CARE 15, 401 18.00 0 18.00 0 Ω INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 15, 401 30.00 114, 133 10, 042 14, 853 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 2, 193 627 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 661 03630 ULTRA SOUND 54.01 0 0 0 0 0 0 0 0 0 0 0 0 0 54.01 0 C 05700 CT SCAN 0 0 57.00 57 00 98 0 06000 LABORATORY 60.00 0 0 2, 429 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 114 06500 RESPIRATORY THERAPY 65.00 30,605 0 6, 282 0 65.00 06600 PHYSI CAL THERAPY 6, 340 66.00 66.00 537 0 06700 OCCUPATIONAL THERAPY 67.00 3, 180 524 0 67.00 06800 SPEECH PATHOLOGY 1, 961 68.00 68.00 188 0 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 C 0 07000 ELECTROENCEPHALOGRAPHY 0 Ω 8 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 136, 072 4. 278 0 73.00 07400 RENAL DIALYSIS 74.00 593 0 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 158, 412 136, 072 14, 853 15, 401 118. 00 26, 381 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 0 191. 00 19100 RESEARCH 0 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194. 00 07950 BI OTERRORI SM GRANT 0 0 0 o 0 194.00 194. 01 07951 MARKETI NG 0 194, 01 0 0 C 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 158, 412 136, 072 26, 381 14, 853 15, 401 202. 00

Provider CCN: 152020

Peri od:

194. 00

194. 01

200. 00

201.00

202.00

Health Financial Systems ST VINCENT SETON SPECIALITY HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 152020 Peri od: Worksheet B From 07/01/2014 Part II 06/30/2015 Date/Time Prepared: 11/25/2015 11:28 am Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adj ustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01500 PHARMACY 15.00 15.00 16.00 |01600 | MEDI CAL RECORDS & LI BRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01851 PASTORAL CARE 18.00 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 778, 950 0 1, 778, 950 30.00 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 26, 998 26, 998 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 31, 596 0 31, 596 54.00 03630 ULTRA SOUND 54.01 0 54.01 57.00 05700 CT SCAN 10, 633 0 10, 633 57.00 06000 LABORATORY 0 60.00 23, 238 23, 238 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 3,052 3, 052 63.00 63.00 06500 RESPIRATORY THERAPY 65.00 111,016 0 111,016 65.00 06600 PHYSI CAL THERAPY 35,000 35,000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 23, 461 23, 461 67.00 06800 SPEECH PATHOLOGY 19, 575 19, 575 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 0 69.00 0 0 07000 ELECTROENCEPHALOGRAPHY 70.00 59 59 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 140.820 0 140, 820 73.00 07400 RENAL DIALYSIS 74.00 17, 121 0 17, 121 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1-117) 0 2, 221, 519 2, 221, 519 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 191. 00 19100 RESEARCH 0 0 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 0 193. 00 19300 NONPALD WORKERS 0 0 0 193.00

503

0

3,571

2, 225, 593

0

0

0

503

C

3, 571

2, 225, 593

194. 00 07950 BI OTERRORI SM GRANT

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

194. 01 07951 MARKETI NG

200.00

201.00

202.00

			NCENT SETON SP			In Lie	eu of Form CMS-:	
COST A	ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
						rom 07/01/2014	D-+- /T: D	
						o 06/30/2015	Date/Time Pre 11/25/2015 11	pared:
			CADITAL DEL	LATED COSTS			11/23/2013 11	. 20 alli
			CAFITAL KLI	LAILD COSTS				
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Doconci Li ati on	ADMI NI STRATI VE	
		cost center bescription			BENEFITS	Reconciliation	& GENERAL	
			(SQUARE FEET)	(SQUARE FEET)				
					DEPARTMENT		(ACCUM. COST)	
					(GROSS			
			1 00	2.00	SALARI ES)	ΕΛ	F 00	
	CENED	AL SERVICE COST CENTERS	1.00	2. 00	4. 00	5A	5. 00	
1.00		CAP REL COSTS-BLDG & FIXT	49, 633					1.00
		CAP REL COSTS-BLDG & FIXT	49,033					1
2.00				49, 633				2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	_			04 0/0 047	4. 00
5.00		ADMINISTRATIVE & GENERAL	2, 333		1			1
7. 00	4	OPERATION OF PLANT	2, 487		1		1, 992, 282	1
8. 00		LAUNDRY & LINEN SERVICE	406	l .	1	0	156, 685	1
9.00	4	HOUSEKEEPI NG	564		1	0	465, 908	1
10. 00	4	DIETARY	2, 013		C	0	710, 737	10.00
13.00	01300	NURSING ADMINISTRATION	3, 276	3, 276	1, 205, 288	0	1, 806, 302	13. 00
15.00	01500	PHARMACY	1, 182	1, 182	1, 449, 906	0	4, 509, 200	15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY	537	537	121, 849	0	316, 339	16. 00
17.00	01700	SOCIAL SERVICE	295	295	136, 739	0	191, 387	17. 00
18.00		PASTORAL CARE	364	364	1		93, 124	1
	I NPAT	IENT ROUTINE SERVICE COST CENTERS				"		1
30.00		ADULTS & PEDIATRICS	33, 561	33, 561	7, 088, 173	0	13, 348, 196	30.00
	ANCI L	LARY SERVICE COST CENTERS			,	"		1
50.00		OPERATI NG ROOM	356	356	176, 665	0	536, 651	50.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	640	640			352, 257	54.00
54. 01		ULTRA SOUND	0		1	0	0	1
57. 00		CT SCAN	170		-	0	206, 871	1
60.00	1	LABORATORY	139	l .	1		765, 210	1
63. 00		BLOOD STORING, PROCESSING & TRANS.	0		l .	0	143, 612	1
65. 00		RESPI RATORY THERAPY	252			-	3, 166, 792	1
66. 00		PHYSI CAL THERAPY	353				734, 914	1
67. 00		OCCUPATIONAL THERAPY	353	l .			325, 990	1
68. 00	1	SPEECH PATHOLOGY	353		1			1
	4	•	352		· ·		213, 837	1
69. 00		ELECTROCARDI OLOGY	0	0		-	0	
70.00		ELECTROENCEPHALOGRAPHY	0	0	829		2, 503	1
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73. 00		DRUGS CHARGED TO PATIENTS	0	0			22, 989	
74. 00	07400	RENAL DIALYSIS	0	0	C	0	807, 885	74. 00
	SPECI	AL PURPOSE COST CENTERS	i	1	1			ļ
	1	INTEREST EXPENSE						113. 00
118.00	_	SUBTOTALS (SUM OF LINES 1-117)	49, 633	49, 633	16, 648, 701	-9, 724, 423	30, 869, 671]118. 00
		I MBURSABLE COST CENTERS	1 _	1 -	1 -		г <u>-</u>	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				l	190. 00
		RESEARCH	0	_			l	191. 00
		PHYSICIANS' PRIVATE OFFICES	0	0) C	0	l .	192. 00
		NONPALD WORKERS	0	0) C	0		193. 00
		BIOTERRORISM GRANT	0	0	C	0	24, 583	194. 00
194. 01	07951	MARKETI NG	0	0) c	0	174, 563	194. 01
200.00)	Cross Foot Adjustments						200.00
201.00)	Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B,	939, 296	729, 106	4, 374, 189		9, 724, 423	202. 00
		Part I)						
203.00	o	Unit cost multiplier (Wkst. B, Part I)	18. 924828	14. 689944	0. 262735	5	0. 312996	203.00
204.00	o	Cost to be allocated (per Wkst. B,			[c		635, 615	1
		Part II)						
205.00)	Unit cost multiplier (Wkst. B, Part			0. 000000)	0. 020458	205.00
		11)						

COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 152020

Peri od: Worksheet B-1 From 07/01/2014

06/30/2015 Date/Time Prepared: 11/25/2015 11:28 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE (SQUARE FEET) (TOTAL PATIENT ADMINISTRATION PLANT (SQUARE FEET) (POUNDS OF DAYS) (DIRECT NURS LAUNDRY) HRS.) 7.00 8.00 9.00 10.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 44, 813 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 406 100 9.00 00900 HOUSEKEEPI NG 564 C 43,843 9.00 10.00 01000 DI ETARY 2,013 2,013 22, 085 10.00 01300 NURSING ADMINISTRATION 3.276 348, 335 13 00 3 276 Ω 13 00 01500 PHARMACY 15.00 1, 182 C 1, 182 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 537 537 0 0 16.00 01700 SOCIAL SERVICE 17.00 295 C 295 0 0 17.00 01851 PASTORAL CARE 18.00 364 18 00 Ω 364 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 100 30.00 33, 561 33, 561 22, 085 250, 966 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 356 356 4,822 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 640 0 640 0 0 54.00 0 54.01 03630 ULTRA SOUND 0 54.01 0 0 C 05700 CT SCAN 0 0 57 00 170 170 57 00 0 06000 LABORATORY 0 60.00 139 0 139 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 63.00 65.00 06500 RESPIRATORY THERAPY 252 0 252 0 67, 299 65.00 06600 PHYSICAL THERAPY Ω 13, 942 66.00 353 353 66.00 06700 OCCUPATIONAL THERAPY 67.00 353 0 353 6, 993 67.00 352 06800 SPEECH PATHOLOGY 4, 313 68.00 352 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 0 C 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 0 07400 RENAL DIALYSIS 74.00 C 0 Ω 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 100 43, 843 22, 085 348, 335 118. 00 44, 813 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 191. 00 19100 RESEARCH 0 0 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194. 00 07950 BI OTERRORI SM GRANT 0 0 0 o 0 194.00 0 194, 01 194. 01 07951 MARKETI NG 0 C 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 2, 615, 858 229, 426 1, 080, 298 2, 611, 066 202. 00 644, 657 Part I) 58. 372749 7. 495847 203. 00 203 00 Unit cost multiplier (Wkst. B, Part I) 2, 294. 260000 48 915463 14 703761 204.00 Cost to be allocated (per Wkst. B, 124, 358 17, 979 30,056 89, 173 158, 412 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 2.775043 179. 790000 0.685537 4. 037718 0. 454769 205. 00 Π

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCI AL SERVI CE (TOTAL PATIENT DAYS)	(TOTAL PATIENT DAYS)	
	OFNEDAL CEDIUSE COCT OFNEDO	15. 00	16. 00	17. 00	18. 00	
1 00	GENERAL SERVICE COST CENTERS					1 00
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00 15. 00 16. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01300 NURSING ADMINISTRATION 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 000 0 0	121, 046, 984 0	22, 085		1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 13.00 15.00 16.00 17.00
18. 00		o	0		22, 085	18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	0	46, 099, 651	22, 085	22, 085	30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	2, 876, 101		- 1	50. 00
54. 00		0	3, 030, 334		0	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	54. 01
57. 00	05700 CT SCAN	0	448, 415		0	57. 00
60.00	06000 LABORATORY	0	11, 140, 130		0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	524, 516		0	63.00
65. 00	06500 RESPI RATORY THERAPY	0	28, 814, 697		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	2, 461, 176		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	2, 405, 798		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	862, 134		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	38, 879	9 0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	1, 000	19, 623, 883		0	73. 00
74. 00	07400 RENAL DIALYSIS	0	2, 721, 270) 0	0	74. 00
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE		404 044 004		00.005	113. 00
118.00		1, 000	121, 046, 984	22, 085	22, 085	118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190. 00
	19100 RESEARCH	0	0		0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	1	0	192. 00
	19300 NONPALD WORKERS	0	0	1	0	193. 00
	07950 BIOTERRORISM GRANT	0	0	ή	0	194. 00
	07951 MARKETI NG	0	0	0	0	194. 01
200.00						200. 00
201.00		, ,,,,		070 040	440.074	201. 00
202.00	· ·	6, 006, 939	454, 594	272, 848	148, 871	202. 00
202.00	Part I)	4 004 020000	0.002757	12 254440	4 740000	202.00
203. 00 204. 00		6, 006. 939000	0. 003756			203. 00 204. 00
∠∪4. ∪(Cost to be allocated (per Wkst. B, Part II)	136, 072	26, 381	14, 853	15, 401	204.00
205.00		136. 072000	0. 000218	0. 672538	0. 697351	205. 00
200.00		155. 572550	5. 000210	3.072330	3.077331	203.00
	1 1			İ		ı

Health Financial Systems	ST VINCENT SETON SPECIALITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 152020	Peri od: Worksheet C From 07/01/2014 Part I To 06/30/2015 Date/Time Prepared:

				To 06/30/2015	Date/Time Pre	pared:
		T: +1	e XVIII	Hospi tal	11/25/2015 11 PPS	: 28 am_
		11 (1	e xviii	Costs	PP3	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.	Total Costs	Di sal I owance	Total Costs	
	Part I, col.	Auj .		Di Sai i Owance		
	26)					
	1, 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00	0.00	00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	23, 764, 394		23, 764, 394	1 0	23, 764, 394	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	777, 585		777, 585	5 0	777, 585	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	520, 663		520, 663	0	520, 663	54.00
54. 01 03630 ULTRA SOUND	0		(o	0	54. 01
57.00 05700 CT SCAN	285, 728		285, 728	0	285, 728	57. 00
60. 00 06000 LABORATORY	1, 056, 718		1, 056, 718	0	1, 056, 718	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	190, 532		190, 532	0	190, 532	63. 00
65. 00 06500 RESPIRATORY THERAPY	4, 789, 091	0	4, 789, 091	0	4, 789, 091	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 104, 486	0	1, 104, 486	0	1, 104, 486	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	515, 274	0	515, 274	1 0	515, 274	67. 00
68. 00 06800 SPEECH PATHOLOGY	342, 058	0	342, 058	0	342, 058	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		(0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 432		3, 432	0	3, 432	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 110, 830		6, 110, 830		6, 110, 830	
74. 00 07400 RENAL DIALYSIS	1, 070, 971		1, 070, 97	0	1, 070, 971	74. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	40, 531, 762	0	40, 531, 762	2 0	40, 531, 762	
201.00 Less Observation Beds	0		(201. 00
202.00 Total (see instructions)	40, 531, 762	0	40, 531, 762	2 0	40, 531, 762	202. 00

120, 920, 042

126, 942

121 046 984

202. 00

202.00

Total (see instructions)

Health Financial Systems	ST VINCENT SETON SPECIAL	ITY HOSPITAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN:	152020	Peri od: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/25/2015 11:28 am

				11/25/2015 11:28 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0. 270361			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 171817			54.00
54.01 03630 ULTRA SOUND	0. 000000			54. 01
57. 00 05700 CT SCAN	0. 637195			57. 00
60. 00 06000 LABORATORY	0. 094857			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 363253			63. 00
65. 00 06500 RESPI RATORY THERAPY	0. 166203			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 448764			66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	0. 214180			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 396757			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 088274			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 311398			73. 00
74. 00 07400 RENAL DIALYSIS	0. 393556			74. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	ST VINCENT SETON SPECIAL	_ITY HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152020	Peri od:	Worksheet C

Health Financial Systems SI VI	NCENT SETON SP	ECTALITY HOSPI	IAL	In Lie	u of Form CMS-2	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 11/25/2015 11	
		Ti t	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	23, 764, 394		23, 764, 39	4 0	0	30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	777, 585		777, 58	5 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	520, 663		520, 66	3 0	0	54.00
54. 01 03630 ULTRA SOUND	0			0 0	0	54. 01
57. 00 05700 CT SCAN	285, 728		285, 72	8 0	0	57. 00
60. 00 06000 LABORATORY	1, 056, 718		1, 056, 71	8 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	190, 532		190, 53	2 0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	4, 789, 091	0	4, 789, 09	1 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 104, 486	0	1, 104, 48	6 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	515, 274	0	515, 27	4 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	342, 058	0	342, 05	8 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 432		3, 43	2 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 110, 830		6, 110, 83	0 0	0	73. 00
74.00 07400 RENAL DIALYSIS	1, 070, 971		1, 070, 97	1 0	0	74.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	40, 531, 762	0	40, 531, 76	2 0	0	200. 00
201.00 Less Observation Beds	0			o	0	201. 00
202.00 Total (see instructions)	40, 531, 762	0	40, 531, 76	2 0	0	202. 00

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68.00

69.00

70.00

71.00

72 00

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

07000 ELECTROENCEPHALOGRAPHY

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 IMPL. DEV. CHARGED TO PATIENTS

68.00

69.00

70.00

71.00

72 00

Health Financial Systems	ST VINCENT SETON SPECIAL	ITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 152020	From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared:

			10 00/00/2010	11/25/2015 11: 28 am
		Title XIX	Hospi tal	Cost
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. 000000			50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 01 03630 ULTRA SOUND	0. 000000			54. 01
57. 00 05700 CT SCAN	0. 000000			57. 00
60. 00 06000 LABORATORY	0. 000000			60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 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
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000			74. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems ST V	INCENT SETON SP	ECLALITY HOSPI	TAL	In Lieu of Form CMS-2552-			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D		
				From 07/01/2014 To 06/30/2015		pared:	
					11/25/2015 11	: 28 am	
		Ti tl	e XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)		
	(from Wkst. B,		Related Cost				
	Part II, col.		(col. 1 - col				
	26)		2)				
	1.00	2. 00	3.00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	1, 778, 950	0	1, 778, 95	0 22, 085	80. 55	30.00	
200.00 Total (lines 30-199)	1, 778, 950		1, 778, 95	0 22, 085		200.00	
Cost Center Description	I npati ent	I npati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)					
	6. 00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDI ATRI CS	13, 615	1, 096, 688				30.00	
200.00 Total (lines 30-199)	13, 615	1, 096, 688				200. 00	

Health Financial Systems ST V	INCENT SETON SP	PECIALITY HOSPI	TAL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Worksheet D	
				From 07/01/2014 To 06/30/2015	Part II	nanad.
				To 06/30/2015	Date/Time Pre 11/25/2015 11	pareu: ·28 am
-		Ti tl	e XVIII	Hospi tal	PPS	. 20 a
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		T	T			
50. 00 05000 OPERATI NG ROOM	26, 998					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	31, 596	3, 030, 334	l .			
54. 01 03630 ULTRA SOUND	0	0	0.00000		0	54. 01
57. 00 05700 CT SCAN	10, 633					57. 00
60. 00 06000 LABORATORY	23, 238					60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 052					63. 00
65. 00 06500 RESPI RATORY THERAPY	111, 016					
66. 00 06600 PHYSI CAL THERAPY	35, 000					
67. 00 06700 OCCUPATI ONAL THERAPY	23, 461					67. 00
68. 00 06800 SPEECH PATHOLOGY	19, 575	862, 134				
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	59	38, 879			l	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	140, 820					
74. 00 07400 RENAL DI ALYSI S	17, 121					
200.00 Total (lines 50-199)	442, 569	74, 947, 333	l	45, 277, 955	268, 747	200. 00

Health Financial Systems ST V	INCENT SETON SF	PECI AI	LITY HOSPI	TAL	In Li∈	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS			Period: From 07/01/2014 To 06/30/2015	Date/Time Pre 11/25/2015 11	
				e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Alli	ed Health	All Other	Swi ng-Bed	Total Costs	
			Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	t Amount (see	1 through 3,	
					instructions)	minus col. 4)	
	1.00		2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	0		0		0 0	0	30.00
200.00 Total (lines 30-199)	0	İ	0		0	0	200. 00
Cost Center Description	Total Patient	Per I	Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷	col. 6)	Program Days	Program		
					Pass-Through		
					Cost (col. 7 x		
					col. 8)		
	6. 00		7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS	•						
30. 00 03000 ADULTS & PEDIATRICS	22, 085		0.00	13, 61	5 0		30.00
200.00 Total (lines 30-199)	22, 085	1		13, 61			200. 00

Health Financial Systems	ST VINCENT SETON	SPECIALITY HOSPITAL	In Lieu	of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER P	PASS Provi der CCN:		From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/25/2015 11:28 am

					11/25/2015 11	: 28 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician N	lursing School	Allied Health	All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	0	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
54. 01 03630 ULTRA SOUND	0	0	0	0	0	54. 01
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
65. 00 06500 RESPIRATORY 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	O	0	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	ITS 0	0	0	o	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	О	0	0	o	0	73. 00
74.00 07400 RENAL DIALYSIS	О	0	0	o	0	74. 00
200.00 Total (lines 50-199)	О	0	0	o	0	200. 00

U. I.I. 5: I. 6 . I.	INGENT CETON CE	SECULAL LEV LICEDI	T.4.1		6.5. 046.4	2550 40
	INCENT SETON SP				u of Form CMS-1	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider		Period: From 07/01/2014	Worksheet D Part IV	
THROUGH COSTS				o 06/30/2015		pared:
					11/25/2015 11	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cost		Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	2, 876, 101				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	3, 030, 334	•		1, 544, 411	1
54. 01 03630 ULTRA SOUND	0	0	0. 000000			54. 01
57. 00 05700 CT SCAN	0	448, 415				57. 00
60. 00 06000 LABORATORY	0	11, 140, 130				60.00
63.00 O6300 BLOOD STORING, PROCESSING & TRANS.	0	524, 516			-	63. 00
65. 00 06500 RESPI RATORY THERAPY	0	28, 814, 697				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	2, 461, 176		0.000000	1, 477, 387	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	2, 405, 798	0.000000	0.000000	1, 379, 181	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	862, 134	0.000000	0.000000	510, 495	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.000000	0.000000	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	38, 879	0.000000	0. 000000	21, 730	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0. 000000	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 000000	0. 000000	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	19, 623, 883	0.000000	0. 000000	12, 259, 800	73. 00
74.00 07400 RENAL DIALYSIS	0	2, 721, 270	0. 000000	0. 000000	2, 010, 117	74.00
200.00 Total (lines 50-199)	0	74, 947, 333			45, 277, 955	200. 00

Health Financial Systems	ST VINCENT SETON SPECIAL	LITY HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 152020	Peri od: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared:

					11/23/2013 11.26 dill
		Ti tl	e XVIII	Hospi tal	PPS
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Through	1	
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11. 00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	()	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	14, 380)	0	54.00
54. 01 03630 ULTRA SOUND	0	C		0	54. 01
57. 00 05700 CT SCAN	0	C)	0	57. 00
60. 00 06000 LABORATORY	0	517	'	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0	111, 835	5	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
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	83		О	73. 00
74. 00 07400 RENAL DIALYSIS	0	C		o	74.00
200.00 Total (lines 50-199)	0	126, 815	;	o	200. 00
	- 1			1	

Health Financial Syst	rems ST VINCENT S	SETON SPECIALITY HOSPITAL	In Lie	eu of Form CMS-2552-

Health Financial Systems ST VI	NCENT SETON SF	PECIALITY HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST			Period: From 07/01/2014 To 06/30/2015	11/25/2015 11	pared: :28 am
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1	·			
50. 00 05000 OPERATI NG ROOM	0. 270361			0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 171817	.,		0	2, 471	
54. 01 03630 ULTRA SOUND	0. 000000	l .		0 0	0	
57. 00 05700 CT SCAN	0. 637195			0	0	57. 00
60. 00 06000 LABORATORY	0. 094857			0	49	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 363253			0	0	00.00
65. 00 06500 RESPIRATORY THERAPY	0. 166203	111, 835		0	18, 587	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 448764	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 214180			0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 396757	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 088274	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 311398	83		0 127	26	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 393556	0		0 0	0	74. 00
200.00 Subtotal (see instructions)		126, 815		0 127	21, 133	200. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0		201. 00
202.00 Net Charges (line 200 +/- line 201)		126, 815		0 127	21, 133	202. 00

ALTONITONWENT OF WEDTOAL, OTHER HEALTH SERVICES AND	VACCINE COST	Trovider	CCN. 132020	From 07/01/2014 To 06/30/2015	Part V Date/Time Pre 11/25/2015 11	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	1			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1			54. 00
54. 01 03630 ULTRA SOUND	0	0	1			54. 01
57. 00 05700 CT SCAN	0	0	1			57. 00
60. 00 06000 LABORATORY	0	0	1			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 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
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	40)			73. 00
74. 00 07400 RENAL DI ALYSI S	0	0)			74. 00
200.00 Subtotal (see instructions)	0	40	1			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	40	1			202. 00

Health Financial Systems STV	T VINCENT SETON SPECIALITY HOSPITAL In Lieu of Form CMS					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 07/01/2014 To 06/30/2015		
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)		Per Diem (col. 3 / col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 778, 950	C	1, 778, 95	0 22, 085	80. 55	30.00
200.00 Total (lines 30-199)	1, 778, 950		1, 778, 95	0 22, 085		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
LAUDATI ENT. DOUTLINE OFFICE OF COOT OFFITEDO	6. 00	7. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 0/0	05.000				00.00
30. 00 ADULTS & PEDI ATRI CS	1, 060		1			30.00
200.00 Total (lines 30-199)	1, 060	85, 383	5			200. 00

Heal th	Financial Systems ST V	INCENT SETON SP	ECI AL	ITY HOSPI	TAL	ı	n Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		Provi der	CCN: 152020	Peri od:	/004.4	Worksheet D	
						From 07/01 To 06/30			pared:
								11/25/2015 11	:28 am
					le XIX	Hospi ta		Cost	
	Cost Center Description	Capi tal			Ratio of Cos			Capital Costs	
				Wkst. C,				(column 3 x	
		(from Wkst. B,	Part		(col . 1 ÷ co	I. Charge	es	column 4)	
		Part II, col.		8)	2)				
		26)							
	ANOLILIABLE OFFICE COOT OFFITTED	1.00		2. 00	3. 00	4. 00)	5. 00	
	ANCILLARY SERVICE COST CENTERS	04,000		0.07/.404	0.000	07	0.044	4.457	F0 00
	05000 OPERATING ROOM	26, 998		2, 876, 101			23, 214		
	05400 RADI OLOGY-DI AGNOSTI C	31, 596		1, 899, 223	1		20, 326	-	
	03630 ULTRA SOUND	0		1, 131, 111			0		
	05700 CT SCAN	10, 633		448, 415	1		1, 304		
	06000 LABORATORY	23, 238		1, 140, 130			6, 906		
	06300 BLOOD STORING, PROCESSING & TRANS.	3, 052		524, 516			9, 312		
	06500 RESPIRATORY THERAPY	111, 016		8, 814, 697			86, 785	-	
	06600 PHYSI CAL THERAPY	35, 000		2, 461, 176			21, 600	-	
	06700 OCCUPATI ONAL THERAPY	23, 461		2, 405, 798			7, 721	953	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	19, 575		862, 134	0. 0227 0. 0000		23, 391	531 0	
	07000 ELECTROENCEPHALOGRAPHY	59		38, 879			0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	59		38, 879	0.000		0	0	
	07200 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		(0.0000		0	_	
		140 020	1	0 422 002			0	7 490	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	140, 820		9, 623, 883			2, 416		
		17, 121		2, 721, 270	1		20, 552		
200. 00	Total (lines 50-199)	442, 569	,	4, 947, 333	기	3,00	3, 527	19, 037	₁ 200.00

Health Financial Systems ST VINCENT SETON SPECIALITY HOSPITAL In Lieu of Form CMS-25							2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS I			Period: From 07/01/2014 To 06/30/2015	Date/Time Pre 11/25/2015 11	pared: :28 am
				le XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Allie	d Health	All Other	Swi ng-Bed	Total Costs	
		C	Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	t Amount (see	1 through 3,	
					instructions)	minus col. 4)	
	1. 00	2	2. 00	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		o		0	0	200. 00
Cost Center Description	Total Patient	Per Di	em (col.	Inpati ent	I npati ent		
·	Days	5 ÷ 0	col. 6)	Program Days	Program		
	Ĭ			o ,	Pass-Through		
					Cost (col. 7 x		
					col . 8)		
	6. 00	7	'. 00	8.00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS					<u>'</u>		
30. 00 03000 ADULTS & PEDI ATRI CS	22, 085		0.00	1, 06	0 0		30. 00
200.00 Total (lines 30-199)	22, 085			1, 06	0 0		200. 00

Health Financial Systems	ST VINCENT SETON SPECIAL	LITY HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 152020	From 07/01/2014	Worksheet D Part IV Date/Time Prepared: 11/25/2015 11:28 am

				0 00, 00, 2010	11/25/2015 11	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Health		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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	C) (0	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C) (0	0	54. 00
54. 01 03630 ULTRA SOUND	0	C) (0	0	54. 01
57. 00 05700 CT SCAN	0	C) (0	0	57. 00
60. 00 06000 LABORATORY	0	C) (0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C) (0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0	C) (0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C) (0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C) (0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	C) (0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C) (0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C) (0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C) (0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C) (0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C) (0	0	73.00
74.00 07400 RENAL DIALYSIS	0	C) (o	0	74.00
200.00 Total (lines 50-199)	0	C) (o o	0	200. 00

Heal th	Financial Systems	ST VINCENT SETON S	PECI AL	_ITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCIL	LARY SERVICE OTHER PAS	SS	Provi der		Peri od:	Worksheet D	
THROUG	H COSTS					From 07/01/2014	Part IV	
						To 06/30/2015	Date/Time Pre 11/25/2015 11	pared:
-				T' 1	1 1/11/			: 28 alli
				III	le XIX	Hospi tal	Cost	
	Cost Center Description	Total	Tota	I Charges	Ratio of Cost	t Outpatient	I npati ent	
		Outpati ent	(from	m Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part	t I, col.	(col. 5 ÷ col	. to Charges	Charges	
		col . 2, 3 and	ı	8)	7)	(col. 6 ÷ col.		
		4)				7)		
		6. 00		7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		0	2, 876, 101	0.00000	0. 000000	123, 214	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		o	1, 899, 223	0. 00000	0. 000000	120, 326	54.00
54. 01	03630 ULTRA SOUND		ol	1, 131, 111	0. 00000	0. 000000	0	54. 01

448, 415

524, 516

11, 140, 130

28, 814, 697

2, 461, 176

2, 405, 798

19, 623, 883

2, 721, 270

74, 947, 333

862, 134

38, 879

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68.00

69.00

70.00

73.00

446, 906

986, 785

121, 600

97, 721

23, 391

1, 042, 416

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0 71.00

0 72.00

20, 552 74. 00

3, 003, 527 200. 00

9, 312

57. 00 | 05700 CT SCAN

63.00

67.00

200.00

60. 00 | 06000 | LABORATORY

65. 00 06500 RESPIRATORY THERAPY

06700 OCCUPATI ONAL THERAPY

66. 00 06600 PHYSI CAL THERAPY

68.00 06800 SPEECH PATHOLOGY

69. 00 06900 ELECTROCARDI OLOGY

74.00 07400 RENAL DIALYSIS

70. 00 07000 ELECTROENCEPHALOGRAPHY

73.00 07300 DRUGS CHARGED TO PATIENTS

06300 BLOOD STORING, PROCESSING & TRANS.

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

72.00 07200 I MPL. DEV. CHARGED TO PATIENTS

Total (lines 50-199)

Health Financial Systems	ST VINCENT SETON SPECIAL	LITY HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 152020	Peri od: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared:

					11/25/2015 11: 28	<u>3 am</u> _
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9)		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C)	O	50	0.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	O	54	4. 00
54.01 03630 ULTRA SOUND	0	C)	O	54	4. 01
57. 00 05700 CT SCAN	0	C		O	57	7.00
60. 00 06000 LABORATORY	0	C		O	60	0.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		O	63	3. 00
65. 00 06500 RESPIRATORY THERAPY	0	C)	0	6!	5. 00
66. 00 06600 PHYSI CAL THERAPY	0	C)	O	60	6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C)	0	6	7. 00
68. 00 06800 SPEECH PATHOLOGY	o	C		0	68	8. 00
69. 00 06900 ELECTROCARDI OLOGY	o	C		0	60	9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	C		O	70	0. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	C		0	7	1. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	C		O	72	2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	C		O	7:	3. 00
74. 00 07400 RENAL DI ALYSI S	o	C		O	74	4. 00
200.00 Total (lines 50-199)	0	C		O	200	0.00

		VINCENT SETON SPECIA			u of Form CMS-2		
COMPUT	TION OF INPATIENT OPERATING COST		Provi der CCN: 152020	Peri od: From 07/01/2014	Worksheet D-1		
				To 06/30/2015	Date/Time Pre 11/25/2015 11		
			Title XVIII	Hospi tal	PPS	. ZO alli	
	Cost Center Description			noopi tai	1.0		
	<u> </u>				1. 00		
	PART I - ALL PROVIDER COMPONENTS					1	
	NPATI ENT DAYS				00.005		
. 00 2. 00	Inpatient days (including private room days		22, 085 22, 085				
. 00							
. 00	do not complete this line.	observation bed days). If you have only pr	vate room days,	0	3.00	
1. 00	Semi-private room days (excluding swing-bed	d and observation bed	days)		22, 085	4.00	
. 00	Total swing-bed SNF type inpatient days (ir			r 31 of the cost	0		
	reporting period	3 1	3 , 3				
. 00	Total swing-bed SNF type inpatient days (ir	ncluding private room	days) after December :	31 of the cost	0	6.00	
	reporting period (if calendar year, enter (
. 00	Total swing-bed NF type inpatient days (ind	cluding private room	days) through December	31 of the cost	0	7. 00	
. 00	reporting period	duding private room	daya) after December 2	1 of the cost	0	8.00	
. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)						
. 00							
	O Total inpatient days including private room days applicable to the Program (excluding swing-bed and 13						
0. 00							
	through December 31 of the cost reporting period (see instructions)						
1. 00	Swing-bed SNF type inpatient days applicable			oom days) after	0	11. 00	
0 00	December 31 of the cost reporting period (i					10.00	
2. 00	Swing-bed NF type inpatient days applicable through December 31 of the cost reporting p		only (including private	e room days)	0	12.00	
3. 00	Swing-bed NF type inpatient days applicable		only (including private	e room days)	0	13.00	
0.00	after December 31 of the cost reporting per				· ·	10.00	
4. 00	Medically necessary private room days appli				0	14.00	
	Total nursery days (title V or XIX only)				0	15.00	
6. 00	Nursery days (title V or XIX only)				0	16.00	
	SWING BED ADJUSTMENT						
7. 00	Medicare rate for swing-bed SNF services ap	oplicable to services	through December 31 o	f the cost	0. 00	17. 00	
8. 00	reporting period Medicare rate for swing-bed SNF services ap	onlicable to services	after December 31 of	the cost	0.00	18.00	
0.00	reporting period	pricable to services	arter becember 31 or	the cost	0.00	10.00	
9. 00	Medicaid rate for swing-bed NF services app	olicable to services	through December 31 of	the cost	0.00	19.00	
	reporting period						
0.00	Medicaid rate for swing-bed NF services app	olicable to services	after December 31 of t	ne cost	0.00	20.00	
	reporting period						
1.00	Total general inpatient routine service cos		24 6 11		23, 764, 394		
2. 00	Swing-bed cost applicable to SNF type servi 5 x line 17)	ces through December	31 of the cost report	ing period (line	0	22. 00	
3. 00	Swing-bed cost applicable to SNF type servi	ces after December 3	1 of the cost reporting	neriod (line 6	0	23. 00	
0. 00	x line 18)	des arter becomber o	To the cost reporting	g perrou (rine o	· ·	20.00	
4. 00	Swing-bed cost applicable to NF type service	es through December	31 of the cost reporti	ng period (line	0	24.00	
	7 x line 19)	3	1	` `			
5. 00	Swing-bed cost applicable to NF type service	ces after December 31	of the cost reporting	period (line 8	0	25. 00	
	x line 20)						
6. 00	Total swing-bed cost (see instructions)				0	26.00	
	General inpatient routine service cost net	-et 1 / 1 / 1	! 04 I! 0/\		23, 764, 394	27.00	

2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	22, 085	2. 00 3. 00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	22, 085	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 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	0	7. 00
7.00	reporting period	١	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	13, 615	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 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)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	Ö	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21 00	reporting period	22 7/4 204	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	23, 764, 394 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	23, 764, 394	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0. 00 0	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	23, 764, 394	37. 00
57.00	27 minus line 36)	20, 104, 374	07.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 076. 04	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	14, 650, 285	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	14 (50 205	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	14, 650, 285	41.00

COMPUT	ATION OF INPATIENT OPERATING COST			Provi der	CCN: 152020	Peri od:	Worksheet D-1	
						From 07/01/2014 To 06/30/2015	Date/Time Pre	
							11/25/2015 11	: 28 am
	Cook Cooker Decoration	T-+-1			e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost		Γotal ient Davs	Average Per		Program Cost (col. 3 x col.	
		•			col . 2)		4)	
12.00	NUDCEDY (+: +1 - V 0 VIV1.)	1. 00		2. 00	3.00	4. 00	5. 00	42.00
12. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units							42.00
13. 00	INTENSIVE CARE UNIT							43. 00
4. 00	CORONARY CARE UNIT							44. 00
5. 00 6. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description	<u> </u>						
10.00	Decree in the second se	-+ D 21 2	1:	- 200)			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines				nns)		10, 303, 280 24, 953, 565	
. ,	PASS THROUGH COST ADJUSTMENTS	<u> </u>					21,700,000]
0.00	Pass through costs applicable to Program inp	atient routine	servi	ces (from	n Wkst. D, sum	of Parts I and	1, 096, 688	50.00
1. 00	III) Pass through costs applicable to Program inp.	atient ancillar	y ser	vices (fr	om Wkst. D, s	sum of Parts II	268, 747	51.00
	and IV)		,	·				
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu-		al atad	non nh	cician anacth	otist and	1, 365, 435 23, 588, 130	
3.00	medical education costs (line 49 minus line		erateu	i, Horr-priy	SICI all allesti	letist, and	23, 366, 130	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,						
4.00	Program di scharges						0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						0. 00 0	1
7. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	
8. 00	Bonus payment (see instructions)						0	
9. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi n	ıg 1996, ι	ipdated and co	ompounded by the	0. 00	59. 00
50.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	odated	by the m	narket basket		0.00	60.00
51. 00	If line 53/54 is less than the lower of line						0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (li	nes 54 x	60), or 1% of	the target		
52. 00	Relief payment (see instructions)	instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uction	s)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doc	ombor	21 of the	cost roporti	ng poriod (Soo	0	64. 00
34.00	instructions)(title XVIII only)	ts through bece	HIDEI	31 OI LIIC	cost reporti	ng perrou (see	0	04.00
55.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31	of the c	ost reportino	period (See	0	65. 00
56. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nl	us line 6	5)(title XVII	Lonly) For	0	66. 00
30. 00	CAH (see instructions)	ne costs (Trie	от рі	us iiiic c	,5) (ti ti e xvi i	1 om y). 1 or	o l	00.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	n Dece	mber 31 c	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after [)ecemb	er 31 of	the cost reno	orting period	0	68. 00
30. 00	(line 13 x line 20)		CCCIIID	CI 31 01	the cost repe	n tring period	Ü	00.00
59. 00	Total title V or XIX swing-bed NF inpatient						0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil							70.00
71. 00	Adjusted general inpatient routine service c	-			• • • • • • • • • • • • • • • • • • • •			71.00
72.00	Program routine service cost (line 9 x line							72. 00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv							73.00
75. 00	Capital -related cost allocated to inpatient	•				Part II, column		75.00
	26, line 45)			,	•			
6.00	Per diem capital related costs (line 75 ÷ li							76.00
7.00 8.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	,						77.00
9.00	Aggregate charges to beneficiaries for exces	,	orovi d	ler record	ls)			79. 00
30.00	Total Program routine service costs for comp		cost I	imitation	ı(line 78 mir	nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on						81.00

			Title	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost Inp	oatient Days			(col. 3 x col.	
				col . 2)		4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00	INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1 00	
10.00						1.00	10.00
48. 00	Program inpatient ancillary service cost (Wk			,		10, 303, 280	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see	e instruction	15)		24, 953, 565	49. 00
FO 00	PASS THROUGH COST ADJUSTMENTS			What Davis	- C D 1	1.00/./00	FO 00
50. 00	Pass through costs applicable to Program inp	oatient routine ser	rvices (Trom	WKST. D, SUM (or Parts I and	1, 096, 688	50. 00
E1 00	Dass through costs applicable to Drogram in	ationt ancillary o	sorvices (fr	om Wkot D cui	of Dorte II	240 747	E1 00
51. 00	Pass through costs applicable to Program inpand IV)	attent and trary s	services (iii	JIII WKSt. D, Sui	II OI PALLS II	268, 747	51. 00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				1, 365, 435	52. 00
53. 00	Total Program inpatient operating cost exclu		tod non nhv	cician anoctho	tist and	23, 588, 130	
55.00	medical education costs (line 49 minus line		teu, non-pny:	siciali allestile	tist, and	23, 366, 130	55.00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
54 00	Program di scharges					0	54. 00
	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	56. 00
	Difference between adjusted inpatient operat	ing cost and targe	et amount (Li	ine 56 minus li	ne 53)	Ö	57. 00
58. 00	Bonus payment (see instructions)	ing cost and targe	or amount (1)	THE GO IIII HAS T	110 00)	ő	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period end	lina 1996 u	ndated and com	nounded by the	0.00	
07.00	market basket	por tring period end	11119 1770, u	baatea ana com	bounded by the	0.00	07.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, updat	ted by the ma	arket basket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of line				ne amount by	0	61. 00
	which operating costs (line 53) are less that				,		
	amount (line 56), otherwise enter zero (see				3		
62.00	Relief payment (see instructions)	,				o	62.00
63.00	Allowable Inpatient cost plus incentive paym	nent (see instructi	ons)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Decembe	er 31 of the	cost reporting	period (See	0	64.00
	instructions)(title XVIII only)						
65.00	Medicare swing-bed SNF inpatient routine cos	sts after December	31 of the co	ost reporting p	period (See	0	65.00
	instructions)(title XVIII only)					ı	
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 6!	5)(title XVIII	only). For	0	66. 00
	CAH (see instructions)					_	
67. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through De	ecember 31 o	f the cost rep	orting period	0	67. 00
(0.00	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routin	ie costs after Dece	ember 31 or	the cost repor	ting period	0	68. 00
(0.00	(line 13 x line 20)	routing socto (lim	no (7 . lino	(0)			40.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service o						70. 00 71. 00
71.00	Program routine service cost (line 9 x line		- /U - IIIIE .	-)			71.00
73. 00	Medically necessary private room cost applic		ino 14 v liv	25)			73.00
74. 00	Total Program general inpatient routine serv	, ,		16 33)			74.00
75. 00	Capital-related cost allocated to inpatient	•		nrksheet R Pai	rt II column		75. 00
73.00	26, line 45)	Toutine Service Co	osts (110m w	JI KSHEEL D, Tai	t II, Cordilli		73.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)				ı	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	Aggregate charges to beneficiaries for exces		/ider_records	5)			79. 00
80. 00				*	s Line 79)		80. 00
81. 00	Inpatient routine service cost per diem limi			(11110 70 11111101	, , , , , , , , , , , , , , , , , , , ,		81. 00
82. 00	Inpatient routine service cost limitation (I						82. 00
83. 00	Reasonable inpatient routine service costs (83. 00
84. 00	Program inpatient ancillary services (see in	,					84. 00
85. 00	Utilization review - physician compensation)				85. 00
86. 00	Total Program inpatient operating costs (sum						86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS		<u> </u>				
87. 00	Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per		ne 2)			0.00	
89. 00	Observation bed cost (line 87 x line 88) (se	•	-			0	
		ŕ				'	

Health Financial Systems ST V	INCENT SETON SP	PECIALITY HOSPI	TAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2014 To 06/30/2015		pared: : 28 am_
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from 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	1, 778, 950	23, 764, 394	0. 07485	8 0	0	90.00
91.00 Nursing School cost	0	23, 764, 394	0.00000	0	0	91. 00
92.00 Allied health cost	0	23, 764, 394	0.00000	0	0	92. 00
93.00 All other Medical Education	0	23, 764, 394	0. 00000	0 0	0	93. 00

	Financial Systems ST VINCENT SETON SPECIA	_		u of Form CMS-2			
COMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 152020	Peri od: From 07/01/2014	Worksheet D-1			
			To 06/30/2015	Date/Time Pre 11/25/2015 11			
		Title XIX	Hospi tal	Cost			
	Cost Center Description			1. 00			
	PART I - ALL PROVIDER COMPONENTS			1.00			
	I NPATI ENT DAYS				1		
. 00	Inpatient days (including private room days and swing-bed days	excluding newborn)		22, 085	1.0		
. 00	Inpatient days (including private room days, excluding swing-be			22, 085			
. 00	Private room days (excluding swing-bed and observation bed days		ivate room days	0	1		
. 00	do not complete this line.	3). It you have only pr	i vate i oom days,	0] 5. (
. 00	Semi-private room days (excluding swing-bed and observation be	d days)		22, 085	4.0		
. 00							
	reporting period	, .,			5.0		
. 00	Total swing-bed SNF type inpatient days (including private room	m davs) after December	31 of the cost	0	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	0	7. (
	reporting period						
. 00							
	reporting period (if calendar year, enter 0 on this line)						
00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and						
	newborn days)						
0. 00	-						
	through December 31 of the cost reporting period (see instructions)						
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11.		
	December 31 of the cost reporting period (if calendar year, en			_			
2. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12.		
0 00	through December 31 of the cost reporting period				4.0		
3. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.		
4 00	after December 31 of the cost reporting period (if calendar yes			0	11		
	Medically necessary private room days applicable to the Program	m (excluding swing-bed	days)	0			
5. 00 6. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			_	16.		
5. 00	SWING BED ADJUSTMENT			U	10.		
7 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	f the cost	0.00	17		
7.00	reporting period	s through becember 31 0	i the cost	0.00	''.		
3. 00	Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0. 00	18		
5. 00	reporting period	3 ditter becomber 31 of	the cost	0.00	10.		
9. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	10		
, 00	reporting period	through becomber of or	the cost	0.00	17.		
0. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.		
	reporting period						
1. 00	00 Total general inpatient routine service cost (see instructions) 23,764,394						
2. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22.		
	5 x line 17)	•					
3. 00	Swing-bed cost applicable to SNF type services after December:	31 of the cost reportin	g period (line 6	0	23.		
	x line 18)	•	• • •				
1. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.		
	7 x line 19)	·					
. 00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25.		
	x line 20)						

	INFAITENT DATS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	22, 085	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	22, 085	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)	22, 085	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
0.00	reporting period		0.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00		ď	0.00
7 00	reporting period (if calendar year, enter 0 on this line)		7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 060	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instructions)	Ĭ	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00		ı	11.00
10.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWI NG BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00		0.00	17.00
40.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	reporting period		
20.00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	23, 764, 394	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)	ď	22.00
22.00			22.00
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	0	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	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	23, 764, 394	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
		•	29. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	•	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	Conoral innations routing corvice cost not of swing had east and animate man east differential (!:!		
	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	23, 764, 394	37. 00
	27 minus line 36)	23, 764, 394	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	23, 764, 394	37.00
	27 minus line 36)	23, 764, 394	37.00
38. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	1, 076. 04	38. 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, 076. 04	38. 00
39. 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) Program general inpatient routine service cost (line 9 x line 38)	1, 076. 04 1, 140, 602	38. 00 39. 00
39. 00 40. 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, 076. 04	38. 00 39. 00 40. 00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi de	er CCN	l: 152020	Peri od:	Worksheet D-1	
						From 07/01/2014 To 06/30/2015	Date/Time Pre	pared:
			Т	itle	XIX	Hospi tal	11/25/2015 11 Cost	:28 am
	Cost Center Description	Total	Total	A۱	verage Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Da	ays Di e	m (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00		3. 00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units							42.00
3. 00	INTENSIVE CARE UNIT							43.00
. 00	CORONARY CARE UNIT							44.00
5. 00	BURN INTENSIVE CARE UNIT							45.00
00	SURGICAL INTENSIVE CARE UNIT							46.00
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47. 00
	cost center bescription						1. 00	
3. 00	Program inpatient ancillary service cost (Wk						700, 759	48. 00
0.00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	<u> </u>	•				1, 841, 361	49.00
. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I an II)						0	50.00
. 00	Pass through costs applicable to Program inpa and IV)		ry services ((from	Wkst. D, s	sum of Parts II	0	51.00
2. 00	Total Program excludable cost (sum of lines						0	52.00
00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0	54. 00
. 00	Target amount per discharge						0.00	
. 00	Target amount (line 54 x line 55)						0	56. 0
. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	
. 00	Bonus payment (see instructions)						0	58. 0
. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	enaing 1996,	upaa	ted and co	ompounded by the	0. 00	59.00
0. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	e mark	et basket		0.00	60.00
. 00	If line 53/54 is less than the lower of line						0	61. 0
	which operating costs (line 53) are less that		ts (lines 54	x 60)	, or 1% of	the target		
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)					0	62. 0
3. 00	Allowable Inpatient cost plus incentive payment	ent (see instru	uctions)				0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	(1)						
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of t	the co	st reporti	ng period (See	0	64. 0
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	e cost	reporti no	period (See	0	65. 0
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	e 65)(title XVII	I only). For	0	66. 0
. 00	CAH (see instructions)	o costs through	Docombon 21	1 of t	ho cost ro	porting poriod	0	47 0
. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs tillougi	i beceiibei 3	ι οι ι	HE COST TE	eporting perrou	0	67.0
. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after [December 31 o	of the	cost repo	orting period	0	68. 0
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU						0	69. 0
. 00	Skilled nursing facility/other nursing facili							70.0
. 00	Adjusted general inpatient routine service c		ine 70 ÷ lir	ne 2)				71.0
. 00	Program routine service cost (line 9 x line		. (line 14	11	25)			72.0
. 00	Medically necessary private room cost applications and program general inpatient routine services.				აა <i>)</i>			73.0
. 00	Capital -related cost allocated to inpatient	•		,	sheet B. F	Part II. column		75.0
	26, line 45)					, 23, 3,		
. 00	Per diem capital-related costs (line 75 ÷ li							76. 0
. 00	Program capital -related costs (line 9 x line							77. 0
. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces:		rovi den rocc	orde)				78. 0 79. 0
. 00	Total Program routine service costs for compa	, ,		-	ine 78 mir	nus line 79)		80.0
	Innatient routine service cost per diem limit			٠ (١		, , ,		81 0

						11/25/2015 11:	: 28 am
				tle XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	sDiem (col. 1 ÷		(col. 3 x col.	
				col . 2)		4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42.00
.2. 00	Intensive Care Type Inpatient Hospital Units						12.00
42.00				1			43. 00
43. 00	INTENSIVE CARE UNIT						
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
	oost contor bescription					1. 00	
40.00	D	-+ D 21 '	2 11 200)				40.00
	Program inpatient ancillary service cost (Wk					700, 759	
49.00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		1, 841, 361	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inp	atient ancilla	rv services (f	rom Wkst. D. su	m of Parts II	0	51.00
	and IV)		,	•			
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclu		alatad non nh	ucician anactha	tict and		
55.00			erateu, non-pri	ysician anestne	tist, and	0	33.00
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56. 00
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus L	ine 53)	0	57.00
58. 00	Bonus payment (see instructions)	ing cost and to	arget amount (TTTIC OU IIITTIGS T	1110 00)	0	58. 00
	' '	norting ported	anding 100/	undated and com	naundad by tha		
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996,	updated and com	pounded by the	0.00	59. 00
	market basket					!	
60. 00	Lesser of lines 53/54 or 55 from prior year					0.00	60. 00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	ser of 50% of t	he amount by	0	61.00
	which operating costs (line 53) are less that	n expected cos	ts (lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see	instructions)	•	,	· ·		
62.00	Relief payment (see instructions)	ŕ				0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instri	uctions)			0	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(300 111311	40110113)				00.00
(4.00		4- 4 D	21 -6 +1-		:! (C		(4.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through bece	ember 31 of th	e cost reportin	g period (See	0	64. 00
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31 of the	cost reporting	period (See	0	65. 00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVIII	only). For	0	66. 00
	CAH (see instructions)						
67.00	Title V or XIX swing-bed NF inpatient routing	e costs through	h December 31	of the cost rep	ortina period	0	67.00
	(line 12 x line 19)				3 1		
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after I	December 31 of	the cost repor	ting period	0	68. 00
00.00	(line 13 x line 20)	c costs arter i	becember or or	the cost repor	tring period		00.00
60.00	,	routing costs	(lino 67 : lin	0 60)			69. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	09.00
	PART III - SKILLED NURSING FACILITY, OTHER NU						
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID row	utine service	cost (line 37)			70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (I	line 70 ÷ line	2)			71. 00
	Program routine service cost (line 9 x line						72. 00
73. 00	Medically necessary private room cost applic		m (line 14 x l	i ne 35)			73. 00
74. 00	Total Program general inpatient routine serv	9	•	,			74. 00
	, ,	•	· ·	•	rt II ooluma		
75. 00	Capital-related cost allocated to inpatient	TOULTHE SERVICE	c CO212 (ILOW	worksneet B, Pa	itii, column		75. 00
- ,	26, line 45)	2)					_,
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77.00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p	provi der recor	ds)			79. 00
80. 00	Total Program routine service costs for compa	, ,		*.	s line 79)		80.00
81. 00	Inpatient routine service cost per diem limi			(75 millu	, , ,		81. 00
			1)				•
82. 00	Inpatient routine service cost limitation (· * .				82. 00
83. 00	Reasonable inpatient routine service costs (ns)				83. 00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
85.00	Utilization review - physician compensation	(see instruction	ons)				85. 00
86. 00	Total Program inpatient operating costs (sum						86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS		/				
87. 00	Total observation bed days (see instructions					0	87. 00
	,		· line 2)			1	
88. 00	Adjusted general inpatient routine cost per						88. 00
89.00	Observation bed cost (line 87 x line 88) (se	e instructions))			0	89. 00

Health Financial Systems ST	VINCENT SETON SE	PECIALITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od: From 07/01/2014	Worksheet D-1	
				To 06/30/2015	Date/Time Pre 11/25/2015 11	pared: :28 am
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from 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 THROUG	H COST					
90.00 Capital -related cost	1, 778, 950	23, 764, 394	0. 07485	8 0	0	90. 00
91.00 Nursing School cost	C	23, 764, 394	0.00000	0	0	91.00
92.00 Allied health cost		23, 764, 394	0.00000	0	0	92. 00
93.00 All other Medical Education	(c	23, 764, 394	0. 00000	0 0	0	93. 00

Health Financial Systems ST VINCENT SETON SPECIALITY INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pro	HOSPITAL vider CCN: 152020	Period:	eu of Form CMS-2 Worksheet D-3	
INPATIENT ANGIELANT SERVICE COST APPORTIONNENT	Vider Con. 132020	From 07/01/2014 To 06/30/2015		pared:
	Title XVIII	Hospi tal	PPS	
Cost Center Description	Ratio of Cos	t Inpatient	Inpati 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		00.017.754	1	
30. 00 03000 ADULTS & PEDI ATRI CS		30, 317, 751		30. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0.0700/	1 2 17/ 202	F00 410	
	0. 27036			
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	0. 17181		265, 356 0	1
57. 00 05700 CT SCAN	0.00000		1	
60. 00 06000 LABORATORY	0. 63719	•		60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 09485 0. 36325			
65. 00 06500 RESPIRATORY THERAPY	0. 36323	•		
66. 00 06600 PHYSI CAL THERAPY	0. 16620			1
67. 00 06700 OCCUPATI ONAL THERAPY	0. 44676			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 39675			
69. 00 06900 ELECTROCARDI OLOGY	0. 00000	•	202, 342	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 08827		1	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.00000	•	1, 710	ł
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 00000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 31139			
74. 00 07400 RENAL DI ALYSI S	0. 39355			
200.00 Total (sum of lines 50-94 and 96-98)	0.07000	45, 277, 955		1
201.00 Less PBP Clinic Laboratory Services-Program only charges (line	: 61)	0,277,700		201. 00
202.00 Net Charges (line 200 minus line 201)		45, 277, 955	l	202. 00

	CT MANOCHT CETON COECUMA	TV 110001	TA1		6.5. 046	0550 40
	Financial Systems ST VINCENT SETON SPECIALI				eu of Form CMS-:	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 152020	Period: From 07/01/2014	Worksheet D-3	
				To 06/30/2015		pared:
					11/25/2015 11	
		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	9	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				1	
30. 00	03000 ADULTS & PEDI ATRI CS			2, 161, 762		30. 00
	ANCILLARY SERVICE COST CENTERS				1	
50. 00	05000 OPERATING ROOM		0. 2703	· ·		
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 27414	· ·	1	
54. 01	03630 ULTRA SOUND		0. 00000		1	54. 01
57. 00	05700 CT SCAN		0. 63719	· ·		57. 00
	06000 LABORATORY		0. 0948			
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 3632			
65. 00	06500 RESPI RATORY THERAPY		0. 16620	986, 785	164, 007	65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 44876	54 121, 60C	54, 570	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0. 21418	97, 721	20, 930	67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 3967	57 23, 391	9, 281	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 00000	00	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 0882	74 C	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000	00	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000	00	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 3113	98 1, 042, 416	324, 606	73. 00
74.00	07400 RENAL DIALYSIS		0. 3935	56 20, 552	8, 088	74. 00
200.00	Total (sum of lines 50-94 and 96-98)			3, 003, 527	700, 759	200.00
004 00			l	1	I .	004 00

Total (sum of lines 50-94 and 96-98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net Charges (line 200 minus line 201)

3, 003, 527

700, 759 200. 00 201. 00 202. 00

201.00 202.00

Health Financial Systems	ST VINCENT SETON SPECIAL	ITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152020	From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared:

			To 06/30/2015	Date/Time Pre 11/25/2015 11	
		Title XVIII	Hospi tal	PPS	. 20 a
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			40	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		21, 133	
3. 00	PPS payments	,		3, 453	
4.00	Outlier payment (see instructions)			0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7. 00 8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	
10. 00	Organ acqui si ti ons	, 551. 15, 11.1.6 255		0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			40	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			107	10.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		127	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	e 07)		127	
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa				15. 00
16. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			127	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	87	
	instructions)		, ,		
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	<pre>instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see</pre>	instructions)		40	21. 00
22. 00	Interns and residents (see instructions)	riisti detrons)		0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			3, 453	24. 00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				05.00
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		0 743	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			2, 750	
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 2, 750	
31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			2,750	
32. 00	Subtotal (line 30 minus line 31)			2, 750	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	34. 00 35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	
37. 00	Subtotal (see instructions)	o :			37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	ctions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 2, 750	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)			55	1
41. 00	Interim payments			2, 681	
42.00					42.00
43.00	00 Balance due provider/program (see instructions)				43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance §115.2	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	
74. UU	Total (Suil OI TITIES 71 and 73)				74.00

Health Financial Systems ST VINCENTAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 | Peri od: | Worksheet E-1 | From 07/01/2014 | Part I | To 06/30/2015 | Date/Time Prepared: Provi der CCN: 152020

				'	0 00/30/2015	11/25/2015 11:	
			Ti tl	e XVIII	Hospi tal	PPS	
			Inpatier	nt Part A	Par	t B	
		mm /	dd/yyyy	Amount	mm/dd/yyyy	Amount	
			1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1.00	20, 116, 507		2, 681	1. 00
2.00	Interim payments payable on individual bills, either			20, 110, 307		2,001	2.00
2.00	submitted or to be submitted to the contractor for						2.00
	services rendered in the cost reporting period. If none,						
	write "NONE" or enter a zero						
3.00	List separately each retroactive lump sum adjustment						3.00
	amount based on subsequent revision of the interim rate						
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	01/	22/2015	54, 700		0	3. 01
3.02				()	0	3. 02
3.03				()	0	3. 03
3.04				()	0	3. 04
3.05				(0	3. 05
	Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM			(0	3. 50
3. 51						0	3. 51
3. 52				C		0	3. 52
3.53						0	3. 53
3.54				(0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			54, 700)	0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			20, 171, 207	,	2, 681	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as			20, 171, 207		2,001	7.00
	appropriate)						
	TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after						5.00
	desk review. Also show date of each payment. If none,						
	write "NONE" or enter a zero. (1)						
	Program to Provider						
5. 01	TENTATI VE TO PROVI DER					0	5. 01
5.02				(0	5. 02
5. 03				()	0	5. 03
F F0	Provi der to Program	_		1	ı		
5.50	TENTATI VE TO PROGRAM					0	5. 50
5. 51 5. 52							5. 51 5. 52
5. 5∠ 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines						5. 99
5. 77	5. 50-5. 98)					U	3.77
6. 00	Determined net settlement amount (balance due) based on						6. 00
5. 00	the cost report. (1)] 0.00
6. 01	SETTLEMENT TO PROVIDER			97, 199)	14	6. 01
6. 02	SETTLEMENT TO PROGRAM			· c)	0	6. 02
7.00	Total Medicare program liability (see instructions)			20, 268, 406		2, 695	7. 00
					Contractor	NPR Date	
					Number	(Mo/Day/Yr)	
	To the second se			0	1. 00	2. 00	
8. 00	Name of Contractor						8.00

Health Financial Systems	ST VINCENT SETON SPECIAL	LITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152020	From 07/01/2014	Worksheet E-3 Part IV Date/Time Prepared: 11/25/2015 11:28 am
		Title XVIII	Hosni tal	DDS

				11/25/2015 11:	: 28 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			17, 814, 839	
2.00	Outlier Payments			4, 424, 418	
3.00	Total PPS Payments (sum of lines 1 and 2)			22, 239, 257	
4.00	Nursing and Allied Health Managed Care payments (see instructio	ns)		0	
5.00	Organ acquisition (DO NOT USE THIS LINE)				5. 00
6.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	6. 00
7.00	Subtotal (see instructions)			22, 239, 257	7. 00
8.00	Primary payer payments			0	8. 00
9.00	Subtotal (line 7 less line 8).			22, 239, 257	9. 00
10.00	Deducti bl es			28, 408	10.00
11. 00	Subtotal (line 9 minus line 10)			22, 210, 849	11. 00
12.00	Coinsurance			2, 116, 353	12.00
13.00	Subtotal (line 11 minus line 12)			20, 094, 496	13.00
14.00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		903, 925	14.00
15.00	Adjusted reimbursable bad debts (see instructions)			587, 551	15. 00
16.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		862, 346	16.00
17.00	Subtotal (sum of lines 13 and 15)			20, 682, 047	17. 00
18.00	Direct graduate medical education payments (from Wkst. E-4, lin	e 49)		0	18. 00
19.00	Other pass through costs (see instructions)			0	19. 00
20.00	Outlier payments reconciliation			0	20. 00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	21. 00
21. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	21. 50
21. 99	Recovery of Accelerated Depreciation			0	21. 99
22. 00	Total amount payable to the provider (see instructions)			20, 682, 047	22. 00
22. 01	Sequestration adjustment (see instructions)			413, 641	•
23.00	Interim payments			20, 171, 207	23. 00
24.00	Tentative settlement (for contractor use only)			0	•
25. 00	Balance due provider/program (line 22 minus lines 22.01, 23 and	24)		97, 199	25. 00
26. 00	Protested amounts (nonallowable cost report items) in accordance		chapter 1.	, o	
	§115. 2		,		
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see inst	ructions)		0	50. 00
	Outlier reconciliation adjustment amount (see instructions)	•		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instruc	tions)		0.00	52.00
53.00	Time Value of Money (see instructions)	•		0	53. 00
					•

Health Financial Systems	ST VINCENT SETON SPECIAL	LITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 152020	Peri od: From 07/01/2014	Worksheet E-3 Part VII

To 06/30/2015 Date/Time Prepared: 11/25/2015 11:28 am Title XIX Hospi tal Cost Outpati ent Inpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 1, 841, 361 1.00 2.00 Medical and other services 2.00 Λ 3.00 Organ acquisition (certified transplant centers only) 3.00 Subtotal (sum of lines 1, 2 and 3) 4.00 1, 841, 361 4.00 5.00 Inpatient primary payer payments 5.00 Outpatient primary payer payments 6.00 Ω 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 1,841,361 Ω 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 2, 161, 762 8.00 9.00 Ancillary service charges 3, 003, 527 0 9.00 10.00 Organ acquisition charges, net of revenue 10.00 0 11 00 Incentive from target amount computation 11 00 0 12.00 Total reasonable charges (sum of lines 8 through 11) 5, 165, 289 0 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 5, 165, 289 16.00 3, 323, 928 17.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 18.00 (see instructions) 19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 20.00 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 1, 841, 361 0 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers 22.00 0 0 22.00 Other than outlier payments 23.00 Outlier payments 0 23.00 Λ 0 24.00 Program capital payments 24.00 0 25.00 Capital exception payments (see instructions) 25.00 26.00 26 00 Routine and Ancillary service other pass through costs 0 Subtotal (sum of lines 22 through 26) 0 27.00 0 27.00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 1, 841, 361 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 1, 841, 361 0 31.00 32.00 Deducti bl es 32.00 0 33 00 33 00 Coi nsurance 0 0 34.00 Allowable bad debts (see instructions) 0 Λ 34.00 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36, 00 1, 841, 361 36, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 0 37.00 38.00 Subtotal (line 36 ± line 37) 1, 841, 361 38.00 0 Direct graduate medical education payments (from Wkst. E-4) 39.00 39.00 1, 841, 361 40.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 41.00 Interim payments 1, 841, 361 0 41.00 Balance due provider/program (line 40 minus line 41) 42.00 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 43.00 0 43.00 0

chapter 1, §115.2

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

Provi der CCN: 152020

Peri od: Worksheet G From 07/01/2014 To 06/30/2015 Date/Time Prepared:

				10 06/30/2015	Date/Time Pre 11/25/2015 11	
		General Fund	Speci fi c	Endowment Fund		20 am
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1. 00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	0	(0	0	1.00
2.00	Temporary investments	0		o	0	
3.00	Notes receivable	0		o	0	3.00
4.00	Accounts receivable	15, 282, 059	1	0	0	
5.00	Other receivable	389, 772	l .	0	0	
6.00	Allowances for uncollectible notes and accounts receivable		1	0	0	
7. 00 8. 00	Inventory Prepai d expenses	518, 829		0	0	
9. 00	Other current assets	26, 059			0	
10.00	Due from other funds	20,037			0	
11. 00	Total current assets (sum of lines 1-10)	10, 537, 575			0	
	FIXED ASSETS			-		
12.00	Land	850, 786	(0	0	12.00
13.00	Land improvements	0	(0	0	
14. 00	Accumulated depreciation	0	1	0	0	
15.00	Bui I di ngs	21, 889, 320	1	0	0	
16.00	Accumulated depreciation	-10, 369, 164	. (0	
17. 00 18. 00	Leasehold improvements Accumulated depreciation	0			0	
19. 00	Fi xed equipment				0	
20. 00	Accumulated depreciation	0			0	
21. 00	Automobiles and trucks	0		ol ol	0	
22. 00	Accumul ated depreciation	0	(o	0	22. 00
23.00	Major movable equipment	0		o	0	23.00
24.00	Accumulated depreciation	0	(0	0	
25. 00	Mi nor equi pment depreci abl e	0	(0	0	
26. 00	Accumulated depreciation	0		0	0	
27. 00 28. 00	HIT designated Assets	0			0	
29. 00	Accumulated depreciation Minor equipment-nondepreciable	0			0	
30.00	Total fixed assets (sum of lines 12-29)	12, 370, 942			0	
00.00	OTHER ASSETS	12/0/0///2	1	۷, ۳		1 00.00
31.00	Investments	86, 747, 516	(0	0	31.00
32.00	Deposits on Leases	0	(0	0	32.00
33. 00	Due from owners/officers	0	(0	0	
34.00	Other assets	13, 011	(0	0	
35. 00	Total other assets (sum of lines 31-34)	86, 760, 527	1		0	1
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	109, 669, 044	1	o _l o _l	0	36.00
37. 00	Accounts payable	760, 953		ol o	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 799, 496	1	ol ol	0	
39. 00	Payroll taxes payable	321, 193		o	0	
40.00	Notes and Loans payable (short term)	0	(o	0	40.00
41.00	Deferred income	0	(0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	(0	0	
44. 00		7, 848, 437	1		0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	10, 730, 079		0	0	45. 00
46. 00	Mortgage payable	1 0		0	0	46. 00
47. 00	Notes payable	0	l è		0	
48.00	Unsecured Loans	414, 884		o	0	1
49.00	Other long term liabilities	0	(o	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	414, 884		0	0	
51.00	Total liabilites (sum of lines 45 and 50)	11, 144, 963	(0	0	51.00
	CAPI TAL ACCOUNTS		1			
52. 00	General fund balance	98, 524, 081				52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted					53.00
55. 00	Donor created - endowment fund balance - restricted					55.00
56. 00	Governing body created - endowment fund balance			n		56. 00
57. 00	Plant fund balance - invested in plant				0	
58.00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	98, 524, 081		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	109, 669, 044	'	0	0	60.00
	[59]	1	I			l

In Lieu of Form CMS-2552-10 Health Financial Systems ST VINCENT SETON SPECIALITY HOSPITAL STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 152020 Peri od: Worksheet G-1 From 07/01/2014 06/30/2015 Date/Time Prepared: 11/25/2015 11:28 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 90, 729, 558 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 7, 794, 180 2.00 3.00 Total (sum of line 1 and line 2) 98, 523, 738 0 3.00 4.00 RECONCILING ITEM 0 343 0 4.00 5.00 0 5.00 0000 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 343 10.00 Subtotal (line 3 plus line 10) 98, 524, 081 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 0 0 0 0 13.00 13.00 14.00 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 98, 524, 081 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 RECONCILING ITEM 4.00 4.00 5.00 0 5.00 0 6.00 6.00

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MCRI F32 - 8. 1. 158. 3

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12.00

13. 00 14. 00

15. 00 16. 00

17.00

18.00

19.00

Total additions (sum of line 4-9)

Deductions (debit adjustments) (specify)

Total deductions (sum of lines 12-17)

Fund balance at end of period per balance

Subtotal (line 3 plus line 10)

sheet (line 11 minus line 18)

Health Financial Systems ST VINGSTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 152020

			To 06/30/2015	Date/Time Prep 11/25/2015 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	. 20 aiii
	Social Social Person	1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES			2. 22	
	General Inpatient Routine Services				
1.00	Hospi tal	44, 218, 48	1	44, 218, 481	1.00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4. 00	SUBPROVI DER				4. 00
5. 00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7. 00	SKILLED NURSING FACILITY			· ·	7. 00
8. 00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	44, 218, 48	1	44, 218, 481	
10.00	Intensive Care Type Inpatient Hospital Services	1 44, 210, 40	-	77, 210, 401	10.00
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	200	0	0	16. 00
10.00	111-15)	ies	١	U	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	44, 218, 48	1	44, 218, 481	17. 00
18. 00	Ancillary services	76, 701, 56		76, 701, 562	18.00
19. 00			0 126, 942		19.00
	Outpatient services		0 126, 942	126, 942	
20.00	RURAL HEALTH CLINIC		0 0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		이 이	0	21.00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0 0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 120, 920, 04	3 126, 942	121, 046, 985	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		20,001,042		20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		38, 091, 943		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
39. 00			0		39. 00
40.00			0		40. 00
41. 00			0		41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	38, 091, 943		43. 00
	to Wkst. G-3, line 4)	I	1		l

Heal th	Financial Systems ST VINCENT SETON SPECIA	LITY HOSPITAL	Inlie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 152020	Peri od:	Worksheet G-3	1002 10
		77.007.407. 00.11. 102020	From 07/01/2014 To 06/30/2015	Date/Time Prep 11/25/2015 11	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	,		121, 046, 985	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			74, 475, 585	2. 00
3.00	Net patient revenues (line 1 minus line 2)			46, 571, 400	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	5)		38, 091, 943	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			8, 479, 457	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15. 00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other tha	n 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			0	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			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER MI SCELLANEOUS REVENUE			120, 167	24. 00
24. 01				0	24. 01
24. 02	BAD DEBTS			301, 341	24. 02
25. 00	Total other income (sum of lines 6-24)			421, 508	25. 00
26.00				8, 900, 965	
27 00	LOCC ON LINVECTMENTS			724 104	

44 1, 106, 785 28. 00 7, 794, 180 29. 00

27. 00 382, 547 27. 01

27. 02

724, 194

27. 00 LOSS ON INVESTMENTS
27. 01 IMPAIRMENT, RESTRUCTURING, NON-RECUR

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

27. 02 OTHER NONOPERATING ACTIVITY