	Financial Systems	ST. VINCENT CLA				u of Form CMS	
	eport is required by law (42 USC 1395g; 42 CF ts made since the beginning of the cost repor					OMB NO. 0938	
HOSPI T AND SE	AL AND HOSPITAL HEALTH CARE COMPLEX COST REPO TTLEMENT SUMMARY	0,	· .	CCN: 151309 P F	eriod: rom 07/01/2013 o 06/30/2014	Worksheet S Parts I-III	epared:
	- COST REPORT STATUS						
Provi d					Date: 11/21/2	014 Time:	9:53 am
use on			<u> </u>				
	3. [0] If this is an amended report 4. [F] Medicare Utilization. Enter	F" for full or "				ost report	
Contra use on	ly (1) Ås Submitted 7. Contr (2) Settled without Audit 8. [N]	Received: actor No. Initial Report f Final Report for	or this Provi this Provide	der CCN 12. [C	<pre>? Date: tractor's Vendo)]If line 5, cc number of tim</pre>	or Code: olumn 1 is 4: nes reopened =	4 Enter 0-9.
PART I	I - CERTIFICATION						
ADMI NI PROVI D	RESENTATION OR FALSIFICATION OF ANY INFORMATI STRATIVE ACTION, FINE AND/OR IMPRISONMENT UND ED OR PROCURED THROUGH THE PAYMENT DIRECTLY O STRATIVE ACTION, FINES AND/OR IMPRISONMENT MA	ER FEDERAL LAW. R INDIRECTLY OF A	FURTHERMORE,	IF SERVICES I	DENTIFIED IN TH	HIS REPORT WEF	RE
	CERTIFICATION BY OFFICER OR ADMINI	STRATOR OF PROVID	DER(S)				
	I HEREBY CERTIFY that I have read the above electronically filed or manually submitted Expenses prepared by ST. VINCENT CLAY HOSPI ending 06/30/2014 and to the best of my knc complete and prepared from the books and re except as noted. I further certify that I health care services, and that the services laws and regulations.	cost report and TAL (151309) for weledge and belie cords of the pro- am familiar with	the Balance S or the cost r f, this repor vider in acco the laws and	Sheet and State reporting perio rt and statemer ordance with ap d regulations r	ement of Revenue od beginning 07, nt are true, com oplicable instru- regarding the pu	e and /01/2013 and rrect, uctions, rovision of	
		(Si gned)				
		(or gride		er or Administ	rator of Provid	ler(s)	
			Title				
			Date				
			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	ніт	Title XIX	
	·	1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY	· · · · · · · · · · · · · · · · · · ·					
1.00	Hospi tal	0	129, 914	-245, 402			0 1.00
2.00	Subprovider - IPF	0	0	0			0 2.00
3.00	Subprovider - IRF	0	0	0			0 3.00
5.00	Swing bed - SNF	0	43, 641	0			0 5.00
6.00 200.00	Swing bed - NF	0	170 555	-245, 402			0 6.00 0 200.00
-	ove amounts represent "due to" or "due from"	the applicable pr	<u>173,555</u>				01200.00
	ing to the Paperwork Reduction Act of 1995, n						sit
	vs a valid OMB control number The valid OMB						

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.

IIUSPII	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX I			Y HOSPIT		l. 151200	1	n Lieu			2552-10
	AL AND HUSPITAL HEALTH CARE CUMPLEX I	DENTIFICATION DA	IA	Prov	i der CCN	N: 151309	Period: From 07/01 To 06/30	/2013 /2014	Part I Date/T	eet S-2 ime Pre	pared:
	1.00	2	00		3.00			4.00	11/21/	2014 9:	44 am
	Hospital and Hospital Health Care Cor		00		0.00			1.00			
1.00	Street: 1206 EAST NATIONAL AVENUE	P0 Box:									1.00
2.00	City: BRAZIL	State: I			e: 47834		ty: CLAY				2.00
		Component Na	ame	CCN Number	CBSA Number	Provi de Type	r Date Certified		ent Sys , 0, or		
								V	XVIII	-	_
	Usenital and Usenital Decod Company	1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospital and Hospital-Based Componen ⁻ Hospital	ST. VINCENT CLAY		151309	45460	1	08/08/200	1 N	0	0	3.00
5.00		HOSPI TAL		131307	+3+00		00/00/200				5.00
4.00	Subprovider - IPF										4.00
	Subprovider - IRF										5.00
	Subprovider - (Other)										6.00
7.00		ST. VINCENT CLAY BEDS	SWI NG	15Z309	45460		08/08/200	1 N	0	N	7.00
8.00	Swing Beds - NF	DEDG									8.00
	Hospital-Based SNF										9.00
	Hospital-Based NF										10.00
	Hospital-Based OLTC										11.00
	Hospital-Based HHA Separately Certified ASC										12.00
	Hospi tal -Based Hospi ce										13.00
	Hospital-Based Health Clinic - RHC										15.00
	Hospital-Based Health Clinic - FQHC										16.00
	Hospital-Based (CMHC) I										17.00
	Renal Dialysis										18.00
19.00	Other										19.00
							From 1.0			o: 00	-
	Cost Reporting Period (mm/dd/yyyy)						07/01/		06/30	/2014	20.00
21.00	Type of Control (see instructions)							1			21.00
22 00	Inpatient PPS Information Does this facility qualify and is it	currently receiv	/ing pavr	ments for	di spro	portionate	e N			N	22.00
221 00	share hospital adjustment, in accorda	ance with 42 CFR	§412.106								
	for yes or "N" for no. Is this facili									•	
				ction §47							
	amendment hospital?) In column 2, ent	ter "Y" for yes c	or "N" fo	ction §4´ or no.	2.06(c)	(2) (Pi ckl e					00.01
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23. 00 24. 00 25. 00	amendment hospital ?) In column 2, ent Did this hospital receive interim und period? Enter in column 1, "Y" for ye reporting period occurring prior to (no for the portion of the cost report instructions) Which method is used to determine Mee 1, enter 1 if date of admission, 2 if method of identifying the days in thi used in the prior cost reporting peri set in the prior cost reporting peri Medicaid eligible unpaid days in col. out-of-state Medicaid paid days in col. out-of-state Medicaid and eligible unpaid 4, Medicaid HMO paid and eligible but column 5, and other Medicaid days in	er "Y" for yes c compensated care es or "N" for no October 1. Enter ing period occur dicaid days on li census days, or s cost reporting od? In column 2 enter the l, in-state 2, ol. 3, d days in col. t unpaid days in column 6. e in-state	or "N" fo payments for the in colum rring on nes 24 a 3 if da period <u>2, enter</u> In-Stat Medicai paid da	ction §4' or no. s for thi portion no 2 "Y" or after and/or 25 ate of di differer "Y" for ce In-S d Medi ys elig unp da 2. 0	2.06(c) s cost of the of for yes Octobe below? scharge tfrom yes or tate caid ible M aid pa ys 00 0	(2) (Pickle reporting cost or "N" fo r 1. (see In column . Is the the methoo "N" for n Out-of State edicaid aid days 3.00 0	or Out-of State Medicaid eligible unpaid 4.00 0	Medica HMO da	id (ys Me	N Dither di cai d days 6. 00	23.00
23. 00 24. 00 25. 00	amendment hospital?) In column 2, ent Did this hospital receive interim und period? Enter in column 1, "Y" for ye reporting period occurring prior to (no for the portion of the cost report instructions) Which method is used to determine Mee 1, enter 1 if date of admission, 2 if method of identifying the days in thi used in the prior cost reporting peri Medicaid eligible unpaid days in col. out-of-state Medicaid paid days in col. out-of-state Medicaid paid days in col. 4, Medicaid HMO paid and eligible but column 5, and other Medicaid days in If this provider is an IRF, enter the Medicaid paid days in col. 1, the in- eligible unpaid days in col. 2, out-of	er "Y" for yes of compensated care es or "N" for no October 1. Enter ting period occur dicaid days on li f census days, or s cost reporting od? In column 2 enter the l, in-state 2, ol. 3, d days in col. t unpaid days in column 6. e in-state estate Medicaid of-state	or "N" fo payments for the in colum rring on nes 24 a 3 if da period <u>2, enter</u> In-Stat Medicai paid da	ction §4' or no. s for thi portion no 2 "Y" or after and/or 25 ate of di differer "Y" for ce In-S d Medi ys elig unp da 2. 0	2.06(c) s cost of the of for yes Octobe below? scharge tfrom yes or tate caid ible M aid pa ys 00 0	(2) (Pickle reporting cost or "N" fo r 1. (see In column . Is the the methoo "N" for n Out-of State edicaid aid days 3.00 0	or Out-of State Medicaid eligible unpaid 4.00 0	Medica HMO da	id (ys Me	N Dither di cai d days 6. 00	23.00
23. 00 24. 00 25. 00	amendment hospital?) In column 2, ent Did this hospital receive interim und period? Enter in column 1, "Y" for ye reporting period occurring prior to (no for the portion of the cost report instructions) Which method is used to determine Mee 1, enter 1 if date of admission, 2 if method of identifying the days in thi used in the prior cost reporting peri Medicaid eligible unpaid days in col. out-of-state Medicaid paid days in col. out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible but column 5, and other Medicaid days in If this provider is an IRF, enter the Medicaid paid days in col. 1, the in- eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-state	ter "Y" for yes of compensated care es or "N" for no October 1. Enter ting period occur dicaid days on li f census days, or s cost reporting od? In column 2 enter the l, in-state 2, ol. 3, d days in col. t unpaid days in column 6. e in-state estate Medicaid of-state e Medicaid	or "N" fo payments for the in colum rring on nes 24 a 3 if da period <u>2, enter</u> In-Stat Medicai paid da	ction §4' or no. s for thi portion no 2 "Y" or after and/or 25 ate of di differer "Y" for ce In-S d Medi ys elig unp da 2. 0	2.06(c) s cost of the of for yes Octobe below? scharge tfrom yes or tate caid ible M aid pa ys 00 0	(2) (Pickle reporting cost or "N" fo r 1. (see In column . Is the the methoo "N" for n Out-of State edicaid aid days 3.00 0	or Out-of State Medicaid eligible unpaid 4.00 0	Medica HMO da	id (ys Me	N Dither di cai d days 6. 00	23.00
23. 00 24. 00 25. 00	amendment hospital?) In column 2, ent Did this hospital receive interim und period? Enter in column 1, "Y" for ye reporting period occurring prior to (no for the portion of the cost report instructions) Which method is used to determine Mee 1, enter 1 if date of admission, 2 if method of identifying the days in thi used in the prior cost reporting peri Medicaid eligible unpaid days in col. out-of-state Medicaid paid days in col. out-of-state Medicaid paid days in col. 4, Medicaid HMO paid and eligible but column 5, and other Medicaid days in If this provider is an IRF, enter the Medicaid paid days in col. 1, the in- eligible unpaid days in col. 2, out-of	er "Y" for yes of compensated care es or "N" for no October 1. Enter ting period occur dicaid days on li f census days, or s cost reporting od? In column 2 enter the l, in-state 2, ol. 3, d days in col. t unpaid days in column 6. e in-state state Medicaid of-state e Medicaid caid HMO paid	or "N" fo payments for the in colum rring on nes 24 a 3 if da period <u>2, enter</u> In-Stat Medicai paid da	ction §4' or no. s for thi portion no 2 "Y" or after and/or 25 ate of di differer "Y" for ce In-S d Medi ys elig unp da 2. 0	2.06(c) s cost of the of for yes Octobe below? scharge tfrom yes or tate caid ible M aid pa ys 00 0	(2) (Pickle reporting cost or "N" fo r 1. (see In column . Is the the methoo "N" for n Out-of State edicaid aid days 3.00 0	or Out-of State Medicaid eligible unpaid 4.00 0	Medica HMO da	id (ys Me	N Dither di cai d days 6. 00	23.00

			LAY HOSPITAL		1	n Lieu	u of For	m CMS-2	2552-10
HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der	F	eriod: rom 07/01, o 06/30,		Workshe Part I Date/Ti 11/21/2	me Pre	pared:
			·		Urban/Rui 1.00			Geogr	
26.00	Enter your standard geographic classification (not			jinning of the	1.00	2	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban	wage) st or "2" f	atus at the end or rural. If ap			2			27.00
35.00	enter the effective date of the geographic reclass If this is a sole community hospital (SCH), enter effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00		Endi ı 2. 0		
36.00	Enter applicable beginning and ending dates of SCH of periods in excess of one and enter subsequent d		Subscript line	36 for number					36.00
	If this is a Medicare dependent hospital (MDH), en in effect in the cost reporting period.	ter the n				0			37.00
38.00	Enter applicable beginning and ending dates of MDH of periods in excess of one and enter subsequent d		Subscript line	38 for number					38.00
	· · · ·				Y/N 1.00		Y/I 2. 0		
39.00	Does this facility qualify for the inpatient hospi hospitals in accordance with 42 CFR §412.101(b)(2) or "N" for no. Does the facility meet the mileage CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for y	(ii)? Ent requireme	er in column 1 nts in accordar	"Y" for yes nce with 42	N		<u> </u>		39.00
			101 1101 (000 1		1	V 1.00	XVIII 2.00	XI X 3.00	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45.00	Does this facility qualify and receive Capital pay with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment e pursuant to 42 CFR §412.348(f)? If yes, complete W III.	xception orksheet	for extraordina L, Part III and	ary circumstand 1 L-1, Parts I	ces through	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS c					N N	N N	N N	47.00
48.00 56.00	Is the facility electing full federal capital paym Teaching Hospitals Is this a hospital involved in training residents					N		IN	56.00
	or "N" for no.				5				
	If line 56 is yes, is this the first cost reportin GME programs trained at this facility? Enter "Y" is "Y" did residents start training in the first m for yes or "N" for no in column 2. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, If line 56 is yes, did this facility elect cost re	for yes o onth of t "Y", com Part II,	r "N" for no ir his cost report plete Worksheet if applicable.	n column 1. If ing period? I E-4. If colum	column 1 Enter "Y" nn 2 is				57.00
	defined in CMS Pub. 15-1, section 2148? If yes, co	mplete Wo	rksheet D-5.		13				
	Are costs claimed on line 100 of Worksheet A? If Are you claiming nursing school and/or allied heal					N N			59.00 60.00
	provider-operated criteria under §413.85? Enter "	Y" for ye Y/N	s or "N" for no IME	o. (see instru Direct GME	ctions) IME		Di rect	GME	
		1.00	2.00	3.00	4.00	<u> </u>	5.0	0	
61.00	Did your hospital receive FTE slots under ACA	N	2.00	3.00	4.00	, 0. 00	5.0		61.00
61. 01	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary car	e	0.00	0.0	þ				61.01
	FTEs from the hospital's 3 most recent cost report ending and submitted before March 23, 2010. (see instructions)	S							
61. 02	Enter the current year total unweighted primary ca FTE count (excluding OB/GYN, general surgery FTEs,	re	0.00	0.0	þ				61.02
61.03	and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used fo	r	0.00	0.0	þ				61.03
	determining compliance with the 75% test. (see instructions)								
ol. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.0					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (li		0. 00	0.0	þ				61.05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimar care or general surgery. (see instructions)		0.00	0.0	5				61.06

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATI	ON DATA	Provi der		eriod:	Worksheet S-2	2552-1
				rom 07/01/2013 o 06/30/2014		
	Progr	am Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	. 00	2.00	3.00	4.00	
 1.10 Of the FTEs in line 61.05, specify each new prog special ty, if any, and the number of FTE residen for each new program. (see instructions) Enter i column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GW FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see 	ts n E			0. oc 0. oc		61. 1
instructions) Enter in column 1 the program name enter in column 2 the program code, enter in col 3 the IME FTE unweighted count and enter in colu direct CME_FTE unweighted count	umn					
direct GME FTE unweighted count.			1			
					1.00	
ACA Provisions Affecting the Health Resources ar 2.00 Enter the number of FTE residents that your hosp				od for which	0.00	62. (
your hospital received HRSA PCRE funding (see in	structions)					
2.01 Enter the number of FTE residents that rotated f during in this cost reporting period of HRSA THC Teaching Hospitals that Claim Residents in Non-F	program. (see	instructio		your hospital	0.00	62.(
3.00 Has your facility trained residents in non-provi "Y" for yes or "N" for no in column 1. If yes, c	der settings d	uring this o	instructions)		N	63. (
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents period that begins on or after July 1, 2009 and			inis base year	is your cost r	reporting	
4.00 Enter in column 1, if line 63 is yes, or your fain the base year period, the number of unweighter resident FTEs attributable to rotations occurrin settings. Enter in column 2 the number of unwei resident FTEs that trained in your hospital. Ent of (column 1 divided by (column 1 + column 2)).	cility trained d non-primary g in all non-p ghted non-prim er in column 3	residents care rovider ary care the ratio	0.00	0. 00	0. 000000	64. C
Program Name	e Progr	am Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
1.00	2	. 00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column			0.00	D O. OC	0. 000000	

Health Financial Systems	ST. VIN	ICENT CLAY H	SPI TAL		I	n Lie	u of Form	CMS-2	552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ΛTΑ	Provi der	1	Period: From 07/01, Fo 06/30,		Workshee Part I Date/Tim 11/21/20	ie Prep	oared: 14 am
				Unweighted FTEs Nonprovider Site	Unwei gh FTEs Hospi t	n al	Ratio (cc (col. 1 + 2))	ol. 1/ · col.	<u> </u>
Section 5504 of the ACA Current	Year FTF Residents i	n Nonprovide	r settina	1.00 IsEffective f	2.00		3.00		
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit	010 unweighted non-primar occurring in all non-p unweighted non-primar	ry care resi provider set ry care resi	dent tings. dent	0.0		0.00	<u> </u>		66.00
(column 1 divided by (column 1 +	column 2)). (see ins	structions)							
	Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs i Hospi t	n	Ratio (cc (col. 3 + 4))		
47.00 Enter in column 1 the program	1.00	2.0	0	3.00	4.00		5.00		67.00
67.00 Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)				0.0	0	0.00			67.00
						1.00	2.00	3.00	
70.00 Is this facility an Inpatient Ps		IPF), or doe	s it conta	ain an IPE sub	provi der?	N			70.00
Enter "Y" for yes or "N" for no).								
71.00 If line 70 yes: Column 1: Did th recent cost report filed on or b Column 2: Did this facility trai §412.424 (d)(1)(iii)(D)? Enter or 3 respectively in column 3. (beginning of the fourth year, er the new teaching program in exis Inpatient Rehabilitation Facili	pefore November 15, 20 n residents in a new Y" for yes or "N" for (see instructions) If iter 4 in column 3, or stence, enter 5. (see	004? Enter teaching pr r no. Column this cost r r if the 5th	"Y" for ye ogram in a 3: If col eporting p or subsections	es or "N" for accordance wit lumn 2 is Y, e period covers	no. h 42 CFR nter 1, 2 the			0	71.00
75.00 Is this facility an Inpatient Re	habilitation Facility	y (IRF), or	does it co	ontain an IRF		N			75.00
<pre>subprovider? Enter "Y" for yes 76.00 If line 75 yes: Column 1: Did th recent cost reporting period enc no. Column 2: Did this facility CFR §412.424 (d) (1) (iii) (D)? En1 1, 2 or 3 respectively in column beginning of the fourth year, er the new teaching program in exis</pre>	ne facility have an ap ling on or before Nove train residents in a cer "Y" for yes or "N" o 3. (see instructions nter 4 in column 3, or	ember 15, 20 new teachin 'for no. Co s) If this c rif the 5th	04? Enter g program lumn 3: li ost repor or subsec	"Y" for yes o in accordance f column 2 is ting period co	r "N" for with 42 Y, enter vers the			0	76.00
							1.00)	
80.00 Long Term Care Hospital PPS Is this a long term care hospita TEFRA Providers	al (LTCH)? Enter "Y"	for yes and	"N" for I	no.			N		80.00
85.00 Is this a new hospital under 42 86.00 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excl uded un				no.	N		85. 00 86. 00
					V		XIX		
Title V and XIX Services					1.00		2.00)	
90.00 Does this facility have title V yes or "N" for no in the applica	•	hospital se	rvi ces? Ei	nter "Y" for	N		Y		90.00
91.00 Is this hospital reimbursed for	title V and/or XIX th				N		N		91.00
full or in part? Enter "Y" for y 92.00 Are title XIX NF patients occupy							Y		92.00
instructions) Enter "Y" for yes 93.00 Does this facility operate an IC	or "N" for no in the	appl i cabl e	column.		N		N		93.00
"Y" for yes or "N" for no in the 94.00 Does title V or XIX reduce capit	e applicable column.				N		N		94.00
applicable column.95.00 If line 94 is "Y", enter the red		-				0. 00		0. 00	95.00

Health Financial Systems ST. VINCENT CLAY	HOSPI TAL			In Lie		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 151309	Peri od:		Worksheet S	
			From 07/0 To 06/3	01/2013 30/2014	Part I Date/Time P	ronarod
					11/21/2014	
				/	XIX	_
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes of	r "N" for n	in the	1.	1	2.00 N	96.00
applicable column.		o in the		•		70.00
97.00 If line 96 is "Y", enter the reduction percentage in the appli	cable colum	ו.		0.00	0.	00 97.00
Rural Providers 105.00Does this hospital qualify as a Critical Access Hospital (CAH)	2			(105.00
106.00 If this facility qualifies as a CAH, has it elected the all-ir		nod of paymer		l.		106.00
for outpatient services? (see instructions)						
107.00 Column 1: If this facility qualifies as a CAH, is it eligible			1	J	N	107.00
for I &R training programs? Enter "Y" for yes or "N" for no i instructions) If yes, the GME elimination would not be on Work						
25 and the program would be cost reimbursed. If yes complete V						
Column 2: If this facility is a CAH, do I&Rs in an approved n			1			
train in the CAH's excluded IPF and/or IRF unit? Enter "Y" f column 2. (see instructions)	or yes or "I	N" for no in				
108.00 Is this a rural hospital gualifying for an exception to the CF	NA fee sche	dule? See 42	2	J		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.						
_	Physi cal 1.00	Occupationa 2.00		ech 00	Respirator 4.00	У
109.00 If this hospital qualifies as a CAH or a cost provider, are	Y	Y		<u> </u>	N 1.00	109.00
therapy services provided by outside supplier? Enter "Y"						
for yes or "N" for no for each therapy.						_
				1.00	2.00 3.0	00
Miscellaneous Cost Reporting Information						-
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "				N	0	115.00
enter the method used (A, B, or E only) in column 2. If columr either "93" percent for short term hospital or "98" percent fo						
psychiatric, rehabilitation and long term hospital providers)						
15-1, §2208.1.						
116.00 Is this facility classified as a referral center? Enter "Y" for 117.00 Is this facility legally-required to carry malpractice insurar			"N" for	N Y		116.00
no.	ce? Enter	r tot yes of	N TOT	T		117.00
118.00 Is the malpractice insurance a claims-made or occurrence polic	y? Enter 1 i	f the policy	/ is	2		118.00
claim-made. Enter 2 if the policy is occurrence.						
						_
		Premiums	Los	ses	Insurance	
		Premi ums	Los	ses	Insurance	
110.01 list arguints of malarcastics arguing and said losses		1.00	2.	00	3.00	
118.01 List amounts of malpractice premiums and paid losses:			2.		3.00	0 118. 01
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.	000	3.00	
118.02 Are malpractice premiums and paid losses reported in a cost ce		1.00 5,5 than the	2. 51 1.	000	3.00	0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost co Administrative and General? If yes, submit supporting schedul		1.00 5,5 than the	2. 51 1.	00 0	3.00	0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost ce		1.00 5,5 than the	2. 51 1.	00 0	3.00	 0118.01 118.02
 118.02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H 	e listing co armless prov	1.00 5, t than the ost centers vision in ACA	2. 51 1.	00 00 00	3.00	0 118. 01 118. 02 119. 00
 118.02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119.00 DN TUSE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in contact. 	e listing co armless prov olumn 1 "Y"	1.00 5,5 than the ost centers /ision in AC/ for yes or	2. 51	00 00 00	3.00	0 118. 01 118. 02 119. 00
118.02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119.00 DN TUSE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H \$3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual	e listing co armless prov olumn 1 "Y" ifies for th	1.00 5,5 than the post centers vision in AC/ for yes or ne Outpatient	2. 51	00 00 00	3.00	0 118. 01 118. 02 119. 00
 118.02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119.00 DN TUSE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in contact. 	e listing co armless prov olumn 1 "Y" ifies for th	1.00 5,5 than the post centers vision in AC/ for yes or ne Outpatient	2. 551	00 0 00 1	3.00	 0118.01 118.02
 118. 02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2 "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implant 	e listing co armless prov olumn 1 "Y" ifies for th ? (see instr	1.00 5,5 than the ost centers /ision in AC/ for yes or ne Outpatient ructions)	2. 551	00 00 00	3.00	0 118. 01 118. 02 119. 00
 118. 02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments. Enter in column 2 "Y" for yes or "N" for no. 121. 00 DId this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no. 	e listing co armless prov olumn 1 "Y" ifies for th ? (see instr	1.00 5,5 than the ost centers /ision in AC/ for yes or ne Outpatient ructions)	2. 551	00 0 00 1	3.00	0 118. 01 118. 02 119. 00 120. 00
 118. 02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2 "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implant 	e listing co armless prov olumn 1 "Y" ifies for tl ? (see instr able devices	1.00 5,5 than the post centers vision in AC/ for yes or ne Outpatient ructions) s charged to	2. 51	00 0 00 1	3.00	0 118. 01 118. 02 119. 00 120. 00
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Health Financial Systems	ST. VINCENT CL	AY HOSPITAL			Inlie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX		Provi der	CCN: 15130			Worksheet S- Part I	-2 Tepared:
AII Provi ders					1.00	2.00	
140.00 Are there any related organization chapter 10? Enter "Y" for yes or "N are claimed, enter in column 2 the	" for no in column 1. If	yes, and home	office co		Y	15H046	140. 00
1.00	2.0	0			3.00		
If this facility is part of a chain home office and enter the home offi	ce contractor name and c	ontractor numb	er.				
141.00Name: ST. VINCENT HEALTH 142.00Street: 10330 N. MERIDIAN ST.	Contractor's Name: WP PO Box:	PS	Contr	actor's	Number: 0800)1	141.00 142.00
143.00 City: INDIANAPOLIS	State: IN	1	Zip C	Code:	4629	90	143.00
						1.00	_
144.00 Are provider based physicians' cost 145.00 If costs for renal services are cla services only? Enter "Y" for yes or	imed on Worksheet A, line		costs for	- inpati∈	ent	Y N	144. 00 145. 00
146.00 Has the cost allocation methodology	changed from the previou	usly filed cost	t report?		1.00 N	2.00	146.00
Enter "Y" for yes or "N" for no in enter the approval date (mm/dd/yyyy	column 1. (See CMS Pub.			/es,	IN .		140.00
147.00 Was there a change in the statistic	al basis? Enter "Y" for				Ν		147.00
148.00Was there a change in the order of 149.00Was there a change to the simplifie no.				for	N N		148.00 149.00
110.		Part A	Part	В	Title V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a provid or charges? Enter "Y" for yes or "N							
155. 00 Hospi tal		N	N	<u>D. (300</u>	N	N	155.00
156.00 Subprovider - IPF		N	N		N	N	156.00
157. 00 Subprovi der – IRF 158. 00 SUBPROVI DER		N	N		N	N	157.00 158.00
159. 00 SNF		Ν	N		Ν	N	159.00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161.00 CMHC			N		N	N	161.00
						1.00	
Multicampus 165.00 s this hospital part of a Multicam	nus hosnital that has on	e or more campi	isos in di	fforont	CBSAs2	N	165.00
Enter "Y" for yes or "N" for no.				rrerent	CD3A3:	N	103.00
	Name	County	State	Zip Coc		FTE/Campus	_
166.00 If line 165 is yes, for each	0	1.00	2.00	3.00	4.00	5.00	00 166. 00
campus enter the name in column						0.0	
0, county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5							
						1.00	_
Health Information Technology (HIT)							
167.00 Is this provider a meaningful user						N	167.00
168.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI			e 167 TS	r), ent	er the		0168.00
169.00 If this provider is a meaningful us	er (line 167 is "Y") and	is not a CAH ((line 105	is "N"),	enter the	0.0	00169.00
transition factor. (see instruction	s)				Begi nni ng	Endi ng	
					1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	ginning date and ending o	date for the re	eporting				170.00

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	ST. VINCENT CLAY HOSPITAL STIONNAIRE Provid	er CCN: 151309	In Lie Period: From 07/01/2013 To 06/30/2014		2 epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for all NO	responses. Ente	1.00 er all dates in	2.00 the	
	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If yes, enter the date of t			N		1.00
		x	Y/N	Date	V/I	
. 00	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "1" for involuntary.		1.00 N	2.00	3.00	2.00
00	Is the provider involved in business transact 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)	, chain home offices, dru d to the provider or its , or members of the board	9			3.00
			Y/N 1.00	2.00	Date 3.00	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for Compiled enter date available in	C Y	A	09/11/2014	4.00
00	Are the cost report total expenses and total those on the filed financial statements? If y	revenues different from	. N			5.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for nursing scho the legal operator of the program?	5	the provider is			6.00
00 00	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog cost reporting period? If yes, see instruction	grams approved and/or rene	wed during the	N N		7.00 8.00
00	Are costs claimed for Intern-Resident program yes, see instructions.		·			9.00
	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center			g N N		10.00
	Teaching Program on Worksheet A? If yes, see				Y/N	
	Bad Debts				1.00	-
2. 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments waived?	lfyes, see ins	structions.	N	14.00
5.00	Did total beds available change from the pric	or cost reporting period?			N	15.00
		Description	Pa Y/N	art A Date	Part B Y/N	
		0	1.00	2.00	3.00	
	PS&R Data				T	
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see		Y	10/21/2014	Y	16.00
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is		N		Ν	17.00
. 00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not		N		N	18.00
9. 00	included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of		Ν		N	19.00
0. 00	other PS&R Report information? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe		Ν		N	20.00

Heal th	Financial Systems	ST. VINCENT CI	LAY HOSPITAL		In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		eriod:	Worksheet S-	2
					rom 07/01/2013 0 06/30/2014	Part II Date/Time Pro	enared
					0 00/ 30/ 2014	11/21/2014 9	
				Par	rt A	Part B	
			ption	Y/N	Date	Y/N	
		(0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		Ν	21.00
				•			
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)			
	Capital Related Cost						
	Have assets been relifed for Medicare purpose					N	22.00
23.00	Have changes occurred in the Medicare depreci	ation expense	due to apprais	als made durin	g the cost	N	23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing If yes, see instructions	g leases entere	ed into during	this cost repo	rting period?	Ν	24.00
25.00	Have there been new capitalized leases entere	ed into during	the cost repor	ting period? I	f yes, see	Ν	25.00
26.00	instructions. Were assets subject to Sec.2314 of DEFRA acqu	uired during th	ne cost reporti	ng period?lf	ves, see	Ν	26.00
	instructions.	Ū.		0 1	5	N	07.00
27.00	Has the provider's capitalization policy char copy.	nged during the	e cost reportin	ig period? it y	es, submit	Ν	27.00
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter	rs of credit er	ntered into dur	ing the cost r	eporting	N	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation a			bt Service Res	erve Fund)	Ν	29.00
	treated as a funded depreciation account? If						
30.00	Has existing debt been replaced prior to its instructions.	scheduled matu	irity with new	debt? IT yes,	see	Ν	30.00
31.00	Has debt been recalled before scheduled matur instructions.	rity without is	ssuance of new	debt? If yes,	see	Ν	31.00
	Purchased Services						
32.00	Have changes or new agreements occurred in pa	atient care ser	vices furnishe	d through cont	ractual	N	32.00
	arrangements with suppliers of services? If			Ū.			
33.00	If line 32 is yes, were the requirements of S no, see instructions.	Sec. 2135.2 app	olied pertainin	ig to competiti	ve bidding? If	Ν	33.00
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili	ity under an ar	rangement with	provi der-base	d physi ci ans?	Y	34.00
05 00	If yes, see instructions.						05 00
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			its with the pr	ovi der-based	N	35.00
	[p···] = · · · · · · · · · · · · · · · ·	,			Y/N	Date	
					1.00	2.00	
	Home Office Costs						
	Were home office costs claimed on the cost re If line 36 is yes, has a home office cost sta		repared by the	home office?	Y Y		36.00 37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end o	of the home off	ice different	from that of	N		38.00
	the provider? If yes, enter in column 2 the t	fiscal year end	d of the home o	offi ce.			
39.00	If line 36 is yes, did the provider render se see instructions.	ervices to othe	er chain compon	ents? If yes,	N		39.00
40.00	If line 36 is yes, did the provider render se instructions.	ervices to the	home office?	lf yes, see	N		40.00
			1.	00	2.	00	
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title held by the cost report preparer in columns	•	JILL		HILL		41.00
42.00	respectively. Enter the employer/company name of the cost r	report	ST. VINCENT HE	ALTH			42.00
	preparer.	·				NCENT ODC	
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv		317-583-3519		JILL. HILL@STVII	NUENT. UKG	43.00

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ST. VINCENT CI STIONNAIRE	Provider CCN: 151309	Period:	u of Form CMS-2552 Worksheet S-2
				From 07/01/2013 To 06/30/2014	Part II Date/Time Prepare 11/21/2014 9:44 a
		Part B			
		Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	10/21/2014			16.
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns				17.
18.00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file				18.
19.00	this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see				19.
20. 00	instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.
	Cont Depart Department Contact Information		3.00		
	Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns respectively.		REIMBURSEMENT MANAGER		41.
42.00	Enter the employer/company name of the cost i preparer.	report			42.
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv				43.

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ST. VINCENT CL			CCN: 151309	Pe	eri od:	u of Form CMS Worksheet S-		002 10
105111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC			110VI del			rom 07/01/2013	Part I Date/Time Pr 11/21/2014 9	гер	
								I/P Days / O/ Visits / Trip		
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	15	
		Line Number			Avai I abl e					
		1.00		2.00	3.00		4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00		25	9, 1	25	39, 000. 00		0	1.00
2.00	HMO and other (see instructions)									2.00
3.00 4.00	HMO IPF Subprovider									3.00 4.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF								0	4.00
6.00	Hospital Adults & Peds. Swing Bed NF								ol	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			25	9, 1	25	39, 000. 00		0	7.00
8.00	INTENSIVE CARE UNIT									8.00
9.00 10.00	CORONARY CARE UNIT									9.00 10.00
10.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT									10.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13.00	NURSERY									13.00
14.00	Total (see instructions)			25	9, 1	25	39,000.00		0	14.00
15.00	CAH visits								0	15.00
16.00	SUBPROVIDER - IPF									16.00
17.00	SUBPROVIDER - IRF									17.00
18.00	SUBPROVI DER									18.00
19.00	SKILLED NURSING FACILITY									19.00
20.00	NURSING FACILITY									20.00
21.00	OTHER LONG TERM CARE									21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)									23.00
24.00	HOSPI CE									24.00
24.10	HOSPICE (non-distinct part)	30.00								24.10
25.00	CMHC - CMHC									25.00
26.00 26.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER									26.00 26.25
26.25	Total (sum of lines 14-26)			25						20.25
28.00	Observation Bed Days			25					0	28.00
29.00	Ambul ance Trips								1	29.00
30.00	Employee discount days (see instruction)									30.00
31.00	Employee discount days - IRF									31.00
32.00	Labor & delivery days (see instructions)			0		0				32.00
32.01	Total ancillary labor & delivery room			U		-				32.01
	outpatient days (see instructions)									
33 00	LTCH non-covered days								1	33.00

IOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC				Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part I Date/Time Pre 11/21/2014 9:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	987	105			10.00	1.0
. 00	HMO and other (see instructions)	86	47				2.0
. 00 . 00	HMO I PF Subprovi der	0	47				3.0
. 00	HMO I RF Subprovider	0	0				4.0
5. 00	Hospital Adults & Peds. Swing Bed SNF	782	0	78	2		5.0
. 00 . 00	Hospital Adults & Peds. Swing Bed NF	7.02	0	6			6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 769	105				7.0
. 00	INTENSIVE CARE UNIT						8.0
. 00	CORONARY CARE UNIT						9. (
0. 00	BURN INTENSIVE CARE UNIT						10. (
1.00	SURGICAL INTENSIVE CARE UNIT						11. (
2.00	OTHER SPECIAL CARE (SPECIFY)						12. (
3.00	NURSERY						13.0
4.00	Total (see instructions)	1, 769	105			103.63	
5.00	CAH visits	10, 766	1, 967	30, 99	/		15.0
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF						17.0
8.00							18.0
9.00 0.00	SKILLED NURSING FACILITY NURSING FACILITY						19. (20. (
1.00	OTHER LONG TERM CARE						20.
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						22.
4.00	HOSPICE						24.
4.10	HOSPICE (non-distinct part)	0	0		0		24.
5.00	CMHC - CMHC	Ű	0		0		25.0
6.00	RURAL HEALTH CLINIC						26.
6. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.
7.00	Total (sum of lines 14-26)				0.00	103.63	
3.00	Observation Bed Days		0	57			28.0
9.00	Ambul ance Trips	0					29.
0. 00	Employee discount days (see instruction)				0		30.
1.00	Employee discount days - IRF				0		31.
2.00	Labor & delivery days (see instructions)	0	0		o		32.
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)		-		0		32. (
3.00	LTCH non-covered days	0					33.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	CCN: 151309	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part I Date/Time Pre 11/21/2014 9:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	28	35 33	512	1.00
2.00 3.00 4.00 5.00 6.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF				0		2.00 3.00 4.00 5.00 6.00
8.00 9.00 10.00 11.00 12.00 13.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
$\begin{array}{c} 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\end{array}$	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY	0.00	o	28	35 33	512	14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00
23. 00 24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00					23. 00 24. 00 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01

Heal th	Financial Systems ST. VINCENT CLAY HO	SPI TAL		In Lie	eu of Form CMS-	2552-10		
H0SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151309	Peri od:	Worksheet S-1	0		
				From 07/01/2013				
				To 06/30/2014	Date/Time Pre 11/21/2014 9:			
					11/21/2014 9.			
					1.00			
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by lir	ne 202 column	1.8)	0, 294642	1,00		
	Medicaid (see instructions for each line))				
2.00	Net revenue from Medicaid				0	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	payments 1	From Medicaid	1?	ĺ	4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from I		0	5.00				
6.00	Medi cai d charges				9, 238, 118	6.00		
7.00	Medicaid cost (line 1 times line 6)				2, 721, 938	7.00		
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 minu	us sum of lir	nes 2 and 5; if	2, 721, 938	8.00		
	< zero then enter zero)							
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach line)					
9.00	Net revenue from stand-alone SCHIP				0	9.00		
10.00								
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0					
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 mi	nus line 9;	if < zero then	0	12.00		
	enter zero)				<u> </u>	-		
	Other state or local government indigent care program (see instru					1 4 9 9 9		
13.00	Net revenue from state or local indigent care program (Not inclu		0					
14.00	Charges for patients covered under state or local indigent care	program (i	NOT INCIUAEA	in lines 6 or	0	14.00		
15.00	10) State on least indigent core program cost (line 1 times line 14)				0	15.00		
15.00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indi	aont cara	program (Lir	o 15 minus lino				
10.00	13; if < zero then enter zero)	gent care	program (TT		1	10.00		
	Uncompensated care (see instructions for each line)				l			
17.00	Private grants, donations, or endowment income restricted to fun	ding chari	ty care		0	17.00		
18.00	Government grants, appropriations or transfers for support of ho				12, 745			
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local			ns (sum of lines	2, 721, 938			
	8, 12 and 16)	rnargont	our o program		2,721,700			
			Uni nsured	Insured	Total (col. 1			
			patients	pati ents	+ col. 2)			
			1.00	2.00	3.00			
20.00	Total initial obligation of patients approved for charity care (4, 046, 63	36 15, 436	4, 062, 072	20.00		
	charges excluding non-reimbursable cost centers) for the entire							
21.00	Cost of initial obligation of patients approved for charity care	(line 1	1, 192, 30	9 4, 548	1, 196, 857	21.00		
~~ ~~	times line 20)							
22.00	Partial payment by patients approved for charity care			0 0	0	22.00		
23.00	Cost of charity care (line 21 minus line 22)		1, 192, 30	9 4, 548	1, 196, 857	23.00		
					1.00			
24.00	Does the amount in line 20 column 2 include charges for patient		ad a longth a	fotovilimit	1.00 N	24.00		
24.00	imposed on patients covered by Medicaid or other indigent care p		id a rength c	n stay minit	IN IN	24.00		
25.00	If line 24 is "yes," charges for patient days beyond an indigen		oaram's Lenat	h of stav limit	0	25.00		
20.00	Medicare bad debts for the entire hospital complex (see instruct				408, 261			
27.00	Non-Medicare and non-reimbursable Medicare bad debt expense (lin		sline 27)		1, 515, 683			
20.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (This			28)	446, 584			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 643, 441			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			4, 365, 379			

Health Financial Systems	ST. VINCENT CLAY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der		Peri od:	Worksheet A	
				From 07/01/2013 To 06/30/2014	Date/Time Pre	narod
				10 00/ 30/ 2014	11/21/2014 9:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	0.00	0.00	4.00	col. 4)	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT	[458, 932	458, 93	2 - 188, 496	270, 436	1.00
2.00 00200 CAP REL COSTS MVBLE EQUIP		821, 883				2.00
2. 01 00201 CAP REL COSTS-MOB		321, 647	321, 64			2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	157, 737	1, 583, 230				4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	1, 454, 099	2, 740, 400				5.00
7.00 00700 OPERATION OF PLANT	272, 685	500, 304	772, 98		772, 988	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	38, 665	38, 66	5 -3	38, 662	8.00
9. 00 00900 HOUSEKEEPI NG	0	329, 424	329, 42	4 -78	329, 346	9.00
10. 00 01000 DI ETARY	0	350, 538	350, 53	8 -168,008	182, 530	10.00
11. 00 01100 CAFETERI A	0	0		0 168, 005	168, 005	11.00
13.00 01300 NURSING ADMINISTRATION	236, 798	37, 477	274, 27			
14.00 01400 CENTRAL SERVICES & SUPPLY	0	14, 265				
15. 00 01500 PHARMACY	0	784, 226				
16.00 O1600 MEDICAL RECORDS & LIBRARY	167, 632	32, 257	199, 88	9 -12	199, 877	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	895, 490	100 500	1 010 01	21 202	00/ 010	30.00
ANCI LLARY SERVICE COST CENTERS	895, 490	122, 522	1, 018, 01	2 -31, 202	986, 810	30.00
50. 00 05000 OPERATING ROOM	436, 016	219, 627	655, 64	3 -79, 973	575, 670	50.00
53. 00 05300 ANESTHESI OLOGY	143, 990	781	144, 77			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	611, 570	407, 094	1, 018, 66			
60. 00 06000 LABORATORY	992	1,074,158				
65. 00 06500 RESPI RATORY THERAPY	120, 135	36, 178				
66.00 06600 PHYSI CAL THERAPY	0	640, 342				
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 42, 046	42, 046	67.00
68.00 06800 SPEECH PATHOLOGY	0	13, 057	13, 05	7 0	13, 057	68.00
69. 00 06900 ELECTROCARDI OLOGY	103, 983	31, 015	134, 99	B -4, 922	130, 076	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	243, 560				
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	290, 111	290, 11			•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	13, 697	13, 69	7 –11, 890	1, 807	73.00
	000,000	001 054	1 700 57	7 74 410	1 71/ 1/5	01 00
91.00 09100 EMERGENCY	809, 323	981, 254	1, 790, 57	7 -74, 412	1, 716, 165	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 410, 450	12,086,644	17, 497, 09	4 3, 698	17, 500, 792	118 00
NONREI MBURSABLE COST CENTERS	5,410,450	12,000,044	17,477,07	4 3,070	17, 300, 772	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	18, 202		-	-	192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
193.01 19301 CLAY CITY MEDICAL CLINIC	0	0		0 0		193.01
193. 02 19302 PUBLIC RELATIONS	9, 653	629	10, 28	2 0		
193. 03 19303 FOUNDATI ON	0	0		0 C		193. 03
193. 04 19304 MI SSI ON SERVI CES	1, 058	1, 385	2, 44	3 0	2, 443	193. 04
193. 05 19305 OTHER NON-REI MBURSABLE	0	0		0 0	-	
200.00 TOTAL (SUM OF LINES 118-199)	5, 421, 161	12, 106, 860	17, 528, 02	1 0	17, 528, 021	200. 00

REULAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der CCM	N: 151309	Period: Worksheet From 07/01/2013 Date/Time To 06/30/2014 Date/Time 11/21/2014 11/21/2014	Prepared:
	Cost Center Description		Net Expenses for Allocation			<u>, , , , , , , , , , , , , , , , , , , </u>
		6.00	7.00			
	GENERAL SERVICE COST CENTERS	· · · · · ·	I			
1.00	00100 CAP REL COSTS-BLDG & FIXT	-136, 589	133, 847			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-91, 921	893, 257			2.00
2.01	00201 CAP REL COSTS-MOB	0	257, 460			2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	116, 310	1, 857, 277			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-385, 394	3, 852, 232			5.00
7.00	00700 OPERATION OF PLANT	-1, 404	771, 584			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	38, 662			8.00
9.00	00900 HOUSEKEEPI NG	0	329, 346			9.00
10.00	01000 DI ETARY	0	182, 530			10.00
11.00	01100 CAFETERI A	-29, 239	138, 766			11.00
13.00	01300 NURSING ADMINISTRATION	12, 972	287, 083			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-15	13, 718			14.00
15.00	01500 PHARMACY	- 4	783, 704			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-5, 463	194, 414			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS		· · ·			
30.00	03000 ADULTS & PEDIATRICS	-244	986, 566			30.00
	ANCI LLARY SERVICE COST CENTERS	· · ·				
50.00	05000 OPERATING ROOM	-4, 782	570, 888			50.00
53.00	05300 ANESTHESI OLOGY	-143, 990	781			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-24, 247	951, 937			54.00
60.00	06000 LABORATORY	-238	1, 074, 518			60.00
65.00	06500 RESPI RATORY THERAPY	-8	149, 310			65.00
66.00	06600 PHYSI CAL THERAPY	-60	638, 754			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	42, 046			67.00
68.00	06800 SPEECH PATHOLOGY	0	13, 057			68.00
69.00	06900 ELECTROCARDI OLOGY	-152	129, 924			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	506, 580			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	290, 111			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-598	1, 209			73.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	-150, 123	1, 566, 042			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
440.00	SPECIAL PURPOSE COST CENTERS	0.45 4.00	1/ / 55 / 00			
118.00		-845, 189	16, 655, 603			118.00
100 0	NONREI MBURSABLE COST CENTERS		0			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	14, 504			192.00
	19300 NONPALD WORKERS	0	0			193.00
	19301 CLAY CITY MEDICAL CLINIC	0	10, 292			193.01
	2 19302 PUBLIC RELATIONS	0	10, 282 0			193.02
102 01	3 19303 FOUNDATI ON	0	0			193. 03
			0 440			102 04
193.04	19304 MISSION SERVICES 19305 OTHER NON-REIMBURSABLE	0 101, 321	2, 443 101, 321			193.04 193.05

	Financial Systems SIFICATIONS		ST. VINCENT CLA	Provi der CCN: 1	51309	Peri od:	u of Form CMS-2 Worksheet A-6	
						From 07/01/2013 To 06/30/2014	Date/Time Prep 11/21/2014 9:4	
		Increases					11/21/2014 7.4	14 am
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - MEDICAL OFFICE BUILDING							
. 00	OCCUPATI ONAL THERAPY	67.00	0	2, 803				1.00
. 00	PHYSI CAL THERAPY	66.00	0	42, 052				2.00
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	19, 331				3.00
. 00	OCCUPATI ONAL THERAPY	67.00	0	159				4.00
. 00	PHYSI CAL THERAPY	66.00	0	2, 380				5.00
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 094				6.00
. 00	TOTALS		— — — <u>o</u>	67,819				0.00
	B - INTEREST		9	07,017				
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	25, 201				1.00
. 00	CAP REL COSTS-MVBLE EQUI P	2.00	0	151, 878				2.00
. 00	CAI NEE COSTS-MIVBEE EQUIT	0.00	0	0				3.00
. 00	TOTALS — — — —		0	177, 079				5.00
	C - CAFETERIA		<u>Ч</u>	177,073				
. 00	CAFETERIA	11.00	0	168, 005				1.00
. 00	TOTALS		— — — o	168,005				1.00
	D - PROPERTY INSURANCE		<u>Ч</u>	108, 003				
. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11, 417				1.00
. 00	TOTALS		0	<u>11, 417</u>				1.00
	E - MEDICAL SUPPLIES		ų	11, 417				
. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	263, 020				1.00
. 00	PATIENTS	, 1. 00	Ŭ	200, 020				1. 00
. 00	I ATTENTO	0.00	0	0				2.00
. 00		0,00	0	Ő				3.00
. 00		0.00	Ő	Ő				4.00
. 00		0.00	0	Ö				5.00
. 00		0.00	0	Ö				6.00
. 00		0.00	0	Ő				7.00
. 00		0.00	0	Ö				8.00
. 00		0.00	Ő	Ö				9.00
0.00		0.00	0	Ö				10.00
1.00		0.00	0	0				11.00
2.00		0.00	0	Ö				12.00
3.00		0.00	0	0				13.00
4.00		0.00	0	0				14.00
5.00		0.00	0	0				15.00
6.00		0.00	0	0				16.00
6.00 7.00		0.00	0	0				17.00
7.00 8.00		0.00	0	0				17.00
8.00 9.00		0.00		0				19.00
7.00				263, 020				19.00
	F - OT RECLASS		U	203, 020				
. 00	OCCUPATIONAL THERAPY	67.00	0	39, 084				1.00
. 00	TOTALS	07.00	0	<u>39,084</u> 39,084				1.00

11/21/2014 9:44 am Y: \28250 - St. Vincent Clay\300 - Medicare Cost Report\20140631\28250-14.mcrx

	SIFICATIONS			Provi der C		Period: From 07/01/2013	Worksheet A-6	
						To 06/30/2014	Date/Time Prepared 11/21/2014 9:44 ar	
		Decreases					11/21/2014 7.44 di	
	Cost Center	Line #	Sal ary	Other Wk	st. A-7 Ref.			
	6. 00	7.00	8.00	9.00	10.00			
	A - MEDICAL OFFICE BUILDING					-1		
1.00	CAP REL COSTS-MOB	2.01	0	64, 187		9		. 00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3, 632	(0		. 00
3.00		0.00	0	0	(0		. 00
4.00		0.00	0	0	(0		. 00
5.00		0.00	0	0	(0		. 00
6.00			0		(<u>0</u>	6.	. 00
	TOTALS		0	67, 819				
1.00	B - INTEREST CAP REL COSTS-BLDG & FIXT	1,00	0	25, 201	1.	1	1	. 00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	151, 878	1 [.]			. 00
2.00	CAP REL CUSIS-BLDG & FIXI	0.00	0	151, 878	1 1'			. 00
3.00	TOTALS		— — — 0	177,079	'		J.	00
	C - CAFETERIA		0	177,079				
1.00	DI ETARY	10.00	0	168, 005	(0	1	. 00
1.00	TOTALS		<u>0</u>	168,005	`		1.	00
	D - PROPERTY INSURANCE		9	100,000				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11, 417	1.	1	1	. 00
	TOTALS		— — — o	11, 417		1		00
	E - MEDICAL SUPPLIES	I				1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 499	(0	1.	. 00
2.00	OPERATION OF PLANT	7.00	0	1	(o	2.	. 00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	3	(0	3.	. 00
4.00	HOUSEKEEPI NG	9.00	0	78	(0	4.	. 00
5.00	DI ETARY	10.00	0	3	(0	5.	. 00
6.00	NURSING ADMINISTRATION	13.00	0	164		0		. 00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	532		0		. 00
8.00	PHARMACY	15.00	0	518		0		. 00
9.00	MEDI CAL RECORDS & LI BRARY	16.00	0	12	(0		. 00
10.00	ADULTS & PEDIATRICS	30.00	0	31, 202	(0	10.	
11.00	OPERATING ROOM	50.00	0	79, 973	(0	11.	
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	42, 480	(0	12.	
13.00	LABORATORY	60.00	0	394	(0	13.	
14.00		65.00	0	6, 995	(14.	
15.00	PHYSI CAL THERAPY	66.00	0	6, 876		0	15.	
16.00	ELECTROCARDI OLOGY	69.00	0	4, 922		0	16.	
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	11, 890		0	17.	
18.00	EMERGENCY	91.00	0	74, 412		0	18.	
19.00	PHYSICIANS' PRIVATE OFFICES TOTALS	<u> </u>		6666	(19.	00
	F - OT RECLASS		0	203, 020				
1.00	PHYSICAL THERAPY	66.00	0	39, 084		0	1	. 00
1.00	TOTALS		— — — o	39,084	`		1.	00
500.00	Grand Total: Decreases		0	726, 424		-	500.	.00
			9	, ,		1	10001	

ST. VINCENT CLAY HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems

11/21/2014 9:44 am Y: \28250 - St. Vincent Clay\300 - Medicare Cost Report\20140631\28250-14.mcrx

Heal th	Financial Systems	ST. VINCENT CL	AY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151309	Period: From 07/01/2013 To 06/30/2014		pared:
				Acqui si ti on	s		
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL AS	SSET BALANCES					
1.00	Land	2, 500	0		0 0	0	1.00
2.00	Land Improvements	312, 487	0		0 0	7, 496	2.00
3.00	Buildings and Fixtures	8, 986, 463	2, 539, 052		0 2, 539, 052	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	9, 458, 981	0		0 0	2, 617, 082	5.00
6.00	Movable Equipment	0	0		0 0	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18, 760, 431	2, 539, 052		0 2, 539, 052	2, 624, 578	8.00
9.00	Reconciling Items	0	0		0 0	0	
10.00	Total (line 8 minus line 9)	18, 760, 431	2, 539, 052		0 2, 539, 052	2, 624, 578	10.00
		Endi ng Bal ance	Fully			i	
		0	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL AS	SSET BALANCES					
1.00	Land	2, 500	0				1.00
2.00	Land Improvements	304, 991	0				2.00
3.00	Buildings and Fixtures	11, 525, 515	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	6, 841, 899	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	18, 674, 905	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	18, 674, 905	0				10.00

Heal th	Financial Systems	ST. VINCENT CI	ST. VINCENT CLAY HOSPITAL			In Lieu of Form CMS-2552-10			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 07/01/2013 To 06/30/2014				
			SL	JMMARY OF CAP	TAL				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)			
		9.00	10.00	11.00	12.00	13.00			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK								
1.00	CAP REL COSTS-BLDG & FIXT	188, 045		253, 71		0	1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	372, 690			0 869	0	2.00		
2.01	CAP REL COSTS-MOB	7, 919			0 0	0	2.01		
3.00	Total (sum of lines 1-2)	568, 654		253, 71	18, 046	0	3.00		
		SUMMARY O							
	Cost Center Description	Other	Total (1) (sum						
		Capi tal -Rel ate	of cols. 9						
		d Costs (see	through 14)						
		instructions)							
		14.00	15.00						
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM							
1.00	CAP REL COSTS-BLDG & FIXT	0	458, 932				1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	821, 883				2.00		
2.01	CAP REL COSTS-MOB	0	321, 647				2.01		
3.00	Total (sum of lines 1-2)	0	1, 602, 462				3.00		

Health Financial Systems	ST. VINCENT CI	AY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			F	Period: From 07/01/2013 Fo 06/30/2014	Date/Time Prep 11/21/2014 9:4	
	COME	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	11, 833, 006		,		0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	6, 841, 899	0	6, 841, 899		0	2.00
2.01 CAP REL COSTS-MOB	0	0	(0. 000000	0	2.01
3.00 Total (sum of lines 1-2)	18, 674, 905		18, 674, 905			3.00
	ALLOCA	FION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0) (51, 456	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(280, 769	448, 324	2.00
2.01 CAP REL COSTS-MOB	0	0	(-56, 268	313, 728	2.01
3.00 Total (sum of lines 1-2)	0	0	(275, 957	762, 052	3.00
		SL	JMMARY OF CAPI	TAL		
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		47.477			400.017	4 00
1.00 CAP REL COSTS-BLDG & FLXT	65, 214			0	133, 847	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	163, 295		1	0 0	893, 257	2.00
2.01 CAP REL COSTS-MOB	0	0		0 0	257, 460	2.01
3.00 Total (sum of lines 1-2)	228, 509	18, 046	1 (ןס וי	1, 284, 564	3.00

	nancial Systems ITS TO EXPENSES		ST. VINCENT	CLAY HOSPITAL Provi der CCN: 151309	Peri od:	worksheet A-8	
					From 07/01/2013 To 06/30/2014		
				Expense Classification To/From Which the Amount			
					-		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
	vestment income – CAP REL STS-BLDG & FIXT (chapter 2)	В		80 CAP REL COSTS-BLDG & FIXT	1.00		1.00
2.00 In	vestment income - CAP REL	В	-91, 9	21 CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
	STS-MVBLE EQUIP (chapter 2) vestment income - CAP REL			OCAP REL COSTS-MOB	2.01	0	2. 01
	STS-MOB (chapter 2) vestment income - other	В	-15,2	52 ADMI NI STRATI VE & GENERAL	5.00	0	3.00
(cl	hapter 2) ade, quantity, and time				0.00		
dis	scounts (chapter 8)						
ex	funds and rebates of penses (chapter 8)			0	0.00	0	5.00
	ntal of provider space by ppliers (chapter 8)			0	0.00	0	6.00
7.00 Te	lephone services (pay ations excluded) (chapter	А	-1, (92 ADMI NI STRATI VE & GENERAL	5.00	0	7.00
3. 00 Te	, levision and radio service hapter 21)	А	-1, 3	54 OPERATION OF PLANT	7.00	0	8. 00
9.00 Par 10.00 Pro	rking lot (chapter 21) ovider-based physician justment	A-8-2	-170, 6	0 95	0.00	000	
1.00 Sa	le of scrap, waste, etc.			0	0.00	0	11.00
2.00 Re tra	hapter 23) Lated organization ansactions (chapter 10)	A-8-1	1, 163, 0	81		0	12.00
	undry and linen service feteria-employees and guests	В	-29.2	0 39 CAFETERI A	0.00 11.00		13.00 14.00
5.00 Rei	ntal of quarters to employee d others			0	0.00		15.00
6.00 Sa su	le of medical and surgical pplies to other than			0	0.00	0	16.00
7.00 Sa	tients le of drugs to other than	В	-5	98 DRUGS CHARGED TO PATIENTS	73.00	0	17.00
1.1.1	tients le of medical records and	В	-5,4	63 MEDI CAL RECORDS & LI BRARY	16.00	о	18.00
	stracts rsing school (tuition, fees,			0	0.00	0	19.00
bo	oks, etc.) nding machines				0.00		20.00
1.00 In in	come from imposition of terest, finance or penalty			0	0.00		20.00
2.00 In ove	arges (chapter 21) terest expense on Medicare erpayments and borrowings to			0	0.00	0	22.00
3.00 Adj the	pay Medicare overpayments justment for respiratory erapy costs in excess of	A-8-3		ORESPIRATORY THERAPY	65.00		23.00
4.00 Adj the	mitation (chapter 14) justment for physical erapy costs in excess of	A-8-3		OPHYSI CAL THERAPY	66.00		24.00
25. 00 Uti ph	mitation (chapter 14) ilization review - ysicians' compensation			0*** Cost Center Deleted *	** 114.00		25.00
	hapter 21) preciation – CAP REL			OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
CO	STS-BLDG & FIXT preciation - CAP REL			OCAP REL COSTS-MVBLE EQUIP			27.00
CO	STS-MVBLE EQUIP						
CO	preciation - CAP REL STS-MOB			OCAP REL COSTS-MOB	2.01		
	n-physician Anesthetist ysicians' assistant			0 *** Cost Center Deleted *	** 19.00 0.00		28.00 29.00
0.00 Adj	justment for occupational erapy costs in excess of mitation (chapter 14)	A-8-3		OOCCUPATI ONAL THERAPY	67.00		30.00
0. 99 Ho	spice (non-distinct) (see			OADULTS & PEDIATRICS	30.00		30. 99
31.00 Adj	structions) justment for speech thology costs in excess of mitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES Provider CCN: 151309 Period: To 06/30/2014 Workshee Date/Tim 11/21/20 Cost Center Description Basi s/Code (2) Amount Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Worksheet A To/From Which the Amount is to be Adjusted 32.00 CAH HI T Adjustment for Depreciation and Interest 0 0.00 0.00 33.01 PROVIDER TAX B -1, 284, 486 ADMINI STRATI VE & GENERAL 13, 235 NURSI NG ADMINI STRATI ON 33.02 5.00 32.01 CAH HI T Adjustment for Depreciation and Interest 0 0.00 33.01 TUITION REIMBURSEMENT REFUND 33.01 B -1, 284, 486 ADMINI STRATI VE & GENERAL 5.00 5.00 33.03 MI SC. INCOME - AAG B -5, 527 ADMINI STRATI VE & GENERAL 5.00 5.00 33.04 MI SC. INCOME - NURSI NG ADMIN B -60 PHYSI CAL THERAPY 66.00 66.00 33.05 MI SC. INCOME - PT B -60 PHYSI CAL THERAPY 66.00 60.00 33.05 MI SC. INCOME - PT B -263 NURSI NG ADMINI STRATI ON 50.00 13.00 33.06 LINCE - SURGERY B -4, 307 OPERATI NG ROM 50.00 50.00 33.07 MI SC. INCOME - PLANT OPS B -50 OPERATI NG ROM 50.00 50.00	IS-2552-10
Cost Center Description Basi s/Code (2) Amount Cost Center Line # Wkst. A-7 32.00 CAH HI T Adj ustment for Depreciation and Interest 0 0 0.00 5.00 33.00 PROVI DER TAX B -1,284,486 ADMI NI STRATI VE & GENERAL 5.00 33.01 TUI TI ON REI MBURSEMENT REFUND B 13,225 NURSI NG ADMI NI STRATI VE & GENERAL 5.00 33.02 MI SC. INCOME - A&G B -1,284,486 ADMI NI STRATI VE & GENERAL 5.00 33.03 MI SC. INCOME - A&G B -1,324,486 ADMI NI STRATI VE & GENERAL 5.00 33.04 MI SC. INCOME - RADI OLOGY B -1,810 RADI OLOGY-DI AGNOSTI C 54.00 33.05 MI SC. INCOME - PT B -60 PHYSI CAL THERAPY 66.00 33.06 MI SC. INCOME - NURSI NG ADMI N B -263 NURSI NG ADMI NI STRATI ON 13.00 33.06 MI SC. INCOME - PT B -60 PHYSI CAL THERAPY 66.00 33.07 MI SC. INCOME - SURGERY B -4,307 OPERATI NG ROOM 50.00	Prepared:
1.002.003.004.005.0032.00CAH HI T Adj ustment for Depreciation and Interest00.0033.00PROVI DER TAXB-1,284,486 ADMI NI STRATI VE & GENERAL5.0033.01TUI TI ON REI MBURSEMENT REFUNDB13,235 NURSI NG ADMI NI STRATI ON13.0033.02MI SC. INCOME - A&GB-5,527 ADMI NI STRATI VE & GENERAL5.0033.04MI SC. INCOME - RADI OLOGYB-1,810 RADI OLOGY-DI AGNOSTI C54.0033.05MI SC. INCOME - NURSI NG ADMI NB-263 NURSI NG ADMI NI STRATI ON13.0033.06MI SC. INCOME - NURSI NG ADMI NB-263 NURSI NG ADMI NI STRATI ON13.0033.07MI SC. INCOME - NURSI NG ADMI NB-263 NURSI NG ADMI NI STRATI ON13.0033.08LOBBYI NGA-648 ADMI NI STRATI ON OF PLANT7.0033.09DONATI ONSA-11,463 ADMI NI STRATI VE & GENERAL5.0033.10NON-REI MBURSABLEA-143,990 ANESTHESI OLOGY53.0033.11NON-REI MBURSABLE ALCOHOLA-5,543 ADMI NI STRATI VE & GENERAL5.0033.12PHYSI CI AN RECRUI TMENTA-100,043 ADMI NI STRATI VE & GENERAL5.00	
32. 00CAH HIT Adjustment for Depreciation and Interest00.0033. 00PROVIDER TAXB-1, 284, 486 ADMINISTRATIVE & GENERAL5. 0033. 01TUITION REIMBURSEMENT REFUNDB13, 235 NURSING ADMINISTRATION13. 0033. 02MISC. INCOME - A&GB-5, 527 ADMINISTRATIVE & GENERAL5. 0033. 03MISC. INCOME - RADIOLOGYB-1, 810 RADIOLOGY-DIAGNOSTIC54. 0033. 04MISC. INCOME - PTB-60 PHYSICAL THERAPY66. 0033. 05MISC. INCOME - NURSING ADMINB-263 NURSING ADMINISTRATION13. 0033. 06MISC. INCOME - SURGERYB-4, 307 OPERATING ROOM50. 0033. 07MISC. INCOME - PLANT OPSB-50 OPERATION OF PLANT7. 0033. 08LOBBYINGA-648 ADMINISTRATIVE & GENERAL5. 0033. 09DONATIONSA-11, 463 ADMINISTRATIVE & GENERAL5. 0033. 10NON-REIMBURSABLEA-143, 990 ANESTHESI OLOGY53. 0033. 11NON-REIMBURSABLE ALCOHOLA-5, 543 ADMINISTRATIVE & GENERAL5. 0033. 12PHYSICIAN RECRUITMENTA-100, 043 ADMINISTRATIVE & GENERAL5. 00	ef.
Depreciation and InterestB-1,284,486 ADMINISTRATIVE & GENERAL5.0033.00PROVIDER TAXB13,235 NURSING ADMINISTRATION13.0033.01TUITION REIMBURSEMENT REFUNDB13,235 NURSING ADMINISTRATION13.0033.02MISC. INCOME - A&GB-5,527 ADMINISTRATIVE & GENERAL5.0033.03MISC. INCOME - RADIOLOGYB-1,810 RADIOLOGY-DIAGNOSTIC54.0033.04MISC. INCOME - PTB-60PHYSICAL THERAPY66.0033.05MISC. INCOME - NURSING ADMINB-263 NURSING ADMINISTRATION13.0033.06MISC. INCOME - PTB-4,307 OPERATING ROOM50.0033.07MISC. INCOME - PLANT OPSB-50 OPERATION OF PLANT7.0033.08LOBBYINGA-648 ADMINISTRATIVE & GENERAL5.0033.09DONATIONSA-11,463 ADMINISTRATIVE & GENERAL5.0033.10NON-REIMBURSABLEA-143,990 ANESTHESI OLOGY53.0033.11NON-REIMBURSABLE ALCOHOLA-5,543 ADMINISTRATIVE & GENERAL5.0033.12PHYSICIAN RECRUITMENTA-100,043 ADMINISTRATIVE & GENERAL5.00	
33.01TUITION REIMBURSEMENT REFUNDB13,235NURSING ADMINISTRATION13.0033.02MISC. INCOME - A&GB-5,527ADMINISTRATIVE & GENERAL5.0033.03MISC. INCOME - RADIOLOGYB-1,810RADIOLOGY-DIAGNOSTIC54.0033.04MISC. INCOME - PTB-60PHYSICAL THERAPY66.0033.05MISC. INCOME - NURSING ADMINB-263NURSING ADMINISTRATION13.0033.06MISC. INCOME - SURGERYB-4,307OPERATING ROM50.0033.07MISC. INCOME - PLANT OPSB-50OPERATION OF PLANT7.0033.08LOBBYINGA-648ADMINISTRATIVE & GENERAL5.0033.09DONATIONSA-114,463ADMINISTRATIVE & GENERAL5.0033.10NON-REIMBURSABLEA-143,990ANESTHESIOLOGY53.0033.11NON-REIMBURSABLE ALCOHOLA-5,543ADMINISTRATIVE & GENERAL5.0033.12PHYSICIAN RECRUITMENTA-100,043ADMINISTRATIVE & GENERAL5.00	0 32.00
33. 02MI SC.I NCOME- A&GB-5, 527 ADMI NI STRATI VE & GENERAL5. 0033. 03MI SC.I NCOME- RADI OLOGYB-1, 810 RADI OLOGY-DI AGNOSTI C54. 0033. 04MI SC.I NCOME- PTB-60 PHYSI CAL THERAPY66. 0033. 05MI SC.I NCOME- NURSI NG ADMI NB-263 NURSI NG ADMI NI STRATI ON13. 0033. 06MI SC.I NCOME- SURGERYB-4, 307 OPERATI NG ROOM50. 0033. 07MI SC.I NCOME- PLANT OPSB-50 OPERATI ON OF PLANT7. 0033. 08LOBBYI NGA-648 ADMI NI STRATI VE & GENERAL5. 0033. 09DONATI ONSA-11, 463 ADMI NI STRATI VE & GENERAL5. 0033. 10NON-REI MBURSABLEA-143, 990 ANESTHESI OLOGY53. 0033. 11NON-REI MBURSABLE ALCOHOLA-5, 543 ADMI NI STRATI VE & GENERAL5. 0033. 12PHYSI CI AN RECRUI TMENTA-100, 043 ADMI NI STRATI VE & GENERAL5. 00	0 33.00
33.03MI SC.I NCOMER ADI OLOGYB-1,810R ADI OLOGY-DI AGNOSTI C54.0033.04MI SC.I NCOME - PTB-60PHYSI CAL THERAPY66.0033.05MI SC.I NCOME - NURSI NG ADMI NB-263NURSI NG ADMI NI STRATI ON13.0033.06MI SC.I NCOME - SURGERYB-4,307OPERATI NG ROOM50.0033.07MI SC.I NCOME - PLANT OPSB-50OPERATI ON OF PLANT7.0033.08LOBBYI NGA-648ADMI NI STRATI VE & GENERAL5.0033.09DONATI ONSA-11,463ADMI NI STRATI VE & GENERAL5.0033.10NON-REI MBURSABLEA-143,990ANESTHESI OLOGY53.0033.11NON-REI MBURSABLE ALCOHOLA-5,543ADMI NI STRATI VE & GENERAL5.0033.12PHYSI CI AN RECRUI TMENTA-100,043ADMI NI STRATI VE & GENERAL5.00	0 33.01
33.04MI SC.I NCOME - PTB-60PHYSI CAL THERAPY66.0033.05MI SC.I NCOME - NURSI NG ADMI NB-263NURSI NG ADMI NI STRATI ON13.0033.06MI SC.I NCOME - SURGERYB-4,307OPERATI NG ROOM50.0033.07MI SC.I NCOME - PLANT OPSB-50OPERATI ON OF PLANT7.0033.08LOBBYI NGA-648ADMI NI STRATI VE & GENERAL5.0033.09DONATI ONSA-111,463ADMI NI STRATI VE & GENERAL5.0033.10NON-REI MBURSABLE ANESTHESI OLOGY CRNAA-143,990ANESTHESI OLOGY53.0033.11NON-REI MBURSABLE ALCOHOLA-5,543ADMI NI STRATI VE & GENERAL5.0033.12PHYSI CI AN RECRUI TMENTA-100,043ADMI NI STRATI VE & GENERAL5.00	0 33.02
33.05 MI SC. I NCOME - NURSI NG ADMI N B -263 NURSI NG ADMI NI STRATI ON 13.00 33.06 MI SC. I NCOME - SURGERY B -4,307 OPERATI NG ROOM 50.00 33.07 MI SC. I NCOME - PLANT OPS B -50 OPERATI ON OF PLANT 7.00 33.08 LOBBYI NG A -648 ADMI NI STRATI VE & GENERAL 5.00 33.09 DONATI ONS A -111,463 ADMI NI STRATI VE & GENERAL 5.00 33.10 NON-REI MBURSABLE ANESTHESI OLOGY CRNA A -143,990 ANESTHESI OLOGY 53.00 33.11 NON-REI MBURSABLE ALCOHOL A -5,543 ADMI NI STRATI VE & GENERAL 5.00 33.12 PHYSI CI AN RECRUI TMENT A -100,043 ADMI NI STRATI VE & GENERAL 5.00	0 33.03
33.06 MISC. INCOME - SURGERY B -4,307 OPERATING ROOM 50.00 33.07 MISC. INCOME - PLANT OPS B -50 OPERATION OF PLANT 7.00 33.08 LOBBYING A -648 ADMINISTRATIVE & GENERAL 5.00 33.09 DONATIONS A -11,463 ADMINISTRATIVE & GENERAL 5.00 33.10 NON-REI MBURSABLE ANESTHESI OLOGY CRNA A -143,990 ANESTHESI OLOGY 53.00 33.11 NON-REI MBURSABLE ALCOHOL A -5,543 ADMINISTRATIVE & GENERAL 5.00 33.12 PHYSI CI AN RECRUI TMENT A -100,043 ADMINISTRATIVE & GENERAL 5.00	0 33.04
33.07MI SC.I NCOME - PLANT OPSB-50OPERATION OF PLANT7.0033.08LOBBYI NGA-648ADMI NI STRATIVE & GENERAL5.0033.09DONATIONSA-11,463ADMI NI STRATIVE & GENERAL5.0033.10NON-REI MBURSABLEA-143,990ANESTHESI OLOGY53.0033.11NON-REI MBURSABLE ALCOHOLA-5,543ADMI NI STRATIVE & GENERAL5.0033.12PHYSI CI AN RECRUI TMENTA-100,043ADMI NI STRATI VE & GENERAL5.00	0 33.05
33.08LOBBYI NGA-648ADMI NI STRATI VE & GENERAL5.0033.09DONATI ONSA-11, 463ADMI NI STRATI VE & GENERAL5.0033.10NON-REI MBURSABLE ANESTHESI OLOGY CRNAA-143, 990ANESTHESI OLOGY53.0033.11NON-REI MBURSABLE ALCOHOLA-5, 543ADMI NI STRATI VE & GENERAL5.0033.12PHYSI CI AN RECRUI TMENTA-100, 043ADMI NI STRATI VE & GENERAL5.00	0 33.06
33. 09DONATI ONSA-11, 463ADMI NI STRATI VE & GENERAL5. 0033. 10NON-REI MBURSABLE ANESTHESI OLOGY CRNAA-143, 990ANESTHESI OLOGY53. 0033. 11NON-REI MBURSABLE ALCOHOLA-5, 543ADMI NI STRATI VE & GENERAL5. 0033. 12PHYSI CI AN RECRUI TMENTA-100, 043ADMI NI STRATI VE & GENERAL5. 00	0 33.07
33. 10NON-REI MBURSABLE ANESTHESI OLOGY CRNAA-143, 990ANESTHESI OLOGY53. 0033. 11NON-REI MBURSABLE ALCOHOLA-5, 543ADMI NI STRATI VE & GENERAL5. 0033. 12PHYSI CI AN RECRUI TMENTA-100, 043ADMI NI STRATI VE & GENERAL5. 00	0 33.08
ANESTHESI OLOGY CRNAA-5, 543 ADMI NI STRATI VE & GENERAL5. 0033. 11NON-REI MBURSABLE ALCOHOLA-100, 043 ADMI NI STRATI VE & GENERAL5. 0033. 12PHYSI CI AN RECRUI TMENTA-100, 043 ADMI NI STRATI VE & GENERAL5. 00	0 33.09
33. 12 PHYSI CI AN RECRUI TMENT A -100, 043 ADMI NI STRATI VE & GENERAL 5. 00	0 33.10
	0 33.11
	0 33.12
33. 13 0 0 0. 00	0 33.13
33.14 0 0.00	0 33.14
33.15 0 0.00	0 33.15
33.16 0 0.00	0 33.16
33.17 0 0.00	0 33.17
33.18 0 0.00	0 33.18
33.19 0 0.00	0 33.19
50.00 TOTAL (sum of lines 1 thru 49) -743,868	50.00
(Transfer to Worksheet A,	
column 6, line 200.)	

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	ST. VINCENT	CLAY HOSPITAL	In Lie	eu of Form CMS-	2552-10
STATEME	NT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	8-1
OFFI CE	COSTS			From 07/01/2013		
				To 06/30/2014	Date/Time Pre 11/21/2014 9:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	<u>44 uiii</u>
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:	T	1			
1.00			HOME OFFICE	1, 850, 239	801, 630	1.00
2.00			HOME OFFICE	101, 321	0	2.00
3.00		EMPLOYEE BENEFITS DEPARTMENT		184, 975	184, 975	3.00
3.01			ASCENSION CHARGEBACK	1, 031, 553	1, 031, 553	3.01
3.02		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ASCENSION CHARGEBACK	0	66, 719	3. 02
4.00		7.00 OPERATION OF PLANT		104, 794	104, 794	4.00
4.01			ASCENSION CHARGEBACK	53, 208	53, 208	4.01
4.02			ASCENSION CHARGEBACK	4, 176	4, 176	4.02
4.03	54.00	RADI OLOGY-DI AGNOSTI C	ASCENSION CHARGEBACK	11, 352	11, 352	4.03
4.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF-INSURANCE	903, 622	870, 500	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	138, 301	228, 510	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	15, 252	25, 201	4.06
4.07	14.00	CENTRAL SERVICES & SUPPLY	TRIMEDX	2, 314	2, 329	4.07
4.08	15.00	PHARMACY	TRIMEDX	590	594	4.08
4.09	30.00	ADULTS & PEDIATRICS	TRIMEDX	37, 590	37, 834	4.09
4.10	50.00	OPERATING ROOM	TRIMEDX	73, 132	73, 607	4.10
4.11	54.00	RADI OLOGY-DI AGNOSTI C	TRIMEDX	268, 396	270, 138	4.11
4.12	60.00	LABORATORY	TRIMEDX	36, 625	36, 863	4.12
4.13	65.00	RESPI RATORY THERAPY	TRIMEDX	1, 155	1, 163	4.13
4.14	69.00	ELECTROCARDI OLOGY	TRIMEDX	23, 386	23, 538	4.14
4.15	91.00	EMERGENCY	TRIMEDX	18, 996	19, 119	4.15
4.16	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	206, 847	56, 940	4.16
5.00	0		0	5, 067, 824	3, 904, 743	5.00

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

has not been posted to worksheet A, cordinas i and/or 2, the amount arrowable should be than cated in cordinary or this part.									
				Related Organization(s) and/					
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownership		Ownership				
	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 HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	В	ST. VINCENT HOS	100.00	ST. VINCENT HOS	100.00	7.00
8.00	G	ASCENSI ON	100.00	ASCENSION	100.00	8.00
9.00	A	TRI MEDX	0.00	TRIMEDX	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	HOME OFFICE				100.00
	non-financial) specify:					

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

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

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

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

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

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

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

Health Financial Systems	ST. VINCENT CLAY H	IOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FF	ROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 151309	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 07/01/2013	

UFFICE	0313				To 06/30/2014	Date/Time Prepared:
	Net	Wkst. A-7 Ref.				11/21/2014 9:44 am
	Adjustments	WKSL. A-7 Rel.				
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			ENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH DELATED O		
	HOME OFFICE COS	TS.	ENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED 0	KGANIZATIONS OK (
1.00	1, 048, 609	0				1.00
2.00	101, 321	0				2.00
3.00	0	0				3.00
3.01	0	0				3.0
3.02	-66, 719	0				3. 02
4.00	0	0				4.00
4.01	0	0				4.0
4.02	0	0				4.02
4.03	0	0				4.03
4.04	33, 122	0				4.04
4.05	-90, 209	9				4.05
4.06	-9, 949	0				4.00
4.07	-15	0				4.0
4.08	-4	0				4.08
4.09	-244	0				4.09
4.10	-475	0				4.10
4.11	-1, 742	0				4.11
4.12	-238	0				4.12
4.13	-8	0				4.13
4.14	-152	0				4.14
4.15	-123	0				4.15
4.16	149, 907	0				4.16
5.00	1, 163, 081					5.00

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

110	been posted to norksheet n,	conditions in and/or 2, the amount arrowable should be that cated in condition part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i ci indui			
6.00	ADMI NI STRATI ON		6.00
7.00	HOSPI TAL		7.00
8.00	ADMI NI STRATI ON		8.00
9.00	TECHNOLOGY MGMT		9.00
10.00			10.00
100.00		11	00.00

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

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

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

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

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

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

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

Health Financial Systems

ST. VINCENT CLAY HOSPITAL

In Lieu of Form CMS-2552-10

Hearth	Financial Syste	enis	ST. VINCENT	LAT HUSPITAL		IN LIG	eu or Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provi der	1	Period: From 07/01/2013 To 06/30/2014		
							11/21/2014 9:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		EMERGENCY	682, 969					1.00
2.00		RADI OLOGY-DI AGNOSTI C	20, 695				0	2.00
3.00		EMERGENCY	150, 000			-	-	3.00
4.00	0.00		130,000	0			0	4.00
4.00 5.00	0.00			0	3		0	
			0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			853, 664	170, 695	682, 969		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		EMERGENCY	0					1.00
2.00		RADI OLOGY-DI AGNOSTI C	0				-	2.00
3.00		EMERGENCY	0				0	3.00
4.00	0.00		0	0		-	0	4.00
4.00 5.00	0.00		0	0	-	-	0	5.00
			0	0	0	0	0	
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	0		1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	20, 695		2.00
3.00	91.00	EMERGENCY	0	0	0	150,000		3.00
4.00	0.00		0	0	0			4.00
5.00	0,00	4	0	0	0	0		5.00
6.00	0.00		0	0	-	0		6.00
7.00	0.00	4	0	-	-	0		7.00
8.00	0.00	4		0				8.00
8.00 9.00	0.00	4			-	-		9,00
10.00	0.00		-					10.00
200.00	1	l	0	0	0	170, 695		200. 00

	DE SUPPLIERS	<u>ST. VINCENT CL</u> FURNI SHED BY		CCN: 151309	Period: From 07/01/2013 To 06/30/2014	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 11/21/2014 9:	-3 pared:
					Physical Therapy	Cost	
						1.00	
	PART I - GENERAL INFORMATION						
. 00	Total number of weeks worked (excluding aides	s) (see instruct	ti ons)			52	1.00
2.00 3.00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	or or thoropics	was on provi	dor cito (co	o instructions)	780 300	2.00 3.00
4. 00	Number of unduplicated days in which supervise Number of unduplicated days in which therapy nor therapist was on provider site (see instr	assistant was o				9	4.00
5.00 5.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - there	apy assistants ((include only	visits made		0 0	5.00 6.00
	assistant and on which supervisor and/or ther instructions)	apist was not p	present during	the visit(s)) (see		
. 00	Standard travel expense rate					5.21	7.00
3.00	Optional travel expense rate per mile	-				0.00	8.00
		Supervi sors	Therapi sts	Assistants		Trai nees	
9.00	Total hours worked	1.00	2.00	3.00 3,952.	4.00 00 4,921.00	5.00	9.00
0.00		96. 31	77.05				
1.00		38. 53	38.53	28.	90		11.00
	one-half of column 2, line 10; column 3,						
2.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0		0		12.00
2.00	Number of travel hours (offsite)	0	0		0		12.00
3.00	Number of miles driven (provider site)	О	0		0		13.00
3. 01	Number of miles driven (offsite)	0	0		0		13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
						129, 633	
5.00 6.00						261, 200 228, 386	
6.00 7.00			atory therapy	or lines 14	-16 for all	619, 219	17.00
7.00	others)		atory therapy	of times 14		017, 217	17.00
8.00						189, 606	
9.00						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					808, 825	20.00
	occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete						
21.00	5 5 5			m of columns	1 and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3,						
2.00	0 Weighted allowance excluding aides and trainees (line 2 times line 21)						22 00
23.00	Total salary equivalency (see instructions)		3 1110 21)			0 808, 825	
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL		UTATION - PR	OVIDER SITE	-	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	ANCE AND TRAVEL		UTATION - PR	OVIDER SITE	808, 825	23.00
24.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	ANCE AND TRAVEL		UTATION - PR	OVI DER SI TE	808, 825	23.00 24.00
24.00 25.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)		EXPENSE COMP		OVI DER SI TE	808, 825 11, 559 260	23.00 24.00 25.00
24.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	EXPENSE COMP	II others)		808, 825	23.00 24.00 25.00 26.00
24.00 25.00 26.00 27.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	sum of lines 24 for respiratory	A and 25 for a therapy or s	ll others) um of lines	3 and 4 for all	808, 825 11, 559 260 11, 819 1, 610	23.00 24.00 25.00 26.00 27.00
24.00 25.00 26.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	sum of lines 24 for respiratory	A and 25 for a therapy or s	ll others) um of lines	3 and 4 for all	808, 825 11, 559 260 11, 819	23.00 24.00 25.00 26.00 27.00
24.00 25.00 26.00 27.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	sum of lines 24 for respiratory travel expense	A and 25 for a therapy or s	ll others) um of lines	3 and 4 for all	808, 825 11, 559 260 11, 819 1, 610	23.00 24.00 25.00 26.00 27.00
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel AllowanceTherapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of 	sum of lines 24 for respiratory travel expense Expense of columns 1 and	A and 25 for a therapy or s at the provid	ll others) um of lines	3 and 4 for all	808, 825 11, 559 260 11, 819 1, 610 13, 429	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel AllowanceTherapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, line 10 times column 3,	sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12)	A and 25 for a therapy or s at the provid	ll others) um of lines er site (sum	3 and 4 for all	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 30. 00 31. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum column 3, line 10 times column 3, subtotal (line 29 for respiratory therapy or	sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a	II others) um of lines er site (sum II others)	3 and 4 for all of lines 26 and	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 0	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum cAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3,	sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a	II others) um of lines er site (sum II others)	3 and 4 for all of lines 26 and	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0	23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00
24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 30. 00 31. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum cAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times columnscolumns 1-3, line 13 for all others)	sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line	A and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir	II others) um of lines er site (sum II others)	3 and 4 for all of lines 26 and	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00
24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 33.00 34.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times columnscolumns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and standard travel	sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an	II others) um of lines er site (sum II others) atory therap d 31)	3 and 4 for all of lines 26 and	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel	sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 25 s 1 and 2, line expense (line expense (sum of expense (sum of	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00
24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 33.00 34.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 25 s 1 and 2, line expense (line expense (sum of expense (sum of	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00
24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 33.00 34.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 25 s 1 and 2, line expense (line expense (sum of expense (sum of	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelColumns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelDotional travel allowance and standard travelDotional travel allowance and standard travelDotional travel allowance and standard travelDianal travel allowance and st	sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 25 s 1 and 2, line expense (line expense (sum of expense (sum of	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00
24.00 25.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and standard travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)	sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of NCE AND TRAVEL	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 20, 734 0 0 20, 734 0 0 0 20, 734 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 38.00
24.00 25.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travel optional travel allowance and standard travelStandard travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sum	sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 26 t and 2, line expense (line expense (sum of NCE AND TRAVEL	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 0 0 0 0 0 0 0 0 0 0	24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00
24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum columns 1, line 29 for respiratory therapy orOptional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional Travel	sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 a 1 and 2, line expense (line expense (sum of NCE AND TRAVEL n of lines 5 and Expense	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 20, 734 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 34.00 35.00 36.00 37.00 38.00 39.00
24.00 25.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional Travel	sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of expense (sum of NCE AND TRAVEL	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 20, 734 0 0 20, 734 0 0 0 20, 734 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum columns 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.0Assistants (column 3, line 12.01 times column	sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of expense (sum of NCE AND TRAVEL	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 20, 734 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00
44.00 55.00 66.00 77.00 88.00 99.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 10.00 10.00 11.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.0Assistants (column 3, line 12.01 times columnSubtotal (sum of lines 40 and 41)Optional travel expense (line 8 times the sum	sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (sum of expense (sum of expense (sum of NCE AND TRAVEL n of lines 5 and Expense 1 times column n 3, line 10) n of columns 1-3	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	II others) um of lines er site (sum II others) atory therap d 31) d 32) TATION - SER	3 and 4 for all of lines 26 and y or sum of VICES OUTSIDE PRC	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 20, 734 0 0 20, 734 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00
44.00 55.00 66.00 77.00 88.00 99.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 10.00 10.00 10.00 10.00 11.00 2.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.0Assistants (column 3, line 12.01 times columnSubtotal (sum of lines 40 and 41)Optional travel expense (line 8 times the sumTotal Travel Allowance and Travel Expense - 0	sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (sum of expense (sum of expense (sum of NCE AND TRAVEL n of lines 5 and Expense 1 times column n 3, line 10) n of columns 1-3	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	II others) um of lines er site (sum II others) atory therap d 31) d 32) TATION - SER	3 and 4 for all of lines 26 and y or sum of VICES OUTSIDE PRC	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 20, 734 0 0 20, 734 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00 37.00 37.00 38.00 37.000 37.000 37.000 37.0000000000
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 0. 000	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.01Assistants (column 3, line 12.01Assistants (column 3, line 14)Optional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.01Assistants (column 3, line 12.01Assistant	sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29 a 1 and 2, line expense (sum of expense (sum of NCE AND TRAVEL n of lines 5 and Expense 1 times column a 3, line 10) n of columns 1-3 offsite Services	EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU 4 6) 2, line 10) 3, line 13.01) 5; Complete on	II others) um of lines er site (sum II others) atory therap d 31) d 32) TATION - SER	3 and 4 for all of lines 26 and y or sum of VICES OUTSIDE PRC	808, 825 11, 559 260 11, 819 1, 610 13, 429 0 0 0 20, 734 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00

ASONABLE COST DETERMINATION FOR THERAPY SERVICES I ITSIDE SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151309	Period: From 07/01/2013 To 06/30/2014	Date/Time Pre 11/21/2014 9:	pared:
				Physical Therapy	Cost	
					1.00	
5.00 Optional travel allowance and optional travel	expense (sum o	of lines 42 an	d 43 - see ir	nstructions)	0	46.00
	Therapi sts	Assi stants	Ai des	Trai nees	Total	
	1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION 7.00 Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.00
period (if column 5, line 47, is zero or equal to or greater than 2,080, do not	0.00	0.00	0.0	0.00	0.00	47.00
complete lines 48-55 and enter zero in each column of line 56)						
3.00 Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00
0.00 Total overtime (including base and overtime	0.00	0.00				49.00
allowance) (multiply line 47 times line 48)	0.00	0.00		0100		
CALCULATION OF LIMIT						
0.00 Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.00
(divide the hours in each column on line 47						
by the total overtime worked - column 5, line 47)						
.00 Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51.00
for one full-time employee times the						
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE	77.05					
2.00 Adjusted hourly salary equivalency amount (see instructions)	77.05	57.79	38.5	0.00		52.00
8.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.0
52)	-	-		-		
1.00 Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
line 49 or line 53)		0				
5.00 Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55.00
line 47 times line 52)						
b.00 Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56.00
if negative enter zero) (Enter in column 5						
the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3						
for all others.)						
					1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
7.00 Salary equivalency amount (from line 23)	(from Linco 22	24 05 25))			808, 825	
 B. 00 Travel allowance and expense - provider site D. 00 Travel allowance and expense - Offsite service)		20, 734 0	
0.00 Overtime allowance (from column 5, line 56)	.63 (110///11163	44, 45, 01 40			0	
1.00 Equipment cost (see instructions)					0	
2.00 Supplies (see instructions)					0	
8.00 Total allowance (sum of lines 57-62)					829, 559	63.0
1.00 Total cost of outside supplier services (from	n your records)				585, 976	64.0
5.00 Excess over limitation (line 64 minus line 63	3 - if negative,	enter zero)			0	65.0
LINE 33 CALCULATION	oum of Linco 24	and 25 for a	ll athera		11 010	100.0
00.00 Line 26 = line 24 for respiratory therapy or 00.01 Line 27 = line 7 times line 3 for respiratory				others	11, 819 1, 610	
00.02 Line 33 = line 28 = sum of lines 26 and 27	therapy of Sui			other 3	13, 429	
LINE 34 CALCULATION						
01.00 Line 27 = line 7 times line 3 for respiratory	therapy or sum	n of lines 3 a	nd 4 for all	others	1, 610	
01.01 Line 31 = line 29 for respiratory therapy or	sum of lines 29) and 30 for a	II others			101.0
01.02 Line 34 = sum of lines 27 and 31					1, 610	101. 0
LINE 35 CALCULATION	cum of Linco 20	and 20 for -	11 others			102 0
02.00 Line 31 = line 29 for respiratory therapy or 02.01 Line 32 = line 8 times columns 1 and 2, line				imps 1_3 line		102. 0 102. 0
13 for all others	is for respirat	ory therapy 0			0	102.0

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	ST. VI NCENT CI FURNI SHED BY			In Lie Period: From 07/01/2013 To 06/30/2014 Occupational Therapy	u of Form CMS- Worksheet A-8 Parts I-VI Date/Time Pre 11/21/2014 9: Cost	-3 pared:	
						1.00		
1 00	PART I - GENERAL INFORMATION	a) (aaa imatrus	ti ana)			F.2	1 00	
1.00 2.00	Total number of weeks worked (excluding aide: Line 1 multiplied by 15 hours per week	s) (see instruc	trons)			52 780	1	
3.00 4.00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy	assistant was				189 0	1	
5.00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe		apists (see in	structions)		0	5.00	
6.00	assistant and on which supervisor and/or the	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy 0 6. assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						
7.00	Standard travel expense rate					5. 21		
8.00	Optional travel expense rate per mile	Ai des	0.00 Trai nees	8.00				
	1	Supervi sors 1.00	Therapists 2.00	Assistants 3.00	4.00	5.00		
9.00 10.00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	788.00 73.04	0.0		0.00	9.00 10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36. 52	36.52	0.0		0.00	11.00	
12.00	Number of travel hours (provider site)	0	0		b		12.00	
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0				12.01 13.00	
13.00	Number of miles driven (offsite)	0	0		5		13.00	
						1.00		
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0 57, 556		
16.00	Assistants (column 3, line 9 times column 3,					0		
17.00	Subtotal allowance amount (sum of lines 14 al others)	nd 15 for respi	ratory therapy	or lines 14-	16 for all	57, 556	17.00	
18.00	Aides (column 4, line 9 times column 4, line	10)				0	18.00	
19.00 20.00	Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17–19 fo		thoropy or lin	oc 17 and 19 t	For all others)	0 57, 556	19.00 20.00	
20.00	If the sum of columns 1 and 2 for respiratory	/ therapy or co	lumns 1-3 for	physical thera	apy, speech path	ology or	20.00	
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		no entries on	lines 21 and 2	22 and enter on	line 23		
21.00	Weighted average rate excluding aides and tra	ainees (line 17		m of columns '	1 and 2, line 9	0.00	21.00	
22.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train					0	22.00	
23.00	Total salary equivalency (see instructions)					57, 556	23.00	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVE	L EXPENSE COMP	UTATION - PROV	TIDER SITE		-	
	Therapists (line 3 times column 2, line 11)					6, 902		
25.00 26.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	others)		0 6, 902		
27.00	Standard travel expense (line 7 times line 3				and 4 for all	985		
28.00	others) Total standard travel allowance and standard 27)	travel expense	e at the provid	er site (sum o	of lines 26 and	7, 887	28.00	
	Optional Travel Allowance and Optional Travel							
29.00 30.00	Therapists (column 2, line 10 times the sum a Assistants (column 3, line 10 times column 3		nd 2, line 12)			0		
30.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for a	II others)		0	31.00	
32.00	Optional travel expense (line 8 times column				or sum of	0	32.00	
33.00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave	expense (line	28)			7, 887	33.00	
34.00	Optional travel allowance and standard trave			d 31)		0	34.00	
35.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				CES OUTSIDE PRO	0 VIDER SITE	35.00	
36.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0		
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	n of lines 5 ar	d 6)			0		
J 7. UU	Optional Travel Allowance and Optional Travel					0	37.00	
40.00	Therapists (sum of columns 1 and 2, line 12.)	01 times column	2, line 10)			0	•	
41.00 42.00	Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	n 3, line 10)				0		
42.00	Optional travel expense (line 8 times the su					0		
	Total Travel Allowance and Travel Expense - (or 46, as appropriate.	Offsite Service	s; Complete on	e of the follo	owing three line	es 44, 45,		
44.00	Standard travel allowance and standard trave	expense (sum	of lines 38 an	d 39 - see ins	structions)	0	44.00	
11/01/	2014 9:44 am Y:\28250 - St. Vincent Clav\300	Madi cara Cact	Doport\ 201404	21\ 20250 14 m	262			

15.00 16.00					From 07/01/2013 To 06/30/2014		
					Therapy		
						1.00	
·6. UU	Optional travel allowance and standard travel					0	
	Optional travel allowance and optional travel	Therapi sts	of lines 42 an Assistants	Ai des	Trai nees	0 Total	46.00
	-	1.00	2.00	3.00	4.00	5.00	
17.00	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting	0.00	0.00	0.00	0.00	0.00	47.00
.7.00	period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00		0.00	47.00
18.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
9.00	Total overtime (including base and overtime	0.00	0.00	0.00	0.00		49.00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						1
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0. 00	0.00	0.00	0.00	0. 00	50.00
1. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE			I			1
2.00	Adjusted hourly salary equivalency amount (see instructions)	73.04	0.00	0.00	0.00		52.00
3. 00	Overtime cost limitation (line 51 times line 52)	0	0	(0 0		53.00
4.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	(0 0		54.00
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	(0 0		55.00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3	0	0	(0	0	56.00
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
8.00 9.00 0.00 1.00 2.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62)	•)		57, 556 7, 887 0 0 0 0 0 65, 443	58.00 59.00 60.00 61.00 62.00
5.00	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	- if negative				39, 084 0	65.00
00. 01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others	985	100. 00 100. 01 100. 02
01. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				nns 1-3, line		102. 00 102. 01

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	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151309	Peri od: From 07/01/2013 To 06/30/2014 Speech Pathology	Date/Time Pre 11/21/2014 9:	pared:
						1.00	
	PART I – GENERAL INFORMATION						
1.00 2.00 3.00 4.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy nor therapist was on provider site (see inst	sor or therapist assistant was o	t was on provi			32 480 46 0	2.00 3.00
5.00 6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther instructions)	rvisors or thera	(include only	visits made		0	
7.00	Standard travel expense rate					5.21	
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8.00
		1.00	2.00	3.00	4.00	5.00	
9.00 10.00 11.00	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0. 00 0. 00 35. 10	169. 00 70. 20 35. 10	0.	00 0.00 00 0.00 00		
12. 01 13. 00	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (offsite)	0 0 0 0	0 0 0 0		0 0 0		12.00 12.01 13.00 13.01
				1		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						1 4 4 9 9
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0 11, 864	
	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 ar others)	line10)	ratory therapy	or lines 14	-16 for all	0 11, 864	16.00
	0 Aides (column 4, line 9 times column 4, line 10) 0 Trainees (column 5, line 9 times column 5, line 10)						18.00 19.00 20.00
21. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra	lines 21-23.				70.20	21.00
	for respiratory therapy or columns 1 thru 3,	line 9`for all	others)				
22. 00 23. 00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)		-			33, 696 33, 696	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	IANCE AND TRAVEL	_ EXPENSE COMP	UTATION - PR	OVIDER SITE		-
	Therapists (line 3 times column 2, line 11)					1, 615	24.00
	Assistants (line 4 times column 3, line 11)		4			0	
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				3 and 4 for all	1, 615 240	
28. 00	others) Total standard travel allowance and standard	travel expense	at the provid	er site (sum	of lines 26 and	1, 855	28.00
	27) Optional Travel Allowance and Optional Travel	Fynense					-
29. 00	Therapists (column 2, line 10 times the sum of		d 2, line 12)			0	29.00
30.00	Assistants (column 3, line 10 times column 3,	,				0	
31. 00 32. 00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns				y or sum of	0	1
33.00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel	expense (line	28)			1, 855	33.00
34.00	Optional travel allowance and standard travel			d 31)		0	
35.00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense				VICES OUTSIDE PRO	OVIDER SITE	35.00
36.00	Therapists (line 5 times column 2, line 11)					0	
37.00	Assistants (line 6 times column 3, line 11)					0	1
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur		d 6)			0	
40.00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0		2. line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times column		_,			0	1
42.00 43.00	Subtotal (sum of lines 40 and 41)	n of columps 1 '	3 lina 12 01)			0	
	Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - C or 46, as appropriate.	Offsite Services	s; Complete on	e of the fol	0	es 44, 45,	
44.00	Standard travel allowance and standard travel Optional travel allowance and standard travel						44.00 45.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151309	Period: From 07/01/2013 To 06/30/2014		pared:
					Speech Pathology	Cost	
						1.00	
16.00	Optional travel allowance and optional travel					0	46.0
		Therapists	Assi stants	Ai des	Trai nees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting	0.00	0.00	0.	0.00	0.00	47. C
1.00	period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.1	0.00	0.00	47.0
8.00	Overtime rate (see instructions)	0.00	0.00	0.	0. 00		48.0
19.00	Total overtime (including base and overtime	0.00	0.00	0.	0.00		49.0
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT					0.00	
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0. (0.00	0.00	50.0
51.00	Allocation of provider's standard work year	0.00	0.00	0.	0. 00	0.00	51. C
	for one full-time employee times the	0100	0100		0.00	0.00	
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount	70. 20	0.00	0.	0.00		52. (
	(see instructions)		0				
53.00	Overtime cost limitation (line 51 times line	0	0		0 0		53.0
54.00	52) Maximum overtime cost (enter the lesser of	о	0		0 0		54.0
55.00	line 49 or line 53) Portion of overtime already included in	0	0		0 0		55.0
55.00	hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.0
56.00	Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56. (
	if negative enter zero) (Enter in column 5	Ŭ	0		0	Ū	
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
57.00	Salary equivalency amount (from line 23)					33, 696	57.(
	Travel allowance and expense - provider site					1, 855	
	Travel allowance and expense - Offsite servic	es (from lines)	44, 45, or 46)		0	
	Overtime allowance (from column 5, line 56)					0	
1.00	Equipment cost (see instructions)					0	
2.00	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					35, 551	
	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63		optor zoro)			12, 987	65.0
5.00	LINE 33 CALCULATION	s - Ti negative,	enter zero)			0	05.0
00.00	Line 26 = line 24 for respiratory therapy or	sum of lines 24	4 and 25 for a	others		1, 615	100. (
00.01	Line 27 = line 7 times line 3 for respiratory	therapy or sur	m of lines 3 a	nd 4 for all	others		100. (
	Line 33 = line 28 = sum of lines 26 and 27	15				1, 855	
	LINE 34 CALCULATION						1
	Line 27 = line 7 times line 3 for respiratory				others	240	101.
	Line 31 = line 29 for respiratory therapy or	sum of lines 20	9 and 30 for a	II others		0	101. 101.
	Line 34 = sum of lines 27 and 31						1101

LINE 35 CALCULATION	
102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0 102.00
102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line	0 102. 01
13 for all others	
102.02 Line 35 = sum of lines 31 and 32	0 102. 02

COST ALL			AY HOSPITAL			u of Form CMS-:	2552-10
	OCATION - GENERAL SERVICE COSTS		Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet B Part I Date/Time Pre	pared:
			CAPI	TAL RELATED	COSTS	11/21/2014 9:	44 am
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	MOB	EMPLOYEE	
		for Cost Allocation				BENEFI TS DEPARTMENT	
		(from Wkst A				DEPARTMENT	
		col. 7)					
		0	1.00	2.00	2.01	4.00	
	NERAL SERVICE COST CENTERS	400.047	100.047				1 1 00
	100 CAP REL COSTS-BLDG & FIXT	133, 847	133, 847	893, 25	7		1.00
	0200 CAP REL COSTS-MVBLE EQUIP 0201 CAP REL COSTS-MOB	893, 257 257, 460		893, 20	0 257, 460		2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	1, 857, 277	0		0 237,400	1, 857, 277	4.00
	0500 ADMI NI STRATI VE & GENERAL	3, 852, 232	49, 898	325, 92	-	527, 531	5.00
	0700 OPERATION OF PLANT	771, 584	27, 468	179, 41		98, 927	7.00
8.00 00	0800 LAUNDRY & LINEN SERVICE	38, 662	2, 871	18, 75	2 0	0	8.00
9.00 00	900 HOUSEKEEPI NG	329, 346	1, 592	10, 39	9 0	0	9.00
	000 DI ETARY	182, 530	3, 536	23, 09		0	10.00
	100 CAFETERI A	138, 766	2, 006	13, 10		0	11.00
	300 NURSING ADMINISTRATION	287,083		20, 47		85, 908	•
	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY	13, 718			0 0	0	14.00 15.00
	600 MEDICAL RECORDS & LIBRARY	783, 704 194, 414	1, 571 13, 928	10, 26 90, 97		60, 815	
	IPATIENT ROUTINE SERVICE COST CENTERS	174,414	13, 720	70, 71	4 0	00, 013	10.00
	8000 ADULTS & PEDI ATRI CS	986, 566	9, 041	59, 05	6 0	324, 875	30.00
	ICI LLARY SERVI CE COST CENTERS						
	000 OPERATING ROOM	570, 888	3, 712	24, 24	4 0	158, 182	50.00
	300 ANESTHESI OLOGY	781	0		0 0	0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	951, 937	2, 574	16, 81		221, 871	54.00
		1,074,518		13, 74		360	
	500 RESPI RATORY THERAPY 5600 PHYSI CAL THERAPY	149, 310 638, 754	2, 538 0	16, 57	0 30, 281	43, 584 0	65.00 66.00
	000 OCCUPATI ONAL THERAPY	42,046	0		0 30, 281	0	67.00
	5800 SPEECH PATHOLOGY	13, 057	0		0 0	0	68.00
	900 ELECTROCARDI OLOGY	129, 924	0		0 0	37, 724	69.00
	2000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	506, 580	0		0 0	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	290, 111	0		0 0	0	72.00
	300 DRUGS CHARGED TO PATIENTS	1, 209	0		0 0	0	73.00
	ITPATIENT SERVICE COST CENTERS	1 5 (/ 0.42	7 440	40.74		293, 614	01 00
	2000 OBSERVATION BEDS (NON-DISTINCT PART)	1, 566, 042	7, 448	48, 64	.6 0	293, 614	91.00 92.00
	ECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	16, 655, 603	133, 422	871, 48	4 53, 372	1, 853, 391	1118.00
	NREI MBURSABLE COST CENTERS					.,	1
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	344	2, 24	7 0	0	190.00
	2200 PHYSI CLANS' PRI VATE OFFI CES	14, 504	0		0 204, 088		192.00
	2300 NONPALD WORKERS	0	0		0 0		193.00
	2301 CLAY CITY MEDICAL CLINIC	0	0	18, 99			193.01
	2302 PUBLI C RELATI ONS	10, 282	81	53			193.02
	2303 FOUNDATION	0	0		0 0		193.03
	2304 MI SSI ON SERVI CES 2305 OTHER NON-REI MBURSABLE	2, 443 101, 321	0				193.04 193.05
170.00119		101, 321	0		0	0	200.00
	LUFOSS FOOT ADJUSTMENTS						
200.00 201.00	Cross Foot Adjustments Negative Cost Centers		0		0 0	0	201.00

COST ALLOC	ATION - GENERAL SERVICE COSTS		Provi der	CCN: 151309	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part I Date/Time Pre 11/21/2014 9:	pared: 44 am
	Cost Center Description	Subtotal	ADMI NI STRATI VE & GENERAL	PLANT	F LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
05115		4A	5.00	7.00	8.00	9.00	<u> </u>
	RAL SERVICE COST CENTERS						1
	0 CAP REL COSTS-BLDG & FIXT						1.00
	O CAP REL COSTS-MVBLE EQUIP						2.00
	1 CAP REL COSTS-MOB						2.01
	O EMPLOYEE BENEFITS DEPARTMENT						4.00
	0 ADMINISTRATIVE & GENERAL	4, 768, 420			- /		5.00
	O OPERATION OF PLANT	1,077,394	427, 562				7.00
	O LAUNDRY & LINEN SERVICE	60, 285	23, 924				8.00
	O HOUSEKEEPI NG	341, 337	135, 459			519, 950	
	DI ETARY	209, 165	83, 007			0	
	O CAFETERI A	153, 874	61, 065			0	
	O NURSING ADMINISTRATION	396, 595	157, 388			0	
	0 CENTRAL SERVICES & SUPPLY	13, 718	5, 444		0 0	0	
	0 PHARMACY	795, 536	315, 707			0	
16.00 0160	0 MEDICAL RECORDS & LIBRARY	360, 131	142, 917	333, 84	47 0	0	16.00
	TI ENT ROUTI NE SERVI CE COST CENTERS			1			4
	0 ADULTS & PEDIATRICS	1, 379, 538	547, 467	216, 7	16 46, 441	265, 129	30.00
	LLARY SERVICE COST CENTERS	1					4
	O OPERATING ROOM	757, 026	300, 424			134, 014	
	0 ANESTHESI OLOGY	781	310		0 0	0	53.00
	0 RADI OLOGY-DI AGNOSTI C	1, 193, 195	473, 517			40, 269	
	0 LABORATORY	1, 100, 989	436, 925			40, 269	
	0 RESPI RATORY THERAPY	212, 011	84, 136			0	
	0 PHYSI CAL THERAPY	669, 035	265, 505			0	
	O OCCUPATIONAL THERAPY	42,046	16, 686		0 0	0	
	O SPEECH PATHOLOGY	13, 057	5, 182		0 0	0	
	0 ELECTROCARDI OLOGY	167, 648	66, 531		0 0	0	
	0 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	506, 580	201, 035		0 0	0	
	O IMPL. DEV. CHARGED TO PATIENTS	290, 111	115, 130		0 0	0	
	0 DRUGS CHARGED TO PATIENTS	1, 209	480		0 0	0	73.00
	ATIENT SERVICE COST CENTERS	1 045 750	7/0.0/0	170 5		10.0/0	1
	0 EMERGENCY	1, 915, 750	760, 260	178, 51	16 46, 459	40, 269	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
	TAL PURPOSE COST CENTERS	14 405 401	4 (0) 0(1	1 404 7	(4 152.005	F10.0F0	1110 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	16, 425, 431	4, 626, 061	1, 494, 70	64 153, 025	519, 950	1118.00
	ELMBURSABLE COST CENTERS	2 501	1 000	0.0	47 0	0	1100 0
	0 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 591	1, 028				190.00
	0 PHYSI CI ANS' PRI VATE OFFI CES	218, 592	86, 748		0 0		192.00
	NONPALD WORKERS	0	0		0 0		193.00
	1 CLAY CITY MEDICAL CLINIC	18, 996	7, 539		0 0		193.01
	2 PUBLIC RELATIONS	14, 395	5, 713				193.02
		0	0		0 0		193.0
	4 MISSION SERVICES	2,827	1, 122		0 0		193.04
	05 OTHER NON-REI MBURSABLE	101, 321	40, 209		0 0	0	193.05
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	16, 784, 153	4, 768, 420	1, 504, 95	56 153, 025	519, 950	1202.0

	Financial Systems	ST. VINCENT CL				u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151309	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part I Date/Time Prep 11/21/2014 9:4	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI C	SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 CAP REL COSTS-MOB						2.01
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY	376, 937					10.00
	01100 CAFETERIA	0,0,707	263, 020				11.00
	01300 NURSI NG ADMI NI STRATI ON	0	13, 232		32		13.00
	01400 CENTRAL SERVICES & SUPPLY	0	. c, 202		0 19, 162		14.00
	01500 PHARMACY	0	C		0 0	1, 148, 899	15.00
	01600 MEDICAL RECORDS & LIBRARY	0	21, 237	7	0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	•					
30.00	03000 ADULTS & PEDIATRICS	376, 937	71, 427	342, 33	38 0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	35, 797	85, 88		0	50.00
	05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	43, 595		0 0	0	54.00
	06000 LABORATORY	0	83		0 0	0	60.00
65.00		0	10, 494		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	C		0 0	0	67.00 68.00
	06900 ELECTROCARDI OLOGY	0	7, 425		0 0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	7,420		0 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 19, 162	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	1, 148, 899	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	59, 564	1 214, 11	1 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		376, 937	262, 854	642, 33	32 19, 162	1, 148, 899	118.00
	NONREI MBURSABLE COST CENTERS			1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	C		0 0		192. 00 193. 00
	19300 NONPALD WORKERS 19301 CLAY CITY MEDICAL CLINIC	0			0 0		193.00 193.01
	19302 PUBLIC RELATIONS	0	C C			1	193.01
102 (17)	19303 FOUNDATI ON		C				193.02
		0			0 0	1	193.03
193.03		0	166		() ()		
193. 03 193. 04	19304 MI SSI ON SERVI CES	0	166 C		0 0		
193. 03 193. 04	19304 MISSION SERVICES 19305 OTHER NON-REIMBURSABLE	0	166 C)	0 0	0	193.05
193. 03 193. 04 193. 05	19304 MISSION SERVICES 19305 OTHER NON-REIMBURSABLE Cross Foot Adjustments	0	166 C			0	

Heal th	Financial Systems	ST. VINCENT CL	AY HOSPITAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - GENERAL SERVICE COSTS			CCN: 151309	Peri od:	Worksheet B	
					From 07/01/2013	Part I	
					To 06/30/2014	Date/Time Pre	
		NEDLOAL			11/21/2014 9:	44 am
	Cost Center Description	MEDI CAL	Subtotal	Intern &	Total		
		RECORDS &		Residents Cos	st		
		LI BRARY		& Post			
				Stepdown			
		16.00	24.00	Adjustments			
		16.00	24.00	25.00	26.00		
1 00	GENERAL SERVICE COST CENTERS	1					1 1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
2.00							2.00
2.01	00201 CAP REL COSTS-MOB						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	858, 132					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	56, 597	3, 302, 590		0 3, 302, 590		30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	100, 014	1, 524, 458		0 1, 524, 458		50.00
53.00	05300 ANESTHESI OLOGY	0	1, 091		0 1, 091		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	276, 199	2, 114, 595		0 2, 114, 595		54.00
60.00	06000 LABORATORY	141, 965	1, 808, 925		0 1, 808, 925		60.00
65.00	06500 RESPI RATORY THERAPY	9, 356	376, 838		0 376, 838		65.00
66.00	06600 PHYSI CAL THERAPY	55, 703	1, 109, 809		0 1, 109, 809		66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 412	62, 144		0 62, 144		67.00
68.00	06800 SPEECH PATHOLOGY	369	18, 608		0 18, 608		68.00
69.00	06900 ELECTROCARDI OLOGY	30, 832	272, 436		0 272, 436		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	726, 777		0 726, 777		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	405, 241		0 405, 241		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 150, 588		0 1, 150, 588		73.00
, 01 00	OUTPATIENT SERVICE COST CENTERS		.,	1	1,100,000		10100
91.00	09100 EMERGENCY	183, 685	3, 398, 614		0 3, 398, 614		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,000	0,0,0,011		0		92.00
72100	SPECIAL PURPOSE COST CENTERS	II		1			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
118.00		858, 132	16, 272, 714		0 16, 272, 714		118.00
110.00	NONREI MBURSABLE COST CENTERS	030, 132	10, 272, 714	1	0 10,272,714		
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 866		0 11,866		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	305, 340		0 305, 340		192.00
	19300 NONPALD WORKERS	0	000, 040 0		0 0		193.00
	19301 CLAY CITY MEDICAL CLINIC		26, 535		0 26, 535		193.00
		0					193.01
	19302 PUBLIC RELATIONS 19303 FOUNDATION	0	22, 053		0 22,053		193. 02 193. 03
			U 4 115		-		
	19304 MI SSI ON SERVI CES	0	4, 115		0 4, 115		193.04
	19305 OTHER NON-REI MBURSABLE	0	141, 530		0 141, 530		193.05
200.00			0		0 0		200.00
201.00	5	0	14 704 150		0 0 0		201.00
202.00	TOTAL (sum lines 118-201)	858, 132	16, 784, 153	I	0 16, 784, 153		202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CON 151309 Provider CON 1510000000 Provider CON 15130000000 <thp< th=""><th>Heal th</th><th>Financial Systems</th><th>ST. VINCENT CI</th><th>LAY HOSPITAL</th><th></th><th>In Lie</th><th>u of Form CMS-</th><th>2552-10</th></thp<>	Heal th	Financial Systems	ST. VINCENT CI	LAY HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Center Description Directly Assigned New Capped New Bible Costs CAPITAL BLATE COSTS Subtotal ELREAL SERVICE COST CENTERS 0	ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	CCN: 151309	From 07/01/2013	Part II Date/Time Pre	epared: 44 am
Assigned few Capit tal Related Costs Assigned few Capit tal Related Costs Assigned few Capit tal Related Costs Assigned few Capit tal Related Costs 1.00 00200 CAP REL COST CENTERS 1.00 2.00 2.01 2A 1.00 00200 CAP REL COST S-BLOG & FIXT 0 0.00 2.01 <td></td> <td></td> <td></td> <td>CAPI</td> <td>TAL RELATED</td> <td>COSTS</td> <td></td> <td></td>				CAPI	TAL RELATED	COSTS		
ENERGAL SERVICE COST CENTERS 1.00 000100 CAP FIEL COSTS-MUG & FUXT 0 0.00 <		Cost Center Description	Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	MOB	Subtotal	
1.00 OtOTOD CAP REL COSTS-HUDE & FLXT 1.00 2.01 OD2001 CAP REL COSTS-WOBE 2.01 2.01 OD2001 CAP REL COSTS-WOBE 2.01 2.01 OD2001 CAP REL COSTS-WOBE 2.01 0.00 OD4000 DEPLOYTE BENERT IS DEPARTIENT 0 2.04, 68 7.0 0.700 0.00 OD6000 ADMINISTRATIVE & GENERAL 290, 527 24, 648 179, 415 0 206, 883 7.00 0.00 OD6000 HUSEKEEPING 0 2, 77 18, 752 0 21, 623 8.00 0.00 OD0000 HUSEKEEPING 0 3, 334 20, 470 0 13, 00 113, 00 0 0 0 14, 00 1.00 OTIOOD CENTRAL SERVICES & SUPPLY 0 0 0 0 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 16, 00 16, 00 16, 00 16, 00 16, 00 16, 00 16, 00 16, 00 16, 00 16, 00			0	1.00	2.00	2.01	2A	
2.00 002001 CAP REL COSTS-WUBL E FOULP 0			1					
9.00 000000 HUSEKEEPING 0 1,592 10,399 0 11,991 9.00 11.00 01100 CAFETERIA 0 2,064 13,102 0 15,108 11.00 13.00 01300 CAFETERIA 0 2,064 13,102 0 13,00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 14,00 15.00 01500 PHARMACY 0 1,1,921 0 14,00 16.00 01600 PHARMACY 0 1,571 10,261 0 14,00 16.00 01600 014,002 13,228 90,974 0 104,902 16.00 01 000 000 0 3,712 24,244 0 27,956 50.00 01 05300 PRDI ATRIC SCONT 0 2,574 16,813 0 19,837 54.00 00 0000 0 0 0 0 0 0	2.00 2.01 4.00 5.00 7.00	00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MOB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	27, 468	179, 41	5 0	679, 184 206, 883	2.00 2.01 4.00 5.00 7.00
15:00 015:00 PHARMACY 0 1.571 1.0.261 0 11.832 15:00 10:00 0000 MEDI CAL RECORDS & LI BRARY 0 30.90 90.974 0 104.902 16:00 1NPATI ENT ROUTI NE SERVICE COST CENTERS 0 9.041 59.056 0 68.097 30:00 05000 (ABULICAL RECORDS & LI BRARY 0 3.712 24.244 0 27.956 50.00 30:00 05000 (ABURSTHESI OLOGY 0 0 0 0 53.00 50:00 05000 (ABURSTHESI OLOGY 0 2.574 16.813 0 19.387 54.00 60:00 06000 (ABURATORY 0 2.538 16.579 0 19.117 65.00 66:00 06000 PHYSICAL THERAPY 0 0 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 68.00 0 0 0 0 67.00 68.00	9.00 10.00 11.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A		1, 592 3, 536 2, 006	10, 39 23, 09 13, 10	09 0 09 0 02 0	11, 991 26, 635 15, 108	9.00 10.00 11.00
ANCLLARY SERVICE COST CENTERS ANCLLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 3, 712 24, 244 0 27, 956 50.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 54.00 05400 RADI OLOGY -DI AGNOSTI C 0 2, 574 16, 813 0 19, 387 54.00 00 0 0 2, 105 13, 749 10, 257 26, 111 60.00 66.00 6600 PHYSI CAL THERAPY 0 2, 538 16, 579 0 19, 117 65.00 66.00 06600 SPEECH PATHORY THERAPY 0 0 0 0 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 67.00 68.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 7	15.00	01500 PHARMACY 01600 MEDI CAL_RECORDS & LI BRARY	-	1, 571		0	11, 832	15.00
50.00 05000 0PERATING ROOM 0 3, 712 24, 244 0 27, 956 50.00 53.00 05300 ANESTHESI OLOGY 0<	30.00		0	9, 041	59, 05	6 0	68, 097	30.00
54.00 05400 RADI OLOGY-JI AGNOSTI C 0 2,574 16,813 0 19,387 54.00 60.00 06000 RESPI RATORY 0 2,105 13,749 10,257 26,111 60.00 65.00 06500 RESPI RATORY THERAPY 0 2,538 16,579 0 19,117 65.00 66.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 66.00 68.00 68.00 06800 SPECH PATHOLOGY 0 0 0 67.00 67.00 69.00 0 0 0 0 67.00 67.00 69.00 0 0 0 0 68.00 0 69.00 0 0 0 0 0 0 70.00 70.00 70.00 70.00 70.00 70.00 70.00 71.00 73.00 0 0 0 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.88 64.64 0 56.094 91.00 92.00 92.00 92.015		05000 OPERATING ROOM	0		24, 24		27, 956	
60.00 06000 LABORATORY 0 2,105 13,749 10,257 26,111 60.00 65.00 06500 RESPIRATORY THERAPY 0 2,538 16,579 0 19,117 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 30,281 30,281 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 67.00 69.00 06900 ELECTROCARDI OLOGY 0			0	°,	16, 81	-	-	
66.00 06600 PHYSI CAL THERAPY 0 0 30,281 30,281 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 0 66.00 68.00 OBGOO CUPATI ONAL THERAPY 0			0					
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 0 67.00 68.00 69.00 70.00 71.00 72.00 70.00 71.00 72.00 72.00 70.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.0	65.00	06500 RESPI RATORY THERAPY	0	2, 538	16, 57		19, 117	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 0 <th< td=""><td></td><td></td><td>0</td><td>-</td><td></td><td>0 30, 281</td><td>30, 281</td><td></td></th<>			0	-		0 30, 281	30, 281	
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 69.00 70.00 70.00 COTOOD ELECTROCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 0 70.00 COLCAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71.00 0 0 0 0 0 0 0 71.00 COLCAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72.00 73.00 0 0 0 0 0 0 72.00 73.00 0 0 0 0 0 73.00 0 0 0 0 0 73.00 0 0 0 74.48 48,646 0 56,094 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00<			0	0		0 0		
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL 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 OT300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 7.448 48,646 0 56,094 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 7.448 48,646 0 56,094 91.00 92.00 OBSERVATION BEDS (SUM OF LINES 1-117) 290,527 133,422 871,484 53,372 1,348,805 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 2,991 190.00 192.00 IPVSI CLANS' PRI VATE OFFICES 0 0 0 0 193.00 193.00 19300 IPSCI AL PURPOSE COST CENTERS <			0	0		0 0	-	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 72.00 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 72.00 00 0 0 0 0 0 0 0 0 0 72.00 00 0 0 0 0 0 0 0 0 0 72.00 72.00 72.00 0 0 0 0 0 0 0 72.00 72.00 0			0	0		0 0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 0 0 0 0 0 0 73.00 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>			0	0		0 0	-	
73.00 OT300 DRUGS CHARGED TO PATIENTS O			0	0		0 0		
OUTPATI ENT SERVICE COST CENTERS O 7,448 48,646 O 56,094 91.00 92.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) O 7,448 48,646 O 56,094 91.00 92.00 <			0	0		-		
91.00 09100 EMERGENCY 0 7,448 48,646 0 56,094 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 7,448 48,646 0 56,094 91.00 SPECIAL PURPOSE COST CENTERS 0 133,422 871,484 53,372 1,348,805 118.00 NONREI MBURSABLE COST CENTERS 0 344 2,247 0 2,591 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 2,247 0 2,591 190.00 193.00 19000 OPHYSI CLANS' PRI VATE OFFICES 0 0 0 0 0 193.00 0 0 193.00 193.00 193.00 193.01 193.01 193.01 193.02 193.02 193.02 193.02 193.02 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.04 193.04 193.04 193.04 193.04 193.04 193.04 193.05 193.05 193.05 193.05 193.05 193.04 193.04	75.00		0	0		0 0	0	/ 5. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 290, 527 133, 422 871, 484 53, 372 1, 348, 805 118. 00 NONREL MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 2, 247 0 2, 591 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 0 193. 00 193. 00 19300 NONREL WENTERS 0 0 0 0 0 193. 00 193. 01 19301 CLAY CITY MEDICAL CLINIC 0 0 0 0 193. 01 193.02 193.02 193.03 FOUNDATION 0 0 0 0 0 193. 02 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.04 193.04 193.04 193.05 193.05 <td>91.00</td> <td></td> <td>0</td> <td>7, 448</td> <td>48, 64</td> <td>6 0</td> <td>56.094</td> <td>91.00</td>	91.00		0	7, 448	48, 64	6 0	56.094	91.00
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 290,527 133,422 871,484 53,372 1,348,805 118.00 SUBTOTALS (SUM OF LINES 1-117) 290,527 133,422 871,484 53,372 1,348,805 190.00 190.00 GET CENTERS 190.00 190.00 344 2,247 0 2,591 190.00 19200 PYSI CI ANS' PRI VATE OFFICES 0 <td></td> <td></td> <td>-</td> <td>.,</td> <td>, -</td> <td>-</td> <td></td> <td></td>			-	.,	, -	-		
NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 2, 247 0 2, 591 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 204, 088 204, 088 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 193.01 19301 CLAY CITY MEDI CAL CLINIC 0 0 18, 996 0 18, 996 193.01 193.02 19302 PUBLI C RELATIONS 0 81 530 0 611 193.02 193.03 19303 FOUNDATION 0 0 0 0 193.03 193.04 19304 MISSI ON SERVICES 0 0 0 0 193.04 193.05 19305 OTHER NON-REI MBURSABLE 0 0 0 0 193.04 193.04 19304 MISSI ON SERVICES 0 0 0 193.04			1					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 2, 247 0 2, 591 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 204, 088 204, 088 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 193.01 19301 CLAY CITY MEDICAL CLINIC 0 0 18, 996 0 18, 996 193.01 193.02 19302 PUBLIC RELATIONS 0 81 530 0 611 193.02 193.03 19303 FOUNDATION 0 0 0 0 193.03 193.04 19304 MISSI ON SERVICES 0 0 0 0 193.04 193.05 19305 OTHER NON-REI MBURSABLE 0 0 0 0 193.04 193.04 0 Cross Foot Adjustments 0 0 0 0 0 193.04 193.05 193.05 19305 OTHER NON-REI MBURSABLE 0 0 0 0 0 <t< td=""><td>118.00</td><td></td><td>290, 527</td><td>133, 422</td><td>871, 48</td><td>53, 372</td><td>1, 348, 805</td><td>118.00</td></t<>	118.00		290, 527	133, 422	871, 48	53, 372	1, 348, 805	118.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 204,088 204,088 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 193.01 19301 CLAY CITY MEDICAL CLINIC 0 0 18,996 0 18,996 193.01 193.02 19302 PUBLIC RELATIONS 0 81 530 0 611 193.02 193.03 19303 FOUNDATION 0 0 0 0 193.03 193.04 19304 MISSION SERVICES 0 0 0 193.04 193.05 19305 OTHER NON-REI MBURSABLE 0 0 0 193.04 200.00 Cross Foot Adjustments	100 00		0	211	2.2/	0	2 501	100 00
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.01 19301 CLAY CITY MEDICAL CLINIC 0 0 18,996 0 18,996 193.01 193.02 19302 PUBLIC RELATIONS 0 81 530 0 611 193.02 193.03 19303 FOUNDATION 0 0 0 0 193.03 193.04 19304 MISSI ON SERVICES 0 0 0 193.04 193.05 0THER NON-REI MBURSABLE 0 0 0 0 193.04 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			-		2, 25			
193.01 193.01 CLAY CITY MEDICAL CLINIC 0 0 18,996 0 18,996 193.01 193.02 19302 PUBLIC RELATIONS 0 81 530 0 611 193.02 193.03 19304 FOUNDATION 0 0 0 0 193.03 193.04 19305 OTHER NON-REI MBURSABLE 0 0 0 0 193.04 193.05 19305 OTHER NON-REI MBURSABLE 0 0 0 193.05 200.00 Cross Foot Adjustments 0 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 201.00			0					
193.02 19302 PUBLIC RELATIONS 0 81 530 0 611 193.02 193.03 FOUNDATION 0 0 0 0 193.03 193.04 19304 MISSION SERVICES 0 0 0 193.04 193.05 19305 OTHER NON-REI MBURSABLE 0 0 0 193.05 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	Ŭ	18 90	0		
193.03 FOUNDATION 0 0 0 193.03 193.03 FOUNDATION 0 0 0 193.03 193.04 19304 MISSION SERVICES 0 0 0 193.04 193.05 19305 OTHER NON-REI MBURSABLE 0 0 0 0 193.05 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00								
193.04 19304 MISSION SERVICES 0 0 0 193.04 193.05 19305 0THER NON-REI MBURSABLE 0 0 0 0 193.05 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			-	0	00			
193.05 0THER NON-REI MBURSABLE 0 0 0 193.05 200.00 Cross Foot Adjustments 0 0 200.00 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00			0	0		-		
200.00 Cross Foot Adjustments 0 200.00 0 200.00 0 200.00 0 201.00 0 0 0 0 0 201.00 0			0	0		0 0		
201.00 Negative Cost Centers 0 </td <td></td> <td></td> <td>1</td> <td></td> <td></td> <td></td> <td>0</td> <td>200.00</td>			1				0	200.00
				0		0 0	0	201.00
	202.00	TOTAL (sum lines 118-201)	290, 527	133, 847	893, 25	257, 460	1, 575, 091	202.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Pre 11/21/2014 9:	pared: 44 am
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	-	-		1		1 4 00
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00201 CAP REL COSTS-MOB						2.01
	00400 EMPLOYEE BENEFITS DEPARTMENT	C					4.00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00
	00800 LAUNDRY & LINEN SERVICE		001,000	267, 783			7.00
	00900 HOUSEKEEPING		0, 100	12, 245 6, 790		39, 291	9.00
	01000 DI ETARY			15, 083		39, 291	10.00
	01100 CAFETERI A			8, 555		0	11.00
	01300 NURSI NG ADMI NI STRATI ON		-,	13, 366		0	13.00
	01400 CENTRAL SERVICES & SUPPLY			13, 300	-	0	14.00
	01500 PHARMACY			6, 700	-	0	15.00
	01600 MEDICAL RECORDS & LIBRARY			59, 403	-	0	
	INPATIENT ROUTINE SERVICE COST CENTERS		20,000	0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>		1 101 00
	03000 ADULTS & PEDI ATRI CS	C	77, 978	38, 561	11, 313	20, 035	30. 00
	ANCI LLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	C	42, 791	15, 830	5, 440	10, 127	50.00
53.00	05300 ANESTHESI OLOGY	C	44	C	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	67, 445	10, 978	6, 363	3, 043	54.00
60.00	06000 LABORATORY	C	62, 233	15, 782	2 0	3, 043	60.00
	06500 RESPI RATORY THERAPY	C	11, 984	10, 826	0	0	65.00
	06600 PHYSI CAL THERAPY	C	37, 817	20, 087	1, 626	0	66.00
	06700 OCCUPATI ONAL THERAPY	C	2/0//	C		0	67.00
	06800 SPEECH PATHOLOGY	C		C		0	68.00
	06900 ELECTROCARDI OLOGY	C		C	-	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	C	, e	C	° °	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		C	-	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	C		C		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	C	68	C	0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	C	100.000	21 744	11 210	2.042	01 00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	L C	108, 283	31, 764	11, 318	3, 043	91.00 92.00
	SPECIAL PURPOSE COST CENTERS						92.00
118.00		C	658, 907	265, 970	37, 276	39, 291	1118 00
	NONREI MBURSABLE COST CENTERS		030, 907	203, 770	57,270	57,271	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	146	1, 467	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES			1, 10, C			192.00
	19300 NONPALD WORKERS			C			193.00
	19301 CLAY CITY MEDICAL CLINIC			C			193.01
	19302 PUBLIC RELATIONS	C		346	0	0	193.02
	19303 FOUNDATION	C	0	C			193.03
193.04	19304 MI SSI ON SERVI CES	C	160	C	0	0	193.04
	19305 OTHER NON-REI MBURSABLE	C	5, 727	C	0		193.05
200.00	Cross Foot Adjustments	1					200.00
201.00	Negative Cost Centers	C	0 0	C	0 0	0	201.00
202.00	TOTAL (sum lines 118-201)	C	679, 184	267, 783	37, 276	39, 291	1202 00

	Financial Systems TION OF CAPITAL RELATED COSTS	ST. VINCENT CL		er CCN: 151309	Peri od:	u of Form CMS- Worksheet B	2002 1
ALLUUF	TION OF CAPITAL RELATED COSTS		Provide	I CCN: 151309	From 07/01/2013 To 06/30/2014	Part II Date/Time Pre 11/21/2014 9:	epared: 44 am
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRAT	CENTRAL I ON SERVI CES & SUPPLY	PHARMACY	
	1	10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
2.01	00201 CAP REL COSTS-MOB						2.01
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY	53, 541					10.00
11.00	01100 CAFETERIA	00,011	32, 3	61			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	1,6		016		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	.,-	0	0 775		14.00
15.00	01500 PHARMACY	0		0	0 0	63, 500	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	2,6	13	0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	53, 541	8, 7	88 32,	519 0	0	30.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0	4,4		158 0	0	50.00
53.00	05300 ANESTHESI OLOGY	0		0	0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 3		0 0	0	
60.00		0		10	0 0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	1, 2	0	0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0		0	0 0	0	
68.00	06800 SPEECH PATHOLOGY	0		0	0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	9	14	0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	,	0	0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0 775	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	0 0	63, 500	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	7,3	29 20,	339 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	50.54				(0.500	1
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	53, 541	32, 3	41 61,	016 775	63, 500	1118. OC
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0 0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0		0	0 0		192.00
	19300 NONPALD WORKERS	0		0	0 0		193.00
	19301 CLAY CITY MEDICAL CLINIC	0		0	0 0		193.01
	19302 PUBLIC RELATIONS	0		0	0 0		193. 02
	19303 FOUNDATI ON	0		0	0 0	0	193. 03
	19304 MI SSI ON SERVI CES	0		20	0 0	0	193. 04
	19305 OTHER NON-REIMBURSABLE	0		0	0 0	0	193. 0
200.00							200.00
201.00		0		0	0 0		201.00
202.00	TOTAL (sum lines 118-201)	53, 541	32, 3	61 61,	016 775	63 500	202.00

Heal th	Financial Systems	ST. VINCENT CLA	AY HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCA	TI ON OF CAPI TAL RELATED COSTS		Provi der	CCN: 151309	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Pre 11/21/2014 9:	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments			
		16.00	24.00	25.00	26.00		
2.01 4.00 5.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MOB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						1.00 2.00 2.01 4.00 5.00 7.00 8.00
9.00 10.00 11.00 13.00 14.00 15.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						9.00 10.00 11.00 13.00 14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	187, 274					16.00
30. 00	03000 ADULTS & PEDI ATRI CS	12, 350	323, 182		0 323, 182		30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM 05300 ANESTHESI OLOGY	21,824	136, 530 44		0 136, 530 0 44		50.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C	60, 290	172, 870		0 172, 870		54.00
	06000 LABORATORY	30, 978	138, 157		0 138, 157		60.00
	06500 RESPI RATORY THERAPY	2,042	45, 260		0 45, 260		65.00
	06600 PHYSI CAL THERAPY	12, 155	101, 966		0 101, 966		66.00
	06700 OCCUPATI ONAL THERAPY	745	3, 122		0 3, 122 0 818		67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	80 6, 728	818 17, 118		0 818 0 17, 118		68.00 69.00
	07000 ELECTROENCEPHALOGRAPHY	0,728	17, 110		0 17, 118		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29, 409		0 29,409		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	16, 399		0 16, 399		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	63, 568		0 63, 568		73.00
	OUTPATIENT SERVICE COST CENTERS			•			
	09100 EMERGENCY	40, 082	278, 252		0 278, 252		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS	T T					
118.00		187, 274	1, 326, 695		0 1, 326, 695		118.00
100.00	NONREI MBURSABLE COST CENTERS	0	4 204		0 4, 204		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	4, 204 216, 444		0 4, 204 0 216, 444		190. 00 192. 00
	19300 NONPALD WORKERS	0	210, 444		0 210, 444		192.00
	19301 CLAY CITY MEDICAL CLINIC	0	20, 070		0 20.070		193.00
	19302 PUBLIC RELATIONS	0	1, 771		0 1, 771		193.02
	19303 FOUNDATION	0	0		0 0		193.02
	19304 MI SSI ON SERVI CES	0	180		0 180		193.04
	19305 OTHER NON-REI MBURSABLE	0	5, 727		0 5, 727		193.05
200.00	Cross Foot Adjustments		0		0 0		200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	187, 274	1, 575, 091		0 1, 575, 091		202.00

Health Financial Systems	ST. VINCENT C	LAY HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 07/01/2013 Fo 06/30/2014		narod
				10 00/ 30/ 2014	11/21/2014 9:	
	CAP	ITAL RELATED CO	OSTS			
Cast Contor Description	BLDG & FIXT	MVBLE EQUIP	МОВ		Decenciliation	
Cost Center Description	(SQUARE FEET)	(SQUARE FEET)		EMPLOYEE BENEFI TS	Reconciliation	
	(SQUARE ILLI)	(SUUARL ILLI)	(SUUARE ILLI)	DEPARTMENT		
				(GROSS		
				SALARI ES)		
	1.00	2.00	2.01	4.00	5A	
GENERAL SERVICE COST CENTERS	L	1	1	1	1	
1.00 00100 CAP REL COSTS-BLDG & FIXT	82, 473					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		84, 265	1			2.00
2.01 00201 CAP REL COSTS-MOB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0				2.01
5. 00 00500 ADMINI STRATI VE & GENERAL	30, 746					
7. 00 00700 OPERATI ON OF PLANT	16, 925					1
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 769				-	1
9. 00 00900 HOUSEKEEPI NG	981				0	1
10. 00 01000 DI ETARY	2,179		1		0	
11. 00 01100 CAFETERIA	1,236		1	0	0	1
13.00 01300 NURSING ADMINISTRATION	1, 931	1, 931		236, 798	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	14.00
15. 00 01500 PHARMACY	968	968	(15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	8, 582	8, 582	(167, 632	0	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T	1	1		1	
30. 00 03000 ADULTS & PEDI ATRI CS	5, 571	5, 571	(895, 490	0 0	30.00
ANCI LLARY SERVI CE COST CENTERS	2 207	2 207		42(01(
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI 0LOGY	2, 287	2, 287	1	0 436,016		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 586				-	1
60. 00 06000 LABORATORY	1, 380					
65. 00 06500 RESPIRATORY THERAPY	1, 564					
66. 00 06600 PHYSI CAL THERAPY	0	1,001				1
67.00 06700 OCCUPATI ONAL THERAPY	0	0				
68.00 06800 SPEECH PATHOLOGY	0	0	(0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		103, 983	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0) (0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0 0	0 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			-	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0 0	0 0	73.00
OUTPATIENT SERVICE COST CENTERS	1	1	1			
91.00 09100 EMERGENCY	4, 589	4, 589		809, 323	0	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	82, 211	82, 211	5, 11	5, 108, 723	-4, 768, 420	118 00
NONREI MBURSABLE COST CENTERS	02,211	02,211	J	5, 100, 725	-4, 700, 420	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	212		0 0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0					192.00
193. 00 19300 NONPAI D WORKERS	0	0				193.00
193.01 19301 CLAY CITY MEDICAL CLINIC	0	1, 792		0		193.01
193. 02 19302 PUBLIC RELATIONS	50		1	9, 653		193. 02
193. 03 19303 FOUNDATI ON	0	0) (0		193. 03
193. 04 19304 MI SSI ON SERVI CES	0	0		1, 058		193. 04
193. 05 19305 OTHER NON-REI MBURSABLE	0	0		0 0	0	193.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	133, 847	893, 257	257, 460	1, 857, 277		202.00
Part I)	1 (00010	10 (00570	10 40444	0 0/0700		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 622919	10. 600570	10. 43446	0.362790		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)						204.00
205.00 Unit cost multiplier (Wkst. B, Part				0.000000		205.00
				3.000000		
	1		•	1		

OST A	Financial Systems LLOCATION - STATISTICAL BASIS		LAY HOSPITAL Provider	CCN: 151309	Peri od:	u of Form CMS-: Worksheet B-1	
					From 07/01/2013		
					To 06/30/2014	Date/Time Pre 11/21/2014 9:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	44 0
		& GENERAL	PLANT	LINEN SERVIC		(MEALS SERVED)	
		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	SERVICE)	, , , , , , , , , , , , , , , , , , ,	
		· · · ·		LAUNDRY)			
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	1	1	1			
. 00	00100 CAP REL COSTS-BLDG & FIXT						1
. 00	00200 CAP REL COSTS-MVBLE EQUIP						2
. 01	00201 CAP REL COSTS-MOB						2
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	10 015 700					4
. 00	00500 ADMINISTRATIVE & GENERAL	12,015,733					5
. 00 . 00	00700 OPERATION OF PLANT	1,077,394					7
00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	60, 285					8
	01000 DI ETARY	341, 337 209, 165			0 0,070	100	
	01100 CAFETERIA	153, 874			0 0	0	
	01300 NURSI NG ADMI NI STRATI ON	396, 595			0 0	0	
	01400 CENTRAL SERVICES & SUPPLY	13, 718			0 0	0	
	01500 PHARMACY	795, 536			0 0	0	
	01600 MEDICAL RECORDS & LIBRARY	360, 131			0 0	0	
5. 00	INPATIENT ROUTINE SERVICE COST CENTERS	500,131	0, 302	1	0 0	0	
0. 00	03000 ADULTS & PEDI ATRI CS	1, 379, 538	5, 571	35, 68	4, 115	100	30
	ANCI LLARY SERVICE COST CENTERS	.,			.,		
0. 00	05000 OPERATING ROOM	757,026	2, 287	17, 16	2,080	0	50
3. 00	05300 ANESTHESI OLOGY	781	0		0 0	0	
4.00	05400 RADI OLOGY-DI AGNOSTI C	1, 193, 195	1, 586	20, 07	625	0	
0. 00	06000 LABORATORY	1, 100, 989			0 625	0	60
5.00	06500 RESPI RATORY THERAPY	212,011	1, 564		0 0	0	65
5.00	06600 PHYSI CAL THERAPY	669,035			30 O	0	66
7.00	06700 OCCUPATI ONAL THERAPY	42,046	0		0 0	0	67
B. 00	06800 SPEECH PATHOLOGY	13, 057	0		0 0	0	68
9.00	06900 ELECTROCARDI OLOGY	167, 648	0		0 0	0	69
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	506, 580	0		0 0	0	71
	07200 IMPL. DEV. CHARGED TO PATIENTS	290, 111	0		0 0	0	72
3.00	07300 DRUGS CHARGED TO PATIENTS	1, 209	0		0 0	0	73
	OUTPATIENT SERVICE COST CENTERS	1		1			
	09100 EMERGENCY	1, 915, 750	4, 589	35, 70	625	0	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
10 00	SPECIAL PURPOSE COST CENTERS	44 (57 044	00.405	447.50	0.070	100	1
18.00		11, 657, 011	38, 425	117, 59	8, 070	100	118
	NONREI MBURSABLE COST CENTERS	2 501	212	1	0	0	1100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	2, 591	212		0 0		190
	19300 NONPALD WORKERS	218, 592			0 0		192 193
	19301 CLAY CITY MEDICAL CLINIC	10 004			0 0		193
	19301 PUBLIC RELATIONS	18, 996 14, 395					193
	19303 FOUNDATION	14, 393	0		0 0		193
	19304 MI SSI ON SERVI CES	2,827			0 0		193
	19305 OTHER NON-REI MBURSABLE	101, 321			0 0		193
0.00	Cross Foot Adjustments	101, 321			0	0	200
)0.00)1.00	Negative Cost Centers						200
)2.00	Cost to be allocated (per Wkst. B,	4, 768, 420	1, 504, 956	153, 02	25 519, 950	376, 937	
JZ. UU	Part I)	4, 700, 420	1, 304, 930	103,02	5 517, 750	370, 437	202
03.00	Unit cost multiplier (Wkst. B, Part I)	0. 396848	38. 900819	1. 30127	64. 429988	3, 769. 370000	203
03.00 04.00	Cost to be allocated (per Wkst. B,	679, 184				53, 541	
	Part II)	077,104	207,703	37,27	5 57,271	55, 541	204
05.00	Unit cost multiplier (Wkst. B, Part	0. 056525	6. 921783	0. 31698	4. 868773	535. 410000	205
		5. 000020	1 3. 721703	1 0.01070	1.000770		1-00

COCT A	Financial Systems	ST. VINCENT C	LAY HOSPITAL		In Lie	u of Form CMS-2	2552-10
CUST A	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2013	Worksheet B-1	
					To 06/30/2014	Date/Time Pre 11/21/2014 9:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDICAL	
		(HOURS)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
				SUPPLY	REQUIS.)	LIBRARY	
			(DI RECT NURS.	(COSTED		(GROSS	
		11.00	HRS.) 13.00	REQUIS.) 14.00	15.00	CHARGES) 16.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1			1		1.00
2.00	00200 CAP REL COSTS-DEDG & TTXT						2.00
2.00	00201 CAP REL COSTS-MOB						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERIA	6, 341					11.00
	01300 NURSI NG ADMI NI STRATI ON	319					13.00
	01400 CENTRAL SERVICES & SUPPLY	C		100			14.00
	01500 PHARMACY			(15.00
	01600 MEDI CAL RECORDS & LI BRARY	512	-	(48, 347, 988	1
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 ADULTS & PEDIATRICS	1,722	2, 296	(0 0	3, 188, 759	30.00
	ANCI LLARY SERVICE COST CENTERS	· · ·	1		-1 -1		
50.00	05000 OPERATI NG ROOM	863	576	(0 0	5, 634, 890	50.00
	05300 ANESTHESI OLOGY	C		(0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 051			0	15, 561, 188	
	06000 LABORATORY	2	0	(0	7, 998, 500	
65.00	06500 RESPI RATORY THERAPY	253	0	(0 0	527, 135	
66.00	06600 PHYSI CAL THERAPY	c		(0 0	3, 138, 373	
67.00	06700 OCCUPATI ONAL THERAPY	C	0 0	(0 0	192, 229	67.00
68.00	06800 SPEECH PATHOLOGY	C	0 0	(0 0	20, 763	68.00
69.00	06900 ELECTROCARDI OLOGY	179	0	(0 0	1, 737, 111	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	C	0 0	(0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0 0	100	0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0 0	(0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0 0	(1, 000	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	1, 436	1, 436	(0 0	10, 349, 040	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
118.00	· · · · · · · · · · · · · · · · · · ·	6, 337	4, 308	100	1,000	48, 347, 988	118.00
	NONREI MBURSABLE COST CENTERS	-	-		-1 -1	-	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C		(190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	C	-		0 0		192.00
	19300 NONPALD WORKERS	C	0 0	(0 0		193.00
193.01	19301 CLAY CITY MEDICAL CLINIC	C	0	() O		193.01
	19302 PUBLIC RELATIONS	C	0	(0		193.02
	19303 FOUNDATION		0	(193.03
	19304 MI SSI ON SERVI CES	4	0	(193.04
	19305 OTHER NON-REI MBURSABLE	C	0	(ן ע	0	193.05
200.00							200.00
201.00		2/2 000	(40.000	10 4/7	1 140 000	050 400	201.00
202.00		263, 020	642, 332	19, 162	2 1, 148, 899	858, 132	202.00
202 00	Part I)	41 470040	140 100104	101 (2000)	1 140 000000	0 017740	202 00
		41. 479262 32, 361		191. 620000 775		0. 017749 187, 274	
203.00		1 37 301	1 01.010	//5	63, 500	107,274	1204.00
203.00		02,001					
	Part II)	5. 103454		7.750000		0.003873	

Health Financial Systems	ST. VINCENT C	LAY HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Pre 11/21/2014 9:	
		Ti tl	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	(from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDI ATRI CS	3, 302, 590		3, 302, 59	0 0	0	30.00
ANCI LLARY SERVI CE COST CENTERS	1			1		
50.00 05000 OPERATI NG ROOM	1, 524, 458		1, 524, 45		0	
53. 00 05300 ANESTHESI OLOGY	1, 091		1, 09		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 114, 595		2, 114, 59		0	
60. 00 06000 LABORATORY	1, 808, 925		1, 808, 92		0	
65. 00 06500 RESPI RATORY THERAPY	376, 838		376, 83		0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 109, 809		1, 109, 80		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	62, 144		62, 14		0	67.00
68.00 06800 SPEECH PATHOLOGY	18, 608		18, 60		0	
69. 00 06900 ELECTROCARDI OLOGY	272, 436		272, 43	6 0	0	
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	726, 777		726, 77		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	405, 241		405, 24	1 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 150, 588		1, 150, 58	8 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	3, 398, 614		3, 398, 61	4 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	631, 760		631, 76	0	0	
200.00 Subtotal (see instructions)	16, 904, 474	0	16, 904, 47	4 0	0	200. 00
201.00 Less Observation Beds	631, 760		631, 76	0	0	201.00
202.00 Total (see instructions)	16, 272, 714	0	16, 272, 71	4 0	0	202.00

Health Financial Systems	ST. VINCENT CL	AY HOSPITAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period:	Worksheet C	
				From 07/01/2013 To 06/30/2014		narod
				10 00/30/2014	11/21/2014 9:	
		Ti tl	e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-1		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 543, 344		2, 543, 34	4		30.00
ANCI LLARY SERVI CE COST CENTERS						4
50. 00 05000 OPERATI NG ROOM	611, 447	5,023,443	5, 634, 89			
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	631, 367	14, 929, 821	15, 561, 18			
60. 00 06000 LABORATORY	706, 656	7, 291, 844				
65. 00 06500 RESPI RATORY THERAPY	340, 200	186, 935				
66. 00 06600 PHYSI CAL THERAPY	412, 576	2, 725, 797				
67.00 06700 OCCUPATI ONAL THERAPY	154, 034	38, 195			0.00000	
68.00 06800 SPEECH PATHOLOGY	5, 198	15, 565				
69. 00 06900 ELECTROCARDI OLOGY	286, 870	1, 450, 241				
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	692, 722	1, 957, 105				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	247,071	302, 668				
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 275, 093	2, 406, 141	3, 681, 23	4 0. 312555	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						4
91.00 09100 EMERGENCY	0	10, 349, 040				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	645, 415			0.00000	
200.00 Subtotal (see instructions)	7, 906, 578	47, 322, 210	55, 228, 78	8		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	7, 906, 578	47, 322, 210	55, 228, 78	8		202.00

Health Financial Systems	ST. VINCENT CLA	AY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151309	Period:	Worksheet C
			From 07/01/2013 To 06/30/2014	Part I Date/Time Prepared:
			10 00/30/2014	11/21/2014 9:44 am
		Title XVIII	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
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0. 000000			50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
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 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	ST. VINCENT CI	AY HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 07/01/2013	Worksheet C Part I	
				To 06/30/2014		pared:
					11/21/2014 9:	
		Tit	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description		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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.000.500		0.000.50		0.000.500	
30. 00 03000 ADULTS & PEDIATRICS	3, 302, 590		3, 302, 59	0 0	3, 302, 590	30.00
ANCI LLARY SERVI CE COST CENTERS	1 504 450		1 504 45	0 0	1 504 450	
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	1, 524, 458		1, 524, 45		1, 524, 458	
	1,091		1,09		1, 091	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 114, 595		2, 114, 59		2, 114, 595	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	1, 808, 925		1, 808, 92		1, 808, 925	•
	376, 838		376, 83		376, 838	•
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	1, 109, 809		1, 109, 80		1, 109, 809	•
68. 00 06800 SPEECH PATHOLOGY	62, 144		62, 14		62, 144	•
69. 00 06900 ELECTROCARDI OLOGY	18, 608		18, 60		18, 608	
70. 00 07000 ELECTROCARDIOLOGY	272, 436		272, 43	0 0	272, 436 0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	726, 777		726, 77	0 0	-	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	405, 241		405, 24		726, 777 405, 241	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 150, 588		1, 150, 58		1, 150, 588	•
OUTPATIENT SERVICE COST CENTERS	1, 150, 566		1, 150, 56		1, 150, 566	/3.00
91. 00 09100 EMERGENCY	3, 398, 614		3, 398, 61	4 0	3, 398, 614	91 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	631, 760		631, 76		631, 760	•
200.00 Subtotal (see instructions)	16, 904, 474					
201.00 Less Observation Beds	631, 760		631, 76		631, 760	
202.00 Total (see instructions)	16, 272, 714					
	1 10, 212, 114	0	1 10, 2, 2, 71		1 10, 2, 2, 7, 14	1202.00

Health Financial Systems	ST. VINCENT CL				u of Form CMS-	2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 07/01/2013 To 06/30/2014		
			le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS				-1		_
30. 00 03000 ADULTS & PEDIATRICS	2, 543, 344		2, 543, 344	4		30.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	611, 447	5, 023, 443	5, 634, 890			
53. 00 05300 ANESTHESI OLOGY	0	0	(0.00000		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	631, 367	14, 929, 821	15, 561, 188			
60. 00 06000 LABORATORY	706, 656	7, 291, 844				
65. 00 06500 RESPI RATORY THERAPY	340, 200	186, 935				
66. 00 06600 PHYSI CAL THERAPY	412, 576	2, 725, 797				
67.00 06700 OCCUPATIONAL THERAPY	154, 034	38, 195			0.00000	
68.00 06800 SPEECH PATHOLOGY	5, 198	15, 565				
69. 00 06900 ELECTROCARDI OLOGY	286, 870	1, 450, 241	1, 737, 11			
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	692, 722	1, 957, 105	2, 649, 82			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	247,071	302, 668	549, 739	9 0. 737152	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 275, 093	2, 406, 141	3, 681, 234	4 0. 312555	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS	-r					
91.00 09100 EMERGENCY	0	10, 349, 040				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	645, 415			0. 000000	
200.00 Subtotal (see instructions)	7, 906, 578	47, 322, 210	55, 228, 788	В		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	7, 906, 578	47, 322, 210	55, 228, 788	В		202.00

11/21/2014 9:44 am Y: \28250 - St. Vincent Clay\300 - Medicare Cost Report\20140631\28250-14.mcrx

Health Financial Systems	ST. VINCENT CL	AY HOSPI TAL	In Lie	u of Form CMS-2552-10	0
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151309	Period:	Worksheet C	_
			From 07/01/2013 To 06/30/2014	Part I	
			To 06/30/2014	Date/Time Prepared: 11/21/2014 9:44 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	0
ANCI LLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000			50.00	
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00	Э
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00	
60. 00 06000 LABORATORY	0. 000000			60.00	Э
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	Э
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00	0
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00	0
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0. 000000			91.00	Э
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00	
200.00 Subtotal (see instructions)				200.00	0
201.00 Less Observation Beds				201.00	Э
202.00 Total (see instructions)				202.00	С

Health Financial Systems ST. VINCENT CLAY HOSPITAL In Lieu of Form C						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	IL COSTS	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Pre 11/21/2014 9:-	pared: 44 am
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Program	Capital Costs (column 3 x column 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	136, 530	5, 634, 890	0. 02422	356, 315	8, 633	50.00
53. 00 05300 ANESTHESI OLOGY	44	0	0.0000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	172, 870				4, 084	54.00
60. 00 06000 LABORATORY	138, 157				7, 835	60.00
65. 00 06500 RESPI RATORY THERAPY	45, 260					65.00
66. 00 06600 PHYSI CAL THERAPY	101, 966				2, 300	
67.00 06700 OCCUPATI ONAL THERAPY	3, 122					67.00
68.00 06800 SPEECH PATHOLOGY	818					68.00
69. 00 06900 ELECTROCARDI OLOGY	17, 118	1, 737, 111			1, 682	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	,	0. 00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 409				3, 583	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	16, 399	549, 739			5, 114	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	63, 568	3, 681, 234	0.01726	599, 016	10, 344	73.00
OUTPATIENT SERVICE COST CENTERS		-				
91. 00 09100 EMERGENCY	278, 252	10, 349, 040	0. 02688	37 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	84,034		0. 13020		0	92.00
200.00 Total (lines 50-199)	1, 087, 547	52, 685, 444		2, 695, 813	57, 693	200. 00

Health Financial Systems	ST. VINCENT C			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der	CCN: 151309	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2013		
				To 06/30/2014	Date/Time Pre 11/21/2014 9:	
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	-				
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0)	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0)	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0 0)	0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0)	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
200.00 Total (lines 50-199)	0	0)	0 0	0	200. 00
					-	-

Health Financial Systems ST. VINCENT CLAY HOSPITAL In Lieu of Form CMS-25						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	S Provi der		Period: From 07/01/2013 To 06/30/2014		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of			. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	r	1	-		
50.00 05000 OPERATING ROOM	0	5, 634, 890				
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	15, 561, 188				54.00
60. 00 06000 LABORATORY	0	7, 998, 500				
65. 00 06500 RESPI RATORY THERAPY	0	527, 135	0.00000	0 0. 000000	159, 268	65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 138, 373	0.00000	0 0. 000000	70, 804	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	192, 229	0.00000	0 0. 000000	21, 989	67.00
68.00 06800 SPEECH PATHOLOGY	0	20, 763	0.00000	0 0. 000000	2, 184	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 737, 111	0.00000	0 0. 000000	170, 711	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0. 000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 649, 827	0. 00000	0 0. 000000	322, 890	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	549, 739	0. 00000	0 0. 000000	171, 448	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 681, 234	0. 00000	0 0. 000000	599, 016	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	10, 349, 040	0.00000	0 0. 000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	645, 415	0. 00000	0 0. 000000	0	92.00
200.00 Total (lines 50-199)	0	52, 685, 444			2, 695, 813	200. 00

Health Financial Systems ST. VINCENT CLAY HOSPITAL In Lieu of Form CMS-2552-						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 151309	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2013		mod.
				To 06/30/2014	Date/Time Prepar 11/21/2014 9:44	reu: . am
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS	TT		1			
50. 00 05000 OPERATING ROOM	0	0)	0		50.00
53. 00 05300 ANESTHESI OLOGY	0	0)	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0		54.00
60. 00 06000 LABORATORY	0	0)	0	-	50.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0		56.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C)	0		57.00
68.00 06800 SPEECH PATHOLOGY	0	C)	0	-	58.00
69. 00 06900 ELECTROCARDI OLOGY	0	C)	0		59.00
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	0)	0	7	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
91.00 09100 EMERGENCY	0	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C)	0		92.00
200.00 Total (lines 50-199)	0	C		0	20	00.00

Health Financial Systems	ST. VINCENT C	LAY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Pre 11/21/2014 9:	
		Titl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 270539		2, 064, 24	3 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 135889		4, 578, 73		0	54.00
60. 00 06000 LABORATORY	0. 226158	0	2, 716, 05	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 714879	0	64, 04	8 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 353626	0	936, 02	6 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 323281	0	5, 03	6 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 896210	0	3, 93	1 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 156833	0	239, 26	2 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 274273	0	762, 60	3 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 737152	0	180, 93	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 312555	0	1, 072, 64	6 12, 597	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0. 328399	0	2, 337, 37	9 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 978843	0	311, 62	2 0	0	92.00
200.00 Subtotal (see instructions)		0	15, 272, 51	4 12, 597	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	15, 272, 51	4 12, 597	0	202.00

Health Financial Systems	ST. VINCENT C	LAY HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 151309	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Pre 11/21/2014 9:	
		Titl	e XVIII	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				-
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	558, 458					50.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	622, 200					54.00
60. 00 06000 LABORATORY	614, 256					60.00
65. 00 06500 RESPI RATORY THERAPY	45, 787					65.00
66. 00 06600 PHYSI CAL THERAPY	331,003					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 628					67.00
68.00 06800 SPEECH PATHOLOGY	3, 523					68.00
69.00 06900 ELECTROCARDI OLOGY	37, 524	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	209, 161					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	133, 373					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	335, 261	3, 937				73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	767, 593					91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	305, 029					92.00
200.00 Subtotal (see instructions)	3, 964, 796	3, 937				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	3, 964, 796	3, 937				202.00

Health Financial Systems	ST. VINCENT CI	LAY HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period:	Worksheet D	
		Component		From 07/01/2013 To 06/30/2014	Part V Date/Time Pre	narad
		component	CCN. 152309	To 06/30/2014	11/21/2014 9:	
		Ti tl	e XVIII	Swing Beds - SNF		<u></u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		-	1	-	-	
50. 00 05000 OPERATI NG ROOM	0. 270539			0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0.00000			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 135889			0 0	0	54.00
60. 00 06000 LABORATORY	0. 226158			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 714879			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 353626	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 323281	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 896210			0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 156833			0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 274273			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 737152			0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 312555	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			1	a .	-	
91.00 09100 EMERGENCY	0. 328399			0 0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 978843	0		0	0	1 2.00
200.00 Subtotal (see instructions)		0		0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges				0	~	202.00
202.00 Net Charges (line 200 +/- line 201)	I	0	1	0 0	0	202.00

Health Financial Systems	ST. VINCENT C	LAY HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151309	Peri od:	Worksheet D	
				From 07/01/2013	Part V	
		Component	CCN: 15Z309	To 06/30/2014	Date/Time Pre 11/21/2014 9:	
		Ti tl	e XVIII	Swing Beds - SNF		
	Co	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS	-1	1				
50. 00 05000 OPERATI NG ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0 0				54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
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	0				73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0 0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	0				202.00

Heal th	Financial Systems ST. VINCENT CLAY	HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 151309	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Pre	
		Title XVIII	Hospi tal	11/21/2014 9: Cost	44 am
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			3, 039	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivate room davs	2, 196 0	2.00 3.00
3.00	do not complete this line.	s). Ti you have only pr	rvate room days,	0	3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		r 21 of the cost	1, 625 391	4.00 5.00
5.00	reporting period	5		571	5.00
6.00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	391	6.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	31	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	30	8.00
	reporting period (if calendar year, enter 0 on this line)	5			
9.00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	987	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	391	10.00
11.00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	391	11.00
12 00	December 31 of the cost reporting period (if calendar year, ent			0	12 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13.00
14.00	Medically necessary private room days applicable to the Program			0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15.00 16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services reporting period	s through December 31 o	f the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services reporting period		18.00		
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	126.36	19.00		
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)			3, 302, 590	21.00
22.00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	31 of the cost report	ing period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reportin	g period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	3, 917	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December 3 [°]	of the cost reporting	period (line 8	3, 791	25.00
26.00	x line 20) Total swing-bed cost (see instructions)			872, 921	26.00
27.00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		2, 429, 669	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	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)		0.00000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	s line 22)(see instruc	tions)	0.00 0.00	
34.00	Average per diem private room cost differential (line 34 x line	, ,	(1013)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	,		0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line	2, 429, 669	37.00
	27 minus line 36)	· · · · · · · · · · · · · · · · · · ·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	STMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see i			1, 106. 41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 3			1, 092, 027	39.00
40.00	Medically necessary private room cost applicable to the Program			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 -	- line 40)		1, 092, 027	41.00

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provi der	CCN: 151309	Period: From 07/01/2013	Worksheet D-1	
					To 06/30/2014	Date/Time Pre 11/21/2014 9:	
			Ti tl	e XVIII	Hospi tal	Cost	44 a
	Cost Center Description	Total Inpatient Cost	Total Inpatient Davs	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
			2.00	col. 2) 3.00		<u>4)</u> 5. 00	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
00	Intensive Care Type Inpatient Hospital Uni	ts					1 4 2
. 00 . 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T						43.
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1.00	
00	Program inpatient ancillary service cost (>		825, 834	
. 00	Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	es 41 through 48)(see instructio	ns)		1, 917, 861	49
. 00	Pass through costs applicable to Program i	npatient routine	services (from	Wkst. D, su	m of Parts I and	0	50
. 00) Pass through costs applicable to Program i	nnatient ancillar	v services (fr	om Wkst D	sum of Parts II	0	51
	and IV)		,		0, Turto II		
. 00 . 00	Total Program excludable cost (sum of line Total Program inpatient operating cost exc		lated non new	elcion anost	hatist and	0	
. 00	medical education costs (line 49 minus lin			si ci ali dileSt	Ποτιστ, dHU	0	33
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
. 00 . 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	
. 00	Difference between adjusted inpatient oper	ating cost and ta	rget amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	0	0		ŗ	0	58
. 00	Lesser of lines 53/54 or 55 from the cost	reporting period	ending 1996, u	pdated and c	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior yea	ir cost report. un	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of li				the amount by	0	
	which operating costs (line 53) are less t		s (lines 54 x	60), or 1% o	f the target		
2. 00	amount (line 56), otherwise enter zero (se Relief payment (see instructions)	e instructions)				0	62
. 00	Allowable Inpatient cost plus incentive pa	yment (see instru	ctions)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine c	asts through Doco	mbor 21 of the	cost roport	ing pariod (Soo	432, 606	64
. 00	instructions) (title XVIII only)	JUSTS THI OUGH DECE		cost report	ing period (see	432,000	04
. 00	Medicare swing-bed SNF inpatient routine of	osts after Decemb	er 31 of the c	ost reportin	g period (See	432, 606	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rou	tine costs (line)	64 nlus line 6	5)(title XVI	LL only) For	865, 212	66
. 00	CAH (see instructions)					000,212	
. 00	Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 c	f the cost r	eporting period	0	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient rout	ine costs after D	ecember 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)				3 1		
9.00	Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER					0	69
0. 00	Skilled nursing facility/other nursing fac						70
. 00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x lin	,		\			72
. 00	Medically necessary private room cost appl			ne 35)			73
. 00 . 00	Total Program general inpatient routine se Capital-related cost allocated to inpatien			orksheet B.	Part II. column		74
	26, line 45)				,		
. 00	Per diem capital -related costs (line 75 ÷						76
. 00 . 00	Program capital-related costs (line 9 x li Inpatient routine service cost (line 74 mi						77
. 00	Aggregate charges to beneficiaries for exc	,	rovi der record	s)			79
. 00	Total Program routine service costs for co	• •			nus line 79)		80
. 00	Inpatient routine service cost per diem li		、 、				81
. 00	Inpatient routine service cost limitation	•	· .				82
. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see	•	5)				83
. 00	Utilization review - physician compensation		ns)				85
. 00	Total Program inpatient operating costs (s						86
	PART IV - COMPUTATION OF OBSERVATION BED P						1
7.00	Total observation bed days (see instruction Adjusted general inpatient routine cost pe		Line 2)			571 1, 106. 41	
3. 00							

Health Financial Systems	ST. VINCENT CLAY HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 07/01/2013 To 06/30/2014	Date/Time Pre 11/21/2014 9:	pared: 44 am
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	323, 182	2, 429, 669	0. 13301	5 631, 760	84, 034	90.00
91.00 Nursing School cost	0	2, 429, 669	0.00000	0 631, 760	0	91.00
92.00 Allied health cost	0	2, 429, 669	0.00000	0 631, 760	0	92.00
93.00 All other Medical Education	0	2, 429, 669	0.00000	0 631, 760	0	93.00

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

 COMPUTATION OF INPATIENT OPERATING COST
 Provider CCN: 151309
 Period: From 07/01/2013 To 06/30/2014
 Worksheet D-1

			To 06/30/2014	Date/Time Pre 11/21/2014 9:	
		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,			3, 039	
2.00 3.00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivata noom dava	2, 196 0	2.00
3.00	do not complete this line.). If you have only pr	rvate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		1, 625	4.00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	391	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	391	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember	ST OF the cost	571	0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	31	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private room	dave) after December 2	1 of the cost	30	8.00
8.00	reporting period (if calendar year, enter 0 on this line)	uays) al ter beceniber 3	I UI THE COST	50	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	105	9.00
10.00	newborn days)	v (including private r	and days)	0	10.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		uays)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days) after	0	11.00
10.00	December 31 of the cost reporting period (if calendar year, ent			0	10.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	oniy (including privat	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar yea	r, enter O on this lin	e)		
14.00 15.00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	14.00 15.00
16.00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18.00
101 00	reporting period				10100
19.00	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 t	he cost	0 00	20.00
20.00	reporting period			0.00	20100
21.00	Total general inpatient routine service cost (see instructions)			3, 302, 590	
22.00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	31 of the cost report	ing period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23.00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24.00
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 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ino 21 minus lino 26)		867, 238 2, 435, 352	
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	The 21 minus The 20)		2, 433, 352	27.00
28.00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0 0. 000000	30.00 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	11110 20)		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minu		tions)	0.00	
35.00 36.00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	35.00 36.00
37.00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	2, 435, 352	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see i			1, 109.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 3	8)		116, 445	39.00
40.00	Medically necessary private room cost applicable to the Program	. ,		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 +	line 40)		116, 445	41.00

MPUT	FATION OF INPATIENT OPERATING COST		Provi der	CCN: 151309	Period: From 07/01/2013	Worksheet D-1	
					To 06/30/2014	Date/Time Pre 11/21/2014 9:	
	Cost Center Description	Total	Total	le XIX Average Pei	Hospital Program Days	Cost Program Cost	
		Inpatient Costl	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	1.0
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	ts					42.
00	INTENSIVE CARE UNIT						43.
. 00	CORONARY CARE UNIT						44.
. 00	SURGICAL INTENSIVE CARE UNIT						45.
00							47
	Cost Center Description					1.00	-
00	Program inpatient ancillary service cost (Wkst. D-3. col. 3	line 200)			1.00	5 48
00	Total Program inpatient costs (sum of line			ns)		223, 010	
~~	PASS THROUGH COST ADJUSTMENTS				<u> </u>		1 50
00	Pass through costs applicable to Program i	npatient routine :	services (Tron	IWKST. D, SU	m of Parts I and	C	50
00	Pass through costs applicable to Program i	npatient ancillar	y services (fr	om Wkst. D,	sum of Parts II	C	51
0.2	and IV)	50 1 51				_	
. 00 . 00	Total Program excludable cost (sum of line Total Program inpatient operating cost exc		lated non-nh	sician anost	hetist and		
	medical education costs (line 49 minus lin	5 1					
	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00	Program di scharges					0	
00	Target amount per discharge Target amount (line 54 x line 55)					0.00 C	
00	Difference between adjusted inpatient oper	ating cost and ta	rget amount (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)	0	0			C	
00	Lesser of lines 53/54 or 55 from the cost	reporting period	ending 1996, ι	pdated and c	ompounded by the	0.00	59
00	market basket Lesser of lines 53/54 or 55 from prior yea	r cost report. up	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of li					C	
	which operating costs (line 53) are less t		s (lines 54 x	60), or 1% o	f the target		
. 00	amount (line 56), otherwise enter zero (se Relief payment (see instructions)	e instructions)				C	62
. 00	Allowable Inpatient cost plus incentive pa	yment (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	osts through Dece	mber 31 of the	e cost report	ing period (See	C	64
. 00	Medicare swing-bed SNF inpatient routine c	osts after Decemb	er 31 of the c	ost reportin	q period (See	C	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient rou	tine costs (line)	64 plus line 6	5)(title XVI	II only). For	C) 66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 d	of the cost r	eportina period	C	67
	(line 12 x line 19)	5			1 31	-	
. 00	5 1	ine costs after D	ecember 31 of	the cost rep	orting period	C	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatien	t routine costs (line 67 + line	68)		C	69
	PART III - SKILLED NURSING FACILITY, OTHER						
. 00	Skilled nursing facility/other nursing fac	2		• • •			70
. 00 . 00	Adjusted general inpatient routine service Program routine service cost (line 9 x lin		ine 70 ÷ line	2)			71
. 00	Medically necessary private room cost appl	,	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine se						74
. 00	Capital-related cost allocated to inpatien	t routine service	costs (from W	lorksheet B,	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷	line 2)					76
. 00	Program capital -related costs (line 9 x li						77
00	Inpatient routine service cost (line 74 mi	nus line 77)					78
00	Aggregate charges to beneficiaries for exc			· · · · · · · · · · · · · · · · · · ·			79
00 00	Total Program routine service costs for co Inpatient routine service cost per diem li	•	USCIIMITATION	i (line /8 mi	nus i i ne 79)		80
00	Inpatient routine service cost per drem ri Inpatient routine service cost limitation)				82
00	Reasonable inpatient routine service costs	•					83
00	Program inpatient ancillary services (see		```				84
00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (s PART IV - COMPUTATION OF OBSERVATION BED P						86
. 00	Total observation bed days (see instruction					571	87
. 00	Adjusted general inpatient routine cost pe	•	line 2)			1, 108. 99	
. 00	Observation bed cost (line 87 x line 88) (SOO INSTRUCTIONS)				633, 233	(

Health Financial Systems	ST. VINCENT C	LAY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 07/01/2013	Worksheet D-1	
				To 06/30/2014	Date/Time Pre 11/21/2014 9:	pared: 44 am
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	323, 182	2, 435, 352	0. 13270	4 633, 233	84, 033	90.00
91.00 Nursing School cost	0	2, 435, 352	0.00000	0 633, 233	0	91.00
92.00 Allied health cost	0	2, 435, 352	0.00000	0 633, 233	0	92.00
93.00 All other Medical Education	0	2, 435, 352	0.00000	0 633, 233	0	93.00

Health Financial Systems	ST. VINCENT CLAY HOS	PI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	P	rovi der	CCN: 151309	Peri od:	Worksheet D-3	
				From 07/01/2013 To 06/30/2014	Date/Time Pre	nared
				10 00/ 30/ 2014	11/21/2014 9:	
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1 00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS				1, 115, 735		30.00
ANCI LLARY SERVICE COST CENTERS				1, 113, 733		30.00
50. 00 05000 OPERATING ROOM			0. 27053	39 356, 315	96, 397	50.00
53. 00 05300 ANESTHESI OLOGY			0. 00000		0	1
54.00 05400 RADI OLOGY-DI AGNOSTI C			0.13588		49, 954	54.00
60. 00 06000 LABORATORY			0. 2261	58 453, 582	102, 581	60.00
65. 00 06500 RESPI RATORY THERAPY			0.7148	79 159, 268	113, 857	65.00
66. 00 06600 PHYSI CAL THERAPY			0.35362	70, 804	25, 038	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 32328	31 21, 989	7, 109	67.00
68.00 06800 SPEECH PATHOLOGY			0.8962	10 2, 184	1, 957	68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 15683	33 170, 711	26, 773	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 2742		88, 560	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 7371		126, 383	1
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 3125	55 599, 016	187, 225	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY			0. 32839		0	1 1 1 0 0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 97884		0	12.00
200.00 Total (sum of lines 50-94 and 96-98)		(4)		2, 695, 813	825, 834	
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (li	ne 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		I		2, 695, 813		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 151309 Component CCN: 152309 Period: From 07/01/2013 To 06/30/2014 Worksheet D-3 Date/Time Prepared: 11/21/2014 9: 44 am Cost Center Description Title XVIII Swing Beds - SNF Cost Inpatient Program Costs ANCILLARY SERVICE COST CENTERS Inpatient Program Costs (col 1 x col 2) Inpatient Program Costs (col 1 x col 2) 30.00 30.00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS 0 30.00 30.00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS 0 30.00 30.00 05300 ARESTHESI OLOGY 0.000000 0 0.53.00 54.00 05000 REDGY-DIAGNOSTI C 0.135889 48.632 6.609 66.00 06000 PHYSI CLI HERAPY 0.226158 94.266 21.319 60.00 66.00 06000 PHYSI CLI HERAPY 0.335322 6.609 54.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 66.00 99.190 66.00 7.00 7.00 7.00 7.00 7.00 7.00	Health Financial Systems	ST. VINCENT CLAY HOSPIT	AL		In Lie	u of Form CMS-	2552-10
Component CCN: 152309 To 06/30/2014 Date/Time Prepared: 11/21/2014 9: 44 am Title XVIII Swing Beds - SNF Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Costs Col. 1 x col. 2) Inpatient Program Costs Col. 1 x col. 2) 1000 2.00 3.00 000 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS 0 30.00 000 05300 ANESTHESI OLOGY 0 0 50.00 53.00 53.00 53.00 53.00 54.00 0 50.00 53.00 54.00 0 53.00 54.00 0 55.00 0 55.00 0 55.00 0 56.00 0.5000 LABORATORY 0.226158 94.268 21.319 60.00 56.00 66.00 66.00 66.00 45.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Prov	ider C			Worksheet D-3	
Impact of the approximation of the approximate thequapproximate the approximate the approximate the app		Comp	opont			Data /Tima Dra	nonod.
Title XVIII Swing Beds - SNF Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges 30.00 0 2.00 3.00 30.00 00000 (ADULTS & PEDIATRICS 0 30.00 ANCILLARY SERVICE COST CENTERS 0 30.00 50.00 05300 (ANESTHESI OLOGY 0.270539 0 0 50.00 54.00 05400 (ADU OLGY - DI AGNOSTI C 0.135889 48,632 6,609 54.00 65.00 06600 (DABORATORY 0.226158 94,266 21,319 58,772 65.00 66.00 06600 (DRESPI RATORY THERAPY 0.333281 111,064 35,905 67.00 67.00 0600 (DABORATOW) 0.353626 280,495 99,190 66.00 67.00 0600 (DELETROCARDI OLOGY 0.353626 280,495 99,190 66.00 69.00 0.00000 0 0.110,683 2,102 330 69.00		Comp	onent	CCN. 152509	10 00/30/2014		
Cost Center Description Rati o of Cost To Charges Inpatient Program Charges Inpa			Title	XVIII	Swing Beds - SNF		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30. 00 1.00 2.00 3.00 30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00 3.00 30. 00 3.00 50. 00 05000 ADULTS & PEDI ATRI CS 0 30. 00 30. 00 30. 00 30. 00 53. 00 53. 00 0.270539 0 0 53. 00 53. 00 53. 00 54. 00 05400 RABI OLOGY 0. 000000 0 0 53. 00 54. 00 05400 RABI OLOGY HERAPY 0.270539 0 0 0 53. 00 54. 00 05400 RABI OLOGY HERAPY 0.226158 94. 268 21. 319 60. 00 66. 00 66. 00 0.6000 LABORATORY 0.233281 111. 064 35. 905 67. 00 66. 00 0.6300 SPECH PATHOLOGY 0.335362 280. 495 99. 190 66. 00 69. 00 0.6900 ELECTROCARDI OLOGY 0.156833 2. 102 33. 69. 00 71. 00 72. 00 71. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 7	Cost Center Description		R				
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 0 30.00 ANCI LLARY SERVI CE COST CENTERS 0 30.00 50.00 05000 OPERATI NG ROOM 0.270539 0 0 50.00 51.00 05000 OPERATI NG ROOM 0.270539 0 0 53.00 54.00 05400 RADI OLOGY DI AGNOSTI C 0.135889 48.632 6.609 54.00 60.00 06000 LABORATORY 0.226158 94.268 21,319 60.00 65.00 06500 RESPI RATORY THERAPY 0.333626 280,495 99,190 66.00 66.00 06600 SPECH PATHOLOGY 0.383281 111,064 35,905 67.00 68.00 06900 SPECH PATHOLOGY 0.3836210 2,225 1,994 68.00 69.00 0 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00 72.01 72.00				To Charges			
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73. 00 07300 DRUGS CHARGED TO PATIENTS 0.312555 175, 346 54, 805 73. 00 0UTPATIENT SERVICE COST CENTERS 001704 EMERGENCY 0.328399 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.978843 0 0 92. 00 200. 00 Total (sum of lines 50-94 and 96-98) 844, 581 292, 154 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 27427	48, 236	13, 230	71.00
OUTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.328399 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.978843 0 0 92.00 200.00 Total (sum of lines 50-94 and 96-98) 844, 581 292, 154 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 73715	0	0	72.00
91. 00 09100 EMERGENCY 0. 328399 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 978843 0 0 92. 00 200. 00 Total (sum of lines 50-94 and 96-98) 844, 581 292, 154 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00	73.00 07300 DRUGS CHARGED TO PATIENTS			0. 31255	5 175, 346	54, 805	73.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.978843 0 92.00 200.00 Total (sum of lines 50-94 and 96-98) 844,581 292,154 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201.00							
200.00 Total (sum of lines 50-94 and 96-98) 844, 581 292, 154 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00						0	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 97884	3 0	0	92.00
					844, 581	292, 154	1
202.00 Net Charges (line 200 minus line 201) 844, 581 202.00		ogram only charges (line	61)		0		
	202.00 Net Charges (line 200 minus line 201)				844, 581		202.00

Health Financial Systems	ST. VINCENT CLAY H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 151309	Peri od:	Worksheet D-3	;
				From 07/01/2013 To 06/30/2014	Date/Time Pre	nared
				10 00/ 30/ 2014	11/21/2014 9:	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			1	177, 262		30.00
ANCI LLARY SERVICE COST CENTERS				177,202		
50. 00 05000 OPERATING ROOM			0, 2705;	39 41, 296	11, 172	50.00
53. 00 05300 ANESTHESI OLOGY			0.0000		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 13588	42, 210	5, 736	54.00
60. 00 06000 LABORATORY			0. 2261	58 47, 267	10, 690	60.00
65. 00 06500 RESPI RATORY THERAPY			0. 7148	79 48, 918	34, 970	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 35362		4, 001	
67.00 06700 OCCUPATI ONAL THERAPY			0. 32328		0	01100
68.00 06800 SPEECH PATHOLOGY			0. 8962		217	
69. 00 06900 ELECTROCARDI OLOGY			0. 15683			
70.00 07000 ELECTROENCEPHALOGRAPHY			0.0000		0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS			0. 2742			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS			0.7371		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 3125	55 100, 916	31, 542	73.00
0UTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY			0. 32839		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 3283			1 00
200.00 Total (sum of lines 50-94 and 96-98)			0. 97004	328, 644	8	
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)		520, 044 Λ	100, 505	200.00
202.00 Net Charges (line 200 minus line 201)	ogram onry charges (328, 644		202.00
			1	320, 044	I	1202.00

LCUL#	Financial Systems ST. VINCENT CLAY	Provider CCN: 151309	Period: From 07/01/2013 To 06/30/2014		
		Title XVIII	Hospi tal	Cost	
				1.00	
1	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
oc	Medical and other services (see instructions)			3, 968, 733	
	Medical and other services reimbursed under OPPS (see instructi	ons)		0	
	PPS payments Outlier payment (see instructions)			0	3.0
	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruct	tions)		0.000	
	Line 2 times line 5			0.000	
00	Sum of line 3 plus line 4 divided by line 6			0.00	7.0
	Transitional corridor payment (see instructions)			0	
	Ancillary service other pass through costs from Worksheet D, Pa	art IV, column 13, line	200	0	9.0
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			3, 968, 733	
	COMPUTATION OF LESSER OF COST OR CHARGES			3, 700, 733	1
	Reasonabl e charges				1
	Ancillary service charges			0	
	Organ acquisition charges (from Worksheet D-4, Part III, line 6 Total reasonable charges (sum of lines 12 and 13)	59, COL. 4)		0	
	Customary charges			0	14.
. 00	Aggregate amount actually collected from patients liable for pa			0	15.
	Amounts that would have been realized from patients liable for	payment for services of	n a chargebasis	0	16.
	had such payment been made in accordance with 42 CFR 413.13(e)			0,00000	17
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	
	Excess of customary charges over reasonable cost (complete only	/ifline 18 exceeds li	ne 11) (see	0	
	instructions)				
	Excess of reasonable cost over customary charges (complete only	/ifline 11 exceeds li	ne 18) (see	0	20.
	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		4, 008, 420	21.
	Interns and residents (see instructions)	riisti ucti olis)		4, 008, 420	
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	
	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			38, 435	25.
	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH. see instructions)		2, 558, 967	
	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus 1			1, 411, 018	
	see instructions)				
	Direct graduate medical education payments (from Worksheet E-4,	-		0	28.
	ESRD direct medical education costs (from Worksheet E-4, line 3 Subtotal (sum of lines 27 through 29)	36)		0 1, 411, 018	
	Primary payer payments			594	
	Subtotal (line 30 minus line 31)			1, 410, 424	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)		-	
	Composite rate ESRD (from Worksheet 1–5, line 11) Allowable bad debts (see instructions)			0 439, 513	33.
	Adjusted reimbursable bad debts (see instructions)			386, 771	
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		366, 207	
	Subtotal (see instructions)			1, 797, 195	
	MSP-LCC reconciliation amount from PS&R			0	38.
. 00 . 98	Partial or full credits received from manufacturers for replace	ad devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	39.
	Subtotal (see instructions)			1, 797, 195	40.
	Sequestration adjustment (see instructions)			35, 944	
	Interim payments			2, 006, 653	
	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 -245, 402	42.
	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2.	chapter 1.	-243, 402	43.
ļ	§115. 2				_ · ··
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90.
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	
	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			0	

IALY:	I Financial Systems ST. VINCENT C SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	LAY HOSPITAL Provider	CCN: 151309	Peri od:	u of Form CMS-2 Worksheet E-1	
				From 07/01/2013 To 06/30/2014		nareo
					11/21/2014 9:	
			e XVIII	Hospi tal	Cost	
		Inpatier	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		1, 522, 3		2, 006, 653	1.
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2.
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3
03				0	0	3
04				0	0	
05	Provider to Program			0	0	3
50	ADJUSTMENTS TO PROGRAM		1	0	0	3
51				0	0	
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 522, 3	71	2, 006, 653	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate)					
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1			5
00	desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1)					
	Program to Provider		-			
01	TENTATI VE TO PROVIDER			0	0	
02 03				0	0	5
03	Provider to Program			0	0	
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
00	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		129, 9	14	0	6
02	SETTLEMENT TO PROGRAM			0	245, 402	6
00	Total Medicare program liability (see instructions)		1, 652, 2		1, 761, 251	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
00	Name of Contractor					8

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		F	eriod: rom 07/01/2013		
		Component	t CCN: 15Z309 T	06/30/2014	Date/Time Pre 11/21/2014 9:	
		Titl	e XVIII S	wing Beds - SNF		44 ai
		Inpatien	nt Part A		тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		1, 097, 236		0	
00	Interim payments payable on individual bills, either		C		0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					J .
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			1		
01	ADJUSTMENTS TO PROVIDER		C		0	
2			C		0	
23			0		0	
04 05					0	
55	Provider to Program				0	- 3
50	ADJUSTMENTS TO PROGRAM		l c		0	1 3
51			0		0	
52			c d		0	3
53			0		0	3
54			C		0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		1, 097, 236		0	4
50	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 077, 230		0	4
	appropriate)					
	TO BE COMPLÉTED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					-
01	TENTATI VE TO PROVIDER		0		0	15
)2					0	
03			c d		0	5
	Provider to Program	1		1		
50	TENTATI VE TO PROGRAM		C		0	
51			0		0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	
19	5. 50-5. 98)				0	5
00	Determined net settlement amount (balance due) based on					6
01	the cost report. (1) SETTLEMENT TO PROVIDER		43, 641		0	6
)1)2	SETTLEMENT TO PROVIDER		43, 641		0	
)2)0	Total Medicare program liability (see instructions)		1, 140, 877		0	
- 0			.,	Contractor	NPR Date	t í
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	

Heal th	Financial Systems ST. VINCENT CLAY H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15130	F	Period: From 07/01/2013	Worksheet E-2	
		Component CCN: 15Z3	09 1	To 06/30/2014	Date/Time Pre 11/21/2014 9:4	
		Title XVIII	S	Swing Beds - SNF	Cost	
				Part A	Part B	
				1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)			873, 864	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)					2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part	A, and sum of Wkst.	D,	295, 076	0	3.00
	Part V, columns 6 and 7, line 202 for Part B) (For CAH, see ins	tructions)				
4.00	Per diem cost for interns and residents not in approved teaching	g program (see			0.00	4.00
	instructions)					
5.00	Program days			782	0	5.00
6.00	Interns and residents not in approved teaching program (see ins				0	6.00
7.00	Utilization review - physician compensation - SNF optional method	od only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)			1, 168, 940	0	8.00
9.00	Primary payer payments (see instructions)			0	0	9.00
10.00	Subtotal (line 8 minus line 9)			1, 168, 940	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applical professional services)	ble to physician		0	0	11.00
12.00	Subtotal (line 10 minus line 11)			1, 168, 940	0	12.00
13.00	Coinsurance billed to program patients (from provider records) for physician professional services)	(exclude coinsurance	Э	4, 780	0	13.00
14.00	80% of Part B costs (line 12 x 80%)				0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1, 164, 160	0	15.00
16.00)		1, 104, 100	0	16.00
16.50	RURAL DEMONSTRATION PROJECT			0	0	16.50
17.00	Allowable bad debts (see instructions)			0	0	
17.00	Adjusted reimbursable bad debts (see instructions)			0	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	ctions)		0	0	18.00
19.00	Total (see instructions)			1, 164, 160	0	
19.00	Sequestration adjustment (see instructions)			23, 283	0	
20.00	Interim payments			1, 097, 236	0	20.00
20.00	Tentative settlement (for contractor use only)			1, 077, 230	0	
21.00	Balance due provider/program line 19 minus lines 19.01, 20 and 2	01		43, 641	0	21.00
22.00	Protested amounts (nonallowable cost report items) in accordance		5	43, 041	0	22.00
23.00	section 115.2	e with CMS Pub. 15-2	<u> </u>	0	0	23.00

	Financial Systems ST. VINCENT CLA ATION OF REIMBURSEMENT SETTLEMENT	AY HOSPITAL Provider CCN: 151309	Peri od:	u of Form CMS-2 Worksheet E-3	
ALGOL			From 07/01/2013 To 06/30/2014	Part V Date/Time Pre 11/21/2014 9:4	pared
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	F PART A SERVICES - COST	RELMBURSEMENT	1.00	
. 00	Inpatient services			1, 917, 861	1 1.
. 00	Nursing and Allied Health Managed Care payment (see instruct	i on)		0	2.
. 00	Organ acquisition	,		0	3.
. 00	Subtotal (sum of lines 1 thru 3)			1, 917, 861	4.
. 00	Primary payer payments			10, 000	5.
. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 927, 040	6.
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
. 00	Routi ne servi ce charges			0	7.
. 00	Ancillary service charges			0	8.
. 00	Organ acquisition charges, net of revenue			0	9.
0.00	Total reasonable charges			0	10.
	Customary charges				
1.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	11.
2.00	Amounts that would have been realized from patients liable f	for payment for services o	n a charge basis	0	12.
	had such payment been made in accordance with 42 CFR 413.13(e)			
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13.
4.00	Total customary charges (see instructions)			0	14
5.00	Excess of customary charges over reasonable cost (complete o	nly if line 14 exceeds li	ne 6) (see	0	15.
	instructions)				
6.00	Excess of reasonable cost over customary charges (complete o	nly if line 6 exceeds lin	e 14) (see	0	16.
	instructions)				
7.00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	17.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
8.00	Direct graduate medical education payments (from Worksheet E	4, line 49)		0	-
9.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 927, 040	
0.00	Deductibles (exclude professional component)			258, 085	
1.00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			1, 668, 955	
3.00	Coinsurance			4, 440	
4.00	Subtotal (line 22 minus line 23)			1, 664, 515	
5.00	Allowable bad debts (exclude bad debts for professional serv	(see instructions)		24, 420	
6.00	Adjusted reimbursable bad debts (see instructions)	tructions)		21, 490	
7.00	Allowable bad debts for dual eligible beneficiaries (see ins	iructions)		13, 791	
3.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 686, 005	
9.00	Descurry of Assal anatod Despect -+:			0	
9.99	Recovery of Accelerated Depreciation			0	
0.00	Subtotal (line 28, plus or minus lines 29)			1, 686, 005	
0.01	Sequestration adjustment (see instructions)			33, 720	
	Interim payments			1, 522, 371	
2.00	Tentative settlement (for contractor use only)	and 22		0	
3.00 4.00	Balance due provider/program line 30 minus lines 30.01, 31,		abortor 1	129, 914	
4 UU	Protested amounts (nonallowable cost report items) in accord	ance with UMS PUD. 15-2,	chapter I,	0	34.

CALCUL	Financial Systems ST. VINCENT CLAY HO ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151309	Peri od:	Worksheet E-3	
			From 07/01/2013 To 06/30/2014	Part VII Date/Time Pre 11/21/2014 9:4	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	CES FOR TITLES V OR X	IX SERVICES		-
1.00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient hospital/SNF/NF services		223, 010		1.00
2.00	Medical and other services		223,010	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		223, 010	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		223, 010	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
8.00	Routi ne servi ce charges		2, 613, 561		8.00
9.00	Ancillary service charges		328, 644	0	9.00
10.00	Organ acquisition charges, net of revenue		0	-	10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2, 942, 205	0	12.00
	CUSTOMARY CHARGES	· ·			1 4 9 9 9
13.00	Amount actually collected from patients liable for payment for so	ervices on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable for p	avment for services o	n	0	14.00
14.00	a charge basis had such payment been made in accordance with 42			0	14.00
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)		2, 942, 205	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only	ifline 16 exceeds	2, 719, 195	0	17.00
	line 4) (see instructions)				10.00
18.00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	IT LINE 4 exceeds LIN	e 0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	,	223, 010	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	mpleted for PPS provi	ders.		
22.00	Other than outlier payments		0	0	
	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00 26.00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	25.00 26.00
20.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		223, 010	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		223, 010	0	
32.00	Deductibles		0	0	
	Coinsurance Allowable bad debts (see instructions)		0	0	
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	223, 010	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	0	37.00
38.00	Subtotal (line 36 ± line 37)		223, 010	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		223, 010	0	
41.00	Interim payments		223, 010	0	
42.00 43.00	Balance due provider/program (line 40 minus line 41)		0	0	
	Protested amounts (nonallowable cost report items) in accordance	WITH UNS PUD 15-2.	0	0	43.00

	SHEET (If you are nonproprietary and do not maintain			Period:	Worksheet G	
ind-ty	pe accounting records, complete the General Fund column onl	y)		rom 07/01/2013 o 06/30/2014	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	11/21/2014 9: Plant Fund	44 8
			Purpose Fund			
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
	Cash on hand in banks	922, 93	3 0	0	0	1 1
	Temporary investments	80, 38			0	
	Notes recei vabl e		o c	0 0	0	
00	Accounts receivable	6, 025, 01	B C	0 0	0	4
	Other receivable	1, 905, 51			0	
	Allowances for uncollectible notes and accounts receivable	-3, 428, 96			0	
	Inventory	490, 91		-	0	
	Prepaid expenses	238, 91			0	
	Other current assets	-88, 52			0	
	Due from other funds Tatal surrent assats (sum of lines 1 10)				0	
	Total current assets (sum of lines 1-10) FIXED ASSETS	6, 146, 18		0	0	1'
	Land	2, 50		0 0	0	11:
	Land improvements	304, 99			0	
	Accumul ated depreciation	-299, 69			0	
. 00	Buildings	8, 931, 16	в с	0 0	0	1!
	Accumulated depreciation	-3, 498, 09	1 C	0 0	0	10
	Leasehold improvements	435, 08			0	
	Accumul ated depreciation	-413, 05			0	
	Fixed equipment	2, 710, 35			0	
	Accumulated depreciation	-2, 288, 56			0	
	Automobiles and trucks				0	
	Accumulated depreciation	(050 02)			0	
	Major movable equipment Accumulated depreciation	6, 850, 02 -5, 915, 81			0	
	Mi nor equi pment depreci abl e				0	
	Accumul ated depreciation				0	
	HIT designated Assets				0	
	Accumul ated depreciation				0	
	Mi nor equi pment-nondepreci abl e				0	
	Total fixed assets (sum of lines 12-29)	6, 818, 90	2 C	0 0	0	30
	OTHER ASSETS		-			
	Investments		o C		0	
	Deposits on Leases		o c	0 0	0	
	Due from owners/officers		D C	0 0	0	
	Other assets	36, 406, 28			0	
	Total other assets (sum of lines 31-34)	36, 406, 28			0	
	Total assets (sum of lines 11, 30, and 35)	49, 371, 37	2 1, 773, 368	3 0	0	36
	CURRENT LI ABI LI TI ES Accounts payable	735, 94	7 0	0 0	0	37
	Sal ari es, wages, and fees payable	730, 23			0	
	Payroll taxes payable	750,25			0	
	Notes and Loans payable (short term)	112, 82			0	
	Deferred income			0	0	
	Accelerated payments		b			42
	Due to other funds		o c	0	0	
. 00	Other current liabilities	1, 859, 19			0	
. 00	Total current liabilities (sum of lines 37 thru 44)	3, 438, 20	в с	0 0	0	4!
	LONG TERM LIABILITIES			1		
	Mortgage payable				0	
	Notes payable	7, 773, 14	3 0	0	0	
	Unsecured Loans	40.00			0	
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 40	42, 92 7, 816, 06			0	
	Total long term liabilities (sum of lines 46 thru 49 Total liabilites (sum of lines 45 and 50)	11, 254, 27			0	
	CAPITAL ACCOUNTS	11, 204, 27		<u></u>	0	10
	General fund balance	38, 117, 09	9			5
	Specific purpose fund	00, 117, 09	1, 773, 368	3		5
	Donor created - endowment fund balance - restricted			0		5
	Donor created - endowment fund balance - unrestricted			0		5
	Governing body created - endowment fund balance			0		5
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	38, 117, 09			0	
. 00	Total liabilities and fund balances (sum of lines 51 and	49, 371, 37	2 1, 773, 368		0	60

near th	Financial Systems	ST. VINCENT CLA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
STATEN	IENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 151309	Period: From 07/01/2013 To 06/30/2014	Worksheet G-1 Date/Time Pres	hared.
						11/21/2014 9:4	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		32, 627, 008		1, 577, 878		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6, 330, 981				2.00
3.00	Total (sum of line 1 and line 2)		38, 957, 989		1, 577, 878		3.00
4.00	DEFERRED PENSION COSTS	94, 080			0	0	4.00
5.00	CONTRI BUTI ONS	314, 490		350, 1		0	5.00
6.00	RESTRICTED INVEST. INCOME - HSD	0		73, 8		0	6.00
7.00		0			0	0	7.00
8.00 9.00	OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD	0		105, 1	36	0	8.00 9.00
9.00 10.00	Total additions (sum of line 4-9)	0	408, 570		530, 188	Ű	9.00 10.00
11.00	Subtotal (line 3 plus line 10)		39, 366, 559		2, 108, 066		11.00
12.00	TRANSFERS TO AFFILIATES	1, 248, 474	37, 300, 337		2, 108, 000	0	12.00
13.00	NET ASSETS RELEASED FROM RESTRI - OP	1, 240, 474		15, 50	-	0	13.00
14.00	RESTRICTED INVEST. INCOME - NON-HSD	0		4, 70		0	14.00
15.00	NET ASSETS RELEASED FROM RESTRI - CA	0		314, 4		0	15.00
16.00	OTHER RESTRICTED ACTIVITY	986		0.171	0	0	16.00
17.00	ROUNDI NG	0			0	0	17.00
18.00	Total deductions (sum of lines 12-17)		1, 249, 460		334, 698		18.00
19.00	Fund balance at end of period per balance		38, 117, 099		1, 773, 368		19.00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		6.00	7.00				
			7.00	8,00			
1.00	Fund balances at beginning of period	0	7.00	8.00	0		1.00
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		7.00	8.00	0		1.00 2.00
			7.00	8.00	0		
2.00	Net income (loss) (from Wkst. G-3, line 29)	0	7.00	8.00			2.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) DEFERRED PENSION COSTS CONTRIBUTIONS	0		8.00			2.00 3.00 4.00 5.00
2.00 3.00 4.00 5.00 6.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) DEFERRED PENSION COSTS	0		8.00			2.00 3.00 4.00 5.00 6.00
2.00 3.00 4.00 5.00 6.00 7.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) DEFERRED PENSION COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD	0		8.00			2.00 3.00 4.00 5.00 6.00 7.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Net income (loss) (From Wkst. G-3, line 29) Total (sum of line 1 and line 2) DEFERRED PENSION COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY	0		8.00			2.00 3.00 4.00 5.00 6.00 7.00 8.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (From Wkst. G-3, line 29) Total (sum of line 1 and line 2) DEFERRED PENSION COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD	0		8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Net income (loss) (From Wkst. G-3, line 29) Total (sum of line 1 and line 2) DEFERRED PENSION COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD Total additions (sum of line 4-9)	0		8.00			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Net income (Loss) (From WKst. G-3, Line 29) Total (sum of Line 1 and Line 2) DEFERRED PENSLON COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD Total additions (sum of Line 4-9) Subtotal (Line 3 plus Line 10)	0		8.00	0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$	Net income (Loss) (From WKst. G-3, Line 29) Total (sum of Line 1 and Line 2) DEFERRED PENSLON COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD Total additions (sum of Line 4-9) Subtotal (Line 3 plus Line 10) TRANSFERS TO AFFILIATES	0		8.00	0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$	Net income (Loss) (From WKst. G-3, Line 29) Total (sum of Line 1 and Line 2) DEFERRED PENSLON COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD Total additions (sum of Line 4-9) Subtotal (Line 3 plus Line 10) TRANSFERS TO AFFILIATES NET ASSETS RELEASED FROM RESTRI - OP	0		8.00	0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Net income (Loss) (From Wkst. G-3, Line 29) Total (sum of Line 1 and Line 2) DEFERRED PENSLON COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD Total additions (sum of Line 4-9) Subtotal (Line 3 plus Line 10) TRANSFERS TO AFFLLIATES NET ASSETS RELEASED FROM RESTRI - OP RESTRICTED INVEST. INCOME - NON-HSD	0		8.00	0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	Net income (Loss) (From Wkst. G-3, Line 29) Total (sum of Line 1 and Line 2) DEFERRED PENSION COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD Total additions (sum of Line 4-9) Subtotal (Line 3 plus Line 10) TRANSFERS TO AFFILIATES NET ASSETS RELEASED FROM RESTRI - OP RESTRICTED INVEST. INCOME - NON-HSD NET ASSETS RELEASED FROM RESTRI - CA	0		8.00	0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (Loss) (From Wkst. G-3, Line 29) Total (sum of Line 1 and Line 2) DEFERRED PENSION COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD Total additions (sum of Line 4-9) Subtotal (Line 3 plus Line 10) TRANSFERS TO AFFILLATES NET ASSETS RELEASED FROM RESTRI - OP RESTRICTED INVEST. INCOME - NON-HSD NET ASSETS RELEASED FROM RESTRI - CA OTHER RESTRICTED ACTIVITY	0		8.00	0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (Loss) (From Wkst. G-3, Line 29) Total (sum of Line 1 and Line 2) DEFERRED PENSION COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD Total additions (sum of Line 4-9) Subtotal (Line 3 plus Line 10) TRANSFERS TO AFFILIATES NET ASSETS RELEASED FROM RESTRI - OP RESTRICTED INVEST. INCOME - NON-HSD NET ASSETS RELEASED FROM RESTRI - CA OTHER RESTRICTED ACTIVITY ROUNDING	0		8.00	0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	Net income (Loss) (From WKst. G-3, Line 29) Total (sum of Line 1 and Line 2) DEFERRED PENSION COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD Total additions (sum of Line 4-9) Subtotal (Line 3 plus Line 10) TRANSFERS TO AFFILIATES NET ASSETS RELEASED FROM RESTRI - OP RESTRICTED INVEST. INCOME - NON-HSD NET ASSETS RELEASED FROM RESTRI - CA OTHER RESTRICTED ACTIVITY ROUNDING Total deductions (sum of Lines 12-17)	0		8.00	0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (Loss) (From Wkst. G-3, Line 29) Total (sum of Line 1 and Line 2) DEFERRED PENSION COSTS CONTRIBUTIONS RESTRICTED INVEST. INCOME - HSD OTHER RESTRICTED ACTIVITY UNREALIZED LOSS-RESTR. HSD & NON HSD Total additions (sum of Line 4-9) Subtotal (Line 3 plus Line 10) TRANSFERS TO AFFILIATES NET ASSETS RELEASED FROM RESTRI - OP RESTRICTED INVEST. INCOME - NON-HSD NET ASSETS RELEASED FROM RESTRI - CA OTHER RESTRICTED ACTIVITY ROUNDING	0		8.00	0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$

Heal th	Fi nanci al	Systems
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In Lieu of Form CMS-2552-10

Heal th	Financial Systems ST. VINCENT CLAY F	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet G-2 Parts I & II Date/Time Pre 11/21/2014 9:	pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		2, 490, 95	6	2, 490, 956	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	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)		2, 490, 95	6	2, 490, 956	10.00
	Intensive Care Type Inpatient Hospital Services		1			
11.00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of I 11-15)	i nes		0	0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		2, 490, 95	6	2, 490, 956	17.00
18.00	Ancillary services		5, 203, 03	3 36, 633, 696	41, 836, 729	18.00
19.00	Outpatient services			0 11, 046, 843	11, 046, 843	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVI CES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	ANESTHESI OLOGY			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	7, 693, 98	9 47, 680, 539	55, 374, 528	28.00
	G-3, line 1)					
	PART II – OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			17, 528, 021		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	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		17, 528, 021		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems ST. VINCENT CLAY	HOSPI TAI	Inlie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provider CCN: 151309	Peri od:	Worksheet G-3	
			From 07/01/2013		
			To 06/30/2014		pared:
				11/21/2014 9:	44 am
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	20)		55, 374, 528	1.00
2.00	Less contractual allowances and discounts on patients' account:			35, 522, 593	2.00
3.00	Net patient revenues (line 1 minus line 2)	5		19, 851, 935	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4)	3)		17, 528, 021	4.00
4.00 5.00	Net income from service to patients (line 3 minus line 4)	3)		2, 323, 914	
5.00	OTHER INCOME			2, 323, 714	5.00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			1, 437, 676	7.00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8.00
9.00	Revenue from tel evi si on and radi o servi ce			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			29, 239	14.00
15.00	Revenue from rental of living guarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other the	an patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			598	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			90, 226	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			10, 223	24.00
24.01	ASSETS RELEASED FROM RESTRICTION			15, 503	24.01
24.02	UNREALI ZED LOSS			2, 419, 190	24.02
24.03	GRANT REVENUE			9, 167	24.03
24.04	MANAGEMENT FEE REVENUE			7, 256	
24.05	GAIN ON SALE OF PP&E			1, 500	
25.00	Total other income (sum of lines 6-24)			4, 020, 578	
26.00	Total (line 5 plus line 25)			6, 344, 492	
27.00				0	
27.01	FUNDRAI SI NG EXPENSES			13, 511	
28.00	Total other expenses (sum of line 27 and subscripts)			13, 511	
29.00	Net income (or loss) for the period (line 26 minus line 28)			6, 330, 981	29.00