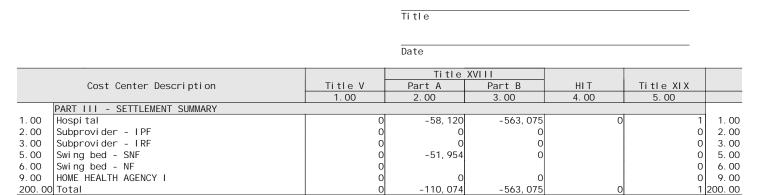
Health Financial Syst	tems	SI. VINCENI RANDOLPH	I HUSPITAL	In Lieu	」of Form CMS-2	2552-10
This report is requi	red by I aw (42 USC 1395g;	; 42 CFR 413.20(b)). Failu	ire to report can res	sult in all interim	FORM APPROVED	
payments made since	the beginning of the cos	t reporting period being c	eemed overpayments ((42 USC 1395g).	OMB NO. 0938-0	0050
HOSPITAL AND HOSPITA AND SETTLEMENT SUMMA	L HEALTH CARE COMPLEX CO RY	ST REPORT CERTIFICATION	Provider CCN: 15130	1 Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prep 11/21/2014 9:4	
PART I - COST REPORT	STATUS					
Provider 1. [X]Electronically filed c	ost report		Date: 11/21/20	014 Time: 9	:48 am
use only 2. []Manually submitted cos	t report				
		report enter the number of Enter "F" for full or "L"		resubmitted this co	ost report	
use onl y (1) (2) (3) (4)	As Submitted 7 Settled without Audit 8	b. Date Received: 7 Contractor No. 8. [N] Initial Report for 9. [N] Final Report for th	this Provider CCN 12			
PART II - CERTIFICAT	ION					
ADMINISTRATIVE ACTIO PROVIDED OR PROCURED	N, FINE AND/OR IMPRISONM	FORMATION CONTAINED IN THI ENT UNDER FEDERAL LAW. FU ECTLY OR INDIRECTLY OF A K MENT MAY RESULT.	RTHERMORE, IF SERVIC	CES IDENTIFIED IN TH	IS REPORT WERE	

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT RANDOLPH HOSPITAL (151301) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)

Officer or Administrator of Provider(s)



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

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1. 00 2. 00 2. 01 3. 00 4. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital?) In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to no for the portion of the cost repor instructions) Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per If this provider is an IPPS hospital in-state Medicaid paid days in col. Medicaid eligible unpaid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible unpaid column 5, and other Medicaid days in	Ance with ity subjecter "Y" for compensatives or "N" October 1 ting peri dicaid da f census is cost r iod? In , enter 1 1, in-sta . 2, col. 3, d days in t unpaid column 6	the act col. days in b.	§412.106 2 CFR Sec payments for the in colum rring on nes 24 a - 3 if da period 2, enter In-Stat Medicai paid da	6? In constraints of the second secon	blumn 1, 12.06(c) s cost of the for yes c 0ctobe 5 below scharge yes or tate caid ible 1 aid p ys 00	enter "Y)(2)(Pickl reporting cost s or "N" f er 1. (see ? In colum e. Is the the metho "N" for n Out-of State Medicaid vaid days 3.00	e N or or of State Medicaid eligible unpaid	2 Medi ca HMO da	i d C ys Me	N N di cai d days 6. 00	21. 00 22. 00 22. 01 23. 00 23. 00 24. 00
1. 00 2. 00 2. 01 3. 00 4. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital? In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to no for the portion of the cost repor instructions) Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting period out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in RF, enter th	ance with ity subjecter "Y" of compensations october 1 ting peri dicaid da f census is cost r iod? In , enter 1 1, in-sta . 2, col. 3, d days ir t unpaid e in-stat	the attention of the ted care of the form of the ted care of the form of the ted care of the the coll of the the the the coll.	§412.106 2 CFR Sec payments for the in colum rring on nes 24 a - 3 if da period 2, enter In-Stat Medicai paid da	6? In constraints of the second secon	olumn 1, 12.06(c) s cost of the for yes c 0ctobe 5 below? scharge nt from yes or tate caid i ble 1 aid p ys 00	enter "Y (2)(Pickl reporting cost s or "N" f er 1. (see ? In colum the metho "N" for n Out-of State Medicaid vaid days 3.00	e N e N or n d o. Out-of State Medicaid el igible unpaid 4.00 0	2 Medi ca HMO da	id C ys Me	N N di cai d days 6. 00	21. 00 22. 00 22. 01
1. 00 2. 00 2. 01 3. 00 4. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital?) In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to no for the portion of the cost repor instructions) Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per If this provider is an IPPS hospital in-state Medicaid paid days in col. Medicaid eligible unpaid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible unpaid column 5, and other Medicaid days in	ance with ity subjecter "Y" of compensations october 1 ting peri dicaid da f census is cost r iod? In , enter 1 1, in-sta . 2, col. 3, d days ir t unpaid e in-state Me	the attention of the ted care of the form of the ted care of the form of the ted care of the the coll of the the the the coll.	§412.106 2 CFR Sec payments for the in colum rring on nes 24 a - 3 if da period 2, enter In-Stat Medicai paid da	6? In constraints of the second secon	olumn 1, 12.06(c) s cost of the for yes c 0ctobe 5 below? scharge nt from yes or tate caid i ble 1 aid p ys 00	enter "Y (2)(Pickl reporting cost s or "N" f er 1. (see ? In colum the metho "N" for n Out-of State Medicaid vaid days 3.00	e N e N or n d o. Out-of State Medicaid el igible unpaid 4.00 0	2 Medi ca HMO da	id C ys Me	N N di cai d days 6. 00	21. 00 22. 00 22. 01 23. 00 23. 00 24. 00
1. 00 2. 00 2. 01 3. 00 4. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital? In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to no for the portion of the cost repor instructions) Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting period out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-state	ance with ity subjecter "Y" if compensatives or "N" October 1 ting peri dicaid da f census is cost r iod? In , enter t 1, in-state . 2, . ol. 3, d days in t unpaid of of state Me of state Me	the act col. days in b. days in b.	§412.106 2 CFR Sec payments for the in colum rring on nes 24 a - 3 if da period 2, enter In-Stat Medicai paid da	6? In constraints of the second secon	olumn 1, 12.06(c) s cost of the for yes c 0ctobe 5 below? scharge nt from yes or tate caid i ble 1 aid p ys 00	enter "Y (2)(Pickl reporting cost s or "N" f er 1. (see ? In colum the metho "N" for n Out-of State Medicaid vaid days 3.00	e N e N or n d o. Out-of State Medicaid el igible unpaid 4.00 0	2 Medi ca HMO da	id C ys Me	N N di cai d days 6. 00	21. 00 22. 00 22. 01 23. 00 23. 00 24. 00
1. 00 2. 00 2. 01 3. 00 4. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital? In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to no for the portion of the cost repor instructions) Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting perior out-of-state Medicaid paid days in col. Medicaid eligible unpaid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in col. 1, the in eligible unpaid days in col. 2, out-	ance with ity subjecter "Y" if compensatives or "N" October 1 ting peri dicaid da f census is cost r iod? In , enter 1 1, in-sta . 2, col. 3, d days ir it unpaid column 6 e in-state Me of-state de Medicai caid HMO	the act col. days in b. days in b.	§412.106 2 CFR Sec payments for the in colum rring on nes 24 a - 3 if da period 2, enter In-Stat Medicai paid da	6? In constraints of the second secon	olumn 1, 12.06(c) s cost of the for yes c 0ctobe 5 below? scharge nt from yes or tate caid i ble 1 aid p ys 00	enter "Y (2)(Pickl reporting cost s or "N" f er 1. (see ? In colum the metho "N" for n Out-of State Medicaid vaid days 3.00	e N e N or n d o. Out-of State Medicaid el igible unpaid 4.00 0	2 Medi ca HMO da	id C ys Me	N N di cai d days 6. 00	21. 00 22. 00 22. 01 23. 00 23. 00 24. 00

Health Financial Systems ST. VINC	ENT RAND	OOLPH HOSPITAL		I	n Lieu	ı of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der		eriod: rom 07/01/	/2013	Workshe Part I		
			T	0 06/30/	/2014	Date/Ti 11/21/2	me Pre 014 8:	pared: 34 am
				Urban/Run 1.00			Geogr	
26.00 Enter your standard geographic classification (not w			jinning of the	1.00	2	2.0	0	26.00
cost reporting period. Enter "1" for urban or "2" fo 27.00 Enter your standard geographic classification (not w			l of the cost		2			27.00
reporting period. Enter in column 1, "1" for urban o	r"2" f	or rural. If ap						
enter the effective date of the geographic reclassif 35.00 If this is a sole community hospital (SCH), enter th			CH status in		0			35.00
effect in the cost reporting period.				Begi nni	ng:	Endi ı	ng:	
36.00 Enter applicable beginning and ending dates of SCH s	tatua	Cubconint Line	24 for number	1.00	Ŭ	2.0	0	36.00
of periods in excess of one and enter subsequent dat	es.							
37.00 If this is a Medicare dependent hospital (MDH), ente in effect in the cost reporting period.	r the n	umber of period	is MDH status		0			37.00
38.00 Enter applicable beginning and ending dates of MDH s of periods in excess of one and enter subsequent dat		Subscript line	38 for number					38.00
	5.			Y/N		Y/I		
39.00 Does this facility qualify for the inpatient hospita	l payme	nt adjustment f	for low volume	1.00		2.0	0	39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage re								
CFR 412. 101(b) (2) (ii)? Enter in column 2 "Y" for yes								
					V 1.00	XVIII 2.00	XI X 3.00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payme	nt for (disproportionat	e share in acc	ordance	N	N	N	45.00
with 42 CFR Section §412.320? (see instructions)								
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wor					N	N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300 PPS cap	ital?	Enter "Y for ve	es or "N" for r	10	N	N	N	47.00
48.00 Is the facility electing full federal capital paymen					N	N	N	48.00
Teaching Hospitals56.00Is this a hospital involved in training residents in	approv	ed GME programs	? Enter "Y" f	for yes	N			56.00
or "N" for no. 57.00 f line 56 is yes, is this the first cost reporting					N			57.00
GME programs trained at this facility? Enter "Y" fo	r yes o	r "N" for no in	n column 1. If	column 1				57.00
is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	Y", com	plete Worksheet						
"N", complete Worksheet D, Part III & IV and D-2, Pa 58.00 If line 56 is yes, did this facility elect cost reim			ins' services a	is	N			58.00
defined in CMS Pub. 15-1, section 2148? If yes, comp	lete Wo	rksheet D-5.			N			59.00
60.00 Are you claiming nursing school and/or allied health	costs	for a program t	hat meets the		N			60.00
provider-operated criteria under §413.85? Enter "Y"	for yes	s or "N" for no IME	Direct GME	tions)		Direct	GME	
	1.00	2.00	3.00	4.00	<u>, </u>	E_0	0	
61.00 Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	0.00	5.0		61.00
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)								
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0.00	0.00					61.01
ending and submitted before March 23, 2010. (see								
instructions) 61.02 Enter the current year total unweighted primary care		0.00	0.00	5				61.02
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								
ACA). (see instructions)		0.00						(1.00
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for		0.00	0.00					61.03
determining compliance with the 75% test. (see instructions)								
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61.04
current cost reporting period. (see instructions).								
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.00	1				61.05
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)								
61.06 Enter the amount of ACA §5503 award that is being		0.00	0.00					61.06
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)								

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	DENTIFICATION DA	TA	Provi der	F	eriod: rom 07/01/2013 o 06/30/2014	Worksheet S-2 Part I Date/Time Prep 11/21/2014 8:3	pared:
		Program	n Name	Program Code	Unweighted IME FTE Count		
		1. (00	2.00	3.00	4.00	
 1.10 Of the FTEs in line 61.05, specify early specialty, if any, and the number of l for each new program. (see instruction column 1 the program name, enter in column 3 the ll unweighted count and enter in column 4 FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify early program specialty, if any, and the num residents for each expanded program. Instructions) Enter in column 1 the preneter in column 2 the program code, enter in column 1 the preneter in column 2 the program code, enter in column 2 the IME FTE unweighted count and enter in column 1 the preneter in column 2 the program code. 3 the IME FTE unweighted count. 	FTE residents ns) Enter in olumn 2 the WE FTE 4 direct GME ch expanded mber of FTE (see rogram name, nter in column				0.00		61. 2
						1.00	
ACA Provisions Affecting the Health R						0.00	
2.00 Enter the number of FTE residents that your hospital received HRSA PCRE fund			this cost	reporting peri	od for which	0.00	62. (
2.01 Enter the number of FTE residents that during in this cost reporting period of	t rotated from a of HRSA THC prog	a Teaching ⊦ gram. (see i	nstruction		your hospital	0.00	62. (
.00 Has your facility trained residents in "Y" for yes or "N" for no in column 1	n non-provider s	settings dur	ing this o	instructions)		N	63.
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	<u> </u>			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE period that begins on or after July 1				inis base year	is your cost r	eporting	
4.00 Enter in column 1, if line 63 is yes, in the base year period, the number or resident FTEs attributable to rotation settings. Enter in column 2 the number resident FTEs that trained in your how of (column 1 divided by (column 1 + column)	or your facilit f unweighted non ns occurring in er of unweighted spital. Enter in olumn 2)). (see	y trained r p-primary ca all non-pro non-primar column 3 t instruction	residents pre vvider y care he ratio ps)	0. 00			
P	rogram Name	Program	1 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	0.00	0. 000000	

	Financial Systems		NT RANDOLPH HOSPI	TAL	In	Lieu of F	orm CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provi	F	Period: From 07/01/20 To 06/30/20	013 Part 014 Date/	heet S-2 I Time Pre /2014 8:	pared:
				Unwei ghted FTEs Nonprovi der Si te	Unweighte FTEs in Hospital	d Ratio (col.	(col. 1/ 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider set	<u> </u>	2.00 for cost repo		i. 00 i ods	
44 00	beginning on or after July 1, 20 Enter in column 1 the number of	010	•	0.0	· · ·	0.00	0. 000000	66 00
00.00	FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	occurring in all non-p unweighted non-primar al. Enter in column 3	provider settings. ry care resident 3 the ratio of				0.000000	00.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighte FTEs in Hospital	(col.	(col. 3/ 3 + col. 4))	
		1.00	2.00	3. 00	4.00	5	. 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 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.0	0 C	0.00	0. 000000	67.00
						1.00 2.0	0 3.00	
	Inpatient Psychiatric Facility F					1.00 2.0	5 5.00	
70.00	ls this facility an Inpatient Ps Enter "Y" for yes or "N" for no		PF), or does it o	contain an IPF sub	provi der?	N		70.00
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 Facilit	ne facility have an appefore 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	04? Enter "Y" fo teaching program no. Column 3: If this cost reporti if the 5th or su	or yes or "N" for in accordance wit column 2 is Y, e ng period covers	no. h 42 CFR nter 1, 2 the	N N	0	71.00
75.00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or does i	t contain an IRF		N		75.00
76.00	subprovider? Enter "Y" for yes 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)? Ent 1, 2 or 3 respectively in column beginning of the fourth year, er the new teaching program in exis	ne facility have an ap ling on or before Nove train residents in a rer "Y" for yes or "N" a. (see instructions nter 4 in column 3, or	mber 15, 2004? Er new teaching proc ' for no. Column 3 s) If this cost re r if the 5th or su	nter "Y" for yes o gram in accordance 3: If column 2 is eporting period co	r "N" for with 42 Y, enter vers the	N N	0	76.00
						1	. 00	
80. 00	Long Term Care Hospital PPS Is this a long term care hospita TEFRA Providers	N (LTCH)? Enter "Y"	for yes and "N" f	or no.			N	80.00
	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded unit) ur			0.	N	85. 00 86. 00
					V			
	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 services	? Enter "Y" for	N		Y	90.00
91.00	Is this hospital reimbursed for	title V and/or XIX th	nrough the cost re	eport either in	N		Υ	91.00
92.00	full or in part? Enter "Y" for y Are title XIX NF patients occupy	ving title XVIII SNF k	oeds (dual certifi	cation)? (see			Ν	92.00
93.00	instructions) Enter "Y" for yes Does this facility operate an IC				N	,	N	93.00
	"Y" for yes or "N" for no in the Does title V or XIX reduce capit	applicable column.			N		N	94.00
	applicable column.		-					
7 0.00	If line 94 is "Y", enter the rec	iuction percentage in	пе аррпсавге со	n ullin.	1 (. 00	0.00	95.00

Health Financial Systems ST. VINCENT RANDOLPH HOSPITAL In Lieu of Fo	rm CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151301 Period: Worksh	eet S-2
From 07/01/2013 Part To 06/30/2014 Date/7	ime Prepared:
11/21/	2014 8:34 am
	I X 00
	N 96.00
applicable column.97.00If line 96 is "Y", enter the reduction percentage in the applicable column.0.00	0.00 97.00
Rural Providers 105.00 Does this hospital qualify as a Critical Access Hospital (CAH)?	105.00
106.00 If this facility qualify as a CAH, has it elected the all-inclusive method of payment N for outpatient services? (see instructions)	105.00
	N 107.00
25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in	
column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	108.00
Physical Occupational Speech Respi	ratory
	00 N 109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	107.00
	3.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for ves or "N" for no in column 1. If yes. N	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, N enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS	0 115.00
15-1, §2208.1.	
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Y	116.00 117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is 2 claim-made. Enter 2 if the policy is occurrence.	118.00
	rance
1.00 2.00 3.	00
118.01 List amounts of mal practice premiums and paid losses: 14,753 0	0 118. 01
1.00 2. 118.02 Are mal practice premiums and paid losses reported in a cost center other than the N	00 118.02
Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	
119.00 DO NOT USE THIS LINE	119.00
§3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient	N 120.00
Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	
121.00 Did this facility incur and report costs for high cost implantable devices charged to Y patients? Enter "Y" for yes or "N" for no.	121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If N	125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification date	126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certification date	127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.	128.00
129.00 If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.	129.00
130.00 If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.	130.00
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155. 00Hospital N 160.00 0 10.00	Does this facility contain a prov	ider that qualifies for a						
156. 00Subprovider - IPF N </td <td>or charges? Enter "Y" for yes or '</td> <td><u>"N" for no for each compo</u></td> <td><u>nent for Part A</u></td> <td>and Part B.</td> <td>(See 42 CFR</td> <td>₹§413.13)</td> <td></td>	or charges? Enter "Y" for yes or '	<u>"N" for no for each compo</u>	<u>nent for Part A</u>	and Part B.	(See 42 CFR	₹§413.13)		
157.00Subprovi der - 1RF N N N N N N 157.00 158.00SUBPROVI DER N N N N N N 158.00 159.00SNF N N N N N N N 159.00 160.00HOME HEALTH AGENCY N N N N N N N 159.00 165.00 15 this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0 0 0.00 166.00 166.00 campus enter the name in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 1, state in column 3, CBSA in column 4, FTE/Campus in column 5 N N 167.00 168.00 if this provider a meaningful user under Section \$1886(n)? Enter "Y" for yes or "N" for no. N 167.00 168.00 168.00 168.00 168.00 <td< td=""><td></td><td></td><td>N</td><td></td><td></td><td></td><td></td></td<>			N					
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1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170.00	transition factor. (see instruction	ons)						
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170.00						,	<u> </u>	
period respectively (mm/dd/yyyy)	170 00 Entor in columns 1 and 2 the FUD I	poginning data and and and	data far tha	porting	1.00	2.00		
	period respectivel v (mm/dd/vvvv)	segranning uate and ending		sporting			170.00	

	Financial Systems S AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	T. VINCENT RANDOLPH HOSPITA STIONNAIRE Provide	er CCN: 151301	Peri od:	eu of Form CMS Worksheet S-	
				From 07/01/2013 To 06/30/2014	Date/Time Pr	
				Y/N	11/21/2014 8 Date	s: 34 an
		E N C H N		1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for all NO	responses. Enter	r all dates in ^r	the	
~~	Provider Organization and Operation		£ +b +	N		
00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of t			N		1.
			Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Program? If	1.00 N	2.00	3.00	2.
00	yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.	on and in column 3, "V" for				2.
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 the relationships? (see instructions)	, chain home offices, drug d to the provider or its , or members of the board				3.
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements pre Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled,		A		4.
00	column 3. (see instructions) If no, see instructions		N			
00	Are the cost report total expenses and total those on the filed financial statements? If		N			5.
				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?	ool?Column 2: If yes, is	the provider is	N		6.
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 renew	ed during the	N N		7. 8.
00	Are costs claimed for Intern-Resident program		ost report? If	N		9.
00	yes, see instructions. Was an Intern-Resident program been initiated	d or renewed in the current	cost reporting	N		10.
	period? If yes, see instructions.					
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		pproved	N		11.
					Y/N	
	Bad Debts				1.00	-
. 00	Is the provider seeking reimbursement for bac	d debts? If yes, see instru	ictions.		Y	12.
	If line 12 is yes, did the provider's bad del			st reporting	N	13.
. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	and/or co-payments waived?	If ves see ins	tructions	N	14.
00	Bed Complement		<u>Jes, see ms</u>			
00	Did total beds available change from the price	or cost reporting period? I	- r		N	15.
		Description	Y/N	rt A Date	Part B Y/N	
		0	1.00	2.00	3.00	
00	PS&R Data		Y	10/20/2014	Y	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		Ť	10/20/2014	Y	10.
	instructions)		N			17
~~	Was the cost report prepared using the PS&R Report for totals and the provider's records		N		N	17.
00	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns		1			18.
			N		N	
	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 included on the PS&R Report used to file		Ν		N	
. 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 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		N		N	19.
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 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					19.

Heal th	Financial Systems S	T. VINCENT RAN	IDOLPH 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 o 06/30/2014		enared
						11/21/2014 8	34 am
					rt A	Part B	
			<u>iption</u> 0	Y/N 1.00	Date 2.00	Y/N 3.00	
21.00	Was the cost report prepared only using the		0	N 1.00	2.00	N	21.00
21.00	provider's records? If yes, see						21.00
	instructions.						
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (FXC)	EPT CHILDRENS H			1.00	
	Capital Related Cost			1001111120)			-
	Have assets been relifed for Medicare purpose					N	22.00
23.00	Have changes occurred in the Medicare depreci	ation expense	due to apprais	sals made durin	g the cost	N	23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing	a Loasos optor	od into during	this cost ropo	rting poriod?	N	24.00
24.00	If yes, see instructions	g reases enter	eu mito during	this cost repo	i tring period?	IN	24.00
25.00	Have there been new capitalized leases entere	ed into during	the cost repor	ting period? I	f yes, see	N	25.00
	instructions.						
26.00	Were assets subject to Sec.2314 of DEFRA acquinstructions.	urred during t	he cost reporti	ng period? If	yes, see	N	26.00
27.00	Has the provider's capitalization policy char	haed durina th	e cost reportir	na period? If v	ves. submit	N	27.00
	сору.	3		5111 5			
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit e	ntered into dur	ring the cost r	eporting	N	28.00
29.00	Did the provider have a funded depreciation a	account and/or	bond funds (De	ebt Service Res	erve Fund)	N	29.00
	treated as a funded depreciation account? If	yes, see inst	ructions				
30.00	Has existing debt been replaced prior to its	schedul ed mat	urity with new	debt? If yes,	see	Ν	30.00
31.00	instructions. Has debt been recalled before scheduled matur	aitu withaut i	couches of new	dabt2 If yoo		N	31.00
31.00	instructions.	T LY WI LIIUUL T	SSUAILCE OF HEW	debt? IT yes,	266	IN	31.00
	Purchased Servi ces						
32.00	Have changes or new agreements occurred in pa			ed through cont	ractual	N	32.00
33.00	arrangements with suppliers of services? If If line 32 is yes, were the requirements of 9			a to compotiti	vo bidding2 lf	N	33.00
33.00	no, see instructions.	sec. 2155.2 ap	pireu pertainii	ig to competiti	ve bruurny: Ti	IN	33.00
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili	ty under an a	rrangement with	n provider-base	d physi ci ans?	Y	34.00
25 00	If yes, see instructions.	an amondod av	icting carcomer	to with the pr	ouidor boood	N	35.00
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?		0 0	its with the pr	ovi dei -based	IN	35.00
	physicians daring the cost reporting period.	11 903, 300 1			Y/N	Date	
	F				1.00	2.00	
24 00	Home Office Costs				V		34 00
	Were home office costs claimed on the cost re If line 36 is yes, has a home office cost sta	•	renared by the	home office?	Y Y		36.00
07.00	If yes, see instructions.	been p	repared by the				07.00
38.00	If line 36 is yes, was the fiscal year end o				N		38.00
20.00	the provider? If yes, enter in column 2 the t	2			N		20.00
39.00	If line 36 is yes, did the provider render se see instructions.	ervices to oth	er chain compor	ients? IT yes,	N		39.00
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lf yes, see	Ν		40.00
	instructions.			-			
			1	00	2	00	_
	Cost Report Preparer Contact Information		<u> </u>	00	Ζ.	00	
41.00	Enter the first name, last name and the title	e/position	JILL		HILL		41.00
	held by the cost report preparer in columns ?	1, 2, and 3,					
12 00	respectively.	conort		Т			42.00
42.00	Enter the employer/company name of the cost preparer.	eport	ST VINCENT HEA				42.00
43.00	Enter the telephone number and email address	of the cost	317-583-3232		JI LL. HI LL@STVI	NCENT. ORG	43.00
	report preparer in columns 1 and 2, respectiv	vel y.	1				

	Financial Systems S AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Pre 11/21/2014 8:	epared:
		Part B Date					
		4.00					
	PS&R Data						
6. 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)	10/20/2014					16.0
	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)						17. C
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.						18. C
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						19. (
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20. (
	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.0
		_	3	00			
	Cost Report Preparer Contact Information				I		
	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		EIMBURSEMENT	MANAGER			41.(
	Enter the employer/company name of the cost r preparer.	report					42.
	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43. (

	Financial Systems S TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	T. VINCENT RAND AI DATA		- CCN: 151301	Peri od:	u of Form CMS-2 Worksheet S-3	1002 10
					From 07/01/2013 To 06/30/2014	Part I	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available 3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	30. 00	2:00				1.00
2. 00 3. 00	for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider						2.00 3.00
4.00 5.00 6.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	4.00 5.00 6.00
7.00 8.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT		2	5 9, 1	25 42, 024. 00	0	7.00 8.00
9.00 10.00 11.00 12.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF	43. 00	2	5 9, 1	25 42, 024. 00	0 0 0	13.00 14.00 15.00
17.00 18.00 19.00 20.00	SUBPROVI DER – I RF SUBPROVI DER SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY						17.00 18.00 19.00 20.00
21.00 22.00 23.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	101.00				0	21. 0 22. 0 23. 0
24.00 24.10 25.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	116. 00 30. 00		0	0		24.00 24.10 25.00
26.00 26.25 27.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)		2	5		0	26.0 26.2 27.0
28.00 29.00 30.00 31.00	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF					0	28.00 29.00 30.00 31.00
32.00 32.01 33.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days			0	0		32.00 32.01 33.00

IOSPI ⁻	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	F	eriod: rom 07/01/2013 o 06/30/2014	Worksheet S-3 Part I Date/Time Pre 11/21/2014 8:	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	752	52	1, 751			1. C
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)	131	349				2.0
. 00	HMO IPF Subprovider	0	0				3.0
. 00	HMO IRF Subprovider	o	0				4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	193	0	193			5. (
. 00	Hospital Adults & Peds. Swing Bed NF		0	55			6.1
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	945	52	1, 999			7.
00	INTENSIVE CARE UNIT						8.
00	CORONARY CARE UNIT						9.
). 00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	OTHER SPECIAL CARE (SPECIFY)		011	100			12.
3.00	NURSERY	0.45	311	420		107 74	13.
4.00	Total (see instructions)	945	363	2, 419		137.74	
5.00 5.00	CAH visits SUBPROVIDER - IPF	12, 641	2, 771	40, 742			15. 16.
7.00	SUBPROVIDER - I RF						10.
3.00	SUBPROVIDER - TRF						17.
<i>9.</i> 00	SKILLED NURSING FACILITY						10.
). 00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	
3.00	AMBULATORY SURGICAL CENTER (D. P.)	U U	Ű	0	01.00	0100	23.
1.00	HOSPICE	0	0	0	0.00	0.00	
1.10	HOSPICE (non-distinct part)	o	0	0			24.
5.00	СМНС – СМНС						25.
5. 00	RURAL HEALTH CLINIC						26.
6. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.
7.00	Total (sum of lines 14-26)				0.00	137.74	27.
3. 00	Observation Bed Days		0	558			28.
9. 00	Ambul ance Tri ps	3					29.
0. 00	Employee discount days (see instruction)			30			30.
1.00	Employee discount days - IRF			0			31.
2.00	Labor & delivery days (see instructions)	0	57	93			32.
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.
3.00	LTCH non-covered days	0					33.

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151301	Period: From 07/01/2013 To 06/30/2014		pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00	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) HMO and other (see instructions)		0		45 42 40 0		1.00 2.00
3.00 4.00 5.00 6.00 7.00 8.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9.00 10.00 11.00 12.00 13.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0. 00	0	2	65 42	747	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	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0.00					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	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0. 00					20. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

Heal th	Financial Systems ST. VINCENT RANDOLPH	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151301	Peri od:	Worksheet S-10	0
				From 07/01/2013		
				To 06/30/2014		
					11/21/2014 8:	34 am
					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 li	ne 202 column	8)	0. 261708	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				5, 783, 637	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	payments	from Medicaid	?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from	Medi cai d			2, 752, 374	5.00
6.00	Medi cai d charges				16, 654, 623	6.00
7.00	Medicaid cost (line 1 times line 6)				4, 358, 648	7.00
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lin	es 2 and 5: if	0	8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instructi	ons for e	ach line)			
9.00	Net revenue from stand-alone SCHIP		/		0	9.00
10.00	Stand-al one SCHIP charges				0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 m	inus line Q.	if < zero then	0	12.00
12.00	enter zero)		innus inne 7,		0	12.00
	Other state or local government indigent care program (see instr	uctions f	or each line)		I	
13.00	Net revenue from state or local indigent care program (Not inclu		,)	0	13.00
14.00	Charges for patients covered under state or local indigent care				0	14.00
14.00	10)	program (Not The udeu	III IIIes 0 01	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)				0	15.00
16.00	Difference between net revenue and costs for state or local indi		nrogram (lin	o 15 minus lino	0	16.00
10.00	13; if $<$ zero then enter zero)	gent care			0	10.00
	Uncompensated care (see instructions for each line)				I	
17.00	Private grants, donations, or endowment income restricted to fun	ding char	ity care		0	17.00
18.00	Government grants, appropriations or transfers for support of ho				97, 748	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local			c (cum of linoc	0	19.00
19.00	8, 12 and 16)	r nur gent	care program	s (suil of filles	0	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
			1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full	6, 668, 76			20.00
20.00	charges excluding non-reimbursable cost centers) for the entire		0,000,70	17,010	0, 110, 112	20.00
21.00	Cost of initial obligation of patients approved for charity care		1, 745, 26	8 12, 303	1, 757, 571	21 00
21.00	times line 20)		1, 110, 20	12,000	1,707,071	21.00
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, 745, 26	-	-	23.00
23.00			1,743,20	12, 303	1,757,571	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient	dave bevo	nd a length c	f stav limit	1.00	24.00
24.00	imposed on patients covered by Medicaid or other indigent care p			i stay i i iii t		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
26.00	Total bad debt expense for the entire hospital complex (see inst			ii or otay rimit	2, 750, 706	
	Medicare bad debts for the entire hospital complex (see instruct					
27.00		,	a line 27)		491, 835	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (lin			20)	2, 258, 871	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (IIne	I TIMES IINE	∠ŏ)	591, 165	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	20)			2, 348, 736	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	e 30)			2, 348, 736	31.00

Heal th	Financial Systems S	T. VINCENT RAND	OLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		eriod:	Worksheet A	
					rom 07/01/2013 o 06/30/2014	Date/Time Pre 11/21/2014 8:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 087, 190	1, 087, 190	0	1, 087, 190	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P		269, 645	269, 645		269, 645	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	125, 708	2, 323, 452	2, 449, 160	0	2, 449, 160	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 609, 089	2, 999, 978	4, 609, 067	-2, 911	4, 606, 156	5.00
7.00	00700 OPERATION OF PLANT	257, 570	1, 077, 153	1, 334, 723		1, 333, 105	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	49, 279	49, 279		49, 279	8.00
9.00	00900 HOUSEKEEPI NG	0	320, 035	320, 035		320, 035	9.00
10.00	01000 DI ETARY	0	398, 609	398, 609		147, 146	10.00
	01100 CAFETERIA	(21,002)	0	C		251, 463	11.00
	01300 NURSI NG ADMI NI STRATI ON	621,093	55, 848	676, 941	-46	676, 895	13.00
	01400 CENTRAL SERVICES & SUPPLY	101, 876	25, 405	127, 281		127, 241	14.00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	262, 062 187, 376	663, 953 68, 765			925, 257	15.00 16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	107, 370	06, 705	256, 141	0	256, 141	10.00
30.00	03000 ADULTS & PEDI ATRI CS	1, 924, 688	261, 862	2, 186, 550	-692, 553	1, 493, 997	30.00
	04300 NURSERY	0	0	2, 100, 000		208, 059	43.00
	ANCI LLARY SERVI CE COST CENTERS	· · · · ·					
50.00	05000 OPERATI NG ROOM	388, 258	665, 313	1, 053, 571	-102, 248	951, 323	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	448, 454	448, 454	52.00
53.00	05300 ANESTHESI OLOGY	221, 405	54, 740	276, 145	0	276, 145	53.00
	05400 RADI OLOGY-DI AGNOSTI C	565, 117	105, 952	671, 069	-1, 887	669, 182	54.00
	05700 CT SCAN	46, 448	32, 675	79, 123		78, 340	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	44, 885	178, 374	223, 259		223, 246	58.00
60.00	06000 LABORATORY	0	1, 402, 154	1, 402, 154		1, 402, 021	60.00
	06500 RESPI RATORY THERAPY	384, 310	34, 217	418, 527		314, 260	65.00
65.01	03950 SLEEP LAB	51, 562	30, 723	82, 285		80, 662	65.01
66.00	06600 PHYSI CAL THERAPY	304, 785	30, 865	335, 650		333, 373	66.00
	06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY	56, 918 13, 558	49 26, 181	56, 967 39, 739		56, 967 133, 732	67.00 69.00
	07000 ELECTROEARDI OLOGI	13, 558	3, 200	39, 739		3, 200	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	80, 208	80, 208		289, 189	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	183, 244	183, 244		183, 244	72.00
	07300 DRUGS CHARGED TO PATIENTS	218, 478	116, 411	334, 889		325, 245	73.00
	OUTPATIENT SERVICE COST CENTERS				.,		
91.00	09100 EMERGENCY	755, 677	1, 121, 559	1, 877, 236	-38, 173	1, 839, 063	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	C	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	0	0	0			116.00
118.00	, , , , , , , , , , , , , , , , , , ,	8, 140, 863	13, 667, 039	21, 807, 902	513	21, 808, 415	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
	19100 RESEARCH	0	0		0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	37, 899	3, 705	41, 604	-	41, 380	
	19300 NONPALD WORKERS	0,,0,,	0,700	C			193.00
	07950 OTHER NRCC - PUBLIC RELATIONS	0	0	C			194.00
	07951 OTHER NRCC - FOUNDATION	31, 440	78, 155	-	-	109, 588	
	07952 OTHER NRCC - GRANTS	13, 329	89, 456			102, 503	
200.00		8, 223, 531	13, 838, 355			22, 061, 886	200. 00

RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet A Date/Time Pr	
	Cost Center Description	Adjustments	Net Expenses			11/21/2014 8	<u>3:34 am</u>
			or Allocation	-			
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	- I I					
. 00	00100 CAP REL COSTS-BLDG & FIXT	-567, 717	519, 473				1.0
. 00	00200 CAP REL COSTS-MVBLE EQUIP	1, 265	270, 910				2.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	18, 544	2, 467, 704				4.0
. 00	00500 ADMINISTRATIVE & GENERAL	682, 234	5, 288, 390				5.0
. 00	00700 OPERATION OF PLANT	-18, 018	1, 315, 087				7.0
. 00	00800 LAUNDRY & LINEN SERVICE	0	49, 279				8. (
. 00	00900 HOUSEKEEPI NG	0	320, 035				9. (
0.00	01000 DI ETARY	0	147, 146				10. (
1.00	01100 CAFETERI A	-73,077	178, 386				11. (
3.00	01300 NURSING ADMINISTRATION	-33	676, 862				13.0
4.00	01400 CENTRAL SERVICES & SUPPLY	0	127, 241				14. (
5.00		-783	924, 474				15. (
	01600 MEDI CAL RECORDS & LI BRARY	-6, 108	250, 033	1			16.0
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
0. 00		-590, 401	903, 596				30. 0
3.00		0	208, 059				43. (
0.00	ANCI LLARY SERVI CE COST CENTERS		200,007	1			- 10. 1
0. 00		-237, 500	713, 823	1			50.
2.00		-237, 300	448, 454	1			52.
2.00		-267, 933	8, 212	•			53.0
3.00 4.00		-207, 933					54.
			661, 766				
7.00		0	78, 340	1			57.0
8.00		0	223, 246				58.
0.00		0	1, 402, 021				60.
5.00	06500 RESPI RATORY THERAPY	0	314, 260	1			65.
5.01	03950 SLEEP LAB	0	80, 662	1			65.
6.00		-6, 270	327, 103				66.
7.00		0	56, 967				67.
9.00		0	133, 732				69.0
0.00		0	3, 200				70.
1.00		0	289, 189	1			71.
2.00		0	183, 244				72.0
3.00		0	325, 245				73.
	OUTPATIENT SERVICE COST CENTERS						
1.00		-253, 003	1, 586, 060				91. (
2.00							92. (
	OTHER REIMBURSABLE COST CENTERS						
01. 0	D10100 HOME HEALTH AGENCY	0	0				101. (
	SPECIAL PURPOSE COST CENTERS						
16.0	D 11600 HOSPI CE	0	C				116. (
18. 0	SUBTOTALS (SUM OF LINES 1-117)	-1, 326, 216	20, 482, 199				118. (
	NONREI MBURSABLE COST CENTERS						
90.0	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.
	D 19100 RESEARCH	0	C	•			191.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	41, 380				192.
	D 19300 NONPAI D WORKERS	0	0				193.
	07950 OTHER NRCC - PUBLIC RELATIONS	137, 200	137, 200				194.
	107951 OTHER NRCC - FOUNDATION	0	109, 588				194.
	207952 OTHER NRCC - GRANTS	0	102, 503	1			194.
	D TOTAL (SUM OF LINES 118-199)	-1, 189, 016	20, 872, 870	1			200.

Heal th	Financial Systems	S	T. VINCENT RANDO	LPH HOSPITAL		In Lie	u of Form CMS-2552-10
RECLASS	SIFICATIONS			Provi der	CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet A-6 Date/Time Prepared: 11/21/2014 8:34 am
		Increases					
	Cost Center	Li ne #	Salary	Other			
	2,00	3.00	4.00	5.00			
	A – CAFETERIA						
1.00	CAFETERI A	11.00	0	251, 463			1.00
	TOTALS		— — — o	251, 463			
	B - EKG	I	· · · ·				
1.00	ELECTROCARDI OLOGY	69.00	86, 309	7, 684			1.00
	TOTALS		86, 309	7,684			
	C - NURSERY RECLASS		· · ·				
1.00	NURSERY	43.00	181, 101	26, 958			1.00
	TOTALS		181, 101	26, 958			
	D - LDR RECLASS	•					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	390, 348	58, 106			1.00
	TOTALS		390, 348	58, 106			
	E - MEDICAL SUPPLIES RECLASS	· · ·	· · · ·				
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	208, 981			1.00
2.00		0.00	o	0			2.00
3.00		0.00	0	0			3.00
4.00		0.00	0	0			4.00
5.00		0.00	0	0			5.00
6.00		0.00	0	0			6.00
7.00		0.00	o	0			7.00
8.00		0.00	o	0			8.00
9.00		0.00	o	0			9.00
10.00		0.00	0	0			10.00
11.00		0.00	o	0			11.00
12.00		0.00	o	0			12.00
13.00		0.00	o	0			13.00
14.00		0.00	o	0			14.00
15.00		0.00	0	0			15.00
16.00		0.00	0	0			16.00
17.00		0.00	0	0			17.00
18.00		0.00	0	0			18.00
19.00		0.00	0	0			19.00
	TOTALS		o	208, 981			
500.00	Grand Total: Increases		657, 758	553, 192			500.00

Heal th	Financial Systems	S	T. VINCENT RAND	OLPH HOSPITAL	-	In Lieu	u of Form CMS-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 151301	Peri od:	Worksheet A-6
						From 07/01/2013 To 06/30/2014	Date/Time Prepared: 11/21/2014 8:34 am
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	₽.	
	6. 00	7.00	8.00	9.00	10.00		
	A – CAFETERIA						
1.00	DI ETARY		0	251, 463		Q	1.00
	TOTALS		0	251, 463			
	B - EKG				1		
1.00	RESPIRATORY_THERAPY	65.00	<u> </u>	7,684		<u>o</u>	1.00
	TOTALS		86, 309	7, 684			
	C – NURSERY RECLASS	1			1	I	
1.00	ADULTS & PEDIATRICS	30.00	18 <u>1, 1</u> 01	<u> </u>		0	1.00
	TOTALS		181, 101	26, 958			
	D - LDR RECLASS				1		
1.00	ADULTS & PEDIATRICS		39 <u>0, 3</u> 48	5 <u>8, 1</u> 06		Q	1.00
	TOTALS		390, 348	58, 106			
	E - MEDICAL SUPPLIES RECLASS				1		
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2, 911		0	1.00
2.00	OPERATION OF PLANT	7.00	0	1, 618		0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	46		0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	40		0	4.00
5.00	PHARMACY	15.00	0	758		0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	36, 040		0	6.00
7.00	OPERATING ROOM	50.00	0	102, 248		0	7.00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 887		0	8.00
9.00	CT SCAN	57.00	0	783		0	9.00
10.00	MAGNETIC RESONANCE IMAGING	58.00	0	13		0	10.00
44 00	(MRI)	(0.00)		100			11.00
11.00		60.00	0	133		0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	10, 274		0	12.00
13.00	SLEEP LAB	65.01	0	1, 623		0	13.00
14.00	PHYSICAL THERAPY	66.00	0	2, 277		0	14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,644			15.00
16.00		91.00	0	38, 173			16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	224			17.00
18.00	OTHER NRCC - FOUNDATION	194.01	0	/ 282			18.00
19.00	OTHER_NRCC - GRANTS	1 <u>94.</u> 02	Ŷ			빅	19.00
E00 00	Grand Total: Decreases		457 759	208, 981 553, 192			500.00
SUU. UU	Granu Total: Decreases		657, 758	553, 192	I	I	500. 00

Heal th	Financial Systems S	T. VINCENT RAND	OLPH HOSPITAL		In Lie	eu of Form CMS-	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151301	Period: From 07/01/2013 To 06/30/2014		pared:
				Acqui si ti on	S		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES			÷		
1.00	Land	696, 652	C)	0 0	0	1.00
2.00	Land Improvements	25, 100	0		0 0	0	2.00
3.00	Buildings and Fixtures	18, 048, 925	0		0 0	6, 822	3.00
4.00	Building Improvements	0	C		0 0	0	4.00
5.00	Fixed Equipment	481, 378	111, 170)	0 111, 170	0	5.00
6.00	Movable Equipment	5, 530, 406	C		0 0	67, 131	6.00
7.00	HIT designated Assets	0	C		0 0	0	
8.00	Subtotal (sum of lines 1-7)	24, 782, 461	111, 170)	0 111, 170	73, 953	
9.00	Reconciling Items	0)	0 0	0	•
10.00	Total (line 8 minus line 9)	24, 782, 461	111, 170		0 111, 170	73, 953	
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
		6.00	7.00	1			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	696, 652	C)			1.00
2.00	Land Improvements	25, 100	C				2.00
3.00	Buildings and Fixtures	18, 042, 103	C				3.00
4.00	Building Improvements	0	C				4.00
5.00	Fixed Equipment	592, 548	C				5.00
6.00	Movable Equipment	5, 463, 275	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	24, 819, 678	Ő				8.00
9.00	Reconciling Items	0	0				9.00
	Total (line 8 minus line 9)	24, 819, 678	C				10.00
		= .,,	0	i.			

Heal th	Financial Systems S	T. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151301	Period:	Worksheet A-7	
					From 07/01/2013 To 06/30/2014		narod
					10 00/30/2014	11/21/2014 8:	
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 087, 190			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	269, 645	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 356, 835			0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 087, 190				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	269, 645				2.00
3.00	Total (sum of lines 1-2)	0	1, 356, 835				3.00

Health Financial Systems S	T. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 07/01/2013 Fo 06/30/2014		pared: 34 am
	COM	PUTATION OF RAT	10S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio (col. 1 - col. 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	19, 356, 403		19, 356, 403		0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	5, 463, 275		5, 463, 27			2.00
3.00 Total (sum of lines 1-2)	24, 819, 678		24, 819, 678			3.00
	ALLOCA	TION OF OTHER C	CAPITAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	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	(519, 473		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(270, 910		2.00
3.00 Total (sum of lines 1-2)	0	0	(790, 383	0	3.00
		SL	IMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)			
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT	INTERS 0				E10 472	1.00
2.00 CAP REL COSTS-BLDG & FIXT	0	-		0	519, 473 270, 910	2.00
3.00 Total (sum of lines 1-2)	0	-			790, 383	2.00
5.00 10tal (Sull 01 11165 1-2)	0	1 0	l (/70,303	3.00

	Financial Systems MENTS TO EXPENSES	51	. VINCENT KAN		eriod: rom 07/01/2013	eu of Form CMS-2 Worksheet A-8	
				T			
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
. 00	Investment income - CAP REL	1.00 A	2.00 -251,048	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.0
. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00		
	COSTS-MVBLE EQUIP (chapter 2)						
. 00	Investment income - other (chapter 2)	A	-27, 686	CAP REL COSTS-BLDG & FIXT	1.00	9	3.0
. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.0
. 00	Refunds and rebates of		0		0.00	0	5.0
. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.0
	suppliers (chapter 8)		-				
. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.0
. 00	21) Television and radio service		0		0.00	0	8.0
	(chapter 21)		-				
. 00 0. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 1, 297, 883-		0.00	0	
1. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.0
	(chapter 23)		-		0.00		
2.00	Related organization transactions (chapter 10)	A-8-1	1, 762, 247			0	12.0
3.00 4.00	Laundry and linen service Cafeteria-employees and guests	В	0	CAFETERI A	0.00 11.00		
4.00 5.00	Rental of quarters to employee		-73,077	CAFETERTA	0.00		
6. 00	and others Sale of medical and surgical		0		0.00	0	16.
	supplies to other than						
7.00	patients Sale of drugs to other than		0		0.00	0	17. (
8. 00	patients Sale of medical records and		0		0.00	0	18. (
	abstracts Nursing school (tuition, fees,						
9. 00	books, etc.)		0		0.00	0	19. (
0. 00 1. 00	Vending machines Income from imposition of		0		0. 00 0. 00		
1.00	interest, finance or penalty		0		0.00		21.
2. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.
	overpayments and borrowings to repay Medicare overpayments						
3.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
	therapy costs in excess of limitation (chapter 14)						
4.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.0
	limitation (chapter 14)						
5.00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. (
6. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. (
	COSTS-BLDG & FIXT						
7.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.0
8.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.0
9.00 0.00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29. (30. (
	therapy costs in excess of limitation (chapter 14)						
0. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 9
1. 00	instructions) Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.0
	pathology costs in excess of limitation (chapter 14)						
2.00	CAH HIT Adjustment for		0		0.00	0	32.0
3.00	Depreciation and Interest PROVIDER ASSESSMENT TAX	А	-1, 107. 888	ADMI NI STRATI VE & GENERAL	5.00	0	33. 0
	ADJUSTMENT		, , ,				

 ADJUSTMENT
 Andres

 11/21/2014
 8: 34 am Y: \28750 - St. Vincent Randol ph\300 - Medicare Cost Report\20140631\28750-14. mcrx

Heal th	Financial Systems	S	T. VINCENT RAN	DOLPH HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 07/01/2013 To 06/30/2014		narodi
					10 00/30/2014	11/21/2014 8:	34 am
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Pasis(Codo (2))	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4.00	5.00	
33.02	OTHER OPERATING INCOME	B		ADMI NI STRATI VE & GENERAL	5.00		33.02
33.03	OTHER PLANT OPERATION REVENUE	B		OPERATION OF PLANT	7.00		33.03
33.04	OTHER PHARMACY REVENUE	В		PHARMACY	15.00		33.04
33.05	OTHER HIM REVENUE	В	-6, 108	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06	OTHER OPERATING REVENUE	В	-887	ADULTS & PEDIATRICS	30.00	0	33.06
33.08	OTHER RADIOLOGY REVENUE	В	-1, 565	RADI OLOGY-DI AGNOSTI C	54.00	0	33.08
33.09	OTHER PHYSICAL THERAPY REVENUE	В	-5, 570	PHYSICAL THERAPY	66.00	0	33.09
33.10	DONATI ONS	A	-1, 075	ADMI NI STRATI VE & GENERAL	5.00	0	33. 10
33. 11	AHA & IHA DUES	A		ADMI NI STRATI VE & GENERAL	5.00	0	33. 11
33. 13	PAVILION DEPRECIATION	A		CAP REL COSTS-BLDG & FIXT	1.00		33. 13
33.14	CARRYFORWARD	A		CAP REL COSTS-BLDG & FIXT	1.00		33.14
33.16	LOSS ON SALE OF PPE	A		CAP REL COSTS-MVBLE EQUIP	2.00		33. 16
33.17	HOSPI TALI ST	A		ADULTS & PEDIATRICS	30.00		33. 17
33.18	NON REIMB EXPENSE	A		NURSING ADMINISTRATION	13.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49)		-1, 189, 016				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 RAI	NDOLPH HOSPITAL	In Lie	eu of Form CMS-	2552-10
		RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	-1
OFFI CE	COSTS			From 07/01/2013 To 06/30/2014		narod
				10 00/30/2014	11/21/2014 8:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
1.00		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	0	91, 898	1.00
2.00			HOME OFFICE	2, 895, 469	1, 104, 172	2.00
3.00		OTHER NRCC - PUBLIC RELATION		137, 200	1, 104, 172	3.00
4.00		EMPLOYEE BENEFITS DEPARTMENT		202, 478	202, 478	4.00
4.01			ST. VINCENT HLTH CHARGEBACK	1,005,032	1,005,032	4.01
4.02			ST. VINCENT HLTH CHARGEBACK	-62, 868	-62, 868	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HLTH CHARGEBACK	91, 162	91, 162	4.03
4.04			ST. VINCENT HLTH CHARGEBACK	-174, 120	-174, 120	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HLTH CHARGEBACK	156, 012	156, 012	4.05
4.06	30.00	ADULTS & PEDIATRICS	ST. VINCENT HLTH CHARGEBACK	5, 964	5, 964	4.06
4.07	50.00	OPERATING ROOM	ST. VINCENT HLTH CHARGEBACK	3, 852	3, 852	4.07
4.08	53.00	ANESTHESI OLOGY	ST. VINCENT HLTH CHARGEBACK	6, 468	6, 468	4.08
4.09			ST. VINCENT HLTH CHARGEBACK	8, 604	8, 604	4.09
4.10		EMPLOYEE BENEFITS DEPARTMENT		1, 029, 034	1, 146, 222	4.10
4.11			ASCENSION INTEREST	251, 048	414, 797	4.11
4.12			ASCENSION INTEREST	27, 686	45, 745	4.12
4.13			TRIMEDX	459, 992	462, 978	4.13
4.14		EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	331, 344	103, 714	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20 5.00	0.00		0	4 274 257	4 412 110	4.20 5.00
5.00	ν		ν	6, 374, 357	4, 612, 110	5.00

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

				Related Organization(s) and	'or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	G	ST. VINCENT HTH	100.00 ST. VINCENT HTH	100.00	6.00
7.00	G	ASCENSI ON	100.00 ASCENSI ON	100.00	7.00
8.00	В	ST. VINCENT HSP	100.00 ST. VINCENT HSP	100.00	8.00
9.00	A	TRI MEDX	0. 00 TRI MEDX	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	HOME OFFICE			100.00
	non-financial) specify:				

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

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

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

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 RANDOLPH	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED	ORGANIZATIONS AND HOME	Provider CCN: 151301	Period:	Worksheet A-8-1
OFFICE COSTS			From 07/01/2013 To 06/30/2014	Date/Time Prepared:

					10 06/30/2014 D	1/21/2014 8:34 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			MENTS REQUIRED AS A RESULT OF TRANS	SACTIONS WITH RELATED OF	RGANIZATIONS OR CL	AIMED
	HOME OFFICE CO					
1.00	-91, 898					1.00
2.00	1, 791, 297					2.00
3.00	137, 200	0				3.00
4.00	0	0				4.00
4.01	0	0				4.01
4.02	0	0				4. 02
4.03	0	0				4.03
4.04	0	0				4.04
4.05	0	0				4. 05
4.06	0	0				4.06
4.07	0	0				4.07
4.08	0	0				4.08
4.09	0	0				4.09
4.10	-117, 188	0				4.10
4.11	-163, 749	9				4.11
4.12	-18, 059	9				4. 12
4.13	-2, 986	0				4.13
4.14	227,630	0				4.14
4.15	0	0				4.15
4.16	0	0				4.16
4.17	0	0				4. 17
4.18	0	0				4. 18
4.19	0	0				4. 19
4.20	0	0				4. 20
5.00	1, 762, 247					5.00

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

Related Organization(s)					
and/or Home Office					
Type of Business					
6.00					
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

rerinbur	Schone under trette Aviri.	
6.00	ADMI NI STRATI ON	6.00
7.00	ADMI NI STRATI ON	7.00
8.00	HOSPI TAL	8.00
9.00	TECHNOLOGY MGMT	9.00
10.00		10.00
100.00		100.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTNENT Provider CRL 151301 Feriad: For 02/07/2011 Worksheet A-6-2 MKST. A LINE # Cost Center/PhysicIan IdentiTier Total Memuneration Provider Component RCE Amount Provider PhysicIan/Tespician/Tespician/ PhysicIan/Tespician/ PhysicIan/Tespician/ PhysicIan/Tespician/ PhysicIan/Tespician/ PhysicIan/Tespician/ PhysicIan/Tespician/ PhysicIan/TespicIan/ PhysicIa	Heal th I	Financial Syste	ems	ST. VINCENT RAI	NDOLPH HOSPITAL	_	In Li	eu of Form CMS-	2552-10
Vikst. A Line Cost Center/Physician Identifier Total Identifier Professional Remuneration Support Provider Component Support RCE Amount Component Component Support RCE Amount Physician/Provider Component Support 1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 1.00 50.000/PERTINE (DIGY 200.05 545.400 528.800 2.735 0 0 2.00 4.00 5.000 6.00 7.00 0 0 5.00 6.00 7.00 1.00 3.00 4.00 5.00 6.00 7.00 0 0 5.00 6.00 7.00 0 0 5.00 0						- CCN: 151301	Peri od:	Worksheet A-8	
Wist. A Line # Cost Center/Physician Identifia Total Renureration Protessional Component RCE Amount Provider Component RCE Amount Provider Component Provider Returns 1.00 3.00 4.00 5.00 6.00 7.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 3.00 53.00/ARSTHESI OLGY 227.0668 227.735 0 0 0 2.00 5.00 6.00 9.00 1.064.004/YSI CAL THERAPY 700 700 0								Date/Time Pre	
Identifier Remuneration Component Component ider Component ider Component 1.00 30.00 4.00 5.00 6.00 7.00 1 1.00 30.00 4.00 5.00 6.00 7.00 1 2.00 50.00 6.00 7.00 0 0 1.00 30.00 50.00 6.00 7.00 0		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		o r cim
1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 30.00AUITS & PEDIATRICS 564.60 532.096 12.513 0 0 1.00 2.00 50.00PERATING ROM 237.500 237.500 2.015 0 0 1.00 3.00 53.00ARSTHESI LOAGY 270.68 267.933 2.735 0 0 3.00 4.00 54.00RADIOLOCY-0I AGNOSTIC 5.851 5.851 0				Remuneration	Component	Component			
1 0 30. OQADULTS & PEDI ATRICS 545, 409 532, 896 12, 513 0<									
2.00 50.00/DPERATING ROOM 237,500 0 0 0 2.00 2.00 50.00 0 0 0 0.00 0 0.00 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
3.00 53.00 AMESTHESI OLOGY 270, 668 267, 933 2, 735 0 0 3.00 6.00 54.00 RAD IOLOGY-DI AGNOSTI C 5, 851 5, 851 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
4.00 SA1_00[ADD (LOGY-D1 AGNOSTIC 5.851 5.851 0									
5.00 66.00 PHYSICAL THERAPY 700 700 700 0 0 0 5.00 7.00 955, 319 253, 003 702, 316 0									
6.00 91.00 EMEGENCY 955,319 253,003 702,316 0 <							-	-	
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8.00 0.00 0.00 0 <th< td=""><td></td><td></td><td>EMERGENCY</td><td>955, 319</td><td>253, 003</td><td>702, 310</td><td>5 0</td><td>-</td><td></td></th<>			EMERGENCY	955, 319	253, 003	702, 310	5 0	-	
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10.00 0.00 <t< td=""><td></td><td></td><td></td><td>0</td><td>C</td><td>) (</td><td>0</td><td>0</td><td></td></t<>				0	C) (0	0	
200.00				0	C) (0	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit RCE Unadjusted RCE Limit Cost of Memberships & Continuing Education Provider Share of col. Physician Cost of Malpractice Insurance 1.00 30.00 ADULTS & PEDIATRICS 0 0 0 12.00 13.00 14.00 1.00 50.00 OPERATING ROM 0 0 0 0 0 0 0 14.00 3.00 53.00 ANESTHESIOLOGY 0 </td <td></td> <td>0.00</td> <td></td> <td>0</td> <td>C</td> <td>) (</td> <td>-</td> <td>0</td> <td></td>		0.00		0	C) (-	0	
Identifier Limit Unadjusted RCE Limit Remberships & Component Limit Component Share of col. of Mal practice Insurance 1.00 2.00 8.00 9.00 12.00 10.00 10.00 2.00 50.00/PERATING ROM 0								0	200.00
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1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 30.00 ADULTS & PEDIATRICS 0 <t< td=""><td></td><td></td><td></td><td></td><td>Limit</td><td></td><td></td><td>Insurance</td><td></td></t<>					Limit			Insurance	
1.00 30.00 ADULTS & PEDIATRICS 0		1.00	2.00	0.00	0.00			14.00	
2.00 50.00 OPERATING ROOM 0	1 00								1 00
3.00 53.00 ANESTHESI OLOGY 0 0 0 0 0 3.00 4.00 54.00 RADI OLOGY-DI AGNOSTI C 0					, s				
4.00 54.00 RADI OLOGY - DI AGNOSTI C 0 <				0	, s				
5.00 66.00 PHYSI CAL THERAPY 0 <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>-</td> <td></td> <td></td>				0			-		
6.00 91.00 EMERGENCY 0				0			-	-	
7.00 0.00 0 0 0 0 7.00 8.00 0.00 0				0				-	
8.00 0.00 0.00 0			EMERGENCI	0				-	
9.00 0.00 0.00 0.00 <				0				0	
10.00 0.00 0<				0				0	
200.00 Cost Center/Physician Identifier Provider Component Share of col. 14 Adjusted RCE Li mit RCE Di sal I owance Adjustment Adjustment Adjustment 1.00 2.00 15.00 16.00 17.00 18.00 1.00 30.00 ADULTS & PEDI ATRICS 0 0 0 237,500 2.00 3.00 53.00 ANESTHESI OLOGY 0 0 0 237,500 2.00 3.00 53.00 ARESTHESI OLOGY 0 0 0 267,933 3.00 4.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0 253,003 6.00 5.00 66.00 PHYSI CAL THERAPY 0 0 0 7.00 7.00 8.00 7.00 8.00 0 0 9.00 0 9.00 9.00 9.00 9.00 10.00 9.00 9.00 10.00 9.00 9.00 10.00 9.00 10.00							°	0	
Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. 14 Adjusted RCE Limit RCE Disal Iowance Adjustment 1.00 2.00 15.00 16.00 17.00 18.00 1.00 30.00 ADULTS & PEDI ATRICS 0 0 0 237,500 2.00 2.00 50.00 OPERATI NG ROOM 0 0 0 237,500 2.00 3.00 53.00 ANESTHESI OLOGY 0 0 0 2.00 3.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0 7.00 5.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 5.00 6.00 7.00 0 7.00		0.00					-	0	
Identifier Component Share of col. 14 Limit Disal I owance Image: Component Share of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 30.00 ADULTS & PEDI ATRICS 0 0 0 532,896 1.00 2.00 50.00 OPERATI NG ROOM 0 0 0 237,500 2.00 3.00 53.00 ANESTHESI OLOGY 0 0 0 2.00 3.00 4.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0 700 5.00 6.00 91.00 EMERGENCY 0 0 0 700 5.00 6.00 91.00 EMERGENCY 0 0 0 7.00 7.00 7.00 0.00 0 0 0 0 7.00 8.00 9.00 0.00 0 0 0 9.00 9.00 9.00 9.00		Wkst Aline #	Cost Center/Physician	Provider	Adjusted RCF		°	0	200.00
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1.00 30.00 ADULTS & PEDIATRICS 0 0 532,896 1.00 2.00 50.00 OPERATING ROOM 0 0 0 237,500 2.00 3.00 53.00 ANESTHESI OLOGY 0 0 0 267,933 3.00 4.00 54.00 RADIOLOGY - DI AGNOSTI C 0 0 0 5.851 4.00 5.00 66.00 PHYSI CAL THERAPY 0 0 0 700 5.00 6.00 91.00 EMERGENCY 0 0 0 700 5.00 7.00 0.00 0 0 0 0 7.00 7.00 8.00 0.00 0 0 0 0 7.00 8.00 9.00 9.00 9.00 10.00 9.00 10.00 9.00 9.00 10.00 9.00 10.00 9.00 9.00 10.00 9.00 9.00 10.00 9.00 10.00 9.00 10.00 10.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
2.00 50.00 OPERATING ROOM 0 0 237,500 2.00 3.00 53.00 ANESTHESI OLOGY 0 0 0 267,933 3.00 4.00 54.00 RADI OLOGY - DI AGNOSTI C 0 0 0 5,851 4.00 5.00 66.00 PHYSI CAL THERAPY 0 0 0 700 5.00 6.00 91.00 EMERGENCY 0 0 0 253,003 6.00 7.00 0.00 0 0 0 7.00 7.00 6.00 9.00				15.00	16.00	17.00	18.00		
3.00 53.00 ANESTHESI OLOGY 0 0 267,933 3.00 4.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0 5,851 4.00 5.00 66.00 PHYSI CAL THERAPY 0 0 0 700 5.00 6.00 91.00 EMERGENCY 0 0 0 253,003 6.00 7.00 0.00 0 0 0 0 7.00 6.00 9.00 0.00 0 0 0 9.00 9.00 9.00 9.00 9.00 10.00 10.00	1.00	30.00	ADULTS & PEDIATRICS	0	C) (532, 896		1.00
4.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 5,851 4.00 5.00 66.00 PHYSI CAL THERAPY 0 0 0 700 5.00 6.00 91.00 EMERGENCY 0 0 0 253,003 6.00 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 8.00 8.00 9.00 0.00 0 0 0 9.00 9.00 10.00 0.00 0 0 0 0 9.00	2.00	50.00	OPERATING ROOM	0	C) (237, 500		2.00
5.00 66.00 PHYSI CAL THERAPY 0 0 700 700 5.00 6.00 91.00 EMERGENCY 0 0 0 253,003 6.00 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 9.00 0 9.00 10.00 0.00 0 0 0 0 10.00	3.00	53.00	ANESTHESI OLOGY	0	C) (267, 933		3.00
6.00 91.00 EMERGENCY 0 0 253,003 6.00 7.00 0.00 0 0 0 7.00 8.00 0.00 0 0 0 8.00 9.00 0.00 0 0 9.00 0 9.00 10.00 0.00 0 0 0 10.00	4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	C) (5, 851		4.00
7.00 0.00 0 0 0 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 0 9.00 10.00 0.00 0 0 0 0 10.00	5.00	66.00	PHYSI CAL THERAPY	0	C) (5.00
8.00 0.00 0 0 0 8.00 9.00 0 0 0 0 9.00 0 9.00 0 0 0 0 9.00 9.00 10.00 0 0 0 0 0 0 10.00	6.00		EMERGENCY	0	C) (253, 003		6.00
9.00 0.00 0 0 0 9.00 10.00 0.00 0 0 0 0 10.00	7.00			0	C) (0 0		
10.00 0.00 0 0 0 10.00	8.00	0.00		0	C) (0 0		8.00
				0	C) (0 0		
200.00 0 0 1,297,883 200.00		0.00		0	C) (0 0		
	200.00			0	C) (0 1, 297, 883		200.00

Health Fina	ncial Systems	ST. VINCENT RANE	OOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - GENERAL SERVICE COSTS		Provi der	1	Period: From 07/01/2013 Fo 06/30/2014	Worksheet B Part I Date/Time Pre 11/21/2014 8:	pared: 34 am
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FI XT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	RAL SERVICE COST CENTERS			1			
2.00 0020 4.00 0040 5.00 0050	0 CAP REL COSTS-BLDG & FIXT 0 CAP REL COSTS-MVBLE EQUIP 0 EMPLOYEE BENEFITS DEPARTMENT 0 ADMINISTRATIVE & GENERAL 0 ADDIATION OF & AUT	519, 473 270, 910 2, 467, 704 5, 288, 390	0 81, 723	270, 910 (42, 620	2, 467, 704 537, 598	5, 950, 331	1
8.00 0080 9.00 0090 10.00 0100	O OPERATION OF PLANT O LAUNDRY & LINEN SERVICE O HOUSEKEEPING O DIETARY O CAFETERIA	1, 315, 087 49, 279 320, 035 147, 146 178, 386	31, 039 4, 237 3, 973 14, 738 3, 469	2, 210 2, 072 7, 680	D 0 2 0 5 0	1, 448, 367 55, 726 326, 080 169, 570 183, 664	8.00 9.00 10.00
13.00 0130 14.00 0140 15.00 0150	0 CATELERIA 0 NURSI NG ADMI NI STRATI ON 0 CENTRAL SERVI CES & SUPPLY 0 PHARMACY 0 MEDI CAL RECORDS & LI BRARY	676, 862 127, 241 924, 474 250, 033	953 0	49	7 207, 508 0 34, 037 0 87, 991	885, 820 161, 278 1, 012, 465 327, 576	13.00 14.00 15.00
I NPA	TI ENT ROUTI NE SERVI CE COST CENTERS	903, 596	· · · · · · · · · · · · · · · · · · ·	· ·			
43.00 0430	NURSERY	208, 059	60, 490 828			1, 283, 424 269, 825	•
	LLARY SERVICE COST CENTERS	713, 823	51, 147	26, 674	4 129, 717	921, 361	50.00
	0 DELIVERY ROOM & LABOR ROOM 0 ANESTHESIOLOGY	448, 454 8, 212	15, 553 0			602, 534 8, 959	•
54.00 0540	0 RADI OLOGY-DI AGNOSTI C 0 CT SCAN	661, 766 78, 340	41, 203 0		3 188, 806	913, 263 93, 858	54.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	223, 246	0		0 14, 996	238, 242	58.00
	0 LABORATORY 0 RESPI RATORY THERAPY	1, 402, 021 314, 260	11, 540 12, 044			1, 419, 579 432, 147	•
	0 SLEEP LAB 10 PHYSI CAL THERAPY	80, 662 327, 103	2, 807 19, 896	1, 464 10, 370		102, 160 458, 970	
67.00 0670	O OCCUPATI ONAL THERAPY	56, 967	2, 099	1, 09!	5 19, 016	79, 177	67.00
70.00 0700	0 ELECTROCARDI OLOGY 0 ELECTROENCEPHALOGRAPHY	133, 732 3, 200	0			167, 098 3, 200	70.00
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 IMPL. DEV. CHARGED TO PATIENTS	289, 189 183, 244	11, 143 0	5, 81		306, 143 183, 244	•
73.00 0730	0 DRUGS CHARGED TO PATIENTS ATIENT SERVICE COST CENTERS	325, 245	7, 661	3, 99	5 72, 558	409, 459	
91.00 0910 92.00 0920	O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS	1, 586, 060	28, 133	14, 67	1 252, 472	1, 881, 336 0	1
101.001010	O HOME HEALTH AGENCY	0	0	(0 0	0	101. 00
116. 00 1160 118. 00		0 20, 482, 199	0 414, 495	(216, 164		0 20, 294, 856	116. 00 118. 00
190. 00 1900 191. 00 1910	0 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 RESEARCH	0	847 0		0 0	0	190. 00 191. 00
193.001930	0 PHYSICIANS' PRIVATE OFFICES 0 NONPAID WORKERS	41, 380 0	0			211, 147 0	192.00 193.00
	0 OTHER NRCC - PUBLIC RELATIONS 1 OTHER NRCC - FOUNDATION	137, 200 109, 588	437 437	228		137, 865 120, 757	•
	2 OTHER NRCC - GRANTS Cross Foot Adjustments Negative Cost Centers	102, 503	0			106, 956 0	
202.00	TOTAL (sum lines 118-201)	20, 872, 870	519, 473	270, 910	2, 467, 704		

Health Financial Systems	ST. VINCENT RANI	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period:	Worksheet B	
				rom 07/01/2013 o 06/30/2014	Part I Date/Time Pre	nared
				0 00/ 30/ 2014	11/21/2014 8:	
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS			1			1 1 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	5, 950, 331					5.00
7.00 00700 OPERATION OF PLANT	577, 533					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	22, 221	21, 108				8.00
9. 00 00900 HOUSEKEEPI NG	130, 024					9.00
10. 00 01000 DI ETARY	67, 616				328, 202	10.00
11. 00 01100 CAFETERIA	73, 236				0	11.00
13.00 01300 NURSING ADMINISTRATION	353, 219				0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	64, 309	0	C	0 0	0	14.00
15. 00 01500 PHARMACY	403, 718		C	0 0	0	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	130, 620	48, 910	C	11, 726	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	511, 763	301, 311	38, 253	3 72, 237	328, 202	30.00
43. 00 04300 NURSERY	107, 592	4, 123	C	988	0	43.00
ANCILLARY SERVICE COST CENTERS	1		1			
50.00 05000 OPERATI NG ROOM	367, 391	254, 775			0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	240, 259				0	52.00
53. 00 05300 ANESTHESI OLOGY	3, 572		C		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	364, 162				0	54.00
57.00 05700 CT SCAN	37, 426		-		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	94, 999		C		0	58.00
	566, 054				0	60.00
65. 00 06500 RESPIRATORY THERAPY	172, 318			,	0	65.00
65. 01 03950 SLEEP LAB 66. 00 06600 PHYSI CAL THERAPY	40, 736			-,	0	65.01
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	183, 013 31, 572				0	66.00 67.00
69. 00 06900 ELECTROCARDI OLOGY	66, 630			_,	0	69.00
70. 00 07000 ELECTROEARDFOLOGT	1, 276		-		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	122,074		-	-	0	70.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	73, 068				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	163, 271	38, 159			0	73.00
OUTPATI ENT SERVICE COST CENTERS	100,271	00,107		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		/ 0. 00
91. 00 09100 EMERGENCY	750, 178	140, 135	38, 691	33, 596	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	C	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	0	0	C	0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 719, 850	1, 502, 993	99, 055	350, 528	328, 202	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	514	4, 222	C	1, 012		190. 00
191. 00 19100 RESEARCH	0	0	C	0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	84, 194	514, 331	C	123, 308	0	192.00
193. 00 19300 NONPAI D WORKERS	0	0	C	0 0		193.00
194.0007950 OTHER NRCC - PUBLIC RELATIONS	54, 973			522		194.00
194.0107951OTHER NRCC - FOUNDATION	48, 152		C	522		194. 01
194.0207952 OTHER NRCC - GRANTS	42, 648	0	(C	0 0	0	194. 02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118-201)	5, 950, 331	2, 025, 900	99, 055	475, 892	328, 202	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ST. VINCENT RAN		CCN: 151301	Peri od:	u of Form CMS- Worksheet B	2552-10
					From 07/01/2013 To 06/30/2014	Part I Date/Time Pre 11/21/2014 8:	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON		PHARMACY	MEDI CAL RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & 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		278, 325					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	28, 772			2		13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	6, 435 7, 618		232, 02			14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	15,888			0 1, 423, 801 0 0	534, 720	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	15,000	0		<u>v</u> <u>v</u>	554,720	10.00
30.00	03000 ADULTS & PEDI ATRI CS	51,020	479, 556		0 0	29, 604	30.00
43.00	04300 NURSERY	7,379			0 0	5, 096	1
	ANCILLARY SERVICE COST CENTERS	.,				-,	
50.00	05000 OPERATING ROOM	17, 011	159, 887		0 0	60, 922	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	15, 904	149, 487		0 0	10, 984	52.00
53.00	05300 ANESTHESI OLOGY	17	156		0 0	4, 659	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	26, 096			0 0	55, 597	1
57.00	05700 CT SCAN	2, 311			0 0	84, 144	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 918	0		0 0	18, 654	
60.00		15 07/	0		0 0	117, 981	
65.00 65.01	06500 RESPI RATORY THERAPY 03950 SLEEP LAB	15,076				13, 999 3, 578	
66. 00	06600 PHYSI CAL THERAPY	15, 110				3, 578 12, 616	1
67.00	06700 OCCUPATI ONAL THERAPY	2, 149			0	3, 085	
69.00	06900 ELECTROCARDI OLOGY	4, 884			0	6, 634	1
70.00	07000 ELECTROENCEPHALOGRAPHY	4,004	0		0 0	134	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	117, 25	-	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ő	114, 77		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 296	0		0 1, 423, 801	0	1
	OUTPATIENT SERVICE COST CENTERS				· · · ·		
91.00	09100 EMERGENCY	41, 053	385, 863		0 0	107, 033	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS		1				
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS	-	-	1	-1 -1		
		0	-		0 0		116.00
118.00		270, 192	1, 244, 310	232, 02	2 1, 423, 801	534, 720	118.00
100.00	NONREIMBURSABLE COST CENTERS	0	0		0 0	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0				190.00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 127	29, 389				192.00
	19300 NONPALD WORKERS	3, 127	27, 307		0 0		193.00
	07950 OTHER NRCC - PUBLIC RELATIONS		0		0 0		194.00
	07951 OTHER NRCC - FOUNDATION	1, 746	0		0 0		194.00
	07952 OTHER NRCC - GRANTS	3, 260			0 0		194.02
200.00							200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	278, 325	1, 273, 699	232, 02	2 1, 423, 801	534, 720	202.00

Health Financial Systems	ST. VINCENT RANI	OOLPH HOSPITAL		In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part I Date/Time Prepared: 11/21/2014 8:34 am
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00	_	
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 ADMINISTRATIVE & GENERAL					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 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY					16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1				
30. 00 03000 ADULTS & PEDIATRICS	3, 095, 370				30.00
43.00 04300 NURSERY	464, 364	0	464, 3	54	43.00
ANCI LLARY SERVICE COST CENTERS	1	-			
50. 00 05000 OPERATI NG ROOM	1, 853, 482	0			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 115, 212	0			52.00
53. 00 05300 ANESTHESI OLOGY	17, 363	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 624, 618	0			54.00
57.00 05700 CT SCAN	217, 739	0	, .		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	353, 813	0			58.00
	2, 174, 881	0			60.00
65. 00 06500 RESPI RATORY THERAPY	707, 915	0			65.00
65. 01 03950 SLEEP LAB	166, 066	0			65.01
66. 00 06600 PHYSI CAL THERAPY	792, 576	0	792, 5		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	128, 944	0	128, 9		67.00
69. 00 06900 ELECTROCARDI OLOGY	245, 246	0			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 610	0	4,6		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	614, 281	0			71.00
73. 00 07200 TMPL. DEV. CHARGED TO PATIENTS	371, 083 2, 053, 134	0			72.00
OUTPATIENT SERVICE COST CENTERS	2,055,154	0	2,000,1	54	/3.00
91. 00 09100 EMERGENCY	3, 377, 885	0	3, 377, 8	35	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 577, 005	0		55	92.00
OTHER REIMBURSABLE COST CENTERS		0	1		72.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	101.00
SPECIAL PURPOSE COST CENTERS				-1	
116. 00 11600 HOSPI CE	0	0		0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	19, 378, 582				118.00
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,037	0	7,0	37	190.00
191. 00 19100 RESEARCH	0	0		0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	965, 496	0		-	192.00
193. 00 19300 NONPAID WORKERS	0	0		0	193.00
194.00 07950 OTHER NRCC - PUBLIC RELATIONS	195, 537	0	195, 5	37	194.00
194.01 07951 OTHER NRCC - FOUNDATION	173, 354	0	173, 3		194.01
194.02 07952 OTHER NRCC - GRANTS	152, 864	0			194.02
200.00 Cross Foot Adjustments	0	0		0	200.00
201.00 Negative Cost Centers	0	0		0	201.00
202.00 TOTAL (sum lines 118-201)	20, 872, 870	0	20, 872, 8	70	202.00
				1	1

Heal th	Financial Systems S	ST. VINCENT RAND	OLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		eriod: com 07/01/2013 o 06/30/2014	Worksheet B Part II Date/Time Pre 11/21/2014 8:3	pared: 34 am
			CAPI TAL REL	ATED COSTS		1172172011 0.	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	01 700	0	0 501 404	0	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	377, 143	81, 723	42, 620	501, 486	0	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	31, 039 4, 237	16, 187 2, 210	47, 226	0	7.00 8.00
8.00 9.00	00900 HOUSEKEEPING	0	4, 237 3, 973	2,210	6, 447 6, 045	0	9.00
9.00 10.00	01000 DI ETARY	0	14, 738	7, 686	22, 424	0	10.00
11.00	01100 CAFETERI A	0	3, 469	1, 809	5, 278	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	953	497	1, 450	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	7JJ	477	1, 430	0	14.00
	01500 PHARMACY	34, 644	0	0	34, 644	0	15.00
	01600 MEDICAL RECORDS & LIBRARY	2,753	9, 819	5, 121	17, 693	0	16.00
101.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,121			10100
30.00	03000 ADULTS & PEDI ATRI CS	61, 491	60, 490	31, 546	153, 527	0	30.00
43.00	04300 NURSERY	0	828	432	1, 260	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	43, 855	51, 147	26, 674	121, 676	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	15, 553	8, 111	23, 664	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	41, 203	21, 488	62, 691	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	177, 400	0	0	177, 400	0	58.00
60.00	06000 LABORATORY	375	11, 540	6, 018	17, 933	0	60.00
65.00	06500 RESPI RATORY THERAPY	1, 726	12,044	6, 281	20, 051	0	65.00
65.01	03950 SLEEP LAB	458	2,807	1, 464	4, 729	0	65.01
66.00	06600 PHYSI CAL THERAPY	4, 421	19, 896	10, 376	34, 693	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY	0	2, 099	1, 095 0	3, 194	0	67.00
69.00 70.00	07000 ELECTROCARDI OLOGY	0	0	0	0	0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 143	5, 811	16, 954	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 143	5, 811	10, 934	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7, 661	3, 995	11, 656	0	73.00
75.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	7,001	5, 775	11,000	0	/3.00
91.00	09100 EMERGENCY	3, 742	28, 133	14, 671	46, 546	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			,	0	-	92.00
	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPI CE	0	0	0	0	0	116.00
118.00		708, 008	414, 495	216, 164	1, 338, 667	0	118.00
	NONREIMBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	847	442	1, 289		190.00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	481	103, 257	53, 848	157, 586	0	192.00
	19300 NONPAI D WORKERS	0	0	0	0		193.00
	07950 OTHER NRCC - PUBLIC RELATIONS	0	437	228	665		194.00
	07951 OTHER NRCC - FOUNDATION	0	437	228	665		194.01
	07952 OTHER NRCC - GRANTS	0	0	0	0		194.02
200.00	· · · · · · · · · · · · · · · · · · ·		~		0		200.00
201.00 202.00		700 400	0 519, 473	0 270, 910	0 ارتو ۱۹۵۵ 1		201. 00 202. 00
202.00	10TAL (SUIII TITIES 110-201)	708, 489	017,473	270,910	1, 498, 872	0	202.00

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		eri od:	Worksheet B	
				rom 07/01/2013 o 06/30/2014	Part II Date/Time Pre	narod
			1	o 06/30/2014	11/21/2014 8:	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS		1	1	,		
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINI STRATI VE & GENERAL	501, 486					5.00
7.00 00700 OPERATION OF PLANT	48, 674					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1,873					8.00
9.00 00900 HOUSEKEEPI NG	10, 958					9.00
10. 00 01000 DI ETARY	5, 699			664	32, 262	1
11. 00 01100 CAFETERI A	6, 172			156	0	
13. 00 01300 NURSI NG ADMI NI STRATI ON	29, 769	225	C C	43	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	5, 420	0) C	0	0	14.00
15. 00 01500 PHARMACY	34, 025	0	0 0	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	11,009	2, 315	c C	442	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	43, 131	14, 263	3, 599	2, 723	32, 262	30.00
43. 00 04300 NURSERY	9, 068	195	i C	37	0	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	30, 963	12, 060	1, 040	2, 303	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	20, 249	3, 667	' C	700	0	52.00
53.00 05300 ANESTHESI OLOGY	301	0	C	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	30, 691	9, 715	1, 040	1, 855	0	54.00
57.00 05700 CT SCAN	3, 154	0	C	1	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	8,006	0	C	0	0	58.00
60. 00 06000 LABORATORY	47, 706		c c	520	0	60.00
65. 00 06500 RESPI RATORY THERAPY	14, 523	2, 840) c	542	0	65.00
65. 01 03950 SLEEP LAB	3, 433			126	0	65.01
66. 00 06600 PHYSI CAL THERAPY	15, 424		c c	896	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 661				0	67.00
69.00 06900 ELECTROCARDI OLOGY	5, 615			0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	108			0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 288			-	0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	6, 158				0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	13, 760				0	1
OUTPATIENT SERVICE COST CENTERS	107700	1,000	1	0.0		10100
91. 00 09100 EMERGENCY	63, 224	6, 634	3, 640	1, 267	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	00,221	0,001	0,010	1,207	0	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101. 00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101.00
SPECIAL PURPOSE COST CENTERS	0	0		ų U	0	101.00
116. 00 11600 HOSPI CE	0	0		0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	482,062					118.00
NONREI MBURSABLE COST CENTERS	402,002	/1,140	η <u>7,</u> 317	13, 213	52, 202	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	43	200		38	0	190. 00
	43					
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	7,096	-		4,647		191.00 192.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 193. 00 19300 NONPALD WORKERS	1,090	24, 348		4,047		192.00
193. 00 19300 NUNPAID WORKERS 194. 00 07950 OTHER NRCC - PUBLIC RELATIONS	4, 633	103		20		193.00
194. 01 07951 OTHER NRCC - POBLIC RELATIONS	4, 033			20		194.00
				20		
194. 02 07952 OTHER NRCC - GRANTS	3, 594		, U	0	0	194.02
200.00Cross Foot Adjustments201.00Negative Cost Centers		_			~	200. 00 201. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	E01 494	-	9, 319	17, 940		201.00
202.00 10TAL (SUIII 111185 110-201)	501, 486	y 90, 900	'I 9,319	17, 940	32, 202	1202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	<u>ST. VINCENT RAN</u>		CCN: 151301	Period: From 07/01/2013 To 06/30/2014	u of Form CMS-: Worksheet B Part II Date/Time Pre 11/21/2014 8:	epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.00	00500 ADMINI 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	12, 424					11.00
13.00	01300 NURSING ADMINISTRATION	1, 284	32, 771				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	287	0	5, 70)7		14.00
15.00	01500 PHARMACY	340			0 69, 009		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	709	0		0 0	32, 168	16.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.077	10.000		<u>a</u> a	4 700	
30.00	03000 ADULTS & PEDIATRICS	2, 277			0 0	1, 780	1
43.00		329	1, 785		0 0	306	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	759	4, 114		0 0	3, 663	50.00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	710			0 0	3, 883	
53.00	05300 ANESTHESI OLOGY	/10	3, 040		0 0	280	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 165	4		0 0	3, 343	
57.00	05700 CT SCAN	103			0 0	5, 059	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	86			0 0	1, 122	1
60.00	06000 LABORATORY	0			0 0	7, 111	1
65.00	06500 RESPI RATORY THERAPY	673	0		0 0	842	1
65.01	03950 SLEEP LAB	101	0		0 0	215	65.01
66.00	06600 PHYSI CAL THERAPY	674	0		0 0	759	66.00
67.00	06700 OCCUPATI ONAL THERAPY	96	0		0 0	185	67.00
69.00	06900 ELECTROCARDI OLOGY	218	0		0 0	399	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	8	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2, 88		0	
72.00	07200 I MPL. DEV. CHARGED TO PATI ENTS	0	0	2, 82		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	415	0		0 69,009	0	73.00
91.00	OUTPATIENT SERVICE COST CENTERS	1 022	9, 928		0 0	(12(91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 833	9, 928		0 0	6, 436	91.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
101 00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS						101.00
116.00	11600 HOSPI CE	0	0		0 0	0	116.00
118.00		12,060	-	5, 70			118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191.00	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	140	756		0 0		192.00
	19300 NONPAI D WORKERS	0	0		0 0		193.00
	07950 OTHER NRCC - PUBLIC RELATIONS	0	-		0 0		194.00
	07951 OTHER NRCC - FOUNDATION	78			0 0		194.01
					0		
194.02	07952 OTHER NRCC - GRANTS	146	0		0 0	0	194.02
194. 02 200. 00	Cross Foot Adjustments	146	0				200.00
194.02	Cross Foot Adjustments Negative Cost Centers	146 0 12, 424	0	5, 70	0 0 0 0 07 69,009	0	

Heal th	Fi nanci	al Syst	ems
	TI 011 05	OADL TAL	

Heal th Financi	ial Systems	ST. VINCENT RAN	DOLPH	HOSPI TAL			In Lieu of Form	CMS-2552-10
ALLOCATION OF	CAPITAL RELATED COSTS			Provi der	CCN:		Period: Workshee From 07/01/2013 Part II	t B
						1	To 06/30/2014 Date/Tim	
C	Cost Center Description	Subtotal	L In	ntern &		Total	11/21/20	14 8:34 am
C	bost center bescription	Subtotal		lents Cost		10121		
				Post				
			St	epdown				
			Adj ı	ustments				
		24.00		25.00		26.00		
	_ SERVICE COST CENTERS		1					
	CAP REL COSTS-BLDG & FIXT							1.00
1 1	CAP REL COSTS-MVBLE EQUIP							2.00
	MPLOYEE BENEFITS DEPARTMENT							4.00 5.00
	DERATION OF PLANT							7.00
	AUNDRY & LINEN SERVICE							8.00
	IOUSEKEEPI NG							9.00
10.00 01000 D								10.00
	CAFETERIA							11.00
	IURSI NG ADMI NI STRATI ON							13.00
	CENTRAL SERVICES & SUPPLY							14.00
	PHARMACY							15.00
16.00 01600 M	IEDI CAL RECORDS & LI BRARY							16.00
	ENT ROUTINE SERVICE COST CENTERS							
30.00 03000 A	ADULTS & PEDIATRICS	265, 900		0		265, 900		30.00
43.00 04300 N		12, 980		0		12, 980	<u>)</u>	43.00
	ARY SERVICE COST CENTERS	474 570						
	DERATING ROOM	176, 578	1	0		176, 578		50.00
	DELIVERY ROOM & LABOR ROOM	53, 496		0		53, 496		52.00
	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	586 110, 500	1	0		110 500		53.00 54.00
57.00 05700 C		8, 316		0		110, 500 8, 316		57.00
	MAGNETIC RESONANCE IMAGING (MRI)	186, 614		0		186, 614		58.00
	ABORATORY	75, 991		0		75, 99		60.00
	RESPI RATORY THERAPY	39, 471		0		39, 47		65.00
	SLEEP LAB	9, 266		0		9, 266		65.01
	PHYSI CAL THERAPY	57, 137		0		57, 137		66.00
67.00 06700 0	CCUPATIONAL THERAPY	6, 725		0		6, 725		67.00
69.00 06900 E	LECTROCARDI OLOGY	6, 232		0		6, 232	2	69.00
70.00 07000 E	LECTROENCEPHALOGRAPHY	116		0		116	5	70.00
71.00 07100 M	MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 256		0		33, 256	5	71.00
	MPL. DEV. CHARGED TO PATIENTS	8, 981		0		8, 981		72.00
	DRUGS CHARGED TO PATIENTS	96, 991		0		96, 991	<u> </u>	73.00
	ENT SERVICE COST CENTERS	100 500				400 50		
	EMERGENCY DBSERVATION BEDS (NON-DISTINCT PART)	139, 508		0		139, 508	3	91.00
	REIMBURSABLE COST CENTERS		I	0	'			92.00
	IOME HEALTH AGENCY	C		0				101.00
	_ PURPOSE COST CENTERS			0			1	
116.0011600 H		C		0		(116.00
118.00 S	SUBTOTALS (SUM OF LINES 1-117)	1, 288, 644		0		1, 288, 644	4	118.00
	IBURSABLE COST CENTERS							
190.0019000 G	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 570		0		1, 570	2	190.00
191.00 19100 R		C		0		(C	191.00
	PHYSICIANS' PRIVATE OFFICES	194, 573		0		194, 573	3	192.00
	IONPAI D WORKERS	C		0		(193.00
	THER NRCC - PUBLIC RELATIONS	5, 421		0		5, 42		194.00
	OTHER NRCC - FOUNDATION	4,924		0		4, 924		194.01
	OTHER NRCC - GRANTS	3,740		0	1	3, 740		194.02
	Cross Foot Adjustments	C		0		(200. 00 201. 00
	legative Cost Centers TOTAL (sum lines 118-201)	0 1, 498, 872		0		1, 498, 872		201.00
202.00	UTAL (SUII TITIES TID-201)	1,470,072	1	0	T	1, 470, 0/2	-1	1202.00

Heal th	Fi nanci al	Systems	
00ST A			R۸

In Lieu of Form CMS-2552-10

Health Financial Systems	ST. VINCENT RAN	DOLPH_HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 151301 P	eriod:	Worksheet B-1	
				rom 07/01/2013 0 06/30/2014		nared
					11/21/2014 8:	34 am
	CAPI TAL REI	LATED COSTS				
Cast Castan Description	BLDG & FIXT			Decenciliation		
Cost Center Description	(SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
	(SOUNCE FEET)		DEPARTMENT		(ACCUM. COST)	
			(GROSS			
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS		1	1	1	1	
1.00 00100 CAP REL COSTS-BLDG & FIXT	78, 458					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	78, 458				2.00
5.00 00500 ADMINISTRATIVE & GENERAL	12, 343	-	.,		14, 922, 539	
7.00 00700 OPERATION OF PLANT	4, 688				1, 448, 367	
8.00 00800 LAUNDRY & LINEN SERVICE	640			0	55, 726	
9. 00 00900 HOUSEKEEPING	600			0 0	326, 080	
10. 00 01000 DI ETARY	2, 226	2, 226	c c	0 0	169, 570	
11. 00 01100 CAFETERI A	524	524	C	0 0	183, 664	11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	144	144			885, 820	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	-			161, 278	
15.00 01500 PHARMACY	0	-	200,000		1, 012, 465	
16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 483	1, 483	187, 376	0	327, 576	16.00
30. 00 03000 ADULTS & PEDIATRICS	9, 136	9, 136	861, 392	2 0	1, 283, 424	30.00
43. 00 04300 NURSERY	125					
ANCI LLARY SERVICE COST CENTERS	120	1 120	101,101		207,020	10.00
50. 00 05000 OPERATING ROOM	7,725	7, 725	388, 258	8 0	921, 361	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 349				602, 534	
53. 00 05300 ANESTHESI OLOGY	0	C	2, 236	0	8, 959	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 223	6, 223			913, 263	
57. 00 05700 CT SCAN	0		10/110		93, 858	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		44, 885	0	238, 242	
60. 00 06000 LABORATORY	1,743			0	1, 419, 579	
65. 00 06500 RESPI RATORY THERAPY 65. 01 03950 SLEEP LAB	1,819				432, 147 102, 160	
66. 00 06600 PHYSI CAL THERAPY	3,005				458, 970	
67. 00 06700 OCCUPATI ONAL THERAPY	317				79, 177	
69. 00 06900 ELECTROCARDI OLOGY	0				167, 098	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C	C	0 0	3, 200	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 683	1, 683	C C	0 0	306, 143	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	C	0 0	183, 244	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 157	1, 157	217, 173	0	409, 459	73.00
	4.040	4.040		,	1 001 004	01 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 249	4, 249	755, 677	0	1, 881, 336	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	0	C	C	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	0	C) C	0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	62, 603	62, 603	7, 303, 438	-5, 950, 331	14, 344, 525	118.00
NONREI MBURSABLE COST CENTERS	1	1		1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	128			0 0		190.00
	15 505		-	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	15, 595	15, 595	37, 899	0	211, 147	
193.00 19300 NONPALD WORKERS 194.00 07950 OTHER NRCC - PUBLIC RELATIONS	66	66		0	137, 865	193.00
194.0107951 OTHER NRCC - FOUNDATION	66				120, 757	
194. 02 07952 OTHER NRCC - GRANTS	0	C	13, 329		106, 956	
200.00 Cross Foot Adjustments			, 52,			200.00
201.00 Negative Cost Centers				1		201.00
202.00 Cost to be allocated (per Wkst. B,	519, 473	270, 910	2, 467, 704		5, 950, 331	
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	6. 621033	3. 452930	0. 334101		0. 398748	
204.00 Cost to be allocated (per Wkst. B,			0		501, 486	204.00
Part II)			0.000000		0.000/0/	
205.00 Unit cost multiplier (Wkst. B, Part			0.000000		0. 033606	205.00
	I	I	I	I	I	I

T ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2013	Worksheet B-1	
				To 06/30/2014	Date/Time Pre 11/21/2014 8:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(HOURS)	
	(SQUARE FEET)	LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS	- 1	1	1			ł.,
0 00100 CAP REL COSTS-BLDG & FIXT						1
0 00200 CAP REL COSTS-MVBLE EQUI P 0 00400 EMPLOYEE BENEFI TS DEPARTMENT						2
0 00500 ADMINISTRATIVE & GENERAL						4
0 00700 OPERATION OF PLANT	61, 427	7				
0 00800 LAUNDRY & LINEN SERVICE	640					
0 00900 HOUSEKEEPI NG	600		60, 187	7		9
00 01000 DI ETARY	2, 226	-	2, 226			10
00 01100 CAFETERIA	524		524		200, 725	11
00 01300 NURSING ADMINISTRATION	144	0	144	4 0	20, 750	13
00 01400 CENTRAL SERVICES & SUPPLY	C	0) (0 0	4, 641	14
00 01500 PHARMACY	C	0) (0 0	5, 494	15
00 01600 MEDICAL RECORDS & LIBRARY	1, 483	6 C	1, 483	3 0	11, 458	16
INPATIENT ROUTINE SERVICE COST CENTERS		1	1			
00 03000 ADULTS & PEDIATRICS	9, 136				36, 796	
00 04300 NURSERY	125	o C	125	5 0	5, 322	43
ANCI LLARY SERVI CE COST CENTERS	7 70	11 771	7 70	-	10.0/0	
00 05000 OPERATING ROOM	7,725				12, 268	
00 05200 DELIVERY ROOM & LABOR ROOM 00 05300 ANESTHESI OLOGY	2, 349				11, 470 12	
00 05400 RADI OLOGY-DI AGNOSTI C	6, 223				18, 820	
00 05700 CT SCAN	0, 223				1, 667	
00 05800 MAGNETIC RESONANCE IMAGING (MRI)		-			1, 383	
00 06000 LABORATORY	1, 743	-	1, 743		1, 303	
00 06500 RESPIRATORY THERAPY	1, 819		1, 819		10, 873	
01 03950 SLEEP LAB	424		424		1, 626	
00 06600 PHYSI CAL THERAPY	3,005	5 O	3, 005	5 0	10, 897	66
00 06700 OCCUPATI ONAL THERAPY	317	′ C	317	7 0	1, 550	67
00 06900 ELECTROCARDI OLOGY	C	0) (3, 522	
00 07000 ELECTROENCEPHALOGRAPHY	C	-) (0	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 683		.,		0	
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	1
00 07300 DRUGS CHARGED TO PATIENTS	1, 157	C	1, 157	7 0	6, 704	73
OUTPATIENT SERVICE COST CENTERS 00 09100 EMERGENCY	4, 249	41, 200	4,249	9 0	29, 607	91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 245	41,200	4, 24	9 0	29,007	92
OTHER REIMBURSABLE COST CENTERS						1 72
. 00 10100 HOME HEALTH AGENCY	0			0 0	0	101
SPECIAL PURPOSE COST CENTERS		·[1			1.0.
0. 00 11600 HOSPI CE	0			0 0	0	116
SUBTOTALS (SUM OF LINES 1-117)	45, 572	105, 479	44, 332	2 100	194, 860	118
NONREIMBURSABLE COST CENTERS						
0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	3 O	128	3 0		190
. 00 19100 RESEARCH	C	0) (0 0		191
00 19200 PHYSI CLANS' PRI VATE OFFI CES	15, 595	0	15, 595		2, 255	
00 19300 NONPALD WORKERS	0			0 0		193
00 07950 OTHER NRCC - PUBLIC RELATIONS	66		66			194
01 07951 OTHER NRCC - FOUNDATION	66		66	6 O	1, 259	
02 07952 OTHER NRCC - GRANTS 0.00 Cross Foot Adjustments				ן א	2, 351	
0.00 Cross Foot Adjustments .00 Negative Cost Centers						200
2.00 Cost to be allocated (per Wkst. B,	2, 025, 900	99,055	475, 892	328, 202	278, 325	
Part I)	2, 025, 900	, 99,000	4/0,892	320, 202	210, 325	202
.00 Unit cost multiplier (Wkst. B, Part I)) 32. 980611	0. 939097	7. 906890	3, 282. 020000	1. 386599	203
. 00 Cost to be allocated (per Wkst. B,	95, 900				12, 424	
Part II)	, , , , , , , , , , , , , , , , , ,	., 517		02,202	,	
.00 Unit cost multiplier (Wkst. B, Part	1. 561203	0. 088349	0. 298071	322. 620000	0. 061896	205
			1			1

	· · · · · · · · · · · · · · · · · · ·	T. VINCENT RAND				u of Form CMS-2552-
COST A	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 07/01/2013 To 06/30/2014	Worksheet B-1 Date/Time Prepared 11/21/2014 8:34 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	<u>11/21/2014 8.34 dii</u>
		13.00	14.00	15.00	16.00	
1 00	GENERAL SERVICE COST CENTERS	1 1			1	
14. 00 15. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	97, 730 0 0 0	472, 433 0 0	10, 000		1. (2. (4. (5. (7. (8. (9. (10. (11. (13. (14. (13. (14. (15. (16. (
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·				
	03000 ADULTS & PEDI ATRI CS	36, 796	0			30. (
43.00	04300 NURSERY	5, 322	0	(620, 235	43.0
	ANCI LLARY SERVI CE COST CENTERS	10.040				
	05000 OPERATING ROOM	12, 268	0			50.0
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	11, 470 12	0		1, 336, 861 567, 059	52. (53. (
	05400 RADI OLOGY-DI AGNOSTI C	12	0		6, 766, 945	53.0
57.00	05700 CT SCAN	0	0		10, 241, 426	57.0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		2, 270, 446	58.0
	06000 LABORATORY	0	0		14, 355, 989	60.0
	06500 RESPI RATORY THERAPY	0	0			65.0
	03950 SLEEP LAB	0	0	0	435, 523	65.0
66.00	06600 PHYSI CAL THERAPY	0	0	C	1, 535, 566	66. 0
	06700 OCCUPATI ONAL THERAPY	0	0	C	375, 459	67. (
	06900 ELECTROCARDI OLOGY	0	0	C	807, 507	69.0
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	16, 320	70.0
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	238, 742	0	0	71. (
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	233, 691	10.000	0	72. (
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	10, 000	0 0	73. (
91.00	OUTPATIENT SERVICE COST CENTERS	29,607	0	0	12 027 241	91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	29,007	0		13, 027, 361	91.0
72.00	OTHER REIMBURSABLE COST CENTERS					72.0
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101. (
	SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPI CE	0	0	0	0 0	116. (
118.00	SUBTOTALS (SUM OF LINES 1-117)	95, 475	472, 433	10, 000	65, 078, 819	118. (
	NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C		190. (
	19100 RESEARCH	0	0	0	0	191. (
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 255	0		0	192. (
	19300 NONPAID WORKERS 07950 OTHER NRCC - PUBLIC RELATIONS	0	0			193. (
	07950 OTHER NRCC - FOUNDATION	0	0			194. (194. (
	07952 OTHER NRCC - GRANTS	0	0			194.0
200.00			0			200. 0
201.00						201. (
202.00		1, 273, 699	232, 022	1, 423, 801	534, 720	202. (
	Part I)					
203.00		13. 032835	0. 491121			203. (
204.00		32, 771	5, 707	69, 009	32, 168	204.0
205 02	Part II)	0.005000	0 010000	(000000	0.000404	
205.00	Unit cost multiplier (Wkst. B, Part)	0. 335322	0. 012080	6. 900900	0. 000494	205. (
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Health Financial Systems	ST. VINCENT RAN	DOLPH_HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 07/01/2013 To 06/30/2014	Date/Time Pre 11/21/2014 8:	
		Titl	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 095, 370		3, 095, 37	0 0	0	
43. 00 04300 NURSERY	464, 364		464, 36	4 0	0	43.00
ANCI LLARY SERVICE COST CENTERS		-				
50.00 05000 OPERATING ROOM	1, 853, 482		1, 853, 48	2 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 115, 212		1, 115, 21	2 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	17, 363	5	17, 36	3 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 624, 618	5	1, 624, 61	8 0	0	54.00
57.00 05700 CT SCAN	217, 739		217, 73	9 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	353, 813		353, 81	3 0	0	58.00
60. 00 06000 LABORATORY	2, 174, 881		2, 174, 88	1 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	707, 915	C	707, 91	5 0	0	65.00
65.01 03950 SLEEP LAB	166, 066	C	166, 06	6 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	792, 576	0	792, 57	6 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	128, 944	. 0	128, 94	4 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	245, 246		245, 24	6 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 610		4, 61	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	614, 281		614, 28	1 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	371, 083		371, 08	3 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 053, 134		2, 053, 13	4 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	3, 377, 885		3, 377, 88	5 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	688, 784		688, 78	4	0	92.00
OTHER REI MBURSABLE COST CENTERS	-	1				
101.00 HOME HEALTH AGENCY	C			0	0	101.00
SPECIAL PURPOSE COST CENTERS		J	1	a	2	11/ 00
116.00 11600 HOSPI CE				0		116.00
200.00 Subtotal (see instructions)	20, 067, 366					200.00
201.00 Less Observation Beds	688, 784		688, 78			201.00
202.00 Total (see instructions)	19, 378, 582	c C	19, 378, 58	2 0	0	202.00

COMPUTATION OF F	Systems SRATIO OF COSTS TO CHARGES		OLPH HOSPITAL Provider	CCN: 151301	Peri od:	u of Form CMS- Worksheet C	
					From 07/01/2013		
					To 06/30/2014	Date/Time Pre 11/21/2014 8:	
			Titl	e XVIII	Hospi tal	Cost	
			Charges				
Cos	t Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
						Rati o	
		6.00	7.00	8.00	9.00	10.00	
	ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
	LTS & PEDIATRICS	2, 896, 170		2, 896, 1			30.00
43.00 04300 NUR		620, 235		620, 2	35		43.00
	SERVICE COST CENTERS			1			
	RATING ROOM	1, 564, 624	5, 850, 425				
	IVERY ROOM & LABOR ROOM	971, 898	364, 963				
	STHESI OLOGY	82, 421	484, 638				
	I OLOGY-DI AGNOSTI C	197, 747	6, 569, 198			0. 000000	
57.00 05700 CT 3		127, 488	10, 113, 938			0.00000	
	NETIC RESONANCE IMAGING (MRI)	24, 479	2, 245, 967				
60.00 06000 LAB		801, 987	13, 554, 002				
65. 00 06500 RESI	PI RATORY THERAPY	728, 948	974, 943	1, 703, 8	91 0. 415470	0.00000	65.00
65. 01 03950 SLEI	EP LAB	0	435, 523	435, 5	23 0. 381302	0.00000	65.01
66.00 06600 PHY	SI CAL THERAPY	140, 495	1, 395, 071	1, 535, 5	66 0. 516146	0.000000	66.00
67.00 06700 0CCI	UPATIONAL THERAPY	33, 306	342, 153	375, 4	59 0. 343430	0.00000	67.00
69.00 06900 ELE	CTROCARDI OLOGY	103, 491	704, 016	807, 5	07 0. 303708	0.000000	69.00
70.00 07000 ELE	CTROENCEPHALOGRAPHY	870	15, 450	16, 3	20 0. 282475	0.00000	70.00
71.00 07100 MED	ICAL SUPPLIES CHARGED TO PATIENTS	865, 116	1, 419, 361	2, 284, 4	0. 268893	0. 000000	71.00
72.00 07200 I MPI	L. DEV. CHARGED TO PATIENTS	331, 335	254, 739	586, 0	74 0. 633167	0. 000000	72.00
73.00 07300 DRU	GS CHARGED TO PATIENTS	1, 307, 000	4, 790, 243	6, 097, 2	43 0. 336732	0. 000000	73.00
OUTPATI EN	T SERVICE COST CENTERS	· · · ·					1
91.00 09100 EMEI	RGENCY	8, 900	13, 018, 461	13, 027, 3	61 0. 259292	0.00000	91.00
92.00 09200 OBSI	ERVATION BEDS (NON-DISTINCT PART)	1, 796	705, 216	707, 0	0. 974218	0.000000	92.00
OTHER REI	MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
101.00 10100 HOMI		0	0		0		101.00
	URPOSE COST CENTERS						1
116.00 11600 HOSI		0	0		0		116. 00
200.00 Sub	total (see instructions)	10, 808, 306	63, 238, 307		13		200.00
	s Observation Beds	,,,,	,, 00,				201.00
	al (see instructions)	10, 808, 306	63, 238, 307	74, 046, 6	13		202.00

Health Financial Systems	ST. VINCENT RANDOL	PH_HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/21/2014 8:34 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
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57.00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
65. 01 03950 SLEEP LAB	0. 000000			65.01
66. 00 06600 PHYSI CAL THERAPY	0.000000			66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000			67.00
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 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS	0.000000			
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			72.00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				101.00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				201.00
	1 1			1202.00

Heal th Finar	ncial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES			CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Date/Time Pre 11/21/2014 8:	
			Tit	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	IENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	3, 095, 370		3, 095, 37	0 0	3, 095, 370	30.00
	NURSERY	464, 364		464, 36	04 0	464, 364	43.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	1, 853, 482		1, 853, 48	32 0		
52.00 05200	DELIVERY ROOM & LABOR ROOM	1, 115, 212		1, 115, 21	2 0	1, 115, 212	52.00
53.00 05300	ANESTHESI OLOGY	17, 363		17, 36	03 0	17, 363	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	1, 624, 618		1, 624, 61	8 0	1, 624, 618	54.00
57.00 05700	CT SCAN	217, 739		217, 73	39 0	217, 739	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	353, 813		353, 81	3 0	353, 813	58.00
60.00 06000	LABORATORY	2, 174, 881		2, 174, 88	31 0	2, 174, 881	60.00
65.00 06500	RESPI RATORY THERAPY	707, 915	0	707, 91	5 0	707, 915	65.00
65.01 03950	SLEEP LAB	166, 066	0	166, 06	6 0	166, 066	65.01
66.00 06600	PHYSI CAL THERAPY	792, 576	0	792, 57		792, 576	66.00
67.00 06700	OCCUPATIONAL THERAPY	128, 944		128, 94	4 0	128, 944	67.00
69.00 06900	ELECTROCARDI OLOGY	245, 246		245, 24	6 0	245, 246	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	4, 610		4, 6	0 0	4, 610	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614, 281		614, 28	31 0	614, 281	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	371,083		371, 08	33 0	371, 083	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2, 053, 134		2, 053, 13	34 0	2, 053, 134	73.00
OUTPA	TIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	3, 377, 885		3, 377, 88	35 0	3, 377, 885	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	688, 784		688, 78	34	688, 784	92.00
	REIMBURSABLE COST CENTERS						
101.0010100	HOME HEALTH AGENCY	0			0	0	101.00
	AL PURPOSE COST CENTERS			•			
116.0011600		0			0	0	116.00
200.00	Subtotal (see instructions)	20, 067, 366	C	20, 067, 36	6 0		
201.00	Less Observation Beds	688, 784		688, 78		688, 784	
202.00	Total (see instructions)	19, 378, 582					
1				•			•

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	ST. VINCENT KANE	OLPH HOSPITAL	CON. 1E1201	Peri od:	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151301	From 07/01/2013	Worksheet C Part I	
				To 06/30/2014	Date/Time Pre	pared:
					Date/Time Pre 11/21/2014 8:	34 am
			le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
	(00	7.00	0.00	0.00	Ratio	
INPATIENT ROUTINE SERVICE COST CENTER	6.00	7.00	8.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	2, 896, 170		2, 896, 1	70		30.00
						43.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	620, 235		620, 23	35		43.00
50. 00 05000 OPERATING ROOM	1, 564, 624	5, 850, 425	7, 415, 04	0, 249962	0, 000000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	971, 898					
53. 00 05300 ANESTHESI OLOGY	82, 421	484, 638				
54. 00 05400 RADI OLOGY - DI AGNOSTI C	197, 747	6, 569, 198			0. 000000	
57. 00 05700 CT SCAN	197, 747	10, 113, 938			0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI		2, 245, 967			0. 000000	
60. 00 06000 LABORATORY	801, 987	13, 554, 002				
65. 00 06500 RESPI RATORY THERAPY	728, 948	974, 943				
65. 01 03950 SLEEP LAB	, 20, , 40	435, 523			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	140, 495	1, 395, 071			0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	33, 306	342, 153				
69. 00 06900 ELECTROCARDI OLOGY	103, 491	704, 016				
70. 00 07000 ELECTROENCEPHALOGRAPHY	870	15, 450				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT		1, 419, 361				
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS	331, 335	254, 739			0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 307, 000	4, 790, 243				
OUTPATIENT SERVICE COST CENTERS		.,				
91. 00 09100 EMERGENCY	8,900	13, 018, 461	13, 027, 3	61 0. 259292	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT		705, 216				
OTHER REIMBURSABLE COST CENTERS			, · · · ·			
101.00 10100 HOME HEALTH AGENCY	0	C		0		101.00
SPECIAL PURPOSE COST CENTERS						1
116.00 11600 HOSPI CE	0	C		0		116.00
200.00 Subtotal (see instructions)	10, 808, 306	63, 238, 307	74, 046, 6	13		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	10, 808, 306	63, 238, 307	74, 046, 6	13		202.00

ati ent io 00 00 000000 000000 000000 000000 00000	Provi der CCN: 151301	Peri od: From 07/01/2013 To 06/30/2014 Hospi tal	Worksheet C Part I Date/Time Pre 11/21/2014 8: Cost	34 am 30.00 43.00 50.00 52.00 53.00
i o 00 00 000000 000000 000000 000000 00000	Title XIX	Hospi tal	Cost	43.00 50.00 52.00 53.00
i o 00 00 000000 000000 000000 000000 00000				43.00 50.00 52.00 53.00
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Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF			Period: From 07/01/2013 To 06/30/2014		
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 853, 482	176, 578	1, 676, 90	04 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 115, 212	53, 496	1, 061, 7	6 0	0	52.00
53.00 05300 ANESTHESI OLOGY	17, 363	586	16, 7	7 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 624, 618	110, 500	1, 514, 1	8 0	0	54.00
57.00 05700 CT SCAN	217, 739	8, 316	209, 42	23 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	353, 813	186, 614	167, 19	09 0	0	58.00
60. 00 06000 LABORATORY	2, 174, 881	75, 991	2, 098, 89	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	707, 915	39, 471	668, 44	4 0	0	65.00
65. 01 03950 SLEEP LAB	166,066	9, 266	156, 80	0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	792, 576	57, 137	735, 43	39 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	128, 944	6, 725	122, 2	9 0	0	67.00
69.00 06900 ELECTROCARDI OLOGY	245, 246	6, 232	239,0	4 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	4,610			04 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	614, 281				0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	371,083				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,053,134				0	73.00
OUTPATIENT SERVICE COST CENTERS	1 1 1 1 1 1 1			<u> </u>		
91.00 09100 EMERGENCY	3, 377, 885	139, 508	3, 238, 37	7 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	688, 784				0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	C		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	-	-	·			
116. 00 11600 HOSPI CE	0	C		0 0	0	116.00
200.00 Subtotal (sum of lines 50 thru 199)	16, 507, 632	-				200.00
201.00 Less Observation Beds	688, 784					201.00
202.00 Total (line 200 minus line 201)	15, 818, 848					202.00
	•		•			•

Health Financial Systems	ST. VINCENT RAND	OLPH HOSPITAL		In Lie	u of Form CMS-25	552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provi der	CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part II Date/Time Prepa 11/21/2014 8:34	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description		Total Charges				
	Capital and	(Worksheet C,	Cost to Charg	je		
	Operating Cost	Part I, column	Ratio (col.	6		
	Reducti on	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 853, 482	7, 415, 049	0. 24996	52		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 115, 212	1, 336, 861	0.83420)2		52.00
53.00 05300 ANESTHESI OLOGY	17, 363	567, 059	0. 0306	19		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 624, 618	6, 766, 945	0. 24008	31		54.00
57.00 05700 CT SCAN	217, 739	10, 241, 426	0. 02126	51		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	353, 813	2, 270, 446	0. 15583	34		58.00
60. 00 06000 LABORATORY	2, 174, 881	14, 355, 989	0. 15149	96		60.00
65. 00 06500 RESPI RATORY THERAPY	707, 915	1, 703, 891	0. 41547	70		65.00
65. 01 03950 SLEEP LAB	166, 066	435, 523	0. 38130)2		65.01
66. 00 06600 PHYSI CAL THERAPY	792, 576	1, 535, 566	0. 51614	16		66.00
67.00 06700 OCCUPATI ONAL THERAPY	128, 944	375, 459	0. 34343	30		67.00
69. 00 06900 ELECTROCARDI OLOGY	245, 246	807, 507	0. 30370	08		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	4,610	16, 320	0. 28247	75		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	614, 281	2, 284, 477	0. 26889	93		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	371,083			57		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,053,134	6,097,243				73.00
OUTPATIENT SERVICE COST CENTERS				· - I		
91.00 09100 EMERGENCY	3, 377, 885	13, 027, 361	0.25929	92		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	688, 784			8		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0.0000	00	1	01.00
SPECIAL PURPOSE COST CENTERS			0.00000			01100
116. 00 11600 HOSPI CE	0	0	0.0000	00	1	16.00
200.00 Subtotal (sum of lines 50 thru 199)	16, 507, 632	-				200.00
201.00 Less Observation Beds	688, 784	,0,000,200				201.00
202.00 Total (line 200 minus line 201)	15, 818, 848	0				02.00

Health Financial Systems	T. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Pre 11/21/2014 8:	pared: 34 am
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	I	1	1		
50. 00 05000 OPERATI NG ROOM	176, 578					
52.00 05200 DELIVERY ROOM & LABOR ROOM	53, 496					
53. 00 05300 ANESTHESI OLOGY	586					53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	110, 500					54.00
57.00 05700 CT SCAN	8, 316					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	186, 614					58.00
60. 00 06000 LABORATORY	75, 991					60.00
65. 00 06500 RESPI RATORY THERAPY	39, 471				9, 873	
65. 01 03950 SLEEP LAB	9, 266				0	65.01
66. 00 06600 PHYSI CAL THERAPY	57, 137					66.00
67.00 06700 OCCUPATI ONAL THERAPY	6, 725				252	67.00
69. 00 06900 ELECTROCARDI OLOGY	6, 232				775	
70. 00 07000 ELECTROENCEPHALOGRAPHY	116	16, 320	0.00710	8 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 256	2, 284, 477	0. 01455	7 312, 809	4, 554	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 981	586, 074	0. 01532	4 78, 830	1, 208	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	96, 991	6, 097, 243	0. 01590	7 546, 786	8, 698	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	139, 508					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	64, 258	707, 012	0. 09088	7 1, 796	163	92.00
200.00 Total (lines 50-199)	1,074,022	70, 530, 208		2, 298, 803	38, 101	200. 00

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	ERVICE OTHER PAS	S Provi der		Period: From 07/01/2013	Worksheet D Part IV	
				To 06/30/2014	Date/Time Pre 11/21/2014 8:	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	0			0 0	0	54.00 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	57.00
60. 00 06000 LABORATORY	0				0	60.00
65. 00 06500 RESPIRATORY THERAPY	0			0 0	0	65.00
65. 01 03950 SLEEP LAB	0			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0				0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0				0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0				0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	C		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	c		0 0	0	200. 00

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2013	Part IV	norod.
				To 06/30/2014	Date/Time Pre 11/21/2014 8:	
·		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Total		Ratio of Cost		Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50. 00 05000 OPERATI NG ROOM	0	7, 415, 049				1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 336, 861			9, 364	52.00
53. 00 05300 ANESTHESI OLOGY	0	567, 059				1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	6, 766, 945				1
57.00 05700 CT SCAN	0	10, 241, 426				
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2, 270, 446				
60. 00 06000 LABORATORY	0	14, 355, 989				1
65. 00 06500 RESPI RATORY THERAPY	0	1, 703, 891			426, 196	1
65.01 03950 SLEEP LAB	0	435, 523			0	65.01
66. 00 06600 PHYSI CAL THERAPY	0	1, 535, 566				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	375, 459				
69.00 06900 ELECTROCARDI OLOGY	0	807, 507				
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	16, 320				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 284, 477				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	586, 074				
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 097, 243	0.00000	0.00000	546, 786	73.00
OUTPATIENT SERVICE COST CENTERS	-			_		
91. 00 09100 EMERGENCY	0					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	707, 012		0. 000000		
200.00 Total (lines 50-199)	0	70, 530, 208			2, 298, 803	200. 00

Health Financial Systems	ST. VINCENT RAND	OLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	6 Provi der	CCN: 151301	Period: From 07/01/2013	Worksheet D Part IV	
THROUGH COSTS				To 06/30/2014	Date/Time Pre	epared.
				10 00,00,2011	11/21/2014 8:	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS			1			_
50.00 05000 OPERATI NG ROOM	0	C		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
57.00 05700 CT SCAN	0	C		0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	D	0		58.00
60. 00 06000 LABORATORY	0	C	D	0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	C	D	0		65.00
65. 01 03950 SLEEP LAB	0	C		0		65.01
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		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		200.00

Health Financial Systems S	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period:	Worksheet D	
				From 07/01/2013		norod.
				To 06/30/2014	Date/Time Pre 11/21/2014 8:	
		Ti tl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	_	-				
50.00 05000 OPERATING ROOM	0. 249962		1, 488, 57	4 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 834202	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 030619	0	134, 65	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 240081	0	1, 572, 54	4 0	0	54.00
57.00 05700 CT SCAN	0. 021261	0	3, 049, 03	5 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 155834	0	652, 45	0 8	0	58.00
60. 00 06000 LABORATORY	0. 151496	0	3, 311, 36	9 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 415470	0	237, 62	.8 0	0	65.00
65. 01 03950 SLEEP LAB	0. 381302	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 516146	0	512, 99	06 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 343430	0	94, 86	6 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 303708	0	579, 91	6 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 282475	0	136, 49		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 268893		609, 43		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 633167		90, 25		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 336732				0	
OUTPATIENT SERVICE COST CENTERS		-	.,	_,	-	1
91. 00 09100 EMERGENCY	0, 259292	0	3, 446, 03	8 3, 795	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 974218		243, 45		0	
200.00 Subtotal (see instructions)		0	17, 829, 13		-	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0	, i i i i i i i i i i i i i i i i i i i	201.00
Only Charges				-		
202.00 Net Charges (line 200 +/- line 201)		0	17, 829, 13	6, 509	0	202.00

Health Financial Systems S	T. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Pre 11/21/2014 8:	
		Titl	e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	372, 087					50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	-				52.00
53.00 05300 ANESTHESI OLOGY	4, 123					53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	377, 538					54.00
57.00 05700 CT SCAN	64, 826					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	101, 675					58.00
60. 00 06000 LABORATORY	501, 659					60.00
65. 00 06500 RESPI RATORY THERAPY	98, 727					65.00
65. 01 03950 SLEEP LAB	0	0				65.01
66. 00 06600 PHYSI CAL THERAPY	264, 781	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	32, 580	0				67.00
69. 00 06900 ELECTROCARDI OLOGY	176, 125	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	38, 555	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	163, 874	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	57, 147	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	562, 148	914				73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	893, 530	984				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	237, 178	0				92.00
200.00 Subtotal (see instructions)	3, 946, 553	1, 898				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	3, 946, 553	1, 898				202.00

Health Financial Systems S	T. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 07/01/2013	Part V	
		Component	CCN: 15Z301	To 06/30/2014	Date/Time Pre 11/21/2014 8:	
		Ti tl	e XVIII	Swing Beds - SNF		<u>34 alli</u>
			Charges	oning bodd on	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9	· · ·	Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 249962			0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 834202			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 030619	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 240081	0		0 0	0	54.00
57.00 05700 CT SCAN	0. 021261	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 155834	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 151496	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 415470	0		0 0	0	65.00
65. 01 03950 SLEEP LAB	0. 381302	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 516146	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 343430	0		0 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 303708	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 282475	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 268893	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 633167	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 336732	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 259292	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 974218	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	1	0 0	0	202.00

Health Financial Systems S	T. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151301	Period: From 07/01/2013	Worksheet D Part V	
		Component	CCN: 15Z301	To 06/30/2014		
		Ti †I	e XVIII	Swing Beds - SNF		<u>54 alli</u>
	Co	sts		Joining Boddo Chin	0001	
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 05300 ANESTHESI OLOGY	0	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00 05700 CT SCAN	0	0	1			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1			58.00
60. 00 06000 LABORATORY	0	0	1			60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
65. 01 03950 SLEEP LAB	0	0				65.01
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
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		I				
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	-				201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	0				202.00

Health Financial Systems	T. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 151301	Period: From 07/01/2013	Worksheet D Part I	
				To 06/30/2014		pared: 34 am
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	265, 900	20, 511	245, 38	2, 309	106.28	30.00
43.00 NURSERY	12, 980		12, 98	30 420	30.90	43.00
200.00 Total (lines 30-199)	278, 880		258, 36	2, 729		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	52	5, 527				30.00
43.00 NURSERY	311	9, 610				43.00
200.00 Total (lines 30-199)	363	15, 137				200. 00

Health Financial Systems	T. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Pre 11/21/2014 8:	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	I	1			
50.00 05000 OPERATI NG ROOM	176, 578					
52.00 05200 DELIVERY ROOM & LABOR ROOM	53, 496				0	52.00
53. 00 05300 ANESTHESI OLOGY	586					53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	110, 500		1		525	
57.00 05700 CT SCAN	8, 316					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	186, 614					
60. 00 06000 LABORATORY	75, 991					
65. 00 06500 RESPI RATORY THERAPY	39, 471				2, 743	
65. 01 03950 SLEEP LAB	9, 266				0	65.01
66. 00 06600 PHYSI CAL THERAPY	57, 137					66.00
67.00 06700 OCCUPATI ONAL THERAPY	6, 725					
69. 00 06900 ELECTROCARDI OLOGY	6, 232				24	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	116			0 8	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 256	2, 284, 477	0. 01455	7 73, 048	1, 063	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 981	586, 074	0. 01532		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	96, 991	6, 097, 243	0. 01590	295, 083	4, 694	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	139, 508				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	64, 258			0	0	
200.00 Total (lines 50-199)	1,074,022	70, 530, 208		1, 336, 613	22, 188	200. 00

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provi der		Period: From 07/01/2013 To 06/30/2014		
			le XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	C	0)	0 0	0	30.00
43. 00 04300 NURSERY	C			0	0	43.00
200.00 Total (lines 30-199)	C			0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 309	0.00) 5	2 0	1	30.00
43. 00 04300 NURSERY	420	0.00	31	1 0	1	43.00
200.00 Total (lines 30-199)	2, 729		36	3 0	ĺ	200. 00

Health Financial Systems		ST. VINCENT RA	ANDOLPH	HOSPI TAL		_	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT THROUGH COSTS	/OUTPATIENT ANCILLARY	SERVICE OTHER PA	ASS	Provi der	CCN: 151301		riod: om 07/01/2013 06/30/2014	Worksheet D Part IV Date/Time Pre	oared:
								11/21/2014 8:	
					le XIX		Hospi tal	Cost	
Cost Center De	scription			ng School	Allied Heal	th	All Other	Total Cost	
		Anestheti st	t				Medi cal	(sum of col 1	
		Cost				E	ducation Cost	J.	
		1.00		2.00	2.00		4.00	4)	
	OCT CENTERS	1.00		2.00	3.00		4.00	5.00	
ANCI LLARY SERVICE CO			0			0	0	0	50.00
52. 00 05200 DELIVERY ROOM			0	0		0	0	0	50.00 52.00
53. 00 05300 ANESTHESI OLOGY			0	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AG			0	0		0	0	0	54.00
57. 00 05700 CT SCAN	NOSTIC		0	0		0	0	0	57.00
58.00 05800 MAGNETIC RESON	ANCE IMAGING (MRL)		0	0		0	0	0	58.00
60. 00 06000 LABORATORY			0	0		0	0	0	60.00
65. 00 06500 RESPI RATORY TH	FRAPY		0	0		0	0	0	65.00
65. 01 03950 SLEEP LAB			0	0		0	0	0	65.01
66.00 06600 PHYSI CAL THERA	PY		0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL T			0	0		0	0	0	67.00
69.00 06900 ELECTROCARDI OL	.0GY		0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHA	LOGRAPHY		0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLI	ES CHARGED TO PATIENTS	;	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHA			0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED	TO PATIENTS		0	0		0	0	0	73.00
OUTPATIENT SERVICE (COST CENTERS								
91.00 09100 EMERGENCY			0	0		0	0	0	91.00
	DS (NON-DISTINCT PART)		0	0		0	0	0	92.00
200.00 Total (lines 5	0-199)		0	0	1	0	0	0	200. 00

Health Financial Systems	ST. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2013	Part IV	
				To 06/30/2014	Date/Time Pre 11/21/2014 8:	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Total	Total Charges	Ratio of Cost		Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS	- 1	1	1	- F		
50.00 05000 OPERATI NG ROOM	0	7, 415, 049			460, 325	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 336, 861			0	52.00
53. 00 05300 ANESTHESI OLOGY	0	567, 059				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	6, 766, 945				
57.00 05700 CT SCAN	0	10, 241, 426				
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2, 270, 446				
60. 00 06000 LABORATORY	0	14, 355, 989				
65. 00 06500 RESPI RATORY THERAPY	0	1, 703, 891	0.00000	0. 000000	118, 419	
65. 01 03950 SLEEP LAB	0	435, 523				65.01
66. 00 06600 PHYSI CAL THERAPY	0	1, 535, 566	0.00000	0. 000000	3, 275	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	375, 459				
69. 00 06900 ELECTROCARDI OLOGY	0	807, 507				
70.00 07000 ELECTROENCEPHALOGRAPHY	0	16, 320		0. 000000		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 284, 477				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	586, 074				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 097, 243	0.00000	0. 000000	295, 083	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	707, 012		0. 000000		
200.00 Total (lines 50-199)	0	70, 530, 208			1, 336, 613	200.00

Health Financial Systems	ST. VINCENT RAND	OLPH HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	6 Provi der	CCN: 151301	Period: From 07/01/2013	Worksheet D Part IV	
THROUGH COSTS				To 06/30/2014	Date/Time Pre	epared:
					11/21/2014 8:	
			le XIX	Hospi tal	Cost	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)	10.00	x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS			1	0		50,00
	0	C		0		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	0	C		0		54.00
	0	C		0		57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0		58.00
	0	C		0		60.00
65. 00 06500 RESPIRATORY THERAPY	0	C		0		65.00
65. 01 03950 SLEEP LAB	0	C		0		65.01
66.00 06600 PHYSI CAL THERAPY	0	Ĺ		0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C)	0		70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	C)	0		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C)	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0)	0		73.00
OUTPATIENT SERVICE COST CENTERS			J	0		01.00
91.00 09100 EMERGENCY	0	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	Ĺ		0		92.00
200.00 Total (lines 50-199)	l O	C	4	0		200.00

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 151301	Period:	Worksheet D-1	
			From 07/01/2013 To 06/30/2014	Date/Time Pre 11/21/2014 8:	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	oveluding nowhern)		2, 557	1.00
2.00	Inpatient days (including private room days, excluding swing-bed days,			2, 307	
3.00	Private room days (excluding swing-bed and observation bed days		ivate room days,	0	
	do not complete this line.)		1 751	4 00
1.00 5.00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	1, 751 96	4.00 5.00
	reporting period	adyo) thi dagn booombe		,,,	
b. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	97	6.00
. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	27	7.00
	reporting period				
3.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	28	8.00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	752	9.00
	newborn days)	0			
0.00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	96	10.00
1.00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	97	11.00
	December 31 of the cost reporting period (if calendar year, ent	er 0 on this line)	5		
2.00	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
3.00	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	-	,		
4.00 5.00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excl udi ng swi ng-bed	days)	0	
6.00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 c	of the cost		17.00
8.00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18.00
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	126.36	20.00
1 00	reporting period			2 OOF 270	21 00
21.00 22.00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	3, 095, 370 0	
	5 x line 17)		51 (Ũ	
23.00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportir	ng period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	3, 412	24.00
	7 x line 19)		0, ,		
25.00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	3, 538	25.00
26.00	Total swing-bed cost (see instructions)			245, 185	26.00
27.00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		2, 850, 185	27.00
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)		iai ges)	0	1
80.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
3.00 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 33) (con instruc	tions)	0.00 0.00	
4.00 5.00	Average per diem private room cost differential (line 34 x line	, ,		0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	<i>.,</i>		0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	2, 850, 185	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	THENTO			-
8. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see i			1, 234. 38	38.00
39.00	Program general inpatient routine service cost per drem (see 1			928, 254	
		(lino 14 v lino 25)			

Heal th	Financial Systems S	T. VINCENT RAND	DOLPH HOSPITA	AL.	In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi de	er CCN: 151301	Peri od:	Worksheet D-1	
					From 07/01/2013 To 06/30/2014		pared [.]
						11/21/2014 8:	
				tle XVIII	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Pe ysDiem (col. 1		Program Cost (col. 3 x col.	
		inpatrent cost			-	4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0		0 0.	00 0	0	42.00
42 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						42.00
	CORONARY CARE UNIT						43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGI CAL INTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			702, 756	48.00
49.00	Total Program inpatient costs (sum of lines 4	41 through 48)(see instruct	i ons)		1, 631, 010	
	PASS THROUGH COST ADJUSTMENTS					1	
50.00	Pass through costs applicable to Program inpa	atient routine	services (fr	om Wkst. D, su	m of Parts I and	0	50.00
51.00	<pre>III) Pass through costs applicable to Program inpa and IV)</pre>	atient ancillar	y services (from Wkst. D,	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines !	50 and 51)				0	52.00
	Total Program inpatient operating cost exclud		elated, non-p	hysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line 5	52)					
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55.00
	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operati	ing cost and ta	irget amount	(line 56 minus	line 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost rep market basket	sorting period	ending 1996,	upuated and c	compounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lines					0	61.00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54	x 60), or 1% c	r the target		
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of t	he cost report	ing period (See	118, 500	64 00
01.00	instructions) (title XVIII only)	to through beec			ing period (bee	110,000	01.00
65.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the	cost reportir	g period (See	119, 735	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	II only). For	238, 235	66, 00
	CAH (see instructions)						
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 a	f the cost rep	orting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (line 67 + li	ne 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU						
	Skilled nursing facility/other nursing facili						70.00
71.00 72.00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ine /0 ÷ lin	e 2)			71.00 72.00
	Medically necessary private room cost applica		line 14 x	line 35)			73.00
	Total Program general inpatient routine servi	U U					74.00
75.00	Capital-related cost allocated to inpatient i	routine service	e costs (from	Worksheet B,	Part II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
	Program capital -related costs (line 9 x line	,					77.00
	Inpatient routine service cost (line 74 minus						78.00
	Aggregate charges to beneficiaries for excess	· · ·			1. 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ost iimitati	un (IIne /8 mi	nus i ne 79)		80.00 81.00
81.00 82.00	Inpatient routine service cost per drem finm Inpatient routine service cost limitation (li)				81.00
	Reasonable inpatient routine service costs (s						83.00
84.00	Program inpatient ancillary services (see ins						84.00
	Utilization review - physician compensation	•					85.00 86.00
00. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		1 Jugi 63)			I	00.00
	Total observation bed days (see instructions))					87.00
	Adjusted general inpatient routine cost per (1, 234. 38	
87. UU	Observation bed cost (line 87 x line 88) (see	= Instructions)				688, 784	89.00

Health Financial Systems S	T. VINCENT RAN	DOLPH HOSPITAL		In Lie	u of Form CMS-2	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 8:	pared: 34 am
		Titl	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	265, 900	2, 850, 185	0. 09329	2 688, 784	64, 258	90.00
91.00 Nursing School cost	0	2, 850, 185	0.00000	0 688, 784	0	91.00
92.00 Allied health cost	0	2, 850, 185	0.00000	0 688, 784	0	92.00
93.00 All other Medical Education	0	2, 850, 185	0.00000	0 688, 784	0	93.00

^{11/21/2014 8:34} am Y: \28750 - St. Vincent Randol ph\300 - Medicare Cost Report\20140631\28750-14.mcrx

From 07/07/0713 Dus/Tim Preserved Ittle XX Insertion Insertion Ittle XX Insertion Insertion Ittle XX Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Insertion Inseared Insertion <thinsertion< th=""></thinsertion<>		Financial Systems ST. VINCENT RANDOLF	PH HOSPITAL Provider CCN: 151301	In Lie Period:	u of Form CMS-2 Worksheet D-1	2552-10		
Title XIX Despital Cent NMAT L1 - ALL PROVIDER COMMONDS 1.00 1.00 NMAT L1 - ALL PROVIDER COMMONDS 2.51 1.10 NMAT L1 - ALL PROVIDER COMMONDS 2.51 2.51 1.10 NMAT L1 - ALL PROVIDER COMMONDS 2.51 2.51 1.11 2.51 1.11 NMAT L1 - ALL PROVIDER COMMONDS 2.51 1.11 2.51 1.11 2.51 1.11 2.51 1.11 2.51 1.11 2.51								
PART 1 ALL PRIVIDER COMPONENTS 1.00 IMPARTENT DATS 1.00 Impartent days (Including private room days, excluding saving head newson rasys) 2,557 1.01 Impartent days (Including private room days) 1,731 4.1 2.00 Frivate room days (excluding saving head and observation bed days). 1702 1703 6.1 2.00 Total saving-bed SME type inpaitent days (Including private room days) after December 31 of the cost 72 7.6 1.00 Total saving-bed SME type inpaitent days (Including private room days) after December 31 of the cost 72 7.6 1.00 Total inpartent days (Including private room days) after December 31 of the cost 72 7.6 1.00 Total inpartent days applicable to 1114 XMII and (Including private room days) 0 10.1 1.00 Sking-bed SME type inpaitent days applicable to 1114 XMII and (Including private room days) 0 10.1 1.00 Sking-bed SME type inpaitent days applicable to 11116 XMII and (Including private room days)			Title XIX	Hospi tal				
IDMATENT DAYS ID Inpatient days (including private room days, excluding swing-bed days, excluding swing-bed and newtorm days) 2.57 2.00 Inpatient days (including private room days, excluding swing-bed and newtorm days) 2.50 2.01 Private room days (coluding swing-bed and observation bed days) 3.1 2.00 Total swing-bed XF type inpatient days (including private room days) through December 31 of the cost 0.5 1.01 Total swing-bed XF type inpatient days (including private room days) after December 31 of the cost 7.7 7.00 Total swing-bed XF type inpatient days (including private room days) after December 31 of the cost 2.8 7.00 Total swing-bed XF type inpatient days (including private room days) after December 31 of the cost 2.8 7.00 Total swing-bed XF type inpatient days applicable to title XVIII only (including private room days) 0 10.00 Sing-bed SF type inpatient days applicable to title XVIII only (including private room days) 0 10 11.00 Sing-bed SF type inpatient days applicable to title XVIII only (including private room days) 0 11 12.00 Sing-bed XF type inpatient days applicable to title XV or XX only (including private room days) 0 11 13.00 Sing-be		Cost Center Description			1.00			
100 Impatient days (including private room days, and seing-bed days). excluding newborn) 2.557 1. 2.00 Inpatient days (including private room days, excluding saing-bed and besarvation bed days). 17 you have only private room days, 0.0 3.00 Frivate room days (excluding saing-bed and desarvation bed days). 17 you have only private room days, 0.0 3.00 Frivate room days (excluding saing-bed and desarvation bed days). 17 you have only private room days, 0.0 3.00 Frivate room days (excluding saing-bed and desarvation bed days). 17 you have only private room days, 17,57 4. 5.00 Total sain g-bed SNF type inpatient days (including private room days) after becember 31 of the cost 173. 6. 7.00 Trapatient days including private room days) after becember 31 of the cost 28 8. 7.00 Total is wing-bed SNF type inpatient days applicable to 111e XVIII only (including private room days) 10.								
3.00 Private room days (oxcluding swing-bed and observation bed days). If you have only private room days. 0 3.4 4.00 Semi-private room days. (culding swing-bed and observation bed days.) 1.751 4.6 5.00 Total swing-bed 3K type inpatient days. (Including private room days.) through December 31 of the cost 1.751 4.6 6.00 Total swing-bed 3K type inpatient days. (Including private room days.) through December 31 of the cost 1.751 4.6 7.00 Total swing-bed W type inpatient days. (Including private room days.) after December 31 of the cost 2.7 7.7 8.00 Total swing-bed W type inpatient days. (Including private room days.) after December 31 of the cost 2.7 7.0 9.00 Total swing-bed W type inpatient days. applicable to title XVII only. (Including private room days.) 10.1 10.1 10.00 Sing-bed SK type inpatient days. applicable to title XVII only. (Including private room days.) 0 10.1 11.00 Sing-bed KT type inpatient days. applicable to title XVII only. (Including swing-bed days.) 0 11.0 12.00 Sing-bed KT type inpatient days. applicable to titles V or XIX only. (Including swing-bed days.) 0 11.0 13.00 Sing-bed KT type inpatient days. applicable to services after December 31 o		Inpatient days (including private room days and swing-bed days				1.00		
4.00 Semi-private room days (excluding swing-bed and observation bed days) 1,751 4,10 5.00 Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost reporting period 5,6 7.00 Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost reporting period 27 7,0 6.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (inclusing private room days) 0 10.01 10.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 11.01 11.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 0 11.01 12.00 Madia and bab SS Swing-bed		Private room days (excluding swing-bed and observation bed day		ivate room days,		2.00 3.00		
reporting period (1 calendar year, enter 0 on this line) Total sing-bed SK type inpatient days (including private room days) after December 31 of the cost reporting period (1 calendar year, enter 0 on this line) Total inpatient days including private room days) after December 31 of the cost reporting period (1 calendar year, enter 0 on this line) Total inpatient days including private room days) after December 31 of the cost reporting period (1 calendar year, enter 0 on this line) Total inpatient days including private room days) after December 31 of the cost reporting period (1 calendar year, enter 0 on this line) 10.00 Swing-bed SK type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SK type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SK type inpatient days applicable to titles V or XIX only (including private room days) 11.00 Swing-bed SK type inpatient days applicable to titles V or XIX only (including private room days) 11.00 Swing-bed SK type inpatient days applicable to titles V or XIX only (including private room days) 11.00 Swing-bed K type inpatient days applicable to titles V or XIX only (including private room days) 11.00 Swing-bed K type inpatient days applicable to services through December 31 of the cost reporting period (1 calendar year, enter 0 on this line) 11.00 Swing-bed K type inpatient days applicable to services through December 31 of the cost reporting period swing-bed SKF services applicable to services after December 31 of the cost reporting period (1 or XIX only) 11.00 Swing-bed SKF services applicable to services after December 31 of the cost reporting period (1 or XIX only) 11.00 Swing-bed cost applicable to SKF type services after December 31 of the cost reporting period (1 or SK type services after December 31 of the cost reporting period (1 or 5 wing-bed cost applicable to SKF type services after December 31 of the cost reporting period (1 or 5 wing-bed cost applic		Semi-private room days (excluding swing-bed and observation bed days) 1,751						
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27.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)2,856,59827.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT628.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0030.0033.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0032.0034.00Average per diem private room cost differential (line 3 x line 31)0.0035.0035.00Average per diem private room cost differential adjustment (line 3 x line 35)036.0037.00General inpatient routine service cost per diem (see instructions)0.0035.0038.00Adjusted general inpatient routine service cost per diem (see instructions)1,237.1638.00Adjusted general inpatient routine service cost (line 9 x line 38)1,237.1639.00Program general inpatient routine service cost (line 9 x line 38)64,33240.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0		x line 20)			-			
28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.029.00Private room charges (excluding swing-bed charges)029.030.00Semi-private room charges (excluding swing-bed charges)030.031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.032.00Average private room per diem charge (line 29 + line 3)0.0032.033.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0032.034.00Average per diem private room cost differential (line 3 x line 31)0.0034.035.00Average per diem private room cost differential (line 3 x line 35)0.00035.037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 856, 59837.037.00General inpatient routine service cost per diem (see instructions)0.30.038.00Adjusted general inpatient routine service cost per diem (see instructions)1, 237.1638.00Adjusted general inpatient routine service cost per diem (see instructions)1, 237.1639.00Program general inpatient routine service cost (line 9 x line 38)64, 33240.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0		General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)					
30.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0032.0034.00Average per diem private room cost differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 34 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.30.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 856, 59837.0027 minus line 36)PART II - HOSPITAL AND SUBPROVIDERS ONLY0.80PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 237.1638.0038.00Adjusted general inpatient routine service cost per diem (see instructions)1, 237.1638.0039.00Program general inpatient routine service cost (line 9 x line 38)64, 33239.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	28.00		and observation bed ch	arges)	0	28.00		
31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 + line 4)0.0032.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0033.0035.00Average per diem private room cost differential (line 34 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 856, 5980.3037.00PART 11 - HOSPITAL AND SUBPROVIDERS ONLY0.310.00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 237.1638.0038.00Program general inpatient routine service cost per diem (see instructions)1, 237.1638.0039.00Program general inpatient routine service cost (line 9 x line 38)64, 33239.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00					-	29.00		
32.00 Average private room per diem charge (line 29 + line 3) 0.00 32.0 33.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 33.0 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.0 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 34.0 35.00 Average per diem private room cost differential adjustment (line 3 x line 35) 0.00 35.0 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 35.0 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 856, 598 37.0 9.00 PART 11 - HOSPITAL AND SUBPROVIDERS ONLY 27 minus line 36) 0 9.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 237.16 38.0 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 64, 332 39.0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.0			line 28)					
33.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 33.00 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 34.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 35.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 856, 598 37.00 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY 2.856, 598 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1, 237.16 38.00 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 1, 237.16 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 64, 332 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		•	11110 20)			1		
35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 856, 598 0 36.00 27. minus line 36) 2, 856, 598 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1, 237.16 38.00 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 1, 237.16 38.00 64, 332 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 40.00						1		
36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 27.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 856, 598 37.00 27.00 <td></td> <td></td> <td></td> <td>tions)</td> <td></td> <td></td>				tions)				
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 856, 598 27 minus line 36) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1, 237.16 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 1, 237.16 38.00 9.00 Program general inpatient routine service cost applicable to the Program (line 14 x line 35) 64, 332 39.00			e 31)					
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 237.16 38.0 39.00 Program general inpatient routine service cost (line 9 x line 38) 64, 332 39.0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.0		General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	-	36.00 37.00		
PROGRAM I NPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38.00Adjusted general inpatient routine service cost per diem (see instructions)1, 237.1639.00Program general inpatient routine service cost (line 9 x line 38)64, 33240.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0								
39.00Program general inpatient routine service cost (line 9 x line 38)64, 33239.040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.0		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU						
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.0						1		
						1		
		Total Program general inpatient routine service cost (line 39			-			

) MPUT	Financial Systems TATION OF INPATIENT OPERATING COST	ST. VINCENT RANE			CCN: 151301	Peri od:		u of Form CMS- Worksheet D-1	
				uer		From 07/01/ To 06/30/		Date/Time Pre 11/21/2014 8:	epare
				Ti t	le XIX	Hospi tal		Cost	
	Cost Center Description	Total	Total	_	Average Per			Program Cost	
		Inpatient Cost	Inpatient	Days		÷		(col. 3 x col.	
		1.00	2.00		<u>col. 2)</u>	4.00		4)	-
00	NUDSERV (+i +i o V & VIV only)	1.00	2.00	420	3.00	4.00	211	5.00	1 12
2.00	NURSERY (title V & XIX only)	464, 364		420	1, 105. (53	311	343, 851	1 42.
00	Intensive Care Type Inpatient Hospital Unit	ts			[1 42
3.00									43.
1.00	CORONARY CARE UNIT								44.
5.00	BURN INTENSIVE CARE UNIT								45.
5.00	SURGI CAL INTENSI VE CARE UNI T								46.
7.00	OTHER SPECIAL CARE (SPECIFY)								47.
	Cost Center Description						-	1.00	-
		What D 2 and 2		<u>,,</u>				1.00	10
8.00	Program inpatient ancillary service cost (`			340, 128	
. 00	Total Program inpatient costs (sum of line	s 41 through 48)(see instru	ictio	ns)			748, 311	1 49.
	PASS THROUGH COST ADJUSTMENTS								
). 00	Pass through costs applicable to Program in	npatient routine	servi ces	from	Wkst. D, sur	n of Parts I	and	C	50.
								_	
I. 00	Pass through costs applicable to Program in	npatient ancillar	y services	s (fr	om Wkst. D, s	sum of Parts	11	C) 51.
	and IV)	50 1 51						-	
2.00	Total Program excludable cost (sum of line							C	
3.00	Total Program inpatient operating cost excl		erated, nor	1-phy	sıcian anestł	netist, and		C	53.
	medical education costs (line 49 minus line	e 52)							-
_	TARGET AMOUNT AND LIMIT COMPUTATION								
	Program discharges							C	
. 00	Target amount per discharge							0.00	
. 00	Target amount (line 54 x line 55)							C	
. 00	Difference between adjusted inpatient opera	ating cost and ta	ırget amoui	nt (I	ine 56 minus	line 53)		C	
8.00	Bonus payment (see instructions)							C	
00 .	Lesser of lines 53/54 or 55 from the cost	reporting period	ending 199	96, u	pdated and co	mpounded by	the	0.00	59
	market basket								
). 00	Lesser of lines 53/54 or 55 from prior year							0.00	0 60
I. 00	If line 53/54 is less than the lower of lin							C) 61.
	which operating costs (line 53) are less the		s (lines !	54 x	60), or 1% of	the target			
	amount (line 56), otherwise enter zero (see	e instructions)							
2.00	Relief payment (see instructions)							C	
3.00	Allowable Inpatient cost plus incentive pay	yment (see instru	ictions)					C) 63.
	PROGRAM INPATIENT ROUTINE SWING BED COST								
1.00	Medicare swing-bed SNF inpatient routine co	osts through Dece	ember 31 of	f the	cost reporti	ng period (See	C) 64.
	instructions)(title XVIII only)								
5.00	Medicare swing-bed SNF inpatient routine co	osts after Decemb	er 31 of [.]	he c	ost reporting) period (Se	e	C) 65.
	instructions)(title XVIII only)								
o. 00	Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus li	ne 6	5)(title XVII	I only). Fo	r	C) 66.
	CAH (see instructions)								
7.00	Title V or XIX swing-bed NF inpatient rout	ine costs through	December	31 o	f the cost re	porting peri	i od	C) 67.
	(line 12 x line 19)								
3.00	Title V or XIX swing-bed NF inpatient rout	ine costs after D	ecember 3	of	the cost repo	orting perio	d	C) 68.
	(line 13 x line 20)								
9.00	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	ility/ICF/MR rout	ine servi	ce co	st (line 37)				70
. 00	Adjusted general inpatient routine service	cost per diem (I	ine 70 ÷ 1	i ne	2)				71
. 00	Program routine service cost (line 9 x line	e 71)							72
. 00	Medically necessary private room cost appli	icable to Program	n (line 14	хli	ne 35)				73
. 00	Total Program general inpatient routine set	rvice costs (line	e 72 + line	e 73)					74
. 00	Capital -related cost allocated to inpatien	t routine service	e costs (fi	om W	orksheet B, F	Part II, col	umn		75
	26, line 45)		•			•			
. 00	Per diem capital-related costs (line 75 ÷)	line 2)							76
. 00	Program capital-related costs (line 9 x lin	ne 76)							77
. 00	Inpatient routine service cost (line 74 min								78
. 00	Aggregate charges to beneficiaries for exc		orovider re	ecord	s)				79
00	Total Program routine service costs for co				· · · · · · · · · · · · · · · · · · ·	us line 79)			80
. 00	Inpatient routine service cost per diem lin	•	-						81
. 00	Inpatient routine service cost limitation)						82
. 00	Reasonable inpatient routine service costs	•	· .						83
. 00	Program inpatient ancillary services (see	•							84
. 00			ne)						84
	Utilization review - physician compensation								
. 00	Total Program inpatient operating costs (su		n ougit 85)						86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PART IV - COMPUTATION OF OBSERVATION BED PART						_	FFC	- 07
(11)	Total observation bed days (see instruction		line 2)					558 1, 237. 16	
								1 / 5/ 16	1 88
. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (s							690, 335	

Health Financial Systems S	T. VINCENT RAM	NDOLPH H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Pi	rovi der		Peri od:	Worksheet D-1	
					From 07/01/2013 To 06/30/2014	Date/Time Pre 11/21/2014 8:	pared: 34 am
			Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routin	e Cost	column 1 ÷	Total	Observati on	
		(from I	ine 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	265, 900	0 2,	856, 598	0. 09308	690, 335	64, 258	90.00
91.00 Nursing School cost	(0 2,	856, 598	0.00000	690, 335	0	91.00
92.00 Allied health cost	(0 2,	856, 598	0.00000	690, 335	0	92.00
93.00 All other Medical Education	(0 2,	856, 598	0.00000	690, 335	0	93.00

^{11/21/2014 8:34} am Y: \28750 - St. Vincent Randol ph\300 - Medicare Cost Report\20140631\28750-14.mcrx

Health Financial Systems	ST. VINCENT RANDOLPH HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151301	Peri od:	Worksheet D-3	
			From 07/01/2013 To 06/30/2014		nared
			10 00/00/2011	11/21/2014 8:	
		e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			834, 533		30.00
43. 00 04300 NURSERY			001,000		43.00
ANCI LLARY SERVI CE COST CENTERS				1	
50. 00 05000 OPERATI NG ROOM		0. 2499	52 313, 737	78, 422	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 8342	9, 364	7, 811	52.00
53. 00 05300 ANESTHESI OLOGY		0. 0306	19 16, 184	496	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 2400			
57.00 05700 CT SCAN		0. 0212			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1558			
60. 00 06000 LABORATORY		0. 1514			•
65. 00 06500 RESPI RATORY THERAPY		0. 4154			
65.01 03950 SLEEP LAB		0. 3813			
66.00 06600 PHYSI CAL THERAPY		0. 5161			
67. 00 06700 OCCUPATI ONAL THERAPY		0.3434			
69. 00 06900 ELECTROCARDI OLOGY		0.3037			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2824		-	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0. 2688 0. 6331			
73. 00 07200 DRUGS CHARGED TO PATIENTS		0. 3367			
OUTPATIENT SERVICE COST CENTERS		0. 3307	52 540, 760	164, 120	73.00
91. 00 09100 EMERGENCY		0. 2592	92 8, 645	2 242	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.9742			92.00
200.00 Total (sum of lines 50-94 and 96-98)			2, 298, 803		
201.00 Less PBP Clinic Laboratory Services-F	Program only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			2, 298, 803		202.00

Health Financial Systems	ST. VINCENT RANDOLPH HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
	Companyo		From 07/01/2013		nored.
	Componen	t CCN: 15Z301	To 06/30/2014	Date/Time Pre 11/21/2014 8:	
	Titl	e XVIII S	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost	Inpati ent	I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			-
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		1			-
50.00 05000 OPERATI NG ROOM		0. 24996		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 83420		0	
53. 00 05300 ANESTHESI OLOGY		0. 03061		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 24008		0	
57.00 05700 CT SCAN		0. 02126		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 15583		0	
60. 00 06000 LABORATORY		0. 15149		290	
65. 00 06500 RESPI RATORY THERAPY		0. 41547		23, 108	
65.01 03950 SLEEP LAB		0. 38130		0	
66. 00 06600 PHYSI CAL THERAPY		0. 51614			•
67.00 06700 OCCUPATI ONAL THERAPY		0. 34343		3, 901	•
69. 00 06900 ELECTROCARDI OLOGY		0. 30370		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 28247		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26889		9, 765	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 63316		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 33673	2 61, 422	20, 683	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY		0. 25929		66	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 97421		0	
200.00 Total (sum of lines 50-94 and 96-98)			221, 198	85, 847	200.00
201.00 Less PBP Clinic Laboratory Services-			0		201.00
202.00 Net Charges (line 200 minus line 201)		221, 198		202.00

Health Financial Systems ST. VINCENT F	ANDOLPH HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151301	Peri od:	Worksheet D-3	3
			From 07/01/2013 To 06/30/2014		nared
			10 00/30/2014	11/21/2014 8:	
	Tit	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	1, 536, 754		30.00
43. 00 04300 NURSERY			1, 550, 754		43.00
ANCI LLARY SERVI CE COST CENTERS		1		<u>'</u>	43.00
50. 00 05000 OPERATING ROOM		0.2499	62 460, 325	115, 064	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.8342			1
53. 00 05300 ANESTHESI OLOGY		0. 0306	19 24, 649	755	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2400	31 32, 121	7, 712	54.00
57. 00 05700 CT SCAN		0. 0212	51 30, 233	643	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1558	34 5, 507	858	
60. 00 06000 LABORATORY		0. 1514			
65. 00 06500 RESPI RATORY THERAPY		0. 4154			
65. 01 03950 SLEEP LAB		0. 3813		'I U	
66. 00 06600 PHYSI CAL THERAPY		0. 5161			
67.00 06700 OCCUPATI ONAL THERAPY		0. 3434			
69. 00 06900 ELECTROCARDI OLOGY		0. 3037			
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 2824		0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.2688			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.6331		0	
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS		0.3367	32 295, 083	99, 364	/3.00
91.00 09100 EMERGENCY		0. 2592	22	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9742			
200.00 Total (sum of lines 50-94 and 96-98)		0.7742	1, 336, 613	0	
201.00 Less PBP Clinic Laboratory Services-Program only ch	narges (line 61)		., 000, 010	010,120	201.00
202.00 Net Charges (line 200 minus line 201)			1, 336, 613		202.00
		1	1	1	

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151301	Peri od: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Pre 11/21/2014 8:	pared: 34 am
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00	Medical and other services (see instructions)			3, 948, 451	
00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	
00 00	PPS payments Outlier payment (see instructions)			0	
00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	
00	Line 2 times line 5			0	
00	Sum of line 3 plus line 4 divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	
00	Ancillary service other pass through costs from Worksheet D, Pa	rt IV, column 13, line	e 200	0	
. 00 . 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 3, 948, 451	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES			3, 740, 431	
	Reasonable charges				1
. 00	Ancillary service charges			0	
	Organ acquisition charges (from Worksheet D-4, Part III, line 6	9, col. 4)		0	
. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.
. 00	Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15.
	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR 413.13(e)		÷		
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions)	ifling 10 overade li	no 11) (coo	0	
. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT THE TO EXCEEDS IT	ne II) (see	0	19.
. 00	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)		3, 987, 936	
	Interns and residents (see instructions)	ations)		0	
	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 8 and 9)	ctions)		0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (for CAH, see instructions)			35, 565	
	Deductibles and Coinsurance relating to amount on line 24 (for			2, 897, 339	
. 00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus t	he sum of lines 22 and	d 23} (for CAH,	1, 055, 032	27.
. 00	see instructions) Direct graduate medical education payments (from Worksheet E-4,	line 50)		0	28.
	ESRD direct medical education costs (from Worksheet E-4, line 3	,		0	1
. 00	Subtotal (sum of lines 27 through 29)			1, 055, 032	30.
	Primary payer payments			0	
. 00	Subtotal (line 30 minus line 31)	c)		1, 055, 032	32.
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Worksheet I-5, line 11)	5)		0	33.
	Allowable bad debts (see instructions)			537, 058	
	Adjusted reimbursable bad debts (see instructions)			472, 611	1
	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		399, 578	
	Subtotal (see instructions)			1, 527, 643	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Partial or full credits received from manufacturers for replace	d devices (see instru	ctions)	0	39.
	RECOVERY OF ACCELERATED DEPRECIATION			0	
. 00	Subtotal (see instructions)			1, 527, 643	40.
	Sequestration adjustment (see instructions)			30, 553	
	Interim payments			2, 060, 165	
	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 -563, 075	
	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2	chapter 1.	-565,075	1
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.
	Total (sum of lines 91 and 93)				94.

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151301	Period: From 07/01/2013 To 06/30/2014		pared
		Ti tl	e XVIII	Hospi tal	Cost	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 461, 9	36 0	1, 765, 965 0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0 01/09/2014	294, 200	3.
02				0	0	
03				0	0	
04 05				0	0	
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	
53				0	0	
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0 294, 200	-
77	3. 50-3. 98)			0	274, 200	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 461, 9	36	2, 060, 165	4.
	TO BE COMPLETED BY CONTRACTOR	1				
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5
01	TENTATI VE TO PROVIDER			0	0	15
02				0	0	
03				0	0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		E0 1	0	0	
)2)0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		58, 1 1, 403, 8		563, 075 1, 497, 090	
00			1,403,0	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			Period: From 07/01/2013 To 06/30/2014		
		component	CON: 152501	10 00/ 30/ 2014	11/21/2014 8:	34 am
				Swing Beds - SNI		
		Inpatien	it Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		334, 06		0	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	01/29/2014	35, 90	0	0	3.0'
3.02	ADSUSTMENTS TO TROVIDER	0172772014		0	0	3.02
3.03				0	0	3.03
3.04				o	0	3. 04
3.05				0	0	3.05
	Provider to Program	T	1			
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51 3.52				0	0	3.5 ⁻ 3.5
3.52				0	0	3.52
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		35, 90	0	0	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		369, 96	2	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR	1	1			
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER			0	0	5. 0 ⁴
5.01	TENTATIVE TO PROVIDER			0	0	5.02
5.03				0	0	•
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	
5.51				0	0	5.5
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.52 5.99
5.99	5. 50-5. 98)			0	0	5.9
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6.02	SETTLEMENT TO PROGRAM		51, 95		0	
7.00	Total Medicare program liability (see instructions)		318,00	8 Contractor	0 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(о С	1.00	2.00	
8.00	Name of Contractor					8.00

Heal th	Financial Systems	ST. VINCENT RANDOLPH	I HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING	BEDS	Provider CCN: 151301	Peri od:	Worksheet E-2	
				From 07/01/2013		
			Component CCN: 15Z301	To 06/30/2014	Date/Time Pre 11/21/2014 8:	
			Title XVIII	Swing Beds - SNF		<u>34 alli</u>
				Part A	Part B	
				1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	S				
1.00	Inpatient routine services - swing bed-SNF	(see instructions)		240, 617	0	1.00
2.00	Inpatient routine services - swing bed-NF	(see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, column			, 86, 705	0	3.00
	Part V, columns 6 and 7, line 202 for Part					
4.00	Per diem cost for interns and residents not	t in approved teachin	g program (see		0.00	4.00
	instructions)					
5.00	Program days			193		5.00
6.00	Interns and residents not in approved teach				0	6.00
7.00	Utilization review - physician compensation		od only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lin	327, 322	0	8.00		
9.00	Primary payer payments (see instructions)			0	0	9.00
10.00	Subtotal (line 8 minus line 9)			327, 322	0	10.00
11.00	Deductibles billed to program patients (exc	clude amounts applica	ble to physician	0	0	11.00
	professional services)					
				327, 322		12.00
13.00		om provider records)	(exclude coinsurance	2, 824	0	13.00
	for physician professional services)					
	80% of Part B costs (line 12 x 80%)		、 、	204,400	0	14.00
15.00		-)	324, 498		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI	IFY)		0	0	16.00
16.50				0		16.50
	Allowable bad debts (see instructions)			0	0	17.00
17.01				0	0	17.01
	Allowable bad debts for dual eligible benef	ticiaries (see instru	ctions)	0	0	18.00
19.00		`		324, 498		19.00
19.01	Sequestration adjustment (see instructions))		6, 490		19.01
20.00				369, 962		20.00
	Tentative settlement (for contractor use or		21	E1 054	0	21.00
22.00				-51, 954		22.00
23.00	Protested amounts (nonallowable cost report section 115.2	t items) in accordanc	e with CMS PUD. 15-2,	0	0	23.00
	1500101110.Z					l

	Financial Systems ST. VINCENT RAND			u of Form CMS-2	
CALCUL	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151301	Period: From 07/01/2013	Worksheet E-3	
			To 06/30/2014	Part V Date/Time Pre	nared
	11/21/2014 8:				
		Title XVIII	Hospi tal	Cost	
			DELUBURGENENT	1.00	
1 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	RE PART A SERVICES - COST	REIMBURSEMENT	4 (04 040	1 4 00
1.00	Inpatient services	ti on)		1, 631, 010	
2.00 3.00	Nursing and Allied Health Managed Care payment (see instruction	tion)		0	
3.00 4.00	Subtotal (sum of lines 1 thru 3)			1, 631, 010	
4.00 5.00	Primary payer payments			1, 031, 010	4.00 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 647, 320	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 047, 320	0.00
	Reasonable charges				1
7.00	Routi ne servi ce charges			0	7.00
8.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				1
11.00	Aggregate amount actually collected from patients liable for	r payment for services on	a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable	for payment for services o	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13	(e)			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	
14.00	Total customary charges (see instructions)			0	
15.00	Excess of customary charges over reasonable cost (complete o	only if line 14 exceeds li	ne 6) (see	0	15.00
1/ 00	instructions)		- 14) (0	1/ 00
16.00	Excess of reasonable cost over customary charges (complete of instructions)	only if line 6 exceeds lin	le 14) (see	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see in:	structions)		0	17.00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	17.00
18.00	Direct graduate medical education payments (from Worksheet)	E-4 line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 647, 320	
20.00	Deductibles (exclude professional component)			232, 863	
21.00	Excess reasonable cost (from line 16)			0	
22.00	Subtotal (line 19 minus line 20 and 21)			1, 414, 457	22.00
23.00	Coinsurance				23.00
24.00	Subtotal (line 22 minus line 23)			1, 413, 241	24.00
25.00	Allowable bad debts (exclude bad debts for professional service)	vices) (see instructions)		21, 846	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			19, 224	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see in:	structions)		12, 528	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 432, 465	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29.99	Recovery of Accelerated Depreciation			0	
30.00	Subtotal (line 28, plus or minus lines 29)			1, 432, 465	
30.01	Sequestration adjustment (see instructions)			28, 649	
31.00	Interim payments			1, 461, 936	
32.00	Tentative settlement (for contractor use only)	1.00		0	
33.00	Balance due provider/program line 30 minus lines 30.01, 31,			-58, 120	
34.00	Protested amounts (nonallowable cost report items) in accord §115.2	dance with CMS Pub. 15-2,	cnapter I,	0	34.00

	Financial Systems ST. VINCENT RANDOLPH ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151301	Peri od:	u of Form CMS-2 Worksheet E-3	
		From 07/01/2013 To 06/30/2014	Part VII Date/Time Pre 11/21/2014 8:3	pared:	
		Hospi tal	Cost		
			Inpatient	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIO	YES END TITLES V OD V		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	LS TOK TITLLS V OK A	IN SERVICES		
1.00	Inpatient hospital/SNF/NF services	748, 311		1.00	
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		748, 311	0	
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		740 211	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		748, 311	0	7.00
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		1, 336, 613	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)		1, 336, 613	0	12.00
12 00	CUSTOMARY CHARGES		0	0	13.00
13.00	Amount actually collected from patients liable for payment for set basis	ervices on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for pa	avment for services o	n 0	0	14.00
	a charge basis had such payment been made in accordance with 42 (-	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15.00
	Total customary charges (see instructions)		1, 336, 613	0	
17.00	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	588, 302	0	17.00
10.00	line 4) (see instructions)	fling 1 avagada lin		0	10.00
18.00	Excess of reasonable cost over customary charges (complete only i 16) (see instructions)	r line 4 exceeds lin	ie U	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 instruct	tions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line 16)		748, 311	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con	npleted for PPS provi			
22.00	Other than outlier payments		0	0	
	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0	0	25.00
26.00 27.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		748, 311	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	30.00
30.00			0		
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		748, 311	0	31.00
31.00 32.00	Deducti bl es		0	0	32.00
31.00 32.00 33.00	Deducti bl es Coi nsurance			0	32. 00 33. 00
31.00 32.00 33.00 34.00	Deductibles Coinsurance Allowable bad debts (see instructions)		0	0	32.00 33.00 34.00
31.00 32.00 33.00 34.00 35.00	Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review	2)	0 0 0	0 0 0	32.00 33.00 34.00 35.00
31.00 32.00 33.00 34.00 35.00 36.00	Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	3)	0	0 0 0	32.00 33.00 34.00 35.00 36.00
31.00 32.00 33.00 34.00 35.00 36.00 37.00	Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	3)	0 0 0 748, 311 0	0 0 0	32.00 33.00 34.00 35.00 36.00 37.00
31.00 32.00 33.00 34.00 35.00 36.00	Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	3)	0 0 0	0 0 0 0 0	32.00 33.00 34.00 35.00 36.00 37.00
31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00	Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)	3)	0 0 0 748, 311 0	0 0 0 0 0	32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00
31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00	Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39) Interim payments	3)	0 0 0 748, 311 0 748, 311 0	0 0 0 0 0 0 0 0	32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00
31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00	Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0 0 0 748, 311 0 748, 311 0 748, 311		32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00

	E SHEET (If you are nonproprietary and do not maintain			eriod: rom 07/01/2013	Worksheet G	
und-ty	ype accounting records, complete the General Fund column onl	y)		06/30/2014	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	11/21/2014 8: Plant Fund	34 2
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	20, 299			0	
00	Temporary investments	0	-		0	
	Notes receivable	0	C		0	
	Accounts receivable	8, 922, 499		-	0	
	Other receivable Allowances for uncollectible notes and accounts receivable	3, 038, 726 -5, 728, 598		-	0	
	Inventory	404, 681		0	0	
	Prepai d expenses	17, 554		0	0	
00	Other current assets	-53, 451	C	0	0	9
. 00	Due from other funds	C	C	0	0	10
. 00	Total current assets (sum of lines 1-10)	6, 621, 710	C	0	0	11
	FI XED_ASSETS	(0) (50			0	
	Land	696, 652	1		0	
	Land improvements Accumulated depreciation	25, 100 -24, 224			0	
	Buildings	18, 042, 103		-	0	
	Accumulated depreciation	-7, 371, 778		-	0	
	Leasehold improvements	0	C		0	
. 00	Accumul ated depreciation	0	C	0	0	18
	Fixed equipment	592, 548		-	0	
	Accumulated depreciation	-448, 412			0	
	Automobiles and trucks	12, 322			0	
	Accumulated depreciation	-11, 882 5, 450, 953		-	0	
	Major movable equipment Accumulated depreciation	-4, 925, 123		-	0	
	Mi nor equipment depreciable	-4, 723, 123		-	0	
	Accumulated depreciation		C C	-	0	
	HIT designated Assets	C	C	0	0	
. 00	Accumulated depreciation	0	C	0	0	28
	Mi nor equi pment-nondepreci abl e	0	C		0	
	Total fixed assets (sum of lines 12-29)	12, 038, 259	C	0	0	30
	OTHER ASSETS	21 024 (01			0	1 21
	Investments Deposits on Leases	31, 834, 601			0	
	Due from owners/officers			0	0	
	Other assets	743, 538	53, 451	0	0	
	Total other assets (sum of lines 31-34)	32, 578, 139			0	
	Total assets (sum of lines 11, 30, and 35)	51, 238, 108			0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	1, 342, 730	1		0	
	Salaries, wages, and fees payable	496, 069			0	
	Payroll taxes payable	54, 720			0	
	Notes and Loans payable (short term) Deferred income	204, 804		0	0	1
	Accel erated payments			0	0	42
	Due to other funds		c	0	0	
	Other current liabilities	3, 460, 048		-	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	5, 558, 371		0	0	45
	LONG TERM LIABILITIES	L				
	Mortgage payable	0	C		0	
	Notes payable	14, 109, 989	C	0	0	
	Unsecured Loans			0	0	
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49	52, 717 14, 162, 706		-	0	
	Total liabilites (sum of lines 45 and 50)	14, 162, 706		-	0	
	CAPITAL ACCOUNTS	1,7,721,077		0	0	
. 00	General fund balance	31, 517, 031				52
	Specific purpose fund		53, 451			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Total fund balances (sum of Lines 52 thru 58)	21 517 021	E0 /E1		0	6
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	31, 517, 031 51, 238, 108			0	
	DI D	I JI,∠JO, IU8	ໆ ວວ,451	0	0	1 00

From 07/01/2013 To 06/30/2014 Date/Time P 11/21/2014			T. VINCENT RANDO		CON 151001		eu of Form CMS-	
Image: constraint of the second sec	STATEMI	ENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 151301			pared:
1.00 Fund balances at beginning of period 24,070,489 65,263 2.00 Net income (1055) (from Wkst. 6-3, Line 29) 146,895 0 0 3.00 DEFERRED PENSION COST 146,895 0 9,100 5.00 DOWNTIONS 0 114,831 0 6.00 0 146,895 9,100 7.00 0 146,895 124,021 10.00 Subtotal (Line 3 plus Line 10) 34,428,303 0 10.00 Transferes TO AFFLIATES 2,790,503 34,428,303 0 10.00 Total deductions (sum of Lines 12-17) 120,769 0 0 0 10.00 Fund balance at end of period per balance sheet (Line 11 minus line 18) 120,769 0 0 0 110.00 Fund balances at beginning of period 0 0 0 0 110.00 Fund balances at end of period per balance sheet (Line 11 minus line 18) Endowment Fund Plant Fund 11.00 Fund balances at beginning of period 0 0 0 12.00			General	Fund	Speci al	Purpose Fund	Endowment Fund	
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2.00 Net income (loss) (from Wkst, G-3, line 29) 10, 210, 919 34, 281, 408 65, 263 4.00 DEFERRED PENSION COST 146, 895 9, 190 9, 190 5.00 DOWATIONS 0 114, 831 0 0 7.00 Sub other and line 2) 0 9, 190 0 114, 831 7.00 Sub other and line 3 0 0 114, 895 0 0 9.00 Other and line 3 0 0 114, 895 0 0 9.00 Other PENSION RELATED ADJ 0 146, 895 124, 021 189, 284 12.00 TRANSFERS TO AFFILIATES 2, 790, 503 0 0 189, 284 13.00 OTHER PENSION RELATED ADJ 0 135, 833 0 0 14.00 ROUNDING 0 120, 769 0 0 135, 833 19.00 Fund balances at ded of period per balance sheet (line 11 minus line 18) 120, 769 0 0 0 10.00 Total deductions (sum of lines 12-17) 2, 911, 27	1 00		1.00					
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5.00 DONATIONS 0THER 0 DONATIONS 0 0 HER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			146 905	34, 281, 408		00, 203	0	
6.00 OTHER 0 114,831 7.00 110 114,831 0 9.00 0 0 0 0 9.00 0 0 0 0 0 9.00 114,6895 0 124,021 189,284 12.00 TRANSFERS TO AFFILIATES 2,790,503 0 0 0 14.00 RELEASED OPERATING 0 135,833 189,284 15.00 RELEASED CAPTAL 120,769 0 0 0 16.00 ROUNDI NG 0 135,833 53,451 53,451 18.00 Total deductions (sum of lines 12-17) 2,911,272 135,833 53,451 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) Findowment Fund Plant Fund 135,833 1.00 Fund balances at beginning of period 0 0 0 0 2.00 Net income (loss) (from Wkst. G-3, line 29) 0 0 0 0 3.00 Total (sum of line 4-9) <td></td> <td></td> <td></td> <td></td> <td>0 1</td> <td>0</td> <td>0</td> <td></td>					0 1	0	0	
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8.00 9.00 9.00 10.00 10.00 10.00 11.00 11.00 124,021 14,6,895 124,021 14,6,895 124,021 189,284 19,00 10,		OTHER	0		114,0		0	
9.00 10.			0			0	0	
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12.00 TRANSFERS TO AFFILIATES 2,790,503 0 0 13.00 OTHER PENSION RELATED ADJ 0 0 0 14.00 RELEASED OPERATING 0 0 0 15.00 RELEASED OPERATING 120,769 0 0 16.00 ROUNDING 0 0 0 17.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 120,769 0 0 19.00 Fund balances at beginning of period 2,911,272 135,833 53,451 100 Fund balances at beginning of period 0 0 0 0 100 Fund balances at beginning of period 0 0 0 0 100 Fund solances at beginning of period 0 0 0 0 100 Fund solances at beginning of period 0 0 0 0 0 100 Fund solances at beginning of period 0 0 0 0 0 100 Suborati (sum of line 1 and line 2) 0 0 0 0 0 0 0 0 <t< td=""><td></td><td>. ,</td><td></td><td></td><td></td><td></td><td></td><td>11.00</td></t<>		. ,						11.00
13.00 OTHER PENSI ON RELATED ADJ 0 0 135, 83 14.00 RELASED OPERATING 0 135, 833 15.00 RELEASED CAPITAL 120, 769 0 17.00 0 0 0 18.00 Total deductions (sum of lines 12-17) 0 0 0 19.00 Fund bal ance at end of period per bal ance sheet (line 11 minus line 18) Endowment Fund Plant Fund 1.00 Fund bal ances at beginning of period 0 0 0 2.00 Fund bal ances at beginning of period 0 0 0 2.00 Fund bal ances at beginning of period 0 0 0 2.00 Fund bal ances of line 1 and line 2) 0 0 0 2.00 Fund bal ances of line 1 and line 2) 0 0 0 3.00 Total (sum of line 4-9) 0 0 0 3.00 Total additions (sum of line 4-9) 0 0 0 3.00 Total additions (sum of line 4-9) 0 0 0 10.00 Total additions (sum of line 4-9) 0 0 0 <td></td> <td></td> <td>2 790 503</td> <td>34, 420, 303</td> <td></td> <td>0</td> <td>0</td> <td></td>			2 790 503	34, 420, 303		0	0	
14.00 RELEASED OPERATING 0 135,03 0 15.00 RELEASED CAPITAL 120,769 0 0 16.00 ROUNDING 0 0 0 17.00 100 Total deductions (sum of lines 12-17) 2,911,272 135,833 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 1 1 1 Endowment Fund 1 135,833 53,451 Image: Sheet (line 11 minus line 18) Endowment Fund 1						0	0	
15.00 RELEASED CAPITAL 120,769 0 16.00 ROUNDING 0 0 18.00 Total deductions (sum of lines 12-17) 2,911,272 135,833 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 100 Plant Fund Endowment Fund Plant Fund Ind balances at beginning of period 0 1.00 Fund balances at beginning of period 0 0 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 0 0 0 3.00 Total (sum of line 1 and line 2) 0 0 0 4.00 DEFERRED PENSION COST 0 0 0 5.00 DONATIONS 0 0 0 6.00 0 0 0 0 7.00 8.00 0 0 0 7.00 0 0 0 0 8.00 0 0 0 0 9.00 0 0 0 0			0		135 8	33	0	
16.00 ROUNDING 0 0 17.00 Total deductions (sum of lines 12-17) 0 2,911,272 135,833 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) Endowment Fund Plant Fund Endowment Fund Plant Fund 1.00 Fund balances at beginning of period 0 0 2.00 Net income (loss) (from Wkst. 6-3, line 29) 0 0 3.00 Total (sum of line 1 and line 2) 0 0 2.00 Net income (loss) (from Wkst. 6-3, line 29) 0 0 3.00 Total (sum of line 1 and line 2) 0 0 0 DONATIONS 0 0 0 6.00 0 0 0 0 7.00 8.00 0 0 0 0 0 0 0 0 0 1.00 Fund balances at beginning of period 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			120 769		100,0	0	0	
17.00 Total deductions (sum of lines 12-17) 0 2,911,272 135,833 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) Endowment Fund Plant Fund 10 Fund balances at beginning of period 0 0 0 1.00 Fund balances at beginning of period 0 0 0 1.00 Fund balances at beginning of period 0 0 0 1.00 DefERED PENSION COST 0 0 0 1.00 DEFERED PENSION COST 0 0 0 0.00 OThER 0 0 0 0 1.00 DUNATIONS 0 0 0 0 0.00 OThER 0 0 0 0 1.00 Subtotal (line 3 plus line 10) 0 0 0 0 1.00 Total Additions (sum of line 4-9) 0 0 0 0 1.00 Ther Pension ReLarED ADJ 0 0 0 0 0 1.00 RUNSFERS TO AFFILIATES 0 0 0 0 0						0	0	
18.00 Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) 2,911,272 31,517,031 135,833 53,451 100 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 0 0 0 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 0 0 0 0 0 0 0 0 0 0 1.00 Efference PENSION COST 5.00 0 0 0 0 0 0 0 0 0 0 0 6.00 0 0 0 0 0 0 0 0 <			-			0	0	
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 31, 517, 031 53, 451 Endowment Fund Plant Fund 0 Fund balances at beginning of period 0 0 1.00 Fund balances at beginning of period 0 0 0.00 Net income (loss) (from Wkst. G-3, line 29) 0 0 3.00 Total (sum of line 1 and line 2) 0 0 0.00 DEFERRED PENSION COST 0 0 5.00 DONATI ONS 0 0 0.00 OTHER 0 0 0 7.00 8.00 0 0 0 7.00 0 0 0 0 7.00 0 0 0 0 8.00 0 0 0 0 9.00 0 0 0 0 10.00 Total additions (sum of line 4-9) 0 0 0 10.00 Total additions (sum of line 4-9) 0 0 0 13.00 OTHER PENSION RELATED ADJ 0 0 0		Total deductions (sum of lines 12-17)		2, 911, 272		135, 833	-	18.00
sheet (line 11 minus line 18) Endowment Fund Plant Fund Endowment Fund Plant Fund 6.00 7.00 8.00 1.00 Fund balances at beginning of period 0 0 2.00 Net income (loss) (from Wkst. G-3, line 29) 0 0 0 3.00 Total (sum of line 1 and line 2) 0 0 0 5.00 DONATI ONS 0 0 0 6.00 OTHER 0 0 0 7.00 B.00 0 0 0 6.00 OTHER 0 0 0 7.00 B.00 0 0 0 7.00 DONATI ONS 0 0 0 8.00 0 0 0 0 9.00 0 0 0 0 9.00 0 0 0 0 10.00 Subtotal (line 3 plus line 10) 0 0 0 12.00 TRANSFERS TO AFFILIATES <								19.00
Image: Net income (loss) (from Wkst. G-3, line 29) 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td> </td></t<>								
1.00 Fund balances at beginning of period 0 0 2.00 Net income (loss) (from Wkst. G-3, line 29) 0 0 3.00 Total (sum of line 1 and line 2) 0 0 4.00 DEFERRED PENSION COST 0 0 5.00 DONATIONS 0 0 6.00 OTHER 0 0 7.00 0 0 0 8.00 0 0 0 9.00 0 0 0 11.00 Subtotal (line 3 plus line 10) 0 0 12.00 TRANSFERS TO AFFILIATES 0 0 13.00 OTHER PENSION RELATED ADJ 0 0 14.00 RELEASED CAPITAL 0 0 15.00 RELEASED CAPITAL 0 0 16.00 ROUNDING 0 0 0			Endowment Fund	PI ant	Fund			
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3.00 Total (sum of line 1 and line 2) 0 0 4.00 DEFERRED PENSION COST 0 0 5.00 DONATIONS 0 0 6.00 OTHER 0 0 7.00 0 0 0 8.00 0 0 0 9.00 0 0 0 10.00 Total additions (sum of line 4-9) 0 0 10.00 Total additions (sum of line 4-9) 0 0 11.00 Subtotal (line 3 plus line 10) 0 0 12.00 TRANSFERS TO AFFILIATES 0 0 13.00 OTHER PENSION RELATED ADJ 0 0 14.00 RELEASED CAPITAL 0 0 15.00 RELEASED CAPITAL 0 0 16.00 ROUNDING 0 0 17.00 0 0 0	1.00	Fund balances at beginning of period	0			0		1.00
4.00 DEFERRED PENSION COST 0 5.00 DONATIONS 0 6.00 OTHER 0 7.00 0 0 8.00 0 0 9.00 0 0 10.00 Total additions (sum of line 4-9) 0 0 11.00 Subtotal (line 3 plus line 10) 0 0 12.00 TRANSFERS TO AFFILIATES 0 0 13.00 OTHER PENSION RELATED ADJ 0 0 14.00 RELEASED OPERATING 0 0 15.00 RELEASED CAPITAL 0 0 16.00 ROUNDING 0 0 17.00 0 0 0	2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
5.00 DONATIONS 0 6.00 OTHER 0 7.00 0 0 8.00 0 0 9.00 0 0 10.00 Total additions (sum of line 4-9) 0 0 11.00 Subtotal (line 3 plus line 10) 0 0 12.00 TRANSFERS TO AFFILIATES 0 0 13.00 OTHER PENSION RELATED ADJ 0 0 14.00 RELEASED OPERATING 0 0 15.00 ROUNDING 0 0 17.00 0 0 0	3.00	Total (sum of line 1 and line 2)	0			0		3.00
6.00 OTHER 0 7.00 0 0 8.00 0 0 9.00 0 0 10.00 Total additions (sum of line 4-9) 0 0 11.00 Subtotal (line 3 plus line 10) 0 0 12.00 TRANSFERS TO AFFILIATES 0 0 13.00 OTHER PENSION RELATED ADJ 0 0 14.00 RELEASED OPERATING 0 0 15.00 RELEASED CAPITAL 0 0 16.00 ROUNDING 0 0	4.00	DEFERRED PENSION COST		0				4.00
7.00 0 0 8.00 0 0 9.00 0 0 10.00 Total additions (sum of line 4-9) 0 0 11.00 Subtotal (line 3 plus line 10) 0 0 12.00 TRANSFERS TO AFFILIATES 0 0 13.00 OTHER PENSION RELATED ADJ 0 0 14.00 RELEASED OPERATING 0 0 15.00 RELEASED CAPITAL 0 0 16.00 ROUNDING 0 0	5.00			0				5.00
8.0009.00010.00Total additions (sum of line 4-9)001.00Subtotal (line 3 plus line 10)012.00TRANSFERS TO AFFILIATES013.00OTHER PENSION RELATED ADJ014.00RELEASED OPERATING015.00RELEASED CAPITAL016.00ROUNDING017.0000		OTHER		0				6.00
9.00 0 0 10.00 Total additions (sum of line 4-9) 0 0 11.00 Subtotal (line 3 plus line 10) 0 0 12.00 TRANSFERS TO AFFILIATES 0 0 13.00 OTHER PENSION RELATED ADJ 0 0 14.00 RELEASED OPERATING 0 0 15.00 ROUNDING 0 0 16.00 ROUNDING 0 0	7.00			0				7.00
10.00 Total additions (sum of line 4-9) 0 0 11.00 Subtotal (line 3 plus line 10) 0 0 12.00 TRANSFERS TO AFFILIATES 0 0 13.00 OTHER PENSION RELATED ADJ 0 0 14.00 RELEASED OPERATING 0 0 15.00 RELEASED CAPITAL 0 0 16.00 ROUNDING 0 0 17.00 0 0 0				0				8.00
11.00 Subtotal (line 3 plus line 10) 0 0 12.00 TRANSFERS TO AFFILIATES 0 13.00 OTHER PENSION RELATED ADJ 0 14.00 RELEASED OPERATING 0 15.00 RELEASED CAPITAL 0 16.00 ROUNDING 0 17.00 0 0				0				9.00
12. 00TRANSFERS TO AFFILIATES013. 00OTHER PENSION RELATED ADJ014. 00RELEASED OPERATING015. 00RELEASED CAPITAL016. 00ROUNDING017. 0000			0			0		10.00
13.00 OTHER PENSION RELATED ADJ 0 14.00 RELEASED OPERATING 0 15.00 RELEASED CAPITAL 0 16.00 ROUNDING 0 17.00 0 0			0			0		11.00
14.00 RELEASED OPERATING 0 15.00 RELEASED CAPITAL 0 16.00 ROUNDING 0 17.00 0 0				0				12.00
15.00 RELEASED CAPITAL 0 16.00 ROUNDING 0 17.00 0 0				0				13.00
16.00 ROUNDING 0 17.00 0				0				14.00
17.00 0				0				15.00
		ROUNDING		0				16.00
18.00 lotal deductions (sum of lines 12-17) 0 0				0				17.00
			0			0		18.00
19.00 Fund balance at end of period per balance 0 0 sheet (line 11 minus line 18) 0 0	19.00		0			0		19.00

STATEN	Financial Systems ST. VINCENT RANDOLPI IENT OF PATIENT REVENUES AND OPERATING EXPENSES		CCN: 151301	Per		u of Form CMS-2 Worksheet G-2	
UNTER					m 07/01/2013 06/30/2014	Parts I & II Date/Time Pre 11/21/2014 8:	pared:
	Cost Center Description		I npati ent		Outpatient	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
1 00	General Inpatient Routine Services		F 100 (47		E 100 (47	1 1 00
1.00	Hospital SUBPROVIDER - IPF		5, 123, 6	47		5, 123, 647	1.00
2.00 3.00	SUBPROVIDER - IPF						3.00
4.00	SUBPROVI DER						4.00
5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			0		0	7.00
8.00	NURSI NG FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		5, 123, 6	47		5, 123, 647	
	Intensive Care Type Inpatient Hospital Services		1				
11.00	INTENSIVE CARE UNIT						11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes		0		0	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		5, 123, 6			5, 123, 647	•
18.00	Ancillary services		6, 021, 0		49, 841, 596	55, 862, 604	
19.00	Outpatient services		-34, 1		13, 776, 296	13, 742, 137	
20.00	RURAL HEALTH CLINIC			0	0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY AMBULANCE SERVICES				0	0	
23.00 24.00	CMHC						23.00
24.00 25.00	AMBULATORY SURGICAL CENTER (D. P.)						24.00
26.00	HOSPICE			0	0	0	•
27.00	OTHER			0	6, 320	6, 320	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst	11, 110, 4	-	63, 624, 212	74, 734, 708	•
20.00	G-3, line 1)	o mor		/0	00, 021, 212	, ,, , , , , , , , , , , , , , , , , , ,	20.00
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				22, 061, 886		29.00
30.00	ADD (SPECIFY)			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 (SPECI FY)			0			37.00
38.00				0			38.00
				0			39.00
39.00							40.00
39. 00 40. 00				0			•
39.00 40.00 41.00				0			41.00
39. 00 40. 00	Total deductions (sum of lines 37–41) Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfor-		-	0 22, 061, 886		•

STATEMENT OF REVENUES AND EXPENSES Provider CCN: 151301 Period: From 07/01/2013 Worksheet G-3 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 74, 734, 708 1.00 1.00 Total patient revenues (from Wkst. G-2, Part I, column 4, line 43) 74, 734, 708 1.00 3.00 Net patient revenues (from Wkst. G-2, Part II, line 43) 22, 651, 866 3.00 3.00 Net patient revenues (from Wkst. G-2, Part II, line 43) 22, 661, 866 46, 924, 864 5.00 0 Income from service to patients (line 3 minus line 4) 6, 469, 964 5.00 6.00 Contributions, donations, bequests, etc 35, 768 6.00 8.00 0.00 Revenues from tinvestments 9, 00 1.00 8.00 8.00 8.00 1.00 <th>Heal th</th> <th>Financial Systems ST. VINCENT</th> <th>RANDOLPH HOSPITAL</th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Heal th	Financial Systems ST. VINCENT	RANDOLPH HOSPITAL	In Lie	u of Form CMS-2	2552-10	
To 06/30/2014 Date/Time Prepared: 11/2/2014 8:34 am 1.00 Intervenues (from Wkst. G-2, Part I, column 3, line 28) 74, 734, 708 1.00 2.00 Less contractual allowances and discounts on patients' accounts 46, 202, 858 2.00 3.00 Net patient revenues (from Wkst. G-2, Part II, line 43) 22, 531, 850 3.00 0.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 22, 061, 886 4.00 0.01 Income from investments 6, 469, 964 5.00 0.01 Income from investments 0 6, 649, 964 5.00 0.00 Perenues from thelephone and other miscellaneous communication services 0 9.00 9.00 0.00 Perenue from telephone and other miscellaneous communication services 0 9.00 9.00 0.00 Perenue from landry and linen service 0 11.00 10.00 11.00 0.00 Perenue from allodry and linen service 0 11.00 13.00 13.00 0.00 Revenue from allodry and linen service 0 11.00 13.00 14.00 15.00	STATEM						
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