Health Financia	al Systems	ST VINCENT SA	_EM	In Lieu	u of Form CMS-2552-10
This report is	required by law (42 USC 1395g	; 42 CFR 413.20(b)). Failu	ure to report can re	sult in all interim	FORM APPROVED
payments made	since the beginning of the cos	t reporting period being o	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX CO SUMMARY	ST REPORT CERTIFICATION	Provider CCN: 151314	From 07/01/2013	
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed o	cost report		Date: 3/19/20	15 Time: 1:40 pm
use only	2. [] Manually submitted cos	st report			
-	3. [0] If this is an amended 4. [F] Medicare Utilization.			resubmitted this c	cost report
Contractor use only	(1) As Submitted (2) Settled without Audit	b. Date Received: 7. Contractor No. 8. [N] Initial Report for 9. [N] Final Report for th	11 this Provider CCN 12		
PART II - CERT	I FI CATI ON				
MI SREPRESENTAT	ION OR FALSIFICATION OF ANY IN	FORMATION CONTAINED IN TH	S COST REPORT MAY B	E PUNI SHABLE BY CRI	MINAL, CIVIL AND

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST VINCENT SALEM (151314) 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. further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)

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Officer or Administrator of Provider(s)
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Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
-	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	0	54, 590	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	0	54, 590	0	0	200.00

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

		IDENTIFICATION D	AIA	Provi	der CCN	l: 151314	Period: From 07/0 To 06/3	1/2013 0/2014	Part	sheet S I 'Time Pi	
	1.00		22		2 00		10 00/3			2015 4	
	1.00 Hospital and Hospital Health Care Co		. 00		3.00			4.00			_
00	Street: 911 N. SHELBY STREET	P0 Box:									1.
00	City: SALEM	State:	IN Z	ip Code	e: 47167	Coui	nty: WASHIN				2.
		Component N		CCN	CBSA	Provi de				stem (F	P,
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00	Subprovider - IPF										4.
0	Subprovider - IRF Subprovider - (Other)										5.
0		ST VINCENT SALEN	1 1!	5Z314	31140		12/01/200	02 N	0	N	7.
0	Swing Beds - NF				01110		12, 01, 200				8.
0	Hospital-Based SNF										9.
00											10.
	Hospital-Based OLTC Hospital-Based HHA										11.
	Separately Certified ASC										13.
	Hospi tal -Based Hospi ce										14.
00											15.
	Hospital-Based Health Clinic - FQHC										16.
00	Hospital-Based (CMHC) I Renal Dialysis										17.
	Other										19.
			I				Fro	m:		To:	
							1. (2.00	
00							07/01/		06/3	30/2014	20.
00	Type of Control (see instructions) Inpatient PPS Information							2			21.
00		currently recei	ving payme	nts for	di spro	portiona	te N			N	22.
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil				12.06(c)	(2) (Pi ck	le				
	amendment hospital?) In column 2, en	ter y tor yes									
01	Did this bosnital receive interim un				s cost	renortin	n				22
01	Did this hospital receive interim un period? Enter in column 1, "Y" for y	compensated care	payments [.]	for thi			g				22.
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	<pre>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 lin-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- Medicaid days in col. 3, out-of-state ligible unpaid days in col. 4, Medi and eligible but unpaid days in col. </pre>	compensated care es or "N" for no October 1. Enter ting period occu dicaid days on I f census days, o is cost reportin iod? In column , enter the 1, in-state . 2, ol. 3, d days in col. t unpaid days in column 6. e in-state -state Medicaid of-state e Medicaid caid HMO paid 5, and other	payments for the print of the p	for thi prtion 2 "Y" r after d/or 25 e of di ifferer Y" for In-St Medic eligi unpa day 2.(of the for yes Octobe below? schargent from yes or caid ble Me aid pa ys 0 0 0 0	cost or "N" r 1. (see 2 In coluu 2. Is the the methe "N" for Dut-of State edicaid id days 3.00 0 0	for e nn od no. Out-of State Medicaid eligible unpaid 4.00 0 0 0	HMO da	ys M 0 0 Date	Other ledi cai o days 6.00	23. 0 24. 25.
	<pre>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 lin-state Medicaid paid days in col. Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid days in col colutor 5, and other Medicaid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-state eligible unpaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 6.</pre>	compensated care es or "N" for no October 1. Enter ting period occu dicaid days on I f census days, o is cost reportin iod? In column , enter the 1, in-state . 2, ol. 3, d days in col. t unpaid days in column 6. e in-state -state Medicaid of-state e Medicaid caid HMO paid 5, and other	apayments for the print column in column and a second and a second and a second and a second	for thi prtion 2 "Y" r after d/or 25 e of di ifferer Y" for In-St Medic eligi unpa day 2.(of the for yes Octobe below? schargent from yes or caid ble Me aid pa ys 0 0 0 0	cost or "N" r 1. (see 2 In coluu 2. Is the the methe "N" for Dut-of State edicaid id days 3.00 0 0	for e nn od no. Out-of State Medicaid eligible unpaid 4.00 0 0 0	HMO da 5.00	ys M 0 0 Date	Other ledi cai o days 6.00	23. d 0 24. 25.
	<pre>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 instate Medicaid paid days in col. Medicaid eligible unpaid days in col out-of-state Medicaid eligible unpaid days in col column 5, and other Medicaid days in col. If this provider is an IRF, enter th Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-state eligible unpaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 3, out-of-state Enter your standard geographic class cost reporting period. Enter "1" for Enter your standard geographic class</pre>	compensated care es or "N" for no October 1. Enter ting period occu dicaid days on I f census days, o is cost reportin iod? In column , enter the 1, in-state . 2, ol. 3, d days in col. t unpaid days in column 6. e in-state -state Medicaid of-state e Medicaid caid HMO paid 5, and other ification (not w urban or "2" fo	age) statu:	for thi ortion 2 "Y" r after d/or 25 e of di ifferer Y" for In-St Medic eligi unpa day 2.0 s at the s at the	of the for yes Octobe 5 below? scharge at from yes or cate (caid ble Me aid pa yes 0 0 0 0 0 0 0 0 0 0 0 0	cost or "N" r 1. (see P In coluu e. Is the the methe "N" for Dut-of State edicaid id days 3.00 0 0 0 0	for e nn od no. Out-of State Medicaid eligible unpaid 4.00 0 0 0 0	HMO da 5.00	ys M 0 0 Date	Other ledi cai o days 6.00	23. 0 24. 25. <u>pr</u> 26.
	<pre>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 Medicaid eligible unpaid days in col. Medicaid eligible unpaid days in col out-of-state Medicaid eligible unpaid , Medicaid HMO paid and eligible bu column 5, and other Medicaid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid paid days in col. 1, the in eligible unpaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 6. Enter your standard geographic class cost reporting period. Enter "1" for Enter your standard geographic class reporting period. Enter in column 1, </pre>	compensated care es or "N" for no October 1. Enter ting period occu dicaid days on I f census days, o is cost reportin iod? In column , enter the 1, in-state . 2, ol. 3, d days in col. t unpaid days in column 6. e in-state -state Medicaid of-state e Medicaid caid HMO paid 5, and other ification (not w urban or "2" fo ification (not w "1" for urban o	rage) statu r "2" for	for thi prtion 2 "Y" r after d/or 25 e of di ifferer Y" for In-St Medic eligi unpa day 2.0 s at th s at th rural.	of the for yes octobe below? schargent from yes or cate (caid ble Me aid pa ble Me aid pa <u>yes</u> 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	cost or "N" r 1. (see P In coluu e. Is the the methe "N" for Dut-of State edicaid id days 3.00 0 0 0 0	for e nn od no. Out-of State Medicaid eligible unpaid 4.00 0 0 0 0	HMO da 5.00	ys M 0 0 Date	Other ledi cai o days 6.00	0 24.
	<pre>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 instate Medicaid paid days in col. Medicaid eligible unpaid days in col out-of-state Medicaid eligible unpaid days in col column 5, and other Medicaid days in col. If this provider is an IRF, enter th Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-state eligible unpaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 3, out-of-state Enter your standard geographic class cost reporting period. Enter "1" for Enter your standard geographic class</pre>	compensated care es or "N" for no October 1. Enter ting period occu dicaid days on I f census days, o is cost reportin iod? In column , enter the 1, in-state . 2, ol. 3, d days in col. t unpaid days in column 6. e in-state -state Medicaid of-state e Medicaid caid HMO paid 5, and other ification (not w urban or "2" fo ification (not w "1" for urban o raphic reclassif	r payments for the prince of t	for thi prtion 2 "Y" r after d/or 25 e of di ifferer Y" for In-St Medic eligi unpa day 2.() s at th s at th rural. column	of the for yes Octobe 5 below? schargent from yes or cate (caid ble Me aid pa yo 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	cost or "N" or r 1. (see 2 In coluu 2. Is the the mether "N" for Out-of State edicaid id days 3.00 0 0 0 0	for e nn od no. Out-of State Medicaid eligible unpaid 4.00 0 0 0 0 0 0	HMO da 5.00	ys M 0 0 Date	Other ledi cai o days 6.00	23. 0 24. 25. pr 26.

Health Financial Systems ST HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		T SALEM Provi der (CCN: 151314	l Period: From 07/01 To 06/30	/2013	of For Worksho Part I Date/Ti 3/18/20	eet S-2 ime Pre	2 epared:
				Begi nni	ng:	Endi		
				1.00)	2.	00	
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent date		Subscript line	30 FOR NUMB	er				36.00
37.00 If this is a Medicare dependent hospital (MDH), enter		umber of period	ds MDH statu	s	0			37.00
in effect in the cost reporting period.			20 fan mumb					20.00
38.00 Enter applicable beginning and ending dates of MDH s of periods in excess of one and enter subsequent date		subscript rine		er				38.00
	501			Y/N		Y/		
20 00 Dass this facility qualify for the innetiont beaute	0.01/00.0	nt odiustment :	for low volu	1.00)	2.	00	20.00
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rea CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ent quireme	er in column 1 nts in accorda	"Y" for yes nce with 42					39.00
					V	XVIII	XIX	_
Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45.00 Does this facility gualify and receive Capital payment	nt for	di sproporti ona [.]	te share in	accordance	N	N	N	45.00
with 42 CFR Section §412.320? (see instructions)								
46.00 Is this facility eligible for additional payment exca pursuant to 42 CFR §412.348(f)? If yes, complete Work III.					N	N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300 PPS capi					N	N	N	47.00
48.00 Is the facility electing full federal capital paymen	t? Ent	er "Y" for yes	or "N" for	10.	N	N	N	48.00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in	approv	ed GME programs	s? Enter "Y	for yes	N			56.00
or "N" for no.				5				
57.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon	r yes c	r "N" for no in	n column 1.	lf column 1				57.00
for yes or "N" for no in column 2. If column 2 is " "N", complete Worksheet D, Part III & IV and D-2, Pa	Y", com ^t II,	plete Workshee if applicable.	t E-4. If co	lumn 2 is				
58.00 If line 56 is yes, did this facility elect cost reim			ans' service	s as				58.00
defined in CMS Pub. 15-1, section 2148? If yes, compl 59.00 Are costs claimed on line 100 of Worksheet A? If yes			D-2 Part L		N			59.00
60.00 Are you claiming nursing school and/or allied health					N			60.00
provider-operated criteria under §413.85? Enter "Y"								
	Y/N	IME	Direct GME	IME		Direc	I GME	
	1.00	2.00	3.00	4.00	C	5.0	00	
61.00 Did your hospital receive FTE slots under ACA	N				0.00		0.00	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 ending and submitted before March 23, 2010. (see		0.00	0.	00				61.01
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.	00				61.02
ACA). (see instructions)								
61.03 Enter the base line FTE count for primary care		0.00	0.	00				61.03
and/or general surgery residents, which is used for determining compliance with the 75% test. (see								
instructions)								
61.04 Enter the number of unweighted primary care/or		0.00	0.	00				61.04
surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).								
61.05 Enter the difference between the baseline primary		0.00	0.	00				61.05
and/or general surgery FTEs and the current year's								
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			0.					
care or general surgery. (see instructions)	D		D 0 1			11.5		
	Pr	ogram Name	Program Cod	e Unweigh IME FTE		Unwei Di rec		
						FTE C		
		1.00	2.00	3.00		4. ((1.1-
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents					0.00		0.00	61.10
for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE								
unweighted count and enter in column 4 direct GME FTE unweighted count.								

SPITAL AND HOSPITAL HEALTH CARE COMPI		VINCENT SALEM TA Provider		eri od:	u of Form CMS-2 Worksheet S-2	
			Fi To	rom 07/01/2013 o 06/30/2014	Part I Date/Time Pre 3/18/2015 4:2	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted	
		1.00	2.00	3.00	4.00	1
.20 Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1 enter in column 2 the program co 3 the IME FTE unweighted count a direct GME FTE unweighted count.	the number of FTE gram. (see the program name, ode, enter in column			0.00	0.00	61.2
			(11004)		1.00	
ACA Provisions Affecting the Hea 0.00 Enter the number of FTE resident				iod for which	0.00	62.0
your hospital received HRSA PCRE			reporting per		0.00	02.0
2.01 Enter the number of FTE resident during in this cost reporting pe	eriod of HRSA THC prog	gram. (see instructio		your hospital	0.00	62.0
Teaching Hospitals that Claim Re 8.00 Has your facility trained reside			cost reporting	period? Enter	N	63.0
"Y" for yes or "N" for no in col					IN .	03.0
			Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col . 1 + col . 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Yea period that begins on or after J			-inis base year	r is your cost	reporting	
.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	nber of unweighted nor otations occurring in e number of unweighted our hospital. Enter ir	n-primary care all non-provider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	01.
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column						
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
4)). (see instructions)			Nonprovider Site	Hospi tal	col. 2))	
		n Nonprovider setting	Nonprovider Site 1.00	Hospi tal	3.00	

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	EX IDENTIFICATION DA		Fi	eriod: rom 07/01/2013		
			T	06/30/2014	4 Date/Time Pr 3/18/2015 4:	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 - col. 4))	-
	1.00	2.00	3.00	4.00	5.00	
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			0.00	0.0	0 0.0000	
4)). (see instructions)						-
				1. (0 2.00 3.00)
Inpatient Psychiatric Facility P 00 Is this facility an Inpatient Psy		PF), or does it cont	ain an IPF sub	provider? N		70
Enter "Y" for yes or "N" for no. 00 ffline 70 yes: Column 1: Did the						71
recent cost report filed on or be Column 2: Did this facility train §412.424 (d)(1)(iii)(D)? Enter " or 3 respectively in column 3. (s beginning of the fourth year, en the new teaching program in exis	n residents in a new Y" for yes or "N" for see instructions) If ter 4 in column 3, or tence, enter 5. (see	teaching program in r no. Column 3: If co this cost reporting r if the 5th or subse	accordance wit olumn 2 is Y, e period covers	h 42 CFR nter 1, 2 the		
Inpatient Rehabilitation Facilit 00 Is this facility an Inpatient Rel		(IRF), or does it o	contain an IRF	N		75
subprovider? Enter "Y" for yes a 1f line 75 yes: Column 1: Did the recent cost reporting period endi no. Column 2: Did this facility CFR §412.424 (d)(1)(iii)(D)? Enter 1, 2 or 3 respectively in column beginning of the fourth year, en the new teaching program in exis	e facility have an ap ing on or before Nove train residents in a er "Y" for yes or "N" 3. (see instructions ter 4 in column 3, or	mber 15, 2004? Enter new teaching program 'for no. Column 3: I s) If this cost repor if the 5th or subse	"Y" for yes o n in accordance f column 2 is ting period co	r "N" for with 42 Y, enter vers the	0	76.
					1.00	
	I (LTCH)? Enter "Y"	for yoo and "N" for	20		N	
Long Term Care Hospital PPS 00 Is this a long term care hospital		TO Yes and N TO	110.			80
00 Is this a long term care hospital TEFRA Providers				or "N" for po		
00 Is this a long term care hospital	CFR Section §413.40(1 w Other subprovider (f)(1)(i) TEFRA? Ente (excluded unit) under	er "Y" for yes			85
00 <u>Is this a long term care hospital</u> <u>TEFRA Providers</u> 00 Is this a new hospital under 42 (00 Did this facility establish a new	CFR Section §413.40(1 w Other subprovider (f)(1)(i) TEFRA? Ente (excluded unit) under	er "Y" for yes	n V	. N XI X	85
00 Is this a long term care hospital TEFRA Providers 00 Is this a new hospital under 42 (00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for Title V and XIX Services	CFR Section §413.40(1 w Other subprovider (r yes and "N" for no.	F)(1)(i) TEFRA? Ente (excluded unit) under	er "Y" for yes 42 CFR Sectio	n V 1.00	. N XI X 2. 00	85 86
00 Is this a long term care hospital TEFRA Providers 00 Is this a new hospital under 42 (00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for Title V and XIX Services 00 Does this facility have title V a	CFR Section §413.40(1 w Other subprovider (r yes and "N" for no. and/or XIX inpatient	F)(1)(i) TEFRA? Ente (excluded unit) under	er "Y" for yes 42 CFR Sectio	n V	. N XI X	85 86
00 Is this a long term care hospital TEFRA Providers 00 Is this a new hospital under 42 (00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for 1itle V and XIX Services 00 Does this facility have title V a yes or "N" for no in the applical 00 Is this hospital reimbursed for	CFR Section §413.40(1 w Other subprovider (r yes and "N" for no. and/or XIX inpatient ble column. title V and/or XIX th	F)(1)(i) TEFRA? Ente (excluded unit) under hospital services? E nrough the cost repor	er "Y" for yes 42 CFR Sectio	n V 1.00	. N XI X 2. 00	85 86 90
00 Is this a long term care hospital TEFRA Providers 00 Is this a new hospital under 42 (00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for 11tle V and XIX Services 00 Does this facility have title V a yes or "N" for no in the applicat 01 Is this hospital reimbursed for 11 full or in part? Enter "Y" for ye 00 Are title XIX NF patients occupying 01 Strite XIX NF patients	CFR Section §413.40(1 w Other subprovider of r yes and "N" for no. and/or XIX inpatient ble column. title V and/or XIX th es or "N" for no in t ing title XVIII SNF b	F)(1)(i) TEFRA? Enter (excluded unit) under hospital services? Enrough the cost repor the applicable column beds (dual certificat	er "Y" for yes 42 CFR Sectio Inter "Y" for t either in	n V 1.00 N	. N XIX 2.00 Y	85 86 90 91
<pre>00 Is this a long term care hospital TEFRA Providers 00 Is this a new hospital under 42 0 00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for 00 Does this facility have title V a yes or "N" for no in the applical 00 Is this hospital reimbursed for full or in part? Enter "Y" for yes 00 Are title XIX NF patients occupyi instructions) Enter "Y" for yes to 00 Does this facility operate an ICD</pre>	CFR Section §413.40(1 w Other subprovider of r yes and "N" for no. and/or XIX inpatient ble column. title V and/or XIX th es or "N" for no in th or "N" for no in the F\MR facility for pur	F)(1)(i) TEFRA? Enter (excluded unit) under hospital services? Enrough the cost repor the applicable column beds (dual certificat applicable column.	er "Y" for yes 42 CFR Sectio Enter "Y" for t either in t. tion)? (see	n V 1.00 N	. N XIX 2.00 Y N	85 86 90 91 92
<pre>00 Is this a long term care hospital TEFRA Providers 00 Is this a new hospital under 42 0 00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for 00 Does this facility have title V a yes or "N" for no in the applical 00 Is this hospital reimbursed for full or in part? Enter "Y" for yes 00 Are title XIX NF patients occupyi instructions) Enter "Y" for yes or 00 Does this facility operate an ICI "Y" for yes or "N" for no in the</pre>	CFR Section §413.40(1 w Other subprovider of r yes and "N" for no. and/or XIX inpatient ble column. title V and/or XIX th es or "N" for no in th ing title XVIII SNF b or "N" for no in the F\MR facility for pur applicable column.	f)(1)(i) TEFRA? Enter (excluded unit) under hospital services? Enrough the cost repor the applicable column beds (dual certificat applicable column. rposes of title V and	er "Y" for yes 42 CFR Sectio Enter "Y" for t either in h. cion)? (see d XIX? Enter	n V 1.00 N N	. N XIX 2.00 Y N Y	85 86 90 91 92 93
 00 Is this a long term care hospital TEFRA Providers 00 Is this a new hospital under 42 (00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for Title V and XIX Services 00 Does this facility have title V a yes or "N" for no in the applical 00 Is this hospital reimbursed for full or in part? Enter "Y" for yes 00 Are title XIX NF patients occupyi instructions) Enter "Y" for yes of 00 Does this facility operate an ICI "Y" for yes or "N" for no in the applicable column. 00 If line 94 is "Y", enter the reduced 	CFR Section §413.40(1 w Other subprovider of r yes and "N" for no. and/or XIX inpatient ble column. title V and/or XIX th es or "N" for no in the sr "N" for no in the FVMR facility for pur applicable column. al cost? Enter "Y" for uction percentage in	F)(1)(i) TEFRA? Enter (excluded unit) under hospital services? Entrough the cost repor the applicable column or yes, and "N" for r the applicable column	er "Y" for yes 42 CFR Sectio Enter "Y" for t either in tion)? (see d XIX? Enter no in the nn.	n V 1.00 N N N	. N X1 X 2.00 Y N Y N N N	85 86 90 91 92 93 94 00 95
<pre>00 Is this a long term care hospital TEFRA Providers 00 Is this a new hospital under 42 (00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for 11 E V and XIX Services 00 Does this facility have title V a yes or "N" for no in the applical 00 Is this hospital reimbursed for full or in part? Enter "Y" for yes (00 Does this facility operate an ICI "Y" for yes or "N" for no in the 00 Does this facility operate an ICI "Y" for yes or "N" for no in the 00 Does title V or XIX reduce capita applicable column. 00 If line 94 is "Y", enter the reduced 00 Does this "Y", enter the reduced 00</pre>	CFR Section §413.40(1 w Other subprovider of r yes and "N" for no. and/or XIX inpatient ble column. title V and/or XIX th es or "N" for no in th for "N" for no in the FVMR facility for pur applicable column. al cost? Enter "Y" for uction percentage in ting cost? Enter "Y"	F)(1)(i) TEFRA? Enter (excluded unit) under hospital services? Entrough the cost repor the applicable column cods (dual certificat applicable column. rposes of title V and or yes, and "N" for r the applicable colum for yes or "N" for r	er "Y" for yes 42 CFR Sectio Enter "Y" for t either in t. cion)? (see d XIX? Enter no in the nn. to in the	n V 1.00 N N N N O.0	. N XIX 2.00 Y N Y N N N 0 0.0	80 85 86 90 91 92 93 94 94 95 96 90 95 96 90 97

Health Financial Systems ST VINCEN	T SALEM		In	Li eu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der			2013	Worksheet S- Part I Date/Time Pr <u>3/18/2015 4</u> :	repared:
			V 1.00		2.00	-
107.00 Column 1: If this facility qualifies as a CAH, is it eligi for I &R training programs? Enter "Y" for yes or "N" for n instructions) If yes, the GME elimination would not be on W 25 and the program would be cost reimbursed. If yes complet Column 2: If this facility is a CAH, do I&Rs in an approve train in the CAH's excluded IPF and/or IRF unit? Enter "Y column 2. (see instructions)	o in column 1. orksheet B, Pa e Worksheet D- d medical educ	(see art I, column -2, Part II. cation program	N		2.00	107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		Dessiverter	108.00
	Physi cal 1.00	0ccupational 2.00	Speech 3.00		Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N	109.00
			-	1.00	2.00 3.00)
Miscellaneous Cost Reporting Information	r "N" for no i	n column 1 If		N		115.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o enter the method used (A, B, or E only) in column 2. If col either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital provider 15-1, §2208.1.	umn 2 is "E", for long tern s) based on th	enter in colum n care (include ne definition i	n 3 s	N	0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu no.			"N" for	N Y		116.00 117.00
118.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the policy Premiums		2	Insurance	118.00
			Losses			
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	0	3.00	0118.01
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 D0 NOT USE THIS LINE			1.00 N		2.00	118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2 "Y" for yes or "N" for no.	n column 1 "Y" ualifies for t	' for yes or the Outpatient	N		Ν	120.00
121.00 Did this facility incur and report costs for high cost implication patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Y			121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f	or 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, e		fication date				126.00
in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en		ication date				127.00
in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en	ter the certif	fication date				128.00
in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent		cation date in				129.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center,		ti fi cati on				130.00
date in column 1 and termination date, if applicable, in co 131.00 If this is a Medicare certified intestinal transplant cente	r, enter the c	certification				131.00
date in column 1 and termination date, if applicable, in co 132.00 If this is a Medicare certified islet transplant center, en	ter the certif	fication date				132.00
in column 1 and termination date, if applicable, in column 133.00 If this is a Medicare certified other transplant center, en	ter the certif	ication date				133.00
in column 1 and termination date, if applicable, in column 134.00 If this is an organ procurement organization (OPO), enter t and termination date, if applicable, in column 2. All Providers		in column 1				134.00
140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number	yes, and home	e office costs	Y	1	5H046	140.00

DSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der (CCN: 1513	From O	7/01/2013 6/30/2014	Worksheet S- Part I Date/Time Pr 3/18/2015 4:	epared:
1.00		2. 00			3.00		
If this facility is part of a cha			ugh 143 t	he name an	nd address	of the home	
office and enter the home office							_
41.00 Name: ST VINCENT HEALTH	Contractor's Name:	WPS	Contr	actor's Nu	mber: 0800	1	141.00
42.00 Street: 10330 N. MERIDIAN STREET	PO Box:						142.00
43.00 City: INDIANAPOLIS	State:	IN	Zip (ode:	4629	0	143.00
						1 00	-
44.00 Are provider based physicians' co	to included in Werkeher	+ 10				1.00 Y	144.00
1 1 5			anata fa	r innation	+	N N	144.00
45.00 If costs for renal services are cl services only? Enter "Y" for yes o		The 74, are they	COSTS TO	rinpatien	L	IN	145.00
services only? Enter 1 Tor yes o							
					1.00	2.00	-
46.00 Has the cost allocation methodolog	av changed from the prev	iously filed cos	t report?		N	2.00	146.00
Enter "Y" for yes or "N" for no i					N		140.00
enter the approval date (mm/dd/yy				,,			1
47.00Was there a change in the statist		or ves or "N" for	no.		Ν		147.0
48.00Was there a change in the order o					N		148.0
49.00Was there a change to the simplifi				for	N		149.0
no.							
		Part A	Part	B T	itle V	Title XIX	
		1.00	2.00)	3.00	4.00	1
Does this facility contain a prov	ider that qualifies for	an exemption fro	m the app	lication o	of the low	er of costs	
or charges? Enter "Y" for yes or	"N" for no for each com	ponent for Part A	and Part	B. (See 4	2 CFR §41	3. 13)	
55.00Hospi tal		N	N		Ν	Ν	155.0
56.00 Subprovi der – IPF		N	N		N	N	156.0
57.00 Subprovi der – IRF		N	N		Ν	N	157.0
58. 00 SUBPROVI DER							158.0
59. 00 SNF		N	N		N	N	159.0
60.00HOME HEALTH AGENCY		Ν	N		Ν	Ν	160. 0
61.00 CMHC			N		N	N	161.0
						1.00	
Multicampus							_
65.00 Is this hospital part of a Multica	ampus hospital that has	one or more camp	uses in d	ifferent C	BSAs?	N	165.0
Enter "Y" for yes or "N" for no.	News	Country	Ctata	71 m Carla	CDCA		-
	Name 0	County 1.00	State	Zip Code 3.00	CBSA	FTE/Campus	-
66.00 If line 165 is yes, for each	0	1.00	2.00	3.00	4.00	5.00	0166.0
campus enter the name in column						0.0	0100.0
0, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
col umn 5							
						1.00	
Health Information Technology (HI							
67.00 Is this provider a meaningful use	r under Section §1886(n))? Enter "Y" for	yes or "	N" for no.		Ν	167.0
			e 167 is	"Y"), ente	r the		0168.0
68.00 If this provider is a CAH (line 10	HT assets (see instruct						
reasonable cost incurred for the I			(ling 105	is "N"),	enter the	0.0	0169.0
reasonable cost incurred for the 1 69.00 If this provider is a meaningful	user (line 167 is "Y") a	and is not a CAH	(TITIE 103				
reasonable cost incurred for the I	user (line 167 is "Y") a	and is not a CAH					
reasonable cost incurred for the 1 69.00 If this provider is a meaningful	user (line 167 is "Y") a	and is not a CAH		Beg	gi nni ng	Endi ng	
reasonable cost incurred for the 1 69.00 If this provider is a meaningful	user (line 167 is "Y") a ons)		•	Beg			170.0

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE Provi der		Period: From 07/01/2013	Worksheet S-2 Part II	2
				o 06/30/2014		
			,	Y/N	Date	
	General Instruction: Enter Y for all YES res	nonses Enter N for all NO r	asponsas Enta	1.00	2.00	
	mm/dd/yyyy format.		esponses. Ente			4
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
00	Has the provider changed ownership immediate			Ν		1.
	reporting period? If yes, enter the date of	the change in column 2. (see	Y/N	Date	V/I	
00			1.00	2.00	3.00	
00	Has the provider terminated participation in yes, enter in column 2 the date of terminati		N			2.
00	voluntary or "I" for involuntary. Is the provider involved in business transac	tions, including management	Y			3
	contracts, with individuals or entities (e.g	., chain home offices, drug				
	or medical supply companies) that are relate officers, medical staff, management personne					
	of directors through ownership, control, or					
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements pre	pared by a Certified Public	Y	A	1	4
	Accountant? Column 2: If yes, enter "A" for					
	or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see inst					
00	Are the cost report total expenses and total	revenues different from	N			5
	those on the filed financial statements? If	yes, submit reconciliation.		Y/N	Legal Oper.	
				1.00	2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing sch	ool?Column 2: If yes, is t	he provider is	N		6
	the legal operator of the program?					_
00 00	Are costs claimed for Allied Health Programs Were nursing school and/or allied health pro		d during the	N N		8
~~	cost reporting period? If yes, see instructi		-tt2 f	N		
00	Are costs claimed for Intern-Resident progra yes, see instructions.	ins crarined on the current co	st report? IT	N		9
. 00	Was an Intern-Resident program been initiate period? If yes, see instructions.	d or renewed in the current	cost reporting	Ν		10
. 00	Are GME cost directly assigned to cost cente	ers other than I & R in an Ap	proved	Ν		11
	Teaching Program on Worksheet A? If yes, see	instructions.			Y/N	
					1.00	
00	Bad Debts Ls the provider seeking reimbursement for ha	d dahts? If yes see instruc	tions		1.00	12
	Bad Debts Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de			st reporting		
. 00	Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de period? If yes, submit copy.	bt collection policy change	during this co		1.00 Y N	13
. 00 . 00	Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de period? If yes, submit copy. If line 12 is yes, were patient deductibles Bed Complement	bt collection policy change and/or co-payments waived? I	during this co f yes, see ins	tructions.	1.00 Y	13
. 00 . 00	Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de period? If yes, submit copy. If line 12 is yes, were patient deductibles	bt collection policy change and/or co-payments waived? I	during this co f yes, see ins yes, see inst	tructions.	1.00 Y N N	13 14
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. 00 . 00	Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de period? If yes, submit copy. If line 12 is yes, were patient deductibles Bed Complement Did total beds available change from the pri	bt collection policy change and/or co-payments waived? I or cost reporting period? If	during this co f yes, see ins yes, see inst Pan	tructions. ructions. rt A	1.00 Y N N Part B	13 14
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. 00 . 00 . 00	Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de period? If yes, submit copy. If line 12 is yes, were patient deductibles Bed Complement Did total beds available change from the pri PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see	bt collection policy change and/or co-payments waived? I or cost reporting period? If Description	during this co f yes, see inst yes, see inst Par Y/N 1.00	tructions.	1.00 Y N N Part B Y/N 3.00	13 14 15
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. 00 . 00 . 00 . 00	Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de period? If yes, submit copy. If line 12 is yes, were patient deductibles Bed Complement Did total beds available change from the pri PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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) 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 Tr is yes, were adjustments Here the paid the point used to file this cost report? If yes, were adjustments lf line 16 or 17 is yes, were adjustments	bt collection policy change and/or co-payments waived? I or cost reporting period? If Description 0	during this co f yes, see inst yes, see inst Y/N 1.00 Y	tructions.	1.00 Y N N Part B Y/N 3.00 Y N	13 14 15 16 16 17 18
. 00 . 00 . 00 . 00	Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de period? If yes, submit copy. If line 12 is yes, were patient deductibles Bed Complement Did total beds available change from the pri PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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) 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	bt collection policy change and/or co-payments waived? I or cost reporting period? If Description 0	during this co f yes, see inst yes, see inst Y/N 1.00 Y N	tructions.	1.00 Y N N Part B Y/N 3.00 Y N	13 14 15 16 16 17 18
. 00	Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de period? If yes, submit copy. If line 12 is yes, were patient deductibles Bed Complement Did total beds available change from the pri PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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) 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 Tr is yes, were adjustments Here the paid the point used to file this cost report? If yes, were adjustments lf line 16 or 17 is yes, were adjustments	bt collection policy change and/or co-payments waived? I or cost reporting period? If Description 0	during this co f yes, see inst yes, see inst Y/N 1.00 Y N	tructions.	1.00 Y N N Part B Y/N 3.00 Y N	12. 13. 14. 15. 16. 17. 18.
. 00 . 00 . 00 . 00	Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de period? If yes, submit copy. If line 12 is yes, were patient deductibles Bed Complement Did total beds available change from the pri PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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) 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 other PS&R Report information? If yes, see	bt collection policy change and/or co-payments waived? 1 or cost reporting period? If Description 0	during this co f yes, see inst yes, see inst Y/N 1.00 Y N	tructions.	1.00 Y N N Part B Y/N 3.00 Y N	13. 14. 15. 16. 17.

Heal th	Financial Systems	ST VINCEN	NT SALEM				In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Prov	i der	CCN: 151314		eriod:	Worksheet S-2	2
							rom 07/01/2013 o 06/30/2014	Part II Date/Time Pre	epared:
								3/18/2015 4:2	
		Descri	iption		Y/N	Par	t A Date	Part B Y/N	
			0		1.00		2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				N			N	21.00
					•				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPI Capital Related Cost	TALS ONLY (EXC	EPT CHILDR	ENS I	HOSPI TALS)			1.00	
22.00	Have assets been relifed for Medicare purpos	es?lfyes, se	e instruct	ions				N	22.00
	Have changes occurred in the Medicare deprec reporting period? If yes, see instructions.	J .				duriı	ng the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing If yes, see instructions	g leases enter	ed into du	iri ng	this cost	rep	orting period?	Ν	24.00
25.00	Have there been new capitalized leases enter- instructions.	ed into during	, the cost	repo	rting perio	od?	f yes, see	Ν	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acq instructions.	uired during t	he cost re	porti	ing period	?lf	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy char copy.	nged during th	ne cost rep	orti	ng period?	lf	yes, submit	N	27.00
28.00	Interest Expense Were new Loans, mortgage agreements or lette period? If yes, see instructions.	rs of credit e	entered int	o du	ring the co	ost	reporting	Ν	28.00
29.00	Did the provider have a funded depreciation a treated as a funded depreciation account? If	account and/or	bond fund	ls (D	ebt Service	e Res	serve Fund)	Y	29.00
30.00	Has existing debt been replaced prior to its instructions.			new	debt? If	yes,	see	Ν	30.00
31.00	Has debt been recalled before scheduled matu instructions.	rity without i	ssuance of	new	debt? If	yes,	see	Ν	31.00
	Purchased Services								
	Have changes or new agreements occurred in parrangements with suppliers of services? If	yes, see instr	uctions.		Ū.			N	32.00
33.00	If line 32 is yes, were the requirements of 3 no, see instructions.	Sec. 2135.2 ap	plied pert	ainii	ng to compe	etiti	ve bidding? If	F N	33.00
34.00	Provider-Based Physicians Are services furnished at the provider facil	ity under an a	rrangement	wit	h provider.	-hasi	ed physicians?	Y	34.00
54.00	If yes, see instructions.		in rungement	wi ci		643			54.00
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?				nts with th	he pi		Y	35.00
							Y/N 1.00	Date 2.00	
	Home Office Costs						1.00	2.00	
	Were home office costs claimed on the cost ro If line 36 is yes, has a home office cost st		prepared by	the	home offic	ce?	Y Y		36.00 37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end	of the home of	fice diffe	rent	from that	of	N		38.00
39.00	the provider? If yes, enter in column 2 the If line 36 is yes, did the provider render so					yes,	Ν		39.00
40.00	see instructions. If line 36 is yes, did the provider render se	ervices to the	e home offi	ce?	lfyes, se	ee	Ν		40.00
	instructions.								
				1.	00		2.	00	1
	Cost Report Preparer Contact Information		1						
41.00	Enter the first name, last name and the titl held by the cost report preparer in columns	•	JILL				HILL		41.00
42.00	respectively. Enter the employer/company name of the cost	report	ST. VINCE	NT HE	ALTH				42.00
43.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respecti		317-583-35	519			JILL. HILL@STVI	NCENT. ORG	43.00

Health Financial Systems	ST VINCENT	SALEM		In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Pre 3/18/2015 4:2	pared:
	Part B					
	Date					
	4.00					
PS&R Data	10 (01 (001 1					1
16.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	10/21/2014					16.00
 17.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 						17.00
 18.00 18.00 16 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. 						18.00
 19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. 						19.00
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.00
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.						21.00
		3.	00			
41.00 Enter the first name, last name and the titl held by the cost report preparer in columns		ANAGER, REIMB	URSEMENT			41.00
42.00 Enter the employer/company name of the cost preparer.	report					42.00
43.00 Enter the telephone number and email address report preparer in columns 1 and 2, respecti						43.00

	Financial Systems	ST VINCEN					u of Form CN		552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	ſ	Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014	Worksheet S Part I		
						10 06/30/2014	Date/Time F 3/18/2015		
							I/P Days /		
							0/P Visits	1	
							Tri ps		
	Component	Worksheet A	No. (of Beds	Bed Days	CAH Hours	Title V		
		Line Number			Avai I abl e				
1 00		1.00		. 00	3.00	4.00	5.00		1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		25	9, 12	15, 528. 00		0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2.00
3.00	HMO I PF Subprovi der								3.00
4.00	HMO I RF Subprovi der								4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							o	5.00
6.00	Hospital Adults & Peds. Swing Bed NF							õ	6.00
7.00	Total Adults and Peds. (exclude observation			25	9, 12	15, 528. 00		õ	7.00
	beds) (see instructions)				.,			-	
8.00	INTENSIVE CARE UNIT								8.00
9.00	CORONARY CARE UNIT								9.00
10.00	BURN INTENSIVE CARE UNIT								10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T								11.00
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00
13.00	NURSERY								13.00
14.00	Total (see instructions)			25	9, 12	15, 528. 00		0	14.00
15.00	CAH visits							0	15.00
16.00	SUBPROVIDER - IPF								16.00
17.00	SUBPROVIDER - IRF								17.00
18.00	SUBPROVI DER								18.00
19.00	SKILLED NURSING FACILITY								19.00
20.00 21.00	NURSING FACILITY OTHER LONG TERM CARE								20.00 21.00
21.00	HOME HEALTH AGENCY								21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)								22.00
23.00	HOSPICE								23.00
24.00	HOSPICE (non-distinct part)	30.00							24.00
25.00	CMHC - CMHC	30.00							24.10
26.00	RURAL HEALTH CLINIC	88.00						0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00						ő	26.25
27.00	Total (sum of lines 14-26)	07.00		25				Ĭ	27.00
28.00	Observation Bed Days							o	28.00
29.00	Ambul ance Trips					1			29.00
30.00	Employee discount days (see instruction)								30.00
31.00	Employee discount days - IRF								31.00
32.00	Labor & delivery days (see instructions)			0		0			32.00
32.01	Total ancillary labor & delivery room								32.01
	outpatient days (see instructions)								
33.00	LTCH non-covered days								33.00

C: \28800-14 amended.mcrx

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ST VINCENT		CCN: 151314	Period:	u of Form CMS-2 Worksheet S-3	
SPITAL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC				From 07/01/2013 To 06/30/2014	Part I Date/Time Pre 3/18/2015 4:2	pared
	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	358	20	64	7		1.0
00 HMO and other (see instructions) 00 HMO IPF Subprovider	74 0	14 0				2. (3. (
00 HMO I RF Subprovider	0	0				4.0
00 Hospital Adults & Peds. Swing Bed SNF 00 Hospital Adults & Peds. Swing Bed NF	178	0	17 5			5. 6.
Total Adults and Peds. (exclude observation beds) (see instructions)	536	20	87			7.
00 I NTENSI VE CARE UNI T						8.
00 CORONARY CARE UNIT						9.
. 00 BURN I NTENSI VE CARE UNI T . 00 SURGI CAL I NTENSI VE CARE UNI T						10. 11.
. 00 OTHER SPECIAL CARE (SPECIFY)						12.
. 00 NURSERY						13.
.00 Total (see instructions)	536	20	87	8 0.00	108.95	
.00 CAH visits	9, 269	1, 841	29, 28	5		15.
. 00 SUBPROVIDER - IPF						16.
. 00 SUBPROVIDER - IRF						17.
. 00 SUBPROVIDER						18
. 00 SKILLED NURSING FACILITY . 00 NURSING FACILITY						19. 20.
. OO OTHER LONG TERM CARE						20
. OO HOME HEALTH AGENCY						22
00 AMBULATORY SURGICAL CENTER (D. P.)						23
. 00 HOSPI CE						24.
.10 HOSPICE (non-distinct part)	0	0		0		24.
. OO CMHC - CMHC						25.
. 00 RURAL HEALTH CLINIC	0	0		0.00		
.25 FEDERALLY QUALIFIED HEALTH CENTER .00 Total (sum of lines 14-26)	0	0		0.00		
.00 Observation Bed Days		0	51		100. 75	27.
. 00 Ambulance Trips	0	0	01	, 		29.
.00 Employee discount days (see instruction)	J.			6		30.
.00 Employee discount days - IRF				D		31
.00 Labor & delivery days (see instructions)	О	0		0		32.
.01 Total ancillary labor & delivery room				D		32.
outpatient days (see instructions)						
.00 LTCH non-covered days	0					33

	Financial Systems	ST VINCENT				u of Form CMS-2	
HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014		pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0				1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	HMO and other (see instructions) HMO IPF Subprovider HMO IPF 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 CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NUMBER OF				29 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 24.00 24.10 25.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0.00	0	1.	12 18	215	13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0.00 0.00 0.00					26. 00 26. 25 27. 00 28. 00 30. 00 31. 00 32. 00 32. 01 33. 00

C: \28800-14 amended.mcrx

Heal th	Financial Systems ST VINCENT S	ALEM		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151314	Peri od:	Worksheet S-1	
				From 07/01/2013		
				To 06/30/2014		
					<u>3/18/2015 4:2</u>	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ine 202 colum	n 8)	0. 324319	1.00
	Medicaid (see instructions for each line)					
2.00		210, 209	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplementa	1 2	from Medicai	d?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments fro	om Medicaid			0	5.00
6.00	Medi cai d charges				8, 013, 798	6.00
7.00	Medicaid cost (line 1 times line 6)				2, 599, 027	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line 7 mir	nus sum of li	nes 2 and 5; if	2, 388, 818	8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruc	ctions for e	each line)			
9.00	Net revenue from stand-al one SCHIP				0	
	Stand-allone SCHIP charges				0	
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone SCHI	, (IIne II r	minus line 9;	IT < Zero then	0	12.00
	enter zero) Other state or local government indigent care program (see ins	tructions f	For each line	N		-
13.00	Net revenue from state or local indigent care program (Not indigent care pr				0	13.00
14.00	Charges for patients covered under state or local indigent car				0	1
14.00	10)	e program		TH THES U U	0	14.00
15.00	State or local indigent care program cost (line 1 times line)	14)			0	15.00
	Difference between net revenue and costs for state or local in		e program (li	ne 15 minus line	e 0	
101.00	13; if < zero then enter zero)	lar gonte oan e	o program (ri			
	Uncompensated care (see instructions for each line)				1	
17.00	Private grants, donations, or endowment income restricted to	Fundi ng char	rity care		0	17.00
18.00	Government grants, appropriations or transfers for support of	hospital op	perations		19, 494	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and loc	cal indigent	t care progra	ms (sum of lines	2, 388, 818	19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
20,00	Total initial obligation of patients approved for charity care	o (at full	1.00 3,775,92	<u>2.00</u> 8 4,915	3.00	20.00
20.00	charges excluding non-reimbursable cost centers) for the entit			8 4, 915	3, 780, 843	20.00
21.00	Cost of initial obligation of patients approved for charity ca		1, 224, 60	5 1, 594	1, 226, 199	21 00
21.00	times line 20)		1, 224, 00	1, 374	1,220,177	21.00
22.00	Partial payment by patients approved for charity care			0 0	0	22.00
	Cost of charity care (line 21 minus line 22)		1, 224, 60	5 1, 594	1, 226, 199	
			.,,	.,	.,===,	
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patien	nt days beyo	ond a length	of stay limit		24.00
	imposed on patients covered by Medicaid or other indigent care	e program?	-	-		
25.00	If line 24 is "yes," charges for patient days beyond an indig	gent care pr	rogram's leng	th of stay limit		
26.00						
27.00						
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (I				1, 063, 502	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	kpense (line	e 1 times lin	e 28)	344, 914	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 571, 113	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ıne 30)			3, 959, 931	31.00

CLASSI F	ICATION AND ADJUSTMENTS OF TRIAL BALANCE (ST VINCENT		CCN: 151314	Peri od:	u of Form CMS-: Worksheet A	
					From 07/01/2013		
					To 06/30/2014	Date/Time Pre 3/18/2015 4:2	
	Cost Center Description	Sal ari es	Other	Total (col.	1 Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
CEN	ERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	00 CAP REL COSTS-BLDG & FIXT		403, 539	403, 5	39 0	403, 539	1
	OO CAP REL COSTS-DEDG & TTXT		403, 339		0 0		
	00 OTHER CAP RELATED COST		0		0 0	0	
	00 EMPLOYEE BENEFITS DEPARTMENT	45 024	1, 822, 774		-		
	00 ADMINISTRATIVE & GENERAL	65, 026	2, 550, 310			1, 887, 800 3, 897, 410	
	OO OPERATION OF PLANT	1, 348, 422					
		156, 663	1, 455, 911				
	00 LAUNDRY & LINEN SERVICE	0	0		0 0	0	
	00 HOUSEKEEPI NG	0	244, 583			244, 583	
	DOO DI ETARY	0	299, 897				
			0		0 252, 320		
	NURSING ADMINISTRATION	1, 665	9, 213			10, 878	
	00 CENTRAL SERVICES & SUPPLY	139, 782	19, 049				
	OO PHARMACY	184, 004	55, 232				
	00 MEDICAL RECORDS & LIBRARY	269, 541	8, 442	277, 9	83 -7	277, 976	16
	ATIENT ROUTINE SERVICE COST CENTERS	,		1			-
	000 ADULTS & PEDIATRICS	733, 864	80, 906	814, 7	70 –20, 985	793, 785	30
	I LLARY SERVICE COST CENTERS			1		-	_
	OOO OPERATING ROOM	530, 170	499, 448				
	00 RADI OLOGY – DI AGNOSTI C	624, 600	360, 085			977, 332	54
00 058	BOO MAGNETIC RESONANCE IMAGING (MRI)	49, 650	200, 350	250, 0	-19	249, 981	58
	000 LABORATORY	0	1, 218, 175	1, 218, 1	75 0	1, 218, 175	60
00 061	00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0		0 0	0	61
00 065	00 RESPI RATORY THERAPY	231, 290	14, 203	245, 4	93 – 5, 929	239, 564	65
00 066	00 PHYSI CAL THERAPY	369, 780	17, 151	386, 9	31 -44, 292	342, 639	66
	OO OCCUPATI ONAL THERAPY	24, 023	86	24, 1	39, 561	63, 670	67
00 068	OO SPEECH PATHOLOGY	0	0		0 0	0	68
00 069	00 ELECTROCARDI OLOGY	110, 176	5, 662	115, 8	38 -1, 570	114, 268	69
00 070	00 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 826	8, 8	26 283, 084	291, 910	71
	OO IMPLANTABLE DEVICES CHARGED TO	0	122, 847			122, 847	72
	PATIENTS						
00 073	OO DRUGS CHARGED TO PATIENTS	0	236, 700	236, 7	0 00	236, 700	73
	OO RENAL DI ALYSI S	0	0		0 0	0	
	OO ASC (NON-DISTINCT PART)	0	0		0 0	0	75
	50 SLEEP DI SORDER	134, 670	71, 362	206, 0	32 -1, 528	204, 504	
	O1 ADULT MENTAL HEALTH	0	406, 968				
	97 CARDI AC REHABI LI TATI ON	73, 204	6, 942				
	PATIENT SERVICE COST CENTERS	10/201	07712	0071	10 127	,	1 ' '
	BOO RURAL HEALTH CLINIC	0	0		0 0	0	88
	00 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		
	00 CLINIC	0	0		0 0		
	OO EMERGENCY	644, 574	1, 013, 851				
	OO OBSERVATION BEDS (NON-DISTINCT PART)	044, 374	1,013,031	1,000,4		1,010,071	92
	CIAL PURPOSE COST CENTERS						1 12
. 00	SUBTOTALS (SUM OF LINES 1-117)	5, 691, 104	11, 132, 512	16, 823, 6	16 389	16, 824, 005	118
NON	REIMBURSABLE COST CENTERS					· · · · ·	
	OOO GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190
. 00 191	00 RESEARCH	0	0		0 0	0	191
. 00 192	00 PHYSICIANS' PRIVATE OFFICES	123, 207	4, 355	127, 5	62 - 380	127, 182	192
	OO NONPAID WORKERS	0	0		0 0	0	193
	01 MARKETING/ PUBLIC RELATIONS	57, 036	5, 058	62, 0	94 -7	62,087	
	02 NEW HORI ZON OP	13, 447	129			13, 574	
	TOTAL (SUM OF LINES 118-199)	5, 884, 794	11, 142, 054				

	nancial Systems			ovi dom	CCN. 1E1214		J OF Form CMS	
CLASSI F	ICATION AND ADJUSTMENTS OF TRIAL BALANCE	UF EXPENSES	PI	ovider	CCN: 151314	Period: From 07/01/2013	Worksheet A	
						To 06/30/2014		
	Cost Center Description	Adjustments	Net Exp	enses			3/18/2015 4	. <u>20 pi</u> i
		(See A-8)	Fo					
			Alloca					
		6.00	7.0					
	IERAL SERVICE COST CENTERS				1			
	100 CAP REL COSTS-BLDG & FIXT	0		03, 539				1.
	200 CAP REL COSTS-MVBLE EQUIP	0	D	0				2.
	300 OTHER CAP RELATED COST	0		0				3.
	400 EMPLOYEE BENEFITS DEPARTMENT	-52, 473	3 1,8	335, 327				4
	500 ADMINI STRATI VE & GENERAL	428, 430		825, 840				5
	700 OPERATION OF PLANT	-6, 294	1,6	06, 241				7
00 008	300 LAUNDRY & LINEN SERVICE	0	D	0				8
00 009	900 HOUSEKEEPI NG	0) 2	244, 583				9
00 010	DOO DI ETARY	0		47, 577				10
00 011	100 CAFETERI A	-62, 710) 1	89, 610				11
00 013	300 NURSI NG ADMI NI STRATI ON	0	D	10, 878				13
00 014	400 CENTRAL SERVICES & SUPPLY	0) 1	56, 792				14
00 015	500 PHARMACY	-67	/ 2	239, 046				15
00 016	500 MEDICAL RECORDS & LIBRARY	-5, 909	2	272,067				16
I NF	PATIENT ROUTINE SERVICE COST CENTERS							
00 030	DOO ADULTS & PEDIATRICS	-47,000) 7	46, 785				30
ANC	CILLARY SERVICE COST CENTERS		·					
00 050	DOO OPERATING ROOM	0	8 (8	34, 569				50
00 054	400 RADI OLOGY - DI AGNOSTI C	-177, 800) 7	99, 532				54
00 058	BOO MAGNETIC RESONANCE IMAGING (MRI)	0	2	49, 981				58
00 060	DOO LABORATORY	0	1,2	218, 175				60
00 061	100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0				61
	500 RESPI RATORY THERAPY	0	2	239, 564				65
00 066	500 PHYSI CAL THERAPY	0		342, 639				66
00 067	700 OCCUPATI ONAL THERAPY	0		63, 670				67
	BOO SPEECH PATHOLOGY	0		0				68
	POO ELECTROCARDI OLOGY	0	1 1	14, 268				69
	DOO ELECTROENCEPHALOGRAPHY	0		0				70
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2	91, 910				71
	200 IMPLANTABLE DEVICES CHARGED TO	0		22, 847				72
	PATIENTS			,				
00 073	BOO DRUGS CHARGED TO PATIENTS	0	2	236, 700				73
	400 RENAL DI ALYSI S	0		0				74
	500 ASC (NON-DISTINCT PART)	0		0				75
	950 SLEEP DI SORDER	-51, 600	1	52, 904				75
	501 ADULT MENTAL HEALTH	0		06, 930				75
	597 CARDI AC REHABI LI TATI ON	0		79, 717				76
	IPATI ENT SERVICE COST CENTERS				1			
	BOO RURAL HEALTH CLINIC	0		0				88
	POO FEDERALLY QUALIFIED HEALTH CENTER	0		0				89
	DOO CLINIC	0		0				90
	100 EMERGENCY	-150,000		166, 891				91
1	200 OBSERVATION BEDS (NON-DISTINCT PART)	,						92
	ECIAL PURPOSE COST CENTERS		1					1 ''
. 00	SUBTOTALS (SUM OF LINES 1-117)	-125, 423	3 16, 6	98, 582				118
	REIMBURSABLE COST CENTERS		1					
. 00 190	DOO GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0)	0				190
. 00 191	100 RESEARCH	0)	0				191
. 00 192	200 PHYSICIANS' PRIVATE OFFICES	0) 1	27, 182				192
. 00 193	300 NONPAID WORKERS	0		0				193
8. 01 193	301 MARKETING/ PUBLIC RELATIONS	74, 922	2 1	37,009				193
	302 NEW HORIZON OP	0)	13, 574				193
0. 00	TOTAL (SUM OF LINES 118-199)	-50, 501	1 4/ 0	76, 347	1			200

Heal th	Financial Systems		ST VINCENT	SALEM		In Lieu	u of Form CMS-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 151314	Peri od:	Worksheet A-6
						From 07/01/2013 To 06/30/2014	Date/Time Prepared:
						10 00/30/2014	3/18/2015 4:28 pm
		Increases					
	Cost Center	Line #	Sal ary	Other			
	2.00	3.00	4.00	5.00			
	A – CAFETERIA				1		
1.00	CAFETERI A		0	25 <u>2, 3</u> 20			1.00
	TOTALS		0	252, 320			
	B - BILLABLE MEDICAL SUPPLIES				1		
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	283, 084			1.00
2.00		0.00	0	0			2.00
3.00		0.00	0	0			3.00
5.00		0.00	0	0			5.00
6.00		0.00	0	0			6.00
7.00		0.00	0	0			7.00
8.00		0.00	0	0			8.00
9.00		0.00	0	0			9.00
10.00		0.00	0	0			10.00
11.00		0.00	0	0			11.00
12.00		0.00	0	0			12.00
13.00		0.00	0	0			13.00
14.00		0.00	0	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
20.00		0.00	0	0			20.00
21.00			0	0	-		21.00
	TOTALS		0	283, 084	I		
1 00	C - PT / OT	(7.00	24 077	0.504	1		1.00
1.00	OCCUPATI ONAL THERAPY	<u>67.</u> 00	<u>36,977</u>	<u>2,584</u>			1.00
	Grand Total: Increases		36, 977 36, 977	2, 584			500.00
500.00	Granu Total: Increases	I	30, 977	537, 988	1		500.00

C: \28800-14 amended.mcrx

Heal th	Fi nanci al	Systems				
RECLASSI FI CATI ONS						

ST VINCENT SALEM

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLASSIFICATIONS Provider CCN: 151314 Period: From 07/07/2013 To 06/30/2014 Worksheet A-6 Date/Time Prepared: 06/30/2014 Ocst Center Line # Salary Other Other Vest. A-7 Ref. Vest. A-7 Ref. Image: Comparison of the solary	Heal th	Financial Systems		ST VINCENT	SALEM		In Lieu	u of Form CMS	-2552-10
To 06/30/2014 Date/Time Prepared: 3/18/2015 A: 28 pm - Cost Center Line # Sal ary Other Wkst. A-7 Ref. 1.00 <t< td=""><td>RECLAS</td><td>SI FI CATI ONS</td><td></td><td></td><td>Provi der</td><td>CCN: 151314</td><td></td><td>Worksheet A-</td><td>-6</td></t<>	RECLAS	SI FI CATI ONS			Provi der	CCN: 151314		Worksheet A-	-6
Decreases Other Wkst. A-7 Ref. 6.00 7.00 8.00 9.00 10.00 DIETARY								Data/Tima Di	conarad
Decreases Other Wkst. A-7 Ref. 6.00 7.00 8.00 9.00 10.00 A - CAFETERIA - 0 252,320 0 B - BILLABLE MEDICAL SUPPLIES - 0 252,320 0 B - BILLABLE MEDICAL SUPPLIES - 0 0 252,320 0 1.00 Administrative & GENERAL 5.00 0 1,322 0 2.00 3.00 OPERATION OF PLANT 7.00 0 39 0 3.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 2.039 0 6.00 7.00 MAMACY 15.00 0 123 0 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 20,985 0 8.00 9.00 OPERATING ROM 55.00 0 7.333 0 10.00 10.00 RAGNETIC RESONANCE IMAGING 58.00 0 1,570 10 1.528 0 11.00 MACHTIC RESONANCE I							10 00/30/2014		
6.00 7.00 8.00 9.00 10.00 A - CAFETERIA			Decreases						
A CAFETERIA			Line #	Sal ary	Other	Wkst. A-7 Ref	· .		
1.00 DIETARY 10.00 0 252,320 0 1.00 B B B CABLE 0 0 252,320 1.00 2.00 ADMINISTRATIVE & GENERAL 5.00 0 1.322 0 2.00 3.00 OPERATION OF PLANT 7.00 0 39 0 3.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 2.039 0 6.00 7.00 MARMACY 15.00 0 123 0 6.00 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 2.0985 0 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 10.00 8.00 9.00 9.00 9.00 10.00 8.00 9.00 9.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 10.00 10.00 10.00 10.00			7.00	8.00	9.00	10.00			
TOTALS			i			1	-		_
B - BILLABLE MEDICAL SUPPLIES 1.00 0 0 0 0 0 2.00 3.00 OPERATION OF PLANT 7.00 0 3.00 3.00 3.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 2.039 0 3.00 6.00 PHARMACY 15.00 0 1.23 0 6.00 7.00 MEDICAL RECORDS & LIBRARY 16.00 0 7 0 8.00 8.00 ADULTS & PEDIATRICS 30.00 0 20.985 0 8.00 9.00 OPERATING ROOM 50.00 0 7.353 0 11.00 10.00 MADIEL RESONANCE I MAGING 58.00 0 19 0 11.00 11.00 MARNETI C RESONANCE I MAGING 58.00 0 1,570 0 12.00 11.00 MARDI CLOGY 69.00 0 1,570 0 14.00 15.00 SLEEP DI SORDER 75.01 0 1,528 0	1.00		<u>10.00</u>	0			0		1.00
1.00 0.00 0 0 0 0 1.00 2.00 ADMINISTRATIVE & GENERAL 5.00 0 1,322 0 3.00 3.00 OPERATION OF PLANT 7.00 0 39 0 5.00 2.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 2,039 0 5.00 6.00 PHARMACY 15.00 0 123 0 6.00 7.00 MEDICAL RECORDS & LIBRARY 16.00 0 7 0 8.00 9.00 OPERATINO ROM 50.00 0 19,649 0 9.00 9.00 10.00 RADIOLOGY - DI AGNOSTIC 54.00 0 7.353 0 10.00 1.00 10.00 RADIOLOGY - DI AGNOSTIC 54.00 0 1,570 0 11.00 13.00 11.00 MAGNETI C RESONANCE I MAGING 58.00 0 1,570 0 14.00 13.00 12.00 RESPI RATORY THERAPY 65.00 0 1,570 0 15.00 16.00 17.00 14.00 15.00 </td <td></td> <td></td> <td></td> <td>0</td> <td>252, 320</td> <td></td> <td></td> <td></td> <td></td>				0	252, 320				
2.00 ADMINISTRATIVE & GENERAL 5.00 0 1, 322 0 3.00 <td< td=""><td></td><td>B - BILLABLE MEDICAL SUPPLIES</td><td></td><td>-</td><td></td><td></td><td>-</td><td></td><td></td></td<>		B - BILLABLE MEDICAL SUPPLIES		-			-		
3.00 OPERATION OF PLANT 7.00 0 39 0 3.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 2.039 0 6.00 6.00 PHARMACY 15.00 0 123 0 6.00 7.00 MEDICAL RECORDS & LIBRARY 16.00 0 7 0 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 20.985 0 8.00 9.00 OPERATING ROOM 50.00 0 195.049 0 9.00 10.00 RADIOLOGY - DI AGNOSTIC 54.00 0 7,353 0 10.00 11.00 MAGNETIC RESONANCE I MAGING 58.00 0 19 0 11.00 (MRI)				0	-				
5.00 CENTRAL SERVICES & SUPPLY 14.00 0 2,039 0 5.00 6.00 PHARMACY 15.00 0 123 0 6.00 7.00 MEDICAL RECORDS & LIBRARY 16.00 0 7 0 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 20,985 0 8.00 9.00 OPERATING ROOM 50.00 0 195,049 0 9.00 10.00 RAGNETIC RESONANCE IMAGING 58.00 0 19 0 11.00 MGRNETIC RESONANCE IMAGING 58.00 0 19 0 11.00 11.00 MGNETIC RESONANCE IMAGING 55.00 0 5,929 0 12.00 13.00 PHYSICAL THERAPY 65.00 0 4,731 0 13.00 14.00 13.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 15.00 14.00 16.00 17.00 14.00 16.00 17.00 17.00 17.00 17.00 17.00 20.00 20.00 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td></td>				0			0		
6.00 PHARMACY 15.00 0 123 0 6.00 7.00 MEDI CAL RECORDS & LI BRARY 16.00 0 7 0 7.00 8.00 ADULTS & PEDI ATRICS 30.00 0 20,985 0 9.00 9.00 OPERATING ROOM 50.00 0 195,049 0 9.00 10.00 RADI OLOGY - DI AGNOSTI C 54.00 0 7,353 0 11.00 11.00 MAGNETI C RESONANCE IMAGING 58.00 0 19 0 11.00 0 RESPI RATORY THERAPY 65.00 0 5,929 0 12.00 13.00 PHYSI CAL THERAPY 66.00 0 4,731 0 13.00 14.00 ELECTROCARDI OLOGY 69.00 0 1,570 0 14.00 15.00 SLEEP DI SORDER 75.01 0 1,528 0 15.00 16.00 ADULT MENTAL HEALTH 75.03 0 38 0 16.00 17.00 CARDIAC REHABI LI TATI ON 76.97 0 429 0 17.00 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td>1</td>				0			0		1
7.00 MEDI CAL RECORDS & LI BRARY 16.00 0 7 0 7.00 8.00 ADULTS & PEDI ATRI CS 30.00 0 20,985 0 8.00 9.00 OPERATI NG ROOM 50.00 0 195,049 0 9.00 10.00 RADI OLOGY - DI AGNOSTI C 54.00 0 7,33 0 10.00 11.00 MAGNETI C RESONANCE I MAGI NG 58.00 0 19 0 11.00 (MR I)				0					
8.00 ADULTS & PEDIATRICS 30.00 0 20,985 0 8.00 9.00 OPERATING ROOM 50.00 0 195,049 0 9.00 10.00 RADIOLOGY - DIAGNOSTIC 54.00 0 7,353 0 10.00 11.00 MAGNETIC RESONANCE I MAGING 58.00 0 19 0 11.00 (MRI) 12.00 RESPIRATORY THERAPY 65.00 0 5,929 0 12.00 13.00 PHYSICAL THERAPY 66.00 0 4,731 0 13.00 14.00 ELECTROCARDIOLOGY 69.00 0 1,570 0 14.00 15.00 SLEEP DI SORDER 75.01 0 1,528 0 15.00 16.00 ADULT MENTAL HEALTH 75.03 0 38 0 16.00 17.00 CARDIAC REHABILITATION 76.97 0 429 0 18.00 19.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 380 0 19.00 20.00 MARKETING/ PUBLIC RELATIONS 193.01 0 7				0	123				
9.00 OPERATING ROOM 50.00 0 195,049 0 9.00 10.00 RADIOLOGY - DIAGNOSTIC 54.00 0 7,353 0 10.00 11.00 MAGNETIC RESONANCE IMAGING 58.00 0 19 0 11.00 12.00 RESPIRATORY THERAPY 65.00 0 5,929 0 12.00 13.00 PHYSICAL THERAPY 66.00 0 4,731 0 13.00 14.00 ELECTROCARDIOLOGY 69.00 0 1,570 0 14.00 15.00 ADULT MENTAL HEALTH 75.01 0 1,528 0 15.00 16.00 ADULT MENTAL HEALTH 75.03 0 38 0 16.00 17.00 CARDIAC REHABILITATION 76.97 0 429 0 17.00 18.00 EMERGENCY 91.00 0 380 0 19.00 19.00 MARKETING/ PUBLIC RELATIONS 193.01 0 7 0 20.00 20.00 MARKETING/ PUBLIC RELATIONS 193.02 0 283.084 20.00 <td></td> <td></td> <td></td> <td>0</td> <td>20,005</td> <td></td> <td>0</td> <td></td> <td></td>				0	20,005		0		
10.00 RADIOLOGY - DIAGNOSTIC 54.00 0 7,353 0 10.00 11.00 MAGNETIC RESONANCE IMAGING 58.00 0 19 0 11.00 12.00 RESPIRATORY THERAPY 65.00 0 5,929 0 12.00 13.00 PHYSICAL THERAPY 66.00 0 4,731 0 13.00 14.00 ELECTROCARDIOLOGY 69.00 0 1,570 0 14.00 15.00 SLEEP DISORDER 75.01 0 1,528 0 16.00 17.00 ADULT MENTAL HEALTH 75.03 0 38 0 17.00 18.00 EMERGENCY 91.00 0 41,534 0 18.00 19.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 380 0 19.00 20.00 MARKETING/ PUBLIC RELATIONS 193.01 0 7 0 20.00 21.00 21.00 TOTALS 0 28.084 0 21.00 21.00 21.00 10.01 TOTALS 0 2,584 0 <t< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td>0</td><td></td><td></td></t<>				0			0		
11.00 MAGNETIC RESONANCE IMAGING 58.00 0 19 0 11.00 12.00 RESPIRATORY THERAPY 65.00 0 5,929 0 12.00 13.00 PHYSI CAL THERAPY 66.00 0 4,731 0 13.00 14.00 ELECTROCARDI OLOGY 69.00 0 1,570 0 14.00 15.00 SLEEP DI SORDER 75.01 0 1,528 0 15.00 16.00 ADULT MENTAL HEALTH 75.03 0 38 0 16.00 17.00 CARDI AC REHABI LI TATI ON 76.97 0 429 0 17.00 18.00 EMERGENCY 91.00 0 41.534 0 18.00 19.00 PHYSI CI ANS' PRI VATE OFFICES 192.00 0 380 0 20.00 20.00 MARKETI NG/ PUBLIC RELATI ONS 193.01 0 7 0 20.00 20.00 21.00 TOTALS 0 283.084 0 10.00 21.00 21.00 100 PHYSICIAL THERAPY 66.00 36,977				0			0		
(MR1) (MR1) (MR1) (MR1) 12.00 RESPIRATORY THERAPY 65.00 0 5,929 0 12.00 13.00 PHYSI CAL THERAPY 66.00 0 4,731 0 13.00 14.00 ELECTROCARDIOLOGY 69.00 0 1,570 0 14.00 15.00 SLEEP DI SORDER 75.01 0 1,528 0 16.00 6.00 ADULT MENTAL HEALTH 75.03 0 38 0 16.00 17.00 CARDIAC REHABILITATION 76.97 0 429 0 17.00 18.00 EMERGENCY 91.00 0 41,534 0 19.00 19.00 PHYSI CI ANS' PRI VATE OFFI CES 192.00 0 380 0 19.00 20.00 MARKETI NG/ PUBLI C RELATI ONS 193.01 0 7 0 20.00 21.00 TOTALS 0 28.084 10.00 21.00 21.00 21.00 21.00 TOTALS				0					
13.00 PHYSI CAL THERAPY 66.00 0 4,731 0 13.00 14.00 ELECTROCARDIOLOGY 69.00 0 1,570 0 14.00 15.00 SLEEP DI SORDER 75.01 0 1,528 0 15.00 16.00 ADULT MENTAL HEALTH 75.03 0 38 0 16.00 17.00 CARDIAC REHABILITATION 76.97 0 429 0 17.00 18.00 18.00 18.00 EMERGENCY 91.00 0 41,534 0 18.00 19.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 21.00 20.00 21.00	11.00		58.00	0	19		0		11.00
14.00 ELECTROCARDIOLOGY 69.00 0 1,570 0 14.00 15.00 SLEEP DI SORDER 75.01 0 1,528 0 15.00 16.00 ADULT MENTAL HEALTH 75.03 0 38 0 16.00 17.00 CARDIAC REHABILITATION 76.97 0 429 0 17.00 18.00 EMERGENCY 91.00 0 41,534 0 18.00 19.00 PHYSI CI ANS' PRI VATE OFFICES 192.00 0 380 0 19.00 20.00 MARKETING/ PUBLIC RELATIONS 193.01 0 7 0 20.00 20.00 21.00 20.00 21.00 21.00 21.00 21.00 11.00 10.00 21.00	12.00	RESPI RATORY THERAPY	65.00	0	5, 929		0		12.00
15.00 SLEEP DI SORDER 75.01 0 1,528 0 15.00 16.00 ADULT MENTAL HEALTH 75.03 0 38 0 16.00 17.00 CARDI AC REHABI LI TATI ON 76.97 0 429 0 17.00 18.00 EMERGENCY 91.00 0 41,534 0 18.00 19.00 PHYSI CI ANS' PRI VATE OFFICES 192.00 0 380 0 19.00 20.00 MARKETI NG/ PUBLI C RELATI ONS 193.01 0 7 0 20.00 20.00 21.00 20.00 21.00 21.00 21.00 11.00 10 11.00 10 11.00	13.00	PHYSI CAL THERAPY	66.00	0	4, 731		0		13.00
16.00 ADULT MENTAL HEALTH 75.03 0 38 0 16.00 17.00 CARDI AC REHABILITATION 76.97 0 429 0 17.00 18.00 EMERGENCY 91.00 0 41,534 0 18.00 19.00 PHYSI CLANS' PRI VATE OFFICES 192.00 0 380 0 19.00 20.00 MARKETING/ PUBLIC RELATIONS 193.01 0 7 0 20.00 21.00 NEW HORIZON OP	14.00	ELECTROCARDI OLOGY	69.00	0	1, 570		0		14.00
17.00 CARDI AC REHABILITATION 76.97 0 429 0 17.00 18.00 EMERGENCY 91.00 0 41,534 0 18.00 19.00 PHYSI CLANS' PRI VATE OFFICES 192.00 0 380 0 19.00 20.00 MARKETI NG/ PUBLI C RELATI ONS 193.01 0 7 0 20.00 21.00 NEW HORI ZON OP 0 21.00 21.00 C - PT / OT 66.00 36, 977				0			0		
18.00 EMERGENCY 91.00 0 41,534 0 18.00 19.00 PHYSI CI ANS' PRI VATE OFFICES 192.00 0 380 0 19.00 20.00 MARKETI NG / PUBLI C RELATI ONS 193.01 0 7 0 20.00 21.00 NEW HORI ZON OP 193.02 0 22 0 21.00 C - PT / OT 0 283,084 0 10.00 10.00 10.00 1.00 PHYSI CAL THERAPY 66.00 36,977 2,584 0 1.00				0			0		
19.00 PHYSI CI ANS' PRI VATE OFFICES 192.00 0 380 0 19.00 20.00 MARKETI NG/ PUBLI C RELATI ONS 193.01 0 7 0 20.00 21.00 NEW HORI ZON OP 193.02 0 22 0 21.00 21.00 TOTALS 0 283,084 0 21.00 21.00 21.00 1.00 PHYSI CAL THERAPY				0			0		
20.00 MARKETI NG/ PUBLI C RELATI ONS 193.01 0 7 0 20.00 21.00 21.00 193.02 0 22 0 21.00				0			0		
21. 00 NEW HORI ZON OP 193. 02 0 2 0 2 0 21. 00 TOTALS 0 283, 084 0 283, 084 0 21. 00 21. 00 1. 00 PHYSI CAL THERAPY 66. 00 36, 977 2, 584 0 1. 00 1. 00 TOTALS 36, 977 2, 584 0 1. 00				0	380		0		
TOTALS 0 283, 084 C - PT / OT 0 283, 084 1. 00 PHYSI CAL THERAPY 66.00 36, 977 2, 584 0 TOTALS 36, 977 2, 584 0 1.00				0	7		0		
C - PT / OT C - PT / OT 1.00 PHYSICAL THERAPY 66.00 36,977 2,584 0 TOTALS 36,977 2,584 0 1.00	21.00		1 <u>93.</u> 02	0	2		Ō		21.00
1. 00 PHYSICAL THERAPY 66.00 36, 977 2, 584 0 1. 00 TOTALS 36, 977 2, 584 0 1. 00				0	283, 084				
TOTALS 36, 977 2, 584									
	1.00						Ō		1.00
500.00 [Grand Total: Decreases 36, 977] 537, 988] 500.00							_		
	500.00	Grand Total: Decreases		36, 977	537, 988	1			500. 00

C: \28800-14 amended. mcrx

Heal th	Financial Systems	ST VINCEN	T SALEM			In Lie	u of Form CMS-2	2552-10
RECONC	LIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151314	Fro To	iod: m 07/01/2013 06/30/2014		pared:
				Acquisition	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	0	0		0	0	0	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	159, 641	356, 756		0	356, 756	0	3.00
4.00	Building Improvements	856, 968	0		0	0	0	4.00
5.00	Fixed Equipment	503, 807	2		0	2	0	5.00
6.00	Movable Equipment	352, 406	83, 636		0	83, 636	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1, 872, 822	440, 394		0	440, 394	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	1, 872, 822	440, 394		0	440, 394	0	10.00
		Endi ng	Fully					
		Bal ance	Depreciated					
			Assets					
		6.00	7.00	1				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	0	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	516, 397	0					3.00
4.00	Building Improvements	856, 968	0					4.00
5.00	Fixed Equipment	503, 809	0					5.00
6.00	Movable Equipment	436, 042	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	2, 313, 216	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	2, 313, 216	0					10.00

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Heal th	Financial Systems	ST VINCEN	IT SALEM		In Lie	u of Form CMS-2	2552-10
RECONC	LLIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014		pared:
			SL	IMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	<u>WN 2, LINES 1 a</u>	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	389, 636		0 13, 903	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	389, 636		0 13, 903	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	Other	Total (1)				
		Capital-Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	403, 539				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	403, 539				3.00

C: \28800-14 amended.mcrx

Health Financial Systems	ST VINCEN	T SALEM		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 07/01/2013 Fo 06/30/2014		
	COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	<u>, pii</u>
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio (col. 1 -	instructions)		
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 CAP REL COSTS-BLDG & FIXT	2, 313, 216	0	2, 313, 216			1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(0. 000000		2.00
3.00 Total (sum of lines 1-2)	2, 313, 216		2, 313, 216			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5			
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1	i .			
1.00 CAP REL COSTS-BLDG & FIXT	0	0	0	0 0	389, 636	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	0 0	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(0 0	389, 636	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see	9 through 14)	
	11 00	12.00	12.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14.00	15.00	
1.00 CAP REL COSTS-BLDG & FIXT	ENTERS 0	13, 903			403, 539	1.00
2.00 CAP REL COSTS-BLDG & FIXT	0	13, 903			403, 539	2.00
3.00 Total (sum of lines 1-2)	0	13, 903			403, 539	2.00
3.00 protat (Sum OF FILES 1-2)	0	13, 903	1 (ן 0	403, 539	3.00

C: \28800-14 amended.mcrx

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

00021	MENIS IO EXPENSES			Provider CCN: 151314	Period: From 07/01/2013 To 06/30/2014		
			То	Expense Classification c /From Which the Amount i		3/18/2015 4:2	<u>8 pm</u>
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 <u>Ref.</u> 5.00	
. 00	Investment income - CAP REL	1.00		P REL COSTS-BLDG & FIXT	1.00	0	1.00
. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		OCA	P REL COSTS-MVBLE EQUIP	2.00	0	2.00
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other (chapter 2)		О		0.00	0	3.00
00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
00	Tel ephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
00	Tel evision and radio service (chapter 21)		0		0.00	0	8.00
00 . 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -425, 541		0.00	0 0	9.00 10.00
. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
. 00	Related organization transactions (chapter 10)	A-8-1	1, 208, 039			0	12.00
	Laundry and linen service		0		0.00	0	
. 00	Cafeteria-employees and guests Rental of quarters to employee and others	В	-62, 710 CA 0	FETERI A	11. 00 0. 00	0 0	
. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
. 00	patients Sale of drugs to other than patients		О		0.00	0	17.00
. 00	Sale of medical records and abstracts	В	-20, 939ME	DI CAL RECORDS & LI BRARY	16.00	0	18.00
. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
	Vending machines Income from imposition of		0		0.00 0.00	0	
	interest, finance or penalty charges (chapter 21)						
. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	ORE	SPI RATORY THERAPY	65.00		23.00
I. 00	limitation (chapter 14) Adjustment for physical	A-8-3	OPH	YSICAL THERAPY	66.00		24.00
. 00	therapy costs in excess of limitation (chapter 14) Utilization review -		0 * *	* Cost Center Deleted **	* 114.00		25.00
00	physicians' compensation (chapter 21)				1.00	0	
	Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL			P REL COSTS-BLDG & FIXT P REL COSTS-MVBLE EQUIP	1.00 2.00	0	
	COSTS-MVBLE EQUIP Non-physician Anesthetist			* Cost Center Deleted **		0	28.00
. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	CUPATI ONAL THERAPY	0.00	0	
	therapy costs in excess of limitation (chapter 14)						
	Hospice (non-distinct) (see instructions)			ULTS & PEDIATRICS	30.00		30.99
. 00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0 SP	EECH PATHOLOGY	68.00		31.00

Heal th	Financial Systems		ST VINCEN	IT SALEM	In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 07/01/2013			
					To 06/30/2014	Date/Time Pre 3/18/2015 4:2		
				Expense Classification or	Worksheet A	5/10/2013 4.2		
				To/From Which the Amount is				
					··· ··· ··· j ··· · ···			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7		
		(2)				Ref.		
		1.00	2.00	3.00	4.00	5.00		
32.00	CAH HIT Adjustment for		0		0.00	0	32.00	
	Depreciation and Interest							
	OTHER REVENUE - PHARMACY	A		PHARMACY	15.00	0		
33.01	OTHER REVENUE - ADMINISTRATION	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.01	
33.02	ASSOCIATION DUES LOBBYING	A	-603	ADMI NI STRATI VE & GENERAL	5.00	0	33.02	
	EXPENSE	P	050		54.00	0		
33.03	OTHER REVENUE - RADI OLOGY	В		RADIOLOGY - DIAGNOSTIC	54.00	0	00.00	
	MED RECORDS FOR SPN	A		MEDI CAL RECORDS & LI BRARY	16.00	0	33.04	
33.05	PROFFESIONAL COMP. BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN		0	33.05	
33.06	PROVIDER TAX	A		ADMINISTRATIVE & GENERAL	5.00	0	33.06	
33.07	CABLE TV	A		OPERATION OF PLANT	7.00	0	00.07	
33.08	BI OTERRI SM GRANT	B		ADMI NI STRATI VE & GENERAL	5.00	0	33.08	
33.09	QUALITY REVIEW GRANT	В		ADMINISTRATIVE & GENERAL	5.00	0	33.09	
50.00	TOTAL (sum of lines 1 thru 49)		-50, 501				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).

(2) basis of adjustment (see first decrist).
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.

C: \28800-14 amended. mcrx

Heal th	Financial Systems	ST VINCE	ENT SALEM	In Lie	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 151314	Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 07/01/2013 To 06/30/2014		
	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 ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	0	66, 427	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1, 981, 942	798, 128	2.00
3.00	193.01	MARKETING/ PUBLIC RELATIONS	HOME OFFICE	74, 922	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSI ON CHARGEBACKS	158, 197	158, 197	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACKS	706, 639	706, 639	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	ASCENSI ON CHARGEBACKS	143, 599	143, 599	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	ASCENSI ON CHARGEBACKS	59, 124	59, 124	4.03
4.04			ASCENSI ON CHARGEBACKS	11, 256		4.04
4.05		EMPLOYEE BENEFITS DEPARTMENT		948, 866		4.05
4.06			ASCENSION - TRIMEDX	522, 866	526, 260	4.06
4.07		EMPLOYEE BENEFITS DEPARTMENT	ASCENSION - PENSION	240, 173	221, 551	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
5.00	0		0	4, 847, 584	3, 639, 545	5.00

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

nas not	been posted to worksneet A,	corumns r and/or 2,	the amount allowable si	nould be indicated in co	umn 4 or this part.					
				Rel ated Organi zati on(s)	and/or Home Office					
				5 ()						
	Symbol (1)	Name	Percentage of	Name	Percentage of					
	- · · ·		Ownershi p		Ownership					
	1.00	2.00	3.00	4.00	5.00					
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:										

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

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

rerinbur	Schone under trette Avritt.					
6.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	6.00
7.00	G	ST VINCENT HEAL	100.00	ST VINCENT HEAL	100.00	7.00
8.00	G	CATHOLIC HEALTH	100.00	CATHOLIC HEALTH	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 SALEM		In Lieu	of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED	ORGANIZATIONS AND HOME Pro	ovider CCN: 151314 Per	ri od:	Worksheet A-8-1
OFFICE COSTS			om 07/01/2013	

UTTUE	00010						То	06/30/2014	Date/Time 3/18/2015	Pre 4:2	pared: 8 pm
	Net	Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6.00	7.00									
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RES	ULT OF TRANS	ACTIONS WIT	TH RELATED (ORGAN	VIZATIONS OR	CLAIMED HO	DME	
	OFFICE COSTS:										
1.00	-66, 427										1.00
2.00	1, 183, 814	. 9									2.00
3.00	74, 922	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	502	0									4.05
4.06	-3, 394	0								1	4.06
4.07	18, 622	0								1	4.07
4.08	0	0								1	4.08
4.09	0	0								1	4.09
4.10	0	0								1	4.10
4.11	0	0								1	4.11
4.12	0	0								1	4.12
4.13	0	0								1	4.13
5.00	1, 208, 039										5.00
-						1.	1 . 1				

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 no	t been posted to Worksheet A,	columns 1 and/or 2	the amount	allowable should be	i ndi cated	in column 4	of this	part.
	Related Organization(s)							
	and/or Home Office							
	Type of Business	-						1
	51							
	6.00	1						
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S)	AND/OR HOME	OFFICE:				

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

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

i ei iibui	Sement under titte AVIII.	
6.00	HOME OFFICE	6.00
7.00	HOME OFFICE	7.00
8.00	HOME OFFICE	8.00
9.00	TECHNOLOGY MGMT	9.00
10.00		10.00
100.00		100.00
(1) 110	the following combole to in	diasta internalationahin ta nalatad anganizationa.

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Health Financial Systems			ST VINCENT SALEM			In Lieu of Form CMS-2552-10			
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der		Peri od:	Worksheet A-8	3-2	
						From 07/01/2013 To 06/30/2014		narod	
						10 00/30/2014	3/18/2015 4:2		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov		
		I denti fi er	Remuneration	Component	Component		ider Component		
							Hours		
	1.00	2.00	3.00	4.00	5.00	6.00	7.00		
1.00		EMERGENCY	899, 230				0	1.00	
2.00		ADULTS & PEDIATRICS	47,000			-	0	2.00	
3.00		OPERATING ROOM	31, 500				0	3.00	
4.00		RADIOLOGY - DIAGNOSTIC	191, 637				0	4.00 5.00	
5.00 6.00	0.00	SLEEP DI SORDER	51, 600	51,600		-	0	5.00 6.00	
8.00 7.00	0.00			-			0	8.00 7.00	
7.00 8.00	0.00				· · · · · · · · · · · · · · · · · · ·		0	8.00	
9.00	0.00		0		·		0	9.00	
10.00	0.00		0				0	10.00	
200.00	0.00		1, 220, 967	425, 541	·	° .	0	200.00	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00	
	WRSt. A LINC #	I denti fi er			Memberships &		of Malpractice		
		r dentr r er	Erini c	Limit	Continuing	Share of col.	Insurance		
					Education	12			
	1.00	2.00	8.00	9.00	12.00	13.00	14.00		
1.00	91.00	EMERGENCY	0	C		0 0	0	1.00	
2.00	30.00	ADULTS & PEDIATRICS	0	c) (0 0	0	2.00	
3.00	50.00	OPERATING ROOM	0	C) (0 0	0	3.00	
4.00		RADIOLOGY – DIAGNOSTIC	0	C) (0 0	0	4.00	
5.00	75.01	SLEEP DI SORDER	0	C) (0 0	0	5.00	
6.00	0.00		0	C) (0 0	0	6.00	
7.00	0.00		0	C) (0 0	0	7.00	
8.00	0.00		0	C) (0 0	0	8.00	
9.00	0.00		0	C) (0 0	0	9.00	
10.00	0.00		0	C) (0 0	0	10.00	
200.00			0	C) (,	0	200.00	
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment			
		I denti fi er	Component	Limit	Di sal I owance				
			Share of col. 14						
	1.00	2.00	15.00	16.00	17.00	18.00			
1.00		EMERGENCY	0					1.00	
2.00		ADULTS & PEDIATRICS	0					2.00	
3.00		OPERATI NG ROOM	0					3.00	
4.00		RADIOLOGY - DIAGNOSTIC	0		· · · · · · · · · · · · · · · · · · ·	-		4.00	
5.00		SLEEP DI SORDER	0	-				5.00	
6.00	0.00		0					6.00	
7.00	0.00		0			ol o		7.00	
8.00	0.00		0			o o		8.00	
9.00	0.00		0			ol o		9.00	
10.00	0.00		0	c) (0 0		10.00	
200.00			0	C) (425, 541		200.00	

Health Financial Systems	ST VINCEN	T SALEM		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			F	Period: From 07/01/2013 Fo 06/30/2014	Worksheet B Part I	pared:
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS	402 520	402 520	1	1		1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP	403, 539	403, 539	C			1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 835, 327	4, 796				4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	4, 325, 840	45, 296	c	426, 351	4, 797, 487	5.00
7.00 00700 OPERATION OF PLANT	1, 606, 241	56, 090			1, 711, 865	7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE	0		-		0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	244, 583 47, 577	12, 619 40, 358			257, 202 87, 935	9.00 10.00
11. 00 01100 CAFETERI A	189, 610		-	0	189, 610	
13.00 01300 NURSING ADMINISTRATION	10, 878	1, 571	0	526	12, 975	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	156, 792	0	0	44, 197	200, 989	14.00
15. 00 01500 PHARMACY	239, 046				301, 275	1
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	272,067	19, 199	(85, 225	376, 491	16.00
30. 00 03000 ADULTS & PEDIATRICS	746, 785	45, 836		232, 037	1, 024, 658	30.00
ANCILLARY SERVICE COST CENTERS	,			,	.,,	
50.00 05000 OPERATING ROOM	834, 569	44, 437	0	167, 632	1, 046, 638	50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C	799, 532				1, 019, 491	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	249, 981	5,076			270, 756	58.00
60.00 06000 LABORATORY 61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	1, 218, 175	7,627	C	0 0	1, 225, 802 0	60.00 61.00
65. 00 06500 RESPIRATORY THERAPY	239, 564	4, 389		73, 130	317,083	
66.00 06600 PHYSI CAL THERAPY	342, 639				457, 281	66.00
67.00 06700 OCCUPATI ONAL THERAPY	63, 670	1, 793			84, 750	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0		0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	114, 268	11, 501 0		34,836	160, 605 0	69.00 70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	291, 910			-	291, 910	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	122, 847	0		-	122, 847	72.00
PATIENTS						
73. 00 07300 DRUGS CHARGED TO PATIENTS	236, 700		-	-	236, 700	1
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0	0	-		0	74.00 75.00
75. 01 03950 SLEEP DI SORDER	152, 904	-	-	-	207, 141	
75. 03 07501 ADULT MENTAL HEALTH	406, 930				415, 918	1
76. 97 07697 CARDI AC REHABI LI TATI ON	79, 717	5, 407	() (23, 146	108, 270	76.97
OUTPATIENT SERVICE COST CENTERS		-	-			
88.00 08800 RURAL HEALTH CLINIC	0			-		88.00
89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 90. 00 09000 CLINIC	0	0			0	89.00 90.00
91. 00 09100 EMERGENCY	1, 466, 891	18, 487			1, 689, 183	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS	-	-	1	-		
118.00 SUBTOTALS (SUM OF LINES 1-117)	16, 698, 582	381, 061		1, 778, 881	16, 614, 862	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		0	190.00
191. 00 19100 RESEARCH	0					190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	127, 182	-		-	185, 940	
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
193. 01 19301 MARKETING/ PUBLIC RELATIONS	137,009		0	18, 034	155, 043	1
193. 02 19302 NEW HORIZON OP	13, 574	2, 676		4, 252		193.02
200.00Cross Foot Adjustments201.00Negative Cost Centers		n	C	0		200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	16, 976, 347	403, 539			16, 976, 347	
						•

Health Fi	inancial Systems	ST VINCEN	IT SALEM		In Lie	u of Form CMS-:	2552-10
COST ALL	OCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151314	Period: From 07/01/2013	Worksheet B Part I	
					To 06/30/2014	Date/Time Pre	pared:
						3/18/2015 4:2	8 pm
	Cost Center Description	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
GE	ENERAL SERVICE COST CENTERS						
1.00 00	0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00	D200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0500 ADMI NI STRATI VE & GENERAL	4, 797, 487					5.00
	0700 OPERATION OF PLANT	674, 338					7.00
	D800 LAUNDRY & LINEN SERVICE	0	-		0		8.00
	0900 HOUSEKEEPI NG	101, 317			0 459, 784	444 425	9.00
	1000 DI ETARY	34, 639			0 0	446, 435	•
	1100 CAFETERIA 1300 NURSING ADMINISTRATION	74, 691 5, 111			0 4, 894	0	11.00
	1400 CENTRAL SERVICES & SUPPLY	79, 173			0 3, 181	0	14.00
	1500 PHARMACY	118, 678			0 3, 181	0	15.00
	1600 MEDICAL RECORDS & LIBRARY	148, 307			0 5,628	0	•
	NPATIENT ROUTINE SERVICE COST CENTERS	140, 307	134,000	1	0 3,020	0	10.00
	3000 ADULTS & PEDIATRICS	403, 632	367, 820		0 117, 209	446, 435	30.00
	VCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	412, 291	356, 596		0 111, 581	0	50.00
54.00 05	5400 RADIOLOGY - DIAGNOSTIC	401, 597	180, 315		0 21, 533	0	54.00
58.00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)	106, 656	40, 735		0 0	0	58.00
60.00 06	6000 LABORATORY	482, 867	61, 203		0 19, 576	0	60.00
	6100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
	6500 RESPI RATORY THERAPY	124, 905			0 0	0	65.00
	6600 PHYSI CAL THERAPY	180, 132			0 13, 214	0	66.00
	6700 OCCUPATI ONAL THERAPY	33, 385	14, 385		0 0	0	67.00
	6800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
	6900 ELECTROCARDI OLOGY	63, 265			0 11, 990	0	69.00
1	7000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	114, 989			0 0	0	71.00
72.00 07	7200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	48, 392	0		0 0	0	72.00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	93, 241	0		0 5, 628	0	73.00
	7300 RENAL DIALYSIS	93, 241			0 5, 628	0	74.00
	7500 ASC (NON-DISTINCT PART)		-		0 0	0	75.00
	3950 SLEEP DI SORDER	81, 597	-		0 15, 171	0	75.00
	7501 ADULT MENTAL HEALTH	163, 838			0 16, 639	0	
	7697 CARDI AC REHABI LI TATI ON	42, 650			0 10, 767	0	•
	JTPATIENT SERVICE COST CENTERS	12,000	10,070		10,707		
88.00 08	8800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90.00 09	9000 CLINIC	0	0		0 0	0	90.00
91.00 09	9100 EMERGENCY	665, 401	148, 352		0 90, 293	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SF	PECIAL PURPOSE COST CENTERS	1	1	1			
118.00	SUBTOTALS (SUM OF LINES 1-117)	4, 655, 092	2, 205, 822		0 447, 304	446, 435	118.00
	ONREI MBURSABLE COST CENTERS	-	-	1		-	
	9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0			0 1, 958		190.00
	9100 RESEARCH 9200 PHYSI CLANS' PRI VATE OFFI CES	72 245	-		0 0 700		191.00
	9200 PHYSICIANS' PRIVATE OFFICES 9300 NONPALD WORKERS	73, 245	158, 905		0 9, 788		192.00 193.00
	9300 NONPALD WORKERS 9301 MARKETING/ PUBLIC RELATIONS	41 074			0 0		193.00
	9301 MARKETING/ PUBLIC RELATIONS 9302 NEW HORIZON OP	61, 074 8, 076			0 734		193.01
200.00	Cross Foot Adjustments	0,070	21,470		/ 34		200.00
200.00	Negative Cost Centers		0		0 0		200.00
201.00	TOTAL (sum lines 118-201)	4, 797, 487	2, 386, 203		0 459, 784		
202.00	101AE (3011 11103 110-201)	-, / 7 / , 407	1 2, 500, 205	I	437,704	440, 433	1202.00

AAAT A	Financial Systems	ST VINCEN	II SALEM		In Lieu	i of Form CMS-2	2552-10
COSTA	LLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 07/01/2013	Worksheet B Part I	
					To 06/30/2014	Date/Time Pre	epared:
	Cost Costos Deseriation			CENTRAL	DUADMACY	3/18/2015 4:2	28 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	SERVICES &	PHARMACY	MEDICAL RECORDS &	
			N	SUPPLY		LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	1	I I		1 1		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00		269, 195					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	66		202 71			13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	9, 376 6, 767		292, 71 2			14.00
	01600 MEDICAL RECORDS & LIBRARY	25, 944	-		2 0	710, 438	1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	20,711		·		710, 100	10.00
30.00	03000 ADULTS & PEDIATRICS	46, 363	4, 162	4, 64	3 0	89, 866	30.00
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	27, 954		43, 15		127, 310	
54.00	05400 RADI OLOGY - DI AGNOSTI C	38, 478		1, 62		74, 888	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 698			4 0 0 0	0	
60.00 61.00	06000 LABORATORY 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	1, 619		0	0	60.00 61.00
65.00	06500 RESPIRATORY THERAPY	15, 766	1, 850	1, 31	2 0	0	1
66.00	06600 PHYSI CAL THERAPY	18, 300		1, 04		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 035			0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	7, 842		34		0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	-		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-	162, 46		0	
72.00	07200 I MPLANTABLE DEVI CES CHARGED TO PATI ENTS	0	0	68, 37	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 006		0 459, 247	0	73.00
74.00	07400 RENAL DI ALYSI S	0			0 0	0	
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75.01	03950 SLEEP DI SORDER	9, 999	0	33	8 0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	0	-		8 0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	5, 010	694	9	5 0	0	76.97
88.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
90.00	09000 CLINIC	0	0		0 0	0	
91.00	09100 EMERGENCY	39, 186	4, 625	9, 19	0 0	281, 578	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		256, 784	27, 750	292, 63	2 459, 247	573, 642	118.00
100.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	ol		0 0	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0			0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	7, 962	-	8		136, 796	
	19300 NONPALD WORKERS	0	0	0	0 0		193.00
	19301 MARKETING/ PUBLIC RELATIONS	3, 339	0	:	2 0		193.01
193.01	19302 NEW HORIZON OP	1, 110	0		1 0	0	193.02
193.02		1, 110					
193.02 200.00	Cross Foot Adjustments						200.00
193.02	Cross Foot Adjustments Negative Cost Centers	0 269, 195	0	292, 71	0 0 9 459, 247		201.00

	ancial Systems	ST VINCEN	T SALEM		In Lieu of Form C	MS-2552-1
COST ALLOC	CATION - GENERAL SERVICE COSTS		Provi der	CCN: 151314	Period: Worksheet From 07/01/2013 Part I	В
					To 06/30/2014 Date/Time	Prepared:
					3/18/2015	4:28 pm
	Cost Center Description	Subtotal	Intern &	Total		
			Residents			
			Cost & Post Stepdown			
			Adjustments			
		24.00	25.00	26.00		
GEN	ERAL SERVICE COST CENTERS	21.00	20.00	20.00		
	00 CAP REL COSTS-BLDG & FIXT					1.00
	00 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 0040	00 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 0050	00 ADMINISTRATIVE & GENERAL					5.00
7.00 0070	OO OPERATION OF PLANT					7.00
8.00 0080	00 LAUNDRY & LINEN SERVICE					8.00
9.00 0090	00 HOUSEKEEPI NG					9.00
10.00 010	00 DI ETARY					10.00
11.00 0110	00 CAFETERI A					11.00
13.00 0130	OO NURSING ADMINISTRATION					13.00
	00 CENTRAL SERVICES & SUPPLY					14.00
	00 PHARMACY					15.00
	00 MEDICAL RECORDS & LIBRARY					16.00
	ATLENT ROUTINE SERVICE COST CENTERS					
	00 ADULTS & PEDIATRICS	2, 504, 788	C	2, 504,	788	30. 00
	I LLARY SERVICE COST CENTERS			-		
	OO OPERATING ROOM	2, 130, 155	C			50.00
	00 RADI OLOGY - DI AGNOSTI C	1, 741, 629	C			54.00
	OO MAGNETIC RESONANCE IMAGING (MRI)	420, 849	C			58.00
	00 LABORATORY	1, 791, 067	C	1, 791,		60.00
	00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0			0	61.00
	00 RESPI RATORY THERAPY	496, 139	C			65.00
	00 PHYSI CAL THERAPY	748, 534	C			66.00
	00 OCCUPATI ONAL THERAPY	135, 555	C			67.00
	00 SPEECH PATHOLOGY	0	0		0	68.00
		336, 803		336,		69.00
		U 5 (0, 2) (2	0		0	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	569, 362	(569,		71.00
72.00 0720	00 I MPLANTABLE DEVICES CHARGED TO PATIENTS	239, 609	C	239,	609	72.00
73.00 0730	00 DRUGS CHARGED TO PATIENTS	797, 822	C	797,	022	73.00
	00 RENAL DIALYSIS	0		/ / / /	0	74.00
	00 ASC (NON-DISTINCT PART)	0			0	75.00
	50 SLEEP DI SORDER	407, 781	C	407,		75.00
	01 ADULT MENTAL HEALTH	668, 529	C			75.03
	97 CARDI AC REHABI LI TATI ON	210, 876	C			76.97
	PATIENT SERVICE COST CENTERS	210,070		210,	0/0	- /0. //
	OO RURAL HEALTH CLINIC	0	C	b	0	88.00
	00 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0	89.00
90.00 0900		0	(0	90.00
	00 EMERGENCY	2, 927, 808	C		808	91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART)	2, 727, 000	C			92.00
	CIAL PURPOSE COST CENTERS			<u> </u>		/2.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	16, 127, 306	C	16, 127,	306	118.00
	REIMBURSABLE COST CENTERS	10/12//000		10/12/1		
	00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1, 958) 1	958	190.00
	00 RESEARCH	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	C		0	191.00
190.001900		575, 726	ſ	575,	-	192.00
190.00190 191.00191	OOLPHYSECLANS' PREVATE OFFICES	0.0,.20		5.0,	0	193.00
190.001900 191.001910 192.001920	00 PHYSICIANS' PRIVATE OFFICES 00 NONPAID WORKERS	0	(
190. 00 1900 191. 00 1910 192. 00 1920 193. 00 1930	00 NONPAID WORKERS	0 219, 458	(219.	458	
190. 00 1900 191. 00 1910 192. 00 1920 193. 00 1930 193. 01 1930	00 NONPAID WORKERS 01 MARKETING/ PUBLIC RELATIONS	0 219, 458 51, 899	C C	219, 51,		193.01
190. 00 1900 191. 00 1910 192. 00 1920 193. 00 1930 193. 01 1930 193. 02 1930	OO NONPAID WORKERS 01 MARKETING/ PUBLIC RELATIONS 02 NEW HORIZON OP	0 219, 458 51, 899 0			458 899 0	193. 01 193. 02
190. 00 1900 191. 00 1910 192. 00 1920 193. 00 1930 193. 01 1930 193. 02 1930 200. 00	00 NONPALD WORKERS 01 MARKETING/ PUBLIC RELATIONS 02 NEW HORIZON OP Cross Foot Adjustments) 51,	899	193.01
190. 00 1900 191. 00 1910 192. 00 1920 193. 00 1930 193. 01 1930 193. 02 1930	OO NONPAID WORKERS 01 MARKETING/ PUBLIC RELATIONS 02 NEW HORIZON OP			51, 51,	899 0 0	193. 193. 200.

Heal th	Financial Systems	ST VINCEN	T SALEM		In Lie	u of Form CMS-:	2552-10
ALLOC	TTION OF CAPITAL RELATED COSTS		Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014		epared:
			CAPI TAL REL	ATED COSTS		37 107 2013 4.2	
	Cost Center Description	Directly Assigned New Capital <u>Related Costs</u>	BLDG & FIXT	MVBLE EQUIP		EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	481	4, 796		0 5, 277	5, 277	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	739, 554	45, 296		0 784, 850	1, 220	5.00
7.00	00700 OPERATION OF PLANT	391, 723	56, 090		0 447, 813	142	1
8.00	00800 LAUNDRY & LI NEN SERVI CE	0	0		0 0	0	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0 1, 100	12, 619		0 12, 619 0 41, 458	0	
10.00	01100 CAFETERI A	1, 100	40, 358 0		0 41, 458 0 0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 712	1, 571		0 6, 283	2	1
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 591	0		0 1, 591	127	1
15.00	01500 PHARMACY	44, 281	4,050		0 48, 331	167	1
	01600 MEDICAL RECORDS & LIBRARY	4, 405	19, 199		0 23, 604	244	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	14, 117	45, 836		0 59, 953	666	30.00
50.00	ANCI LLARY SERVICE COST CENTERS	55 004	44 407		0 00 774	101	1 50 00
50.00	05000 OPERATI NG ROOM 05400 RADI OLOGY - DI AGNOSTI C	55, 334	44, 437		0 99, 771 0 36, 413	481	1
54.00 58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	13, 943 200, 323	22, 470 5, 076		0 36, 413 0 205, 399	567 45	1
60.00	06000 LABORATORY	1, 867	7,627		0 203, 344	45	1
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	1,007	1,021		0	0	61.00
65.00	06500 RESPIRATORY THERAPY	4, 451	4, 389		0 8, 840	210	1
66.00	06600 PHYSI CAL THERAPY	1, 182	9, 415		0 10, 597	302	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 793		0 1, 793	55	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	4, 803	11, 501		0 16, 304	100	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	1
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	1
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75.01	03950 SLEEP DI SORDER	7, 917	11, 656		0 19, 573	122	75.01
75.03	07501 ADULT MENTAL HEALTH	0	8, 988		0 8, 988	0	75.03
76.97	07697 CARDI AC REHABI LI TATI ON	481	5, 407		0 5,888	66	76.97
00.00	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	1
	09000 CLINIC	0	0		0 0	0	
91.00		3, 986	18, 487		0 22, 473		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,700	10, 10,		0		92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		1, 496, 251	381, 061		0 1, 877, 312	5, 101	118.00
	NONREI MBURSABLE COST CENTERS	1		1	- 1		
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190.00
		0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	962	19, 802		0 20, 764		192.00
	19300 NUNPALD WORKERS	1, 591	0		0 1, 591		193.00 193.01
	19302 NEW HORIZON OP	1, 371	2,676		0 2,676		193.01
200.00			2,070		2,070	12	200.00
201.00			0		0 0	0	201.00
202.00		1, 498, 804	403, 539		0 1, 902, 343		202.00

	Financial Systems	ST VINCEN				u of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der		Period: From 07/01/2013 To 06/30/2014		pared:
	Cost Center Description	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	786, 070					5.00
7.00	00700 OPERATION OF PLANT	110, 488	558, 443				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0		8.00
9.00	00900 HOUSEKEEPI NG	16, 601	23, 699		0 52, 919		9.00
10.00	01000 DI ETARY	5, 676			0 0	122, 927	10.00
11.00	01100 CAFETERI A	12, 238			0 563	0	
13.00	01300 NURSING ADMINISTRATION	837	2, 950		0 0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 973			0 366	0	14.00
15.00	01500 PHARMACY	19, 445			0 0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	24, 300	36, 056		0 648	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	((10)	0/ 001		0 10 101	100.007	1 00 00
30.00	03000 ADULTS & PEDIATRICS	66, 136	86, 081		0 13, 491	122, 927	30.00
F0 00	ANCI LLARY SERVICE COST CENTERS		02.454	1	0 10.040	0	
50.00	05000 OPERATING ROOM	67, 554			0 12, 843	0	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	65, 802			0 2, 478	0	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	17, 476			0 0	0	58.00
60.00	06000 LABORATORY	79, 118	14, 323		0 2, 253	0	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	20 444	0 242		0	0	61.00
65.00		20, 466			0 0 0 1.521	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	29, 515 5, 470			0 1,521 0 0	0	66.00 67.00
		5,470			0 0	-	68.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0			0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	10, 366	21, 599		0 1, 380 0 0	0	70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 841			0 0	0	71.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO PATTENTS	7, 929	-		0 0	0	72.00
72.00	PATIENTS	1,727	0		0	0	12.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15, 278	0		0 648	0	73.00
74.00	07400 RENAL DIALYSIS	0			0 0	0	74.00
75.00	07500 ASC (NON-DI STINCT PART)	0	0		0 0	0	75.00
75.01	03950 SLEEP DI SORDER	13, 370	-		0 1,746	0	75.01
75.03	07501 ADULT MENTAL HEALTH	26, 845			0 1, 915	0	75.03
	07697 CARDI AC REHABI LI TATI ON	6, 988			0 1, 239	0	
	OUTPATIENT SERVICE COST CENTERS	0,700	10,100		1,20,		
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	109, 027	34, 719		0 10, 392	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					-	92.00
	SPECIAL PURPOSE COST CENTERS	1	1	1			
118.00		762, 739	516, 228		0 51, 483	122, 927	1118.00
	NONREI MBURSABLE COST CENTERS	· · · ·		•			
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 225	0	190.00
191.00	19100 RESEARCH	0	0		0 0		191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	12,001	37, 189		0 1, 127		192.00
	19300 NONPAI D WORKERS	0	0		0 0		193.00
	19301 MARKETING/ PUBLIC RELATIONS	10, 007	0		0 0		193.01
170.0	19302 NEW HORIZON OP	1, 323	5, 026		0 84	0	193.02
193.02		1,020	0/020		0		
		1, 020	0,020				200.00
193.02	Cross Foot Adjustments	0	0		0 0		201.00

Heal th	Financial Systems	ST VINCEN	IT SALEM		In Lieu	of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS				eriod:	Worksheet B	
						Part II Date/Time Pre	nared
						3/18/2015 4:2	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI O	SERVICES &		RECORDS &	
		11.00	N 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 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 11.00	01000 DI ETARY	10 001					10.00
13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	12, 801	10, 075				11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	446					14.00
15.00	01500 PHARMACY	322		10, 000	75, 872		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 234		, c		86, 086	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 205	1, 364	246	0	10, 889	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 329		2, 286		15, 427	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	1, 830		1		9, 074	54.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	128				0	58.00
60.00	06000 LABORATORY	0	530	C	0	0	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	75.0	(0)			0	61.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	750 870				0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	144				0	67.00
68.00	06800 SPEECH PATHOLOGY	0				0	68.00
69.00	06900 ELECTROCARDI OLOGY	373		-		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	8, 607	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	3, 621	0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	985	C	75, 872	0	•
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75. 01 75. 03	03950 SLEEP DI SORDER 07501 ADULT MENTAL HEALTH	475 0		18 0		0	75.01 75.03
76.97	07697 CARDI AC REHABI LI TATI ON	238		5		0	•
10. 77	OUTPATIENT SERVICE COST CENTERS	230	221	<u> </u>		0	/0. //
88.00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	C		0	89.00
90.00	09000 CLINIC	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	1, 863	1, 515	487	0	34, 120	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS		1	1			
118.00		12, 210	9, 090	15, 499	75, 872	69, 510	118.00
100.00	NONREI MBURSABLE COST CENTERS	0					100.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0					190. 00 191. 00
191.00	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	379			0		191.00
	19300 NONPALD WORKERS	0					193.00
	19301 MARKETING/ PUBLIC RELATIONS	159	-	0	0		193.00
	19302 NEW HORI ZON OP	53		C C	Ő		193.02
200.00			-				200.00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	12, 801	10, 075	15, 503	75, 872	86, 086	202.00

	ancial Systems	ST VINCEN	T SALEM			In Lieu of Form	n CMS-2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi d	er CCI	N: 151314	Period: Workshe From 07/01/2013 Part II To 06/30/2014 Date/Ti	et B me Prepared:
							15 4:28 pm
	Cost Center Description	Subtotal	Intern &		Total		
			Residents Cost & Pos				
			Stepdown				
			Adj ustment	s			
		24.00	25.00		26.00	—	
GENE	RAL SERVICE COST CENTERS						
1.00 0010	00 CAP REL COSTS-BLDG & FIXT						1.00
	00 CAP REL COSTS-MVBLE EQUIP						2.00
	00 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00 ADMI NI STRATI VE & GENERAL						5.00
	00 OPERATION OF PLANT						7.00
	00 LAUNDRY & LINEN SERVICE						8.00
	00 HOUSEKEEPI NG 00 DI ETARY						9.00
	DO CAFETERIA						11.00
	OO NURSI NG ADMI NI STRATI ON						13.00
	O CENTRAL SERVICES & SUPPLY						14.00
	DO PHARMACY						15.00
	00 MEDICAL RECORDS & LIBRARY						16.00
	TIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	363, 958		0	363, 9	58	30.00
	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	284, 659		0	284, 6	59	50.00
54.00 0540	00 RADIOLOGY - DIAGNOSTIC	159, 661		0	159, 6	61	54.00
	DO MAGNETIC RESONANCE IMAGING (MRI)	232, 581		0	232, 58	81	58.00
	00 LABORATORY	105, 718		0	105, 7	18	60.00
	00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
	00 RESPI RATORY THERAPY	39, 184		0	39, 1		65.00
	00 PHYSI CAL THERAPY	61, 527		0	61, 5		66.00
	00 OCCUPATI ONAL THERAPY	10, 828		0	10, 83		67.00
	00 SPEECH PATHOLOGY	E0 202		0	EQ. 20	0	68.00
		50, 292		0	50, 29	92	69.00
	00 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 448		0	27, 4		70.00
	00 IMPLANTABLE DEVICES CHARGED TO PATTENTS	11, 550		0	27,4		71.00
/2.00 0/20	PATIENTS	11, 330		Ŭ	11, 55		/2.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	92, 783		0	92, 7	83	73.00
	DO RENAL DI ALYSI S	0		0		0	74.00
	DO ASC (NON-DISTINCT PART)	0		0		0	75.00
75.01 0395	50 SLEEP DI SORDER	57, 194		0	57, 19	94	75.01
75.03 0750	1 ADULT MENTAL HEALTH	54, 628		0	54,6	28	75.03
76.97 0769	P7 CARDIAC REHABILITATION	24, 806		0	24, 80	06	76.97
	ATIENT SERVICE COST CENTERS						
	00 RURAL HEALTH CLINIC	0		0		0	88.00
	00 FEDERALLY QUALIFIED HEALTH CENTER	0		0		0	89.00
90.00 0900		0		0		0	90.00
	00 EMERGENCY	215, 181		0	215, 18	81	91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
	CIAL PURPOSE COST CENTERS	1, 791, 998		0	1 701 0	0.0	110.00
118.00 NONE	SUBTOTALS (SUM OF LINES 1-117)	1, 791, 998		0	1, 791, 9	98	118.00
	O GIFT, FLOWER, COFFEE SHOP, & CANTEEN	225		0	2	25	190.00
	00 RESEARCH	225		0	2.	0	190.00
192 00 1920	0 PHYSICIANS' PRIVATE OFFICES	89, 137		ŏ	89, 13	-	191.00
	NONPAID WORKERS	07, 137		ŏ	07, 1.	0	192.00
	1 MARKETING/ PUBLIC RELATIONS	11, 809		ŏ	11, 80	09	193.00
	D2 NEW HORI ZON OP	9, 174		ŏ	9, 1		193.02
	Cross Foot Adjustments	0		0	., .	0	200.00
200.00						0	
200.00 201.00	Negative Cost Centers	0		Ö		0	200.00

	Financial Systems	ST VINCEN		001 454044		u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 07/01/2013	Worksheet B-1	
					06/30/2014		
		CAPITAL RE	ATED COSTS			3/18/2015 4:2	28 pm
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio		
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS		2.00		0.11	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	96, 350					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 145		5, 819, 768		10 170 0/0	4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	10, 815 13, 392	0	1, 348, 422 156, 663			
8.00	00800 LAUNDRY & LINEN SERVICE	13, 392		150, 003	0		
9.00	00900 HOUSEKEEPI NG	3, 013	0	0	0	257, 202	
10.00	01000 DI ETARY	9, 636	0	0	0	87,935	
11.00	01100 CAFETERI A	0	0	0	0	189, 610	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	375	0	1, 665		12, 975	
	01400 CENTRAL SERVICES & SUPPLY	0	0	139, 782		200, 989	
15.00	01500 PHARMACY	967	0	184,004			
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	4, 584	0	269, 541	0	376, 491	16.00
30.00	03000 ADULTS & PEDIATRICS	10, 944	0	733, 864	0	1, 024, 658	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	10,711		700,001	0	1, 02 1, 000	00.00
50.00	05000 OPERATING ROOM	10, 610	0	530, 170	0	1, 046, 638	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	5, 365	0	624,600	0	1, 019, 491	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 212	0	49, 650	0	270, 756	58.00
60.00	06000 LABORATORY	1, 821	0	0	-		
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	1 0 4 0		004 000	0		61.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 048 2, 248		231, 290 332, 803			
67.00	06700 OCCUPATI ONAL THERAPY	428	0	61,000		84, 750	
68.00	06800 SPEECH PATHOLOGY	0	0	01,000	0	01,700	
69.00	06900 ELECTROCARDI OLOGY	2, 746	0	110, 176	0	160, 605	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	-	291, 910	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	0	0	122, 847	72.00
73.00	PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	236, 700	73.00
	07400 RENAL DI ALYSI S	0		0	0	230,700	1
	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	1
	03950 SLEEP DI SORDER	2, 783	0	134, 670	0	207, 141	
	07501 ADULT MENTAL HEALTH	2, 146	0	0	0	415, 918	75.03
76.97	07697 CARDI AC REHABI LI TATI ON	1, 291	0	73, 204	0	108, 270	76.97
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		
90.00	09000 CLINIC	0	0	0	0	-	
	09100 EMERGENCY	4, 414	-	644, 574	-	-	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	.,		011,071		1,007,100	92.00
	SPECIAL PURPOSE COST CENTERS		1		1		1
118.00		90, 983	0	5, 626, 078	-4, 797, 487	11, 817, 375]118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		0			190.00
		0	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	4, 728	0	123, 207	0		192.00
	19301 MARKETING/ PUBLIC RELATIONS	0		57, 036	0	155, 043	
	19302 NEW HORI ZON OP	639	0	13, 447		20, 502	
200.00					-		200.00
201.00							201.00
202.00		403, 539	0	1, 840, 123		4, 797, 487	202.00
000 0-	Part I)		0 00000	0 01/1		0.00001-	
203.00		4. 188262	0. 000000	0. 316185		0. 393919	
204.00	Cost to be allocated (per Wkst. B, Part II)			5, 277		786, 070	204.00
	(((((((((1	1			1	
205.00	Unit cost multiplier (Wkst. B, Part			0. 000907		0.064544	205 00

	n Financial Systems ALLOCATION - STATISTICAL BASIS	ST VINCEN		CCN: 151214		u of Form CMS-	
.051	ALLUCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2013	Worksheet B-1	
					To 06/30/2014	Date/Time Pre 3/18/2015 4:2	epared 28 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	(HOURS)	
			LAUNDRY)		,		
	CENEDAL SEDVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.00	00500 ADMI NI STRATI VE & GENERAL	70,000					5.0
7.00 3.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE	70, 998 0	0				7.0
9.00	00900 HOUSEKEEPI NG	3,013	0	1, 87	9		9.0
0.00	01000 DI ETARY	9, 636	0		0 969		10.0
1.00		0	0	2		168, 341	1
3.00 4.00		375 0	0	1	0 0 3 0	41 5, 863	
5.00		967	0		0 0	4, 232	
6.00		4, 584	0	2		16, 224	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		10, 944	0	47	9 969	28, 994	30.0
50.00	ANCI LLARY SERVI CE COST CENTERS	10, 610	0	45	6 0	17, 481	50.0
54.00		5, 365	0			24, 062	
58.00		1, 212	0		0 0	1, 687	1
0.00		1, 821	0	8	0 0	0	
51.00		1 040	0		0	0.050	61.0
5.00 6.00		1, 048 2, 248	0	5	0 0	9, 859 11, 444	
57.00	06700 OCCUPATI ONAL THERAPY	428	0		0 0	1, 898	
8. 00		0	0		0 0	0	
9.00		2, 746	0	4		4, 904	
0.00		0	0		0 0	0	
'1.00 '2.00		0	0		0 0 0 0	0	
2.00	PATI ENTS	0	0		0	0	/2.0
3.00		0	0	2		0	
4.00		0	0		0 0	0	
′5.00 ′5.01		0 2, 783	0	6	0 0	0 6, 253	
5.01 5.03		2, 783	0			0, 253	
6.97		1, 291	0			3, 133	
	OUTPATIENT SERVICE COST CENTERS				-		
38.00		0	0		0 0	0	
39.00 90.00		0	0		0 0 0 0	0	
	09100 EMERGENCY	4, 414	0	36	-	24, 505	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	SPECIAL PURPOSE COST CENTERS						
18.0	0 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	65, 631	0	1, 82	8 969	160, 580	118.0
90 0	019000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		8 0	0	190. 0
	019100 RESEARCH	0	0		0 0		191.0
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	4, 728	0	4	0 0	4, 979	
	0 19300 NONPAI D WORKERS	0	0		0 0		193. (
	1 19301 MARKETI NG/ PUBLIC RELATI ONS 2 19302 NEW HORI ZON OP	0	0		0 0	2, 088	
93. 0 00. 0		639	0		3 0	694	193. 0 200. 0
01.0							200.0
02.0	5	2, 386, 203	0	459, 78	4 446, 435	269, 195	
	Part I)						
203.0		33. 609440				1. 599105	
204.0	0 Cost to be allocated (per Wkst. B, Part II)	558, 443	0	52, 91	9 122, 927	12, 801	204.0
205.0		7. 865616	0. 000000	28. 16338	5 126. 859649	0. 076042	205. C
							1

Health Financial Systems	ST VINCEN	T SALEM		Inlie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	31 VINCEN			Period:	Worksheet B-1
				rom 07/01/2013 o 06/30/2014	Date/Time Prepared:
					3/18/2015 4:28 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL RECORDS &	
	ADMI NI STRATI O N	SERVICES & SUPPLY	(COSTED REQUIS.)	LIBRARY	
	(DI RECT NURS.	(COSTED	,	(TIME SPENT)	
	HRS.)	REQUIS.)	15.00	1(00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	
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 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT					5.00 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 13. 00 01300 NURSI NG ADMI NI STRATI ON	133				11.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	525, 956			14.00
15. 00 01500 PHARMACY	0	49	100		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	3	(1, 423	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	18	8, 343	(180	30.00
ANCI LLARY SERVICE COST CENTERS	10	0, 343		100	30.00
50. 00 05000 OPERATI NG ROOM	20	77, 548			50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	16	2, 924	(54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 60.00 06000 LABORATORY	0	8 0		-	58.00 60.00
61. 00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	,	0			61.00
65.00 06500 RESPI RATORY THERAPY	8	2, 357	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	13	1, 881	(, i i i i i i i i i i i i i i i i i i i	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		-	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	2	624		-	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	Ō	0	(0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	291, 910	C	-	71.00
72.00 07200 I MPLANTABLE DEVI CES CHARGED TO	0	122, 847	C	0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	13	0	100	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	C		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	(-	75.00
75.01 03950 SLEEP DI SORDER 75.03 07501 ADULT MENTAL HEALTH	0	608 15	(-	75.01 75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	3	171			76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	0	(88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0			89.00 90.00
91. 00 09100 EMERGENCY	20	16, 513		, vi	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS	1 100	505 004			
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	120	525, 801	100	1, 149	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(0	190.00
191. 00 19100 RESEARCH	0	0	(191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	13	151	(192.00
193. 00 19300 NONPALD WORKERS 193. 01 19301 MARKETING/ PUBLIC RELATIONS	0	0			193.00 193.01
193. 02 19302 NEW HORIZON OP	0	5 1	(0	193.01
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	00.75	000 7/-	450.0	740.46	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	30, 756	292, 719	459, 247	710, 438	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	231. 248120	0. 556547	4, 592. 470000	499. 253689	203.00
204.00 Cost to be allocated (per Wkst. B,	10, 075	15, 503			204.00
Part II)	75 751000	0 000477	750 70000	40 40/ 105	005 00
205.00 Unit cost multiplier (Wkst. B, Part	75. 751880	0. 029476	758.720000	60. 496135	205.00
1 1	· ·	'	1		I

Health Financial Systems	ST VINCE	NT SALEM		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014		
		Ti tl	e XVIII	Hospi tal	Cost	_
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 03000 ADULTS & PEDIATRICS	2, 504, 788	8	2, 504, 78	8 0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 130, 155		2, 130, 15			
54.00 05400 RADIOLOGY - DIAGNOSTIC	1, 741, 629		1, 741, 62		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	420, 849		420, 84		0	
60. 00 06000 LABORATORY	1, 791, 067	7	1, 791, 06	07 0	0	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	C			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	496, 139		496, 13		0	00.00
66. 00 06600 PHYSI CAL THERAPY	748, 534		748, 53		0	00.00
67.00 06700 OCCUPATI ONAL THERAPY	135, 555	6 C	135, 55	5 0	0	
68.00 06800 SPEECH PATHOLOGY	C			0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	336, 803	8	336, 80	03 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	C			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	569, 362		569, 36		0	
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO PATI ENTS	239, 609		239, 60	09 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	797, 822	2	797, 82	2 0	0	73.00
74.00 07400 RENAL DI ALYSI S	C			0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	C			0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	407, 781		407, 78	0 0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	668, 529		668, 52	.9 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	210, 876		210, 87	6 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	C)		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C			0 0	0	
90. 00 09000 CLINIC	(C			0 0	0	
91.00 09100 EMERGENCY	2, 927, 808		2, 927, 80		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	964, 665		964, 66		0	
200.00 Subtotal (see instructions)	17, 091, 971					200.00
201.00 Less Observation Beds	964, 665	5	964, 66	5		201.00
202.00 Total (see instructions)	16, 127, 306	o C	16, 127, 30	06 0	0	202.00

Health Financial Systems	ST VINCEN	T SALEM		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CCN: 151314	Period: From 07/01/2013 To 06/30/2014		
		Ti tl	e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	I I					
30. 00 03000 ADULTS & PEDI ATRI CS	3, 447, 184		3, 447, 18	34		30.00
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATI NG ROOM	288, 497	7, 209, 666	7, 498, 10	0. 284090	0. 000000	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	140, 002	10, 447, 567	10, 587, 50	0. 164498	0. 000000	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	10, 487	1, 648, 785	1, 659, 2	0. 253635	0. 000000	58.00
60. 00 06000 LABORATORY	348, 551	7, 195, 907	7, 544, 45	0. 237402	0. 000000	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		0 0. 000000	0. 000000	61.00
65. 00 06500 RESPI RATORY THERAPY	112, 772	735, 054	847, 82	0. 585190	0. 000000	65.00
66.00 06600 PHYSI CAL THERAPY	157, 334	2, 188, 284	2, 345, 6	8 0. 319120	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	35, 638	394, 295	429, 93	0. 315293	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	68.00
69.00 06900 ELECTROCARDI OLOGY	64, 394	1, 197, 907	1, 262, 30	0. 266817	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	379, 718	1, 674, 938	2, 054, 65	6 0. 277108	0. 000000	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	52, 300	345, 698	397, 99	0. 602036	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	336, 534	1, 397, 025	1, 733, 5			
74.00 07400 RENAL DI ALYSI S	0	0		0 0.000000	0.000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0.000000	0.000000	75.00
75. 01 03950 SLEEP DI SORDER	0	862, 422			0.00000	
75.03 07501 ADULT MENTAL HEALTH	0	1, 103, 717				
76. 97 07697 CARDI AC REHABI LI TATI ON	0	156, 910	156, 91	0 1.343930	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90. 00 09000 CLINIC	0	0		0 0.000000		
91.00 09100 EMERGENCY	0	7, 369, 096				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 289	420, 631	425, 92	2. 264897	0.00000	
200.00 Subtotal (see instructions)	5, 378, 700	44, 347, 902	49, 726, 60)2		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	5, 378, 700	44, 347, 902	49, 726, 60	02		202.00

Health Financial Systems	ST VINCENT S	SALEM	In Lieu	ı of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151314	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Pre 3/18/2015 4:2	epared: 28 pm
		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
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0.000000				50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000				54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
60. 00 06000 LABORATORY	0. 000000				60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0. 000000				61.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0,000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0.000000				72.00
PATIENTS					
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75.00
75. 01 03950 SLEEP DI SORDER	0. 000000				75.01
75.03 07501 ADULT MENTAL HEALTH	0. 000000				75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90. 00 09000 CLINIC	0.000000				90.00
91. 00 09100 EMERGENCY	0.000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,000000				92.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
	I I				

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Health Financial Systems	ST VINCE	NT SALEM		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014		
		Ti t	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 03000 ADULTS & PEDIATRICS	2, 504, 788	8	2, 504, 7	38 0	2, 504, 788	30.00
ANCI LLARY SERVICE COST CENTERS	1		1			
50.00 05000 OPERATING ROOM	2, 130, 155		2, 130, 1		2, 130, 155	
54.00 05400 RADI OLOGY - DI AGNOSTI C	1, 741, 629		1, 741, 6		1, 741, 629	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	420, 849		420, 8		420, 849	
60. 00 06000 LABORATORY	1, 791, 067		1, 791, 0		1, 791, 067	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	C			0 0	C	
65.00 06500 RESPI RATORY THERAPY	496, 139		496, 1		496, 139	
66.00 06600 PHYSI CAL THERAPY	748, 534		748, 5		748, 534	
67.00 06700 OCCUPATI ONAL THERAPY	135, 555	C	135, 5	55 0	135, 555	
68.00 06800 SPEECH PATHOLOGY	C	C C		0 0	C	
69.00 06900 ELECTROCARDI OLOGY	336, 803		336, 8	03 0	336, 803	
70.00 07000 ELECTROENCEPHALOGRAPHY)		0 0	C	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	569, 362		569, 3		569, 362	
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	239, 609		239, 6		239, 609	
73.00 07300 DRUGS CHARGED TO PATIENTS	797, 822	2	797, 8	22 0	797, 822	
74.00 07400 RENAL DIALYSIS	C			0 0	C	
75.00 07500 ASC (NON-DISTINCT PART)	C			0 0	C	
75. 01 03950 SLEEP DI SORDER	407, 781		407, 7		407, 781	
75.03 07501 ADULT MENTAL HEALTH	668, 529		668, 5		668, 529	
76. 97 07697 CARDI AC REHABI LI TATI ON	210, 876		210, 8	76 0	210, 876	76.97
OUTPATIENT SERVICE COST CENTERS			1	0		
88.00 08800 RURAL HEALTH CLINIC				0 0	C	00.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC				0 0	C	
90.00 09000 CLINIC 91.00 09100 EMERGENCY	2 0 2 0 0 0		2 0 2 7 0		C 2, 927, 808	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 927, 808		2, 927, 8		2, 927, 808 964, 665	
200.00 Subtotal (see instructions)	17, 091, 971				964, 665 17, 091, 971	
201.00 Less Observation Beds	964, 665		964, 6			200.00
201.00 Total (see instructions)	16, 127, 306					
zuz. vuj jiutal (see mistructions)	10, 127, 300	ין נ	ין וט, וב/, 3	0	10, 127, 300	202.00

Health Financial Systems	ST VINCEN	T SALEM		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I	epared:
			le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	3, 447, 184		3, 447, 18	34		30.00
ANCI LLARY SERVI CE COST CENTERS			_			
50.00 O5000 OPERATI NG ROOM	288, 497	7, 209, 666	7, 498, 10	0. 284090	0. 000000	50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C	140, 002	10, 447, 567	10, 587, 50	0. 164498	0. 000000	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	10, 487	1, 648, 785	1, 659, 2	0. 253635	0. 000000	58.00
60. 00 06000 LABORATORY	348, 551	7, 195, 907	7, 544, 4	58 0. 237402	0. 000000	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		0 0.000000	0. 000000	61.00
65. 00 06500 RESPI RATORY THERAPY	112, 772	735, 054	847, 82	0. 585190	0. 000000	65.00
66.00 06600 PHYSI CAL THERAPY	157, 334	2, 188, 284	2, 345, 6	0. 319120	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	35, 638	394, 295	429, 93	0. 315293	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	68.00
69.00 06900 ELECTROCARDI OLOGY	64, 394	1, 197, 907	1, 262, 30	0. 266817	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	379, 718	1, 674, 938	2, 054, 65	0. 277108	0. 000000	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	52, 300	345, 698	397, 99	0. 602036	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	336, 534	1, 397, 025	1, 733, 5	0. 460222	0. 000000	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0 0.000000	0. 000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0.000000	0. 000000	75.00
75. 01 03950 SLEEP DI SORDER	0	862, 422	862, 42	0. 472832	0. 000000	75.01
75.03 07501 ADULT MENTAL HEALTH	0	1, 103, 717	1, 103, 7 ⁻	0. 605707	0. 000000	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	156, 910	156, 91	1. 343930	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0.000000	0. 000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0. 000000	89.00
90. 00 09000 CLINIC	0	0		0 0.000000	0. 000000	90.00
91.00 09100 EMERGENCY	0	7, 369, 096	7, 369, 09	0. 397309	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 289	420, 631	425, 92	20 2. 264897	0. 000000	92.00
200.00 Subtotal (see instructions)	5, 378, 700	44, 347, 902	49, 726, 60	02		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	5, 378, 700	44, 347, 902	49, 726, 60	02		202.00

C: \28800-14 amended.mcrx

Health Financial Systems	ST VINCENT S	SALEM	In Lieu	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151314	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Pre 3/18/2015 4:2	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					1
50.00 05000 OPERATING ROOM	0. 000000				50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000				54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
60. 00 06000 LABORATORY	0. 000000				60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0. 000000				61.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66, 00 06600 PHYSI CAL THERAPY	0. 000000				66,00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO	0. 000000				72.00
PATIENTS	0.000000				12:00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75.00
75. 01 03950 SLEEP DI SORDER	0. 000000				75.01
75. 03 07501 ADULT MENTAL HEALTH	0. 000000				75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
OUTPATIENT SERVICE COST CENTERS	0.000000				
88.00 08800 RURAL HEALTH CLINIC	0. 000000				88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
90. 00 09000 CLINIC	0. 000000				90.00
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
200.00 Subtotal (see instructions)	0.000000				200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
					202.00

C: \28800-14 amended.mcrx

Health Financial Systems	ST VINCEN	T SALEM		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT,	AL COSTS	Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014		pared:
					3/18/2015 4:2	8 pm
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	004 (50	7 400 4/0	0.0070	4 400.000	4 (04	50.00
50. 00 05000 OPERATING ROOM	284, 659					
54. 00 05400 RADI OLOGY - DI AGNOSTI C	159, 661					
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	232, 581					•
60. 00 06000 LABORATORY	105, 718	7, 544, 458	0. 01401	3 170, 573	2, 390	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	00.404	0.47 00/	0.04/07		0.007	61.00
65. 00 06500 RESPIRATORY THERAPY	39, 184					65.00
66. 00 06600 PHYSI CAL THERAPY	61, 527					
67. 00 06700 OCCUPATI ONAL THERAPY	10, 828				0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0.0000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	50, 292	1, 262, 301	0. 03984		1, 871	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 448					
72.00 07200 I MPLANTABLE DEVI CES CHARGED TO PATI ENTS	11, 550	397, 998	0. 02902	20 5, 200	151	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	92, 783	1, 733, 559			8, 247	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.0000	0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	57, 194	862, 422	0. 0663	8 0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	54, 628	1, 103, 717	0. 04949	95 0	0	75.03
76. 97 07697 CARDIAC REHABILITATION	24, 806	156, 910	0. 15809	01 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0 0	0	89.00
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
91.00 09100 EMERGENCY	215, 181	7, 369, 096	0. 02920		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	162, 002	425, 920	0. 38035	3, 969	1, 510	92.00
200.00 Total (lines 50-199)	1, 590, 042	46, 279, 418		811, 132	26, 076	200.00

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Health Financial Systems	ST VINCENT	SALEM		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS		CCN: 151314	Period: From 07/01/2013 To 06/30/2014		
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Allied Healt	h All Other	Total Cost	
	Anesthetist	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
54.00 05400 RADI OLOGY – DI AGNOSTI C	0	0		0 0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72. 00 07200 I MPLANTABLE DEVI CES CHARGED TO PATI ENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	0	0		0 0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0	0		0 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	· · · · · ·					
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
200.00 Total (lines 50-199)	0	0		0 0	0	200.00

C: \28800-14 amended.mcrx

Health Financial Systems	ST VINCEN	IT SALEM		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der	CCN: 151314	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2013	Part IV	norod.
				To 06/30/2014	Date/Time Pre 3/18/2015 4:2	pared: 8 pm
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	I	1			
50.00 ODERATING ROOM	0	.,				
54.00 05400 RADIOLOGY – DIAGNOSTIC	0					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 659, 272				
60. 00 06000 LABORATORY	0	7, 544, 458	0.0000	0. 000000	170, 573	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	0	847, 826				•
66. 00 06600 PHYSI CAL THERAPY	0	2, 345, 618			42, 796	
67.00 06700 OCCUPATI ONAL THERAPY	0	429, 933			0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0,00000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 262, 301				
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 054, 656	0.0000	0. 000000	139, 828	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	397, 998	0.0000	0. 000000	5, 200	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 733, 559				
74.00 07400 RENAL DIALYSIS	0	0	0.0000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0. 000000	0	75.00
75. 01 03950 SLEEP DI SORDER	0	862, 422	0.0000	0. 000000	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0	1, 103, 717	0.0000	0. 000000	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	156, 910	0.0000	0. 000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0. 000000	0	88.00
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0.0000	0. 000000	0	89.00
90. 00 09000 CLI NI C	0	0	0.0000			90.00
91. 00 09100 EMERGENCY	0	7, 369, 096	0.0000	0. 000000		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	425, 920		0. 000000		
200.00 Total (lines 50-199)	0	46, 279, 418			811, 132	200.00

Health Financial Systems	ST VINCEN	T SALEM		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS		CCN: 151314	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Pro 3/18/2015 4:2	epared: 28 pm
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C)	0		50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	C		0		54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0		58.00
60. 00 06000 LABORATORY	0	C		0		60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
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 IMPLANTABLE DEVICES CHARGED TO	0	Ċ		0		72.00
PATIENTS				-		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
74.00 07400 RENAL DI ALYSI S	0	Ċ		0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	(0		75.00
75. 01 03950 SLEEP DI SORDER	0	C		0		75.01
75. 03 07501 ADULT MENTAL HEALTH	0	(0		75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C C		0		76.97
OUTPATIENT SERVICE COST CENTERS	<u> </u>		1			
88.00 08800 RURAL HEALTH CLINIC	0	(b	0		88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C C		0		89.00
90. 00 09000 CLINIC	0	C C		0		90.00
91. 00 09100 EMERGENCY	0	C C		0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		92.00
200.00 Total (lines 50-199)	0	C		0		200.00
	, v	C C	1			

Health Financial Systems	ST VINCEN	IT SALEM		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der		Period: From 07/01/2013	Worksheet D Part V	
				To 06/30/2014		pared:
					3/18/2015 4:2	
		Titl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9	2.00	(see inst.)	(see inst.)	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0. 284090	0	1, 953, 61	7 0	0	50.00
					-	
	0. 164498 0. 253635				-	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 253635		422, 72		0	58.00
60. 00 06000 LABORATORY			2, 491, 41		0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000			0 0	0	61.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 585190 0. 319120		60, 28		0	65.00
			647, 75		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 315293			0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0.000000		701 10	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 266817		721, 10		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000			0 0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 277108		572, 40		°,	71.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0. 602036		81,40		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 460222		1, 182, 03	2 6, 073	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	0. 472832		267, 71		0	75.01
75.03 07501 ADULT MENTAL HEALTH	0. 605707		808, 86		0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	1. 343930	0	72, 97	8 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			-			
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90. 00 09000 CLINIC	0. 000000			0 0	0	90.00
91.00 09100 EMERGENCY	0. 397309		1, 648, 83		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2. 264897	0	244, 17		0	92.00
200.00 Subtotal (see instructions)		0	14, 027, 62			200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		_			_	
202.00 Net Charges (line 200 +/- line 201)	1	0	14, 027, 62	6 6, 073	0	202.00

C: \28800-14 amended.mcrx

Health Financial Systems	ST VINCEN	T SALEM		In Lieu	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provi der	CCN: 151314	Period: From 07/01/2013	Worksheet D Part V	
				To 06/30/2014	Date/Time Pr 3/18/2015 4:	
		Titl	e XVIII	Hospi tal	Cost	20 pm
	Cos	sts		• • •		
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				
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	555,003	0				50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	469, 201	0				54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	107, 218	0				58.00
	591, 466	0				60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0				61.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	35, 275 206, 712	0				65.00 66.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY						67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				67.00
69. 00 06900 ELECTROCARDI OLOGY	-	0	1			69.00
70. 00 07000 ELECTROCARDIOLOGY	192, 404	0				70.00
70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	158, 617	0				70.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATTENTS	49, 011	0				72.00
PATIENTS	49,011	U	1			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	543, 997	2, 795				73.00
74. 00 07400 RENAL DI ALYSI S	0	2, , , , 3	1			74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	0	1			75.00
75. 01 03950 SLEEP DI SORDER	126, 582	0				75.01
75. 03 07501 ADULT MENTAL HEALTH	489, 938	0	1			75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	98, 077	0	•			76.97
OUTPATIENT SERVICE COST CENTERS		-	1			
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)			89.00
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	655, 097	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	553, 033	0				92.00
200.00 Subtotal (see instructions)	4, 831, 631	2, 795				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	4, 831, 631	2, 795				202.00

Health Financial Systems	ST VINCEN	IT SALEM		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST			Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Pre 3/18/2015 4:2	
		Ti †I	e XVIII S	Swing Beds - SNF		
			Charges	oning bout on	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.	, ,	Ded. & Coi ns.			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 284090	0		0 0	0	50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C	0. 164498	0		0 0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 253635	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 237402	0		0 0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0. 000000			0 0		61.00
65. 00 06500 RESPI RATORY THERAPY	0. 585190	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 319120	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 315293	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 266817	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 277108			0 0	0	71.00
72. 00 07200 I MPLANTABLE DEVI CES CHARGED TO PATI ENTS	0. 602036	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 460222	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	0. 472832	0		0 0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0. 605707	0		0 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	1.343930	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 397309	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2. 264897	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0		0 0		200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0		0 0	0	202.00
	1		1	- I C		

Health Financial Systems	ST VINCEN	T SALEM		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	VACCINE COST	Provi der	CCN: 151314	Peri od:	Worksheet D	
		0		From 07/01/2013	Part V	
		Componen	t CCN: 15Z314	To 06/30/2014	Date/Time Pro 3/18/2015 4::	
		Ti †I	e XVIII	Swing Beds - SNF		
	Cos	sts		joining beas on	0031	
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0	(C				50.00
54.00 05400 RADI OLOGY – DI AGNOSTI C	0	C				54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C				58.00
60. 00 06000 LABORATORY	0	C				60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0					61.00
65. 00 06500 RESPI RATORY THERAPY	0	C				65.00
66. 00 06600 PHYSI CAL THERAPY	0	C)			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C)			67.00
68.00 06800 SPEECH PATHOLOGY	0	C)			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C)			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C)			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C)			71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	C				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0					73.00
74.00 07400 RENAL DI ALYSI S	0					74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0					75.00
75. 01 03950 SLEEP DI SORDER	0					75.01
75.03 07501 ADULT MENTAL HEALTH	0					75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0					76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(C				89.00
90. 00 09000 CLINIC	0	c				90.00
91.00 09100 EMERGENCY	0	C				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C				92.00
200.00 Subtotal (see instructions)	0	C				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	C				202.00

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Health Financial Systems	al Systems ST VINCENT SALEM In Lieu of Form C					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 07/01/2013	Worksheet D Part I	
				To 06/30/2014		
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	363, 958	48, 203	315, 75	5 1, 166	270. 80	30.00
200.00 Total (lines 30-199)	363, 958		315, 75	5 1, 166		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	20	5, 416				30.00
200.00 Total (lines 30-199)	20	5, 416				200.00

C: \28800-14 amended.mcrx

Health Financial Systems	ST VINCEN	T SALEM		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT,	AL COSTS	Provi der	CCN: 151314	Period: From 07/01/2013		
				To 06/30/2014	Date/Time Pre 3/18/2015 4:2	pared: 8 pm
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	284, 659	7, 498, 163				
54.00 05400 RADIOLOGY – DIAGNOSTIC	159, 661	10, 587, 569			33	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	232, 581	1, 659, 272	0. 1401	/1 0	0	58.00
60. 00 06000 LABORATORY	105, 718	7, 544, 458	0. 01401	3 14, 365	201	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	39, 184	847, 826	0. 0462	7 12, 387	572	65.00
66.00 06600 PHYSI CAL THERAPY	61, 527	2, 345, 618	0. 02623	31 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	10, 828	429, 933	0. 02518	35 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0. 00000	0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	50, 292	1, 262, 301	0. 03984	1, 826	73	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 448	2,054,656	0. 01335	59 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	11, 550	397, 998	0. 02902	20 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	92, 783	1, 733, 559	0. 05352	18, 907	1, 012	73.00
74.00 07400 RENAL DIALYSIS	0	0	0. 00000	0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	57, 194	862, 422	0.0663	8 0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	54, 628	1, 103, 717	0. 04949	05 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	24, 806	156, 910	0. 15809	01 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			•			
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0 0	0	89.00
90. 00 09000 CLINIC	0	0	0.00000		0	90.00
91.00 09100 EMERGENCY	215, 181	7, 369, 096			0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	162,002				0	92.00
200.00 Total (lines 50-199)	1, 590, 042			69, 781	2, 654	200. 00

Health Financial Systems	ST VINCEN	IT SALEM		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS	STS Provi der	CCN: 151314	Period: From 07/01/2013	Worksheet D Part III	
				To 06/30/2014		
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Nursi ng	Allied Health	All Other	Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost	instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem	I npati ent	I npati ent		
	Days	(col. 5 ÷	Program Days	s Program		
	-	col. 6)		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	1, 166	0.00		20 0		30.00
200.00 Total (lines 30-199)	1, 166		:	20 0		200.00

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Health Financial Systems	ST VINCENT	SALEM		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS		CCN: 151314	Period: From 07/01/2013 To 06/30/2014		pared: 8 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Allied Healt	h All Other	Total Cost	
	Anestheti st	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
54.00 05400 RADIOLOGY – DIAGNOSTIC	0	0		0 0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	0	0		0 0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0	0		0 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	· ·					1
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
200.00 Total (lines 50-199)	0	0		0 0	0	200.00

C: \28800-14 amended.mcrx

Health Financial Systems	ST VINCEN	IT SALEM		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2013		
				To 06/30/2014	Date/Time Pre 3/18/2015 4:2	pared:
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS	1	1				
50.00 05000 OPERATI NG ROOM	0					
54.00 05400 RADI OLOGY – DI AGNOSTI C	0				2, 187	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 659, 272			0	58.00
60. 00 06000 LABORATORY	0	7, 544, 458	0. 00000	0. 000000	14, 365	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	0	847, 826			12, 387	65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 345, 618			0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	429, 933			0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 262, 301			1, 826	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 054, 656	0.0000		0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	397, 998	0.0000	0. 000000	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 733, 559			18, 907	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.0000		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000		0	75.00
75. 01 03950 SLEEP DI SORDER	0	862, 422			0	75.01
75.03 07501 ADULT MENTAL HEALTH	0	1, 103, 717			0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	156, 910	0.0000	0.00000	0	76.97
OUTPATIENT SERVICE COST CENTERS				_		
88.00 08800 RURAL HEALTH CLINIC	0	0			0	88.00
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0.00000		0	89.00
90. 00 09000 CLI NI C	0	0	0.00000		0	90.00
91.00 09100 EMERGENCY	0	7, 369, 096	0.00000	0. 000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	425, 920	0.00000	0. 000000	0	92.00
200.00 Total (lines 50-199)	0	46, 279, 418			69, 781	200.00

Health Financial Systems	ST VINCEN				u of Form CMS	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI THROUGH COSTS	ERVICE OTHER PAS	S Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Pr 3/18/2015 4:	epared: 28 pm
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C		0		50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C	0	C		0		54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0		58.00
60. 00 06000 LABORATORY	0	C		0		60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C)	0		69.00
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 I MPLANTABLE DEVI CES CHARGED TO PATI ENTS	0	C)	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
74.00 07400 RENAL DIALYSIS	0	C		0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0		75.00
75. 01 03950 SLEEP DI SORDER	0	C		0		75.01
75.03 07501 ADULT MENTAL HEALTH	0	C		0		75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0		76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C)	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.00
90. 00 09000 CLINIC	0	C		0		90.00
91.00 09100 EMERGENCY	0	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		92.00
200.00 Total (lines 50-199)		C		0		200.00

	Financial Systems ST VIN ATION OF INPATIENT OPERATING COST	CENT SALEM Provider CCN: 151314	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2013 To 06/30/2014	Date/Time Pre	
		Title XVIII	Hospi tal	3/18/2015 4:2 Cost	8 pm
	Cost Center Description		- Hoopi tui		
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-be			1, 397	1 1.
00	Inpatient days (including private room days, excluding s			1, 397	
00	Private room days (excluding swing-bed and observation h		rivate room days,	0	
	do not complete this line.		_	(17	
00 00	Semi-private room days (excluding swing-bed and observational swing-bed SNF type inpatient days (including privational structure)	5,	or 21 of the cost	647 89	45
00	reporting period	te room days) through becemb		07	
00	Total swing-bed SNF type inpatient days (including priva		31 of the cost	89	6
~~	reporting period (if calendar year, enter 0 on this line		21	07	_
00	Total swing-bed NF type inpatient days (including privative reporting period	te room days) through Decembe	r 31 of the cost	27	7
00	Total swing-bed NF type inpatient days (including privat	te room days) after December	31 of the cost	26	8
	reporting period (if calendar year, enter 0 on this line	e)			
00	Total inpatient days including private room days applica newborn days)	able to the Program (excludin	g swing-bed and	358	9
. 00	Swing-bed SNF type inpatient days applicable to title XV	/III only (including private	room days)	89	10
	through December 31 of the cost reporting period (see in	nstructions)	•		
. 00	Swing-bed SNF type inpatient days applicable to title XV	/III only (including private	room days) after	89	11
. 00	December 31 of the cost reporting period (if calendar yes Swing-bed NF type inpatient days applicable to titles V		to room dave)	0	12
. 00	through December 31 of the cost reporting period	of XIX only (Therading priva	te room days)	0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V	or XIX only (including priva	te room days)	0	13
00	after December 31 of the cost reporting period (if caler	ndar year, enter 0 on this li	ne)		
	Medically necessary private room days applicable to the Total nursery days (title V or XIX only)	Program (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to s	services through December 31	of the cost		17
00	reporting period Medicare rate for swing-bed SNF services applicable to s	services after December 31 of	the cost		18
. 00	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to se	ervices through December 31 o	f the cost	126.36	19
00	reporting period Medicaid rate for swing-bed NF services applicable to se	arvicos after December 21 of	the cost	126.36	20
. 00	reporting period	ervices after becember 31 01	the cost	120. 30	20
	Total general inpatient routine service cost (see instru			2, 504, 788	21
. 00	Swing-bed cost applicable to SNF type services through [December 31 of the cost repor	ting period (line	0	22
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Dec	cember 31 of the cost reporti	na period (line A	0	23
. 00	x line 18)		ng period (rine e	0	20
. 00	Swing-bed cost applicable to NF type services through De	ecember 31 of the cost report	ing period (line	3, 412	24
00	7 x line 19)	mbor 21 of the cost reportin	a pariod (line 9	3, 285	25
5.00	Swing-bed cost applicable to NF type services after $Dece x$ line 20)	ember 31 of the cost reportin		3, 200	25
b. 00	Total swing-bed cost (see instructions)			337, 546	26
. 00	General inpatient routine service cost net of swing-bed	cost (line 21 minus line 26)		2, 167, 242	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swi	ng_bed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)	ng-bed and observation bed c	narges)	0	
	Semi -private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (lin	ne 27 ÷ line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ lin	ae 4)		0.00 0.00	
	Average per diem private room charge differential (line		ctions)	0.00	
. 00	Average per diem private room cost differential (line 34	4 x line 31)		0.00	35
	Private room cost differential adjustment (line 3 x line			0	
. 00	General inpatient routine service cost net of swing-bed 27 minus line 36)	cost and private room cost d	itterential (line	2, 167, 242	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COS	ST ADJUSTMENTS			1
	Adjusted general inpatient routine service cost per dier			1,858.70	
	Program general inpatient routine service cost (line 9 x	KIINE 38)		665, 415	1 39
	Medically necessary private room cost applicable to the	Program (line 1/ v line 25)		0	40

ealth Financial Systems	ST VINCEN		001 454044		u of Form CMS-		
OMPUTATION OF INPATIENT OPERATING COST		Provi der	1	Period: From 07/01/2013 To 06/30/2014		epared	
		Ti ti	e XVIII	Hospi tal	3/18/2015 4:2 Cost	28 pm	
Cost Center Description	Total I npati ent Cost	Total I npati ent Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital						42.0	
3. 00 INTENSIVE CARE UNIT						43.0	
4. 00 CORONARY CARE UNI T						44.0	
5. 00 BURN INTENSIVE CARE UNIT						45.0	
6.00 SURGICAL INTENSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY)						46. 47.	
Cost Center Description						47.0	
					1.00		
8.00 Program inpatient ancillary service co			onc)		264, 681		
9.00 Total Program inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS	TTHES 41 through 48)	(see instructi	ons)		930, 096	49.	
0.00 Pass through costs applicable to Progr	am inpatient routine	services (fro	m Wkst. D, sun	n of Parts I and	0	50.	
1.00 Pass through costs applicable to Progr and IV)	am inpatient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	0	51.	
2.00 Total Program excludable cost (sum of	lines 50 and 51)				0	52.0	
3.00 Total Program inpatient operating cost	excluding capital r	elated, non-ph	ysician anesth	netist, and	0	53.0	
medical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION	line 52)						
4.00 Program discharges					0	54.	
5.00 Target amount per discharge					0.00		
6.00 Target amount (line 54 x line 55)							
7.00 Difference between adjusted inpatient	operating cost and t	arget amount (line 56 minus	line 53)	0		
8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the c	ost reporting period	endi na 1996	updated and co	moounded by the			
market basket	oot roporting porrou	ondring 17707	apaatoa ana oo	mpoundoù by ene	0,00		
0.00 Lesser of lines 53/54 or 55 from prior					0.00		
1.00 If line 53/54 is less than the lower of which operating costs (line 53) are le					0	61.	
amount (line 56), otherwise enter zero		13 (11163 54 7		the target			
2.00 Relief payment (see instructions)					0		
3.00 Allowable Inpatient cost plus incentiv		uctions)			0	63.	
4.00 Medicare swing-bed SNF inpatient routi		ember 31 of th	e cost reporti	na period (See	165, 424	64.	
instructions)(title XVIII only)	0			0	,		
5.00 Medicare swing-bed SNF inpatient routi	ne costs after Decem	ber 31 of the	cost reporting	g period (See	165, 424	65.	
instructions)(title XVIII only) 6.00 Total Medicare swing-bed SNF inpatient	routine costs (line	64 nlus line	65)(title XVII	lonly) For	330, 848	66	
CAH (see instructions)				1 01113). 101	000,010		
7.00 Title V or XIX swing-bed NF inpatient	routine costs throug	h December 31	of the cost re	eporting period	0	67.	
(line 12 x line 19) B.OO Title V or XIX swing-bed NF inpatient	routing costs after	Docombor 21 of	the cost room	sting poriod	0	68.	
(line 13 x line 20)	Toutime costs after	December 31 01	the cost rept	n tring period	0	00.	
9.00 Total title V or XIX swing-bed NF inpa					0	69.	
PART III - SKILLED NURSING FACILITY, O						1 70	
0.00 Skilled nursing facility/other nursing 1.00 Adjusted general inpatient routine ser	3					70.	
2.00 Program routine service cost (line 9 x			_)			72.	
3.00 Medically necessary private room cost						73.	
4.00 Total Program general inpatient routin 5.00 Capital-related cost allocated to inpa	•		·	Part II column		74.	
5.00 Capital-related cost allocated to inpa 26, line 45)	trent foutine servic		WOLKSHEEL D, F	art II, corumn		/5.	
6.00 Per diem capital-related costs (line 7	5 ÷ line 2)					76.	
7.00 Program capital-related costs (line 9						77.	
3.00 Inpatient routine service cost (line 7 7.00 Aggregate charges to beneficiaries for		nrovi der recor	(sh			78.	
0.00 Total Program routine service costs for				nus line 79)		80.	
1.00 Inpatient routine service cost per die	m limitation		-	-		81.	
2.00 Inpatient routine service cost limitat	•					82.	
3.00 Reasonable inpatient routine service c 4.00 Program inpatient ancillary services (115)				83. 84.	
5.00 Utilization review - physician compens		ons)				85.	
6.00 Total Program inpatient operating cost	s (sum of lines 83 t	hrough 85)				86.	
PART IV - COMPUTATION OF OBSERVATION B					E40	0.7	
7.00 Total observation bed days (see instru 8.00 Adjusted general inpatient routine cos		÷line 2)			519 1, 858. 70		
	- por arom (rino 27				1,000.70	1 00.1	

Health Financial Systems	Financial Systems ST VINCENT SALEM					2552-10
COMPUTATION OF INPATIENT OPERATING COST				Period:	Worksheet D-1	
				From 07/01/2013 To 06/30/2014		
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	363, 958	2, 167, 242	0. 16793	6 964, 665	162, 002	90.00
91.00 Nursing School cost	0	2, 167, 242	0.00000	0 964, 665	0	91.00
92.00 Allied health cost	0	2, 167, 242	0.00000	0 964, 665	0	92.00
93.00 All other Medical Education	0	2, 167, 242	0.00000	0 964, 665	0	93.00

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	Financial Systems ATION OF INPATIENT OPERATING COST	ST VINCENT SALEM Provider CCN: 151314	In Lie Period:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2013 To 06/30/2014	Date/Time Pre	pared:
		Title XIX	Hospi tal	3/18/2015 4:20 Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and s	wing-bed days, excluding newborn)		1, 397	1.00
2.00 3.00	Inpatient days (including private room days, excl Private room days (excluding swing-bed and observ do not complete this line.		rivate room days,	1, 166 0	2.00 3.00
4.00 5.00	Semi-private room days (excluding swing-bed and o Total swing-bed SNF type inpatient days (includin		er 31 of the cost	647 89	4.00 5.00
6.00	reporting period Total swing-bed SNF type inpatient days (includin reporting period (if calendar year, enter 0 on th		31 of the cost	89	6.00
7.00	Total swing-bed NF type inpatient days (including reporting period		r 31 of the cost	30	7.00
8.00	Total swing-bed NF type inpatient days (including reporting period (if calendar year, enter 0 on th		31 of the cost	23	8.00
9.00	Total inpatient days including private room days newborn days)		g swing-bed and	20	9.00
10.00	Swing-bed SNF type inpatient days applicable to t through December 31 of the cost reporting period		room days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to t December 31 of the cost reporting period (if cale	itle XVIII only (including private	room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to ti through December 31 of the cost reporting period		te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to ti after December 31 of the cost reporting period (i			0	13.00
14.00 15.00	Medically necessary private room days applicable Total nursery days (title V or XIX only)	to the Program (excluding swing-bed	days)	0	14.00 15.00
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
	Medicare rate for swing-bed SNF services applicab reporting period	le to services through December 31	of the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicab reporting period	le to services after December 31 of	the cost		18.00
19.00	Medicaid rate for swing-bed NF services applicabl reporting period	e to services through December 31 c	f the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicabl reporting period	e to services after December 31 of	the cost	0.00	20.00
21. 00 22. 00			ting period (line	2, 504, 788 0	21.00 22.00
23.00	Swing-bed cost applicable to SNF type services af x line 18)	ter December 31 of the cost reporti	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services thr 7 x line 19)	ough December 31 of the cost report	ing period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services aft x line 20)	er December 31 of the cost reportin	g period (line 8	0	25.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swi	ng-bed cost (line 21 minus line 26)		331, 735 2, 173, 053	1
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (exclud		harges)	0	28.00
	Private room charges (excluding swing-bed charges Semi-private room charges (excluding swing-bed ch			0	29.00 30.00
	General inpatient routine service cost/charge rat			0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ l	ine 3)		0.00	32.00
	Average semi-private room per diem charge (line 3			0.00	
	Average per diem private room charge differential		ctions)	0.00	
35.00 36.00	Average per diem private room cost differential (Private room cost differential adjustment (line 3			0. 00 0	35.00 36.00
38.00 37.00	General inpatient routine service cost net of swi 27 minus line 36)		ifferential (line		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THRO			1 0/2 /0	20 00
	Adjusted general inpatient routine service cost p Program general inpatient routine service cost (I			1, 863. 68 37, 274	
	Medically necessary private room cost applicable			0	40.00
40.00					

Heal th	Financial Systems	ST VINCEN	IT SALEM		In Lie	u of Form CMS-	2552-10
COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 07/01/2013	Worksheet D-1	
					To 06/30/2014		epared:
			Tit	le XIX	Hospi tal	3/18/2015 4:2 Cost	s pili
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1. 00	2.00	3.00	4.00	5. 00	
42.00	NURSERY (title V & XIX only)						42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		[1			43.00
	CORONARY CARE UNIT						44.00
1	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.00
11100	Cost Center Description		1				
40.00	Description to an interview service and (W)	-+ D 2	2 11 - 200)			1.00	40.00
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		25, 920 63, 194	
	PASS THROUGH COST ADJUSTMENTS		(
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sun	n of Parts I and	0	50.00
51.00	III) Pass through costs applicable to Program inp	atient ancilla	rv services (f	rom Wkst. D. s	sum of Parts II	0	51.00
	and IV)		, , , , , , , , , , , , , , , , , , ,				
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		olated non	Vel el on chost	otict and	0	
53.00	medical education costs (line 49 minus line	5 1	erateu, non-ph	ysician anestr	ierist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION)					
	Program di scharges					0 0.00	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	
57.00	Difference between adjusted inpatient operat	ing cost and t	arget amount (line 56 minus	line 53)	0	57.00
	Bonus payment (see instructions)	narting nariad	anding 1004	undeted and a	maguadad by the	0	
59.00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996,	upuated and co	mpounded by the	0.00	59.00
	Lesser of lines 53/54 or 55 from prior year					0.00	
61.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					0	61.00
	amount (line 56), otherwise enter zero (see		ts (THES 54 X	00), 01 1% 01	the target		
1	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instr	uctions)			0	63.00
	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost reporti	ng period (See	0	64.00
(5 00	instructions)(title XVIII only)	+£+ D	have 01 and the			0	1 (5 00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts arter becem	ber 31 of the	cost reporting	g period (see	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00
(7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	a agata thraugh	h Dacamban 21	of the east re	nerting period	0	67.00
67.00	(line 12 x line 19)	e costs through	n December 31	of the cost re	eporting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after	December 31 of	the cost repo	orting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lin	o 68)		0	69.00
t t	PART III - SKILLED NURSING FACILITY, OTHER N					0	09.00
1	Skilled nursing facility/other nursing facil	2		• • •			70.00
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		line 70 ÷ line	2)			71.00
	Medically necessary private room cost applic	,	m (line 14 x l	ine 35)			73.00
	Total Program general inpatient routine serv	•		·			74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine servic	e costs (from	worksheet B, F	art II, column		75.00
1	Per diem capital-related costs (line 75 ÷ li						76.00
	Program capital -related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provider recor	ds)			78.00 79.00
80.00	Total Program routine service costs for comp	arison to the			nus line 79)		80.00
	Inpatient routine service cost per diem limi		1)				81.00
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00 83.00
84.00	Program inpatient ancillary services (see in		,				84.00
	Utilization review - physician compensation						85.00
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:						86.00
87.00	Total observation bed days (see instructions)				519	
	Adjusted general inpatient routine cost per					1,863.68	
U7. UU	Observation bed cost (line 87 x line 88) (se)			967, 250	07.00

Health Financial Systems	ST VINCEN	T SALEM		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		
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	363, 958	2, 173, 053	0. 16748	7 967, 250	162, 002	90.00
91.00 Nursing School cost	0	2, 173, 053	0. 00000	0 967, 250	0	91.00
92.00 Allied health cost	0	2, 173, 053	0. 00000	0 967, 250	0	92.00
93.00 All other Medical Education	0	2, 173, 053	0.00000	0 967, 250	0	93.00

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Health Financia	al Systems	ST VINCENT SALEM		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCI	LLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151314	Period:	Worksheet D-3	
				From 07/01/2013 To 06/30/2014		narod
				10 00/30/2014	3/18/2015 4:2	
		Ti tl	e XVIII	Hospi tal	Cost	
Со	st Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
			1.00	2.00	col. 2) 3.00	
	IT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ULTS & PEDIATRICS			331,030		30.00
	RY SERVICE COST CENTERS		1	331,030		30.00
	ERATING ROOM		0. 2840	90 123, 393	35,055	50.00
	DIOLOGY - DIAGNOSTIC		0. 1644		11, 451	
	GNETIC RESONANCE IMAGING (MRI)		0. 2536			
	BORATORY		0. 2374	170, 573	40, 494	60.00
61.00 06100 PB	P CLINICAL LAB. SERVICE-PRGM. ONLY		0.0000	0 00	0	61.00
65.00 06500 RE	SPI RATORY THERAPY		0. 5851	90 47, 755	27, 946	65.00
	YSI CAL THERAPY		0. 3191		13, 657	
	CUPATI ONAL THERAPY		0. 3152		0	67.00
	EECH PATHOLOGY		0.0000		0	68.00
	ECTROCARDI OLOGY		0. 2668		12, 531	1
	ECTROENCEPHALOGRAPHY		0.0000		0	
	DICAL SUPPLIES CHARGED TO PATIENTS		0. 2771			71.00
	PLANTABLE DEVICES CHARGED TO PATIENTS		0.6020			
	UGS CHARGED TO PATIENTS		0.4602			1
	NAL DIALYSIS		0.0000		0	
	C (NON-DI STI NCT PART)		0.0000		0	75.00 75.01
	EEP DISORDER ULT MENTAL HEALTH		0. 4728		0	75.01
	RDIAC REHABILITATION		1. 3439		-	76.97
	ENT SERVICE COST CENTERS		1. 3437	50 0	0	/0. 7/
	RAL HEALTH CLINIC		0.0000	00	0	88.00
	DERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90.00 09000 CL			0.0000		0	90.00
91.00 09100 EM	IERGENCY		0. 3973		0	91.00
92.00 09200 OB	SERVATION BEDS (NON-DISTINCT PART)		2. 2648	97 3, 969	8, 989	92.00
200. 00 To	tal (sum of lines 50–94 and 96–98)			811, 132	264, 681	200.00
201.00 Le	ss PBP Clinic Laboratory Services-Progra	am only charges (line 61)		0		201.00
202.00 Ne	t Charges (line 200 minus line 201)	-		811, 132		202.00

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Health Financial Systems ST	VINCENT SALEM		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151314	Period:	Worksheet D-3	
		001 457044	From 07/01/2013		
	Component	CCN: 15Z314	To 06/30/2014	Date/Time Pre 3/18/2015 4:2	
	Ti tl	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
ANCI LLARY SERVI CE COST CENTERS		1			
50.00 05000 OPERATING ROOM		0. 2840		0	50.00
54. 00 05400 RADI OLOGY – DI AGNOSTI C		0. 1644			54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2536		0	58.00
60. 00 06000 LABORATORY		0. 23740		6, 677	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0.0000		0	61.00
65. 00 06500 RESPI RATORY THERAPY		0. 5851		10, 068	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3191		31, 040	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 3152		0	67.00
68.00 06800 SPEECH PATHOLOGY		0.0000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2668		4, 164	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2771			71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS		0.6020		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0.4602			73.00
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART)		0.0000		0	74.00 75.00
		0.0000		0	75.00
75. 01 03950 SLEEP DI SORDER 75. 03 07501 ADULT MENTAL HEALTH		0. 47283 0. 60570		0	75.01
76. 97 07697 CARDIAC REHABILITATION		1. 3439			75.03
OUTPATIENT SERVICE COST CENTERS		1. 3439.		0	/0.9/
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89.00
90. 00 09000 CLINIC		0.0000		0	90.00
91. 00 09100 EMERGENCY		0. 39730		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2.2648		2,990	
200.00 Total (sum of lines 50-94 and 96-98)			239, 564	83, 455	
201.00 Less PBP Clinic Laboratory Services-Program on	ly charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)	,		239, 564		202.00
					•

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Health Financial Systems ST	VINCENT SALEM		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151314	Peri od:	Worksheet D-3	
			From 07/01/2013	Date/Time Pre	norod.
			To 06/30/2014	3/18/2015 4:2	
	Tit	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			36, 400		30.00
ANCI LLARY SERVI CE COST CENTERS		1			
50.00 O5000 OPERATING ROOM		0. 28409			
54.00 05400 RADI OLOGY – DI AGNOSTI C		0. 16449		360	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 25363		0	
60.00 06000 LABORATORY		0. 23740			
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0.0000		0	61.00
65. 00 06500 RESPI RATORY THERAPY		0. 58519		7, 249	
66.00 06600 PHYSI CAL THERAPY		0. 31912		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 31529		0	67.00
68.00 06800 SPEECH PATHOLOGY		0.0000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2668		487	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0.2771		0	71.00
		0.60203		0	72.00 73.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S		0. 46022		8, 701 0	
75. 00 07500 ASC (NON-DI STINCT PART)		0.00000		0	75.00
75. 01 03950 SLEEP DI SORDER		0. 47283		0	75.00
75. 03 07501 ADULT MENTAL HEALTH		0. 60570		0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON		1. 34393		-	76.97
OUTPATIENT SERVICE COST CENTERS		1. 5457		0	/0. //
88. 00 08800 RURAL HEALTH CLINIC		0.0000	0 00	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	89.00
90. 00 09000 CLINIC		0.0000		0	
91. 00 09100 EMERGENCY		0. 39730		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 26489		0	
200.00 Total (sum of lines 50-94 and 96-98)			69, 781	25, 920	200.00
201.00 Less PBP Clinic Laboratory Services-Program on	ly charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			69, 781		202.00

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	Financial Systems ST VINCENT S/ ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151314	Peri od:	u of Form CMS-2 Worksheet E	2002-1
			From 07/01/2013 To 06/30/2014		pared
		Title XVIII	Hospi tal	3/18/2015 4:2 Cost	
			nospi tai		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			4, 834, 426	1.0
. 00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		0	
. 00 . 00	PPS payments Outlier payment (see instructions)			0	3.0
. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	
. 00	Line 2 times line 5			0	6.0
. 00 . 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00 0	
. 00	Ancillary service other pass through costs from Worksheet D, F	Part IV, column 13, lin	e 200	0	
0. 00	Organ acqui si ti ons			0	
1.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 834, 426	11. C
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				1
	Ancillary service charges			0	12.0
	Organ acquisition charges (from Worksheet D-4, Part III, line	69, col. 4)		0	
4.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14. C
5.00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basi s	0	15. C
6. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16. C
7.00	had such payment been made in accordance with 42 CFR 413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000))		0.00000	17.0
	Total customary charges (see instructions)			0.000000	
9.00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds l	ine 11) (see	0	19.0
0.00	instructions) Excess of reasonable cost over customary charges (complete onl	vifling 11 exceeds l	ing 18) (see	0	20.0
0.00	instructions)	y IT THE IT EXCEEDS I	The To) (see	0	20.0
1.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		4, 882, 770	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	cuctions)		0	
4.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	uctions)		0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
5.00 6.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CALL coo instructions	\ \	25, 446 2, 383, 793	
	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus			2, 383, 793	
	see instructions)				
	Direct graduate medical education payments (from Worksheet E-4 ESRD direct medical education costs (from Worksheet E-4, line			0	
	Subtotal (sum of lines 27 through 29)	30)		2, 473, 531	1
	Primary payer payments			2, 726	
2.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	YEC)		2, 470, 805	32.0
3.00	Composite rate ESRD (from Worksheet I-5, line 11)	,L3)		0	33.0
	Allowable bad debts (see instructions)			529, 463	
	Adjusted reimbursable bad debts (see instructions)	suctions)		465, 927	
	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	uctions)		458, 732 2, 936, 732	
	MSP-LCC reconciliation amount from PS&R			0	
9.00				0	
9. 01 9. 98				0	39.0
	RECOVERY OF ACCELERATED DEPRECIATION			0	39.9
	Subtotal (see instructions)			2, 936, 732	
	Sequestration adjustment (see instructions) Interim payments			58, 735 2, 823, 407	
	Tentative settlement (for contractors use only)			2, 023, 407	
3.00	Balance due provider/program (see instructions)			54, 590	
4.00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44.0
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91.0
	Time Value of Money (see instructions)				92.0
	Total (sum of lines 91 and 93)				94.0

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014		pared
		Title	e XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	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		755, 9	94 0	2, 862, 351 0	1. 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	01/13/2015	73, 0	12	0	3.
. 02				0	0	3.
. 03				0	0	3.
. 04 . 05				0	0	3
49				0	0	3
	Provider to Program					-
50	ADJUSTMENTS TO PROGRAM			0 01/13/2015	38, 944	3
51				0	0	3
52				0	0	3
53 54				0	0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		73, 0	-	-38, 944	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)		829, 0	06	2, 823, 407	4
	TO BE COMPLETED BY CONTRACTOR	<u> </u>				
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)					5
	Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5
02 03				0	0	5
55	Provider to Program			0	0	
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			0	54, 590	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		829, 0		2, 877, 997	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
				TO NOT	(

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IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der		eriod: rom 07/01/2013	Worksheet E-1 Part I	
		Component	CCN: 15Z314			
		Titl	e XVIII Sv	ving Beds - SNF		
		I npati en	t Part A	Par	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		325, 850 0		0 0	1. 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)					3.
01	Program to Provider ADJUSTMENTS TO PROVIDER	01/30/2014	32, 400		0	3.
02		01/13/2014	49, 651		0	3.
03			0		0	3.
04			0		0	3
05			0		0	3
49	Durau di daura da Dura muran		0		0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM		0	[0	3
50 51			0		0	3
52			0		0	3
53			0		0	3
54			0		0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		82, 051		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		407, 901		0	4
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
D1	Program to Provider TENTATIVE TO PROVIDER		0		0	5
)2			0		0	5
03			0		0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM		0		0	5
51 52			0		0	5
92 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5
)0	5.50-5.98) Determined net settlement amount (balance due) based on		0		Ū	6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		0		0	6
02	SETTLEMENT TO PROGRAM		0		0	6
00	Total Medicare program liability (see instructions)		407, 901	Contractor	0 NPR Date	7
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

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Heal th	Financial Systems	ST VINCENT SA	LEM		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 1513 Component CCN: 152		Period: From 07/01/2013 To 06/30/2014		pared:
			Title XVIII		Swing Beds - SNF	3/18/2015 4:2 Cost	8 pm
			IIII e XVIII		Part A	Part B	
					1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF (see	instructions)			334, 156	0	1.00
2.00	Inpatient routine services - swing bed-NF (see i						2.00
3.00	Ancillary services (from Wkst. D-3, column 3, li	ine 200 for Part	t A, and sum of Wks	st. D	84, 290	0	3.00
	Part V, columns 6 and 7, line 202 for Part B) (F	For CAH, see ins	structions)				
4.00	Per diem cost for interns and residents not in a	approved teachir	ng program (see			0.00	4.00
	instructions)						
5.00	Program days				178	0	5.00
6.00	Interns and residents not in approved teaching p					0	6.00
7.00	Utilization review - physician compensation - SM		nod only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6	and 7)			418, 446	0	8.00
9.00	Primary payer payments (see instructions)				0	0	9.00
10.00	Subtotal (line 8 minus line 9)				418, 446	0	10.00
11.00	Deductibles billed to program patients (exclude professional services)	amounts applica	able to physician		0	0	11.00
12.00	Subtotal (line 10 minus line 11)				418, 446	0	
13.00	Coinsurance billed to program patients (from pro for physician professional services)	ovider records)	(excl ude coi nsurar	nce	2, 220	0	13.00
14.00	80% of Part B costs (line 12 x 80%)					0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line	e 13, or line 14	4)		416, 226	0	15.00
16.00					0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT				0		16.50
17.00	Allowable bad debts (see instructions)				0	0	
17.01	Adjusted reimbursable bad debts (see instruction				0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiar	ries (see instru	uctions)		0	0	
19.00	Total (see instructions)				416, 226	0	
19.01	Sequestration adjustment (see instructions)				8, 325	0	19.01
20.00	Interim payments				407, 901	0	20.00
21.00					0	0	21.00
22.00	Balance due provider/program line 19 minus lines				0	0	22.00
23.00	Protested amounts (nonallowable cost report item section 115.2	ms) in accordand	ce with CMS Pub. 15	5-2,	0	0	23.00

Heal th	Financial Systems ST VINCENT S/	ALEM	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151314	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Pre 3/18/2015 4:2	pared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COS	T REIMBURSEMENT		
1.00	Inpatient services	`		930, 096	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	on)		0	2.00
3.00	Organ acquisition			0	3.00
4.00 5.00	Subtotal (sum of lines 1 thru 3)			930, 096	4.00 5.00
5.00 6.00	Primary payer payments Total cost (line 4 less line 5). For CAH (see instructions)			939, 397	6.00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			737, 377	0.00
	Reasonable charges				
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11.00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for	1 5	on 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)			0.000000	
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete onl instructions)	y IT line 14 exceeds I	ine 6) (see	0	15.00
16.00	Excess of reasonable cost over customary charges (complete onl	vifline 6 exceeds li	ne 14) (see	0	16.00
	instructions)	5			
17.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4	1, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			939, 397	
	Deductibles (exclude professional component)			104, 085	
	Excess reasonable cost (from line 16)			0	21.00
	Subtotal (line 19 minus line 20 and 21)			835, 312	
23.00 24.00	Coinsurance			0	23.00 24.00
	Subtotal (line 22 minus line 23) Allowable bad debts (exclude bad debts for professional servic	ac) (coo i petructione)		835, 312 12, 060	
25.00	Adjusted reimbursable bad debts (see instructions)	(see fistinctions)		12,000	
28.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	suctions)		6, 694	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			845, 925	
29.00				043, 723	29.00
	Recovery of Accelerated Depreciation			0	29.99
	Subtotal (line 28, plus or minus lines 29)			845, 925	
30.01	Sequestration adjustment (see instructions)			16, 919	30.01
31.00	Interim payments			829, 006	31.00
32.00	Tentative settlement (for contractor use only)			0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, ar	nd 32		0	33.00
34.00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	chapter 1,	0	34.00
	§115. 2				l

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	Financial Systems ST VINCENT S			u of Form CMS-2	
JALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151314	Period: From 07/01/2013 To 06/30/2014		pared:
		Title XIX	Hospi tal	Cost	o pii
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR 2	XIX SERVICES		
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		(0.404		1 1 00
1.00	Inpatient hospital/SNF/NF services		63, 194	0	1.00
2.00 3.00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	2.00
1.00	Subtotal (sum of lines 1, 2 and 3)		63, 194	0	
5.00	Inpatient primary payer payments		00,171	0	5.0
5.00	Outpatient primary payer payments			0	6.0
7.00	Subtotal (line 4 less sum of lines 5 and 6)		63, 194	0	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES]
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		142, 884		8.00
9.00	Ancillary service charges		69, 781	0	
10.00	Organ acquisition charges, net of revenue		0		10.0
11.00 12.00	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)		212, 665	0	
12.00	CUSTOMARY CHARGES		212,005	0	12.0
13.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.0
	basi s			-	
4.00	Amounts that would have been realized from patients liable fo	r payment for services	on 0	0	14.0
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
16.00	Total customary charges (see instructions)		212, 665	0	16.0
17.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	149, 471	0	17.0
18.00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds li	ne 0	0	18.0
10.00	16) (see instructions)	ry II IIIe 4 exceeds II	0	0	10.0
19.00	Interns and Residents (see instructions)		0	0	19.0
20.00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20.0
21.00	Cost of covered services (enter the lesser of line 4 or line	16)	63, 194	0	21.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS prov	ders.		
	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	
24.00	Program capital payments		0		24.0 25.0
25.00 26.00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	20.0
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.0
29.00	Titles V or XIX (sum of lines 21 and 27)		63, 194	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	30.0
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	63, 194	0	
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	33.0
34.00	Allowable bad debts (see instructions)		0	0	
35.00 36.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	q 33)	0 63, 194	0	35.0 36.0
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	u 557	03, 194	0	37.0
38.00	Subtotal (line 36 \pm line 37)		63, 194	0	38.0
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.0
40.00	Total amount payable to the provider (sum of lines 38 and 39)		63, 194	0	
41.00	Interim payments		63, 194	0	41.0
12.00	Balance due provider/program (line 40 minus line 41)		0	0	42.0
43.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43.0
	chapter 1, §115.2				

ALANCE S	nancial Systems ST VINCEN SHEET (If you are nonproprietary and do not maintain e accounting records, complete the General Fund column on	Provi der	CCN: 151314	Period: From 07/01/2013	u of Form CMS- Worksheet G	
unu-type		(y)		To 06/30/2014	Date/Time Pre 3/18/2015 4:2	
		General Fund	Specific Purpose Fund		Plant Fund	
CUE	RRENT ASSETS	1.00	2.00	3.00	4.00	
	ish on hand in banks	7, 697, 309		0 0	0	1.
	mporary investments	0		0 0	0	
	tes receivable	0		0 0	0	3
	counts receivable	6, 539, 592		0 0	0	
	her receivable	494, 186		0 0	0	
	lowances for uncollectible notes and accounts receivable ventory	-3, 882, 105 388, 544		0 0	0	
	epaid expenses	158, 643		0 0	0	
	her current assets	300, 647		0 0	0	
. 00 Du	e from other funds	586, 805		0 0	0	10
	tal current assets (sum of lines 1-10)	12, 283, 621		0 0	0	11
	XED ASSETS		1	0 0	0	1 1 2
	nd nd improvements	0		0 0 0 0	0	
	cumulated depreciation	0		0 0	0	
	i l di ngs	516, 397		0 0	0	
	cumulated depreciation	-36, 296		0 0	0	
	asehold improvements	856, 968		0 0	0	
	cumulated depreciation	-713, 402		0 0	0	
	xed equipment cumulated depreciation	503, 809 -403, 057		0 0 0 0	0	
	tomobiles and trucks	13, 500		0 0	0	
	cumulated depreciation	-8, 156		0 0	0	
	jor movable equipment	422, 542		0 0	0	23
1.00 Ac	cumulated depreciation	-200, 531		0 0	0	24
	nor equipment depreciable	0		0 0	0	
	cumulated depreciation	0		0 0	0	
	T designated Assets ccumulated depreciation			0 0 0 0	0	
	nor equipment-nondepreciable	0		0 0	0	
1	ital fixed assets (sum of lines 12-29)	951, 774		0 0	0	
	HER ASSETS	1	1			
	vestments	0		0 0	0	
1	posits on leases	0		0 0	0	
1	e from owners/officers her assets	289, 991		0 0	0	
	tal other assets (sum of lines 31-34)	289, 991		0 0	0	
1	tal assets (sum of lines 11, 30, and 35)	13, 525, 386		0 0	0	
	RRENT LIABILITIES					
	counts payable	587, 799		0 0	0	
3.00 Sa	laries, wages, and fees payable	345, 691		0 0	0	
	yroll taxes payable ites and loans payable (short term)	0		0 0	0	
	ferred income	0		0 0	0	
	celerated payments	0		-	-	42
3. 00 Du	e to other funds	595, 978		0 0	0	43
	her current liabilities	1, 207, 446		0 0	0	
	tal current liabilities (sum of lines 37 thru 44)	2, 736, 914		0 0	0	45
	NG TERM LIABILITIES			0 0	0	46
	ites payable			0 0	0	
	secured Loans	0		0 0	0	
	her long term liabilities	0		0 0	0	
	tal long term liabilities (sum of lines 46 thru 49	0		0 0	0	
	tal liabilites (sum of lines 45 and 50)	2, 736, 914		0 0	0	51
	PITAL ACCOUNTS	10 700 470				52
	neral fund balance pecific purpose fund	10, 788, 472		0		52
	nor created - endowment fund balance - restricted			0		54
	nor created - endowment fund balance - unrestricted			0		55
	verning body created - endowment fund balance			0		56
	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement,				0	58
	placement, and expansion tal fund balances (sum of lines 52 thru 58)	10 700 470		0	0	59
1	ntal fund balances (sum of lines 52 thru 58) Ital liabilities and fund balances (sum of lines 51 and	10, 788, 472 13, 525, 386		0 0	0	
		.0,020,000		- 0	0	1

Heal th	Financial Systems	ST VINCENT	SALEM			In Lie	u of Form CM	S-2	552-10
	IENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 151314		7/01/2013 6/30/2014	Worksheet C Date/Time F 3/18/2015 4	rep	
		General	Fund	Speci al	Purpose	Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5.00	+	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) DONATION GRANT REVENUE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) PENSION RELATED RP TRANSFER RELEASED OPERATING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	7, 964 21, 250 0 0 0 0 0 0 0 0 0 2, 062, 750 23, 580 0 0 0 0 0	2, 086, 330 2, 086, 347 2, 086 2, 086, 347 2, 086, 347	5.00		0 0 0 0 0 0	0.00	0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund					
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0			_	1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) DONATION GRANT REVENUE	0	0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) PENSION RELATED RP TRANSFER RELEASED OPERATING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0				9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

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Heal th	Financial Systems ST VINCENT SA	_EM		In Lie	eu of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 151314	Period: From 07/01/2013 To 06/30/2014		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services		0.000.7		0.000.777	1
1.00	Hospi tal		3, 892, 7	//	3, 892, 777	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER					3.00 4.00
4.00 5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	1
7.00	SKILLED NURSING FACILITY			0		7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		3, 892, 7	77	3, 892, 777	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)			0		15.00
16.00	Total intensive care type inpatient hospital services (sum of I 11-15)	Thes		0	0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		3, 892, 7	77	3, 892, 777	17.00
18.00	Ancillary services		1, 881, 4			18.00
19.00	Outpatient services		1,001,1	0 7, 385, 414		
20.00	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)				0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 1	O WKST.	5, 774, 1	86 43, 952, 429	49, 726, 615	28.00
	G-3, line 1) PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		1	17, 026, 848		29.00
30.00				0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			C		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00 41.00				0		40.00
41.00	Total deductions (sum of lines 37-41)					41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		17, 026, 848		43.00
	to Wkst. G-3, line 4)	(, 020, 040		
						•

Heal th	Financial Systems ST VINCENT	SALFM	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES		Provi der CCN: 151314	Peri od: From 07/01/2013 To 06/30/2014	Worksheet G-3	pared:
1.00				1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir			49, 726, 615	1.00
2.00	Less contractual allowances and discounts on patients' accour	ITS		30, 516, 226	2.00
3.00	Net patient revenues (line 1 minus line 2)	12)		19, 210, 389	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		17, 026, 848	
5.00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			2, 183, 541	5.00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	n services		0	8.00
9.00	Revenue from tel evision and radio service	1 301 11 003		0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			62, 710	
15.00	Revenue from rental of living quarters			0	
16.00	Revenue from sale of medical and surgical supplies to other t	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			20, 939	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			110, 924	22.00
23.00	Governmental appropriations			0	23.00
24.00	GRANTS			10, 417	24.00
24.01	MI SC REVENUE			1, 427	
24.02	NET ASSETS RELEASED FROM RESTRICTION			24, 358	24.02
24.03	NONOPERATI NG GAI NS/LOSSES			904, 771	24.03
24.04				0	24.04
24.05				0	24.05
24.06				0	24.06
25.00	Total other income (sum of lines 6-24)			1, 135, 546	
26.00	Total (line 5 plus line 25)			3, 319, 087	
27.00				0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			3, 319, 087	29.00

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