Health Financi	al Systems	ST. VINCENT	CARMEL HOSPITAL		In Lieu of Form	m CMS-2552-10
This report is	required by law (42 US	C 1395g; 42 CFR 413.20(b)). Failure to report ca	an result in all i	nterim FORM AP	PROVED
payments made	since the beginning of	the cost reporting period	being deemed overpayme	ents (42 USC 1395g)). OMB NO.	0938-0050
HOSPITAL AND H AND SETTLEMENT		PLEX COST REPORT CERTIFICA	ATION Provider CCN:	From 07/0	1/2014 Workshe Parts I 0/2015 Date/Ti 11/30/2	-111
PART I - COST	REPORT STATUS					
Provi der	1. [X] El ectroni call y	filed cost report		Date: 1	11/30/2015 Ti	ime: 9:47 am
use only	2. [] Manually submi	ted cost report				
		amended report enter the n zation. Enter "F" for full		vider resubmitted	this cost repor	rt
Contractor use only	(1) As Submitted	atus 6. Date Received: 7. Contractor No. Audit 8. [N]Initial Rep Hit 9. [N]Final Repor	oort for this Provider (t for this Provider CCI	10. NPR Date: 11. Contractor' CCN 12. [0]If line number	s Vendor Code: e 5, column 1 i of times reope	is 4: Enter

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT CARMEL HOSPITAL (150157) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
Ti tl	e
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	670, 455	111, 788	-34, 440	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
200.00	Total	0	670, 455	111, 788	-34, 440	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.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150157 Peri od: Worksheet S-2 From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/30/2015 9:44 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 13500 NORTH MERIDIAN STREET 1.00 PO Box: 1.00 2.00 City: CARMEL State: IN Zip Code: 46033 County: HAMILTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST. VINCENT CARMEL 150157 26900 01/14/2004 Ν 0 3.00 1 HOSPI TAL Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2014 06/30/2015 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Υ Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 3 Ν 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d 0ther In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3. 00 4.00 5.00 6.00 147 1, 308 24.00 If this provider is an IPPS hospital, enter the 971 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2. out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

Respiration Republication	Health Financial Systems ST. VINC	CENT CAF	RMEL HOSPITAL		1	n Lieu	of For	m CMS-:	2552-10
27.00 Enter your standard geographic class if cation (not wage) status at the beginning of the cost reporting period. Enter '11' for urban or '27' for rural. 1				Fi	eriod: rom 07/01,	/2014	Workshe Part I Date/Ti	et S-2 me Pre	pared:
2.00 Printer your standard geographs of classification (not sage) status at the beginning of the part of the country in the co							Date of	Geogr	
27.00 Fifther your standard geographic classification (not ways) status at the end of the cost resporting period. Enter in column 1, "I for urban or "2" for rural I feel applicable, a control of the periods SCH status in certain period. The cost reporting period of the periods SCH status in certain period. 35.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods of periods in excess of one and enter subsequent dates. 37.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 37.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 38.00 Enter applicable beginning and ending dates of SCH status. If line 37 is greater than 1, subscript this line for the number of periods INP status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and greater than 1, subscript this line for the number of periods in excess of one and greater than 1, subscript this line for the number of periods in excess of one and greater than 1, subscript this line for the number of periods in excess of one and greater than 1, subscript this line for the number of periods in excess of one and greater than 1, subscript this line for the full type and the period of the excess of one and greater than 1, subscript this line for the full type and type and the full type and ty				ginning of the	1.00	1	2. (10	26. 00
35.00 Citter applicable beginning and ending dates of SCH status. Subscript Tine 36 ror number of periods SCH status in citter applicable beginning and ending dates of SCH status. Subscript Tine 36 ror number of periods in excess of one and enter subsequent dates. 30.00 Citter applicable beginning and ending dates of SCH status. Subscript Tine 36 ror number of periods in excess of one and enter subsequent dates. 37.00 First is a Bedicare objected those Jack (Mith). enter the number of periods MCH status. 0 37.00 37.00 First is a Bedicare objected those Jack (MCH). enter the number of periods MCH status. 0 37.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 3	27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o	age) sta r "2" fo	atus at the enc or rural. If ap	of the cost		1			27. 00
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 37.00 1 periods in excess of one and enter subsequent dates. 37.00 37.00 15 in 16 refer til in the coxist reporting periods (III) is a free free til in the coxist reporting period (III) is a free free til in the coxist reporting period (III) is a free free til in the coxist reporting period (III) is a free free til in the coxist reporting period (III) is a free free til in the coxist reporting period (III) is a free free til in a free free free free free free free fr	35.00 If this is a sole community hospital (SCH), enter th			CH status in		0			35. 00
of particls in excess of one and enter subsequent dates. 7.00 f. this is a Medicare dependent hospital (MDH), enter the number of periods IMDH status. 8.00 s. in effect in the cost reporting period. 8.00 s. in effect in the cost reporting period. 8.00 s. in effect in the cost reporting period. 8.00 s. in effect in the cost reporting period. 8.00 s. in excess of one and senter subsequent dates. 9.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CRF 44(2.1016)/2(11)? Enter in column 1.1 'Y for yes or 'N' for no. Does the facility seet the mileage requirements in accordance with 42 CRF 44(2.1016)/2(11)? Enter in column 1.1 'Y for yes or 'N'									
37.00 If this is a Medicare dependent hospital (MRH), enter the number of periods MRH status 0			Subscript line	36 for number					36. 00
greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. It is line for the number of periods in excess of one and enter subsequent dates. Y/R	37.00 If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	r the n	·			0			
30,00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N	greater than 1, subscript this line for the number o								30.00
hospitals in accordance with 42 CFR \$412.01(b)(2)(1)? Enter in facultan 1 - Y- for yes or "N" for no. Does the facility wheel the mile legal erquirements in accordance with 42 CFR \$412.101(b)(2)(1)? Inter in column 2 - Y- for yes or "N" for no. Column 1 - Y- for yes or "N" for no. In column 2 - for discharges program reduction adjustment? Enter Y- for yes or "N" for no. In column 2 - for discharges on or after October 1. (see instructions) Y									-
40.00 st this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. (see instructions) V XVIII XIX	hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage re	i)? Ento quiremen	er in column 1 nts in accordar	"Y" for yes nce with 42					39. 00
Prospective Payment System (PPS)-Capital	40.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo	n adjus [.] ber 1. l	tment? Enter "\ Enter "Y" for y	" for yes or	N		N		40. 00
Prospective Payment System (PPS)-Capital 5.00 Does this Facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412,320? (see instructions) 4.00 Is this Facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412,300 Pys. camplete Wst. L. Pt. III and Wst. L1, Pt. I through Pt. III. 4.00 Is this a new hospital under 42 CFR §412,300 PPS capital? Enter "Y for yes or "N" for no. N N N N N 44.00 Pt. III. 4.00 Is the facility electing full rederal capital payment? Enter "Y for yes or "N" for no. N N N N N 45.00 Pt. III. 5.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 6.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 6.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 6.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 6.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 6.00 Is this a hospital involved in training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2 is "Y", complete Wst. D. Parts II is N and D.2 Pt. II, if applicable to "A Pt. Pt. II. I is Pt. II. I is Pt. Pt. I is Pt. II. I is Pt. Pt. II. I is Pt. II. I		, , , , ,			'				
with 42 CFR Section \$412,3207 (see instructions) 40.00 Is this facility eligible for additional payment exception for extraordinary circumstances poursuant to 42 CFR \$412,348(f)? If yes, complete Wsst. L. Pt. III and Wsst. L1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR \$412,300 PPS capital? Enter "Y for yes or "N" for no. 47.00 Is this a new hospital under 42 CFR \$412,300 PPS capital? Enter "Y for yes or "N" for no. 47.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 48.00 Is the facility electing full lederal capital payment? Enter "Y" for yes or "N" for no. 48.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 48.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 48.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 48.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 48.00 Is this a hospital involved in training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 2 is "Y" complete Worksheet E-4. If colum		nt for	di enconorti onat	o chara in acc	ordanco				45.00
47.00 sthis a new hospital under 42 CFR \$412.300 PPS capital? Enter "Y for yes or "N" for no.	with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks	eption ⁻	· · for extraordina	ary circumstand	es				
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Wkst D, Parts III & IV and D-2, Pt. II. if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physiclans' services as defined in CMS Pub. 15-1, chapter 21, \$2148? If yes, complete Wkst D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If tyes, complete Wkst D-2, Pt. I. N 59.00 60.00 Are you claiming pursing school and/or allied health costs for a program that meets the provider-operated criteria under \$413.85? Enter "Y" for yes or "N" for no. (see Instructions) 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care ending and submit the defore March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care ending and submit the defore March 23, 2010. (see instructions) 61.03 Enter the current year total unweighted primary care 0.00 0.00 0.00 61.03 61.04 Enter the basel in effe count for primary care/or series 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 series 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) 61.05 Enter the amount of ACA \$5503 award that is being used for cap relief and/or elief and/or elief and/or elief and/or elief and/or elief and/or	47.00 Is this a new hospital under 42 CFR §412.300 PPS cap 48.00 Is the facility electing full federal capital paymen				10.				
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved (ME programs trained at this facility? Enter "Y" for yes or "N" for no in col umn 1. If col umn 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in col umn 2. If col umn 2 is "Y", complete Worksheet E-4. If col umn 2 is "Y", complete Wst. D, Parts III & IV and D-2, Pt. II, If applicable. 1	56.00 Is this a hospital involved in training residents in	approv	ed GME programs	? Enter "Y" f	for yes	N			56. 00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, \$2148? If yes, complete Wkst. D-5.	57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	r yes o th of tl Y", comp	r "N" for no ir his cost report plete Worksheet	n column 1. If ing period? E	column 1 Inter "Y"				57. 00
60.00 Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under \$413.85? Enter "Y" for yes or "N" for no. (see instructions) 1	58.00 If line 56 is yes, did this facility elect cost reim	bursemei	nt for physicia	nns' services a	IS	N			58. 00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding 08/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery all opathic and/or osteopathic FTEs in the current cost reporting period, (see instructions). 61.05 Enter the difference between the baseline primary 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 used for cap relief and/or FTEs that are nonprimary	3.								1
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTE count for primary care 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 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's 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 used for cap relief and/or FTEs that are nonprimary	provider-operated criteria under §413.85? Enter "Y"						Di rect	GME	
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 instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTE sand 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 used for cap relief and/or FTEs that are nonprimary	61.00 Did your hospital receive FTF slots under ACA		2. 00	3. 00	4.00		5. C		61.00
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's 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 used for cap relief and/or FTEs that are nonprimary	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		0.00	0.00					
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's 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 used for cap relief and/or FTEs that are nonprimary 0.00 0.00 0.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.00 61.	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					01.01
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's 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 used for cap relief and/or FTEs that are nonprimary 61.06	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
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's 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 used for cap relief and/or FTEs that are nonprimary 0.00 0.00 61.04 61.04 61.05 61.06	61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.00					61. 03
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary 61.05 61.06	61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61. 04
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary 0.00 0.00 61.06	61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0.00					61. 05
	61.06 Enter the amount of ACA §5503 award that is being		0.00	0.00					61.06

Health Financial Systems ST. VINCENT CARMEL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150157 Peri od: Worksheet S-2 From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/30/2015 9:44 am Program Code Unweighted IME Program Name Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded 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 direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 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 4)). (see instructions)

In Lieu of Form CMS-2552-10 Health Financial Systems ST. VINCENT CARMEL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150157 Peri od: Worksheet S-2 From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/30/2015 9:44 am Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in 2)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 0.000000 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Ratio (col. 3/ Program Name Program Code Unwei ghted Unwei ahted FTEs FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2 00 3.00 4.00 5 00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4. the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 70.00 70.00 Ν If line 70 yes. Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Provi ders 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 \$413.40(f)(i)(i)? Enter "Y" for yes and "N" for no.
Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" Ν 87.00 for yes or "N" for no. ٧/ XI X 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν 90.00 yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Ν 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 92.00 N Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93 00 Ν N 93 00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N 94.00 Ν applicable column.

Health Financial Systems ST. VINCENT CAR HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		F	In Lie Period: From 07/01/2014 To 06/30/2015		epared:
			1. 00	2. 00	
 95.00 If line 94 is "Y", enter the reduction percentage in the apple. Does title V or XIX reduce operating cost? Enter "Y" for yeapplicable column. 1f line 96 is "Y", enter the reduction percentage in the apple. 	s or "N" for no	o in the	0. 00 N	N	95. 00 96. 00 97. 00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (C. 106.00 of this facility qualifies as a CAH, has it elected the all		nod of payment	N N		105.00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see instr	ructions) If	N		107. 00
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	_		N		108. 00
	Physi cal 1.00	Occupati onal 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	N	109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N"		on project (41)	OA Demo)for	N	110. 00
Microel Lancoure Coat Depositing Information			1. 0	0 2.00 3.00)
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide	. If column 2 i nt for long ter	s "E", enter rm care (inclu	in column des	0	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu			"N" for Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence po	licy? Enter 1 i	f the policy	is 1		118. 00
portarii iidadi. Eritor Erit tilo portoj to occar siloci.		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3. 00 712, 26	57 118. 01
			1. 00	2. 00	_
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.			N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §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' µalifies for th	' for yes or ne Outpatient	N	N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implements? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y		121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	for yes and "N"	for no. If	N		125. 00
126.00 If this is a Medicare certified kidney transplant center, ein column 1 and termination date, if applicable, in column		fication date			126. 00
127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi	cation date			127. 00
128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi	cation date			128. 00
129.00 If this is a Medicare certified lung transplant center, enticolumn 1 and termination date, if applicable, in column 2.	er the certific				129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in co	lumn 2.				130.00
131.00 If this is a Medicare certified intestinal transplant cente		ertification			131. 00
date in column 1 and termination date, if applicable, in co				1	1
132.00 If this is a Medicare certified islet transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi 2.				132. 00
132.00 If this is a Medicare certified islet transplant center, en	ter the certifi 2. ter the certifi 2.	cation date			132. 00 133. 00 134. 00

Health Financial Systems		CARMEL HOSPITAL				u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE.	X IDENTIFICATION DATA	Provi der	CCN: 150157	From O	: 7/01/2014 6/30/2015		epared:
					1. 00	2.00	+
All Providers							
140.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1.	If yes, and home	office cos		Y	269008	140. 00
1.00		2. 00	142 +6		3.00	-6 +1	
If this facility is part of a chai home office and enter the home off				e name and	a address	or the	
41.00 Name: ST. VINCENT HEALTH	Contractor's Name:			ctor's Nu	mber: 0810)1	141. 00
42. 00 Street: 10330 N. MERIDIAN STREET	PO Box:	LM	7: 0-	4-	4/00	20	142. 0
43.00 Ci ty: I NDI ANAPOLI S	State:	I N	Zi p Cc	ae:	4629	7 0	143. 00
						1.00	
44.00 Are provider based physicians' cos	ts included in Workshee	t A?				Υ	144. 00
					1. 00	2.00	+
45.00 If costs for renal services are cl	aimed on Wkst. A, line	74, are the costs	s for		N N	2.00	145. 00
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no Lude Medicare utilizati	in column 1. If o	column 1 is	5			
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	column 1. (See CMS Pub			If	N		146. 00
						1.00	4
47.00Was there a change in the statisti	cal hasis? Enter "Y" fo	r ves or "N" for	no			1.00 N	147. 0
48.00 Was there a change in the order of						N N	148. 0
49.00 Was there a change to the simplifi	ed cost finding method?					N	149. 0
		Part A 1.00	Part E	3 T	itle V	Title XIX	4
Does this facility contain a provi	der that qualifies for		2.00 m the appli	cation of	3.00 f the Lowe	4.00	
or charges? Enter "Y" for yes or "							
55. 00 Hospi tal		N	N N		N	N	155. 0
56. 00 Subprovi der - IPF 57. 00 Subprovi der - IRF		N N	N N		N N	N N	156. 0 157. 0
58. 00 SUBPROVI DER		14	"		14		158. 0
59. 00 SNF		N	N N		N	N	159. 0
60. 00 HOME HEALTH AGENCY		N	N N		N N	N	160. 0
61. 00 CMHC			l N		IN	N	161. 0
						1.00	
Mul ti campus							4.5
65.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	one or more camp	uses in dit	Terent CE	SSAS'?	N	165. 0
LETTER 1 FOT YES OF IN FOT INC.	Name	County	State	Zip Code	CBSA	FTE/Campus	
44,001,011	0	1. 00	2. 00	3. 00	4. 00	5.00	
66.00 ffline 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 166. 0
120. 4 0 (355 111511 4011 0115)					1		
						1.00	
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Enter 5 is "Y") and is a mean	"Y" for yes or 'ingful user (line	'N" for no.		the	Y	167. 0 0168. 0
68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?	ot a meaningful user, d 'Enter "Y" for yes or "	oes this provide N" for no. (see i	nstruction	ıs)	·	_	168. 0
69.00 If this provider is a meaningful utransition factor. (see instruction		nd is not a CAH	(IIne 105 i	s "N"), €	enter the	0.5	0169. 0
is and their factor. (see mathdetro	,			Ве	gi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR b	edinning date and endin	a date for the r	enortina	10.	1. 00 /01/2013	2.00	170. 0
period respectively (mm/dd/yyyy)	ognining date and endin	g date for the fe	Spor tring	107	51/2013	07/30/2014	1,0.0

Health Financial Systems	ST.	VI NCENT	CARMEL	HOSPI TAL			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	CATI	ON DATA		Provi der	CCN:	150157	From 07/01/2014		
							To 06/30/2015	Date/Time Pre	
								11/30/2015 9:	<u>44 am</u>
								1. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876								N	171. 00
Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no.									
(see instructions)									

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	ST. VINCENT CARMEI STIONNAIRE			Peri od:	eu of Form CMS- Worksheet S-:	2
					From 07/01/2014 To 06/30/2015	Date/Time Pro	
					Y/N	11/30/2015 9 Date	: 44 a
					1. 00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	onses. Enter N fo	or all NO re	esponses. Enter	r all dates in	the	
	COMPLETED BY ALL HOSPITALS						
0	Provider Organization and Operation Has the provider changed ownership immediatel	y prior to the he	ogi nni ng of	the cost	N		1
	reporting period? If yes, enter the date of t				14		'
				Y/N	Date	V/I	
0	Has the provider terminated participation in	the Medicare Prod	gram? If	1.00 N	2. 00	3.00	2
	yes, enter in column 2 the date of termination						
0	voluntary or "I" for involuntary. Is the provider involved in business transact	tions including m	management	N			3
•	contracts, with individuals or entities (e.g.	, chain home offi	ces, drug				
	or medical supply companies) that are related officers, medical staff, management personnel						
	of directors through ownership, control, or f						
	relationships? (see instructions)				_		
				1.00	7ype 2. 00	3. 00	
	Financial Data and Reports				2.00		
)	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for			Y	Α		4
	or "R" for Reviewed. Submit complete copy or						
	column 3. (see instructions) If no, see instr						Ι.
)	Are the cost report total expenses and total those on the filed financial statements? If y			N			!
		,,		1	Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2.00	
)	Column 1: Are costs claimed for nursing scho	ool? Column 2: If	yes, is t	ne provider is	N		٦,
	the legal operator of the program?) 5			N.		
1	Are costs claimed for Allied Health Programs?		uctions.		N		'
)	Were nursing school and/or allied health prod	arams approved and	d/or renewe	d durina the	N		- 1 - 3
	Were nursing school and/or allied health procost reporting period? If yes, see instruction	ons.		Ü	N		
	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents i	ons. n an approved gra		Ü	N N		
)	cost reporting period? If yes, see instruction	ns. n an approved gra see instructions.	aduate medi	cal education			,
00	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents in program in the current cost report? If yes, so Was an approved Intern and Resident GME programs cost reporting period? If yes, see instruction	ons. n an approved grasee instructions. ram initiated or rons.	aduate medi	cal education the current	N N		10
)))	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center	ons. In an approved grasee instructions. Tam initiated or rons. Tas other than I &	aduate medi	cal education the current	N		10
)))	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents in program in the current cost report? If yes, so Was an approved Intern and Resident GME programs cost reporting period? If yes, see instruction	ons. In an approved grasee instructions. Tam initiated or rons. Tas other than I &	aduate medi	cal education the current	N N	Y/N	10
00000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see	ons. In an approved grasee instructions. Tam initiated or rons. Tas other than I &	aduate medi	cal education the current	N N	Y/N 1. 00	10
0000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so Was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back	ns. n an approved grasee instructions. ram initiated or r ons. rs other than I & instructions.	renewed in R in an Apparent	cal education the current proved	N N N	1. 00 Y	10
000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so Was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad debt	ns. n an approved grasee instructions. ram initiated or r ons. rs other than I & instructions.	renewed in R in an Apparent	cal education the current proved	N N N	1.00	10
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider of the provider's bad debeneriod? If yes, submit copy.	n an approved grasee instructions. ram initiated or rons. rs other than I & instructions.	renewed in R in an Apparent of the see instruction of the see instru	cal education the current proved tions. during this cos	N N N	1. 00 Y	1:
00 00 00 00 00 00 00 00 00 00 00 00 00	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so Was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement	n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, sot collection poli	renewed in R in an Appeared in the see instruction cy change in the see instruction was a waited? It is a wait	cal education the current proved tions. during this cos	N N N st reporting	1. 00 Y N	1:
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back If line 12 is yes, did the provider's bad debut period? If yes, submit copy. If line 12 is yes, were patient deductibles as	n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, sot collection poli	renewed in R in an Appeared in the see instruction cy change in the see instruction was a waited? It is a wait	cal education the current proved tions. during this cos f yes, see ins	N N N st reporting tructions.	1. 00 Y N N	1:
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so Was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement	n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, sot collection poli	renewed in R in an Apparent of the second of	cal education the current proved tions. during this cos f yes, see inst yes, see inst Pa Y/N	N N N st reporting tructions. ructions. rt A Date	1.00 Y N N Y Part B Y/N	1:
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting	renewed in R in an Apparent of the second of	cal education the current proved tions. during this cos f yes, see inst	N N N st reporting tructions. ructions.	1.00 Y N N Y Part B	12 13 14
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so Was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	cal education the current proved tions. during this cos f yes, see inst yes, see inst Pa Y/N	N N N st reporting tructions. ructions. rt A Date	1.00 Y N N Y Part B Y/N	12 12 14
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider is bad debugeriod? If yes, submit copy. If line 12 is yes, did the provider's bad debugeriod? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	tions. during this cost yes, see insti	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00	12 12 14
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so Was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back If line 12 is yes, did the provider's bad debendered of the yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	tions. during this cost yes, see insti	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00	12 13 14
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider is bad debugeriod? If yes, submit copy. If line 12 is yes, did the provider's bad debugeriod? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	tions. during this cost yes, see insti	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00	12 13 14
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider's bad debugeriod? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	tions. during this cost yes, see insti	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00	11:11:11:11:11:11:11:11:11:11:11:11:11:
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	cal education the current proved tions. during this cost yes, see inst Y/N 1.00	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00	11:11:11:11:11:11:11:11:11:11:11:11:11:
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider of the provider seeking reimbursement for back of the provider of the provider seeking t	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	cal education the current proved tions. during this cost yes, see inst Y/N 1.00	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00	12 12 15 16
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bact If line 12 is yes, did the provider's bad debended period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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)	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	cal education the current proved tions. during this cost yes, see inst Y/N 1.00	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00 Y	10 10 11 11 11 11 11 11 11 11 11 11 11 1
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider of the provider seeking reimbursement for back	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	cal education the current proved tions. during this cost yes, see inst Y/N 1.00	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00	10 10 11 11 11 11 11 11 11 11 11 11 11 1
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so Was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back If line 12 is yes, did the provider's bad debendered of the yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, 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	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	cal education the current proved tions. during this cost yes, see inst Y/N 1.00	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00 Y	10 11 12 13 14 18
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for back of the provider of the provider seeking the pr	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	cal education the current proved tions. during this cost yes, see inst Y/N 1.00	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00 Y	10 10 11 11 11 11 11 11 11 11 11 11 11 1
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bact If line 12 is yes, did the provider's bad debended period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	cal education the current proved tions. during this cost yes, see inst Y/N 1.00	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00 Y	10 11 12 13 13 14 15 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, swas an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bactifine 12 is yes, did the provider's bad debended by the period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod total beds available change from the priod ensured by the provider's records for allocation? 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	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	tions. the current proved tions. during this cost yes, see inst Pa Y/N 1.00	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00 Y	10 11 12 13 13 14 15 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18
000000000000000000000000000000000000000	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, so Was an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the prior 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	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	tions. the current proved tions. during this cost yes, see inst Pa Y/N 1.00	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00 Y	10 11 12 13 14 15 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18
00 00 00 00 00 00 00 00 00 00 00 00 00	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents is program in the current cost report? If yes, swas an approved Intern and Resident GME program cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bactifine 12 is yes, did the provider's bad debended by the period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod total beds available change from the priod ensured by the provider's records for allocation? 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	ons. n an approved grasee instructions. ram initiated or rons. rs other than I & instructions. d debts? If yes, so t collection policand/or co-payments or cost reporting Descripti	renewed in R in an Apparent of the second of	tions. the current proved tions. during this cost yes, see inst Pa Y/N 1.00	N N N N N St reporting tructions.	1.00 Y N N Y Part B Y/N 3.00 Y	12 12 13 14 15 16 17 18 18 19 20 20 18 18 18 19 19 19 19 19 19 19 19 19 19 19 19 19

Health Financial Systems	ST. VINCENT CARMEL	HOSPI TAL		In Lie	u of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	JESTI ONNAI RE	Provi der	CCN: 150157	Peri od: From 07/01/2014 To 06/30/2015	Worksheet S- Part II Date/Time Pi 11/30/2015	repared:
			ſ	Part A	Part B	
	Description	on	Y/N	Date	Y/N	
	0		1. 00	2. 00	3. 00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00
					1 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSP	LTALC ONLY (EVCEDT C	ULL DDENC 11	OCDLTALC)		1. 00	
Capital Related Cost	ITALS UNLY (EXCEPT C	HILDKENS H	USPITALS)			
22. 00 Have assets been relifed for Medicare purpo	ses? If was see ins	tructions				22, 00
23.00 Have changes occurred in the Medicare depre			als made dur	ing the cost		23. 00
reporting period? If yes, see instructions.				9		
24.00 Were new Leases and/or amendments to existi	ng leases entered ir	nto during	this cost re	eporting period?		24. 00
25.00 Have there been new capitalized leases ente	red into during the	cost repor	ting period?	'If yes, see		25. 00
instructions.				_		
26.00 Were assets subject to Sec. 2314 of DEFRA ac	quired during the co	st reporti	ng period? I	f yes, see		26. 00
instructions. 27.00 Has the provider's capitalization policy ch	anged during the cos	t reportin	a neriod2 lf	· voe euhmit		27. 00
copy.	anged during the cos	st reporting	g perrou: II	yes, subiii t		27.00
Interest Expense						
28.00 Were new Loans, mortgage agreements or lett	ers of credit entere	ed into dur	ing the cost	reporting		28. 00
period? If yes, see instructions.						
29.00 Did the provider have a funded depreciation			bt Service F	Reserve Fund)		29. 00
treated as a funded depreciation account? I 30.00 Has existing debt been replaced prior to it	r yes, see instructi	ons with now	dobt2 Lf vos	. 600		30.00
instructions.	s scriedured maturity	with new	debt: II yes	o, 300		30.00
31.00 Has debt been recalled before scheduled mat	uritv without issuar	ce of new	debt? If ves	s. see		31.00
instructions.	,		,	,		
Purchased Services						
32.00 Have changes or new agreements occurred in			d through co	ntractual		32. 00
arrangements with suppliers of services? If						
33.00 If line 32 is yes, were the requirements of	Sec. 2135.2 applied	l pertainin	g to competi	tive bidding? If		33. 00
no, see instructions. Provider-Based Physicians						
34. 00 Are services furnished at the provider faci	lity under an arrand	iomont with	nrovi der-ha	sed physicians?		34.00
If yes, see instructions.	irty under an arrang	jonioni wi th	provider-be	isca priysi ci aris:		34.00
35.00 If line 34 is yes, were there new agreement	s or amended existir	ng agreemen	ts with the	provi der-based		35. 00
physicians during the cost reporting period				•		
				Y/N	Date	
				1, 00	2.00	

			1.00	2.00			
	Home Office Costs						
36.00	Were home office costs claimed on the cost report?		Υ		36. 00		
37.00	If line 36 is yes, has a home office cost statement been p	repared by the home office?	Υ		37. 00		
	If yes, see instructions.						
38. 00	1		N		38. 00		
	the provider? If yes, enter in column 2 the fiscal year en						
39. 00		er chain components? If yes,	N		39. 00		
	see instructions.			40.00			
40. 00	00 If line 36 is yes, did the provider render services to the home office? If yes, see N						
	i nstructi ons.						
		1.00	2.	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	JOHN	KUHN		41.00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report	ST. VINCENT HEALTH			42.00		
	preparer.						
43.00	Enter the telephone number and email address of the cost	317-583-3236	JOHN. KUHN@STVI	NCENT. ORG	43.00		
	report preparer in columns 1 and 2, respectively.						

Provi der CCN: 150157

				То	06/30/2015	Date/Time Prep 11/30/2015 9:	
		Part B				117 007 2010 7.	TT GIII
		Date					
		4. 00					
	PS&R Data						
16.00	Was the cost report prepared using the PS&R	10/08/2015					16. 00
	Report only? If either column 1 or 3 is yes,						
	enter the paid-through date of the PS&R						
	Report used in columns 2 and 4 (see						
47.00	instructions)						47.00
17. 00	Was the cost report prepared using the PS&R						17. 00
	Report for totals and the provider's records						
	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns						
	2 and 4. (see instructions)						
18. 00	If line 16 or 17 is yes, were adjustments						18. 00
10.00	made to PS&R Report data for additional						10.00
	claims that have been billed but are not						
	included on the PS&R Report used to file						
	this cost report? If yes, see instructions.						
19.00	If line 16 or 17 is yes, were adjustments						19. 00
	made to PS&R Report data for corrections of						
	other PS&R Report information? If yes, see						
	i nstructi ons.						
20. 00	If line 16 or 17 is yes, were adjustments						20. 00
	made to PS&R Report data for Other? Describe						
21 00	the other adjustments:						21 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see						21. 00
	instructions.						
	That detrons.						
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title	e/position	REIMBURSEMENT MANAGER				41.00
	held by the cost report preparer in columns 1	, 2, and 3,					
	respecti vel y.						
42. 00	Enter the employer/company name of the cost r	report					42. 00
40.00	preparer.	-6 +1					42.00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective						43. 00
	Treport preparer in curumns rand 2, respectiv	vei y.	I	1			

Health Financial Systems ST. VINC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					'	00/30/2013	11/30/2015 9:	
							I/P Days / 0/P	TT GIII
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	INO.	or beds	Avai I abl e	CAIT HOURS	ii tie v	
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		128		0.00	0.00	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		120	40, 720	0.00	U	1.00
	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 IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
	•						o	
5.00	Hospital Adults & Peds. Swing Bed SNF							5. 00
6.00	Hospital Adults & Peds. Swing Bed NF			400	4, 700		0	6. 00
7. 00	Total Adults and Peds. (exclude observation			128	46, 720	0.00	0	7. 00
	beds) (see instructions)	04.00		4.0	0 (50			
8. 00	INTENSIVE CARE UNIT	31. 00		10	3, 650	0.00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00		15	5, 475	0. 00	0	12.00
13. 00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			153	55, 845	0.00	0	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			153				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps						Ŭ	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. 00	Total ancillary labor & delivery room			U				32. 00
J∠. U I	outpatient days (see instructions)							JZ. U1
33. 00	LTCH non-covered days							33. 00
33.00	LIGH HOH COVERED days	ı		ı				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

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

11/30/2015 9:44 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 3, 575 389 11, 476 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) 1, 121 2 00 1.308 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 3,575 389 11, 476 7.00 beds) (see instructions) INTENSIVE CARE UNIT 979 8.00 342 248 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 NEONATAL INTENSIVE CARE UNIT 293 2,025 12.00 0 13.00 NURSERY 187 3,071 13.00 14.00 Total (see instructions) 3, 917 1, 117 17, 551 0.00 600.68 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 0 24.10 25. 00 CMHC - CMHC 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 26.25 26.25 27.00 Total (sum of lines 14-26) 0.00 600.68 27.00 28.00 Observation Bed Days 0 2, 197 28.00 29.00 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 916 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 852 32.00 32.00 Total ancillary labor & delivery room 32.01 0 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

Health Financial Systems ST. VINC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Period: Worksheet S-3 From 07/01/2014 Part I Provi der CCN: 150157

1.00 Hospital Adults & Peds. (columns 5. 6. 7 and 8 exclude Swing Bed. Observation Bed and 9 exclude Swing Bed. Observation Bed and 2 11.00 12.00 13.00 14.00 15.00 1.082 309 5.914 1.00 1.082 309 5.914 1.00 1.082 309 5.914 1.00 1.082 309 3.00 1.082 309 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00 1.082 3.00					F	rom 07/01/2014 o 06/30/2015	Part Date/Time Pre	nared:
Full Time Discharges Equivalents Nonpaid Workers Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title XIX Total All Patients Title XIX Total All Patients Title XIX Total All Title XIX Total All Patients Title XIX Total All Title XIX Total XIX To					''	0 00/ 30/ 2013		
Nonpaid Workers Title V Title XVIII Title XIX Patients		·	Full Time		Di sch	arges		
Norkers			Equi val ents			,		
10.00		Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
1.00								
B exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2			11. 00					
Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMC and other (see instructions) 0 3.00 MC IPS Subprovider 0 3.00 MC IPS Subprovider 0 0 3.00 MC IPS Subprovider 0 0 4.00 4.00 6.00 HMC IRF Subprovider 0 0 4.00 6.00 6.00 HmC IRF Subprovider 0 0 6.00 6.00 6.00 HmC IRF Subprovider 0 0 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00	1. 00			0	1, 082	309	5, 914	1. 00
For the portion of LIDP room available beds 200								
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 4.00 4.00 HM0 IPF Subprovider 6.00 Hospi tail Adult s & Peds. Swing Bed SNF 6.00 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 11.00 SUBROVIDER - INF 15.00 14.00 Total (see instructions) 15.00 NURSERY 16.00 17.00 NURSERY 17.00 NURSERY 18.00 CAH visits 18.00 18.00 CAH visits 18.00 18.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 18.00 19.00 SUBROVIDER - IRF 18.00 19.00 SILLED NURSING FACILITY 19.00 SUBROVIDER - IRF 18.00 19.00 SILLED NURSING FACILITY 19.00 SUBROVIDER - IRF 18.00 19.00 SILLED NURSING FACILITY 19.00 SUBROVIDER - IRF 18.00 19.00 OTHER LONG TERM CARE 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 ON BURSING FACILITY 22.00 OTHER LONG TERM CARE 23.00 ON BORIAL HAZING SUBJECT CONTROLLED SUBJ		1 3 / 1						
3.00	2 00				204	250		2 00
4. 00 HMO IRF Subprovider 5. 00 6. 00 Hospit al Adult ts & Peds. Swing Bed SNF 6. 00 5. 00 Hospit al Adult ts & Peds. Swing Bed NF 6. 00 7. 00 Total Adult ts and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 8. 00 10. 00 BURN INTENSIVE CARE UNIT 9. 00 10. 00 BURN INTENSIVE CARE UNIT 11. 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 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 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 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 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 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 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 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 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 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 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 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 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 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 10. 00 10. 00 10. 00 10. 00 10. 00		,			284	350		
5.00 Hospital Adults & Peds. Swing Bed NF 6.00 Nospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation beds) (see instructions) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00						0		
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 beds) (see Instructions) 8.00 INTENSIVE CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 NURSERY 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 20.00 MURSING FACILITY 20.00 MURSING FACILITY 20.00 HOME HEALTH AGENCY 21.00 HOME HEALTH AGENCY 22.00 HOME HEALTH AGENCY 23.00 HOME HEALTH AGENCY 24.10 HOSPICE (non-distinct part) 25.00 CMC - C						U		
7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) beds) (see instructions) 8. 00 New York 10. 00 1. NTENSIVE CARE UNIT 9. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00								
beds) (see instructions)								
8. 00 INTENSIVE CARE UNIT	7.00	`						7.00
9. 00 CORONARY CARE UNIT 9. 00 10. 00 BURN INTENSIVE CARE UNIT 11. 00 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 NEONATAL INTENSIVE CARE UNIT 12. 00 13. 00 NURSERY 13. 00 14. 00 Total (see instructions) 0. 00 0 1, 082 309 5, 914 14. 00 Total (see instructions) 0. 00 0 1, 082 309 5, 914 14. 00 CAH visits 16. 00 SUBPROVIDER - IPF 16. 00 17. 00 SUBPROVIDER - IRF 16. 00 18. 00 SUBPROVIDER - IRF 18. 00 19. 00 SULLED NURSING FACILITY 18. 00 20. 00 NURSING FACILITY 20. 00 21. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 21. 00 24. 00 HOSPICE 24. 00 24. 00 HOSPICE 24. 00 24. 00 HOSPICE 24. 00 25. 00 CMHC - CMHC 25. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 30. 00 Employee discount days (see instruction) 31. 00 31. 00 Employee discount days (see instructions) 32. 01 00 Total ancillary labor & delivery room 0 utpatient days (see instructions) 32. 01 00 Counter of the count	8 00	, ,						8 00
10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 NEONATAL INTENSIVE CARE UNIT 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 ONURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 32. 01								
11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 15. 00 15. 00 16. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19		1						
12. 00 13. 00 13. 00 13. 00 13. 00 13. 00 14. 00 15. 00 15. 00 15. 00 16. 00 18. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19		1						
13. 00 14. 00 Total (see instructions) 15. 00 CAH Visits 15. 00 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 20 CRURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 29. 00 Employee discount days - IRF 30. 00 Use instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01								
14.00 Total (see instructions) 15.00 CAH visits 15.00 CAH visits 15.00 SUBPROVIDER - IPF 15.00 SUBPROVIDER - IRF 16.00 SUBPROVIDER - IRF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 THER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 40.00 HOSPICE 40.00 HOSPICE 40.00 CMHC - CMHC 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) Employee discount days (see instructions) 10.00 Total ancillary labor & delivery room outpatient days (see instructions)		1						
15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 SUBPROVIDER 19.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 40.00 HOME HEALTH AGENCY 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.05 EFDERALLY QUALIFIED HEALTH CENTER 26.05 Total (sum of lines 14-26) 27.00 Observation Bed Days 28.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 28.00 Employee discount days (see instruction) 29.00 Employee discount days (see instruction) 20.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01			0 00	0	1 082	309	5 914	
16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 19. 00 SKILLED NURSING FACILITY 19. 00 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPI CE 24. 10 HOSPI CE 24. 10 HOSPI CE 26. 25 27. 00 Total (sum of lines 14-26) 28. 00 29. 00 Ambul ance Trip b 30. 00 31. 00 Empl oyee di scount days (see instruction) Empl oyee di scount days - I RF 32. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)		,	0.00	Č	1,002	007	0, 711	
17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 4. 10 HOSPICE 6. 00 RURAL HEALTH CLINIC 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 ROSEPALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 32.01 Total ancillary labor & delivery room outpatient days (see instructions)								
19.00 SKILLED NURSING FACILITY 19.00 20.00 20.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 22.00 21.00 22.00 22.00 23.00 24.00 25.00 22.00 23.00 24.00 24.10 25.00 24.10 25.00 24.10 25.00 26.00 26.25 26.00 26.25 27.00 26.25 27.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.								
21.00 22.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Supployee discount days (see instruction) 29.00 Employee discount days - IRF 21.00 22.00 23.00 24.10 25.00 26.25 27.00 Total (sum of lines 14-26) 28.00 29.00 Ambulance Trips 30.00 31.00 Employee discount days (see instructions) 31.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01			·					19. 00
22.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.00 HOSPICE (non-distinct part) 25.00 RURAL HEALTH CLINIC 25.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 25.00 Labor & delivery days (see instructions) 30.01 Total ancillary labor & delivery room outpatient days (see instructions)	20.00	NURSING FACILITY						20.00
23. 00 24. 00 24. 00 14. 00 14. 00 15. 00 16. 00 16. 00 16. 00 17. 00 18. 00 18. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19	21. 00	OTHER LONG TERM CARE						21.00
24. 00 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 0.00 28. 00 Observation Bed Days Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) Employee discount days (see instructions) 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	22. 00	HOME HEALTH AGENCY						22.00
24. 10 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 27. 00 Observation Bed Days 28. 00 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
25. 00 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 27. 00 Total (sum of lines 14-26) 00 00servation Bed Days 28. 00 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions)	24.00	HOSPI CE						24.00
26. 00 26. 25 27. 00 28. 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 28. 00 00 00 00 00 00 00 00 00 00 00 00 00	24. 10	HOSPICE (non-distinct part)						24. 10
26. 25 27. 00 28. 00 0bservation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Total (sum of lines 14-26) 0. 00 28. 00 29. 00 29. 00 30. 00 31. 00 31. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	25. 00	CMHC - CMHC						25.00
27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 28.00 29.00 Ambulance Trips 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00	26. 00	RURAL HEALTH CLINIC						26.00
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01	26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0. 00					
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room outpatient days (see instructions)	28. 00	Observation Bed Days						
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31.00 32.00								
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.00								
32.01 Total ancillary labor & delivery room outpatient days (see instructions)								
outpatient days (see instructions)								
	32. 01							32. 01
K UD II II H non-covered days	00.00	,						00.00
33. 00 Elon non covered days	33.00	LICH non-covered days			l			33. 00

| Peri od: | Worksheet S-3 | From 07/01/2014 | Part II | To 06/30/2015 | Date/Time Prepared: | Provi der CCN: 150157

					To	06/30/2015	Date/Time Pre 11/30/2015 9:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col. 2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col. 4	001. 0)	
	DADT III WAGE DATA	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	44, 471, 141	0	44, 471, 141	1, 249, 721. 18	35. 58	1.00
2. 00	instructions) Non-physician anesthetist Part		0		0	0. 00	0. 00	2. 00
2.00	A		U			0.00	0.00	2.00
3.00	Non-physician anesthetist Part		0	0	O	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		0	0		0. 00	0.00	4. 00
1.00	Admi ni strati ve					0.00	0.00	1.00
4.01	Physicians - Part A - Teaching		0 120 474	0	0	0.00		
5. 00 6. 00	Physician-Part B Non-physician-Part B		2, 138, 474 0	0	2, 138, 474 0	24, 156. 15 0. 00	1	
7.00	Interns & residents (in an	21. 00	0	0	0	0.00		
7. 01	approved program) Contracted interns and		0	0		0. 00	0.00	7. 01
7.01	residents (in an approved		O			0.00	0.00	7.01
8. 00	programs) Home office personnel		0			0. 00	0. 00	8. 00
9. 00	SNF	44. 00	0	0	0	0.00		
10.00	Excluded area salaries (see		5, 697, 172	0	5, 697, 172	156, 816. 00	36. 33	10.00
	instructions) OTHER WAGES & RELATED COSTS							1
11. 00	Contract Labor: Direct Patient		3, 165, 157	0	3, 165, 157	32, 893. 01	96. 23	11. 00
12. 00	Care Contract Labor: Top Level		410, 109	0	410 100	1 040 99	211 20	12. 00
12.00	management and other		410, 109		410, 109	1, 940. 88	211.30	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		0	0	o	0. 00	0.00	13. 00
10.00	A - Administrative		_					
14. 00	Home office salaries & wage-related costs		11, 836, 022	0	11, 836, 022	233, 115. 00	50. 77	14. 00
15. 00	Home office: Physician Part A		0	О	О	0.00	0.00	15. 00
1/ 00	- Administrative					0.00	0.00	1, 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0		0. 00	0. 00	16. 00
	WAGE-RELATED COSTS							1
17. 00	Wage-related costs (core) (see instructions)		10, 201, 631	0	10, 201, 631			17. 00
18. 00	Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		1, 586, 452	0	1, 586, 452			19. 00
20. 00	Non-physician anesthetist Part		1, 566, 452	0	1, 566, 452			20.00
04.00	A							
21. 00	Non-physician anesthetist Part B		0	0				21. 00
22. 00	Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0				22. 01
23. 00	Physician Part B		595, 486	Ö	595, 486			23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00
25. 00	Interns & residents (in an approved program)		0		0			25. 00
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	312, 628 6, 264, 330		312, 628 6, 264, 330	12, 289. 00 174, 606. 00		
28. 00	Administrative & General under	3. 00	0, 204, 330	Ö	0, 204, 330	0.00		•
	contract (see inst.)							
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	490, 748	0	490, 748	0. 00 32, 213. 00		
31. 00	Laundry & Linen Service	8. 00	0	Ö	0	0.00		31. 00
32.00	Housekeepi ng	9. 00	1 445 000	0	1 445 000	0.00	l e	
33. 00	Housekeeping under contract (see instructions)		1, 665, 808		1, 665, 808	69, 264. 35	24. 05	33. 00
34.00	Di etary	10. 00	0	0		0.00		
35. 00	Di etary under contract (see instructions)		625, 721	0	625, 721	27, 553. 18	22. 71	35. 00
36. 00	Cafeteri a	11. 00	0	0	o	0.00		
37. 00	Maintenance of Personnel	12. 00	1 475 513	0	0	0.00		
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	1, 475, 561 313, 298		1, 475, 561 313, 298	35, 680. 00 16, 669. 00		38. 00 39. 00
	Pharmacy	15. 00	2, 034, 927			50, 124. 00		40. 00

Heal th	Financial Systems	S	ST. VINCENT CA	RMEL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION				Provi der		Period: From 07/01/2014	Worksheet S-3 Part II	
						Γο 06/30/2015		pared: 44 am_
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
	Medical Records & Medical	16. 00	506, 309	0	506, 309	13, 008. 00	38. 92	41. 00
	Records Library							
42. 00	Social Service	17. 00	166, 754	0	166, 75	4, 762. 00	35. 02	42.00
43. 00	Other General Service	18. 00	0	0	(0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 150157 Peri od: From 07/01/2014 To 06/30/2015 11/30/2015 9:44 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col. col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 44, 624, 196 44, 624, 196 1, 322, 382. 56 33. 75 1.00 instructions) 2.00 5, 697, 172 ol 5, 697, 172 156, 816. 00 2.00 Excluded area salaries (see 36. 33 instructions) 3.00 Subtotal salaries (line 1 38, 927, 024 0 38, 927, 024 1, 165, 566. 56 33.40 3.00

0

0

0

15, 411, 288

10, 201, 631

64, 539, 943

13, 856, 084

267, 948. 89

1, 433, 515. 45

436, 168. 53

0.00

57.52

26. 21

45.02

31.77

4.00

5.00

6.00

7.00

15, 411, 288

10, 201, 631

64, 539, 943

13, 856, 084

minus line 2)

(see inst.)

instructions)

costs (see inst.)

Subtotal other wages & related

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

4.00

5.00

6.00

7.00

Health Financial Systems	ST. VINCENT CARMEL	HOSPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		Provi der CCN: 150157	Peri od: From 07/01/2014	Worksheet S-3
				Date/Time Prepared:

	To 06/30/2015	Date/Time Prep 11/30/2015 9:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	955, 268	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	6, 272, 688	8. 00
9.00	Prescription Drug Plan	1, 009, 570	9. 00
10.00	Dental, Hearing and Vision Plan	42, 792	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	38, 910	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	5, 400	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	304, 551	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	32, 200	14. 00
15.00	'Workers' Compensation Insurance	371, 174	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	3, 175, 862	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00		0	19. 00
20.00	State or Federal Unemployment Taxes	76, 767	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	42, 155	21. 00
	instructions))		
	Day Care Cost and Allowances	0	
23.00	Tuition Reimbursement	56, 230	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12, 383, 567	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER	0	25. 00

Heal th	Financial Systems	ST	VINCENT	CARMEL	HOSPI TAL			In lie	eu of Form CMS-:	2552-10
	AL CONTRACT LABOR AND BENEFIT COST	011	,,,,oe,,,	07.11.III.Z.	Provi der	CCN:	150157	Peri od: From 07/01/2014 To 06/30/2015	Worksheet S-3 Part V	pared:
	Cost Center Description							Contract Labor		
								1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost									
	Hospital and Hospital-Based Component Ident									
1. 00	Total facility's contract labor and benefit	cost	t					165, 929		1
2. 00	Hospi tal							165, 929	8, 428, 728	
3.00	Subprovi der - IPF									3. 00
4.00	Subprovi der - I RF									4. 00
5.00	Subprovider - (Other)							0	0	
6.00	Swing Beds - SNF							0	0	
7.00	Swing Beds - NF							0	0	7. 00
8.00	Hospi tal -Based SNF									8. 00
9.00	Hospi tal -Based NF									9. 00
10. 00	Hospi tal -Based OLTC									10.00
	Hospi tal -Based HHA									11. 00
12. 00	Separately Certified ASC									12. 00
	Hospi tal-Based Hospi ce									13. 00
14. 00	Hospital-Based Health Clinic RHC									14. 00
15. 00	Hospital-Based Health Clinic FQHC									15. 00
16.00	Hospi tal -Based-CMHC									16. 00
	Renal Dialysis									17. 00
18. 00	Other							0	2, 153, 550	18. 00

Heal th	Financial Systems ST. VINCENT CARMEL HO	OSPI TAI		In lie	u of Form CMS-2	2552-10						
			CCN: 150157	Peri od:	Worksheet S-10							
				From 07/01/2014								
				To 06/30/2015	Date/Time Prep 11/30/2015 9:4							
					11/30/2013 9.4	44 alli						
	1.00											
	Uncompensated and indigent care cost computation											
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	led by li	ne 202 column	1 8)	0. 231544	1. 00						
	Medicaid (see instructions for each line)											
2.00	Net revenue from Medicaid				1, 914, 005	2. 00						
3.00	Did you receive DSH or supplemental payments from Medicaid?			10	N	3. 00						
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p		rrom Medicaid	1?		4. 00						
5.00	If line 4 is "no", then enter DSH or supplemental payments from N	iedi cai d			0	5. 00						
6. 00 7. 00	Medicaid charges				33, 413, 333	6. 00 7. 00						
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (li	no 7 min	us sum of Lir	oc 2 and E. if	7, 736, 657 5, 822, 652							
0.00	<pre>c zero then enter zero)</pre>	11e / III111	us suii oi iii	ies z aiiu o, i i	3, 622, 632	0.00						
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for e	ach line)									
9. 00	Net revenue from stand-allone SCHIP	113 101 0	den inne)		0	9. 00						
10. 00	Stand-alone SCHIP charges				0	10.00						
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				Ö							
12. 00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 m	inus line 9:	if < zero then	o	12. 00						
	enter zero)				_							
	Other state or local government indigent care program (see instru	ctions f	or each line)									
13.00	Net revenue from state or local indigent care program (Not include	led on li	nes 2, 5 or 9	9)	0	13.00						
14.00	Charges for patients covered under state or local indigent care p	rogram (Not included	in lines 6 or	0	14.00						
	10)											
15. 00	State or local indigent care program cost (line 1 times line 14)				0							
16. 00	Difference between net revenue and costs for state or local indig	jent care	program (lir	ne 15 minus line	0	16. 00						
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)											
17. 00	Private grants, donations, or endowment income restricted to func	ling char	ity care		0	17. 00						
18. 00	Government grants, appropriations or transfers for support of hos				0	18. 00						
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local			ns (sum of lines	5, 822, 652							
	8, 12 and 16)		p9	(0, 0==, 00=							
			Uni nsured	Insured	Total (col. 1							
			pati ents	pati ents	+ col . 2)							
	I=		1.00	2. 00	3. 00							
20. 00	Total initial obligation of patients approved for charity care (a		3, 182, 31	4, 856, 111	8, 038, 425	20. 00						
21. 00	charges excluding non-reimbursable cost centers) for the entire f Cost of initial obligation of patients approved for charity care		736, 84	1, 124, 403	1, 861, 249	21. 00						
21.00	times line 20)	(TITIE T	730, 62	1, 124, 403	1, 001, 249	21.00						
22. 00	Partial payment by patients approved for charity care			0 0	0	22. 00						
23. 00	Cost of charity care (line 21 minus line 22)		736, 84	-	1, 861, 249							
					.,, .,, .,,							
					1. 00	24. 00						
24. 00												
25 00	imposed on patients covered by Medicaid or other indigent care program? 5.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0											
25. 00 26. 00			ogram s rengt	in or Stay TIMIT	6, 588, 980	25. 00 26. 00						
26.00												
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line	,	s line 27)		6, 428, 069							
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (Tries		,	28)	1, 488, 381							
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	136 (1111B	i times tille	, 20)	3, 349, 630							
	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			9, 172, 282							
31.00	1.5ta. a.i. 5. ii. a. 50d and anomponsatod dare 655t (11116-17 prus 11116	. 50)			7, 172, 202	31.00						

			ST. VINCENT CARME				u of Form CMS-2	2552-10
RECLAS	SSIFICA	ATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		eriod: rom 07/01/2014	Worksheet A	
					. T		Date/Time Pre 11/30/2015 9:	pared: 44 am_
		Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Recl assi fi ed	
					+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
							col . 4)	
			1.00	2. 00	3.00	4. 00	5. 00	
	GENER.	AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT		8, 651, 285			8, 596, 070	1
2.00		CAP REL COSTS-MVBLE EQUIP		3, 594, 859			3, 594, 859	1
4.00		EMPLOYEE BENEFITS DEPARTMENT	312, 628	13, 210, 060			13, 522, 688	
5.00	1	ADMINISTRATIVE & GENERAL	6, 264, 330	13, 775, 682			20, 095, 227	5.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	490, 748	2, 906, 757 452, 992		0	3, 397, 505 452, 992	1
9.00		HOUSEKEEPING		4, 300, 970		_	4, 300, 970	1
10. 00		DI ETARY	0	2, 387, 963		-1, 419, 644	968, 319	1
11. 00		CAFETERI A	o o	2,007,700		1, 419, 644	1, 419, 644	1
13. 00		NURSING ADMINISTRATION	1, 475, 561	105, 706		0	1, 581, 267	1
14.00		CENTRAL SERVICES & SUPPLY	313, 298	78, 369		0	391, 667	1
15.00		PHARMACY	2, 034, 927	2, 913, 238	4, 948, 165	0	4, 948, 165	15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY	506, 309	368, 176	874, 485	0	874, 485	16. 00
17. 00		SOCIAL SERVICE	166, 754	74, 312	241, 066	0	241, 066	17. 00
		ENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	9, 091, 398	1, 553, 106			9, 600, 404	1
31.00		INTENSIVE CARE UNIT	1, 014, 924	550, 281			1, 565, 205	•
35. 00 43. 00		NEONATAL INTENSIVE CARE UNIT NURSERY	2, 343, 925	159, 601 0			2, 503, 526	1
43.00		LARY SERVICE COST CENTERS	<u> </u>			1, 044, 100	1, 044, 100	43.00
50. 00		OPERATING ROOM	3, 706, 912	10, 072, 670	13, 779, 582	0	13, 779, 582	50. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	1, 705, 880	1, 571, 810		o	3, 277, 690	1
54.00		RADI OLOGY-DI AGNOSTI C	1, 601, 046	626, 398		0	2, 227, 444	1
54.02	05402	ULTRASOUND	201, 019	4, 164	205, 183	0	205, 183	54. 02
57.00	05700	CT SCAN	484, 621	86, 260	570, 881	0	570, 881	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	371, 237	155, 567	1	0	526, 804	1
59. 00		CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	1	LABORATORY	65, 511	3, 068, 910		0	3, 134, 421	1
65. 00		RESPI RATORY THERAPY	1, 057, 525	121, 768		0	1, 179, 293	1
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	235, 356	27, 408 0		0	262, 764 0	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	19, 185	0		0	19, 185	•
69. 00		ELECTROCARDI OLOGY	113, 392	166, 589		0	279, 981	
70. 00		ELECTROENCEPHALOGRAPHY	76, 781	12, 050		0	88, 831	1
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 663, 185		0	1, 663, 185	1
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	O	4, 374, 317	4, 374, 317	0	4, 374, 317	72. 00
73.00		DRUGS CHARGED TO PATIENTS	0	26, 373	26, 373	0	26, 373	73. 00
75. 00		ASC (NON-DISTINCT PART)	2, 293, 451	6, 323, 880		0	8, 617, 331	1
76. 00		ENDOSCOPY	1, 211, 007	1, 161, 201	2, 372, 208	0	2, 372, 208	76. 00
04 00		TIENT SERVICE COST CENTERS	4 (4(044	740 400	0 000 477		0 000 (77	04 00
	1	EMERGENCY	1, 616, 244	713, 433	2, 329, 677	0	2, 329, 677	
92.00		OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS						92. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	38, 773, 969	85, 259, 340	124, 033, 309	O	124, 033, 309	118 00
110.00		IMBURSABLE COST CENTERS	00,770,707	00, 207, 010	121,000,007	ŭ l	121,000,007	1110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	91, 561	364, 836	456, 397	0	456, 397	190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	290, 907	5, 185	296, 092	0	296, 092	192. 00
		MISSION EFFECTIVENESS	0	5, 988		0		194. 00
		MARKETI NG	0	0		0		194. 01
	1	JOINT VENTURES	0	598		0		194. 02
	1	SCHOOL NURSE	17, 290	1, 242		0		194. 04
	1	SPORTS MEDICINE & OB PHYS	5, 297, 414	1, 232, 605			6, 530, 019	
200.00	기	TOTAL (SUM OF LINES 118-199)	44, 471, 141	86, 869, 794	131, 340, 935	0	131, 340, 935	J200. 00

Health FinancialSystemsST. VINCENTRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

				11/30/2015 9:	44 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FLXT	-1, 308, 201	7, 287, 869		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-49, 623	3, 545, 236		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-285, 636	13, 237, 052		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	74, 301	20, 169, 528		5. 00
7.00	00700 OPERATION OF PLANT	-191, 495	3, 206, 010		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	452, 992		8. 00
9. 00	00900 HOUSEKEEPI NG	-399			9. 00
10. 00	01000 DI ETARY	-180			10.00
11. 00	01100 CAFETERI A	-516, 454	903, 190		11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-219	1, 581, 048		13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	391, 667	l .	14. 00
15. 00	01500 PHARMACY	0	4, 948, 165		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		874, 485		16. 00
		0			
17. 00	01700 SOCIAL SERVICE	0	241, 066		17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2.04/.02/	7 550 440		20.00
30.00	03000 ADULTS & PEDIATRICS	-2, 046, 936		l control of the cont	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	1, 565, 205	·	31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	-1, 222, 538			35. 00
43.00	04300 NURSERY	0	1, 044, 100		43. 00
	ANCILLARY SERVICE COST CENTERS	1			
50. 00	05000 OPERATING ROOM	-1, 096, 625			50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-1, 177, 570		l control of the cont	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-198, 911	2, 028, 533		54.00
54. 02	05402 ULTRASOUND	0	205, 183		54. 02
57.00	05700 CT SCAN	-15, 170			57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	526, 804		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60.00	06000 LABORATORY	0	3, 134, 421		60.00
65.00	06500 RESPI RATORY THERAPY	0	1, 179, 293		65.00
66.00	06600 PHYSI CAL THERAPY	0	262, 764		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	o		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	19, 185		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	279, 981		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	88, 831		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 663, 185		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	4, 374, 317		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	26, 373		73.00
75. 00	07500 ASC (NON-DISTINCT PART)	-208, 734			75. 00
76. 00	03330 ENDOSCOPY	19, 767	2, 391, 975	l control of the cont	76.00
70.00	OUTPATIENT SERVICE COST CENTERS	17, 707	2, 371, 773		70.00
91. 00	09100 EMERGENCY	-124, 912	2, 204, 765		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-124, 712	2, 204, 703		92.00
72.00	SPECIAL PURPOSE COST CENTERS				72.00
118. 00		-8, 349, 535	115, 683, 774		118. 00
110.00	NONREI MBURSABLE COST CENTERS	-0, 347, 333	113,003,774		1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	456, 397		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	296, 092	l control of the cont	192. 00
	07950 MISSION EFFECTIVENESS		5, 988		194. 00
	07950 MISSION EFFECTIVENESS	1, 727, 876			194. 00
	207952 JOINT VENTURES	1,727,876			194. 01
		-	598	l control of the cont	194. 02
	07954 SCHOOL NURSE	0			
	507956 SPORTS MEDICINE & OB PHYS	0	6, 530, 019		194. 06
200.00	TOTAL (SUM OF LINES 118-199)	-6, 621, 659	124, 719, 276		200. 00

Health Financial Systems			ST. VINCENT CA	ARMEL HO	SPI TAL			In Lie	u of Form CMS	-2552-10
RECLASS	RECLASSI FI CATI ONS			P	rovi der	CCN: 1	50157	Peri od:	Worksheet A-	6
								From 07/01/2014 To 06/30/2015	Date/Time Pr 11/30/2015 9	
		Increases								
	Cost Center	Li ne #	Sal ary	0th	er					
	2. 00	3.00	4.00	5. (00					
	A - NURSERY									
1.00	NURSERY	4300	917, 896	<u> </u>	12 <u>6, 2</u> 04					1.00
	TOTALS		917, 896		126, 204					
	B - INTEREST EXPENSE									
1.00	ADMINISTRATIVE & GENERAL	5. 00	0		55, 215					1. 00
	TOTALS		0		55, 215					
	C - CAFETERIA									
1.00	CAFETERI A	11. 00	0	1,	119, 644					1. 00
	TOTALS			1,	419, 644					
500.00	Grand Total: Increases		917, 896	1, (501, 063					500.00
	•	•		•						•

Heal th	Financial Systems		ST. VINCENT CA	ARMEL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	RECLASSI FI CATI ONS			Provi der	CCN: 150157	Peri od:	Worksheet A-	5
						From 07/01/2014 To 06/30/2015	Date/Time Pro	epared:
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref			
	6. 00	7.00	8.00	9. 00	10.00			
	A - NURSERY							
1.00	ADULTS & PEDIATRICS	3000	917, 896	126, 204	<u> </u>	o		1.00
	TOTALS		917, 896	126, 204	ļ			
	B - INTEREST EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5 <u>5, 2</u> 15	5 1	1		1.00
	TOTALS		0	55, 215	5			
	C - CAFETERIA							
1.00	DI ETARY	1000	0	1, 419, 644	ļ <u></u>	0		1.00
	TOTALS		0	1, 419, 644	!			
500.00	Grand Total: Decreases		917, 896	1, 601, 063	3			500.00

				Т	o 06/30/2015	Date/Time Prep 11/30/2015 9:4	pared:
				Acqui si ti ons		117 307 2013 7.	TT GIII
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
F	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	2, 111, 746	0	0	0	0	1.00
2.00	Land Improvements	2, 224, 113	43, 581	0	43, 581	0	2.00
3.00	Buildings and Fixtures	35, 500, 660	18, 299, 411	0	18, 299, 411	0	3.00
4.00	Building Improvements	34, 099, 609	4, 518, 736	0	4, 518, 736	3, 298	4. 00
5.00	Fixed Equipment	2, 791, 447	33, 344	0	33, 344	0	5. 00
6. 00 I	Movable Equipment	31, 244, 238	12, 321, 148	0	12, 321, 148	2, 090, 401	6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
	Subtotal (sum of lines 1-7)	107, 971, 813	35, 216, 220	0	35, 216, 220	2, 093, 699	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	107, 971, 813	35, 216, 220	0	35, 216, 220	2, 093, 699	10.00
		Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6. 00	7. 00				
-	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
	Land	2, 111, 746	0				1. 00
	Land Improvements	2, 267, 694	1, 609, 024				2. 00
	Buildings and Fixtures	53, 800, 071	49, 990, 202				3. 00
4	Building Improvements	38, 615, 047	12, 995, 175				4. 00
	Fi xed Equi pment	2, 824, 791	1, 033, 601				5. 00
	Movable Equipment	41, 474, 985	21, 281, 206				6. 00
4	HIT designated Assets	0	0				7. 00
	Subtotal (sum of lines 1-7)	141, 094, 334	86, 909, 208				8. 00
	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	141, 094, 334	86, 909, 208				10.00

Heal th	Financial Systems	ST. VINCENT CAF	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 150157		Period: From 07/01/2014 Fo 06/30/2015		pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	3, 162, 935	4, 647, 838	655, 953	65, 252	119, 307	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 983, 839	608, 297	(2, 723	0	2. 00
3.00	Total (sum of lines 1-2)	6, 146, 774	5, 256, 135	655, 953	67, 975	119, 307	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	8, 651, 285				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 594, 859				2. 00
3.00	Total (sum of lines 1-2)	0	12, 246, 144				3.00

0 0 0

8, 651, 285 3, 594, 859 12, 246, 144

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	ST. VINCENT CAI	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 07/01/2014 To 06/30/2015	Worksheet A-7 Part III Date/Time Prep 11/30/2015 9:4	
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	DART III DECONCIIIATION OF CARITAL COCTO	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	73, 936, 128	Ι ο	73, 936, 12	8 0. 684772	0	1. 00
2. 00	CAP REL COSTS-BEDG & TTAT	34, 035, 685		34, 035, 68			2. 00
3.00	Total (sum of lines 1-2)	107, 971, 813		107, 971, 81			3. 00
<u> </u>		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					2. 22
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7. 00	8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		1			
1.00	CAP REL COSTS-BLDG & FLXT	0	1		0 2, 695, 522		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0 2, 983, 839		2. 00
3. 00	Total (sum of lines 1-2)	0	V	JMMARY OF CAPI	5, 679, 361	4, 575, 993	3. 00
			50	JIVIIVIARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see instructions)	through 14)	
		11.00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	15.00	14.00	15.00	
1.00	CAP REL COSTS-BLDG & FIXT	458, 682	65, 252	119, 30	7 -18, 590	7, 287, 869	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1		0 -49, 623		2. 00
3. 00	Total (sum of lines 1-2)	458, 682	67, 975	119, 30	7 -68, 213	10, 833, 105	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES ST. VINCENT CARMEL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150157 Peri od: Worksheet A-8 From 07/01/2014 To 06/30/2015 Date/Time Prepared:

				Т	o 06/30/2015	Date/Time Prep 11/30/2015 9:4	pared: 44 am
				Expense Classification on	Worksheet A	117 307 2013 7.	77 (311)
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL	A	-467, 413	CAP REL COSTS-BLDG & FIXT	1.00	9	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	CAL REE COSTS-WINDER EQUIT	2.00	J	2.00
3.00	Investment income - other	A	-48, 498	ADMINISTRATIVE & GENERAL	5. 00	0	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
0.00	expenses (chapter 8)		0		0.00	Ŭ	0.00
6.00	Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)						7.00
7. 00	Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0.00	0	8. 00
	(chapter 21)						
9. 00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-6, 186, 282			0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
	(chapter 23)		· ·		0.00	ŭ	
12.00	Related organization	A-8-1	6, 590, 384			0	12. 00
	transactions (chapter 10)						
13.00	Laundry and linen service	D.	0	CAFETERIA	0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-516, 454 0	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
13.00	and others		0		0.00	J	13.00
16.00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than						
17 00	patients		0		0.00	0	17 00
17. 00	Sale of drugs to other than patients		U		0.00	U	17. 00
18. 00	Sale of medical records and		0		0.00	0	18. 00
	abstracts						
19. 00	Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty		·				
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of						
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation		· ·				
	(chapter 21)			0.0 00. 000-0 0.00			
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
27.00	COSTS-MVBLE EQUIP		· ·	NEE	2.00	ŭ	27.00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest		0		3.00	Ĭ	
33. 00			0		0.00	0	33. 00
34. 00	OTHER MISC REVENUE - BENEFITS	В	-10, 222	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	34. 00

					06/30/2015	Date/lime Pre 11/30/2015 9:	
				Expense Classification on	Worksheet A	, ,	
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
35. 00	OTHER MISC REVENUE - ADMIN	В	-13, 646	ADMINISTRATIVE & GENERAL	5. 00	0	35. 00
36.00	OTHER MISC REVENUE - MAINT	В	-67, 331	OPERATION OF PLANT	7. 00	0	36.00
37.00	OTHER MISC REVENUE - HKPG	В	-399	HOUSEKEEPI NG	9. 00	0	37. 00
38.00	OTHER MISC REVENUE - DIETARY	В	-180	DI ETARY	10.00	0	38. 00
39.00	OTHER MISC REVENUE - ROUTINE	В	-135, 336	ADULTS & PEDIATRICS	30.00	0	39. 00
40.00	OTHER MISC REVENUE -	В	-23	NEONATAL INTENSIVE CARE UNIT	35.00	0	40. 00
	NEONATOLOGY						
41.00	OTHER MISC REVENUE - RADIOLOGY	В	-1, 200	RADI OLOGY-DI AGNOSTI C	54.00	0	41.00
42.00	OTHER MISC REVENUE - ASC	В	-208, 734	ASC (NON-DISTINCT PART)	75.00	0	42.00
43.00	PROPERTY RENTAL INCOME	В	-680, 142	CAP REL COSTS-BLDG & FIXT	1.00	10	43.00
44.00	PROVIDER ASSESSMENT OFFSET	A	-2, 702, 440	ADMINISTRATIVE & GENERAL	5. 00	0	44. 00
45.00	LOBBYI NG	A	-3, 438	ADMINISTRATIVE & GENERAL	5. 00	0	45. 00
46.00	LOSS ON SALE OF PPE	A	-49, 623	CAP REL COSTS-MVBLE EQUIP	2.00	14	46. 00
47.00	CONSOLI DATI NG ENTRY	В	-1, 501, 251	ADMINISTRATIVE & GENERAL	5. 00	0	47. 00
48.00			0		0.00	0	48. 00
49.00	OTHER MISC REVENUE - ENDO	В	19, 767	ENDOSCOPY	76.00	0	49. 00
49. 01	IFUE OPERATING COMFORT IMAGING	В	-18, 590	CAP REL COSTS-BLDG & FIXT	1. 00	14	49. 01
49. 02			0		0.00	0	49. 02
49. 03	NONRECURRING OP EXPENSES	В	27, 887	ADMINISTRATIVE & GENERAL	5. 00	0	49. 03
49.04	ENTERTALNMENT EXP - BENEFITS	A	-318	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49. 04
49.05	ENTERTALNMENT EXP - ADMIN	A	-4	ADMINISTRATIVE & GENERAL	5. 00	0	49. 05
49. 06	ENTERTALNMENT EXP - NURS ADMIN	A	-219	NURSING ADMINISTRATION	13. 00	0	49. 06
49. 07	ENTERTALNMENT EXP - ROUTINE	A	-621	ADULTS & PEDIATRICS	30.00	0	49. 07
49. 08	ENTERTALNMENT EXP - NEONATE	A		NEONATAL INTENSIVE CARE UNIT	35. 00	0	49. 08
49. 09	ENTERTALNMENT EXP - OR	A		OPERATING ROOM	50.00	0	49. 09
49. 10	ENTERTALNMENT EXP - RADIOLOGY	A	·	RADI OLOGY-DI AGNOSTI C	54.00	0	49, 10
49. 11	ENTERTALNMENT EXP - ER	A		EMERGENCY	91.00	0	49. 11
49. 12	INCENTIVE PYMT ADJ - SALARIES	A		ADMINISTRATIVE & GENERAL	5. 00		49. 12
49. 13	INCENTIVE PYMT ADJ - FICA	A	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	49. 13
50.00	TOTAL (sum of lines 1 thru 49)		-6, 621, 659		,,		50.00
	(Transfer to Worksheet A,		.,.,,				
	column 6, line 200.)						
(1) De	scription - all chapter referen	cas in this cal	umn nertain to	CMS Dub 15_1			

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs if cost, including applicable overhead, can be determined.
 B. Amount Received if cost cannot be determined.

- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
- Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150157 Peri od: From 07/01/2014 Worksheet A-8-1

OTTICL	00313			To 06/30/2015	Date/Time Prep 11/30/2015 9:	
	Li ne No.	Cost Center	Expense I tems	Amount of Allowable Cost	Amount	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:			ED ORGANIZATIONS OR	CLAI MED	
1.00		EMPLOYEE BENEFITS DEPARTMENT		0	596, 212	1.00
2.00			H.O. COSTS	13, 301, 395	7, 951, 265	2.00
3.00			H.O. COSTS MARKETING	1, 727, 876	0	3.00
3. 01			SVH CHARGEBACK	-3, 780	-3, 780	3. 01
3.02			SVH CHARGEBACK	761, 144	761, 144	3. 02
3.03			SVH CHARGEBACK	3, 055, 335	3, 055, 335	3. 03
4.00		NURSING ADMINISTRATION	SVH CHARGEBACK	92, 196	92, 196	4. 00
4.01		PHARMACY	SVH CHARGEBACK	-14, 196	-14, 196	4. 01
4.02		MEDICAL RECORDS & LIBRARY	SVH CHARGEBACK	706, 966	706, 966	4. 02
4.03		ADULTS & PEDIATRICS	SVH CHARGEBACK	19, 405	19, 405	4. 03
4.04			SVH CHARGEBACK	401, 496	401, 496	4.04
4.05			SVH CHARGEBACK	975	975	4. 05
4.06	52. 00	DELIVERY ROOM & LABOR ROOM	SVH CHARGEBACK	50	50	4.06
4.07			SVH CHARGEBACK	59, 564	59, 564	4. 07
4.08			SVH CHARGEBACK	-28, 884	-28, 884	4. 08
4. 10			SVH CHARGEBACK	34, 896	34, 896	4. 10
4. 11			SVH CHARGEBACK	275	275	4. 11
4. 12			SVH CHARGEBACK	175	175	4. 12
4. 13			SVH CHARGEBACK	24, 058	24, 058	4. 13
4. 14		SPORTS MEDICINE & OB PHYS	SVH CHARGEBACK	391, 252	391, 252	4. 14
4. 15			SELF INSURANCE	5, 682, 561	6, 144, 933	4. 15
4. 16			ASCENSION INTEREST	513, 897	655, 953	4. 16
4. 17		OPERATION OF PLANT	TRI MEDX	3, 109, 906		4. 17
4. 18		EMPLOYEE BENEFITS DEPARTMENT	PENSI ON	1, 829, 348	992, 166	4. 18
4. 20	0. 00			0	0	4. 20
5. 00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			31, 665, 910	25, 075, 526	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.

			1		
			Related Organization(s) and/	or Home Office	
			= g= == (-/ =		
Symbol (1)	Name	Percentage of	Name	Percentage of	
-5 (.)					
		Ownershi p		Ownershi p	
1, 00	2, 00	3.00	4, 00	5. 00	
1. 00	2.00	3.00	7. 00	5. 00	
B INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			
D. THE ENGLES IT ON SHITT TO RELATE	LD ONG, IN LITTON (3) AND ON THE	WE OITTOE.			4

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

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

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

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

			11/30/2013	7. 44 aiii
		Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
	A. COSTS INCURR	RED AND ADJUSTME	NTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE COS	STS:		
1.00	-596, 212	0		1. 00
2.00	5, 350, 130	0		2. 00
3.00	1, 727, 876	0		3. 00
3. 01	0	9		3. 01
3.02	0	0		3. 02
3.03	0	0		3. 03
4.00	0	0		4. 00
4.01	0	0		4. 01
4.02	0	0		4. 02
4.03	0	0		4. 03
4.04	0	0		4. 04
4.05	0	0		4. 05
4.06	0	0		4. 06
4.07	0	0		4. 07
4.08	0	0		4. 08
4. 10	0	0		4. 10
4. 11	0	0		4. 11
4. 12	0	0		4. 12
4. 13	0	9		4. 13
4.14	0	0		4. 14
4. 15	-462, 372	0		4. 15
4. 16	-142, 056	11		4. 16
4. 17	-124, 164	0		4. 17
4. 18	837, 182	0		4. 18
4. 20	0	0		4. 20
5.00	6, 590, 384			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.

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

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

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

rembursement under titte xviii.							
6.00	HOME OFFICE		6. 00				
7.00	HOME OFFICE		7.00				
8.00	TECHNOLOGY MGMT		8.00				
9.00			9.00				
10.00			10.00				
100.00			100.00				

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

HOSPITAL In Lieu of Form CMS-2552-10
Provider CCN: 150157 | Period: | Worksheet A-8-2 | From 07/01/2014 | To 04/20/2015 | Data/Time Propagation Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

					-	To 06/30/2015	Date/Time Pre 11/30/2015 9:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	443, 486			1	-	1. 00
2.00		ADULTS & PEDIATRICS	1, 910, 979					2.00
3.00		NEONATAL INTENSIVE CARE UNIT	1, 222, 390			1	l ĭ	3. 00
4.00		OPERATING ROOM	1, 094, 748			_	0	4. 00
5. 00		DELIVERY ROOM & LABOR ROOM	1, 177, 570		C	0	0	5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	5, 031	5, 031	C	0	0	6. 00
7. 00		CT SCAN	15, 170	15, 170	C	0	0	7. 00
8. 00		EMERGENCY	124, 667			0	0	8. 00
9.00		RADI OLOGY-DI AGNOSTI C	192, 241	192, 241	C	0	0	9. 00
10. 00	0. 00		0	0	C	1	0	10. 00
200.00			6, 186, 282				0	200. 00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	4.00			0.00	Educati on	12	44.00	
1 00	1.00	2.00 ADMINISTRATIVE & GENERAL	8.00	9.00	12. 00	13.00	14.00	1 00
1.00		1	0	0	_		١	1.00
2.00		ADULTS & PEDIATRICS	0			•	U	2.00
3.00		NEONATAL INTENSIVE CARE UNIT	0	0	_	1	U	3. 00
4.00		OPERATING ROOM	0	0			U	4. 00
5.00		DELIVERY ROOM & LABOR ROOM	0	0		0	U	5. 00
6.00		RADI OLOGY-DI AGNOSTI C CT SCAN	0	0			0	6. 00
7.00		EMERGENCY	0	0			U	7. 00 8. 00
8.00			0	0			0	9. 00
9.00	0.00	RADI OLOGY-DI AGNOSTI C	0	0		0	0	
10. 00 200. 00	0.00		0	0			0	10. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		ruentiffer	Share of col.	LIIIII	Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	C	443, 486		1. 00
2.00	30.00	ADULTS & PEDIATRICS	0	0	C	1, 910, 979		2.00
3.00	35. 00	NEONATAL INTENSIVE CARE UNIT	0	0	C	1, 222, 390		3.00
4.00	50.00	OPERATING ROOM	0	0	C	1, 094, 748		4.00
5.00	52. 00	DELIVERY ROOM & LABOR ROOM	0	0	C	1, 177, 570		5. 00
6.00		RADI OLOGY-DI AGNOSTI C	0	0	C	1		6. 00
7.00		CT SCAN	0	0	C	1		7. 00
8.00	91. OO EMERGENCY		l	Ö				8. 00
9. 00		RADI OLOGY-DI AGNOSTI C	l	Ö	C	1		9. 00
10.00	0.00	1	l 0	Ö		1		10. 00
200.00			0	Ö	C	6, 186, 282		200. 00
		•	•	•	•	•	'	

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150157 Peri od: Worksheet B From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/30/2015 9:44 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 7, 287, 869 1 00 00100 CAP REL COSTS-BLDG & FLXT 7 287 869 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 3, 545, 236 3, 545, 236 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 13, 237, 052 95, 906 1, 201 13, 334, 159 4.00 00500 ADMINISTRATIVE & GENERAL 1, 891, 583 22, 942, 020 5 00 463, 036 417, 873 5 00 20, 169, 528 7.00 00700 OPERATION OF PLANT 3, 206, 010 851, 220 41,065 148, 187 4, 246, 482 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 452, 992 31, 519 484, 511 8.00 00900 HOUSEKEEPI NG 4, 300, 571 136, 862 0 o 4, 437, 433 9.00 9.00 01000 DI ETARY 968, 139 5.652 0 1, 133, 863 10 00 10.00 160, 072 11.00 01100 CAFETERI A 903, 190 186, 763 8, 282 1, 098, 235 11.00 01300 NURSING ADMINISTRATION 17, 508 2, 047, 476 13.00 1, 581, 048 3, 358 445, 562 13.00 01400 CENTRAL SERVICES & SUPPLY 391, 667 162, 352 14, 222 94, 604 662, 845 14.00 14.00 614, 469 15.00 01500 PHARMACY 4, 948, 165 127, 769 186, 873 5, 877, 276 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 874, 485 7, 426 152, 886 1, 034, 797 16.00 C 01700 SOCIAL SERVICE 17.00 241,066 17,622 50, 353 309, 041 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 553, 468 1, 652, 614 228, 278 2, 468, 088 11, 902, 448 30.00 36, 152 03100 INTENSIVE CARE UNIT 169, 337 306, 467 2, 077, 161 31.00 1, 565, 205 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 1, 280, 988 168, 553 12, 293 707, 774 2, 169, 608 35.00 04300 NURSERY 1,044,100 299, 606 30, 754 277, 169 1, 651, 629 43.00 43.00 ANCILLARY SERVICE COST CENTERS 12, 682, 957 649, 800 15, 715, 357 50.00 05000 OPERATING ROOM 1, 263, 257 1, 119, 343 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 100, 120 345, 169 9, 669 515, 109 2, 970, 067 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2,028,533 319, 679 197, 087 483, 453 3, 028, 752 54.00 54.02 05402 ULTRASOUND 205, 183 50, 465 20, 781 60, 700 337, 129 54.02 05700 CT SCAN 57.00 555, 711 81, 936 54, 558 146, 337 838, 542 57.00 195, 293 112, 099 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 526, 804 310, 923 1, 145, 119 58.00 05900 CARDIAC CATHETERIZATION 59.00 C Λ 59 00 3, 275, 887 06000 LABORATORY 3, 134, 421 118, 308 3, 376 19, 782 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 1, 179, 293 50, 049 64.361 319, 331 1, 613, 034 65.00 06600 PHYSI CAL THERAPY 66.00 262, 764 46, 691 691 71, 068 381, 214 66,00 67.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 19, 185 3, 407 C 5, 793 28, 385 68.00 06900 ELECTROCARDI OLOGY 279, 981 11, 127 15, 280 34, 240 69.00 340, 628 69.00 07000 ELECTROENCEPHALOGRAPHY 129, 235 70.00 88,831 3, 774 13, 445 23, 185 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 663, 185 0 0 1, 663, 185 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4, 374, 317 0 0 4, 374, 317 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 26 373 0 0 26, 373 73 00 07500 ASC (NON-DISTINCT PART) 75.00 8, 408, 597 310, 709 225, 486 692, 533 9, 637, 325 75.00 76.00 03330 ENDOSCOPY 2, 391, 975 128, 945 211, 568 365, 677 3, 098, 165 76.00 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 3, 066, 490 91 00 2, 204, 765 333, 699 39.983 488 043 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 115, 683, 774 7, 183, 066 3, 430, 618 11, 613, 835 113, 744, 029 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 456, 397 40, 539 4, 556 27, 648 529, 140 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 296, 092 87, 843 383, 935 192. 00 194.00 07950 MISSION EFFECTIVENESS 5, 988 9, 433 194. 00 0 3.445 0 194. 01 07951 MARKETI NG 1, 727, 876 194. 01 1, 727, 876 Ω C 0 194. 02 07952 JOI NT VENTURES 598 0 598 194. 02 194. 04 07954 SCHOOL NURSE 18,532 21, 691 5, 221 45, 444 194. 04 194.06 07956 SPORTS MEDICINE & OB PHYS 8, 278, 821 194. 06 1, 599, 612 6, 530, 019 42, 573 106, 617 200.00 Cross Foot Adjustments 0 200.00 201.00

124, 719, 276

0 201.00

124, 719, 276 202. 00

3, 545, 236

13, 334, 159

7, 287, 869

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

Provi der CCN: 150157

Peri od: Worksheet B From 07/01/2014 Part I To 06/30/2015 Date/Time Prepared: 11/30/2015 0:44 am

			'	0 00/30/2013	11/30/2015 9:	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS	Т	1		T T		
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	22 042 020					4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	22, 942, 020	F 202 (00				5.00
7. 00 00700 OPERATION OF PLANT	957, 216	5, 203, 698	(21 (22			7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	109, 216	27, 905	621, 632			8.00
9. 00 00900 HOUSEKEEPI NG	1, 000, 260	121, 168	0	-,,	1 (07 000	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	255, 589	141, 717 165, 347	0	,	1, 687, 023 0	10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	247, 558 461, 530	2, 973	0	181, 841 3, 269	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	149, 415	2, 973 143, 735	17, 777		0	14.00
15. 00 01500 PHARMACY	1, 324, 820	113, 117	17,777	124, 402	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	233, 258	6, 575	0		0	16.00
17. 00 01700 SOCIAL SERVICE	69, 662	15, 602	0	17, 158	0	17. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	07,002	13, 002		17, 130		17.00
30. 00 03000 ADULTS & PEDIATRICS	2, 682, 978	1, 463, 102	186, 645	1, 609, 061	1, 466, 127	30.00
31. 00 03100 NTENSI VE CARE UNI T	468, 221	149, 919	24, 209		79, 104	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	489, 060	149, 225	24, 207		77, 104	35.00
43. 00 04300 NURSERY	372, 300	265, 249	28, 705		0	43.00
ANCI LLARY SERVI CE COST CENTERS	072,000	200, 217	20,700	271,710		10.00
50. 00 05000 OPERATING ROOM	3, 542, 463	575, 286	73, 837	632, 675	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	669, 495	305, 588	62, 394		141, 792	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	682, 723	283, 021	13, 054		0	54.00
54. 02 05402 ULTRASOUND	75, 994	44, 678	1, 203		0	54. 02
57. 00 05700 CT SCAN	189, 019	72, 540	3, 346		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	258, 126	172, 898	49, 149		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	O	0	0	0	0	59. 00
60. 00 06000 LABORATORY	738, 431	104, 741	0	115, 190	0	60.00
65. 00 06500 RESPI RATORY THERAPY	363, 600	44, 310	523	48, 730	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	85, 931	41, 337	1, 116	45, 460	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	6, 398	3, 016	82	3, 317	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	76, 782	9, 851	124	10, 834	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	29, 131	3, 342	39	3, 675	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	374, 905	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	986, 032	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 945	0	0	0	0	73. 00
75.00 07500 ASC (NON-DISTINCT PART)	2, 172, 388	275, 079	33, 422	302, 520	0	75. 00
76. 00 03330 ENDOSCOPY	698, 370	114, 159	29, 662	125, 547	0	76. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
91. 00 09100 EMERGENCY	691, 230	295, 433	91, 982	324, 904	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	20, 468, 046	5, 110, 913	617, 269	5, 456, 820	1, 687, 023	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	119, 276	35, 890	0	,		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	86, 544	0	0	0		192. 00
194. 00 07950 MISSION EFFECTIVENESS	2, 126	0	0	0		194. 00
194. 01 07951 MARKETI NG	389, 487	0	0	0		194. 01
194. 02 07952 JOI NT VENTURES	135	0	0	0		194. 02
194. 04 07954 SCHOOL NURSE	10, 244	19, 204	0	21, 119		194. 04
194. 06 07956 SPORTS MEDICINE & OB PHYS	1, 866, 162	37, 691	4, 363	41, 451	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	22, 942, 020	5, 203, 698	621, 632	5, 558, 861	1, 687, 023	202.00

			To	06/30/2015	Date/Time Pre 11/30/2015 9:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	44 (1111
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13.00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	Г					
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 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	1 (02 001					10.00
11. 00 01100 CAFETERI A	1, 692, 981	0 570 000				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	58, 055		4 4/0 570			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	30, 734	1	1, 162, 579	7 500 400		14.00
15. 00 01500 PHARMACY	85, 836	l 1	7, 737	7, 533, 188	4 000 (70	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	21, 817	l I	0	0	1, 303, 678	1
17. 00 01700 SOCIAL SERVICE	7, 927	0	41	0	0	17. 00
I NPATIENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDIATRI CS	386, 621	791, 659	23, 988	5, 754	120, 383	30.00
31. 00 03100 NTENSI VE CARE UNI T	46, 784		5, 331	2, 216	17, 115	•
35. 00 02060 NEONATAL NTENSI VE CARE UNIT	68, 591	140, 448	5, 296	6, 162	39, 122	35. 00
43. 00 04300 NURSERY	51, 768		0, 270	0, 102	22, 271	•
ANCI LLARY SERVI CE COST CENTERS	31,700	100,002	O ₁	<u> </u>	22,271	45.00
50. 00 05000 OPERATING ROOM	202, 861	415, 383	497, 237	536, 436	397, 869	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	92, 679		20, 521	10, 538	83, 010	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	92, 460		15, 940	3, 890	55, 322	54.00
54. 02 05402 ULTRASOUND	7, 168		92	0	9, 849	•
57. 00 05700 CT SCAN	22, 790	l .	789	0	22, 406	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	21, 785		461	576	10, 878	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	О	0	0	0	59. 00
60. 00 06000 LABORATORY	3, 204	0	48	62, 376	89, 363	60.00
65. 00 06500 RESPIRATORY THERAPY	56, 522	o	5, 099	5, 416	14, 634	65. 00
66. 00 06600 PHYSI CAL THERAPY	11, 985	0	606	267	6, 706	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	921	0	0	0	463	68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 985	0	29	0	8, 247	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 845	o	717	0	7, 159	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	102, 374	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	269, 252	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	6, 308, 294	0	73. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	155, 535	537, 452	219, 615	75. 00
76. 00 03330 ENDOSCOPY	57, 000	116, 715	31, 581	25, 791	73, 319	76. 00
OUTPATIENT SERVICE COST CENTERS	T					
91. 00 09100 EMERGENCY	81, 791	167, 477	16, 181	12, 578	105, 947	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS	1 420 120	2 022 252	1 150 055	7 517 74/	1 202 (70	110 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	1, 420, 129	2, 023, 252	1, 158, 855	7, 517, 746	1, 303, 678	1118.00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 469	O	188	O		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	13, 065		22	0		190.00
194. 00 07950 MISSION EFFECTI VENESS	13,003	l 1	22	0		194. 00
194. 01 07951 MARKETI NG	0		0	0		194. 01
194. 02 07952 JOINT VENTURES			0	0		194. 01
194. 04 07954 SCHOOL NURSE		35, 447	0	0		194. 02
194. 06 07956 SPORTS MEDICINE & OB PHYS	251, 318		3, 514	15, 442		194. 04
200.00 Cross Foot Adjustments	251, 510	314,004	3, 314	13, 442	O	200.00
201.00 Negative Cost Centers	0	٥	Ω	ol	Ω	201.00
202.00 TOTAL (sum lines 118-201)	1, 692, 981	2, 573, 303	1, 162, 579	7, 533, 188	1, 303, 678	
	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , ,	, , , , , , , ,		, ,	

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150157 Peri od: Worksheet B From 07/01/2014 Part I 06/30/2015 Date/Time Prepared: 11/30/2015 9:44 am Cost Center Description SOCIAL SERVICE Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 419, 431 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 20, 732, 909 30.00 94 143 20, 732, 909 0 0 31.00 03100 INTENSIVE CARE UNIT 43,042 3, 173, 772 3, 173, 772 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 69, 875 3, 301, 498 0 3, 301, 498 35.00 43.00 04300 NURSERY 2, 789, 634 0 2, 789, 634 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8, 240 22, 597, 644 0 22, 597, 644 50.00 05200 DELIVERY ROOM & LABOR ROOM 53,063 4, 934, 992 4, 934, 992 52.00 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 4, 486, 416 4, 486, 416 54.00 0 54 02 05402 ULTRASOUND 0 525, 248 525, 248 54 02 0 0 57.00 05700 CT SCAN 1, 229, 208 1, 229, 208 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 1, 849, 138 1, 849, 138 58.00 58.00 05900 CARDIAC CATHETERIZATION 0000000000 0 59.00 59.00 4, 389, 240 06000 LABORATORY 0 4. 389. 240 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 2, 151, 868 2, 151, 868 65.00 06600 PHYSI CAL THERAPY 66.00 574, 622 574, 622 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 42, 582 42, 582 68 00 68 00 06900 ELECTROCARDI OLOGY 453, 480 453, 480 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 177, 143 177, 143 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2.140.464 71.00 2, 140, 464 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 5, 629, 601 5, 629, 601 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 6, 340, 612 0 6, 340, 612 73.00 75.00 07500 ASC (NON-DISTINCT PART) 13, 333, 336 0 13, 333, 336 75.00 03330 ENDOSCOPY 21, 974 0 4, 392, 283 76.00 4, 392, 283 76.00 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 107, 090 4, 961, 103 O 4, 961, 103 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 397, 427 110, 206, 793 0 110, 206, 793 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 732.434 732.434 192.00 19200 PHYSICIANS' PRIVATE OFFICES 22,004 505, 570 0 505, 570 192. 00 194.00 07950 MISSION EFFECTIVENESS 0 194. 00 0 11, 559 11, 559 194. 01 07951 MARKETI NG 0 0 194. 01 2, 117, 363 2, 117, 363 194. 02 07952 JOINT VENTURES 0 194. 02 0 733 733 194. 04 07954 SCHOOL NURSE 0 131, 458 0 131, 458 194. 04 194.06 07956 SPORTS MEDICINE & OB PHYS 0 11, 013, 366 11, 013, 366 194.06 Cross Foot Adjustments 200.00 0 200. 00 C 0 0 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118-201) 419, 431 124, 719, 276 124, 719, 276 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150157

					То	06/30/2015	Date/Time Prep 11/30/2015 9:	pared:
				CAPI TAL REI	ATED COSTS		11/30/2013 4.	44 alli
				BLDO & ELVE	10/01 5 50// 0		EMBL 0./EE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs					
	OFNED	AL CERVILOR COCT OFFITERS	0	1. 00	2. 00	2A	4. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	I			T		1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	95, 906	1, 201	97, 107	97, 107	4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	1, 876, 416	463, 036	417, 873	2, 757, 325	13, 775	5. 00
7.00		OPERATION OF PLANT	0	851, 220		892, 285	1, 079	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	31, 519	I	31, 519	0	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	0	136, 862 160, 072	1	136, 862 165, 724	0	9. 00 10. 00
11. 00		CAFETERIA	0	186, 763		195, 045	0	10.00
13. 00		NURSING ADMINISTRATION	0	3, 358		20, 866	3, 245	13. 00
14.00		CENTRAL SERVICES & SUPPLY	0	162, 352		176, 574	689	14. 00
15. 00		PHARMACY	0	127, 769	186, 873	314, 642	4, 475	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	7, 426	1	7, 426	1, 113	
17. 00		SOCIAL SERVICE LENT ROUTINE SERVICE COST CENTERS	0	17, 622	0	17, 622	367	17. 00
30. 00		ADULTS & PEDIATRICS	0	1, 652, 614	228, 278	1, 880, 892	17, 978	30. 00
31. 00		INTENSIVE CARE UNIT	0	169, 337		205, 489	2, 232	31. 00
35. 00		NEONATAL INTENSIVE CARE UNIT	0	168, 553		180, 846	5, 154	
43.00	04300	NURSERY	0	299, 606	30, 754	330, 360	2, 018	43.00
		LARY SERVICE COST CENTERS	1					
50.00	1	OPERATING ROOM	0	649, 800		1, 913, 057	8, 151 3, 751	50.00
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0	345, 169 319, 679		354, 838 516, 766	3, 751	52. 00 54. 00
54. 02		ULTRASOUND	0	50, 465		71, 246	442	54. 02
57. 00		CT SCAN	0	81, 936		136, 494	1, 066	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	195, 293	310, 923	506, 216	816	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00		LABORATORY THE DARW	0	118, 308		121, 684	144	60.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	50, 049 46, 691	64, 361 691	114, 410 47, 382	2, 325 518	65. 00 66. 00
67. 00		OCCUPATIONAL THERAPY	0	40, 091		47, 362	0	67. 00
68. 00		SPEECH PATHOLOGY	0	3, 407		3, 407	42	68. 00
69. 00		ELECTROCARDI OLOGY	0	11, 127	1	26, 407	249	69. 00
70.00		ELECTROENCEPHALOGRAPHY	0	3, 774	13, 445	17, 219	169	70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
75. 00		ASC (NON-DISTINCT PART)	0	310, 709	225, 486	536, 195	5, 043	
76. 00		ENDOSCOPY	0			340, 513	2, 663	76. 00
		TIENT SERVICE COST CENTERS						
91. 00		EMERGENCY	0	333, 699	39, 983	373, 682	3, 554	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	1, 876, 416	7, 183, 066	3, 430, 618	12, 490, 100	84, 579	118 00
110.00		IMBURSABLE COST CENTERS	1,070,410	7, 103, 000	3, 430, 010	12, 470, 100	04, 377	110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40, 539	4, 556	45, 095	201	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
		MI SSI ON EFFECTI VENESS	0	0		3, 445		194. 00
		MARKETI NG	0	0	0	0		194. 01
		JOI NT VENTURES SCHOOL NURSE		0 21, 691		21, 691		194. 02 194. 04
		SPORTS MEDICINE & OB PHYS		42, 573	1	149, 190	11, 649	
200.00		Cross Foot Adjustments		12,373	100,017	0		200. 00
201.00		Negative Cost Centers		0	0	o	0	201. 00
202.00)	TOTAL (sum lines 118-201)	1, 876, 416	7, 287, 869	3, 545, 236	12, 709, 521	97, 107	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150157

				10	06/30/2015	11/30/2015 9:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	T T GIII
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8.00	9. 00	10.00	
G	ENERAL SERVICE COST CENTERS						
1.00 0	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 0	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 0	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 0	00500 ADMINISTRATIVE & GENERAL	2, 771, 100					5. 00
7.00 0	00700 OPERATION OF PLANT	115, 619	1, 008, 983				7. 00
8.00 0	00800 LAUNDRY & LINEN SERVICE	13, 192	5, 411	50, 122			8. 00
9.00 0	00900 HOUSEKEEPI NG	120, 818	23, 494	0	281, 174		9. 00
10.00 0	1000 DI ETARY	30, 872	27, 478	0	7, 883	231, 957	10.00
	01100 CAFETERI A	29, 902			9, 198		1
13.00 0	01300 NURSING ADMINISTRATION	55, 747	576		165		13. 00
14.00 0	01400 CENTRAL SERVICES & SUPPLY	18, 047	27, 870		7, 996	0	14.00
	1500 PHARMACY	160, 021	21, 933		6, 292		15. 00
	01600 MEDICAL RECORDS & LIBRARY	28, 174		1	366		16. 00
	1700 SOCIAL SERVICE	8, 414		1	868		17. 00
	NPATIENT ROUTINE SERVICE COST CENTERS		27 525				1
	03000 ADULTS & PEDIATRICS	324, 068	283, 694	15, 049	81, 389	201, 585	30.00
	03100 NTENSIVE CARE UNIT	56, 555	1		8, 340		
	02060 NEONATAL INTENSIVE CARE UNIT	59, 072			8, 301	0	1
4	04300 NURSERY	44, 969		1	14, 755	0	1
	NCILLARY SERVICE COST CENTERS	,	, , , , , , , , , , , , , , , , , , , ,				1
	05000 OPERATING ROOM	427, 892	111, 546	5, 953	32, 001	0	50.00
52.00 0	05200 DELIVERY ROOM & LABOR ROOM	80, 866			16, 999	19, 496	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	82, 464	54, 877	· ·	15, 744	0	54.00
54. 02 0	05402 ULTRASOUND	9, 179			2, 485	0	54. 02
57.00 0	05700 CT SCAN	22, 831	14, 065	270	4, 035	0	57. 00
58.00 0	05800 MAGNETIC RESONANCE IMAGING (MRI)	31, 178		1	9, 618		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
60.00	06000 LABORATORY	89, 193	20, 309	0	5, 826	0	60.00
65.00 0	06500 RESPIRATORY THERAPY	43, 918	8, 591	42	2, 465		65. 00
	06600 PHYSI CAL THERAPY	10, 379			2, 299		66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	1	. 0	0	67. 00
	06800 SPEECH PATHOLOGY	773	585	7	168	0	68. 00
69.00 0	06900 ELECTROCARDI OLOGY	9, 274	1, 910	10	548	0	69. 00
	77000 ELECTROENCEPHALOGRAPHY	3, 519		3	186	0	70. 00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45, 284	0	1	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	119, 100	0	o	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	718		o	0	0	1
	7500 ASC (NON-DISTINCT PART)	262, 395		2, 695	15, 302	0	1
	03330 ENDOSCOPY	84, 354			6, 350	0	76. 00
	UTPATIENT SERVICE COST CENTERS						1
91.00 0	9100 EMERGENCY	83, 491	57, 284	7, 416	16, 434	0	91. 00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
S	PECIAL PURPOSE COST CENTERS]
118. 00	SUBTOTALS (SUM OF LINES 1-117)	2, 472, 278	990, 992	49, 770	276, 013	231, 957	118. 00
	ONREI MBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 407			1, 996		190. 00
192. 00 1	9200 PHYSI CLANS' PRI VATE OFFI CES	10, 453	0	0	0		192. 00
	07950 MISSION EFFECTIVENESS	257	0	0	0		194. 00
	07951 MARKETI NG	47, 045	0	0	0		194. 01
194. 02 0	07952 JOI NT VENTURES	16	0	0	0		194. 02
	07954 SCHOOL NURSE	1, 237	3, 724		1, 068		194. 04
194. 06 0	07956 SPORTS MEDICINE & OB PHYS	225, 407	7, 308	352	2, 097	0	194. 06
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	2, 771, 100	1, 008, 983	50, 122	281, 174	231, 957	202. 00

Provi der CCN: 150157

					00/30/2013	11/30/2015 9:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00							•
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	266, 205					11. 00
13.00	01300 NURSING ADMINISTRATION	9, 129					13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	4, 833		237, 442			14. 00
15. 00	01500 PHARMACY	13, 497		1, 580	522, 440		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	3, 431		1, 300	322, 440	41, 785	
17. 00	01700 SOCIAL SERVICE	1, 246		8	0	41, 703	17. 00
17.00		1, 240	l V	0	U	U	17.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(0.702	27.404	4 000	200	2.0/5	20.00
30.00	03000 ADULTS & PEDIATRICS	60, 792		4, 899	399	3, 865	30.00
31. 00	03100 I NTENSI VE CARE UNI T	7, 356		1, 089	154	549	31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	10, 785		1, 082	427	1, 256	35. 00
43.00	04300 NURSERY	8, 140	3, 696	0	0	715	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	31, 898	14, 484	101, 559	37, 203	12, 706	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	14, 573	6, 617	4, 191	731	2, 665	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 538	l ol	3, 255	270	1, 776	54.00
54. 02	05402 ULTRASOUND	1, 127	l ol	19	o	316	54. 02
57. 00	05700 CT SCAN	3, 583	ا	161	0	719	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 425		94	40	349	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0, 120		0	0	0	59. 00
60.00	06000 LABORATORY	504		10	4, 326	2, 869	60.00
			0				ı
65. 00	06500 RESPI RATORY THERAPY	8, 888		1, 041	376	470	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 885		124	18	215	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	_	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	145		0	0	15	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 098		6	0	265	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	605	0	146	0	230	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	20, 908	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	54, 990	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	l ol	0	437, 491	0	73. 00
75.00	07500 ASC (NON-DISTINCT PART)		l ol	31, 765	37, 273	7, 050	75. 00
76. 00	03330 ENDOSCOPY	8, 963	4, 070	6, 450	1, 789	2, 354	76. 00
70.00	OUTPATIENT SERVICE COST CENTERS	0,700	1, 0, 0	67 100	.,,,,,	2,00.	70.00
91. 00	09100 EMERGENCY	12, 861	5, 840	3, 305	872	3, 401	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12,001	3, 040	3, 303	0/2	3, 401	92. 00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
110 00		202 202	70 540	227 (02	F01 0/0	41 705	110 00
118. 00		223, 302	70, 548	236, 682	521, 369	41, 785	1118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 332		38	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	2, 054	0	4	0		192. 00
	07950 MISSION EFFECTIVENESS	0	0	0	0		194. 00
194.01	I 07951 MARKETI NG	0	0	0	0	0	194. 01
	2 07952 JOINT VENTURES	0	l ol	0	o	0	194. 02
194.04	1 07954 SCHOOL NURSE	0	1, 236	0	o	0	194. 04
	07956 SPORTS MEDICINE & OB PHYS	39, 517		718	1, 071		194. 06
200.00		1			,]		200. 00
201.00	1 1	0	١	n	n	Λ	201. 00
202.00		266, 205	-	237, 442	522, 440	41, 785	
202.00	1017E (3011 111163 110-201)	200, 200	1 07, 720	231, 442	322, 440	41,700	1202.00

	Financial Systems	SI. VINCENI CAR				U OT FORM CMS-2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 07/01/2014 o 06/30/2015	Worksheet B Part II Date/Time Prepared: 11/30/2015 9:44 am
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17. 00	24. 00	25.00	26. 00	
	GENERAL SERVICE COST CENTERS					
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
17. 00	01700 SOCIAL SERVICE	31, 550				17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 31. 00 35. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	7, 081 3, 238 5, 256 0	2, 909, 295 330, 239 306, 010 458, 398	0 0	2, 909, 295 330, 239 306, 010 458, 398	30. 00 31. 00 35. 00 43. 00
50. 00	05000 OPERATING ROOM	620	2, 697, 070	0	2, 697, 070	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 991	573, 002		573, 002	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	694, 264	1	694, 264	54. 00
54. 02	05402 ULTRASOUND	o	93, 574	1	93, 574	54. 02
57. 00	05700 CT SCAN	O	183, 224	1	183, 224	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	589, 223	o o	589, 223	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	o	0	59.00
60.00	06000 LABORATORY	0	244, 865	0	244, 865	60.00
65. 00	06500 RESPI RATORY THERAPY	0	182, 526		182, 526	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	70, 925		70, 925	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	5, 142	1	5, 142	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	39, 767		39, 767	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	22, 725		22, 725	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66, 192		66, 192	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	174, 090 438, 209		174, 090 438, 209	72. 00 73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	951, 055		951, 055	75. 00
76. 00		1, 653	483, 686			76.00
70.00	OUTPATIENT SERVICE COST CENTERS	1,000	403, 000	ή σ	405, 000	70.00
91 00	09100 EMERGENCY	8, 056	576, 196	0	576, 196	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, , , , ,	2.2,	0		92. 00
	SPECIAL PURPOSE COST CENTERS	'				
118.00		29, 895	12, 089, 677	0	12, 089, 677	118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	70, 028	0	70, 028	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 655	14, 806	1	14, 806	192. 00
	07950 MISSION EFFECTIVENESS	0	3, 702	1	3, 702	194. 00
	07951 MARKETI NG	0	47, 045		47, 045	194. 01
	2 07952 JOI NT VENTURES	0	16		16	194. 02
	107954 SCHOOL NURSE		28, 994	1	28, 994	194. 04
	5 07956 SPORTS MEDICINE & OB PHYS		455, 253		455, 253	194. 06
200.00	1 1		0	0	0	200. 00 201. 00
201. 00 202. 00		31, 550	12, 709, 521	1	12, 709, 521	201.00
202.00	7 101/1E (3dm 111103 110-201)	31, 330	12, 107, 321	ا	12, 107, JZ1	1202.00

	Financial Systems	SI. VINCENI CA		CCN: 150157 5		Warksheet B 1	
CUST A	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2014	Worksheet B-1	
					o 06/30/2015	Date/Time Pre	
		OADLEAL DE	LATED COCTO			11/30/2015 9:	44 am
		CAPITAL RE	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	cost center bescription	(SQUARE FEET)			Reconciliation	& GENERAL	
		(SQUARE TEET)	(BOLLYIK WILDE)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(
				SALARI ES)			
		1.00	2. 00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS				_		
1. 00	00100 CAP REL COSTS-BLDG & FLXT	297, 347	1				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		3, 593, 094	1			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 913				404 777 057	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	18, 892	1				
7. 00 8. 00	OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE	34, 730	1	490, 748		4, 246, 482	1
9. 00	00900 HOUSEKEEPING	1, 286 5, 584				484, 511 4, 437, 433	1
10. 00	01000 DI ETARY	6, 531	1				1
11. 00	01100 CAFETERI A	7, 620	1	1		1, 098, 235	1
13. 00	01300 NURSING ADMINISTRATION	137	1	ı	ĺ		
14. 00	01400 CENTRAL SERVI CES & SUPPLY	6, 624	1			662, 845	
15. 00	01500 PHARMACY	5, 213	1	1			
16.00	01600 MEDICAL RECORDS & LIBRARY	303		1		1, 034, 797	
17.00	01700 SOCIAL SERVICE	719	0	166, 754	0	309, 041	17. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	67, 427	1				•
31. 00	03100 INTENSIVE CARE UNIT	6, 909					1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	6, 877					1
43. 00	04300 NURSERY	12, 224	31, 169	917, 896	0	1, 651, 629	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	2/ 512	1 200 212	2 70/ 01/		15 745 057	F0 00
50. 00 52. 00		26, 512					
54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	14, 083 13, 043	1				
54. 02	05400 RADI OLOGI - DI AGNOSTI C	2, 059					•
57. 00	05700 CT SCAN	3, 343	1	1			•
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	7, 968	1	1			1
59. 00	05900 CARDI AC CATHETERI ZATI ON	1,730		1			1
60.00	06000 LABORATORY	4, 827	3, 422	65, 511	0	3, 275, 887	1
65.00	06500 RESPI RATORY THERAPY	2, 042	1	l			1
66.00	06600 PHYSI CAL THERAPY	1, 905	700	235, 356	0	381, 214	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0) c	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	139	1	19, 185		28, 385	1
69. 00	06900 ELECTROCARDI OLOGY	454		l			1
	07000 ELECTROENCEPHALOGRAPHY	154		1		129, 235	1
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	1		0		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0	4, 374, 317	
73. 00 75. 00	07300 DRUGS CHARGED TO PATLENTS 07500 ASC (NON-DISTINCT PART)	12, 677	228, 530	2 202 451	0	26, 373	1
		5, 261	1			9, 637, 325 3, 098, 165	
70.00	OUTPATIENT SERVICE COST CENTERS	5, 201	214,424	1,211,007	0	3, 076, 103	70.00
91 00	09100 EMERGENCY	13, 615	40, 523	1, 616, 244	1 0	3, 066, 490	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,010		1,010,211		0,000,.70	92. 00
,2.00	SPECIAL PURPOSE COST CENTERS	1		1			72.00
118.00		293, 071	3, 476, 930	38, 461, 341	-22, 942, 020	90, 802, 009	118.00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 654	4, 617	91, 561	0	529, 140	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	290, 907	0	383, 935	192. 00
	07950 MISSION EFFECTIVENESS	0	3, 491	(0		194. 00
	07951 MARKETI NG	0	0	(0		1
	07952 JOINT VENTURES	0	1	C	0		194. 02
	07954 SCH00L NURSE	885		17, 290			194. 04
	07956 SPORTS MEDICINE & OB PHYS	1, 737	108, 056	5, 297, 414	0	8, 278, 821	
200.00	1						200.00
201.00		7 207 040	2 545 227	12 224 150		22 042 020	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	7, 287, 869	3, 545, 236	13, 334, 159	<u>'</u>	22, 942, 020	202.00
203. 00		24. 509644	0. 986681	0. 301961		0. 225414	203. 00
204.00		27.007044	3. 700001	97, 107		2, 771, 100	
	Part II)					_, ,	
205.00				0. 002199		0. 027227	205. 00
						1	

	Financial Systems	ST. VINCENT CAI					u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provid	der	1	Period: From 07/01/2014	Worksheet B-1	
					-	Го 06/30/2015	Date/Time Pre 11/30/2015 9:	
	Cost Center Description	OPERATION OF	LAUNDRY 8	Š.	HOUSEKEEPI NG	DI ETARY	CAFETERI A	44 аш
	·	PLANT	LINEN SERVI		(SQUARE FEET)	(MEALS SERVED)	(HOURS OF	
		(SQUARE FEET)	(POUNDS 0 LAUNDRY)	F			SERVICE)	
		7. 00	8. 00		9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00		71.00	10100	111.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT							1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P							2.00
4. 00 5. 00	OO400							4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	239, 812	•					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 286	494,	597				8. 00
9.00	00900 HOUSEKEEPI NG	5, 584		0	232, 942	1		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	6, 531 7, 620		0	6, 53° 7, 620		990, 773	10.00
13. 00	01300 NURSING ADMINISTRATION	137		0	13	1	33, 975	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 624	14,	144	6, 62	1	17, 986	1
15. 00	01500 PHARMACY	5, 213		0	5, 213	1	50, 233	•
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	303 719		0	300 719	1	12, 768	•
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	/19		U	/ / /	9 0	4, 639	17.00
30. 00	03000 ADULTS & PEDIATRICS	67, 427	148,	504	67, 42	7 36, 438	226, 261	30.00
31.00	03100 INTENSIVE CARE UNIT	6, 909	19,	262	6, 90	1, 966	27, 379	31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	6, 877		0	6, 87	1	40, 141	•
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	12, 224	22,	839	12, 22	4 0	30, 296	43. 00
50. 00	05000 OPERATING ROOM	26, 512	58.	748	26, 512	2 0	118, 719	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	14, 083		643	· ·	1	54, 238	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	13, 043	10,			1	54, 110	1
54. 02	05402 ULTRASOUND	2,059		957	2, 059	1	4, 195	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 343 7, 968	2, 39,	105	3, 343 7, 968	1	13, 337 12, 749	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	07,	0			0	1
60.00	06000 LABORATORY	4, 827		0	4, 82	7 0	1, 875	60.00
65. 00	06500 RESPI RATORY THERAPY	2, 042		416	· ·	1	33, 078	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 905		888		5 O	7, 014 0	1
68. 00	06800 SPEECH PATHOLOGY	139		65	139	-	539	1
69. 00	06900 ELECTROCARDI OLOGY	454		99	454	1	4, 088	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	154		31	154	4 O	2, 250	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		0		0 0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	12, 677	26,	592	12, 67		0	1
76. 00	03330 ENDOSCOPY	5, 261	23,			1	33, 358	76. 00
	OUTPATIENT SERVICE COST CENTERS							
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	13, 615	73,	185	13, 61!	5 0	47, 866	91.00
92.00	SPECIAL PURPOSE COST CENTERS							72.00
118.00		235, 536	491,	126	228, 660	41, 928	831, 094	118. 00
	NONREI MBURSABLE COST CENTERS							
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 654		0	1, 65	1		190.00
	07950 MISSION EFFECTIVENESS	0		0		0 0		192. 00 194. 00
	07951 MARKETI NG	0		0		ol ol	0	194. 01
	07952 JOINT VENTURES	0		0	(0 0	0	194. 02
	07954 SCHOOL NURSE	885		0	88!	1		194. 04
194. 06 200. 00	07956 SPORTS MEDICINE & OB PHYS Cross Foot Adjustments	1, 737	3,	471	1, 73	/ 0	147, 077	194. 06 200. 00
200.00								201. 00
202.00		5, 203, 698	621,	632	5, 558, 86 ⁻	1, 687, 023	1, 692, 981	
000 -	Part I)							
203.00		21. 699073	1. 256			1	1. 708748	
204.00	Part II)	1, 008, 983	50,	122	281, 174	4 231, 957	266, 205	204.00
205.00	1 1 ,	4. 207392	0. 101	339	1. 20705	5. 532270	0. 268684	205. 00

Health Financial Systems	ST. VINCENT CAR	MEL HOSPITAL		In Lie	u of Form CMS-	2552-1
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2014 To 06/30/2015	Worksheet B-1 Date/Time Pre 11/30/2015 9:	pared:
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE (TIME SPENT)	
	(DI RECT NURS.	(COSTED	,	(PATI ENT		
	HRS.) 13. 00	REQUI S.) 14. 00	15. 00	REVENUE) 16. 00	17. 00	
GENERAL SERVICE COST CENTERS			T			
1. 00	735, 466 0 0 0 0	18, 887, 509 125, 704 0 660	2, 825, 07	9 0 394, 772, 696 0 0	13, 896	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS	226, 261	389, 707	2, 15	8 36, 457, 623	3, 119	30.00
31. 00 03100 INTENSI VE CARE UNIT	27, 379	86, 601	83		1, 426	
35.00 02060 NEONATAL INTENSIVE CARE UNIT 43.00 04300 NURSERY	40, 141	86, 034 0	1			
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	30, 296	0		0 6, 744, 829	0	43.00
50. 00 05000 OPERATING ROOM	118, 719	8, 078, 275			273	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	54, 238	333, 382 258, 961	3, 95 1, 45		1, 758 0	
54. 02 05402 ULTRASOUND	0	1, 492		0 2, 982, 837	Ö	1
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	12, 822	1	0 6, 785, 586 6 3, 294, 240	0 0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		7, 485 0		0 3, 294, 240	0	
60. 00 06000 LABORATORY	0	782			0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	82, 834 9, 850			0 0	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	0 0	Ö	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0 471		0 140, 246 0 2, 497, 543	0 0	
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY		11, 652		0 2, 167, 929	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 663, 185		0	0	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	4, 374, 317 0	2, 365, 72	2 0	0 0	
75.00 07500 ASC (NON-DISTINCT PART)	0	2, 526, 853	201, 55	4 66, 509, 542	0	75.00
76. 00 03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS	33, 358	513, 066	9, 67	2 22, 204, 318	728	76. 00
91. 00 09100 EMERGENCY	47, 866	262, 880	4, 71	7 32, 085, 659	3, 548	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	578, 258	18, 827, 013	2, 819, 28	8 394, 772, 696	13, 167	118. 0
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 047		0 0	0	190. 0
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	357		0 0	729	192. 0
194. 00 07950 MISSI ON EFFECTI VENESS 194. 01 07951 MARKETI NG	0	0		0 0		194. 0 194. 0
194. 02 07952 JOINT VENTURES	o o	0		0 0		194. 0
194.04 07954 SCHOOL NURSE 194.06 07956 SPORTS MEDICINE & OB PHYS	10, 131 147, 077	0 57, 092	5, 79	0		194. 0 194. 0
200.00 Cross Foot Adjustments	147,077	57, 092	5, 79			200. 00
Negative Cost Centers Cost to be allocated (per Wkst. B,	2, 573, 303	1, 162, 579	7, 533, 18	8 1, 303, 678	419, 431	201. 00 202. 00
Part I) Unit cost multiplier (Wkst. B, Part I Cost to be allocated (per Wkst. B,	3. 498874 89, 728	0. 061553 237, 442				
Part II) Unit cost multiplier (Wkst. B, Part	0. 122002	0. 012571	0. 18492	9 0. 000106	2. 270438	205. 00

Health Financial Systems	ST. VINCENT CARMEL	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150157	Peri od:	Worksheet C
			From 07/01/2014	
			To 0//20/2015	Doto/Time Dropered.

				To 06/30/2015	Date/Time Pre 11/30/2015 9:	
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	20, 732, 909		20, 732, 909		20, 732, 909	
31.00 03100 INTENSIVE CARE UNIT	3, 173, 772		3, 173, 772		3, 173, 772	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	3, 301, 498		3, 301, 498		3, 301, 498	1
43. 00 04300 NURSERY	2, 789, 634		2, 789, 634	1 0	2, 789, 634	43. 00
ANCILLARY SERVICE COST CENTERS			•	_		
50.00 05000 OPERATING ROOM	22, 597, 644		22, 597, 644		22, 597, 644	
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 934, 992		4, 934, 992		4, 934, 992	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 486, 416		4, 486, 416		4, 486, 416	1
54. 02 05402 ULTRASOUND	525, 248		525, 248		525, 248	
57. 00 05700 CT SCAN	1, 229, 208		1, 229, 208		1, 229, 208	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 849, 138		1, 849, 138	0	1, 849, 138	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		(0	0	59. 00
60. 00 06000 LABORATORY	4, 389, 240		4, 389, 240		4, 389, 240	1
65. 00 06500 RESPI RATORY THERAPY	2, 151, 868	0	_, ,		2, 151, 868	
66. 00 06600 PHYSI CAL THERAPY	574, 622	0	574, 622		574, 622	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(, J	0	
68. 00 06800 SPEECH PATHOLOGY	42, 582	0	42, 582		42, 582	
69. 00 06900 ELECTROCARDI OLOGY	453, 480		453, 480		453, 480	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	177, 143		177, 143	0	177, 143	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 140, 464		2, 140, 464		2, 140, 464	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 629, 601		5, 629, 601		5, 629, 601	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 340, 612		6, 340, 612		6, 340, 612	1
75.00 07500 ASC (NON-DISTINCT PART)	13, 333, 336		13, 333, 336		13, 333, 336	
76. 00 03330 ENDOSCOPY	4, 392, 283		4, 392, 283	0	4, 392, 283	76. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	4, 961, 103		4, 961, 103		4, 961, 103	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 331, 399		3, 331, 399		3, 331, 399	
200.00 Subtotal (see instructions)	113, 538, 192		-, ,		113, 538, 192	
201.00 Less Observation Beds	3, 331, 399		3, 331, 399		3, 331, 399	
202.00 Total (see instructions)	110, 206, 793	0	110, 206, 793	0	110, 206, 793	202. 00

Health Financial Systems	ST. VINCENT CARMEL	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 150157	Peri od: From 07/01/2014	Worksheet C Part I

To 06/30/2015 Date/Time Prepared: 11/30/2015 9:44 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 28, 361, 544 28, 361, 544 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 5, 183, 167 5, 183, 167 31.00 02060 NEONATAL INTENSIVE CARE UNIT 11, 847, 899 11, 847, 899 35.00 35.00 43.00 04300 NURSERY 6, 744, 829 6, 744, 829 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 53, 164, 046 67, 287, 813 120, 451, 859 0.187607 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 24, 460, 923 678, 420 25, 139, 343 0. 196306 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 1, 932, 928 14, 821, 207 54.00 16, 754, 135 0.267780 0.000000 54.00 05402 ULTRASOUND 2, 982, 837 54.02 393.078 2, 589, 759 0.176090 0.000000 54.02 57.00 05700 CT SCAN 1,078,324 5, 707, 263 6, 785, 587 0.181150 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 170, 627 3, 123, 613 3, 294, 240 0.561325 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 0.000000 59.00 15, 527, 035 60.00 06000 LABORATORY 11, 536, 242 27, 063, 277 0.162184 0.000000 60.00 06500 RESPIRATORY THERAPY 2, 959, 680 1, 472, 167 4, 431, 847 0.485547 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 1, 465, 871 564, 946 2, 030, 817 0. 282951 0.000000 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 89, 121 51, 125 140, 246 0.303624 0.000000 68.00 06900 ELECTROCARDI OLOGY 703, 654 1, 793, 889 2, 497, 543 0. 181570 0.000000 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 683, 714 484, 215 2, 167, 929 0.000000 70.00 0.081711 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 15, 512, 707 19, 785, 122 35, 297, 829 0.060640 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 17, 451, 267 3, 258, 350 20, 709, 617 0.271835 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 9, 864, 700 73.00 15, 320, 255 25, 184, 955 0. 251762 0.000000 73.00 66, 509, 542 75 00 07500 ASC (NON-DISTINCT PART) 66, 509, 542 0 200473 0.000000 75 00 03330 ENDOSCOPY 76.00 931, 134 21, 273, 184 22, 204, 318 0.197812 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 4, 640, 739 27, 444, 920 32, 085, 659 0. 154621 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 411, 134 8, 096, 079 92.00 92.00 684, 945 0.411483 0.000000 200.00 Subtotal (see instructions) 206, 316, 694 269, 648, 404 475, 965, 098 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 206, 316, 694 269, 648, 404 475, 965, 098 202 00

Health Financial Systems	ST. VINCENT CAR	MEL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150157	Peri od: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/30/2015 9:44 am

					11/30/2015 9:	44 am_
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30. 00
31.00	03100 INTENSIVE CARE UNIT					31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT					35. 00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 187607				50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 196306				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 267780				54. 00
54.02	05402 ULTRASOUND	0. 176090				54. 02
57.00	05700 CT SCAN	0. 181150				57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 561325				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
60.00	06000 LABORATORY	0. 162184				60.00
65.00	06500 RESPIRATORY THERAPY	0. 485547				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 282951				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00	06800 SPEECH PATHOLOGY	0. 303624				68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 181570				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 081711				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 060640				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 271835				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 251762				73.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 200473				75. 00
76.00	03330 ENDOSCOPY	0. 197812				76. 00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0. 154621				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 411483				92.00
200.00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems	ST. VINCENT CARMEL	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150157	Peri od:	Worksheet C
			From 07/01/2014	
			To 0//20/2015	Doto/Time Dropered.

Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Title XIX Hospital Cost Costs Total Cost Adj. Disallowance	
Cost Center Description Total Cost (from Wkst. B, Part I, col. Therapy Limit Total Costs RCE Total Costs Disallowance Disallowan	
(from Wkst. B, Adj. Disallowance Part I, col.	
Part I, col.	
26)	
1.00 2.00 3.00 4.00 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 20, 732, 909 20, 732, 909 0 20, 732, 909 30. 0). 00
31.00 03100 I NTENSI VE CARE UNI T 3,173,772 3,173,772 0 3,173,772 31.0	. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 3, 301, 498 3, 301, 498 0 3, 301, 498 35. 0	5. 00
43. 00 04300 NURSERY 2, 789, 634 2, 789, 634 0 2, 789, 634 43. 0	3. 00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 22, 597, 644 22, 597, 644 0 22, 597, 644 50. 0). 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 4, 934, 992 4, 934, 992 0 4, 934, 992 52. 0	2. 00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 4, 486, 416 4, 486, 416 0 4, 486, 416 54. 0	1. 00
54. 02 05402 ULTRASOUND 525, 248 525, 248 0 525, 248 54. 0	1. 02
57. 00 05700 CT SCAN 1, 229, 208 1, 229, 208 0 1, 229, 208 57. 0	1.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,849,138 1,849,138 0 1,849,138 58. 0	3. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 0	€. 00
60. 00 06000 LABORATORY 4, 389, 240 4, 389, 240 0 4, 389, 240 60. 0). 00
65. 00 06500 RESPI RATORY THERAPY 2, 151, 868 0 2, 151, 868 0 2, 151, 868 65. 0	5. 00
66. 00 06600 PHYSI CAL THERAPY 574, 622 0 574, 622 0 574, 622 66. 0	5. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67. 0	7.00
68. 00 06800 SPEECH PATHOLOGY 42, 582 0 42, 582 0 42, 582 68. 0	3. 00
69. 00 06900 ELECTROCARDI OLOGY 453, 480 453, 480 0 453, 480 69. 0	€. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 177, 143 177, 143 0 177, 143 70. 0). 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 140, 464 2, 140, 464 0 2, 140, 464 71. 0	1.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 5,629,601 5,629,601 0 5,629,601 72. 0	2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 6, 340, 612 6, 340, 612 0 6, 340, 612 73. 0	
75. 00 07500 ASC (NON-DISTINCT PART) 13, 333, 336 13, 333, 336 0 13, 333, 336 75. 0	
76. 00 03330 ENDOSCOPY 4, 392, 283 4, 392, 283 0 4, 392, 283 76. 0	
OUTPATIENT SERVICE COST CENTERS	
91. 00 09100 EMERGENCY 4, 961, 103 4, 961, 103 0 4, 961, 103 91. 0	1. 00
92.00 09200 BSERVATION BEDS (NON-DISTINCT PART) 3, 331, 399 3, 331, 399 3, 331, 399 92.0	
200.00 Subtotal (see instructions) 113,538,192 0 113,538,192 0 113,538,192 0	
201.00 Less Observation Beds 3, 331, 399 3, 331, 399 3, 331, 399 201.0	
202.00 Total (see instructions) 110, 206, 793 0 110, 206, 793 0 110, 206, 793 202.0	

Health Financial Systems	ST. VINCENT CARMEL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150157	Period: From 07/01/2014	Worksheet C

06/30/2015 Date/Time Prepared: 11/30/2015 9:44 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 28, 361, 544 28, 361, 544 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 5, 183, 167 5, 183, 167 31.00 02060 NEONATAL INTENSIVE CARE UNIT 11, 847, 899 11, 847, 899 35.00 35.00 43.00 04300 NURSERY 6, 744, 829 6, 744, 829 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 53, 164, 046 67, 287, 813 120, 451, 859 0.187607 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 24, 460, 923 678, 420 25, 139, 343 0. 196306 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 1, 932, 928 14, 821, 207 54.00 16, 754, 135 0.267780 0.000000 54.00 05402 ULTRASOUND 393, 078 2, 982, 837 0.000000 54.02 2, 589, 759 0.176090 54.02 57.00 05700 CT SCAN 1,078,324 5, 707, 263 6, 785, 587 0.181150 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 170, 627 3, 123, 613 3, 294, 240 0.561325 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 0.000000 59.00 15, 527, 035 60.00 06000 LABORATORY 11, 536, 242 27, 063, 277 0.162184 0.000000 60.00 06500 RESPIRATORY THERAPY 2, 959, 680 1, 472, 167 4, 431, 847 0.485547 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 1, 465, 871 564, 946 2, 030, 817 0. 282951 0.000000 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 89, 121 51, 125 140, 246 0.303624 0.000000 68.00 06900 ELECTROCARDI OLOGY 703, 654 1, 793, 889 2, 497, 543 0. 181570 0.000000 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 683, 714 484, 215 2, 167, 929 0.000000 70.00 0.081711 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 15, 512, 707 19, 785, 122 35, 297, 829 0.060640 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 17, 451, 267 3, 258, 350 20, 709, 617 0.271835 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 9, 864, 700 73.00 15, 320, 255 25, 184, 955 0. 251762 0.000000 73.00 66, 509, 542 75 00 07500 ASC (NON-DISTINCT PART) 66, 509, 542 0 200473 0.000000 75 00 03330 ENDOSCOPY 76.00 931, 134 21, 273, 184 22, 204, 318 0.197812 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 4, 640, 739 27, 444, 920 32, 085, 659 0. 154621 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 411, 134 8, 096, 079 92.00 92.00 684, 945 0.411483 0.000000 200.00 Subtotal (see instructions) 206, 316, 694 269, 648, 404 475, 965, 098 200.00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 206, 316, 694 269, 648, 404 475, 965, 098 202 00

Health Financial Systems	ST.	VI NCENT	CARMEL	HOSPI TAL			In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Provi der	CCN:	150157	From 07/01/2014	Worksheet C Part I Date/Time Prepared: 11/30/2015 9:44 am

				11/30/2015 9:44 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30. 00
31.00 03100 INTENSIVE CARE UNIT				31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				35. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 02 05402 ULTRASOUND	0. 000000			54. 02
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67.00 06700 OCCUPATIONAL 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 MPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 00 03330 ENDOSCOPY	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	ST. VINCENT CAI	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 07/01/2014 To 06/30/2015	Worksheet D Part I Date/Time Pre 11/30/2015 9:4	pared: 44 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col . 1 - col 2)			
	1.00	2, 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						-
30. 00 ADULTS & PEDI ATRI CS	2, 909, 295	0	2, 909, 29	5 13, 673	212. 78	30. 00
31.00 INTENSIVE CARE UNIT	330, 239		330, 23	9 979	337. 32	31.00
35. OO NEONATAL INTENSIVE CARE UNIT	306, 010		306, 01	0 2, 025	151. 12	35.00
43. 00 NURSERY	458, 398		458, 39	8 3, 071	149. 27	43.00
200.00 Total (lines 30-199)	4, 003, 942		4, 003, 94	2 19, 748		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	6.00	6) 7. 00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	3, 575	760, 689				30. 00
31. 00 INTENSIVE CARE UNIT	342					31. 00
35. 00 NEONATAL INTENSIVE CARE UNIT	0	110,300				35. 00
43. 00 NURSERY	0	l o	,			43. 00
200.00 Total (lines 30-199)	3, 917	876, 052				200. 00

Heal th Financial	Systems	ST.	VINCENT CAR	RMEL F	HOSPI TAL			In Lie	u of Form CMS-	2552-10
APPORTI ONMENT OF	INPATIENT ANCILLARY SERVICE	CAPITAL C	OSTS		Provi der	CCN: 150157	Peri		Worksheet D	
							To	07/01/2014 06/30/2015	Date/Time Pre	
					Ti tl	e XVIII		Hospi tal	PPS	
Cost	Center Description		Capi tal	Total	Charges	Ratio of Cos	st	I npati ent	Capital Costs	
		Re	elated Cost	(from	Wkst. C,	to Charges		Program	(column 3 x	
		(fr	om Wkst. B,	Part	I, col.	(col . 1 + co	1.	Charges	column 4)	
		Pa	rt II, col.		8)	2)				
			26)							

					11/30/2015 9:	44 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 697, 070		•	14, 782, 731	331, 000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	573, 002	25, 139, 343	0. 022793	40, 873	932	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	694, 264	16, 754, 135	0. 041438	554, 460	22, 976	54.00
54. 02 05402 ULTRASOUND	93, 574	2, 982, 837	0. 031371	89, 528	2, 809	54. 02
57.00 05700 CT SCAN	183, 224	6, 785, 587	0. 027002	464, 950	12, 555	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	589, 223	3, 294, 240	0. 178865	63, 650	11, 385	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	0.000000	0	0	59. 00
60. 00 06000 LABORATORY	244, 865	27, 063, 277	0. 009048	3, 446, 868	31, 187	60.00
65. 00 06500 RESPIRATORY THERAPY	182, 526	4, 431, 847	0. 041185	950, 797	39, 159	65. 00
66. 00 06600 PHYSI CAL THERAPY	70, 925	2, 030, 817	0. 034924	842, 381	29, 419	66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	C	0.000000	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	5, 142	140, 246	0. 036664	52, 988	1, 943	68. 00
69. 00 06900 ELECTROCARDI OLOGY	39, 767	2, 497, 543	0. 015922	386, 855	6, 160	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	22, 725	2, 167, 929	0. 010482	702, 976	7, 369	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	66, 192	35, 297, 829	0. 001875	3, 854, 224	7, 227	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	174, 090	20, 709, 617	0. 008406	6, 933, 159	58, 280	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	438, 209	25, 184, 955	0. 017400	4, 194, 106		73. 00
75.00 07500 ASC (NON-DISTINCT PART)	951, 055	66, 509, 542	0. 014300	0	0	1
76. 00 03330 ENDOSCOPY	483, 686			370, 937	8, 080	76. 00
OUTPATIENT SERVICE COST CENTERS		, , , , , ,				
91. 00 09100 EMERGENCY	576, 196	32, 085, 659	0. 017958	2, 059, 746	36, 989	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	467, 472		•	371, 177	•	
200.00 Total (lines 50-199)	8, 553, 207		•	40, 162, 406	•	
			1			

Health Financial Systems	ST. VINCENT CAI	RMEL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 07/01/2014 To 06/30/2015		nared:
				10 00/ 30/ 2013	11/30/2015 9:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	35. 00
43. 00 04300 NURSERY	0	0		0	0	43. 00
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description		Per Diem (col.		I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
	6. 00	7. 00	8. 00	col . 8) 9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00		
30. 00 03000 ADULTS & PEDIATRICS	13, 673	0.00	3, 57	5 0		30.00
31. 00 03100 NTENSI VE CARE UNI T	979					31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	2,025			0		35. 00
43. 00 04300 NURSERY	3, 071					43.00
200.00 Total (lines 30-199)	19, 748		3, 91	7		200. 00
200.00 TOTAL (TITIES 30-177)	17, /40	I] 3, 91	′1		₁ 200.00

RPPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 150157 Provider CCN: 15015	Health Financial Systems	ST. VINCENT CAF	RMEL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
To 06/30/2015 Date/Time Prepared: 11/30/2015 9: 44 am PPS		VICE OTHER PASS	S Provi der				
Title XVIII Hospital PPS	THROUGH COSTS					Date/Time Pre	pared:
Non Physician Anesthetist Cost						11/30/2015 9:	44 am
Anesthetist Cost		l. 5					
Cost Education Cost Through col .	Cost Center Description		Nursing School	Allied Healtr			
ANCI LLARY SERVI CE COST CENTERS							
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		COST			Luucati on cost		
50. 00 05000 OPERATING ROOM 0 0 0 0 0 0 0 0 0		1.00	2.00	3.00	4. 00		
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 54. 02 05402 ULTRASOUND 0 0 0 0 0 0 0 0 54. 02 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 0 57. 00 58. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 0 58. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54. 00 54. 02 05402 ULTRASOUND 0 0 0 0 0 54. 02 57. 00 05700 CT SCAN 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 58. 00 0 0 0 0 58. 00 0 0 0 0 0 0 0 59. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td>50. 00 05000 OPERATING ROOM</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>50.00</td>	50. 00 05000 OPERATING ROOM	0	C		0 0	0	50.00
54. 02 05402 ULTRASOUND 0 0 0 0 54. 02 57. 00 05700 CT SCAN 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0 0 0 0 0 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	C		0 0	0	52. 00
57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 65. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	C		0	0	
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 59. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td< td=""><td></td><td>0</td><td>C</td><td></td><td>0</td><td>1</td><td></td></td<>		0	C		0	1	
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <		0	C		0	1	
60. 00		0	C		0	1	
65. 00	l l	0	C		0	1	
66. 00		0	0	2	0	1	
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03330 ENDOSCOPY 0 0 0 0 0 0 0 75. 00 00TPATI ENT SERVI CE COST CENTERS 91. 00 09200 DBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 92. 00		0			0	·	
68. 00		0			0	ľ	
69. 00		0			0	ľ	
70. 00		0			0	ľ	
71. 00		0			0		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 00 03330 ENDOSCOPY 0 0 0 0 0 00TPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 94. 00 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 0920		0			0	ľ	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 00 76. 00 03330 ENDOSCOPY 0 0 0 0 0 0 0 76. 00 OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 92. 00		0				ľ	
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03330 ENDOSCOPY 0 0 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00		0	7		0	l ~	
76. 00 03330 ENDOSCOPY 0 0 0 0 0 0 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	Ĭ		0	ĺ	
OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 91.00 91.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92.00		0	ĺ		o o	l o	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 92. 00					- 1		1
	91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
200.00 Total (lines 50-199) 0 0 0 0 200.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 0	0	92.00
	200.00 Total (lines 50-199)	0	[c		0 0	0	200.00

		CT MINOENT ON	OMEL LIGGEL TAL			C.E. OHC	2550 40
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIEN		ST. VINCENT CAI		CCN: 150157	In Lie Period:	u of Form CMS-2	2552-10
THROUGH COSTS	NI ANCILLARY SER	VICE UTHER PAS	S Provider		Period: From 07/01/2014	Worksheet D Part IV	
THROUGH CUSTS					To 06/30/2015	Date/Time Pre	pared:
						11/30/2015 9:	44 am_
				le XVIII	Hospi tal	PPS	
Cost Center Description		Total		Ratio of Cos		Inpati ent	
			(from Wkst. C		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)	7.00		7)	40.00	
ANGLE ARY OFRICAS AGOT OFFITER		6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTER	5		400 454 05	0 00000	0 000000	44 700 704	F0 00
50. 00 05000 OPERATI NG ROOM	2011	0	120, 451, 85	1		14, 782, 731	1
52. 00 05200 DELI VERY ROOM & LABOR R	JOM	0	25, 139, 34			40, 873	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0	16, 754, 13				1
54. 02 05402 ULTRASOUND		0	2, 982, 83	1		89, 528	1
57. 00 05700 CT SCAN		0	6, 785, 58	1		464, 950	1
58. 00 05800 MAGNETIC RESONANCE I MAG	ING (MRI)	0	3, 294, 24			63, 650	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		0.00000			59. 00
60. 00 06000 LABORATORY		0	27, 063, 27	1		3, 446, 868	
65. 00 06500 RESPIRATORY THERAPY		0	4, 431, 84	1		950, 797	65.00
66. 00 06600 PHYSI CAL THERAPY		0	2, 030, 81	1		842, 381	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0		0.00000		0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0	140, 24	1		52, 988	
69. 00 06900 ELECTROCARDI OLOGY		0	2, 497, 54	•			•
70. 00 07000 ELECTROENCEPHALOGRAPHY		0	2, 167, 92	1		702, 976	
71. 00 07100 MEDICAL SUPPLIES CHARGE		0	35, 297, 82	1			1
72. 00 07200 I MPL. DEV. CHARGED TO P.		0	20, 709, 61	1		6, 933, 159	1
73. 00 07300 DRUGS CHARGED TO PATIEN	IS	0	25, 184, 95	1		4, 194, 106	
75. 00 07500 ASC (NON-DISTINCT PART)		0	66, 509, 54	1		0	75. 00
76. 00 03330 ENDOSCOPY	DC.	0	22, 204, 31	8 0.00000	0.00000	370, 937	76. 00

0 0 0

0.000000

0.000000

32, 085, 659 8, 096, 079 423, 827, 659

0.000000

0.000000

2, 059, 746 91. 00 371, 177 92. 00 40, 162, 406 200. 00

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50-199)

Health Financial Systems	ST. VINCENT CARMEL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPA THROUGH COSTS	IENT ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared:

					11/30/2015 9: 44	am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	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	8, 724, 878		O	50	0.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	4, 473		O	5:	2. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 345, 459		O	5-	4.00
54. 02 05402 ULTRASOUND	0	302, 018		O	5-	4. 02
57. 00 05700 CT SCAN	0	1, 478, 971		O	5	7. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	749, 440		O	58	8. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	59	9. 00
60. 00 06000 LABORATORY	0	3, 490, 396		O	60	0.00
65. 00 06500 RESPIRATORY THERAPY	0	286, 192		O	6	5. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 813		O	6	6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		O	6	7. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		O	6	8. 00
69. 00 06900 ELECTROCARDI OLOGY	0	530, 922		o	6	9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	60, 135		0	70	0.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	1, 512, 622		0	7	1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	557, 932		0	7:	2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	1, 716, 434		0	7:	3. 00
75. 00 07500 ASC (NON-DISTINCT PART)	o	0		0	7!	75.00
76. 00 03330 ENDOSCOPY	o	2, 145, 013			7.	6.00
OUTPATIENT SERVICE COST CENTERS	, -,	,	'			
91. 00 09100 EMERGENCY	0	5, 321, 309		O	9:	1. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	2, 639, 581		o	9:	2. 00
200.00 Total (lines 50-199)	0	30, 867, 588	•	o o	· · · · · · · · · · · · · · · · · · ·	00.00
	-1	,	1	1		

Health Financial Systems	ST. VINCENT CARMEL	HOSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150157	Peri od:	Worksheet D

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	F	Period: From 07/01/2014 Fo 06/30/2015	Worksheet D Part V Date/Time Pre 11/30/2015 9:4	
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
	1.00	0.00	(see inst.)	(see inst.)	F 00	
ANOLILIADY CERVILOE COCT CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.407/07	0.704.070			4 (0(040	F0 00
50. 00 05000 OPERATING ROOM	0. 187607				1, 636, 848	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 196306		1	0	878	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 267780				360, 287	54.00
54. 02 05402 ULTRASOUND	0. 176090				53, 182	54. 02
57. 00 05700 CT SCAN	0. 181150		l .		267, 916	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 561325				420, 679	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				0	59.00
60. 00 06000 LABORATORY	0. 162184		1		566, 086	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 485547				138, 960	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 282951	1, 813	9		513	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 303624				0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 181570		1		96, 400	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 081711		1			70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 060640			3	91, 725	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 271835		1	0	151, 665	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 251762		i	35, 816	432, 133	
75. 00 07500 ASC (NON-DISTINCT PART)	0. 200473		1	0	0	75. 00
76. 00 03330 ENDOSCOPY	0. 197812	2, 145, 013	(0	424, 309	76. 00
OUTPATIENT SERVICE COST CENTERS			1	_1		
91. 00 09100 EMERGENCY	0. 154621			0	822, 786	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 411483			0	1, 086, 143	
200.00 Subtotal (see instructions)		30, 867, 588	2, 844	35, 816	6, 555, 424	
201.00 Less PBP Clinic Lab. Services-Program			(기 이		201. 00
Only Charges		20 0/7 500	2.04	25 04/	/ FEE 404	202 00
202.00 Net Charges (line 200 +/- line 201)	Ţ	30, 867, 588	2, 844	4 35, 816	6, 555, 424	ZUZ. UÜ

Health Financial Systems	ST. VINCENT CARMEL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150157		Worksheet D
			From 07/01/2014	

				To 06/30/2015	Date/Time Pre	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	1		1			
50. 00 05000 OPERATI NG ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	759	0				54.00
54. 02 05402 ULTRASOUND	0	0				54. 02
57. 00 05700 CT SCAN	0	0				57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	9, 017	1			73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76. 00 03330 ENDOSCOPY	0	0				76. 00
OUTPATIENT SERVICE COST CENTERS 91.00 O9100 EMERGENCY		0	I			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				91.00
	750	0.017				200. 00
200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program	759	9, 017				200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	759	9, 017				202. 00
202.00	1 759	7,017	I			1202.00

Health Financial Systems	ST. VINC	CENT CARMEL	HOSPI TAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der CCN: 150157	Peri od: From 07/01/2014	Worksheet D-1	
				To 06/30/2015	Date/Time Pre 11/30/2015 9:	
			Title XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						
1.00 Inpatient days (including private room	days and swin	g-bed days,	excluding newborn)		13, 673	1.00
2 00 Innation days (including private room	dave eveludi	na swina-he	d and newhorn days)		13 673	2 00

	Title XVIII Hospital	PPS	
	Cost Center Description	1 00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13, 673	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13, 673	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line.	11 474	4. 00
5.00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	11, 476 0	5. 00
3.00	reporting period	١	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	١	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	3, 575	9. 00
	newborn days)	_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	١	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	Ö	15. 00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medical d rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	20, 732, 909	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19	٥	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0 700 000	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	20, 732, 909	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	Ö	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	20, 732, 909	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 516. 34	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	5, 420, 916	39.00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0, 120, 710	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	5, 420, 916	41. 00

COMDIT	Financial Systems ATION OF INPATIENT OPERATING COST	ST. VINCENT CAR		CCN: 150157	In Lie	eu of Form CMS-2 Worksheet D-1	
COIVIPUI	ATTOM OF THE ATTEMS OF ERMITING COST		FIOVIDE	OON. 130137	From 07/01/2014		
					To 06/30/2015	Date/Time Prep 11/30/2015 9:	
	Coat Cantan Daganintian	Total		e XVIII	Hospi tal	PPS Program Cost	
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units	5					
43. 00 44. 00	INTENSIVE CARE UNIT	3, 173, 772	979	3, 241. 8	342	1, 108, 713	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00			0.005				46. 00
47.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	3, 301, 498	2, 025	1, 630. 3	37 <u> </u>	0	47. 00
	·					1. 00	
48.00	Program inpatient ancillary service cost (What Total Program inpatient costs (sum of lines			nc)		8, 187, 268 14, 716, 897	1
49.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 46) (s	see mstructro	115)		14, 710, 697	49.00
50.00	Pass through costs applicable to Program inp	patient routine s	services (from	Wkst. D, sum	of Parts I and	876, 052	50.00
51. 00	<pre> </pre>	oatient ancillary	v services (fr	om Wkst. D. s	um of Parts II	701, 879	51.00
	and IV)	·	, (
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-phy	cician anecth	etist and	1, 577, 931 13, 138, 966	1
33.00	medical education costs (line 49 minus line		rated, non-pny	3i Ci aii ailesti	etrst, and	13, 130, 700	33.00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION						1 54 00
	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56.00	Target amount (line 54 x line 55)						56. 00
57. 00 58. 00	Difference between adjusted inpatient operations payment (see instructions)	ting cost and tar	rget amount (I	ine 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	ending 1996, u	pdated and co	mpounded by the		59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport up	dated by the m	arkot backot		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0.00	1
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	rnstructions)				0	62. 00
63.00	Allowable Inpatient cost plus incentive payr	ment (see instrud	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Decer	mber 31 of the	cost reporti	na period (See	0	64. 00
	instructions)(title XVIII only)	Ü		•			/= 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 o	if the cost re	porting period	0	67. 00
	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service of						71.00
72.00			(1)	05)			72.00
73. 00 74. 00	Medically necessary private room cost application of the cost application of t						73.00
75. 00	Capital-related cost allocated to inpatient				art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for excess	,	covi don rocond	6)			78. 00 79. 00
	Total Program routine service costs for comp			*	us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			•		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	nstructions)					84. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sur						85. 00 86. 00
85.00	riotai erouram ribatrent oberattiu Costs (Sul	11 UL LLINGS OS [[]]	Ouuli 007				1 00.00
85. 00 86. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS						
		S THROUGH COST S)	-			2, 197 1, 516. 34	1

Health Financial Systems	ST. VINCENT CA	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2014 To 06/30/2015	Date/Time Prep 11/30/2015 9:4	oared: 44 am_
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	2, 909, 295	20, 732, 909	0. 14032	3, 331, 399	467, 472	90.00
91.00 Nursing School cost	0	20, 732, 909	0.00000	3, 331, 399	0	91.00
92.00 Allied health cost	0	20, 732, 909	0.00000	3, 331, 399	0	92.00
93.00 All other Medical Education	0	20, 732, 909	0. 00000	3, 331, 399	0	93. 00

Health Financial Systems	ST.	VI NCENT	CARMEL	HOSPI TAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Provi der CCN: 150157	Period: From 07/01/2014	Worksheet D-1	
					To 06/30/2015	Date/Time Pre 11/30/2015 9:	pared: 44 am
				Title XIX	Hospi tal	Cost	
Cost Center Description							
						1. 00	
PART I - ALL PROVIDER COMPONENTS							
I NPATI ENT DAYS							
1.00 Inpatient days (including private room days	s and	swi ng-be	ed days,	excluding newborn)		13, 673	1.00
2.00 Inpatient days (including private room days	s. exc	cludina s	swi na-be	ed and newborn days)		13, 673	2.00

	Cost Center Description	0031	
	3333 3333 3333 333	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13, 673	
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13, 673	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line.	11 474	4. 00
5.00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	11, 476 0	
5.00	reporting period	١	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		l
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	389	9. 00
9.00	newborn days)	309	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12 00	through December 31 of the cost reporting period		12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	ا	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)		15. 00
16. 00	Nursery days (title V or XIX only)		16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		1
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
19.00	reporting period	0.00	19.00
20. 00	Medical dirate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		1
21. 00	Total general inpatient routine service cost (see instructions)	20, 732, 909	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
00.00	5 x line 17)		00.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	٨	24. 00
24.00	7 x Line 19)	١	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		ł
26. 00	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	20, 732, 909	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		20.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	ł
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	ı
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	20, 732, 909	37. 00
	27 minus line 36)		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		ł
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 516. 34	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	589, 856	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	589, 856	1

37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	20, 732, 909	37.0
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 516. 34	38. 0
39.00	Program general inpatient routine service cost (line 9 x line 38)	589, 856	39. 0
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.0
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	589, 856	41.0
		·	

	Financial Systems TATION OF INPATIENT OPERATING COST	ST. VINCENT CAR		CCN: 150157		worksheet D-1	
COMPUI	ATION OF INPATIENT OPERATING COST		Provider		Period: From 07/01/2014		
					To 06/30/2015	Date/Time Pre 11/30/2015 9:	
	Coot Conton Descripti	T-1-1		le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Davs	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1. 00 2, 789, 634	2. 00 3, 071	3. 00 908. 3	4. 00 8 187	5. 00 169, 867	42.00
42.00	Intensive Care Type Inpatient Hospital Units		3,071	906. 3	10/	109, 607	42.00
43.00	INTENSIVE CARE UNIT	3, 173, 772	979	3, 241. 8	5 248	803, 979	1
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
45. 00 46. 00							46.00
	NEONATAL INTENSIVE CARE UNIT	3, 301, 498	2, 025	1, 630. 3	7 293	477, 698	1
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (W	kst. D-3. col. 3	. line 200)			1, 510, 529	48. 00
	Total Program inpatient costs (sum of lines			ns)		3, 551, 929	1
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	aatiant mautina	anni ana (fram	Wkat D aum	of Donto L and	0	F0 00
50.00	Pass through costs applicable to Program III	patrent routine	services (Troil	WKSt. D, Suii	or Parts r and	0	50.00
51.00	Pass through costs applicable to Program in	patient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost excl		lated, non-phy	sician anesth	etist, and	0	
	medical education costs (line 49 minus line	52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55. 00
56. 00	,					0	
57. 00 58. 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	ting cost and ta	rget amount (I	ine 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, u	pdated and co	mpounded by the		59.00
	market basket						/
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60.00
01.00	which operating costs (line 53) are less that						01.00
(2.00	amount (line 56), otherwise enter zero (see	instructions)				0	62. 00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				1
64. 00	Medicare swing-bed SNF inpatient routine con instructions) (title XVIII only)	sts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
// 00	instructions)(title XVIII only)	:+- (1:	/	E) (±: ±1 = \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			// 00
66. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line	64 plus line 6	5)(title XVII	i only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost re	porting period	0	67. 00
40 NN	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	no costs after D	ocombor 21 of	the cost rone	rting ported	_	68. 00
00.00	(line 13 x line 20)	ne costs after D	ecember 31 01	the cost repo	iting period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci					T	70.00
71.00	Adjusted general inpatient routine service						71.00
72.00							72. 00
73. 00 74. 00	Medically necessary private room cost applicated Program general inpatient routine ser			ne 35)			73.00
75. 00	Capital -related cost allocated to inpatient			orksheet B, P	art II, column		75. 00
	26, line 45)						
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ 1 Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	,						78. 00
79.00	Aggregate charges to beneficiaries for exce			*	1. 70)		79.00
80.00	Total Program routine service costs for com Inpatient routine service cost per diem lim		ust limitation	(line /8 min	us line /9)		80.00
82.00	Inpatient routine service cost limitation ()				82. 00
83.00	Reasonable inpatient routine service costs	•	s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (su	m of lines 83 th					86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PAS					2 107	07.00
87. 00	Total observation bed days (see instruction	*				2, 197	•
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 516. 34	88.00

Health Financial Systems	ST. VINCENT CA	RMEL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2014 To 06/30/2015	Date/Time Pre 11/30/2015 9:	pared: 44 am_
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost		Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	2, 909, 295	20, 732, 909	0. 14032	3, 331, 399	467, 472	90.00
91.00 Nursing School cost	0	20, 732, 909	0.00000	0 3, 331, 399	0	91.00
92.00 Allied health cost	0	20, 732, 909	0.00000	0 3, 331, 399	0	92.00
93.00 All other Medical Education	0	20, 732, 909	0. 00000	3, 331, 399	0	93. 00

	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	ST. VINCENT CARMEL		CCN: 150157	In Lie Period: From 07/01/2014 To 06/30/2015	worksheet D-3 Date/Time Pre 11/30/2015 9:	pared:
			Ti +I	e XVIII	Hospi tal	PPS	11 4
	Cost Center Description		11 (Ratio of Cos		Inpati ent	
	5551 551151 55561 Pt 1511			To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS				7, 403, 683		30. 00
	03100 INTENSIVE CARE UNIT				3, 815, 899		31. 00
	02060 NEONATAL INTENSIVE CARE UNIT				0		35. 00
	04300 NURSERY						43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM			0. 18760		2, 773, 344	
	05200 DELIVERY ROOM & LABOR ROOM			0. 19630			1
	05400 RADI OLOGY-DI AGNOSTI C			0. 26778			1
	05402 ULTRASOUND			0. 17609			
	05700 CT SCAN			0. 18115			1
	05800 MAGNETIC RESONANCE I MAGING (MRI)			0. 56132		l	
	05900 CARDI AC CATHETERI ZATI ON			0.00000		0	
	06000 LABORATORY			0. 16218			60.00
	06500 RESPI RATORY THERAPY			0. 48554		461, 657	65. 00
	06600 PHYSI CAL THERAPY			0. 28295		238, 353	
	06700 OCCUPATI ONAL THERAPY			0.00000		0	67. 00
	06800 SPEECH PATHOLOGY			0. 30362		16, 088	
	06900 ELECTROCARDI OLOGY			0. 18157		70, 241	69. 00
	07000 ELECTROENCEPHALOGRAPHY			0. 08171			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 06064			1
	07200 I MPL. DEV. CHARGED TO PATIENTS			0. 27183			
	07300 DRUGS CHARGED TO PATIENTS			0. 25176		1	
	07500 ASC (NON-DISTINCT PART)			0. 20047		0	75. 00
	03330 ENDOSCOPY			0. 19781	2 370, 937	73, 376	76. 00
	OUTPATIENT SERVICE COST CENTERS			1			
	09100 EMERGENCY			0. 15462			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 41148	- '	152, 733	
200.00					40, 162, 406		
201.00	Less PBP Clinic Laboratory Services-P	rogram only charges	(IIne 61)	1	0		201.00

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

40, 162, 406

202. 00

202.00

Health Financial Systems ST. VINCENT CARMEL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	_	CCN: 150157	Peri od:	u of Form CMS- Worksheet D-3	
INFAITENT ANGIELANT SERVICE COST AFFORTIONWENT	FIOVIGE		From 07/01/2014	WOLKSHEET D-3	•
			To 06/30/2015	Date/Time Pre 11/30/2015 9:	pared:
	Ti t	le XIX	Hospi tal	Cost	77 UIII
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
				(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 732, 673	l e	30.00
31. 00 03100 I NTENSI VE CARE UNI T			335, 013		31.0
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			2, 569, 162		35. 00
43. 00 04300 NURSERY			530, 095		43. 0
ANCILLARY SERVICE COST CENTERS		0.107//	2 4/0 170	4/2 225	
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 18760 0. 19630			
54. 00 05200 DELI VERY ROUM & LABOR ROUM 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19630			
54. 02 05400 RADI OLOGY - DI AGNOSTI C 54. 02 05402 ULTRASOUND		0. 26778		6, 324	
57. 00 05700 CT SCAN		0. 1700			
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)		0. 56132		5, 101	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		0, 101	
60. 00 06000 LABORATORY		0. 16218		l .	
65. 00 06500 RESPIRATORY THERAPY		0. 48554			
66. 00 06600 PHYSI CAL THERAPY		0. 28295			
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	00 0	0	67.0
68. 00 06800 SPEECH PATHOLOGY		0. 30362	24 8, 085	2, 455	68. 0
69. 00 06900 ELECTROCARDI OLOGY		0. 18157	70 30, 778	5, 588	69. 0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 0817	11 2, 520	206	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 06064	1, 365, 852	82, 825	71.0
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 27183	35 0	0	72. 0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 25176	938, 110	236, 180	73.0
75. 00 07500 ASC (NON-DISTINCT PART)		0. 20047	73 0	0	75. 0
76. 00 03330 ENDOSCOPY		0. 1978	12 46, 744	9, 247	76.0
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0. 15462		29, 902	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 41148		l ~	
200.00 Total (sum of lines 50-94 and 96-98)			8, 286, 446		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	I	0	l	201.0

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

201. 00

8, 286, 446

201.00 202.00

CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT			Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared:	
		Ti +I	e XVIII	Hospi tal	11/30/2015 9: PPS	44 am
		11 (1	before 1/1	on/after 1/1	113	
	DADT A LINDATIENT HOSDITAL SERVICES HINDED LDDS	0	1. 00	1. 01	2. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			o		1.00
1. 01	DRG amounts other than outlier payments for discharges		2, 247, 94	5		1. 01
1. 02	occurring prior to October 1 (see instructions) DRG amounts other than outlier payments for discharges		8, 468, 01	2		1. 02
1.02	occurring on or after October 1 (see instructions)		0, 400, 01	2		1.02
1. 03	DRG for federal specific operating payment for Model 4			0		1. 03
	BPCI for discharges occurring prior to October 1 (see instructions)					
1.04	DRG for federal specific operating payment for Model 4			О		1. 04
	BPCI for discharges occurring on or after October 1 (see					
2. 00	instructions) Outlier payments for discharges. (see instructions)		74, 21	9		2. 00
2. 01	Outlier reconciliation amount		1	0		2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see			0		2. 02
3.00	instructions) Managed Care Simulated Payments			o		3.00
4.00	Bed days available divided by number of days in the cost		146. 9	8		4. 00
	reporting period (see instructions) Indirect Medical Education Adjustment					
5. 00	FTE count for allopathic and osteopathic programs for the		0.0	ol		5.00
	most recent cost reporting period ending on or before					
6. 00	12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which		0.0	0		6.00
0.00	meet the criteria for an add-on to the cap for new		0.0			0.00
	programs in accordance with 42 CFR 413.79(e)					
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.0	0		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as		O. C	О		7. 01
	specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the					
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for		0.0	0		8.00
	allopathic and osteopathic programs for affiliated					
	programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR					
	50069 (August 1, 2002).					
8. 01	The amount of increase if the hospital was awarded FTE cap		0.0	0		8. 01
	slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.					
8. 02	The amount of increase if the hospital was awarded FTE cap		0.0	О		8. 02
	slots from a closed teaching hospital under section 5506					
9. 00	of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		0.0	0		9.00
	lines (8, 8,01 and 8,02) (see instructions)					
10. 00	FTE count for allopathic and osteopathic programs in the current year from your records		0.0	0		10. 00
11. 00	FTE count for residents in dental and podiatric programs.		0.0	О		11. 00
	Current year allowable FTE (see instructions)		0.0			12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that		0. C 0. C			13. 00 14. 00
1 1. 00	year ended on or after September 30, 1997, otherwise enter		0.0			11.00
15 00	Zero.		0.0			15 00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program		0.0			15. 00 16. 00
17. 00	Adjusment for residents displaced by program or hospital		0.0			17. 00
18. 00	closure Adjusted rolling average FTE count		0.0	0		18. 00
19. 00			0. 00000			19. 00
	line 4).					
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)		0. 00000 0. 00000			20.00
22. 00	IME payment adjustment (see instructions)		0.00000	o		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0		22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Secti Number of additional allopathic and osteopathic IME FTE	on 422 of t	he MMA 0. C			23. 00
20.00	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).					20.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.0			24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.0			25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)		0.00000			26. 00
27. 00	IME payments adjustment factor. (see instructions)		0.00000			27. 00
28. 00	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see			0		28. 00 28. 01
	instructions)					
29. 00	Total IME payment (sum of lines 22 and 28)		I	0		29. 00

Description 101 101 101 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.0				Ti tl	e XVIII	Hospi tal	PPS	
29.01					before 1/1	on/after 1/1	0.00	
20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20.	20 01	Total IME nayment - Managed Care (sum of line	s 22 01 and	0		1.01	2.00	20 01
Disproport invaries Share Adjustment 30.00	29.01		S 22. UT allu		0			29.01
Percentage of SSI recipient patient days (see Instructions) 12.5 s 3.30 3.00 12.5 s 3.10 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20 3.20		Disproportionate Share Adjustment			l .			
31.00 Percentage of Medicaid patient days (see instructions) 12.66 31.00 33.00 33.00 34.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.	30.00		ledi care Part		3. 31			30. 00
32.00 Sum of Fines 30 and 31 32.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.								
			ructions)					
Instructions 10 Inst			500					
10	33.00		366		3.07			33.00
	34.00		ıcti ons)		82, 245			34.00
Incompensated Care Adjustment 0								
Incorpersisted Care Adjustment 3,00 Total Incorpersisted Care about (see instructions) 3,5 co Total Incorpersisted Care (see instructions) 3,5 co Total Incorpersisted Care (see instructions) 3,6 co 4,7						1 01		
Total uncompensated care amount (see 9, 046, 380, 143 7, 647, 644, 885 35, 00 Instructions) Factor 3 (see instructions) 35, 02 Register 3 (see instructions) 36, 02 Register 3 (see instructions) 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00 36, 00		Uncompensated Care Adjustment	()	1.00	1.01	2.00	
Instructions 1	35 00				9 046 380 143		7 647 644 885	35 00
Incident					., ,		., , ,	
Line 34 ls zero, enter zero on this line)								
See Instructions 208,367 522,701 35,03 50.37 7 7 7 35,03 7 7 7 7 35,03 7 7 7 7 35,03 36,00 7 7 7 7 3 3 5,03 7 7 7 3 3 5,03 7 3 3 3 3 3 3 3 3	35. 02				826, 671		698, 849	35. 02
35.03 Pro rate share of the hospit fal uncompensated care payment amount (see instructions) 731,088 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36								
Care payment amount (see instructions) 33,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,00 36,	35 03				208 367		522 701	35 03
and 2 on line 35 03 Additional payment for high percentage of FSBD beneficiary discharges (lines 40 through 46)	00.00				200,007		022,701	00.00
Additional payment for high percentage of ESBD beneficiary discharges (lines 40 through 46)	36.00	Total uncompensated care (sum of columns 1			731, 068			36. 00
40.00 Total Medicare discharges on Worksheet S-3. Part I excluding discharges for WS-DRGs 652. 682. 683. 684 and 685 (see instructions) 0								
Part	40.00		D beneficiary	discharges (Li		46)		40.00
682, 683, 684 and 685 (see instructions)	40.00				1, 094			40.00
41.00 Stock Set, 682, 683, 684 and 685 (see instructions) 41.01 10 10 10 10 10 10 10								
Instructions 1 1.01 Total ESRD Medicare covered and paid discharges excluding MS-DRCs 652. 682, 683, 684 an 685. (see Instructions) 2.00 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1.01 1	41.00				0	0		41. 00
41.01 Total ESRO Medicare covered and paid di discharges excluding MS-DRG 652. 682, 683, 684 an 685. (see instructions) 42.00 Vide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 42.00 Vide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRO Inpatient days excluding 0 43.00 MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments 0.000 0.00 45.00 46.00 Total additional payment (line 45 times line 4.00 46.00 46.00 46.00 Total additional payment (line 45 times line 4.101) 47.00 Subtotal (see instructions) 47.00 48.00 Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions) 49.00 Total payment for inpatient operating costs 11,603,489 49.00 49.00 Total payment for inpatient program capital (from Wkst. L., Pt. I and Pt. II, as applicable) 51.00 Expertion payment for inpatient program 51.00 52.00 Formal MSCH, Letter (see instructions) 52.00 Formal MSCH, Letter (see instructions) 53.00 Payment for inpatient program 54.00 55.00 Net organ acquisition cost (Wkst. L. Pt. III, see instructions) 55.00 Net organ acquisition cost (Wkst. L 4 Pt. III, col. I, line 69) 55.00 Net organ acquisition cost (Wkst. L 4 Pt. III, col. I, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Formal Mkst. D, Pt. IV, col. II line 30 58.00 Formal Mkst. D, Pt. IV, col. II line 30 58.00 Formal Mkst. D, Pt. IV, col. II line 30 58.00 Formal Mkst. D, Pt. IV, col. III line 30 58.00 Formal Mkst. D, Pt. IV, col. III line 30 58.00 Formal Mkst. D, Pt. IV, col. III line 30 58.00 Formal Mkst. D, Pt. IV, col. III line 30 58.00 Formal Mkst. D, Pt. IV, col. III line 30 58.00 Formal Mkst. D, Pt. IV, col. III line 30 58.00 Formal Mkst. D, Pt. IV, c								
discharges excluding MS-DRCs 652, 682, 683, 684 an 685. (See instructions) 42.00 10 vid el line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 10 total Medicare ESRD inpatient days excluding MS-DRCs 652, 682, 683, 684 an 685. (See instructions) 44.00 Ratio of average length of stay to one week (Iline 43 divided by line 41 divided by 7 days) 45.00 46.00 47.00 47.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.0	41 01					0		41 01
684 an 685. (see instructions) 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 43.00 42.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.	41.01				0	O		41.01
42.00 Novide Fline 41 by Fline 40 (If Fless than 10%, Novide Fline 41 by Fline 40 (If Fless than 10%, Novide Fline 41 by Fline 40 (If Fless than 10%, Novide Fline 41 by Fline 4								
43.00 Total Medicare ESR0 inpatient days excluding MS-PRGs 652, 683, 684 an 685. (see Instructions)	42.00				0.00			42. 00
MS-DRGs 652, 682, 683, 684 an 685. (see instructions)								
Instructions	43. 00				0			43. 00
44.00 Ratio of average length of stay to one week (line 43 divided by Tine 41 divided by T days) 45.00 45.00 Average weekly cost for dialysis treatments (see instructions) 46.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00								
(line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41.01) 46.00 Hospi tal specific payments (to be completed by SCH and MbH, small rural hospitals only. (see instructions) 49.00 Total payment for inpatient program capital (from Wsst. L, Pt. I and Pt. II. as applicable) Exception payment for inpatient program capital (from Wsst. L, Pt. III. see instructions) 50.00 Payment for impatient program capital (from Wsst. L, Pt. III. see instructions) 51.00 Exception payment for inpatient program capital (from Wsst. L, Pt. III. see instructions) 52.00 Direct graduate medical education payment (from Wsst. L-4, line 49 see instructions) 53.00 Nursing and Allied Health Managed Care payment 54.00 Special add-on payments for new technologies 55.00 Nursing and Allied Health Managed Care payment 56.00 Cost of physic ians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wsst. D, Pt. III. column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs (from Wsst. D, Pt. III. column 9, lines 30 through 35). 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 60.00 Total amount payable for program beneficiaries (line 59 minus line 60)	44 00				0 000000			44 00
days	00				0.00000			
See Instructions								
46.00 Total additional payment (line 45 times line 44 times line 41.01) 41 times line 41.01) 41.00 5ubtotal (see instructions) 11,603,489 47.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.0	45. 00				0.00	0. 00		45. 00
44 times line 41.01)	44 00							44 00
47.00 Subtotal (see instructions) 47.00 48.00 Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions) 0 49.00 Total payment for inpatient operating costs (see instructions) 11,603,489 49.00 50.00 Payment for inpatient program capital (from W.Kst. L, Pt. III, as applicable) 892,316 50.00 51.00 Exception payment for inpatient program capital (W.Kst. L, Pt. III, see instructions) 0 51.00 52.00 Direct graduate medical education payment (from W.Kst. E-4, line 49 see instructions). 0 52.00 53.00 Nursing and Allied Health Managed Care payment 0 0 53.00 54.00 Special add-on payments for new technologies 0 55.00 55.00 55.00 Net organ acquisition cost (W.Kst. D-4 Pt. III, col. I, Iine 69) 0 55.00 55.00 56.00 Cost of physicians' services in a teaching hospital (see intructions) 0 56.00 56.00 57.00 Routine service other pass through costs (from W.Kst. D, Pt. IIV, col. III line 200) 0 58.00 58.00 Primary service other pass through costs (sa) 0 58.00 6.00 Primary payer p	46.00				U			40.00
by SCH and MDH, small rural hospitals only. (see instructions) 49.00 Total payment for inpatient operating costs (see instructions) 50.00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable) 51.00 Exception payment for inpatient program on capital (Wkst. L, Pt. III, see instructions) 52.00 Di rect graduate medical education payment (from Wkst. E. 4, I ine 49 see instructions) 53.00 Nursing and Allied Heal th Managed Care payment Special add-on payments for new technologies on Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, I ine 69) 56.00 Cost of physic class' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, I ines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through Sa) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)	47.00				11, 603, 489			47. 00
only. (see instructions) 49.00 Total payment for inpatient operating costs (see instructions) 50.00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable) 51.00 Exception payment for inpatient program capital (from Wkst. L, Pt. III, see instructions) 52.00 Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions) 53.00 Nursing and Allied Health Managed Care payment 54.00 Special add-on payments for new technologies 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. I, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, col. mn 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 6.881 60.00 Total amount payable for program beneficiaries (line 59 minus line 60)	48.00	Hospital specific payments (to be completed			0			48. 00
49. 00 Total payment for inpatient operating costs (see instructions) 49. 00 50. 00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable) 892, 316 51. 00 Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) 0 52. 00 Direct graduate medical education payment (from Wkst. E-4, I ine 49 see instructions). 0 53. 00 Nursing and Allied Health Managed Care payment 0 54. 00 Special add-on payments for new technologies 0 55. 00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 69) 0 56. 00 Cost of physicians' services in a teaching hospital (see intructions) 0 57. 00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, Iines 30 through 35). 0 58. 00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 0 59. 00 Total (sum of amounts on lines 49 through beneficiaries (line 59 minus line 60) 12, 495, 805								
(see instructions) 892,316 50.00 Payment for inpatient program capital (from Wkst. L, Pt. III, sa applicable) 51.00 Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) 52.00 Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions). 53.00 Nursing and Allied Health Managed Care payment 54.00 Special add-on payments for new technologies 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 6,881 60.00 Primary payer payments 6,881 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)	40.00				11 (02 400			40.00
50.00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	49.00				11, 603, 489			49.00
Wkst. L, Pt. I and Pt. II, as applicable) 51.00 Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) 0 52.00 Direct graduate medical education payment (from Wkst. E-4, Ilne 49 see instructions). 0 53.00 Nursing and Allied Heal th Managed Care payment 0 55.00 Special add-on payments for new technologies 0 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 0 56.00 Cost of physicians' services in a teaching hospital (see intructions) 0 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 0 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 0 59.00 Total (sum of amounts on lines 49 through 58) 12, 495, 805 58) 60.00 70 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 61.00	50.00				892, 316			50. 00
capital (Wkst. L, Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions). S3.00 Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see intructions) Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through S8) Co. 00 Primary payer payments Co. 00 Cost of physicians' service other pass through costs from Wkst. D, Pt. V, col. 11 line 200) Total (sum of amounts on lines 49 through S8) Co. 00 Cost of physicians' service other pass through costs from Wkst. D, Pt. III, column 9, lines 30 through 35). Cost of physicians' service other pass through costs from Wkst. D, Pt. III, column 9, lines 30 through 35). Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital		Wkst. L, Pt. I and Pt. II, as applicable)						
52.00 Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions). 53.00 Nursing and Allied Health Managed Care payment 54.00 Special add-on payments for new technologies 55.00 Net organ acquisition cost (Wkst. D-4 Pt. lill, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, col umn 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)	51. 00				0			51. 00
(from Wkst. E-4, line 49 see instructions). Nursing and Allied Health Managed Care payment Special add-on payments for new technologies 54.00 Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. lill, col. 1, line 69) Cost of physicians' services in a teaching hospital (see intructions) Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 8.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) Co. 00 Primary payer payments 12, 495, 805 6, 881 60.00 Total amount payable for program beneficiaries (line 59 minus line 60)	E2 00							E2 00
53.00 Nursing and Allied Health Managed Care payment 54.00 Special add-on payments for new technologies 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)	ე∠. 00				ا ا			5∠. 00
54.00 Special add-on payments for new technologies 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)	53. 00	1 '			o			53. 00
55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Anciliary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)								
III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 60.00 Total amount payable for program beneficiaries (line 59 minus line 60)		, , , , , , , , , , , , , , , , , , , ,			1			
56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 56.00 57.00 58.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 5	55. 00				0			55. 00
hospital (see intructions) Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 60.00 Total amount payable for program beneficiaries (line 59 minus line 60) 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)	56 00				0			56 00
57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)	30.00							30.00
through 35). Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 58.00 59.00 59.00 60.00 61.00	57.00	Routine service other pass through costs			0			57. 00
58.00 Anciliary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 0 58.00 59.00 Total (sum of amounts on lines 49 through 58) 12,495,805 59.00 60.00 Primary payer payments 6,881 60.00 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 12,488,924 61.00		(from Wkst. D, Pt. III, column 9, lines 30						
from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 61.00 total amount payable for program beneficiaries (line 59 minus line 60)								
59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments Total amount payable for program beneficiaries (line 59 minus line 60) 59.00 60.00 12, 495, 805 60.00 12, 488, 924 61.00	58. 00				0			58. 00
58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 61.00 beneficiaries (line 59 minus line 60)	59 00				12 495 805			59 00
60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 61.00 beneficiaries (line 59 minus line 60)	57.00	,			12, 473, 003			57.00
61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 12,488,924 61.00	60.00	,			6, 881			60. 00
	61. 00	Total amount payable for program			12, 488, 924			61. 00
62.00 Deductibles billed to program beneficiaries 1,082,452 62.00	(2.00				1 000 450			42.00
	02.00	peductibles billed to program beneficiaries			1, 082, 452			02.00

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT Provi der CCN: 150157

				''	00/30/2013	11/30/2015 9:	
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
				October 1		October 1	
		0		1. 00	1. 01	2. 00	
63. 00	Coinsurance billed to program beneficiaries			18, 698			63. 00
64. 00	Allowable bad debts (see instructions)			82, 271			64. 00
65. 00	Adjusted reimbursable bad debts (see			53, 476			65. 00
44 00	instructions) Allowable bad debts for dual eligible			11 210			66. 00
66. 00	beneficiaries (see instructions)			11, 219			00.00
67. 00	Subtotal (line 61 plus line 65 minus lines			11, 441, 250			67. 00
07.00	62 and 63)			, , 200			07.00
68.00	Credits received from manufacturers for			0			68. 00
	replaced devices for applicable to MS-DRGs						
	(see instructions)						
69.00	Outlier payments reconciliation (sum of			0			69. 00
	lines 93, 95 and 96). (For SCH see						
70.00	instructions)			0			70.00
70.00				0			70.00
70. 01 70. 50	RURAL DEMONSTRATION PROJECT			0			70. 01 70. 50
70. 30	Pioneer ACO demonstration payment adjustment			0			70. 89
70.07	amount (see instructions)			O			70.07
70. 90	HSP bonus payment HVBP adjustment amount			0			70. 90
	(see instructions)						
70. 91	HSP bonus payment HRR adjustment amount (see			0			70. 91
	instructions)						
70. 92	Bundled Model 1 discount amount (see			0			70. 92
	instructions)						
70. 93	HVBP payment adjustment amount (see			30, 291			70. 93
70. 94	instructions) HRR adjustment amount (see instructions)			-6, 775			70. 94
70. 95	Recovery of accel erated depreciation			-0, 773 0			70. 95
70. 75	Low volume adjustment for federal fiscal		0	0			70. 96
70.70	year (yyyy) (Enter in column 0 the		ŭ	ŭ			70.70
	corresponding federal year for the period						
	prior to 10/1)						
70. 97	Low volume adjustment for federal fiscal		0	0			70. 97
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
70.00	ending on or after 10/1)			0			70.00
70. 98 70. 99	Low Volume Payment-3 HAC adjustment amount (see instructions)			0			70. 98 70. 99
71. 00	Amount due provider (line 67 minus lines 68			11, 464, 766			71. 00
71.00	plus/minus lines 69 & 70)			11, 404, 700			71.00
71. 01	Sequestration adjustment (see instructions)			229, 295			71. 01
72.00	Interim payments			10, 565, 016			72. 00
73.00	Tentative settlement (for contractor use			0			73. 00
	onl y)						
74. 00	Balance due provider (Program) (line 71			670, 455			74. 00
75 00	minus lines 71.01, 72, and 73)			0			75 00
75. 00	Protested amounts (nonallowable cost report			0			75. 00
	items) in accordance with CMS Pub. 15-2, chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR (lines 90 throu	iah 96)					
90.00	Operating outlier amount from Wkst. E, Pt.	.5 - /		0			90.00
	A, line 2 (see instructions)						
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0			91. 00
92.00	Operating outlier reconciliation adjustment			0			92.00
00.05	amount (see instructions)			_			00.00
93. 00	Capital outlier reconciliation adjustment			0			93. 00
94. 00	amount (see instructions) The rate used to calculate the time value of			0. 00	ļ		94. 00
74. UU	money (see instructions)			0.00			74.00
95. 00	Time value of money for operating expenses			0			95. 00
2.00	(see instructions)			Ü			
96.00	Time value of money for capital related			0	ļ		96. 00
	expenses (see instructions)						

Health Financial Systems	ST.	VINC	ENT	CARMEL	HOSPI TAL				In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT					Provi der	CCN: 1!		Peri		Worksheet E	
								From	n 07/01/2014 06/30/2015	Part A Date/Time Pre	narod:
								10	00/ 30/ 2013	11/30/2015 9:	44 am
					Ti tl	e XVII	I		Hospi tal	PPS	
						Pri or	to 10/	1		On/After 10/1	
						1	. 00		1. 01	2. 00	
HSP Bonus Payment Amount											
100.00 HSP bonus amount (see instructions)								0		0	100. 00
HVBP Adjustment for HSP Bonus Payment											
101.00 HVBP adjustment factor (see instructions)								0		0	101.00
102.00 HVBP adjustment amount for HSP bonus paymer	nt (s	see in	stru	ctions)				0		0	102.00
HRR Adjustment for HSP Bonus Payment											
103.00 HRR adjustment factor (see instructions)							0.000	00		0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment	(se	e ins	truc	tions)				0		0	104.00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 150157

					'	0 06/30/2015	11/30/2015 9:	
	,				e XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	C		0	1. 00
1. 01	payments DRG amounts other than outlier	1. 01	2, 247, 945	0	2, 247, 945	0	2, 247, 945	1. 01
1. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	8, 468, 012	0	C	8, 468, 012	8, 468, 012	1. 02
1.02	payments for discharges occurring on or after October	1. 02	0, 400, 012	0	C	0, 400, 012	0, 400, 012	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	C	0	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	C	0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	74, 219	0	27, 541	46, 678	74, 219	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	C	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	C	0	0	3. 00
4.00	Managed care simulated payments Indirect Medical Education Adju	3. 00	0	0	С	0	0	4. 00
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	C	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	C	0	0	6. 01
	managed care (see instructions)							
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	C	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	O	0	C	0	0	8. 01
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	O	0	C	0	0	9. 01
	Di sproporti onate Share Adjustme	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0307	0. 0307	0. 0307	0. 0307		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34.00	82, 245	0	17, 253	64, 992	82, 245	11. 00
11. 01	Uncompensated care payments	36.00	731, 068	0	C	618, 301	618, 301	11. 01
	Additional payment for high per		D beneficiary					
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	C		0	
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	11, 603, 489 0	0	2, 292, 739 0	9, 310, 750 0	11, 603, 489 0	13. 00 14. 00
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient	49. 00	11, 603, 489	0	2, 292, 739	9, 310, 750	11, 603, 489	15. 00
16. 00	operating costs (see instructions) Payment for inpatient program	50. 00	892, 316	0	187, 867	704, 449	892, 316	16. 00
17. 00	capital Special add-on payments for	54. 00	0	0	С	О	0	17. 00
17. 01	new technologies Net organ aquisition cost	55. 00	0	0	С	0	0	17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	O	0	С	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	O	0	C	0	0	18. 00
	·					'	'	

LOW VO	LUME CALCULATION EXHIBIT 4					Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Exhibi Date/Time Pre 11/30/2015 9:	pared:
	,				e XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
19. 00	SUBTOTAL			0	2, 480, 60	6 10, 015, 199	12, 495, 805	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2. 00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	857, 013	0	179, 68	2 677, 331	857, 013	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	7, 364	0	2, 32	7 5, 037	7, 364	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0. 0000		22. 00
23. 00	Indirect medical education	6. 00	0	0		0 0	0	23. 00
24. 00	adjustment (see instructions) Allowable disproportionate share percentage (see instructions)	10. 00	0. 0326	0. 0326	0. 032	6 0. 0326		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	27, 939	0	5, 85	8 22, 081	27, 939	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	892, 316	0	187, 86	704, 449	892, 316	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
27.00	Low volume adjustment factor				0.00000	0. 000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0	0	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

From 07/01/2014 Part A Exhibit 5 Date/Time Prepared: 06/30/2015 11/30/2015 9:44 am Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 2, 247, 945 2, 247, 945 2, 247, 945 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1.02 8, 468, 012 8, 468, 012 8, 468, 012 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 С 0 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 74, 219 27, 541 46, 678 74, 219 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 2.01 0 Operating outlier reconciliation 3 00 2 01 O 0 0 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 9.00 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 0.0307 0.0307 0.0307 10.00 33.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 82. 245 17, 253 64.992 82.245 11.00 instructions) 11.01 Uncompensated care payments 36.00 731, 068 208, 366 618, 301 826, 667 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see 12 00 46 00 0 0 instructions) 13.00 Subtotal (see instructions) 47.00 11, 603, 489 2, 501, 105 9, 102, 384 11, 603, 489 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 11, 603, 489 2, 501, 105 9, 102, 384 11, 603, 489 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 892, 316 187, 867 704, 449 892, 316 16.00 Special add-on payments for new technologies 17.00 54.00 17.00 Net organ aquisition cost 55.00 17.01 17.01 0 0 0 17.02 Credits received from manufacturers for 68.00 0 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 18.00 amount (see instructions)

2 688 972

9 806 833

12 495 805 19 00

SUBTOTAL

19 00

Health Financial Systems	ST. VINCENT CARMEL	HOSPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 150157		Worksheet E Part A Exhibit 5

06/30/2015 Date/Time Prepared: To 11/30/2015 9:44 am Title XVIII Hospi tal PPS Wkst. L, line (Amt. from L) Wkst. 2.00 3. 00 4.00 n 1 00 20.00 Capital DRG other than outlier 1.00 857, 013 179, 682 677, 331 857, 013 20.00 20.01 Model 4 BPCI Capital DRG other than outlier 1.01 20.01 Capital DRG outlier payments 21.00 2.00 7, 364 2, 327 5,037 7, 364 21.00 21.01 Model 4 BPCI Capital DRG outlier payments 2.01 0 21.01 22.00 Indirect medical education percentage (see 5.00 0.0000 0.0000 0.0000 22.00 instructions) 23. 00 23.00 Indirect medical education adjustment (see 6.00 0 instructions) 0.0326 0.0326 0.0326 24.00 24 00 Allowable disproportionate share percentage 10 00 (see instructions) 25.00 Disproportionate share adjustment (see 11.00 27, 939 5,858 22, 081 27, 939 25.00 instructions) Total prospective capital payments (see 12.00 892, 316 187, 867 704, 449 892, 316 26.00 instructions) Wkst. E. Pt. (Amt. from A, line Wkst. E, Pt. A) 0 1.00 2.00 3.00 4.00 27. 00 27. 00 28.00 Low volume adjustment prior to October 1 70.96 0 0 28.00 29.00 Low volume adjustment on or after October 1 70.97 0 29.00 HVBP payment adjustment (see instructions) 70. 93 30, 291 -2, 801 33, 092 30, 291 30.00 30.00 HVBP payment adjustment for HSP bonus 30.01 70.90 30.01 payment (see instructions) 31.00 HRR adjustment (see instructions) 70.94 -6, 775 0 -6, 775 -6, 775 31.00 31.01 HRR adjustment for HSP bonus payment (see 70. 91 0 31.01 instructions) (Amt. to Wkst. Pt. A) 3.00 0 1.00 2.00 4.00 32.00 HAC Reduction Program adjustment (see 70.99 0 0 32.00 instructions) 100.00 Transfer HAC Reduction Program adjustment to 100.00 Ν Wkst. E, Pt. A.

Health Financial Systems	ST.	VI NCENT	CARMEL	HOSPI TAL			In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Provi der	CCN:	150157	Peri od: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/30/2015 9:44 am
				T: 11	10.7		11 11 1	DDC

			To 06/30/2015	Date/Time Pre 11/30/2015 9:	
		Title XVIII	Hospi tal	PPS	11 diii
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			9, 776	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		6, 555, 424	
3. 00	PPS payments	,		5, 028, 826	
4.00	Outlier payment (see instructions)			54, 482	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	
6.00	Line 2 times line 5			0	6. 00
7. 00 8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	9. 00
10. 00	Organ acqui si ti ons	7 0011 107 11110 200		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			9, 776	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges			20.770	12.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	۵ (۵)		38, 660	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	e 07)			14. 00
	Customary charges			22, 222	
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17 00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 38, 660	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	28, 884	
	instructions)		, (***	,	
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		9, 776	21. 00
22. 00	Interns and residents (see instructions)	rnstructions)		9,770	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	<u> </u>		5, 083, 308	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)	CALL coo i notruoti ono		727	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			1, 136, 064 3, 956, 293	
27.00	instructions)	45 the 54m of 111165 2.	2 4.14 20] (000	0,700,270	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			3, 956, 293 179	
32. 00	Subtotal (line 30 minus line 31)			3, 956, 114	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		5/1155/1111	
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34. 00	Allowable bad debts (see instructions)			165, 284	
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions)	ctions)		107, 435 94, 867	
37. 00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	Ctrons)		4, 063, 549	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instru	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			4, 063, 549 81, 271	40. 00 40. 01
41. 00	Interim payments			3, 870, 490	
42. 00	Tentative settlement (for contractors use only)			0	1
43.00	Balance due provider/program (see instructions)			111, 788	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money				92. 00
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)		l	0	94. 00

Health Financial Systems ST. VANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 07/01/2014 Part I
To 06/30/2015 Date/Time Prepared: 11/30/2015 9: 44 am Provi der CCN: 150157

					11/30/2015 9: 2	44 am_
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A		⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		10, 565, 01		3, 870, 490	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			<u>'</u>	•	
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0 0	3. 52
3. 53 3. 54				0		3. 53 3. 54
3. 54	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 54
3. 99	3. 50-3. 98)		,	U .		3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		10, 565, 01	6	3, 870, 490	4. 00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		.0,000,0.		0,0,0,1,0	00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			al		
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02 5. 03				0	0 0	5. 02 5. 03
5.03	Provider to Program			U	0	5. 03
5. 50	TENTATI VE TO PROGRAM			0	1 0	5. 50
5. 51	TENTITY E TO TROOM WIT			Ö	l ő	5. 51
5. 52				o o	l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			Ö	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		670, 45		111, 788	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		11, 235, 47		3, 982, 278	7. 00
				Contractor	NPR Date	
		()	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5.00	name of softf dotter				1	0.00

Heal th	Financial Systems	ST. VINCENT CARMEL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	On Miles	Provi der CCN: 15015		Worksheet E-1 Part II	pared:
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA	RD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTI	ON AND CALCULATION				
1.00	Total hospital discharges as defined in AAR	A §4102 from Wkst. S	-3, Pt. I col. 15 li	ne 14	5, 914	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6	sum of lines 1, 8-1	2		3, 917	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, co	I. 6. line 2			1, 121	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8	sum of lines 1, 8-1	2		14, 480	4. 00
5.00	Total hospital charges from Wkst C, Pt. I,	col. 8 line 200			475, 965, 098	5. 00
6.00	Total hospital charity care charges from Wk	st. S-10, col. 3 lin	e 20		8, 038, 425	6. 00
7. 00	CAH only - The reasonable cost incurred for line 168	the purchase of cer	tified HIT technolog	y Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (s	ee instructions)			522, 534	8. 00
9.00	Sequestration adjustment amount (see instru	ctions)			10, 451	9. 00
10.00	Calculation of the HIT incentive payment af	ter sequestration (s	ee instructions)		512, 083	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS	& CAH				
30.00	Initial/interim HIT payment adjustment (see	instructions)			546, 523	30.00
31.00	Other Adjustment (specify)				0	31. 00
22 00	Dalamas dua providar (line 0 (ar line 10) m	inua lina 20 and lin	a 21) (ass instructi	ana)	24 440	22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

546, 523 30. 00 0 31. 00 -34, 440 32. 00

Health Financial Systems	ST.	VI NCENT	CARMEL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Provi der CCN: 150157	Peri od: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2015 9:44 am

			To 06/30/2015	Date/Time Pre 11/30/2015 9:	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		3, 551, 929		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		3, 551, 929	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3, 551, 929	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		3, 490, 863		8. 00
9.00	Ancillary service charges		8, 286, 446	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		11, 777, 309	0	12. 00
12.00	CUSTOMARY CHARGES				12.00
13. 00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13. 00
14. 00	Amounts that would have been realized from patients liable for	normant for convices on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42		٩	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		11, 777, 309	0.000000	•
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	8, 225, 380	0	
17.00	line 4) (see instructions)	TT TTTE TO EXCECUS	0, 220, 000	· ·	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	o	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		o	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	o	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16		3, 551, 929	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid	ers.		
22. 00	1 3		0	0	
	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		3, 551, 929	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1 20 00
30.00	Excess of reasonable cost (from line 18)		2 551 020	0	30. 00 31. 00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		3, 551, 929	0	
32. 00 33. 00	Coinsurance		0	0	
34. 00			0	0	34.00
35. 00	Utilization review		0	Ü	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	3, 551, 929	0	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	3, 331, 727	0	
38. 00			3, 551, 929	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		0,001,727	· ·	39.00
40. 00			3, 551, 929	0	
41. 00	Interim payments		3, 551, 929	0	1
42. 00	Balance due provider/program (line 40 minus line 41)		0,001,727	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2.	o	0	
	chapter 1, §115. 2]		

Health Financial Systems ST. VINCENT CARMED BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 150157

				0 06/30/2015	Date/lime Pre 11/30/2015 9:	
		General Fund	Speci fi c	Endowment Fund	Plant Fund	11 (11)
			Purpose Fund			
	CHIDDENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	CURRENT ASSETS Cash on hand in banks	5, 745, 065		O	0	1.00
2. 00	Temporary investments	0,710,000			0	
3.00	Notes recei vabl e	0	d	0	0	1
4.00	Accounts receivable	49, 102, 241	C	0	0	4. 00
5.00	Other recei vable	3, 584, 861			0	
6.00	Allowances for uncollectible notes and accounts receivable	-22, 955, 977		١	0	
7.00	Inventory Proposid expenses	2, 485, 163		0	0	1
8. 00 9. 00	Prepaid expenses Other current assets	119, 583 470, 261		0	0	
10. 00	Due from other funds	24, 211, 137			0	
11. 00	Total current assets (sum of lines 1-10)	62, 762, 334			0	
	FIXED ASSETS					
12. 00	Land	2, 111, 746			0	
13.00	Land improvements	2, 267, 694			0	
14.00	Accumulated depreciation	-2, 126, 736			0	
15. 00 16. 00	Buildings Accumulated depreciation	80, 155, 097 -40, 518, 621		-	0	15. 00 16. 00
17. 00	Leasehold improvements	3, 913, 471			0	17. 00
18. 00	Accumulated depreciation	-1, 812, 528			0	
19.00	Fi xed equipment	12, 533, 777	c	0	0	19. 00
20.00	Accumulated depreciation	-2, 865, 646	C	0	0	
21. 00	Automobiles and trucks	0	C	0	0	
22. 00	Accumulated depreciation	42 500 200	C		0	
23. 00 24. 00	Major movable equipment Accumulated depreciation	42, 588, 380 -27, 795, 183		١	0	
25. 00	Mi nor equi pment depreci abl e	-27, 793, 163		0	0	25. 00
26. 00	Accumulated depreciation	ĺ		Ö	0	26. 00
27. 00	HIT designated Assets	0	d	0	0	1
28. 00	Accumulated depreciation	0	C	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	C		0	
30. 00	Total fixed assets (sum of lines 12-29)	68, 451, 451	<u> </u>	0	0	30. 00
31. 00	OTHER ASSETS Investments	607, 053, 388		O	0	31. 00
32. 00	Deposits on Leases	007,033,300			0	
33. 00	Due from owners/officers	0	d	0	0	1
34.00	Other assets	30, 467, 412	215, 135	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	637, 520, 800			0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	768, 734, 585	215, 135	0	0	36. 00
37. 00	CURRENT LIABILITIES	2 545 145			0	27.00
38.00	Accounts payable Salaries, wages, and fees payable	3, 545, 165 3, 854, 238		0	0	
39. 00	Payrol I taxes payable	273, 204		0	0	1
40.00	Notes and Loans payable (short term)	0	d	0	0	
41.00	Deferred income	0	C	0	0	41. 00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	25, 417, 500			0	
44. 00 45. 00	Other current liabilities	6, 649, 865 39, 739, 972			0	
43.00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	37, 137, 712		ı o	0	45.00
46. 00	Mortgage payable	0	C	0	0	46. 00
47. 00	Notes payable	0	C	0	0	47. 00
48. 00	Unsecured Loans	0	C	0	0	1
49. 00	Other long term liabilities	20, 479, 572			0	1
50.00	Total long term liabilities (sum of lines 46 thru 49	20, 479, 572			0	
51. 00	Total liabilites (sum of lines 45 and 50) CAPITAL ACCOUNTS	60, 219, 544	<u> </u>	0	0	51.00
52. 00	General fund balance	708, 515, 041				52. 00
53. 00	Specific purpose fund	700,010,011	215, 135			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	708, 515, 041	215, 135	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	768, 734, 585			0	
	59)	l	l			

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150157 | Period: From 07/01/2014

Worksheet G-1 /2014 /2015 Date/Time Prepared:

06/30/2015 11/30/2015 9:44 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 5. 00 2 00 4 00 1.00 Fund balances at beginning of period 711, 236, 924 217, 241 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 55, 405, 949 2.00 3.00 Total (sum of line 1 and line 2) 766, 642, 873 217. 241 3.00 4.00 4.00 0 0 5.00 OTHER ACTIVITY 0 5.00 6.00 GRANT REVENUE 6.00 0 7.00 RESTRICTED INCOME 0 0 7.00 0 RESTRICTED UNREALIZED GAIN 0 8.00 0 8.00 9.00 OTHER ADJUSTMENT 2, 106 0 9.00 10.00 Total additions (sum of line 4-9) 2, 106 10.00 Subtotal (line 3 plus line 10) 766, 644, 979 217, 241 11 00 11.00 12.00 TRANSFER TO AFFLIATES 58, 109, 559 0 0 12.00 13.00 NET ASSETS RELEASED FROM RESTRICTION 20, 380 13.00 OTHER ADJUSTMENT 14.00 2, 106 0 14.00 15.00 0 OTHER ADJUSTMENT 15.00 0 0 16.00 ROUNDI NG 0 0 16.00 17.00 0 17.00 18.00 58, 129, 938 Total deductions (sum of lines 12-17) 2, 106 18.00 Fund balance at end of period per balance 19.00 708, 515, 041 215, 135 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 6.00 7. 00 8.00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 4.00 5.00 OTHER ACTIVITY 0 5.00 GRANT REVENUE 0 6.00 6.00 7.00 RESTRICTED INCOME 0 7 00 8.00 RESTRICTED UNREALIZED GAIN 0 8.00 9.00 OTHER ADJUSTMENT 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 Subtotal (line 3 plus line 10) 0 11.00 0 11.00 12.00 TRANSFER TO AFFLIATES 0 12.00 NET ASSETS RELEASED FROM RESTRICTION 13.00 13.00 14.00 OTHER ADJUSTMENT 0 14.00 OTHER ADJUSTMENT 15.00 0 15.00 16.00 ROUNDI NG 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00 sheet (line 11 minus line 18)

Health Financial Systems ST STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150157

			10 06/30/2015	11/30/2015 9:	
	Cost Center Description	Inpati ent	Outpati ent	Total	44 aiii
	out contain possin per on	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	35, 106, 37	3	35, 106, 373	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	35, 106, 37	3	35, 106, 373	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	5, 183, 16	7	5, 183, 167	11. 00
12.00	CORONARY CARE UNIT				12. 00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	11, 847, 89		11, 847, 899	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	17, 031, 06	6	17, 031, 066	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	52, 137, 43		52, 137, 439	17. 00
18. 00	Ancillary services	150, 517, 64		392, 721, 123	
19. 00	Outpati ent servi ces	3, 661, 61		31, 106, 535	
20.00	RURAL HEALTH CLINIC		0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		0 14 201 204	14 201 204	26. 00
27. 00	PHYSICIAN PROFESSIONAL FEES	. 206, 316, 69	0 14, 391, 294 4 284, 039, 697	14, 391, 294	27. 00 28. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst G-3, line 1)	. 200, 310, 09	4 284, 039, 697	490, 356, 391	28.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		131, 340, 935		29. 00
30. 00	operating expenses (per wkst. A, corumn 3, 1111e 200)		0		30.00
31. 00			0		31. 00
32. 00			0		32. 00
33. 00			Ö		33. 00
34. 00			0		34. 00
35. 00			o		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00	525601 (6.25111)		o		38. 00
39. 00			o		39. 00
40. 00			0		40. 00
41. 00			0		41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	fer	131, 340, 935		43. 00
-	to Wkst. G-3, line 4)				
		•	•		

Heal th	Financial Systems	ST.	VI NCENT	CARMEL	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES				Provi der	- CCN: 1	50157	Peri od:	Worksheet G-3	
								From 07/01/2014 To 06/30/2015	Date/Time Pre	
									11/30/2015 9: 4	44 am
									1. 00	
1.00	Total patient revenues (from Wkst. G-2, Pa	rt I,	column 3	B, line	28)				490, 356, 391	1. 00
2.00	Less contractual allowances and discounts	on pa	tients' a	accounts	5				300, 882, 312	2.00
3.00	Net patient revenues (line 1 minus line 2)								189, 474, 079	3.00
4.00	Less total operating expenses (from Wkst.	G-2,	Part II,	line 43	3)				131, 340, 935	4.00
5.00	Net income from service to patients (line)	3 mir	us line 4	1)					58. 133. 144	5. 00

1.00			11/30/2015 9:	44 am_
Total patle net revenues (from Wkst. G-2, Part I, column 3, line 28)				
2.00 Less contractual allowances and discounts on patients' accounts 300, 882, 312 2.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 131, 340, 935 4.00 6.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 131, 340, 935 4.00 6.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 131, 340, 935 4.00 6.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 131, 340, 935 4.00 7.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 131, 340, 935 4.00 7.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 131, 340, 935 4.00 7.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 131, 340, 935 4.00 7.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 131, 340, 935 4.00 7.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 131, 340, 935 4.00 8.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 131, 340, 935 4.00 8.00 Less total operating expenses (from Wkst. G-2, Part III, Line 43) 131, 340, 935 4.00 9.00 Less total operating expenses (from Wkst. G-2, Part III, Line 43) 131, 340, 935 4.00 9.00 Part Line Holder expenses (from Wkst. G-2, Part III, Line 43) 131, 340, 935 4.00 9.00 Purchase discounts 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				
Net patient revenues (line 1 minus line 2) 189, 474, 079 3. 00 Not patient revenues (line 1 minus line 2) 131, 1340, 955 4. 00 Not income from service to patients (line 3 minus line 4) 58, 133, 144 Not lincome from service to patients (line 3 minus line 4) 58, 133, 144 Other lincome from investments 18, 372, 015 7. 00 Not income from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 372, 015 7. 00 Not lincome from investments 18, 50 7. 00 Not lincome f		Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	490, 356, 391	1. 00
Less total operating expenses (from Wist. 6-2, Part III, line 43) 31, 340, 935 4, 00	2.00	Less contractual allowances and discounts on patients' accounts	300, 882, 312	2. 00
Section Sect	3.00	Net patient revenues (line 1 minus line 2)	189, 474, 079	3. 00
OTHER INCOME	4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	131, 340, 935	4. 00
6. 00 Contributions, donations, bequests, etc 0 0.00 7. 00 Income from investments 18, 372, 015 7, 00 8. 00 Revenues from telephone and other miscellaneous communication services 0 8, 00 9. 00 Revenue from telephone and other miscellaneous communication services 0 9, 00 11. 00 Revenue from telephone and other miscellaneous communication services 0 10, 00 11. 00 Revenue from telephone and other miscellaneous communication services 0 10, 00 12. 00 Revinable from telephone and other miscellaneous communication services 0 10, 00 12. 00 Revinable from telephone and other miscellaneous communication services 0 10, 00 13. 00 Revenue from service 0 12, 00 13. 00 Revenue from all of under and service 0 13, 00 15. 00 Revenue from sele of medical and surgical supplies to other than patients 322, 825 17, 00 16. 00 Revenue from sale of medical and surgical supplies to other than patients 322, 825 17, 00 18. 00 Revenue from sale of medical records and abstracts<	5.00	Net income from service to patients (line 3 minus line 4)	58, 133, 144	5. 00
1.0.00m Income from Investments 18,372,015 7.00 9.00 Revenues from telephone and other miscellaneous communication services 0.0 0.00 0.00 Purchase discounts 0.00 0.00 Purchase discounts 0.00 0.00 0.00 Purchase discounts 0.00 0.00 0.00 Purchase discounts 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		OTHER I NCOME		
8. 00 Revenues from tel ephone and other mi scell aneous communication services 0 8. 00 9. 00 Revenues from tel ephone and radio service 0 9. 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 15. 00 Revenue from meals sold to employees and guests 513, 283 14. 00 15. 00 Revenue from seals of to employees and guests 0 15. 00 15. 00 Revenue from sale of medical and surgical supplies to other than patients 0 15. 00 17. 00 Revenue from sale of fugs to other than patients 322, 825 17. 00 18. 00 Revenue from sale of fugs to other than patients 322, 825 17. 00 18. 00 Revenue from sale of fugs to other than patients 322, 825 17. 00 18. 00 Revenue from sale of fugs to other than patients 322, 825 17. 00 18. 00 Revenue from sale of fugs to other than patients 322, 825 17. 00 18. 00	6.00	Contributions, donations, bequests, etc	0	6. 00
9, 00 Revenue from tell evil sion and radio service 0 9, 00 10.00 Purchase di Scounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 14.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meal s sold to employees and guests 513, 283 14.00 15.00 Revenue from meal s of dedical and surgical supplies to other than patients 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuit ion (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 22.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 22.00 Rental of vending machines 0 21.00 22.00 Revenue from gifts, flowers, coffee shops, and canteen 0	7.00	Income from investments	18, 372, 015	7. 00
10.00 Purchase discounts 0 10.00 Rebates and refunds of expenses 0 11.00 11.00 11.00 12.00 Rebates and refunds of expenses 0 12.00 12.00 13.00 Revenue from laundry and linen service 0 12.00 13.00 Revenue from meals sold to employees and guests 513, 283 14.00 15.00 Revenue from rental of living quarters 0 15.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical and surgical supplies to other than patients 322, 825 17.00 18.00 17.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 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 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 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 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 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 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 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 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 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 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 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 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 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 10.00 10.00 10.00 10.00 10.00	8.00	Revenues from telephone and other miscellaneous communication services	0	8. 00
11.00 Rebates and refunds of expenses 0 11.00 12.00 12.00 13.00 Revenue from laundry and linen service 0 13.00 13.00 14.00 Revenue from meal sold to employees and guests 513, 283 14.00 15.00 15.00 Revenue from rental of living quarters 0 15.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 322, 825 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00	9.00	Revenue from television and radio service	0	9. 00
12.00 Revenue from laundry and linen service 0 12.00 13.00 14.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 513, 283 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 17.00 Revenue from sale of medical and surgical supplies to other than patients 322, 825 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 10.00 19.00 10.00 10.00 19.00 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 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 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 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 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 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 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 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 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 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 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 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 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 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 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00	10.00	Purchase discounts	0	10.00
13.00 Revenue from laundry and linen service 14.00 Revenue from meals sold to employees and guests 513, 283 14.00 15.00 Revenue from seals of living quarters 0 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 322, 825 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19	11. 00	Rebates and refunds of expenses	0	11. 00
14.00 Revenue from meals sold to employees and guests 513, 283 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 16.00 17.00 Revenue from sale of medical and surgical supplies to other than patients 322, 825 17.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00	12.00		0	12.00
15. 00 Revenue from rental of living quarters 0 15. 00 16. 00 Revenue from sale of medical and surgical supplies to other than patients 322, 825 17. 00 18. 00 Revenue from sale of medical records and abstracts 322, 825 17. 00 18. 00 Revenue from sale of medical records and abstracts 0 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00	13.00	Revenue from laundry and linen service	0	13. 00
16. 00 Revenue from sale of medical and surgical supplies to other than patients 0 16. 00 17. 00 Revenue from sale of drugs to other than patients 322,825 17. 00 18. 00 Revenue from sale of medical records and abstracts 0 18. 00 19. 00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19. 00 20. 00 Revenue from gifts, flowers, coffee shops, and canteen 0 20. 00 21. 00 Rental of vending machines 0 21. 00 22. 00 Governmental appropriations 0 23. 00 24. 00 UNREALIZED GAIN ON INVESTMENTS -24, 313, 499 24. 00 24. 01 10 24. 01 24. 01 24. 02 MI SCELLANEOUS REVENUE 656, 270 24. 02 24. 04 1 NOME FROM UNCONSOLIDATED ENTITIES 18, 590 24. 02 24. 05 OTHER NONOPERATING 20, 380 24. 05 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 06 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 56, 550, 538 26. 00<	14.00	Revenue from meals sold to employees and guests	513, 283	14. 00
17. 00 Revenue from sale of drugs to other than patients 322,825 17. 00 18. 00 Revenue from sale of medical records and abstracts 0 18. 00 19. 00 Tuit it on (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 680.142 22. 00 23. 00 Governmental appropriations 0 23. 00 24. 00 UNREALIZED GAIN ON INVESTMENTS 0 24. 01 24. 01 MI SCELLANEOUS REVENUE 656, 270 24. 02 24. 02 HINCOME FROM UNCONSOLIDATED ENTITIES 18. 590 24. 04 24. 05 OTHER NONOPERATING 20. 380 24. 05 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 07 24. 08 STATE PROGRAM REVENUE 59, 397 24. 08 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 27. 02 RES	15.00	Revenue from rental of living quarters	0	15. 00
18. 00 Revenue from sale of medical records and abstracts 0 18. 00 19. 00 Tuit ion (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 680, 142 22. 00 23. 00 Governmental appropriations 0 23. 00 24. 00 UNREALIZED GAIN ON INVESTMENTS -24, 313, 499 24. 00 24. 01 WI SCELLANEOUS REVENUE 656, 270 24. 02 24. 03 INCOME FROM UNCONSOLIDATED ENTITIES 18, 590 24. 03 24. 04 OTHER NONOPERATING 18, 590 24. 04 24. 05 OTHER NONOPERATING 1, 501, 251 24. 06 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 06 24. 09 GAIN ON SALE OF PPE 59, 397 24. 06 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURING & NON	16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 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 680, 142 22. 00 23. 00 Governmental appropriations 0 23. 00 24. 00 UNREALIZED GAIN ON INVESTMENTS -24, 313, 499 24. 00 24. 01 WI SCELLANEOUS REVENUE 656, 270 24. 02 24. 03 INCOME FROM UNCONSOLIDATED ENTITIES 18, 590 24. 04 24. 04 INCOME FROM UNCONSOLIDATED ENTITIES 18, 590 24. 05 24. 05 OTHER NONOPERATING 20, 380 24. 05 24. 06 CONSOLIDATING AMT (BILLING ARRANGE) 1, 501, 251 24. 06 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 07 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURIN	17. 00	Revenue from sale of drugs to other than patients	322, 825	17. 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 680, 142 22. 00 23. 00 Governmental appropriations 0 23. 00 24. 00 UNREALIZED GAIN ON INVESTMENTS -24, 313, 499 24. 00 24. 01 WI SCELLANEOUS REVENUE 656, 270 24. 01 24. 03 INCOME FROM UNCONSOLIDATED ENTITIES 18, 590 24. 02 24. 05 OTHER NONOPERATING 20, 380 24. 05 24. 06 CONSOLIDATING AMT (BILLING ARRANGE) 1, 501, 251 24. 06 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 06 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 27. 01 LOSS ON UNCONSOLIDATED ENTITIES 903, 987 27. 00 27. 02 RESTRUCTURING & NONRECURRING EXPENSE 903, 987 27. 00 27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line	18. 00	Revenue from sale of medical records and abstracts	0	18. 00
21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 680,142 22.00 23.00 Governmental appropriations 0 23.00 24.00 UNREALIZED GAIN ON INVESTMENTS -24,313,499 24.00 24.01 24.02 MI SCELLANEOUS REVENUE 656,270 24.02 24.03 INCOME FROM UNCONSOLIDATED ENTITIES 18,590 24.04 24.05 OTHER NONOPERATING 20,380 24.05 24.06 CONSOLIDATING AMT (BILLING ARRANGE) 1,501,251 24.06 24.07 GOVT CLNC INCENTIVE REV 537,117 24.08 STATE PROGRAM REVENUE 59,397 24.08 24.09 GAIN ON SALE OF PPE 49,623 24.09 25.00 Total other income (sum of lines 6-24) 56,550,538 26.00 27.00 LOSS ON UNCONSOLIDATED ENTITIES 903,987 27.00 27.01 INTEREST RATE SWAP LOSS 27.01 27.02 RESTRUCTURING & NONRECURRING EXPENSE 27,887 27.02 27.03 DONATIONS 20,000 1,144,589 28.00 20.00 Total other expenses (sum of line 27 and subscripts) 1,144,589 28.00 21.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 Consolidation of line 27 and subscripts 1,144,589 28.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 Consolidation of line 27 and subscripts 22.00 22.00 22.00 22.00 23.00 22.00 22.00 24.01 24.01 24.01 24.02 24.02 24.02 25.00 27.01 27.03 27.03 27.03 27.03 28.00 Total other expenses (sum of line 27 and subscripts) 1,144,589 28.00 28.00 28.00 28.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00	19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
22. 00 Rental of hospital space 680, 142 22. 00 23. 00 Governmental appropriations 0 23. 00 24. 00 UNREALI ZED GAIN ON INVESTMENTS -24, 313, 499 24. 00 24. 01 0 24. 01 0 24. 01 24. 02 MI SCELLANEOUS REVENUE 656, 270 24. 02 24. 03 1 NCOME FROM UNCONSOLI DATED ENTITIES 18, 590 24. 03 24. 05 OTHER NONOPERATING 20, 380 24. 05 24. 06 CONSOLI DATI NG AMT (BI LLING ARRANGE) 1, 501, 251 24. 06 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 06 24. 08 STATE PROGRAM REVENUE 59, 397 24. 08 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 26. 00 Total other income (sum of lines 25) 56,555, 538 26. 00 27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURI NG & NONRECURRI NG EXPENSE 27. 02 27. 02 28. 00 Total other expenses (sum of line 27	20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20. 00
23.00 Governmental appropriations 0 23.00 24.00 UNREALIZED GAIN ON INVESTMENTS -24, 313, 499 24.00 24.01 0 24.01 0 24.01 24.02 MI SCELLANEOUS REVENUE 656, 270 24.02 24.03 1NCOME FROM UNCONSOLIDATED ENTITIES 18, 590 24.04 24.04 INCOME FROM UNCONSOLIDATED ENTITIES 18, 590 24.04 24.05 OTHER NONOPERATING 20, 380 24.05 24.06 CONSOLIDATING AMT (BILLING ARRANGE) 1, 501, 251 24.06 24.07 GOVT CLNC INCENTIVE REV 537, 117 24.07 24.08 STATE PROGRAM REVENUE 59, 397 24.08 24.09 GAIN ON SALE OF PPE 49, 623 24.09 25.00 Total other income (sum of lines 6-24) 56, 550, 538 26.00 27.00 LOSS ON UNCONSOLIDATED ENTITIES 903, 987 27.00 27.01 INTEREST RATE SWAP LOSS 2, 015 27.01 27.02 RESTRUCTURING & NONRECURRING EXPENSE 27, 887 27.02 27.03 DONATIONS 210, 700 27.03 28.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 28.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00 29.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00	21.00	Rental of vending machines	0	21. 00
24. 00 24. 01 UNREALI ZED GAIN ON INVESTMENTS -24, 313, 499 24. 00 24. 01 0 24. 01 0 24. 01 0 24. 01 0 24. 01 0 24. 03 0 24. 03 0 24. 03 0 24. 03 0 24. 03 0 24. 03 0 24. 03 0 24. 03 0 24. 03 0 24. 05 0 24. 02 0 24. 03 0 24. 05 0 24. 05 0 24. 05 0 24. 05 0 24. 05 0 24. 06 0 24. 06 0 24. 07 GOVT CLNC INCENTIVE REV 18, 590 24. 06 24. 06 24. 06 24. 06 24. 06 24. 06 25. 00 0 24. 08 STATE PROGRAM REVENUE 0 537, 117 24. 07 24. 08 STATE PROGRAM REVENUE 0 59, 397 24. 08 24. 09 25. 00 Total other income (sum of lines 6-24) 0 25. 00 Total (line 5 plus line 25) 0 25. 00 Total (line 5 plus line 25) 0 25. 00 Total (line 5 plus line 25) 0 27. 00 LOSS ON UNCONSOLI DATED ENTITIES 0 903, 987 27. 00 27. 01 INTEREST RATE SWAP LOSS 0 27. 00 ERSTRUCTURING & NONRECURRING EXPENSE 0 27, 887 27. 02 27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts)	22. 00	Rental of hospital space	680, 142	22. 00
24. 01 24. 02 MI SCELLANEOUS REVENUE 656, 270 24. 02 24. 03 24. 04 I NCOME FROM UNCONSOLIDATED ENTITIES 0 24. 03 24. 05 OTHER NONOPERATING 20, 380 24. 05 24. 06 CONSOLIDATING AMT (BILLING ARRANGE) 1, 501, 251 24. 06 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 07 24. 09 STATE PROGRAM REVENUE 59, 397 24. 08 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 26. 00 Total (line 5 plus line 25) 56, 550, 538 26. 00 27. 00 LOSS ON UNCONSOLIDATED ENTITIES 903, 987 27. 00 27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURING & NONRECURRING EXPENSE 27, 87 27. 02 27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	23.00	Governmental appropriations	0	23. 00
24. 02 MISCELLANEOUS REVENUE 656, 270 24. 02 24. 03 0 24. 03 24. 04 INCOME FROM UNCONSOLIDATED ENTITIES 18, 590 24. 04 24. 05 OTHER NONOPERATING 20, 380 24. 05 24. 06 CONSOLIDATING AMT (BILLING ARRANGE) 1, 501, 251 24. 05 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 07 24. 08 STATE PROGRAM REVENUE 59, 397 24. 08 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 26. 00 Total (line 5 plus line 25) 56, 550, 538 26. 00 27. 01 LOSS ON UNCONSOLIDATED ENTITIES 903, 987 27. 00 27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURING & NONRECURRING EXPENSE 27, 887 27. 02 27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	24.00	UNREALIZED GAIN ON INVESTMENTS	-24, 313, 499	24. 00
24. 03 0 24. 03 24. 04 INCOME FROM UNCONSOLIDATED ENTITIES 18, 590 24. 04 24. 05 OTHER NONOPERATING 20, 380 24. 05 24. 06 CONSOLIDATING AMT (BILLING ARRANGE) 1, 501, 251 24. 06 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 06 24. 08 STATE PROGRAM REVENUE 59, 397 24. 08 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 26. 00 Total (line 5 plus line 25) 56, 550, 538 26. 00 27. 01 INTEREST RATE SWAP LOSS 903, 987 27. 00 27. 02 RESTRUCTURING & NONRECURRING EXPENSE 27, 887 27. 02 27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	24. 01		0	24. 01
24. 04 INCOME FROM UNCONSOLIDATED ENTITIES 18, 590 24. 04 24. 05 OTHER NONOPERATING 20, 380 24. 05 24. 06 CONSOLIDATING AMT (BILLING ARRANGE) 1, 501, 251 24. 06 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 07 24. 08 STATE PROGRAM REVENUE 59, 397 24. 07 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 26. 00 Total (line 5 plus line 25) 56, 550, 538 26. 00 27. 01 LOSS ON UNCONSOLIDATED ENTITIES 903, 987 27. 00 27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURING & NONRECURRING EXPENSE 27. 02 27. 02 27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	24. 02	MI SCELLANEOUS REVENUE	656, 270	24. 02
24. 05 OTHER NONOPERATING 20, 380 24. 05 24. 06 CONSOLI DATING AMT (BILLING ARRANGE) 1, 501, 251 24. 06 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 07 24. 08 STATE PROGRAM REVENUE 59, 397 24. 09 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 26. 00 Total (line 5 plus line 25) 56, 550, 538 26. 00 27. 01 LOSS ON UNCONSOLIDATED ENTITIES 903, 987 27. 00 27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURING & NONRECURRING EXPENSE 27, 387 27. 02 27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	24. 03		0	24. 03
24. 06 CONSOLIDATING AMT (BILLING ARRANGE) 1, 501, 251 24. 06 24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 07 24. 08 STATE PROGRAM REVENUE 59, 397 24. 08 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 26. 00 Total (line 5 plus line 25) 56, 550, 538 26. 00 27. 01 LOSS ON UNCONSOLI DATED ENTITIES 903, 987 27. 00 27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURI NG & NONRECURRI NG EXPENSE 27, 887 27. 02 27. 03 DONATI ONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	24.04	INCOME FROM UNCONSOLIDATED ENTITIES	18, 590	24. 04
24. 07 GOVT CLNC INCENTIVE REV 537, 117 24. 07 24. 08 STATE PROGRAM REVENUE 59, 397 24. 08 24. 09 GAIN ON SALE OF PPE 49, 623 24. 09 25. 00 Total other income (sum of lines 6-24) -1, 582, 606 25. 00 26. 00 Total (line 5 plus line 25) 56, 550, 538 26. 00 27. 01 LOSS ON UNCONSOLI DATED ENTITIES 903, 987 27. 01 27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURI NG & NONRECURRI NG EXPENSE 27, 887 27. 02 27. 03 DONATI ONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	24.05	OTHER NONOPERATING	20, 380	24. 05
24.08 STATE PROGRAM REVENUE 59, 397 24.08 24.09 GAIN ON SALE OF PPE 49, 623 24.09 25.00 Total other income (sum of lines 6-24) -1, 582, 606 25.00 26.00 Total (line 5 plus line 25) 56, 550, 538 26.00 27.00 LOSS ON UNCONSOLIDATED ENTITIES 903, 987 27.00 27.01 INTEREST RATE SWAP LOSS 2, 015 27.01 27.02 RESTRUCTURI NG & NONRECURRI NG EXPENSE 27, 887 27.02 27.03 DONATI ONS 210, 700 27.03 28.00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28.00	24.06	CONSOLI DATI NG AMT (BILLI NG ARRANGE)	1, 501, 251	24. 06
24.09 GAIN ON SALE OF PPE 49, 623 24.09 25.00 Total other income (sum of lines 6-24) -1,582,606 25.00 26.00 Total (line 5 plus line 25) 56,550,538 26.00 27.00 LOSS ON UNCONSOLIDATED ENTITIES 903,987 27.00 27.01 INTEREST RATE SWAP LOSS 2,015 27.01 27.02 RESTRUCTURING & NONRECURRING EXPENSE 27,887 27.02 27.03 DONATIONS 210,700 27.03 28.00 Total other expenses (sum of line 27 and subscripts) 1,144,589 28.00	24.07	GOVT CLNC INCENTIVE REV	537, 117	24. 07
25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25) 27.00 LOSS ON UNCONSOLIDATED ENTITIES 27.01 INTEREST RATE SWAP LOSS 27.02 RESTRUCTURING & NONRECURRING EXPENSE 27.03 DONATIONS 28.00 Total other expenses (sum of line 27 and subscripts) 25.00 56,582,606 25.00 56,550,538 26.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 27.01 2	24. 08	STATE PROGRAM REVENUE	59, 397	24. 08
26.00 Total (line 5 plus line 25) 56,550,538 26.00 27.00 LOSS ON UNCONSOLIDATED ENTITIES 903,987 27.00 27.01 INTEREST RATE SWAP LOSS 2,015 27.01 27.02 RESTRUCTURING & NONRECURRING EXPENSE 27,887 27.02 27.03 DONATIONS 210,700 27.03 28.00 Total other expenses (sum of line 27 and subscripts) 1,144,589 28.00	24. 09	GAIN ON SALE OF PPE	49, 623	24. 09
27. 00 LOSS ON UNCONSOLIDATED ENTITIES 903, 987 27. 00 27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURING & NONRECURRING EXPENSE 27, 887 27. 02 27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	25.00	Total other income (sum of lines 6-24)	-1, 582, 606	25. 00
27. 01 INTEREST RATE SWAP LOSS 2, 015 27. 01 27. 02 RESTRUCTURING & NONRECURRING EXPENSE 27, 887 27. 02 27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	26.00	Total (line 5 plus line 25)	56, 550, 538	26. 00
27. 02 RESTRUCTURING & NONRECURRING EXPENSE 27, 887 27. 02 27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	27. 00	LOSS ON UNCONSOLIDATED ENTITIES	903, 987	27. 00
27. 03 DONATIONS 210, 700 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 1, 144, 589 28. 00	27. 01	INTEREST RATE SWAP LOSS	2, 015	27. 01
28.00 Total other expenses (sum of line 27 and subscripts) 1,144,589 28.00	27. 02	RESTRUCTURING & NONRECURRING EXPENSE	27, 887	27. 02
	27. 03	DONATIONS	210, 700	27. 03
29.00 Net income (or loss) for the period (line 26 minus line 28) 55,405,949 29.00	28. 00	Total other expenses (sum of line 27 and subscripts)	1, 144, 589	28. 00
	29. 00	Net income (or loss) for the period (line 26 minus line 28)	55, 405, 949	29. 00

CVICII	n Financial Systems ST. VINCENT CAR LATION OF CAPITAL PAYMENT	Provider CCN: 150157	Period:	u of Form CMS-2 Worksheet L	2552-10
CALCULATION OF CALITAL PAINMENT		Provider CCN: 150157	From 07/01/2014 To 06/30/2015	Parts I-III Date/Time Pre 11/30/2015 9:	
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				İ
1. 00	Capital DRG other than outlier			857, 013	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2. 00	Capital DRG outlier payments			7, 364	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructi ons)	44. 52	
4.00	Number of interns & residents (see instructions)			0.00	
5. 00 6. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the	ho cum of lines 1 and 1 01	columns 1 and	0.00	
8.00	1.01) (see instructions)	ne sum of fittes fand f.of	, corumns i and	U	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A	natient days (Worksheet F	part A line	3. 31	7.00
	30) (see instructions)		, , , , , , , , , , , , , , , , , , , ,		
8. 00	Percentage of Medicaid patient days to total days (see insti	ructions)		12. 56	8.00
9. 00	Sum of lines 7 and 8			15. 87	
10. 00		ns)		3. 26	
11. 00				27, 939	
12. 00	Total prospective capital payments (see instructions)			892, 316	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
5. 00	Total Impatrent program capital cost (Time 3 x Time 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1 66				-	
	Program inpatient capital costs (see instructions)	(!+)		0	
2.00	Program inpatient capital costs for extraordinary circumstant	nces (see instructions)		0	2.00
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2)	nces (see instructions)		0	2. 00 3. 00
2.00 3.00 4.00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	nces (see instructions)		0 0 0.00	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	,		0 0 0. 00 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	instructions)	line 6)	0 0 0.00	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	instructions)	line 6)	0 0.00 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary	instructions) ry circumstances (line 2 x	line 6)	0 0.00 0 0.00 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to	instructions) ry circumstances (line 2 x licable) capital payments (line 8	less line 9)	0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	instructions) ry circumstances (line 2 x licable) capital payments (line 8 capital payment (from pri	less line 9) or year	0 0.00 0.00 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital minimum payment level minimum payment level to capital minimum payment level minimum payment minimum payment level minim	instructions) ry circumstances (line 2 x licable) capital payments (line 8 capital payment (from pri payments (line 10 plus lin	less line 9) or year e 11)	0 0.00 0.00 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
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	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, entertions).	instructions) ry circumstances (line 2 x licable) capital payments (line 8 capital payment (from pri payments (line 10 plus line er the amount on this line	less line 9) or year e 11)	0 0.00 0 0.00 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, entocarryover of accumulated capital minimum payment level over	instructions) ry circumstances (line 2 x licable) capital payments (line 8 capital payment (from pri payments (line 10 plus line er the amount on this line	less line 9) or year e 11)	0 0.00 0.00 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	instructions) ry circumstances (line 2 x licable) capital payments (line 8 capital payment (from pri payments (line 10 plus line er the amount on this line capital payment for the f	less line 9) or year e 11)	0 0.00 0 0.00 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 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	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, ento Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see in	instructions) ry circumstances (line 2 x licable) capital payments (line 8 capital payment (from pri payments (line 10 plus line er the amount on this line capital payment for the f	less line 9) or year e 11)	0 0.00 0 0.00 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00