Health Financi	al Systems	DEACONESS HOS	ρτται		In Lie	u of Form CMS-2	552-10
This report is	s required by law (42 USC 1395g:	42 CFR 413.20(b)). Fai	lure to repor	t can resu	lt in all interim	FORM APPROVED	
payments made	since the beginning of the cost	reporting period being	deemed overp	ayments (42	2 USC 1395g).	OMB NO. 0938-0	050
HOSPITAL AND H	HOSPITAL HEALTH CARE COMPLEX COS	T REPORT CERTIFICATION	Provider C	CN: 150082	Period:	worksheet S	
AND SETTLEMENT	F SUMMARY		1 N.		From 10/01/2014 To 09/30/2015	Date/Time Prep	arad
					10 09/30/2013	2/26/2016 11:4	7 am
PART T - COST	REPORT STATUS						
Provider	1. [ X ] Electronically filed co	ost report			Date: 2/26/20	16 Time: 11	:47 am
use only	2. [ ] Manually submitted cost	report					
	3.[ 0 ] If this is an amended	report enter the number	of times the	provider r	esubmitted this c	ost report	
	4.[F]Medicare Utilization. I	Enter "F" for full or "L	" for low.				
Contractor		. Date Received:			NPR Date:	an Cada	٨
use only	<ul> <li>(1) As Submitted 7</li> <li>(2) Settled without Audit 8</li> </ul>	. Contractor No.	n this Provid	11.0	Contractor's Vendo	or code:	nter 4
		. [ N ] Final Report for	this Provider	CCN CCN	number of tim	nes reopened = (	)-9.
	(J) Sellieu Willi Audie	. [ It ] i mai nepore for			ridino er or er		
	<ul><li>(4) Reopened</li><li>(5) Amended</li></ul>						
	(5) Amerided						
PART II - CER	TIFICATION						
ADMINISTRATIVE	TION OR FALSIFICATION OF ANY INF E ACTION, FINE AND/OR IMPRISONME	NT UNDER FEDERAL LAW.	FURTHERMORE,	IF SERVICES	S IDENTIFIED IN T	HIS REPORT WERE	
	ROCURED THROUGH THE PAYMENT DIRE E ACTION, FINES AND/OR IMPRISONN		KICKBACK OR	WERE OTHER	WISE ILLEGAL, CRI	MINAL, CIVIL AN	D
	CERTIFICATION BY OFFICER OR	ADMINISTRATOR OF PROVIDE	ER(S)				
						anner ann an ann an	
I HER	EBY CERTIFY that I have read the	e above certification st	atement and t	that I have	examined the acc	ompanying	
elect	ronically filed or manually sub	nitted cost report and t	he Balance Sh	neet and St	atement of Revenu	le and	
Expen	ses prepared by DEACONESS HOSPI	TAL ( 150082 ) for the c	ost reporting	g period be	ginning 10/01/201	4 and ending	
09/30	/2015 and to the best of my know	wledge and belief, this	report and st	tatement ar	e true, correct,	complete and	
prepa	red from the books and records ther certify that I am familiar	of the provider in accor	dance with a	opiicable i	nstructions, exce	pt as noted.	
I fur	ces, and that the services iden	with the laws and regul	ations regard	ided in com	nliance with such	laws and	
	ations.	crited in chrs cosc repo	re were prov	ucu m com	private treating and		
regui	actors.		Sec. 1	11 ,	1 1 -		
En en la	ution Information	(Signed)	U	henry	h VILL		
Encry	ption Information Date: 2/26/2016 Time: 11:47 am		office	r or Admini	strator of Provid	der(s)	
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rwU20	BZC1L0FJ3Kt						
			Title >	<b>VIII</b>			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	Part A 2.00	Part B 3.00	HIT 4.00	5.00	
	II - SETTLEMENT SUMMARY	1.00	2.00	3.00	4.00	5.00	1 00
1.00 Hospita	al	1.00	2.00		4.00	5.00	1.00
1.00 Hospita 2.00 Subprov	al vider – IPF	00	2.00 -851,802 8,341	3.00	4.00 712 0 0	5.00 0 0	2.00
1.00 Hospita 2.00 Subprov 3.00 Subprov	al vider – IPF vider – IRF	1.00	2.00 -851,802 8,341 0	3.00	4.00 712 0 0 0	5.00 0 0 0	2.00 3.00
1.00 Hospita 2.00 Subprov 3.00 Subprov 5.00 Swing b	al vider – IPF vider – IRF bed – SNF		2.00 -851,802 8,341	3.00	4.00 712 0 0	5.00 0 0 0 0 0	2.00 3.00 5.00
1.00 Hospita 2.00 Subprov 3.00 Subprov 5.00 Swing b 6.00 Swing b	al vider – IPF vider – IRF bed – SNF bed – NF		2.00 -851,802 8,341 0 0	3.00	4.00 712 0 0 0	5.00 0 0 0 0 0 0 0	2.00 3.00 5.00 6.00
1.00 Hospita 2.00 Subprov 3.00 Subprov 5.00 Swing b 6.00 Swing b 9.00 HOME HB	al vider – IPF vider – IRF bed – SNF		2.00 -851,802 8,341 0 0	-69,7	4.00 712 0 0 0 0 0 0	5.00 0 0 0 0 0 0 0 0 0	2.00 3.00 5.00 6.00 9.00
1.00 Hospita 2.00 Subprov 3.00 Subprov 5.00 Swing H 6.00 Swing H 9.00 HOME HH 200.00 Total	al vider – IPF vider – IRF bed – SNF bed – NF EALTH AGENCY I		2.00 -851,802 8,341 0 0 0 -843,461	-69,7	4.00 712 0 0 0 0 0 712 0	5.00 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 5.00 6.00
1.00 Hospita 2.00 Subprov 3.00 Subprov 5.00 Swing b 6.00 Swing b 9.00 HOME HE 200.00 Total	al vider - IPF vider - IRF bed - SNF bed - NF EALTH AGENCY I unts represent "due to" or "due	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 -851,802 8,341 0 0 -843,461 ogram for the	3.00 -69,7 -69,7	4.00 712 0 0 0 0 712 0 712 0 f the above comp	5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 5.00 6.00 9.00 200.00
1.00 Hospita 2.00 Subprov 3.00 Subprov 5.00 Swing B 6.00 Swing B 9.00 HOME HE 200.00 Total The above amo	al vider - IPF vider - IRF bed - SNF bed - NF EALTH AGENCY I unts represent "due to" or "due the Paperwork Reduction Act of	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 -851,802 8,341 0 0 -843,461 ogram for the ujred to resp	-69,7 -69,7 e element o pond to a c	4.00 712 0 0 0 712 0 712 0 f the above compl ollection of info	5.00 0 0 0 0 ex indicated. prmation unless	2.00 3.00 5.00 6.00 9.00 200.00
1.00 Hospita 2.00 Subprov 3.00 Subprov 5.00 Swing b 6.00 Swing b 9.00 HOME HE 200.00 Total The above amo According to displays a va	al vider - IPF vider - IRF bed - SNF bed - NF EALTH AGENCY I unts represent "due to" or "due the Paperwork Reduction Act of lid OMB control number. The ya	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 -851,802 8,341 0 0 -843,461 0 0 0 -843,461 0 0 cram for the uired to res or this info	-69,7 -69,7 e element o pond to a c rmation col	4.00 712 0 0 0 0 0 0 0 0 12 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 0 0 0 0 0 0 ex indicated. ormation unless 050. The time	2.00 3.00 5.00 6.00 9.00 200.00
1.00 Hospita 2.00 Subprov 3.00 Subprov 5.00 Swing H 9.00 HOME HH 200.00 Total The above amo According to displays a va required to c	al vider - IPF vider - IRF bed - SNF bed - NF EALTH AGENCY I unts represent "due to" or "due the Paperwork Reduction Act of lid OMB control number. The va omplete and review the informat search existing resources. gat	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 -851,802 8,341 0 0 -843,461 ogram for the uired to resp or this info ted 673 hours complete and	-69,7 -69,7 e element o pond to a c rmation col s per respo d review th	4.00 712 0 0 0 0 0 0 0 1 0 1 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 5.00 9.00 200.00 it
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1.00 Hospita 2.00 Subprov 3.00 Subprov 5.00 Swing B 6.00 Swing B 9.00 HOME HB 200.00 Total The above amo According to displays a va required to c instructions, have any comm 7500 Security	al vider - IPF vider - IRF bed - SNF bed - NF EALTH AGENCY I unts represent "due to" or "due the Paperwork Reduction Act of lid OMB control number. The va omplete and review the informat search existing resources, gat wents concerning the accuracy of Boulevard Attn: PBA Report Cl	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 -851,802 8,341 0 0 0 -843,461 0 0 0 -843,461 0 0 0 0 0 0 0 0 0 0 0 0 0	-69,7 -69,7 e element o pond to a c rmation col s per respo d review th for improv Baltimore,	4.00 712 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 5.00 6.00 9.00 200.00 it
1.00 Hospita 2.00 Subprov 3.00 Subprov 5.00 Swing H 6.00 Swing H 9.00 HOME HH 200.00 Total The above amo According to displays a va required to c instructions, have any comm 7500 Security Please do not	al vider - IPF vider - IRF bed - SNF bed - NF EALTH AGENCY I unts represent "due to" or "due the Paperwork Reduction Act of lid OMB control number. The va omplete and review the informat search existing resources. gat	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 -851,802 8,341 0 0 0 -843,461 ogram for the uired to resp or this info ted 673 hours complete and suggestions op C4-26-05, r any document	-69,7 -69,7 e element o pond to a c rmation col s per respo d review th for improv Baltimore, nts contain	4.00 712 0 0 0 0 0 0 0 0 0 1 1 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 5.00 6.00 9.00 200.00 it

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.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DAT	Α	Provi c	ler CCN:		Period: From 10/01,	/2014	Workshe Part I	eet S-2	
									Date/Ti 2/26/20		
	1.00	2.0	00	3	. 00			4.00	2/20/20	510 11.	
	Hospital and Hospital Health Care Co										
00	Street: 600 MARY STREET	PO Box: State: IN	. 7:	n Codo	47747	Count		DCU			1.
00	City: EVANSVILLE	Component Nam		p Code: CCN	CBSA	Provi der	y: VANDERBU		ent Syst	em (P.	2.
					Number	Туре	Certified		, 0, or		
								V	XVIII	XIX	]
		1.00	2	. 00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospital and Hospital-Based Componen Hospital	T I denti fi cati on: DEACONESS HOSPI TAI	15	0082	21780	1	06/02/1966	N	Р	Р	3.
00	Subprovi der – IPF	DEACONESS PSYCHIA		S082	21780	4	10/01/2009		P	P	4.
		UNI T									
00	Subprovider - IRF										5
)0 )0	Subprovider - (Other) Swing Beds - SNF										6
10	Swing Beds - NF										8
0	Hospi tal -Based SNF										9
00	Hospital-Based NF										10
00	Hospital-Based OLTC										11
00	Hospital-Based HHA	DEACONESS - HHA	15	7132	21780		11/09/1984	N	P	P	12
00 00	Separately Certified ASC Hospital-Based Hospice	DEACONESS - HOSPI	CF 15	1512	21780		02/06/1991				13   14
00	Hospital-Based Health Clinic - RHC		- 10		21700		32, 00, 1771				15
00	Hospital -Based Health Clinic - FQHC										16
00	Hospital-Based (CMHC) I										17
00	Renal Dialysis										18
00	Other						From:		To		19
							1.00		2. (		1
00	Cost Reporting Period (mm/dd/yyyy)						10/01/2		09/30/		20
00	Type of Control (see instructions)							2			21
~~	Inpatient PPS Information Does this facility qualify and is it			h			Y		N	1	
00	share hospital adjustment, in accord						T		IN IN		22
	for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en					<i>,</i> , ,					
01	Did this hospital receive interim un						N		Y		22
	period? Enter in column 1, "Y" for y reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)	-p-:									
02	Is this a newly merged hospital that						N		N		22
	determined at cost report settlement	•	· ·			2	5				
	or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for										
	or after October 1.			03110	Sortring	period of					
03	Did this hospital receive a geograph	ic reclassificatio	on from url	ban to i	rural as	s a resul	t N		N		22
	of the OMB standards for delineating										
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column										
	cost reporting period occurring on o	r after October 1.	(see ins	truction	ne por tr ns) Does	s this	3				
	hospital contain at least 100 but no						n				
_	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N"	for no.								
00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i							3	N		23
	method of identifying the days in th										
	used in the prior cost reporting per										
			In-State	In-Sta	ite O	ut-of	Out-of M	ledi ca		ther	
			Medi cai d	Medi ca		tate		IMO da	-	li cai d	
			oaid days	el i gi b unpai			Medicaid eligible			lays	
		F		anput	·		unpai d				
		F		days					e	5.00	1
		1	1.00	days 2. 00		3. 00	4.00	5.00			
00	If this provider is an IPPS hospital	, enter the	<u>1. 00</u> 6, 821			3. 00 2, 271	4.00 570		576	200	24
00	in-state Medicaid paid days in colum	, enter the n 1, in-state			) :					200	24
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	, enter the n 1, in-state umn 2,			) :					200	24
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c	, enter the n 1, in-state umn 2, olumn 3,			) :					200	24
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	, enter the n 1, in-state umn 2, olumn 3, d days in column			) :					230	24
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	, enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6.	6, 821	2. 00	406	2, 271	570		576	230	
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th	, enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state		2.00	) :					200	
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in 1 f this provider is an IRF, enter th Medicaid paid days in column 1, the	, enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state	6, 821	2.00	406	2, 271	570		576	230	
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in 1f this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	, enter the n 1, in-state umn 2, ol umn 3, d days in col umn t unpaid days in col umn 6. e in-state in-state umn 2,	6, 821	2.00	406	2, 271	570		576	230	
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in 1 f this provider is an IRF, enter th Medicaid paid days in column 1, the	, enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state	6, 821	2.00	406	2, 271	570		576	230	24

Heal th	Financial Systems DEAG	CONESS	HOSPI TAL		I	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der		eriod: rom 10/01, p 09/30,		Workshe Part I Date/Ti 2/26/20	me Pre	pared:
					Urban/Rui 1.00			Geogr	
26.00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for			jinning of the	1.00	1	2.0	0	26.00
27.00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	age) sta - "2" fe	atus at the enc or rural. If ap			1			27.00
35.00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00		Endi 2. (		-
36.00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number					36.00
	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the n				0			37.00
38. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
					Y/N 1.00		Y/ 2. (		-
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec	)? Ento quiremen	er in column 1 nts in accordar	"Y" for yes nce with 42	N		N		39.00
	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob ro in column 2, for discharges on after October	n adjus ber 1. l	tment? Enter "Y Enter "Y" for y	(" for yes or	N		N		40.00
	no in column 2, for discharges on or after October 1.	(see	Instructions)			V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital					1.00		3.00	
45.00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for (	di sproporti onat	e share in acc	ordance	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	eption . L, P	for extraordina t. III and Wkst	ary circumstanc L-1, Pt. I t	es hrough	N	N	N	46.00
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals				10.	N N	N N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in or "N" for no.	approv	ed GME programs	s? Enter "Y" f	or yes	Y			56.00
57.00	IF line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	yes o	r "N" for no ir	n column 1. If	column 1	N			57.00
	for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	(", comp , if a	plete Worksheet pplicable.	E-4. If colum	n 2 is				
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15–1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	comple	te Wkst. D-5.		IS	N N			58.00 59.00
60.00	Are you claiming nursing school and/or allied health	costs	for a program t	hat meets the		Y			60.00
	provider-operated criteria under §413.85? Enter "Y"	Y/N	s or "N" for no IME	Direct GME	IME		Direc	t GME	
		1.00	2.00	3.00	4.00	)	5. (	00	-
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0. OC	0.00					61.02
61. 03	and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care		0.00	0.00					61.03
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00					61.04
61. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		O. OC	0.00					61.05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		O. OC	0.00					61.06
		1	I	1	1	I			1

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA Provi der	FI		2/26/2016 11:	pared:
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
<ol> <li>Of the FTEs in line 61.05, special ty, if any, and the number for each new program. (see instrucol umn 1, the program name, enter program code, enter in col umn 3, unweighted count and enter in col FTE unweighted count.</li> <li>Of the FTEs in line 61.05, special ty, if any, and thresidents for each expanded progrinstructions) Enter in col umn 1, enter in col umn 2, the program cod 3, the IME FTE unweighted count ad, direct GME FTE unweighted court</li> </ol>	of FTE residents actions) Enter in in column 2, the the IME FTE umn 4, direct GME by each expanded are number of FTE am. (see the program name, ade, enter in column ind enter in column			0.00		61. 10
					1.00	
ACA Provisions Affecting the Heal	th Resources and Se	rvices Administration	(HRSA)		1.00	
2.00 Enter the number of FTE residents	that your hospital	trained in this cost		od for which	0.00	62.00
your hospital received HRSA PCRE 2.01 Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Res	that rotated from a iod of HRSA THC proc	a Teaching Health Cen <sup>.</sup> gram. (see instruction		your hospital	0.00	62. 01
3.00 Has your facility trained resider "Y" for yes or "N" for no in colu	its in nonprovider se	ettings during this co	instructions)		Y	63.00
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te 1.00	2.00	3.00	
Section 5504 of the ACA Base Year						
4.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facilit per of unweighted nor ations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 F 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	AMI LY PRACTI CE	1350	2.30	16. 16	0. 124594	63. UL

Health Financial Systems		DEA	CONESS HOSPI	TAL		I	n Lie	u of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALT	TH CARE COMP	LEX IDENTIFICATION DA	ATA	Provi der		eriod: rom 10/01, o 09/30,		Workshe Part I Date/Ti 2/26/20	me Pre	pared:
					Unweighted FTEs Nonprovider Site	Unwei gh FTEs Hospi t	n al	Ratio (c (col. 1 2)	:ol. 1/ + col. )	<u> </u>
Section 5504 of the	ACA Current	Year FTF Residents i	n Nonprovide	er Settina	1.00	2.00 2.00		3.0 na perio		
66.00 Enter in column 1 the FTEs attributable to Enter in column 2 the FTEs that trained in	<u>r July 1, 20</u> e number of rotations o e number of your hospit	010 unweighted non-prima occurring in all nonp unweighted non-prima al. Enter in column	ry care resi rovider sett ry care resi 3 the ratio	dent i ngs. dent	0.00		0.00	<u> </u>	000000	66. 00
(column 1 divided by	(column 1 +	column 2)). (see in: Program Name	structions) Program	Code	Unweighted	Unwei gh	ted	Ratio (c	ol 3/	
					FTĔs Nonprovider Site	FTES Hospit	n	(col. 3 4)	+ col.	
		1.00	2. (	00	3.00	4.00		5.C		(7.00
67.00 Enter in column 1, ti name associated with your primary care pro- which you trained re- Enter in column 2, ti code. Enter in column number of unweighted care FTE residents a to rotations occurri non-provider setting column 4, the number unweighted primary c. resident FTEs that ti your hospital. Enter 5, the ratio of (colu divided by (column 3 4)). (see instruction	each of ograms in sidents. he program n 3, the primary ttributable ng in all s. Enter in of are rained in in column umn 3 + column	FAMILY PRACTICE	1350		4.50	)	16. 01	0.	219405	67.00
Inpatient Psychiatri	c Facility P	PPS					1.00	) 2.00	3.00	
70.00 Is this facility an	Inpatient Ps	sychiatric Facility (	IPF), or doe	s it conta	ain an IPF subp	provi der?	Y			70.00
42 CFR 412.424(d)(1) program in accordance Column 3: If column (see instructions)	mn 1: Did th iled on or b (iii)(c)) Co e with 42 CF 2 is Y, indi	ne facility have an appefore November 15, 20 Jumn 2: Did this fac R 412.424 (d)(1)(iii) cate which program ye	004? Enter ility train )(D)? Enter	"Y" for ye residents "Y" for ye	es or "N" for r in a new teach es or "N" for r	no. (see ni ng no.	N	Ν	0	71.00
Inpatient Rehabilita 75.00 Is this facility an			y (IRF), or	does it co	ontain an IRF		N			75.00
76.00 If line 75 yes: Colum recent cost reporting no. Column 2: Did th CFR 412.424 (d)(1)(i	"Y <sup>"</sup> for yes mn 1: Did th g period end is facility ii)(D)? Ente	and "N" for no. he facility have an a ling on or before Nove train residents in a	pproved GME ember 15, 20 new teachir for no. Col	teaching µ 04? Enter g program umn 3: If	program in the "Y" for yes or in accordance column 2 is Y,	"N" for with 42			0	76.00
								1. C	0	
Long Term Care Hospi 80.00  s this a long term 81.00  s this a LTCH co-lo "Y" for yes and "N"	care hospita cated within					period? E	nter	N N		80. 00 81. 00
TEFRA Providers85.00Is this a new hospit86.00Did this facility esite\$412.40(5)(1)(1)(1)(2)	tablish a ne	w Other subprovider	(excluded un				no.	N		85. 00 86. 00
§413.40(f)(1)(ii)? 87.00 Is this hospital a	subclause (I			n 1886(d)	(1)(B)(iv)(II)?	? Enter "Y		N		87.00
for yes or "N" for n	0.					V		XL	x	
						1.00		2.0		
90.00 Title V and XIX Serv 90.00 Does this facility have yes or "N" for no in	ave title V		hospital se	rvi ces? Ei	nter "Y" for	N		Y		90.00
91.00 Is this hospital rei	mbursed for	title V and/or XIX t				N		N		91.00
full or in part? Ent 92.00 Are title XIX NF pat								N		92.00
instructions) Enter 93.00 Does this facility o	"Y" for yes perate an IC	or"N" for no in the F/IID facility for p	appl i cabl e	column.	, ,	N		N		93.00
94.00 Does title V or XIX applicable column.			or yes, and	"N" for no	o in the	N		Ν		94.00

Health Financial Systems         DEACONESS           HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HOSPI TAL Provi der		eri od:	Lieu of Form ( Worksheet	
		T	rom 10/01/20 09/30/20		
			V 1.00	XI X 2.00	
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.					0.00 95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers	plicable colum	n.	0	. 00	0.00 97.00
105.00 Does this hospital qualify as a critical access hospital (C 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	N N		105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost 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.	nn 1. (see inst	ructions) lf	Ν		107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respirato 4.00	bry
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.					109.00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for	N	110.00
Miscellaneous Cost Reporting Information			1	.00 2.00 3	. 00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provide	2. If column 2 i ent for long te	is "E", enter i rm care (incluc	n column les	N	0 115.00
Pub. 15-1, chapter 22, §2208. 1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu			N" for	N Y	116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence po	olicy? Enter 1	if the policy i	s	1	118.00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insuranc	:e
		1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		944, 564			0 118. 01
			1.00	2.00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.	center other	than tha		2.00	
	edule listing c		N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendmen	d Harmless pro n column 1, "Y qualifies for t	ost centers vision in ACA " for yes or he Outpatient		N	119.00
<ul> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> </ul>	d Harmless pro n column 1, "Y qualifies for th ents? (see inst	ost centers vision in ACA " for yes or he Outpatient ructions)	N		
<ul> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA \$3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for</li> </ul>	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to	N		119. 00 120. 00
119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, e	d Harmless pro n column 1, "Y jualifies for th ents? (see inst antable device: for yes and "N" enter the certi	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to for no. If	N N Y		119. 00 120. 00 121. 00
<ul> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column</li> <li>127.00 If this is a Medicare certified heart transplant center, en</li> </ul>	d Harmless pro n column 1, "Y jualifies for th ents? (see inst antable devices for yes and "N" enter the certifient 2.	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date	N N Y		119. 00 120. 00 121. 00 125. 00
<ul> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column</li> <li>127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column</li> </ul>	d Harmless pro n column 1, "Y yualifies for ti antable device: for yes and "N" enter the certifi 2. hter the certifi 2.	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date	N N Y		119.00 120.00 121.00 125.00 126.00
<ul> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column</li> <li>127.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column</li> <li>129.00 If this is a Medicare certified liver transplant center, ent</li> </ul>	d Harmless pro n column 1, "Y jualifies for t antable device: for yes and "N" enter the certif 2. hter the certif 2. tter the certif 2.	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date ication date	N N Y		119.00 120.00 121.00 125.00 126.00 127.00
<ul> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column</li> <li>127.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column</li> <li>129.00 If this is a Medicare certified liver transplant center, ent column 1 and termination date, if applicable, in column</li> <li>129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column</li> </ul>	d Harmless pro n column 1, "Y ualifies for ti antable device: for yes and "N" enter the certifient ther the certifient ther the certifient enter the certifient enter the certifient	vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date ication date cation date in	N N Y		119.00 120.00 121.00 125.00 126.00 127.00 128.00
<ul> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121. 00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>125. 00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126. 00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column</li> <li>127. 00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128. 00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>129. 00 If this is a Medicare certified liver transplant center, ent column 1 and termination date, if applicable, in column</li> <li>129. 00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column</li> <li>130. 00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2.</li> <li>130. 00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2.</li> </ul>	d Harmless pro n column 1, "Y jualifies for th antable device: for yes and "N" enter the certifient anter the certifient ter the certifient enter the certif	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date ication date cation date in tification	N N Y		119.00 120.00 121.00 125.00 126.00 127.00 128.00 129.00
<ul> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column</li> <li>127.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column</li> <li>129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column</li> <li>130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2.</li> </ul>	d Harmless pro n column 1, "Y jualifies for the antable device: for yes and "N" enter the certifient ther the certifient ther the certifient enter the certifient enter the certifient enter the certifient enter the certifient center the certifient enter the certifient enter the certifient enter the certifient enter the certifient enter the certifient of umn 2.	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date ication date cation date in tification ertification	N N Y		119.00 120.00 121.00 125.00 126.00 127.00 128.00 129.00 130.00
<ul> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121. 00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>125. 00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126. 00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column</li> <li>127. 00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128. 00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>129. 00 If this is a Medicare certified liver transplant center, ent column 1 and termination date, if applicable, in column</li> <li>129. 00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column</li> <li>130. 00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2</li> <li>130. 00 If this is a Medicare certified lung transplant center, date in column 1 and termination date, if applicable, in column 2</li> <li>131. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2</li> </ul>	d Harmless pro n column 1, "Y ualifies for ti ents? (see insti- antable device: for yes and "N" enter the certifi- ther the certifi- enter the certifi- enter the certifi- enter the certifi- enter the certifi- cer the certifi- lumn 2. r, enter the certifi- blumn 2. ther the certifi- clumn 2.	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date cation date in tification ertification ication date	N N Y		119.00 120.00 121.00 125.00 126.00 127.00 128.00 129.00 130.00 131.00

Health Financial Systems	DEACONE	SS HOSPI	TAL				In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Provi der	CCN: 1500		eri od:		Worksheet S-2	
					Fr		0/01/2014 9/30/2015	Part I Date/Time Pre	pared:
								2/26/2016 11:	
							1 00	2.00	
All Providers							1.00	2.00	
140.00 Are there any related organization	or home office costs	as defin	ed in CMS	Pub. 15-	1,		Y		140.00
chapter 10? Enter "Y" for yes or "	N" for no in column 1.	lf yes,	and home	office c					
are claimed, enter in column 2 the			e instruct	i ons)			2 00		
1.00 If this facility is part of a chai		2.00	1/1 throu	uab 1/3 t	ho nam	and	3.00	of the	
home office and enter the home off					ne nai		1 4441 633	of the	
141.00Name:	Contractor's Name				ractor	's Nur	mber:		141.00
142.00 Street:	PO Box:								142.00
143.00 Ci ty:	State:			Zip (	Code:				143.00
								1.00	
144.00 Are provider based physicians' cos	ts included in Workshe	et A?						Y	144.00
							1.00	2.00	
145.00 If costs for renal services are cl inpatient services only? Enter "Y"					i.c.		Y		145.00
no, does the dialysis facility inc									
period? Enter "Y" for yes or "N"			111 3 0031	r opor tring	9				
146.00 Has the cost allocation methodolog	y changed from the pre						Ν		146.00
Enter "Y" for yes or "N" for no in		ıb. 15-2,	chapter 4	0, §4020	) If				
yes, enter the approval date (mm/d	u/yyyy) in corunn 2.								
								1.00	
147.00 Was there a change in the statisti								N	147.00
148.00 Was there a change in the order of					c			N	148.00
149.00 Was there a change to the simplifi	ea cost finding method		Part A	Part			itle V	N Title XIX	149.00
			1.00	2.0			3.00	4.00	
Does this facility contain a provi									
or charges? Enter "Y" for yes or "	N" for no for each com	nponent f			B. (S	See 42			
155.00Hospi tal 156.00Subprovi der – TPF			N N	N N			N N	N N	155.00 156.00
157. 00 Subprovi der – TRF			N	N N			N	N	157.00
158. 00 SUBPROVI DER									158.00
159. 00 SNF			N	N			Ν	N	159.00
160.00 HOME HEALTH AGENCY			N	N			N	N	160.00
161.00 CMHC				N			N	N	161.00
								1.00	
Multicampus									
165.00 Is this hospital part of a Multica	mpus hospital that has	one or	more campu	ises in d	i ffere	nt CB	SAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	Co	unty	State	Zip	Code	CBSA	FTE/Campus	
	0		. 00	2.00	3.		4.00	5.00	
166.00 If line 165 is yes, for each								0.00	166.00
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)									
								1.00	-
Health Information Technology (HIT	) incentive in the Ame	rican Po	covery and	1 Pai nyas	tmont	Act		1.00	
167.00 Is this provider a meaningful user						ACI		Y	167.00
168.00 If this provider is a CAH (line 10						enter	the		168.00
reasonable cost incurred for the H									
168.01 If this provider is a CAH and is n						hard	ship		168. 01
exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful u	ser (line 167 is "Y")	andisn	ot a CAH (	line 105	is "N	"), e	nter the	9,99	169.00
transition factor. (see instructio									
							gi nni ng	Endi ng	
170 00 Enton in columns 1 and 0 the SUD I	oginning data and a "	na dat-	for the "	porti			1.00	2.00	170.00
170.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	egrinning date and endi	ng date	ioi the re	por ting		10/	03/2015	12/31/2015	170. 00

Health Financial Systems	DEACONESS HOSP	TAL	In Lieu	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	K I DENTIFICATION DATA	Provider CCN: 150	i od: n 10/01/2014 09/30/2015		repared:
		I		2,20,2010	
				1.00	
171.00 If line 167 is "Y", does this prov Medicare cost plans reported on Wk (see instructions)				N	171.00

00 H V 00 H V 00 I 00 I 00 F C 00 C 0 0 0 0 0 0 0 0 0 0 0 0 0	eneral Instruction: Enter Y for all YES resp m/dd/yyyy format. COMPLETED BY ALL HOSPITALS 'rovider Organization and Operation las the provider changed ownership immediatel reporting period? If yes, enter the date of t das the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "1" for involuntary. s the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel off of rectors through ownership, control, or f relationships? (see instructions) inancial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instru- te the cost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing sche the legal operator of the program?	y prior to the beginning of the change in column 2. (see the Medicare Program? If on and in column 3, "V" for tions, including management , chain home offices, drug d to the provider or its , or members of the board family and other similar pared by a Certified Public Audited, "C" for Compiled, enter date available in ructions. revenues different from yes, submit reconciliation.	f the cost e instructions) Y/N 1.00 N Y Y Y Y Y Y	N	2/26/2016 11 Date 2.00 the V/I 3.00 Date 3.00	1. C
00 H V 00 H V 00 I 00 I 00 F C 00 C 0 0 0 0 0 0 0 0 0 0 0 0 0	<pre>m/dd/yyyy format. OMPLETED BY ALL HOSPITALS rovider Organization and Operation das the provider changed ownership immediatel reporting period? If yes, enter the date of t das the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary. s the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions) inancial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instruc- Are the cost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?</pre>	y prior to the beginning of the change in column 2. (see the Medicare Program? If on and in column 3, "V" for tions, including management , chain home offices, drug d to the provider or its , or members of the board family and other similar pared by a Certified Public Audited, "C" for Compiled, enter date available in ructions. revenues different from yes, submit reconciliation.	f the cost e instructions) Y/N 1.00 N Y Y Y Y Y Y	N Date 2.00 Type 2.00 A	U/I 3.00 Date 3.00	2. C 3. C 4. C
00 H H 7 00 H Y 00 I C 00 C A 00 C A 00 C A 1 t 00 C A 1 t 00 C C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If yes, enter the date of t Has the provider terminated participation in yes, enter in column 2 the date of terminatic yoluntary or "l" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related of directors through ownership, control, or f relationships? (see instructions) inancial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instructions) Account filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	the change in column 2. (see the Medicare Program? If on and in column 3, "V" for tions, including management , chain home offices, drug d to the provider or its , or members of the board family and other similar obared by a Certified Public Audited, "C" for Compiled, enter date available in ructions. revenues different from yes, submit reconciliation.	e instructions) Y/N 1.00 N Y Y Y Y Y Y Y Y	) Date 2.00 2.00 7ype 2.00 A A	3.00 Date 3.00	2. C 3. C 4. C
00 H y 00 I c 0 0 0 0 0 0 0 0 0 0 0 0 0	reporting period? If yes, enter the date of t das the provider terminated participation in yes, enter in column 2 the date of termination voluntary or "1" for involuntary. s the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions) inancial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instru- tors on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	the change in column 2. (see the Medicare Program? If on and in column 3, "V" for tions, including management , chain home offices, drug d to the provider or its , or members of the board family and other similar obared by a Certified Public Audited, "C" for Compiled, enter date available in ructions. revenues different from yes, submit reconciliation.	e instructions) Y/N 1.00 N Y Y Y Y Y Y Y Y	) Date 2.00 2.00 7ype 2.00 A A	3.00 Date 3.00	2. C 3. C 4. C
00 H y 00 I c o o o r 00 FI 00 C A 0 00 A t 00 I C C A 0 0 C C A 0 0 C C C C C C C C C C C C C	Has the provider terminated participation in yes, enter in column 2 the date of terminatic yoluntary or "1" for involuntary. s the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions) inancial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instru- Are the cost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	the Medicare Program? If on and in column 3, "V" for tions, including management , chain home offices, drug d to the provider or its , or members of the board family and other similar oared by a Certified Public Audited, "C" for Compiled, enter date available in ructions. revenues different from yes, submit reconciliation.	Y/N 1.00 N Y Y Y/N 1.00 Y Y Y	Date 2.00 2.00 Type 2.00 A Y/N	3.00 Date 3.00	3. C
00   I c 00   C 00   C A 00   C A 00   C A 0   C C A 0   C C 1   C 0   C C A 0   C C 1   C 0   C	yes, enter in column 2 the date of terminatic voluntary or "l" for involuntary. s the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related of directors through ownership, control, or f relationships? (see instructions) inancial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instru- the cost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	on and in column 3, "V" for tions, including management , chain home offices, drug d to the provider or its , or members of the board Family and other similar out by a Certified Public Audited, "C" for Compiled, enter date available in ructions. revenues different from yes, submit reconciliation.	N Y Y/N 1.00 Y Y Y	2.00 Type 2.00 A Y/N	3.00 Date 3.00	3. C
00   I c 00   C 00   C A 00   C A 00   C A 0   C C A 0   C C 1   C 0   C C A 0   C C 1   C 0   C	yes, enter in column 2 the date of terminatic voluntary or "l" for involuntary. s the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related of ficers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions) inancial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instru- tract encost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing sche the legal operator of the program?	on and in column 3, "V" for tions, including management , chain home offices, drug d to the provider or its , or members of the board Family and other similar out by a Certified Public Audited, "C" for Compiled, enter date available in ructions. revenues different from yes, submit reconciliation.	Y Y/N 1.00 Y Y Y	2.00 A Y/N	3.00	4. (
00   C 00   C 00 0 00 C A 00 C A 00 C C A 00 C t t	<pre>voluntary or "1" for involuntary. s the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions) inancial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instru- tre the cost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing sche the legal operator of the program?</pre>	tions, including management , chain home offices, drug d to the provider or its , or members of the board family and other similar pared by a Certified Public Audited, "C" for Compiled, enter date available in ructions. revenues different from yes, submit reconciliation.	Y/N 1.00 Y Y	2.00 A Y/N	3.00	4. (
00 Fi 00 C 00 A t 00 A t 00 C t	relationships? (see instructions) inancial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr Are the cost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	bared by a Certified Public Audited, "C" for Compiled, enter date available in ructions. revenues different from yes, submit reconciliation.	1.00 Y Y	2.00 A Y/N	3.00	
00 C A 00 C 00 A t 00 C t	inancial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr Are the cost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	Audited, "C" for Compiled, enter date available in uctions. revenues different from yes, submit reconciliation.	1.00 Y Y	2.00 A Y/N	3.00	
00 C A 00 A t 00 C t	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr Are the cost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	Audited, "C" for Compiled, enter date available in uctions. revenues different from yes, submit reconciliation.	1.00 Y Y	2.00 A Y/N	3.00	
00 C A 0 00 A t 00 C t	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr Are the cost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	Audited, "C" for Compiled, enter date available in uctions. revenues different from yes, submit reconciliation.	Y	Y/N	Legal Oper.	
00 A t 00 C t	Are the cost report total expenses and total those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	revenues different from yes, submit reconciliation.			Legal Oper.	5.
t 00 C t	those on the filed financial statements? If y pproved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	yes, submit reconciliation.			Legal Oper.	
00 C t	Column 1: Are costs claimed for nursing scho the legal operator of the program?	pol?Column 2: If yes, is t	the provider is		Legal Oper.	_
00 C	Column 1: Are costs claimed for nursing scho the legal operator of the program?	ool?Column 2: If yes, is t	the provider is	1.00	2.00	
t	the legal operator of the program?	ool?Column 2: If yes, is t	the provider is		2.00	-
			the provider is		N	6.
	Are costs claimed for Allied Health Programs? Vere nursing school and/or allied health proc		ed during the	Y		7.
С	cost reporting period? If yes, see instruction	ons.	Ū.			
	Are costs claimed for Interns and Residents i program in the current cost report? If yes, s		cal education	Y		9.
	Vas an approved Intern and Resident GME progr		the current	Ν		10.
00 A	cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center	rs other than I & R in an Ap	oproved	Y		11.
	Teaching Program on Worksheet A? If yes, see				Y/N	-
					1.00	
	ad Debts s the provider seeking reimbursement for bac	debts2 If ves see instru	stions		Y	12.
	f line 12 is yes, did the provider's bad deb	<b>J</b>		ost reporting	N	13.
	period? If yes, submit copy.					
	fline 12 is yes, were patient deductibles a red Complement	and/or co-payments waived? I	IT yes, see ins	STRUCTI ONS.	N	14.
	Did total beds available change from the price	or cost reporting period? I1	f <u>yes, see ins</u> t	tructions.	Y	15.
		Description	Pa Y/N	art A Date	Part B Y/N	
		Description 0	1.00	2.00	3.00	-
00 W R e	S&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		N		N	16.
00 W R	nstructions) Vas 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		Y	01/29/2016	Y	17.
00   <sup>2</sup> 00   <sup>1</sup> m	yes, enter the paid-through date in columns 2 and 4. (see instructions) f line 16 or 17 is yes, were adjustments nade to PS&R Report data for additional		Ν		N	18.
i t 00 I	claims that have been billed but are not ncluded on the PS&R Report used to file this cost report? If yes, see instructions. f line 16 or 17 is yes, were adjustments and to PS&P. Depart data for corrections of		N		N	19.
0 00 0	nade to PS&R Report data for corrections of other PS&R Report information? If yes, see nstructions. fline 16 or 17 is yes, were adjustments nade to PS&R Report data for Other? Describe		N		N	20.

JSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der	CCN: 150082	Period: From 10/01/2014 To 09/30/2015 Part A		epared:
		Descri pt	tion	Y/N	Date	Y/N	
		0		1.00	2.00	3.00	
1.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21.00
						1.00	
	COMPLETED BY COST RELMBURSED AND TEFRA HOSPIT Capital Related Cost	ALS ONLY (EXCEPT	CHILDRENS F	IOSPITALS)			-
2.00	Have assets been relifed for Medicare purpose	s?lfves.seei	nstructions				22.00
3. 00	Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.			sals made dur	ring the cost		23.00
4. 00	Were new leases and/or amendments to existing If yes, see instructions	leases entered	into during	this cost re	eporting period?		24.00
5.00	Have there been new capitalized leases entere instructions.	d into during th	ne cost repor	ting period?	?lf yes, see		25.00
5.00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	ired during the	cost reporti	ng period? I	lf yes, see		26.00
7.00	Has the provider's capitalization policy char copy.	ged during the c	cost reportin	ng period? If	fyes, submit		27.00
3. 00	Interest Expense Were new Loans, mortgage agreements or letter	s of credit ente	ered into du	ing the cost	t reporting		28.00
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation a treated as a funded depreciation account? If	ccount and/or bo	ond funds (De	ebt Service F	Reserve Fund)		29.00
0. 00	Has existing debt been replaced prior to its instructions.			debt? If yes	s, see		30. 0
1.00	Has debt been recalled before scheduled matur instructions.	ity without issu	ance of new	debt? If yes	s, see		31.0
2.00	Purchased Services Have changes or new agreements occurred in pa			ed through co	ontractual		32.00
3. 00	arrangements with suppliers of services? If y If line 32 is yes, were the requirements of S no, see instructions.	ves, see instruct Sec. 2135.2 appli	ions. ed pertainir	ng to competi	tive bidding? If		33. 00
1 00	Provider-Based Physicians Are services furnished at the provider facili	ty under an arra	ngomont with	providor b	acad physicilans?	1	34.00
4. 00	If yes, see instructions.		ingement with	i provider-ba	ased physicians?		34.00
5.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?		0 0	nts with the	provi der-based		35.0
					Y/N	Date	
					1.00	2.00	-
5.00 7.00			ared by the	home office?	2		36. 00 37. 00
	If yes, see instructions. If line 36 is yes, was the fiscal year end o		3				38.00
	the provider? If yes, enter in column 2 the f If line 36 is yes, did the provider render se	ïscal year end o	of the home of	offi ce.			39.0
0. 00	see instructions. If line 36 is yes, did the provider render se	ervices to the ho	ome office?	lf yes, see			40.0
	instructions.						_
	Cost Report Preparer Contact Information		1.	00	2	. 00	
1.00	Enter the first name, last name and the title held by the cost report preparer in columns 1		II C		HENDERSON		41.0
	respectively. Enter the employer/company name of the cost r		ACONESS HOSE	PI TAL			42.0
2.00							

Health Financial Systems	DEACONESS HO	OSPI TAL	In Lie	u of Form CMS-255	52-10
HOSPI TAL AND HOSPI TAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE	Provider CCN: 150082	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepar 2/26/2016 11:44	
	Part B				
	Date				
	4.00				
PS&R Data					
16.00 Was the cost report prepared using the I Report only? If either column 1 or 3 is enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	yes,			1	16.00
<ul> <li>17.00 Was the cost report prepared using the l Report for totals and the provider's rea for allocation? If either column 1 or 3 yes, enter the paid-through date in colu 2 and 4. (see instructions)</li> </ul>	cords is			1	17.00
18.00 If line 16 or 17 is yes, were adjustmen made to PS&R Report data for additional claims that have been billed but are no included on the PS&R Report used to file this cost report? If yes, see instruction	t e ons.				18.00
19.00 If line 16 or 17 is yes, were adjustment made to PS&R Report data for corrections other PS&R Report information? If yes, s instructions.	s of see			1	19. 00
20.00 If line 16 or 17 is yes, were adjustment made to PS&R Report data for Other? Desc the other adjustments:				2	20. 00
21.00 Was the cost report prepared only using provider's records? If yes, see instructions.	the			2	21.00
		2.00			
Cost Depart Droppers Contast Lafamatic		3.00			
41.00 Enter the first name, last name and the held by the cost report preparer in colurespectively.	title/position RI	EI MBURSEMENT COORDI NATOR		4	41.00
42.00 Enter the employer/company name of the o	cost report			4	42.00
<ul><li>43.00 Enter the telephone number and email add report preparer in columns 1 and 2, response 1</li></ul>				4	43. 00

Component     Worksheet A     No. of Beds     Bed Days     CAH Hours     I/P D       1.00     Hospital Adults & Peds. (columns 5, 6, 7 and Besclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)     30.00     407     151,037     0.00	sheet S-3 I /Time Prep /2016 11: 4 ays / O/P s / Trips tl e V 5.00 0	
Component     To     09/30/2015     Date 2/20       Understand     No. of Beds     Bed Days     CAH Hours     Vi si t       1.00     2.00     3.00     4.00     1.00       1.00     2.00     3.00     4.00     1.00       1.00     2.00     3.00     4.00       1.00     2.00     3.00     4.00	/Time Prep /2016 11:4 ays / O/P s / Trips tle V 5.00	1.00 2.00
Component     Worksheet A Line Number     No. of Beds     Bed Days Available     CAH Hours     I/P D Visit       1.00     2.00     3.00     4.00       1.00     2.00     3.00     4.00       1.00     2.00     3.00     4.00       1.00     2.00     3.00     4.00	ays / O/P s / Trips tle V 5.00	1.00
Component     Worksheet A     No. of Beds     Bed Days     CAH Hours     Visit       1.00     2.00     3.00     4.00       1.00     8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)     30.00     407     151,037     0.00	<u>s / Trips</u> tle V 5.00	2.00
Line Number     Available       1.00     2.00     3.00     4.00       1.00     2.00     3.00     4.00       1.00     8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)     30.00     407     151,037     0.00	5. 00	2.00
1.002.003.004.001.00Bespital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)30.00407151,0370.00		2.00
1.00Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)30.00407151,0370.00		2.00
8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	2.00
Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		
for the portion of LDP room available beds)		
2.00     HMO and other (see instructions)       3.00     HMO IPF Subprovider		
4.00 HMO I RF Subprovi der		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	o	4.00 5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	6.00
7.00 Total Adults and Peds. (exclude observation 407 151,037 0.00	0	7.00
beds) (see instructions)	0	7.00
8.00 INTENSIVE CARE UNIT 31.00 67 24,455 0.00	0	8.00
9.00 CORONARY CARE UNIT 32.00 16 5,840 0.00	0	9,00
10.00 BURN INTENSIVE CARE UNIT		10.00
11.00 SURGICAL INTENSIVE CARE UNIT		11.00
12.00 OTHER SPECIAL CARE (SPECIFY)		12.00
13. 00 NURSERY		13.00
14.00 Total (see instructions) 490 181, 332 0.00	0	14.00
15.00 CAH visits	0	15.00
16. 00 SUBPROVIDER - IPF 40. 00 16 5, 840	0	16.00
17. 00 SUBPROVIDER - IRF		17.00
18. 00 SUBPROVI DER		18.00
19.00 SKILLED NURSING FACILITY		19.00
20. 00 NURSING FACILITY		20.00
21. 00 OTHER LONG TERM CARE	_	21.00
22. 00 HOME HEALTH AGENCY 101. 00	0	22.00
23. 00 AMBULATORY SURGICAL CENTER (D. P. ) 24. 00 HOSPICE 116. 00 0 0		23.00
		24. 00 24. 10
24.10 HOSPICE (non-distinct part) 30.00 25.00 CMHC - CMHC		24. 10 25. 00
26. 00 RURAL HEALTH CLINIC		25.00 26.00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER		26.00
27.00 Total (sum of lines 14-26) 506		20.23
28.00 Observation Bed Days	0	28.00
29.00 Ambulance Trips	Ű	29.00
30.00 Employee discount days (see instruction)		30.00
31.00 Employee discount days - IRF		31.00
32.00 Labor & delivery days (see instructions) 0 0		32.00
32.01 Total ancillary labor & delivery room		32.01
outpatient days (see instructions)		
33.00 LTCH non-covered days		33.00

HOSPI T	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der		Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part I Date/Time Pre 2/26/2016 11:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9,00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	50, 558	7, 477	106, 29		10.00	1.00
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	16, 969	11, 258				2.00
2.00	HMO IPF Subprovider	10, 909	645				3.00
4.00	HMO I RF Subprovider	0	045				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF	Ŭ	0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	50, 558	7, 477	106, 29	-		7.00
8.00	INTENSIVE CARE UNIT	7, 531	1, 696	18, 35	0		8.00
9.00	CORONARY CARE UNIT	2, 062	471	4, 33	9		9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	60, 151	9, 644	128, 97	9 20.44	3, 780. 27	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF	1, 353	494	3, 47	7 0.00	22.30	
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0		0 0.00	0.00	
23.00	AMBULATORY SURGICAL CENTER (D. P. )					0.00	23.00
24.00	HOSPI CE	0	0		0.00	0.00	•
24.10	HOSPICE (non-distinct part)	0	0		0		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25 27.00	FEDERALLY QUALIFIED HEALTH CENTER				20.44	3, 802. 57	26.25
27.00	Total (sum of lines 14-26) Observation Bed Days		3,004	14, 66		3,802.57	27.00
29.00	Ambul ance Trips	0	3, 004	14,00	4		29.00
30.00	Employee discount days (see instruction)	U			0		30.00
31.00	Employee discount days (see fistraction)				0		31.00
32.00	Labor & delivery days (see instructions)	0	0		0		31.00
32.00	Total ancillary labor & delivery room	0	0		0		32.00
52.01	outpatient days (see instructions)						32.01
22 00	LTCH non-covered days	0					33.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150082	Period: From 10/01/2014 To 09/30/2015	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 2/26/2016 11:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	12, 7	02 1, 582	26, 962	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider			3, 1	60 1, 878 161		2.00 3.00
1.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
5.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
3.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY						13.0
4.00	Total (see instructions)	0.00	0	12, 7	02 1, 582	26, 962	14.0
5.00	CAH visits						15.0
6.00	SUBPROVIDER - IPF	0.00	0	1	58 72	614	16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20. C
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY	0.00					22.0
3.00	AMBULATORY SURGICAL CENTER (D. P. )						23.0
4.00	HOSPI CE	0.00					24.0
4.10	HOSPICE (non-distinct part)						24.1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.2
7.00	Total (sum of lines 14-26)	0.00					27.0
8.00	Observation Bed Days						28.0
9.00	Ambul ance Trips						29. (
0. 00	Employee discount days (see instruction)						30. (
1. 00	Employee discount days - IRF						31. (
2.00	Labor & delivery days (see instructions)						32.0
2. 01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
3 00	LTCH non-covered days			1			33.

PI T <i>i</i>	Financial Systems AL WAGE INDEX INFORMATION			Provi der	F	eriod: rom 10/01/2014 o 09/30/2015	Worksheet S-3 Part II Date/Time Pre 2/26/2016 11:	pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	(col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
0	Total salaries (see	200.00	220, 998, 029	749, 807	221, 747, 836	7, 979, 931. 00	27.79	1.0
0	instructions) Non-physician anesthetist Part		0	0	0	0.00	0. 00	2.0
0	A Non-physician anesthetist Part		777, 223	0	777, 223	9, 586. 00	81.08	3.0
0	B Physician-Part A -		2, 708, 601	0	2, 708, 601	16, 835. 00	160. 89	4.0
1	Administrative Physicians – Part A – Teaching		0	973, 944	973, 944	7, 201. 00	135. 25	4.0
0	Physician-Part B		28, 701, 642		28, 701, 642			•
0	Non-physician-Part B		3, 494, 805		3, 494, 805			•
0	Interns & residents (in an	21.00	0	1, 237, 769	1, 237, 769	43, 240. 00	28.63	7.0
1	approved program) Contracted interns and residents (in an approved		C	0	0	0.00	0.00	7.0
0	programs) Home office personnel		O	0	o	0.00	0. 00	8.0
0	SNF	44.00	0	0	0	0.00	0.00	9.0
00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		10, 126, 666	2, 073, 537	12, 200, 203	525, 867. 00	23. 20	10.0
	Contract Labor: Direct Patient		751, 452	0	751, 452	10, 820. 00	69.45	11.0
00	Care Contract Labor: Top Level management and other management and administrative		C	0	0	0.00	0. 00	12.0
00	services Contract Labor: Physician-Part		6, 980, 548	0	6, 980, 548	52, 304.00	133. 46	13 0
	A - Administrative							
00	Home office salaries & wage-related costs		13, 022, 864	0	13, 022, 864	382, 117.00	34.08	14.0
00	Home office: Physician Part A - Administrative		107, 181	0	107, 181	474.00	226. 12	15.0
	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.0
	WAGE-RELATED COSTS Wage-related costs (core) (see		62, 603, 118	0	62, 603, 118			17.0
00	instructions) Wage-related costs (other)		0	0	0			18. 0
00	(see instructions) Excluded areas		10, 561, 441	0	10, 561, 441			19.0
	Non-physician anesthetist Part		0, 301, 441	0				20. 0
00	Non-physician anesthetist Part		129, 480	0	129, 480			21.0
00	Physician Part A - Administrative		265, 273	0	265, 273			22. 0
01	Physician Part A - Teaching		146, 674	0	146, 674			22.0
	Physician Part B		4, 650, 059	0	4, 650, 059			23.0
	Wage-related costs (RHC/FQHC)		0	0	0			24.0
	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE	<u> </u>	206, 024	0	206, 024			25.0
	Employee Benefits Department	4.00	1, 808, 916	95, 308	1, 904, 224	74, 898. 57	25. 42	26.0
	Administrative & General	5.00	36, 905, 474					
00	Administrative & General under contract (see inst.)		1, 910, 853	0	1, 910, 853	8, 963. 49	213. 18	28.0
00	Maintenance & Repairs	6.00	0	0	0			
	Operation of Plant	7.00	3, 033, 676					
00 00	Laundry & Linen Service Housekeeping	8.00 9.00	581, 328 3, 905, 369					
	Housekeeping under contract	7.00	J, 905, 309 0	0	0	0.00		
	(see instructions)	10 00		1 005 400	1 0/1 0/7	114 017 00	11.00	
	Dietary Dietary under contract (see instructions)	10. 00	3, 357, 447 0	-1, 995, 480 0	1, 361, 967 0	114, 817. 92 0. 00		
	Cafeteria	11.00	0	1, 101, 144	1, 101, 144			
	Maintenance of Personnel	12.00	0	0	0	0.00		37.0
	Nursing Administration	13.00 14.00	2, 026, 252 2, 025, 682					
	Central Services and Supply Pharmacy	14.00	2, 025, 682 7, 781, 883					

Health Financial Systems		DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
					From 10/01/2014 To 09/30/2015		narodi
					0 09/30/2015	2/26/2016 11:	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid 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	
41.00 Medical Records & Medical Records Library	16.00	2, 972, 808	1, 067, 245	4, 040, 053	3 229, 318. 97	17.62	41.00
42.00 Social Service	17.00	3, 070, 815	31, 135	3, 101, 950	122, 332. 41	25.36	42.00
43.00 Other General Service	18.00	C	0		0.00	0.00	43.00

Heal th	Financial Systems		DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
						From 10/01/2014		
						To 09/30/2015	Date/Time Prep 2/26/2016 11:4	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	<u>++ am</u>
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	3)	col. 4	, í	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		189, 935, 212	-1, 461, 906	188, 473, 30	6 7, 703, 848. 49	24.46	1.00
	instructions)							
2.00	Excluded area salaries (see		10, 126, 666	2, 073, 537	12, 200, 20	3 525, 867. 00	23. 20	2.00
	instructions)							
3.00	Subtotal salaries (line 1		179, 808, 546	-3, 535, 443	176, 273, 10	3 7, 177, 981. 49	24.56	3.00
	minus line 2)							
4.00	Subtotal other wages & related		20, 862, 045	0	20, 862, 04	5 445, 715. 00	46. 81	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		62, 868, 391	0	62, 868, 39	1 0.00	35.67	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		263, 538, 982	-3, 535, 443	260, 003, 53	9 7, 623, 696. 49	34.10	6.00
7.00	Total overhead cost (see		69, 380, 503	-2, 544, 452	66, 836, 05	1 2, 800, 168. 07	23.87	7.00
	instructions)							
		I I		I	I	I	1 1	

Heal th	Financial Systems	DEACONESS HOSP	I TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE RELATED COSTS		Provider CCN:	150082	Period: From 10/01/2014 To 09/30/2015		pared:
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					9, 220, 472	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribu	ition				9, 220, 472	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see i					0	3.00
4.00	Qualified Defined Benefit Plan Cost (see inst					10, 886, 866	4.00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External C					10,000,000	4.00
5.00	401K/TSA Plan Administration fees	gam Zati ony				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	ı				0	6.00
7.00	Employee Managed Care Program Administration					0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					35, 131, 704	8.00
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					981, 148	10.00
11.00	Life Insurance (If employee is owner or benef	ĩi ci ary)				189, 809	11.00
12.00	Accident Insurance (If employee is owner or b	eneficiary)				5, 958	12.00
13.00	Disability Insurance (If employee is owner or	beneficiary)				2, 976, 532	13.00
14.00		er or beneficiary)				0	
15.00						1, 640, 775	
16.00		ar, not the extraor	di nary accrual	requi re	d by FASB 106.	0	16.00
	Non cumulative portion)						
47 00	TAXES					15 000 010	47.00
	FICA-Employers Portion Only					15, 000, 243	
18.00						0	
19.00	Unemployment Insurance State or Federal Unemployment Taxes					98, 859	
20.00	OTHER					1, 843	20.00
21.00	Executive Deferred Compensation (Other Than F	Retirement Cost Rep	orted on lines	1 throu	gh 4 above. (see	687, 534	21.00
	instructions))						
22.00						1, 275, 974	
	Tuition Reimbursement					464, 352	
24.00						78, 562, 069	24.00
	Part B - Other than Core Related Cost					-	
25.00						0	25.00

Heal th	Financial Systems	DEACONESS HOSPI	TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150082	Peri od:	Worksheet S-3	
					From 10/01/2014		
					To 09/30/2015	Date/Time Pre 2/26/2016 11:	
	Cost Center Description				Contract Labor		
					1.00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identific	ati on:					
1.00	Total facility's contract labor and benefit cos	st			0	0	1.00
2.00	Hospi tal				0	0	2.00
3.00	Subprovider - IPF				0	0	3.00
4.00	Subprovider - IRF						4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospital-Based SNF						8.00
9.00	Hospital-Based NF						9.00
10.00	Hospital-Based OLTC						10.00
11.00	Hospital-Based HHA				0	0	11.00
12.00	Separately Certified ASC						12.00
13.00	Hospi tal -Based Hospi ce				0	0	13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospital-Based-CMHC						16.00
17.00	Renal Dialysis				0	0	17.00
18.00	Other				0	0	18.00

INDEPITAL UNCOMPENSATED AND TNDIGENT CARE DATA       Provider CCN: 150082       Period: Provider CCN: 150082       Period: Provider CCN: 150082       Period: Provider CCN: 150082       Morksheet S-10	Heal th	Financial Systems DEACONESS HOSPI	TAL		ln Li€	eu of Form CM	MS-2	552-10
To         09/30/2015         DeterTime Prepared: 2722/2016         DeterTime Prepared: 2722/2016           1:00         Cost: to charge ratio (Morsheet C, Part I line 202 column 3 divided by line 202 column 8)         0.237668           2:00 Met revenue from Modical d         0.0237668         1.00           2:00 Met rownee from Modical d         35,060,652         0.03,00           0:00 Did you recolve 08/04 or supplemental payments from Medical d?         35,060,652         0.00           0:00 Hit fune 3 is "yes", does line 2 include all 05H or supplemental payments from Medical d?         36,060,652         0.00           0:00 Medical do cost (line 1 times 1 ine 6)         8.00         262,429,733         6.00           0:00 Medical do cost (line 1 times 1 ine 10)         0.0237668         0.00         9,00           0:00 Stand-alone SCHP charges         0.00         0.00         0.00         0.00         0.00           0:00 Stand-alone SCHP charges         0.00         0.00         0.00         0.00         0.00           0:00 There are on local indigent care program (SCHP) (see instructions for each line)         0.00         0.00         0.00           0:00 There are on local indigent care program (Not included on lines 2, 5 or 9)         0.01         0.00         0.00           0:00 There are on local indigent care program (Not included on lines 2, 5 or 9)	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150082		Worksheet	S-10	)
Incompensated and indigent care cost computation         1.00           1.00         Cast to charge ratio. (Morksheet C, Part 1 line 202 column 3 divided by line 202 column 8)         0.237668           0.00         Did you receive bill or supplemental payments from Medicaid?         35,080,652           0.00         Did you receive bill or supplemental payments from Medicaid?         2,00           0.00         Did you receive bill or supplemental payments from Medicaid?         2,00           0.00         Difference between enter sevene and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if         2,20,480           0.00         Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if         2,20,498           0.00         Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)							_	
Incompensated and indigent care cost computation         1.00           1.00         Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.237668           1.00         Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.237668           1.00         Did you receive 05H or supplemental payments from Medicaid         35.080.652           0.00         If i line 3 is 'yes', does line 2 include all DSH or supplemental payments from Medicaid         20.0           5.00         Medicaid cost (line 1 times line 6)         22.429.733           0.00         Net revenue from State Childrer's Heal th Insurance Program (SCHP) (see instructions for each line)         0.2371.65           0.00         State Childrer's Heal th Insurance Program (SCHP) (see instructions for each line)         0         0           0.00         Net revenue from State or local Indigent care program (see instructions for each line)         0         11.00           1.00         State or local indigent care program (see instructions for each line)         0         12.00           1.00         Difference between net revenue and costs for state or local indigent care program (see instructions for each line)         0         13.00           1.00         Exact or local indigent care program (see instructions for each line)         0         14.00           1.00         Exact or					To 09/30/2015			
Incompensated and Indigent care cost computation         I.00           1.00         Cost to charge ratio (Worksheet, C, Part I line 202 column 3) divided by line 202 column 8)         0.237666           2.00         Net revenue from Medicaid         35.080.652         2.00           3.00         Did you receive DSH or supplemental payments from Medicaid 7         35.080.652         2.00           3.00         Did Ire 3 is 7yes?, does line 2 linclude all DSH or supplemental payments from Medicaid 6         262.497.336         60.4237.150           3.00         DI Fine 4 is *no*, then enter DSH or supplemental payments from Medicaid 6         262.497.336         60.62.371.150         7.00           0.00         Wedicaid charges         27.290.498         8.00         27.290.498         8.00           0.01         Difference between the rownee and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if         0         0.00           0.01         State for line)         0         0.00						2/26/2016	11:4	4 am
Incompensated and Indigent care cost computation         I.00           1.00         Cost to charge ratio (Worksheet, C, Part I line 202 column 3) divided by line 202 column 8)         0.237666           2.00         Net revenue from Medicaid         35.080.652         2.00           3.00         Did you receive DSH or supplemental payments from Medicaid 7         35.080.652         2.00           3.00         Did Ire 3 is 7yes?, does line 2 linclude all DSH or supplemental payments from Medicaid 6         262.497.336         60.4237.150           3.00         DI Fine 4 is *no*, then enter DSH or supplemental payments from Medicaid 6         262.497.336         60.62.371.150         7.00           0.00         Wedicaid charges         27.290.498         8.00         27.290.498         8.00           0.01         Difference between the rownee and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if         0         0.00           0.01         State for line)         0         0.00						1 00		
1.00       Cost to charpe ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)       0.237668       1.00         2.00       Net revenue from Medicaid 3       35,080,652       2.00         3.00       Did you receive DSH or supplemental payments from Medicaid 7       35,080,652       2.00         4.00       Medicaid charges       2.00,171       35,080,652       2.00         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid 7       4.00       4.00         6.00       Medicaid charges       2.02,371,50       7.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       2.7,290,498       8.00         5.00       State Children's Health Insurance Program (ScHIP) (see instructions for each line)       9.00       9.00         0.00       Net revenue from Stand-alone SCHIP cost (line 1 times line 10)       0       10.00       10.00         12.00       Net revenue from state or local indigent care program (Net Included on lines 2, 5 or 9)       0       14.00         13.00       Net revenue from state or local indigent care program (Net Included on lines 2, 5 or 9)       11.00       13.00         14.00       Charges for patients opergram cost (line 1 times line 14)       15.00       15.00       15.00       15.00       15.00		Uncompensated and indigent care cost computation				1.00	-	
Medicaid (see instructions for each line)         2.00           2.00         Net revenue from Medicaid         35,080,652         2.00           3.00         Did you receive DSH or supplemental payments from Medicaid         3.00         3.00           4.00         IF line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid         2.02,429,733         6.00           0.00         Medicaid cost (line 1 times line 6)         8.00         2.02,429,733         6.00           0.00         Netficial charges         7.00         8.03         7.00         8.03           0.00         Netficial charges         7.00         8.03         7.00         8.03           0.01         State Children's likelith lisurance Program (SCHP) (see instructions for each line)         9.00         10.00 <td></td> <td></td> <td>ded by Li</td> <td>ne 202 columr</td> <td>1.8)</td> <td>0 237</td> <td>668</td> <td>1 00</td>			ded by Li	ne 202 columr	1.8)	0 237	668	1 00
2.00       Net revenue from Medicaid       35,080,652       2.00         300       Did you receive vBS for supplemental payments from Medicaid?       35,080,652       2.00         4.00       If line 4 is "yes", does line 2 include all DSI or supplemental payments from Medicaid?       4.00       4.00         5.00       If line 4 is "yes", then enter DSH or supplemental payments from Medicaid?       5.00       6.00         6.00       Medicaid cost (line 1 times line 6)       2.02,429,733       6.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       27,290,498       8.00         5.010       State Children's Health Insurance Program (SCHIP) (see Instructions for each line)       0       0       0         0.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       0       10.00         10.00       State or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00       14.00         10.00       State or local indigent care program (Not include on lines 2, 5 or 9)       0       14.00         11.11       State or local indigent care program (Not included on lines 2, 5 or 9)       0       14.00         10.00       Difference between het revenue and costs for state or local indigent care programs (sum of lines 1 in linus line 1 in li	1.00		ded by II	10 202 001 0		0.207	000	1.00
3.00       Did you receive DSH or supplemental payments from Medicaid?       3.00         4.00       If line 3 is "yes", does line 2 include al DSH or supplemental payments from Medicaid?       4.00         5.00       If line 3 is "yes", does line 2 include al DSH or supplemental payments from Medicaid?       5.00         5.00       Medicaid coast (line 1 times line 6)       62.371.150       7.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 2.7,290,498       7.00         9.00       Net revenue from stand-al one SCHIP (see instructions for each line)       0       0         9.00       Net revenue from stand-al one SCHIP cost (line 1 times line 10)       0       0       0         12.00       Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	2 00					35,080	652	2 00
4.00       If fline 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?       4.00         5.00       If fline 4 is "no", then enter DSH or supplemental payments from Medicaid?       5.00         0.00       Medicaid charges       262,429,733       6.00         0.00       Medicaid charges       6.00       262,429,733       6.00         0.00       Not fifterence between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; If       2.7,290,498       8.00         0.00       Not revenue from Stand-alone SCHIP       0       9.00       0       0.00       <						00,000,	002	
5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicald       0 </td <td></td> <td></td> <td>payments</td> <td>from Medicaid</td> <td>1?</td> <td></td> <td></td> <td></td>			payments	from Medicaid	1?			
6.00       Medicaid charges       226,249,733       6.00         7.00       Medicaid cost (line 1 times line 6)       227,290,498       8.00         6.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if       27,290,498       8.00         7.00       Medicaid cost (line 1 times line 6)       0       0.00       0.00       10:00       State Children's Health Insurance Program (SCHIP) (see Instructions for each line)       0       0.00         0.00       Net revenue from stand-alone SCHIP cost (line 1 times line 10)       0       0.00       0							0	
7.00       Medical d cost (line 1 times line 6)       62, 371, 150       7.00         8.00       Difference between net revenue and costs for Medical d program (line 7 minus sum of lines 2 and 5; if       27, 290, 498       8.00         9.00       Net revenue from stand-al one SCHIP       (see Instructions for each line)       0       9.00         9.00       Net revenue from stand-al one SCHIP cost (line 1 times line 10)       0       0       0       0       0       0.00         10.00       Stand-al one SCHIP cost (line 1 times line 10)       0						262.429.	733	
8.00       Difference between het revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if       27,290,498       8.00         9.00       Net revenue from stand-alone SCHIP       0       9.00       0		5						
< zero then enter zero)			ine 7 min	us sum of lir	nes 2 and 5; if			
9. 00       Net revenue from stand-al one SCHIP       0       9. 00         10. 00       Stand-al one SCHIP cost (line 1 times line 10)       0       00       12.00       00       Net revenue from state or local indigent care program (See instructions for each line)       0       13.00       14.00       00       15.00       00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       16.00       16.00       17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00       18.00       22,200 498       19.00       18.00       19.00       10.00       20.00       3.00       18.00       22,00       3.00       18.00       10.00       20.00       3.00       18.00								
10.00       Stand-alone SCHIP charges       0       10.00         11.00       Stand-alone SCHIP charges       0       11.00         12.00       Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		State Children's Health Insurance Program (SCHIP) (see instructi	ons for e	ach line)				
11:00       Stand-alone SCHIP cost (line 1 times line 10)       011:00       01:00       00       00       00:00       00:00       00:00       00:00       00:00       00:00       00:00       00:00	9.00	Net revenue from stand-alone SCHIP					0	9.00
12.00       Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	10.00	Stand-alone SCHIP charges					0	10.00
enter zero)       Other state or local government indigent care program (see instructions for each line)       13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00         13.00       Net revenue from state or local indigent care program (Not included in lines 6 or 10)       0       0       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0       0         17.00       Private grants, donations, or endownent income restricted to funding charity care       0       17.00         19.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total uncreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 2, 2, 790, 498       19.00         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility       29, 408, 355       11, 433, 844       40, 842, 199       20.00         21.00       Cost of initial obligation of patients approved for charity care       427, 980       0 <td>11.00</td> <td>Stand-alone SCHIP cost (line 1 times line 10)</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>11.00</td>	11.00	Stand-alone SCHIP cost (line 1 times line 10)					0	11.00
Other state or local government indigent care program (see instructions for each line)       13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	12.00	Difference between net revenue and costs for stand-alone SCHIP (	line 11 m	inus line 9;	if < zero then		0	12.00
13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0       13.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0       0       15.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 2, 7.20, 498       19.00         19.00       Total unreimbursed cost centers) for the entire facility care (at full charges excluding non-reimbursable cost centers) for the entire facility       2.00       3.00         20.00       Total initial obligation of patients approved for charity care (line 1 times 1 applients approved for charity care (line 1 times 1 applients approved for charity care (line 1 times 1 applient 2)       3.00       22.00         21.00       Cost of initial obligation of patients approved for charity care (line 1 times 1 applient 2)       427,980       0       427,980       22.00								
14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13)       0       15.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 27, 290, 498       19.00         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility charges excluding non-reimbursable cost centers) for the entire facility times line 20)       0       20.00       3.00         21.00       Cost of charity care (line 1 minus line 22)       6, 561, 445       2, 717, 459       9, 706, 884       21.00         23.00       Cost of charity care (line 21 minus line 22)       6, 561, 445       2, 717, 459       9, 278, 904       23.00         24.00       Does the amount in line 20 cumn 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program								
10)       10.       1							- 1	
15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line)       0       15.00         13: if < zero then enter zero)	14.00	5 1	program (	Not included	in lines 6 or		0	14.00
16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line line)       0       16.00         13. If < zero then enter zero)	45.00							45 00
13: if < zero then enter zero)							۲	
Uncompensated care (see instructions for each line)       0         17.00       Private grants, donations, or endowment income restricted to funding charity care       0         18.00       Government grants, appropriations or transfers for support of hospital operations       0         19.00       Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines       27, 290, 498         19.00       a, 12 and 16)       Uninsured       Insured       Total (col. 1         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility       29, 408, 355       11, 433, 844       40, 842, 199       20. 00         21.00       Cost of initial obligation of patients approved for charity care (line 1       6, 989, 425       2, 717, 459       9, 706, 884       21. 00         22.00       Partial payment by patients approved for charity care       427, 980       0       427, 980       22. 00         23.00       Cost of charity care (line 21 minus line 22)       6, 561, 445       2, 717, 459       9, 278, 904       23. 00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       39, 900, 716       26. 00         25.00       If line 24 is "yes," charges for patient	16.00		gent care	program (TT	le 15 minus line		0	16.00
17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines       27,290,498       19.00         8, 12 and 16)       Uninsured patients       Insured rectify       Total (col. 1       1         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility       1.00       2.00       3.00         21.00       Cost of initial obligation of patients approved for charity care (line 1       6,989,425       2,717,459       9,706,884       21.00         22.00       Partial payment by patients approved for charity care       427,980       0       427,980       22.00         23.00       Cost of charity care (line 21 minus line 22)       6,561,445       2,717,459       9,278,904       23.00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit       N       24.00         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program?       1.00       39,900,716       26.00         26.00       Non-Medicare and						1		
18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines       27,290,498       19.00         20.00       Total initial obligation of patients approved for charity care (at full 29,408,355       11,433,844       40,842,199       20.00         20.00       Total initial obligation of patients approved for charity care (at full 29,408,355       11,433,844       40,842,199       20.00         21.00       Cost of initial obligation of patients approved for charity care (line 1       6,989,425       2,717,459       9,706,884       21.00         22.00       Partial payment by patients approved for charity care       427,980       0       427,980       22.00         23.00       Cost of charity care (line 21 minus line 22)       6,561,445       2,717,459       9,278,904       23.00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       25.00         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program?       39,900,716       26.00         26.00       Non-Medicare bad debts for the entire hospital complex (see instructions)       39,900,716       26.00       <	17 00		ding char	ity care			0	17 00
19.00       Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 27, 290, 498       19.00         8, 12 and 16)       Uninsured patients       Insured patients       Total (col. 1 + col. 2)         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility       29,408,355       11,433,844       40,842,199       20.00         21.00       Cost of initial obligation of patients approved for charity care (line 1 times line 20)       6,989,425       2,717,459       9,706,884       21.00         22.00       Partial payment by patients approved for charity care       427,980       0       427,980       22.00         23.00       Cost of charity care (line 21 minus line 22)       6,561,445       2,717,459       9,278,904       23.00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       25.00         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program?       39,900,716       26.00         26.00       Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)       38,784,134       28.00         27.00       Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)								
8, 12 and 16)       Uninsured patients       Insured patients       Total (col. 1 patients         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility       29, 408, 355       11, 433, 844       40, 842, 199       20. 00         21.00       Cost of initial obligation of patients approved for charity care (line 1 times line 20)       6, 989, 425       2, 717, 459       9, 706, 884       21. 00         22.00       Partial payment by patients approved for charity care       427, 980       0       427, 980       22. 00         23.00       Cost of charity care (line 21 minus line 22)       6, 561, 445       2, 717, 459       9, 278, 904       23. 00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       25.00         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program?       39, 900, 716       26. 00         27.00       Medicare bad debts for the entire hospital complex (see instructions)       1, 116, 582       27. 00         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 27)       38, 784, 134       28. 00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 ti					ns (sum of lines	27 290	- 1	
Uninsured patientsInsured patientsTotal (col. 1 + col. 2)20.00Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.0029,408,35511,433,84440,842,19920.0020.00Total initial obligation of patients approved for charity care (line 1 times line 20)29,408,35511,433,84440,842,19920.0022.00Partial payment by patients approved for charity care times line 20)6,561,4452,717,4599,706,88421.0023.00Cost of charity care (line 21 minus line 22)6,561,4452,717,4599,278,90423.0024.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025.00If line 24 is "yes," charges for patient days beyond an indigent care program?39,900,71626.0027.00Medi care bad debt expense for the entire hospital complex (see instructions)39,900,71626.0027.00Medi care and non-reimbursable Medi care bad debt expense (line 26 minus line 27)38,784,13428.0029.00Cost of non-Medi care and non-reimbursable Medi care bad debt expense (line 1 times line 28)9,217,7489,217,74829.00Cost of non-Medi care and non-reimbursable Medi care bad debt expense (line 1 times line 28)9,217,74827.0029.00Cost of uncompensated care (line 23 column 3 plus line 29)18,496,65230.00			i nai goirt	our o' program		21/2/01		
20. 00Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility times line 20)20. 003. 0021. 00Cost of initial obligation of patients approved for charity care (line 1 times line 20)29, 408, 35511, 433, 84440, 842, 19920. 0022. 00Partial payment by patients approved for charity care times line 20)6, 989, 4252, 717, 4599, 706, 88421. 0022. 00Partial payment by patients approved for charity care times line 22)427, 9800427, 98022. 0023. 00Cost of charity care (line 21 minus line 22)6, 561, 4452, 717, 4599, 278, 90423. 0024. 00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24. 0025. 00If line 24 is "yes," charges for patient days beyond an indigent care program?39, 900, 71626. 0027. 00Medicare bad debt expense for the entire hospital complex (see instructions)39, 900, 71626. 0028. 00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)38, 784, 13428. 0029. 00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9, 217, 74829. 0030. 00Cost of uncompensated care (line 23 column 3 plus line 29)18, 496, 65230. 00				Uni nsured	Insured	Total (col.	1	
20.00Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility times line 20)29, 408, 35511, 433, 84440, 842, 19920.0021.00Cost of initial obligation of patients approved for charity care (line 1 times line 20)6, 989, 4252, 717, 4599, 706, 88421.0022.00Partial payment by patients approved for charity care427, 9800427, 98022.0023.00Cost of charity care (line 21 minus line 22)6, 561, 4452, 717, 4599, 278, 90423.001.0024.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is "yes," charges for patient days beyond an indigent care program?39, 900, 71626.0026.00Total bad debt expense for the entire hospital complex (see instructions)39, 900, 71626.0027.00Medicare bad debts for the entire hospital complex (see instructions)1, 116, 58227.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)38, 784, 13428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9, 217, 7489.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)18, 496, 65230.00				patients	pati ents	+ col. 2)		
charges excluding non-reimbursable cost centers) for the entire facility Cost of initial obligation of patients approved for charity care (line 1 times line 20)6, 989, 425 2, 717, 4592, 717, 4599, 706, 88421. 0022. 00 23. 00Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)427, 980 6, 561, 4450 2, 717, 459427, 980 9, 278, 90422. 0024. 00 imposed on patients covered by Medicaid or other indigent care program?1.0010025. 00If line 24 is "yes," charges for patient days beyond an indigent care program?1.0025. 00If line 24 is "yes," charges for patient days beyond an indigent care program?39, 900, 716 26. 0026. 00Total bad debt expense for the entire hospital complex (see instructions)39, 900, 716 39, 900, 71626. 0027. 00Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)38, 784, 134 28. 0038, 784, 134 28. 0029. 00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9, 217, 748 9, 217, 7489, 217, 748 29. 0030. 00Cost of uncompensated care (line 23 column 3 plus line 29)18, 496, 652 30. 0030, 00								
21.00Cost of initial obligation of patients approved for charity care (line 1 times line 20)6, 989, 425 427, 9802, 717, 4599, 706, 88421.0022.00Partial payment by patients approved for charity care (line 21 minus line 22)427, 980 6, 561, 4450 2, 717, 459427, 980 9, 278, 90422.0024.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025.00If line 24 is "yes," charges for patient days beyond an indigent care program?39, 900, 716 26.000 27.0025.0027.00Medicare bad debt expense for the entire hospital complex (see instructions) 28.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 38.0038, 784, 134 28.0038, 784, 134 28.0029.00Cost of uncompensated care (line 23 column 3 plus line 29)9, 217, 748 29.009, 217, 748 29.00	20.00			29, 408, 3	55 11, 433, 844	40, 842, 1	199	20.00
times line 20)times line 20)times line 20)times line 20)times line 20)times line 20)times line 21, minus line 22)times line 21, minus line 22)times line 21, minus line 22)times line 22, minus line 22, minus line 22)times line 20, minus line 22, minus line 22)times line 20, minus line 22, minus line 22)times line 20, minus line 22, minus line 23, minus line 23, minus line 24, minus line 27, minus line 27, minus line 27, minus line 28, minus line 24, minu								
22.00Partial payment by patients approved for charity care427,9800427,98022.0023.00Cost of charity care (line 21 minus line 22)6,561,4452,717,4599,278,90423.001.0024.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0025.0026.00Total bad debt expense for the entire hospital complex (see instructions)39,900,71626.0027.00Medicare bad debts for the entire hospital complex (see instructions)1,116,58227.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 27)38,784,13428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9,217,74829.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)18,496,65230.00	21.00		(line 1	6, 989, 42	25 2, 717, 459	9, 706, 8	884	21.00
23.00       Cost of charity care (line 21 minus line 22)       6,561,445       2,717,459       9,278,904       23.00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       1.00         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program?       0 25.00       39,900,716       26.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       39,900,716       26.00         27.00       Medicare bad debts for the entire hospital complex (see instructions)       1,116,582       27.00         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)       38,784,134       28.00         29.00       Cost of uncompensated care (line 23 column 3 plus line 29)       18,496,652       30.00	22.00			407.00		407		22.00
24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program?       0       25.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       39,900,716       26.00         27.00       Medicare bad debts for the entire hospital complex (see instructions)       1.16,582       27.00         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)       38,784,134       28.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)       9,217,748       29.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       18,496,652       30.00								
24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit Total bad debt expense for the entire hospital complex (see instructions)025.0027.00Medicare bad debts for the entire hospital complex (see instructions)39,900,71626.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)38,784,13428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9,217,74829.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)18,496,65230.00	23.00	cost of charity care (line 21 minus line 22)		6, 561, 44	2, 117, 459	9, 278, 9	904	23.00
24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit Total bad debt expense for the entire hospital complex (see instructions)025.0027.00Medicare bad debts for the entire hospital complex (see instructions)39,900,71626.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)38,784,13428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9,217,74829.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)18,496,65230.00						1 00		
imposed on patients covered by Medicaid or other indigent care program?025.0001f line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)39,900,71626.0027.00Medicare bad debts for the entire hospital complex (see instructions)1,116,58227.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)38,784,13428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9,217,74829.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)18,496,65230.00	24 00	Does the amount in line 20 column 2 include charges for nationt	davs bevo	nd a length (	of stay limit		-	24 00
25.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)39,900,71626.0027.00Medicare bad debts for the entire hospital complex (see instructions)1,116,58227.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)38,784,13428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9,217,74829.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)18,496,65230.00	24.00			nu a renyth t	n stay mint	IN IN		24.00
26.00Total bad debt expense for the entire hospital complex (see instructions)39,900,71626.0027.00Medicare bad debts for the entire hospital complex (see instructions)1,116,58227.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)38,784,13428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9,217,74829.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)18,496,65230.00	25 00			ogram's Lengt	h of stav limit		0	25 00
27.00Medicare bad debts for the entire hospital complex (see instructions)1, 116, 58227.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)38, 784, 13428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9, 217, 74829.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)18, 496, 65230.00							- 1	
28.00 29.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)38, 784, 13428.0029.00 30.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9, 217, 74829.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)18, 496, 65230.00								
29.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)9, 217, 74829.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)18, 496, 65230.00				s line 27)				
30.00         Cost of uncompensated care (line 23 column 3 plus line 29)         18,496,652         30.00					28)			
					-/			
			e 30)					

CLASS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der		eriod: rom 10/01/2014	Worksheet A	
					09/30/2015	Date/Time Pre 2/26/2016 11:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	-
[	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	00100 CAP REL COSTS-BLDG & FIXT		25, 497, 581	25, 497, 581	150, 346	25, 647, 927	
	00101 CAP REL COSTS-BLDG & FIXT		0		62, 463	62, 463	
	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		5, 426, 527	5, 426, 527	20, 308, 778 0	25, 735, 305 0	
	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 808, 916	37, 225, 061	39, 033, 977	24, 830, 370	63, 864, 347	
	00500 ADMINI STRATI VE & GENERAL	36, 905, 474	60, 875, 193	97, 780, 667	-19, 239, 137	78, 541, 530	
	00700 OPERATION OF PLANT	3, 033, 676	8, 998, 711	12, 032, 387	-213, 674	11, 818, 713	
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	581, 328	594, 175	1, 175, 503	-235, 978	939, 525	
	01000 DI ETARY	3, 905, 369 3, 357, 447	1, 165, 058 3, 337, 184	5, 070, 427 6, 694, 631	-392, 200 -4, 177, 299	4, 678, 227 2, 517, 332	
	01100 CAFETERI A	0	0,007,101	0	2, 035, 251	2,035,251	
	01300 NURSING ADMINISTRATION	2, 026, 252	1, 063, 592	3, 089, 844	-527, 486	2, 562, 358	
	01400 CENTRAL SERVICES & SUPPLY	2,025,682	2, 595, 176	4, 620, 858	-2, 314, 155	2, 306, 703	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	7, 781, 883 2, 972, 808	39, 385, 860 583, 733	47, 167, 743 3, 556, 541	-40, 036, 178 -444, 456	7, 131, 565 3, 112, 085	
	01700 SOCIAL SERVICE	3, 070, 815	524,637	3, 595, 452	-291, 001	3, 304, 451	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1, 237, 769	1, 237, 769	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	1, 065, 596	1, 065, 596	
	02300 PARAMED ED PRGM-PHARMACY 02301 PARAMED ED PRGM-CHAPLAIN	171, 155	25, 680	196, 835 0	24, 713	221, 548	
	02303 PARAMED ED PRGM-CHAPLATN 02303 PARAMED ED PRGM-NURSING	0	0		203, 732 444, 482	203, 732 444, 482	
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			111,102	111/102	
00	03000 ADULTS & PEDIATRICS	47, 299, 349	11, 384, 380			53, 118, 345	
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	10, 163, 529	2, 561, 231	12, 724, 760		11, 321, 937	
	04000 SUBPROVIDER - IPF	2, 494, 100 981, 982	654, 804 102, 795	3, 148, 904 1, 084, 777	-367, 376 -91, 456	2, 781, 528 993, 321	
Ī	ANCI LLARY SERVICE COST CENTERS				,		
	05000 OPERATING ROOM	21, 708, 320	70, 404, 562		-31, 768, 934	60, 343, 948	
	05400 RADI OLOGY-DI AGNOSTI C	9,081,467	12, 955, 971	22, 037, 438		16, 699, 456	
	05500 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON	594, 907 1, 231, 150	7, 917, 192 3, 964, 792	8, 512, 099 5, 195, 942	-73, 753 -2, 944, 230	8, 438, 346 2, 251, 712	
	06000 LABORATORY	11, 730, 046	19, 146, 344	30, 876, 390		29, 298, 023	
	06400 I NTRAVENOUS THERAPY	646, 862	1, 227, 093	1, 873, 955	-71, 791	1, 802, 164	
	06500 RESPIRATORY THERAPY	3, 112, 131	1,094,035	4, 206, 166		3, 323, 658	
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0 375, 754	13, 548, 684 501, 028	13, 548, 684 876, 782	-33, 559 1, 218, 145	13, 515, 125 2, 094, 927	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	001,020	0	15, 370, 326	15, 370, 326	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20, 904, 585	20, 904, 585	
	07300 DRUGS CHARGED TO PATLENTS 07400 RENAL DLALYSES	0	1 600 709	1 020 457	38, 865, 224	38, 865, 224	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	237, 749	1, 600, 708 0	1, 838, 457 0	-17, 404 0	1, 821, 053 0	7
	OUTPATIENT SERVICE COST CENTERS			-	· · · ·		
	09000 CLINIC	1, 579, 195	508, 733			1, 948, 617	
	09001 FAMILY PRACTICE CLINIC 09002 OUTPATIENT PSYCH SERVICES	3, 100, 567 411, 915	840, 425 260, 141	3, 940, 992 672, 056	-2, 494, 647 244, 593	1, 446, 345 916, 649	
	09003 INFUSION CENTER	394, 574	606, 354	1, 000, 928		962, 447	
04	09004 PRIMARY CARE FOR SENIORS	2,061,497	609, 052	2, 670, 549		2, 491, 353	
	09005 PAIN MANAGEMENT	2, 315, 647	1, 521, 429	3, 837, 076		2, 950, 782	
06 07	09006 WOUND CARE CENTER 09007 SLEEP CENTER	375, 146 1, 933, 723	147,614	522, 760 2, 595, 871		422, 371	
	09007 SLEEP CENTER 09100 EMERGENCY	20, 146, 553	662, 148 10, 231, 754	30, 378, 307	-592, 731 -2, 497, 902	2, 003, 140 27, 880, 405	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2011101000	10/201/701		2/ 17/ 702	27,000,100	9
	OTHER REIMBURSABLE COST CENTERS	I					١.,
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	2, 407, 532	5, 091, 606	7, 499, 138 0		6, 839, 367	10
	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	<u> </u>	0	10
	11600 HOSPI CE	0	0		-		111
. 00	· · · · · · · · · · · · · · · · · · ·	212, 024, 500	354, 841, 043	566, 865, 543	1, 370, 520	568, 236, 063	11
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1, 725, 384	1, 725, 384	1190
	19200 PHYSI CLANS' PRI VATE OFFI CES	5, 458, 781	1, 913, 441	7, 372, 222	-247, 058	7, 125, 164	
	19201 DEACONESS URGENT CARE	0	0	0	0		192
	19202 HEARTCARE	207, 021	942, 278	1, 149, 299		1, 133, 349	
	19203 FAMILY PRACTICE 07950 MISC NONREI MBURSABLE	579, 332 752, 237	9, 243, 604 1, 439, 134	9, 822, 936 2, 191, 371	-692, 963 -69, 135	9, 129, 973 2, 122, 236	
	07950 MISC NORRET MBURSABLE 07951 OCCUPATIONAL HEALTH	364, 367	1, 439, 134 182, 092	2, 191, 371 546, 459	-09, 135 -19, 159	2, 122, 238	
	07952 OTHER FACILITIES	0	3, 549, 496			2, 986, 980	
I. 03	07953 HEART HOSPI TAL	0	1, 582, 852	1, 582, 852	-1, 338, 421	244, 431	194
	07954 PUBLIC RELATIONS	558, 140	1, 195, 017	1, 753, 157	-105, 299	1, 647, 858	
	07955 CHILD CARE CENTER	1,048,627	299, 496	1, 348, 123	-44, 028	1, 304, 095	1194

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A	
				From 10/01/2014 Fo 09/30/2015	Date/Time Pre 2/26/2016 11:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.07 07957 DEACONESS VNA	361	630, 437	630, 798	3 712	631, 510	194. 07
200.00 TOTAL (SUM OF LINES 118-199)	220, 998, 029	375, 844, 206	596, 842, 23	5 0	596, 842, 235	200. 00

	n Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	DEACONESS DF EXPENSES		CCN: 15008		eu of Form CN Worksheet A	
					To 09/30/2015		
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7.00				
1 00	GENERAL SERVICE COST CENTERS	(42.012					1 00
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT	643, 013 C					1.00
2.00	00200 CAP REL COSTS-MUBLE EQUIP						2.00
3.00	00300 OTHER CAP REL COSTS						3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-19, 158	63, 845, 189				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-1, 122, 287	77, 419, 243				5.00
7.00	00700 OPERATION OF PLANT	C					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	121, 918					8.00
9.00 10.00	00900 HOUSEKEEPING	C 255 771					9.00
11.00		255, 771 -1, 073, 389					10.00
13.00		100,000					13.00
14.00		C					14.00
15.00		C					15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	572, 707	3, 684, 792				16.00
17.00		-205, 031					17.00
21.00		C					21.00
22.00		C					22.00
23.00 23.01							23.00
	02303 PARAMED ED PRGM-CHAPLATIN 02303 PARAMED ED PRGM-NURSING						23.01
25.05	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>				23.03
30.00		-13, 851, 757	39, 266, 588				30.00
31.00		-52, 011					31.00
32.00	03200 CORONARY CARE UNI T	C					32.00
40.00		C	993, 321				40.00
50.00	ANCI LLARY SERVI CE COST CENTERS	04 500 450					
50.00 54.00		-31, 583, 459 -1, 048, 616					50.00 54.00
55.00		-5, 154, 636					55.00
59.00		-110, 966					59.00
60.00		-671, 624					60.00
64.00		-16, 907					64.00
65.00		C	3, 323, 658				65.00
66.00		-5, 494, 817					66.00
69.00		-12, 254					69.00
71.00		160, 264					71.00
72.00 73.00		64, 153 C					72.00
74.00		-1, 492					74.00
76.00		C					76.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	8, 057	1, 956, 674				90.00
	09001 FAMILY PRACTICE CLINIC	-129, 659					90.01
	09002 OUTPATIENT PSYCH SERVICES	0					90.02
90.03		-1, 236					90. 03 90. 04
90.04 90.05		-1, 374, 025 -416, 201					90.04
	09006 WOUND CARE CENTER	-73, 620					90.05
90.07		-591, 529					90.07
91.00	09100 EMERGENCY	-12, 756, 998	15, 123, 407				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	-					_
	09600 DURABLE MEDICAL EQUIP-RENTED	C					96.00
101.0	0 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	C	0 0				101.00
116 0	0 11600 HOSPI CE	C	0				116.00
118.0		-73, 835, 789					118.00
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C					190.00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	C					192.00
	1 19201 DEACONESS URGENT CARE	C					192.01
	2 19202 HEARTCARE		1, 133, 349				192.02
	3 19203 FAMILY PRACTICE		9, 129, 973				192.03
	0 07950 MISC NONREI MBURSABLE 1 07951  OCCUPATI ONAL HEALTH		2, 122, 236 527, 300				194.00 194.01
	207952 OTHER FACILITIES		2, 986, 980				194.01
	3 07953 HEART HOSPI TAL		2, 900, 900				194.02
	4 07954 PUBLIC RELATIONS						194.04
	5 07955 CHI LD CARE CENTER	C					194.05
194.0	6 07956 CENTER FOR LIFE BALANCE	C					194.06
	7 07957 DEACONESS VNA	C					194.07
200.0	0 TOTAL (SUM OF LINES 118-199)	-73, 835, 789	523, 006, 446				200.00

DEACONESS HOSPI TAL

In Lieu of Form CMS-2552-10

Health Financial Systems

	Financial Systems		DEACONESS		CCN: 15008		u of Form CM Worksheet	
RECERS						From 10/01/2014 To 09/30/2015	Date/Time	
		Increases					2/26/2016	
	Cost Center	Line #	Sal ary	Other				
	2.00 A - BUILDING DEPRECIATION	3.00	4.00	5.00				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	580, 444				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00	TOTALS		00	0 580, 444				4.00
	B - EQUI PMENT DEPRECIATION		U	300, 444				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	19, 671, 284				1.00
2.00 3.00		0. 00 0. 00	0 0	0 0				2.00
3.00 4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00 9.00		0. 00 0. 00	0	0 0				8.00 9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00 14.00		0. 00 0. 00	0 0	0				13.00 14.00
14.00 15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19. 00 20. 00		0. 00 0. 00	0 0	0				19.00 20.00
20.00		0.00	0	0				20.00
22.00		0.00	О	0				22.00
23.00		0.00	0	0				23.00
24. 00 25. 00		0. 00 0. 00	0	0				24.00 25.00
26.00		0.00	0	0				25.00
27.00		0.00	0	0				27.00
28.00		0.00	0	0				28.00
29.00		0.00	0	0				29.00
30. 00 31. 00		0. 00 0. 00	0 0	0				30.00 31.00
32.00		0.00	0	0				32.00
33.00		0.00	0	0				33.00
34.00		0.00	0	0				34.00
35.00 36.00		0. 00 0. 00	0 0	0				35.00 36.00
37.00		0.00	0	0				37.00
38.00		0.00	0	0				38.00
39.00		0.00	0	0				39.00
40. 00 41. 00		0.00 0.00	0	0				40.00
41.00		0.00	0	0				41.00
43.00		0.00	0	0				43.00
44.00		0.00	0	0				44.00
45.00	TOTALS	0.00	0	00 				45.00
	C - INTEREST EXPENSE		0	17, 071, 204				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	266, 664				1.00
2.00		0.00	0	0				2.00
	TOTALS D - CAFETERIA		0	266, 664				_
1.00	CAFETERIA	11.00	1, 101, 144	0				1.00
2.00	GIFT, FLOWER, COFFEE SHOP &	190.00	933, 495	0				2.00
2 22	CANTEEN		_	_				0.05
3.00 4.00	CAFETERI A	0. 00 11. 00	0	0 934, 107				3.00 4.00
4.00 5.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	791, 889				4.00
	CANTEEN		5	,,				
6.00				0				6.00
	TOTALS E - INCENTIVE COMPENSATION		2, 034, 639	1, 725, 996				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	105, 267	0				1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	2, 529, 312	0				2.00
3.00	OPERATION OF PLANT	7.00	235, 369	0				3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	16, 784	0				4.00
5.00 6.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	61, 512 53, 843	0				5.00 6.00
	I= · = · · · · · ·	10.00	00, 010	0				1 0.00

## Health Financial Systems RECLASSIFICATIONS

## DEACONESS HOSPI TAL

Provider CCN: 150082

In Lie	u of Form CMS-2552-10
Peri od:	Worksheet A-6 Date/Time Prepared: 2/26/2016 11:44 am
From 10/01/2014	
To 09/30/2015	Date/Time Prepared:
	2/26/2016 11:44 am

Increases         Increases           0         Line & Settry         0.01er         0.01						10 09/30/2015 Date/Time Pr 2/26/2016 11	
z $200$ $3.00$ $4.00$ $5.90$ $2.00$ 0.00         HERLIGA ADMINISTRATION         11.00 $47.97$ $0.00$ $4.000$ $2.00$ $4.000$ $0.00$ 0.00         HERLIGA ADMINISTRATION         11.00 $2.00$ $0.00$			Increases				
7.00         NURSING ADMINSTRATION         15.00         47.97         0         7.00           9.00         REWICES & SUPPLY         16.00         200.951         0         8.00           9.00         REWICES & SUPPLY         16.00         200.951         0         8.00           9.00         REWICES & SUPPLY         15.00         10.00         10.00         10.00           10.00         REWICES & SUPPLY         10.00         10.00         10.00         10.00           10.00         REWICES & SUPPLY         10.00         10.05         10.00         11.00           10.00         REWICES & SUPPLY         10.00         10.05         11.00         11.00           10.00         REWICES & SUPPLY         10.00         10.565         0         11.00           10.00         REWICES & SUPPLY         40.00         11.50         10.00         10.00           10.00         REWICE							
8:00         CENIRGL SERVICES & SUPPY         11.00         90.14         0         90.00           00         PRAMEY CONSTRATING AND	7.00						7.00
9.00         HARMACY         15.00         209,514         0         9.00           100         BUSLALE LEVELS         11.00         200,00         11.00           110         BUSLALE LEVELS         11.00         200,00         11.00           110         BUSLALE LEVELS         200,00         11.00         200,00         11.00           110         BUSLALE LEVELS         200,00         44.44,440         0         11.00           110         BUSLALE STELATER         30.00         44.4,440         0         11.00           110         BUSLALE STELATER         30.00         44.4,440         0         11.00           110         BUSLALE STELATER         50.00         224.64         0         11.00           110         BUSLALE STELATER         50.00         224.55         0         11.00           110         BUSLALE STELATER         50.00         24.55         0         22.00           110         BUSLALE STELATER         50.00         24.55         0         22.00           110         BUSLALE STELATER         50.00         24.55         0         22.00           110         BUSLALE STELATER         50.00         70.00         70.00							
10.00         belor (L. BECHOSE & L BRAWY         16.00         70, (b)         0         10.00         10							
12 00         PRAMED ED PROCHAMANCY         22 00         908         0         12.00	10.00	MEDICAL RECORDS & LIBRARY					
13 00         ADULTS a PEDIATRICS         30.00         454,410         0         112.00         112.00           14 00         INTERNIC CARE UNIT         31.00         146,440         0         112.00           15 00         CARDIAGY CARE UNIT         32.00         36,544         0         112.00           15 00         CARDIAGY CARE UNIT         32.00         36,544         0         112.00           16 00         KADICIONY, HEARPENTIC         55.00         22,555         0         120.00           20 00         CARDIAC CATHERT PATION         97.00         14,464         0         220.00           21 00         CARDIAC CATHERT PATION         97.00         14,464         0         220.00           21 00         CARDIAC CATHERT PATION         97.00         14,464         0         220.00           22 00         CARDIAC CATHERT PATION         97.00         14,464         0         220.00           23 00         KESIN RATORY THEARY         46.00         270.00         220.00         220.00         220.00         220.00         220.00         220.00         220.00         220.00         220.00         220.00         220.00         220.00         220.00         220.00         220.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
14.00         INTERSING CARE UNIT         31.00         14.6,440         0           15.00         CRAWARY CARE UNIT         32.00         35.644         0           15.00         CRAWARY CARE UNIT         32.00         35.644         0           15.00         CRAWARY CARE UNIT         32.00         35.644         0           16.00         CRAWARY CARE UNIT         52.00         35.644         0           17.00         CRAWARY CARE UNIT         52.00         25.655         0           18.00         CRAWARY CARE UNIT         52.00         25.655         0         18.00           19.00         CRAWARY CARE UNIT         52.00         25.65         0         25.00         25.00           21.00         CRAWARY CARE UNIT         62.00         25.727         0         22.00         23.00           23.00         CRAWARY PROFILIC/GLINIC SS         90.00         17.184         0         22.00         23							
15.00         DEROMARY CART UNIT         32.00         33.504         0         15.00         DEROMARY CART UNIT         32.00         35.504         0         15.00         15					-		
16.00         SUBPROVIDER - IFF         40.00         10,355         0         16.00         16.00         16.00         16.00         16.00         17.00							
18.00         RADIOLOCY-DEARPERTY         54.00         146.663         0           19.00         RADIOLOCY-THEARPENTIC         55.00         25.455         0         20.00           20.01         CANDIAC CATHERT REAVITO         39.00         14.464         0         20.00           21.00         DESPIRATION         39.00         14.464         0         20.00           22.00         DESPIRATON         46.00         20.01         22.00         22.00           24.00         ELETRORN         90.00         17.666         0         22.00           26.00         CLINIC         90.00         17.666         0         28.00           26.00         CLINIC         90.00         17.666         0         28.00           20.00         MIPATIENT ENTRIN ORS         90.02         17.97         0         33.00           31.00         MIRINENTIN         99.06         13.797         0         33.00           32.00         DARABLE MEDICAL FUENTIN         99.06         1.97         0         33.00           33.00         DEARLE MEDICAL FUENTIN         99.06         1.97         0         33.00           33.00         DEARLE MEDICAL FUENTIN         90.06							
19. 00         MAID COVEY—THE RAPFUTIC         55. 00         25. 655         0         19. 00           20. 00         MAID ALCOVEY—THE RAPFUTIC         55. 00         25. 655         0         20. 00           21. 00         LARDAR TORY         60. 00         291, 419         0         20. 00           21. 00         LARDAR TORY         60. 00         291, 419         0         20. 00           21. 00         LARDAR TORY         60. 00         291, 419         0         20. 00           21. 00         LECTROCKED TOLOGY         69. 00         20. 00         27. 00 <td>17.00</td> <td></td> <td></td> <td>298, 018</td> <td></td> <td></td> <td>17.00</td>	17.00			298, 018			17.00
20.00         CARDIAC CATHEFITER ZATION         \$9.00         14.449         0           21.00         LABRATORY         \$9.00         14.449         0           22.00         INTERVENUES THERAPY         64.00         47.76         0           22.00         INTERVENUES THERAPY         64.00         27.47         0           22.00         INTERVENUES THERAPY         64.00         27.40         22.00           23.00         CHARLATORY THERAPY         64.00         27.41         0           24.00         CLINIC         00.00         75.566         0         22.00           25.00         OUTPATHENT FEVENTSCH SERVICES         90.02         10.045         28.00         29.00           30.00         PRIMARC CARE FOR SENIORS         90.04         15.122         0         30.00           31.00         DURABLE MEDICAL EQUIP-RENTE         90.02,4742         0         33.00          33.00         SLEPP CENTER         90.02,4742         0         33.00           33.00         COMPARCILLENT ICE         192.00         13.80         36.00         33.00           34.00         BURASLEMEDICAL EQUIP FORTICE         192.00         13.80         0         36.00           37.00							
21.00       LMORATORY       60.00       291.40       0       22.00       22.00         22.00       INTAWINDIS THERAPY       64.00       4.776       0       22.00       23.00         23.00       RESPLATORY THERAPY       64.00       4.776       0       22.00       23.00         24.00       ELECTORATIONES THERAPY       64.00       55.027       0       22.00       23.00         24.00       ELECTORATIONES THERAPY       66.00       20.00       24.00       25.00       25.00       33.00       33.00       33.00       33.00       33.00       33.00       33.00       33.00       33.00       35.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
22.00         INTRAVENUUS THERAPY         64.00         4.776         0         22.00         33.00         33.00         33.00         33.00         33.00         33.00         33.00         33.00         35.00         35.00							
23.00         RESPLATORY         HERATORY         45.00         55.927         0         22.00         23.00							
26.00         CLINC         90.00         20.91         0         20.00         20.00         27.00         30.00         30.00         30.00         30.00         33.00         30.00         33.00         33.00         33.00         33.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         36.00         36.00         37.00         38.00         39.00         36.00         36.00         37.00         36.00         40.00         41.00         42.00         43.00         44.00         43.00         44.00         43.00         43.00         43.00         43.00         43.00         43.	23.00	RESPI RATORY THERAPY	65.00	55, 927			23.00
27.00       FAMILY PRACTICE CLINIC       90.01       75.066       0       27.00       72.00<							
28. 00         UITTAT ENT PSYCH SERVICES         90. 02         10. 045         0         22. 00           90. 01         NEXION CENTER         90. 03         166         0         30. 00           00. 00         PRIMARY CARE FOR SENIORS         90. 04         15, 122         0         31. 00           32. 00         MOUND CARE CENTER         90. 06         1, 197         0         32. 00           32. 00         DELERGENCY         91. 00         24/, 742         0         33. 00           34. 00         ELERGENCY         91. 00         24/, 742         0         35. 00           35. 00         DURARE MEDICAL FOLID P-RENTED         92. 00         13. 300         36. 00         36. 00           36. 00         MIXIN VERCTICES         192. 00         13. 20         37. 00         36. 00           36. 00         MIXIN VERCTICES         192. 00         13. 20         37. 00         37. 00         37. 00         37. 00         37. 00         37. 00         37. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00         47. 00							
29.00         INVESTOR CENTER         90.03         186         0         29.00         30.00           00.00         PRIAW VCARE FOR SENIORS         90.04         15.122         0         30.00           20.00         DRIAN DARACELENT         90.06         28.776         0         33.00           20.00         DRIAN CARE CONTER         90.06         1.197         0         33.00           31.00         DRIAN CARE CONTER         90.06         29.04         34.00         34.00           35.00         DRIAN CARE CONTER         90.06         85.299         0         36.00         35.00           30.00         HARTCARE         192.02         10.495         0         35.00         36.00           30.00         MAIL PRACTICE         192.02         10.495         0         38.00         39.00         MAIL PRACTICE         192.02         38.22         0         40.00							
90.00         PRIMARY CARE FOR SENIORS         90.04         15,122         0         30.00         30.00         30.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         32.00         MANAGEVERT         90.06         1,197         0         32.00         32.00         Step Centre         90.04         12.00         33.00         32.00         33.00         33.00         33.00         34.00         Eter Centre         90.04         14.04         34.00         34.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         36.00							
32.00         NOUND CARE CENTER         90.06         1.197         0         32.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00         33.00         32.00         33.00         32.00         33.00         34.00         34.00         34.00         34.00         34.00         34.00         34.00         34.00         34.00         34.00         34.00         34.00         34.00         35.00         33.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         35.00         36.00         37.00         38.00         37.00         38.00         36.00         38.00         38.00         38.00         38.00         42.00         41.00         42.00         41.00         42.00							
33.00         SLEEP CENTER         90.07         29.484         0         33.00           34.00         DURGENCY         91.00         204.742         0         35.00         35.00           61.00         PHSICIANS' PRIVATE OFFICES         192.02         10.495         0         37.00         37.00         37.00         37.00         37.00         37.00         37.00         37.00         37.00         37.00         37.00         37.00         38.00         37.00         37.00         37.00         37.00         37.00         38.00         39.00         40.00         40.00         40.00         40.00         40.00         40.00         40.00         41.00         42.00         42.00         42.00         43.00         44.00         43.00         44.00         43.00         44.00         43.00         44.00<							
94.00         EMERGENCY         91.00         204,742         0         35.00           95.00         DURABLE MEDICAL EQUIP-RENTED         96.00         85.299         0         35.00           35.00         DURABLE MEDICALE EQUIP-RENTED         192.00         11.360         0         37.00           36.00         FAMILY PRATTICE         192.02         10.496         0         38.00         39.00         38.00         39.00         38.00         39.00         39.00         36.00         0         04.00         40.00         40.00         40.00         40.00         40.00         40.00         40.00         40.00         41.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
15.00       DURABLE MEDICAL EQUIP-RENTED       96.00       85.299       0       35.00       36.00         05.00       PHSC ICARS' PRI VATE OFFICES       192.02       10.495       0       37.00       37.00         38.00       PAIL VP PRATICE       192.02       10.495       0       37.00       37.00       37.00       39.00         38.00       PAIL VP PRATICE       192.02       3.221       0       0       39.00       40.00       40.00       40.00       40.00       41.00       43.633       0       41.00       43.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
36.00       PHYSICIANS' PRIVATE OFFICES       192.00       11.300       0       36.00       36.00       37.00       37.00       37.00       37.00       37.00       37.00       37.00       38.00       37.00       38.00       37.00       38.00       37.00       38.00       39.00       40.00       41.00       41.00       41.00       41.00       41.00       42.00       42.00       42.00       42.00       42.00       42.00       44.00       44.00       44.00       44.00       55.587.76.3       0       42.00       44.00       44.00       44.00       44.00       44.00       45.00       40.00       2.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
37. 00       HEARTCARE       192. 02       10. 495       0       37. 00       38. 00       54. 00       38. 00       38. 00       38. 00       38. 00       38. 00       38. 00       38. 00       38. 00       38. 00       39. 00       40. 00       38. 00       39. 00       40. 00       39. 00       40. 00       40. 00       40. 00       40. 00       40. 00       40. 00       40. 00       41. 00       41. 00       42. 00       43. 00       43. 00       43. 00       44. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00       45. 00							
99.00       MISC NONRETHNBURSABLE       194.00       36.010       0         00.00       COUPATIONAL HEALTH       194.01       18.653       0         01.00       DEACOMESS VNA       194.04       34.704       0         02.00       DEACOMESS VNA       194.05       72.056       0         01.00       DEACOMESS VNA       194.07       1.197       0         01.00       CAP REL COSTS-BLDC & FIXT       2.00       0       242.296         1.00       CAP REL COSTS-NVBLE EQUIP       2.00       0       242.296       2.00         1.00       CAP REL COSTS-MVBLE EQUIP       2.00       0       242.296       2.00         1.00       CAP REL COSTS-MVBLE EQUIP       2.00       0       242.296       2.00         1.00       CAP REL COSTS-MVBLE EQUIP       0.00       0       0       0       0.00         1.00       CAP REL COSTS-MVBLE EQUIP       0.00       0       0       0       0       0.00       0	37.00		192.02	10, 495			37.00
0.000         OCCUPATIONAL HEALTH         194.01         18.653         0         40.00           100         PRILIC PELATIONS         194.05         72.056         0         42.00           41.00         OPACINESS VNA         194.07         1.197         0         42.00         44.00           101         CAP REL COSTS-BLDG & FIXT         0.00         0         44.00         44.00           100         CAP REL COSTS-BLDG & FIXT         1.00         434.707         1.00         2.00           1.00         CAP REL COSTS-NUBLE EQUIP         2.00         0         242.296         2.00           3.00         CAP REL COSTS-NUBLE EQUIP         0.00         0         0         30.00         30.00           1.00         CAP REL COSTS-NUBLE EQUIP         0.00         0         0         30.00         30.00           1.00         DEVECS         TOTALS         0.00         0         0         30.00         30.00         30.00           2.00         TOTALS         0.00         0         0         38.865.224         1.00         2.00           1.00         DEVECHARGED TO         71.00         0         1.836.644         1.900         2.00         30.00         2.0							
11.00       PUBLIC RELATIONS       194.04       34.704       0       41.00         20       CHLIC RELATIONS       194.05       72.056       0       42.00         44.00					-		
42.00         CHLD CARE CENTER         194.05         72.056         0         42.00         43.00         EACONESS WAA         194.05         72.056         0         43.00         43.00         EACONESS WAA         194.07         1.197         0         43.00         EACONESS WAA         194.07         1.197         0         0         43.00         EACONESS WAA         194.07         1.197         0         0         43.00         EACONESS WAA         194.07         1.197         0         0         43.00         EACONESS WAA         194.07         1.107         0         0         43.00         EACONESS         EACONESS         EACONES         EACONES         2.00         0         242.09         2.00							
43.00         DEACONESS VNA         194.07         1,197         0         43.00           44.00         TOTALS         0.00         0         0         0         0         44.00           F - LEASES         F         1.00         CAP REL COSTS-BLDG & FIXT         1.00         0         434.00         44.00           1.00         CAP REL COSTS-BLDG & FIXT         1.00         0         434.707         2.00         0         2.00         2.00         0         2.00         3.00           3.00         CAP REL COSTS-MURE EQUIP         2.00         0         2.00         3.00         4.00         4.00           6 - DRUGS         -         -         0         677.003         5.00         5.00         5.00         5.00         2.00         4.00           707ALS         -         0.00         0         38.865.224         1.00         2.00         4.00           1.00         DRUGS CHARGED TO         71.00         0         1.836.644         1.00         2.00         4.00         2.00         3.00         2.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00					-		
TOTALS							
F - LEASES	44.00		0.00		0		44.00
1.00         CAP REL COSTS-BLDG & FIXT         1.00         0         434,707         1.00         200         CAP REL COSTS-MVBLE EQUIP         2.00         0         434,707         2.00         2.00         2.00         2.00         0         2.00         2.00         0         2.00         2.00         0         2.00         0         2.00         0				5, 587, 763	0		-
2.00         CAP REL COSTS-MVBLE EQUIP         2.00         0         242,296         3.00         3.00           3.00         0.00         0         0         0         0         3.00           4.00         0.00         0         0         0         0         3.00           5.00         TOTALS         0         0         0         0         0         5.00           0         FRINGS CHARGED TO PATIENTS         73.00         0         38,865,224         2.00         2.00           1.00         MEDICAL SUPPLY         0         0         38,865,224         1.00         2.00           H         - CENTRAL SUPPLY	1 00		1 00	0	434 707		1 00
4.00       0.00       0       0       0       0       0       0       0       5.00       4.00         5.00       TOTALS       0       0       0       6       77.003       5.00       5.00         G - DRUGS       DUGS CHARGED TO PATIENTS       73.00       0       38.865.224       1.00       2.00         TOTALS       0.00       0       38.865.224       1.00       2.00       2.00         H - CENTRAL SUPPLY       1.00       0       1.836.644       1.00       2.00         2.00       IMPL. DEV. CHARGED TO       71.00       0       1.836.644       1.00         2.00       IMPL. DEV. CHARGED TO       72.00       0       113.777       2.00         3.00       TOTALS							
5.00							
TOTALS				-	0		
G - DRUGS           1.00         DRUGS CHARGED TO PATIENTS         73.00         0         38,865,224         2.00           TOTALS         0.00         0         0         38,865,224         2.00           H - CENTRAL SUPPLI         0         38,865,224         1.00         2.00           H - CENTRAL SUPPLIES CHARGED TO         71.00         0         1,836,644         1.00           PATIENTS         0.00         0         0         13,777         2.00           3.00         0         0         1,950,421         3.00         3.00           1 - RESIDENTS         0         1,237,769         0         1.00         1.00           1 - RESIDENTS         1.00         1,237,769         0         1.00         1.00           1 - RESIDENTS         0         1,237,769         0         1.00         1.00         1.00           1 - RESIDENTS         0         1,237,769         0         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00           2.00         0.03         0.00         0         0         0         0.00         0         0         0.00         0.00         0.00	5.00						5.00
1.00       DRUGS CHARGED TO PATIENTS       73.00       0       38,865,224       1.00         2.00       TOTALS       0       0       38,865,224       2.00         H - CENTRAL SUPPLY       0       38,865,224       1.00         1.00       MEDICAL SUPPLIES CHARGED TO       71.00       0       1,836,644         2.00       IMPL. DEV. CHARGED TO       72.00       0       113,777         PATIENTS       0       0       0       1,950,421         1.00       TOTALS       0       0       1,237,769       0         1.00       IAR SERVICES-SALARY & 21.00       1,237,769       0       1.00         2.00       IAR SERVICES-OTHER PRGM       22.00       973,944       0       2.00         2.00       IAR SERVICES-OTHER PRGM       22.00       0       91,652       3.00         3.00       IAR SERVICES-OTHER PRGM       22.00       0       0       4.00         5.00       0.00       0       0       0       6.00         0.00       0.00       0       0       0       6.00         1.00       2.211,713       91,652       0       0.00       0.00         1.00       0.00 <td< td=""><td></td><td></td><td></td><td>UU</td><td>077,003</td><td></td><td></td></td<>				UU	077,003		
TOTALS         Image: constraint supply           H - CENTRAL SUPPLY         0         38, 865, 224           H - CENTRAL SUPPLIES CHARGED TO         71.00         0         1, 836, 644           PATI ENTS         0         0         1, 836, 644           2.00         IMPL. DEV. CHARGED TO         72.00         0         113, 777           3.00         0         0         1, 950, 421         3.00           1         RESIDENTS         0         1, 237, 769         0           1.00         I&R SERVI (CES-SALARY & 21.00         1, 237, 769         0         1.00           2.00         I &R SERVI (CES-SALARY & 22.00         973, 944         0         2.00           2.00         I&R SERVI (CES-OTHER PRGM         22.00         91, 652         3.00           3.00         I&R SERVI (CES-OTHER PRGM         22.00         0         91, 652         3.00           3.00         I&R SERVI (CES-OTHER PRGM         22.00         0         0         4.00         5.00           6.00         0.00         0         0         0         0         5.00           6.00         0.00         0         0         0         6.00         5.00           J - PASTORAL EDUC	1.00		73.00	0	38, 865, 224		1.00
H - CENTRAL SUPPLY       1.00         MEDI CAL SUPPLIES CHARGED TO       71.00       0       1.836,644         PATI ENTS       72.00       0       113,777       2.00         IMPL. DEV. CHARGED TO       72.00       0       113,777       2.00         ATI ENTS       0       0       0       1,950,421       3.00         I - RESIDENTS       0       1,237,769       0       1.00         I & R SERVI CES-SALARY & 21.00       1,237,769       0       1.00         RAR SERVI CES-OTHER PRGM       22.00       973,944       0       2.00         2.00       I&R SERVI CES-OTHER PRGM       22.00       0       91,652       3.00         3.00       0       I&R SERVI CES-OTHER PRGM       22.00       0       91,652       3.00         4.00       0.00       0       0       0       5.00       6.00         J - PASTORAL EDUCATION       23.01       198,735       0       6.00       6.00         J - PASTORAL EDUCATION       23.01       198,735       0       1.00       3.00         1.00       0.00       0       0       0       3.00       3.00         J - PASTORAL EDUCATION       0.00       0	2.00	L	0.00		š		2.00
1.00       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       71.00       0       1,836,644       1.00         2.00       IMPL. DEV. CHARGED TO PATI ENTS       72.00       0       113,777       2.00         3.00				0	38, 865, 224		
PATI ENTS       IMPL. DEV. CHARGED TO       72.00       0       113,777       2.00         3.00       TOTALS       0       0       0       0       0       3.00         100       IAR SERVI CES-SALARY &       0       0       1,950,421       3.00       3.00         1.00       IAR SERVI CES-SALARY &       21.00       1,237,769       0       1.00       1.00         2.00       IAR SERVI CES-OTHER PRGM       22.00       973,944       0       2.00       2.00         3.00       IAR SERVI CES-OTHER PRGM       22.00       0       91,652       3.00       3.00         3.00       IAR SERVI CES-OTHER PRGM       22.00       0       91,652       3.00       4.00         5.00       0       0.00       0       0       0       6.00       5.00         4.00       0.00       0       0       0       6.00       5.00       6.00         1.00       TOTALS       2.211,713       91,652       4.00       5.00       6.00         1.00       2.211,713       91,652       0       6.00       5.00       6.00         1.00       2.211,713       91,652       0       6.00       6.00       6.	1 00		71.00	0	1 026 611		1 00
2.00       IMPL. DEV. CHARGED TO       72.00       0       113,777       2.00         3.00	1.00		71.00	0	1, 030, 044		1.00
3.00	2.00		72.00	0	113, 777		2.00
TOTALS		PATI ENTS					
I - RESIDENTS       Image: Constraint of the second s	3.00			0	0		3.00
1.00       I&R SERVI CES-SALARY & 21.00       1, 237, 769       0       1.00         2.00       I&R SERVI CES-OTHER PRGM       22.00       973, 944       0       2.00         3.00       I&R SERVI CES-OTHER PRGM       22.00       0       91, 652       3.00         4.00       0.00       0       0       0       4.00         5.00       0.00       0       0       0       5.00         6.00       0.00       0       0       0       5.00         70TALS       2.211, 713       91, 652       6.00       6.00         70TALS       2.01       198, 735       0       1.00         1.00       PARAMED ED PRGM-CHAPLAI N       23.01       198, 735       0       1.00         2.00       0.00       0       0       0       3.00       1.00         2.00       0.00       0       0       0       3.00       1.00         2.00       0.00       0       0       0       1.00       2.00         3.00       0.00       0       0       0       1.00       2.00         3.00       0.00       0       0       0       1.00       3.00				U	1, 950, 421		-
2.00       FRINGES APPRVD I&R SERVICES-OTHER PRGM       22.00       973,944       0       2.00         3.00       I&R SERVICES-OTHER PRGM       22.00       0       91,652       3.00         4.00       COSTS APPRVD       0.00       0       0       4.00         5.00       0.00       0       0       0       5.00         6.00       0.00       0       0       0       5.00         70TALS       2.01,713       91,652       6.00       5.00         70TALS       2.01       198,735       0       6.00         7.00       PARAMED ED PRGM-CHAPLAI N       23.01       198,735       0       1.00         2.00       PARAMED ED PRGM-CHAPLAI N       23.01       0       4.997       2.00         3.00       0.00       0       0       0       0       3.00         4.00       0.00       0       0       0       3.00	1.00		21.00	1, 237, 769	0		1.00
COSTS APPRVD         22.00         91,652         3.00           4.00         0.00         0         0         4.00           5.00         0.00         0         0         0         4.00           5.00         0.00         0         0         0         4.00           1.00         TOTALS         2.211,713         91,652         6.00         6.00           1.00         PARAMED ED PRGM-CHAPLAI N         23.01         198,735         0         1.00         2.00           2.00         PARAMED ED PRGM-CHAPLAI N         23.01         198,735         0         2.00         3.00           3.00         0.00         0         0         4.00         4.00         4.00         4.00				.,	-		
3.00       I&R SERVICES-OTHER PRGM COSTS APPRVD       22.00       0       91,652       3.00         4.00       0.00       0       0       0       4.00         5.00       0.00       0       0       0       5.00         6.00       0.00       0       0       0       5.00         1.00       PARAMED ED PRGM-CHAPLAI N       23.01       198,735       0       1.00         2.00       0.00       0       0       0       3.00         4.00       0.00       0       0       0       0         0       0.00       0       0       0       0       0         1.00       PARAMED ED PRGM-CHAPLAI N       23.01       198,735       0       1.00       2.00         3.00       0.00       0       0       0       3.00       4.00       3.00	2.00		22.00	973, 944	0		2.00
4.00       0.00       0       0       0       4.00         5.00       0.00       0       0       0       5.00         6.00       0.00       0       0       0       6.00         TOTALS       0.00       0       0       0       6.00         J - PASTORAL EDUCATION       23.01       198,735       0       1.00         2.00       PARAMED ED PRGM-CHAPLAIN       23.01       0       4,997       2.00         3.00       0.00       0       0       0       3.00       4.00	2 00		22.00	0	01 450		2 00
4.00       0.00       0       0       0       4.00         5.00       0.00       0       0       0       5.00         6.00       0.00       0       0       0       6.00         TOTALS       2,211,713       91,652       6.00       6.00         J - PASTORAL EDUCATION       23.01       198,735       0       1.00         2.00       PARAMED ED PRGM-CHAPLAIN       23.01       0       4,997       2.00         3.00       0.00       0       0       0       3.00         4.00       0.00       0       0       4.00	3.00		22.00	0	91,052		3.00
5.00       0.00       0 </td <td>4.00</td> <td></td> <td>0.00</td> <td>О</td> <td>0</td> <td></td> <td>4.00</td>	4.00		0.00	О	0		4.00
TOTALS         2,211,713         91,652           J - PASTORAL EDUCATI ON         J         PARAMED ED PRGM-CHAPLAI N         23.01         198,735         0         1.00           2.00         PARAMED ED PRGM-CHAPLAI N         23.01         0         4,997         2.00           3.00         0.00         0         0         3.00         4.00         4.00				0	0		5.00
J - PASTORAL EDUCATI ON           1.00         PARAMED ED PRGM-CHAPLAI N         23.01         198,735         0         1.00           2.00         PARAMED ED PRGM-CHAPLAI N         23.01         0         4,997         2.00           3.00         0.00         0         0         3.00         3.00	6.00			0	0		6.00
1.00         PARAMED ED PRGM-CHAPLAIN         23.01         198,735         0         1.00           2.00         PARAMED ED PRGM-CHAPLAIN         23.01         0         4,997         2.00           3.00         0.00         0         0         3.00         3.00           4.00         0.00         0         0         4.00         4.00				2, 211, 713	91, 652		-
2.00         PARAMED ED PRGM-CHAPLAIN         23.01         0         4,997         2.00           3.00         0.00         0         0         0         3.00           4.00         0.00         0         0         0         4.00	1 00		23 01	198 735	0		1 00
3.00       0.00       0       0       3.00         4.00       0.00       0       0       4.00					-		
	3.00		0.00				3.00
101ALS     198, 735  4, 997	4.00		0.00	0	0		4.00
		IIVIALS	I I	198, 735	4, 997		I

	Financial Systems SIFICATIONS		DEACONESS H		CCN: 150082	In Lie Period:	u of Form CMS-2552-10 Worksheet A-6
RECLAS	STELETIONS			PI OVI dei	CCN. 150082	From 10/01/2014 To 09/30/2015	Date/Time Prepared: 2/26/2016 11:44 am
		Increases					272072010 11.44 am
	Cost Center	Line #	Sal ary	Other			
	2.00 K - INSURANCE	3.00	4.00	5.00			
1.00	K - INSURANCE CAP REL COSTS-BLDG & FIXT	1.00	0	504, 150			1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.01	0	8, 389			2.00
3.00		0.00	<u>o</u>	0			3.00
			0	512, 539			
1.00	L – PUBLIC RELATIONS ADMINISTRATIVE & GENERAL	5.00	716	0			1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	65, 855			2.00
3.00		0.00	0	0			3.00
4.00			0 				4.00
	M - NURSING EDUCATION		/10	03, 833			
1.00	PARAMED ED PRGM-NURSING	23.03	444, 482	0			1.00
2.00		0.00	0	0			2.00
3.00 4.00		0. 00 0. 00	0	0			3.00
4.00 5.00		0.00	0	0			4.00 5.00
6.00		0.00	0	0			6.00
7.00		0.00	0	0			7.00
8.00		0.00	0	0			8.00
9. 00 10. 00		0. 00 0. 00	0	0			9.00 10.00
11.00		0.00	0	0			11.00
12.00		0.00	0	0			12.00
	TOTALS		444, 482	0			
1.00	N - MEDI CAL SUPPLIES CHARGED MEDI CAL SUPPLIES CHARGED TO	71.00	0	13, 533, 682			1.00
1.00	PATI ENTS	/1.00	0	13, 555, 062			1.00
2.00	IMPL. DEV. CHARGED TO	72.00	0	20, 790, 808			2.00
	PATI ENTS						
3.00 4.00		0.00 0.00	0	0			3.00 4.00
4.00 5.00		0.00	0	0			5.00
6.00		0.00	0	0			6.00
7.00		0.00	0	0			7.00
8.00		0.00	0	0			8.00
9.00	TOTALS		0	<u>34, 324, 490</u>			9.00
	0 - SALARI ES			0110211110			
1.00	MEDICAL RECORDS & LIBRARY	16.00	1, 000, 000	0			1.00
2.00				— — <u>o</u>			2.00
	P - BENEFITS		1,000,000	0			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23, 824, 704			1.00
2.00		0.00	0	0			2.00
3.00		0. 00 0. 00	0	0			3.00
4.00 5.00		0.00	0	0 0			4.00 5.00
6.00		0.00	0	0			6.00
7.00		0.00	0	0			7.00
8.00		0.00	0	0			8.00
9.00		0.00	0	0			9.00
10. 00 11. 00		0. 00 0. 00	0 0	0 0			10.00
12.00		0.00	0	0			11. 00 12. 00
13.00		0.00	0	0			13.00
14.00		0.00	0	0			14.00
15.00		0.00	0	0			15.00
16.00		0.00	0	0			16.00
17.00 18.00		0. 00 0. 00	0	0 0			17.00 18.00
19.00		0.00	0	0			19.00
20.00		0.00	0	0			20.00
21.00		0.00	0	0			21.00
22.00		0.00	0	0			22.00
23. 00 25. 00		0. 00 0. 00	0	0 0			23.00 25.00
25.00		0.00	0	0			25.00
28.00		0.00	0	0			28.00
29.00		0.00	0	0			29.00
30.00		0.00	0	0			30.00
31.00 32.00		0. 00 0. 00	0	0 0			31.00 32.00
32.00 33.00		0.00	0	0			32.00
	•	. 1		-			1

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

	Financial Systems SIFICATIONS		DEACONESS H		CON 150000		u of Form CMS	
REULAS	SIFICATIONS			Provider	CCN: 150082	Period: From 10/01/2014 To 09/30/2015	Worksheet A- Date/Time Pr 2/26/2016 1	repared:
		Increases				1	272072010 1	
	Cost Center	Line #	Salary	Other				
34.00	2.00	3.00	4.00	5.00 0				34.00
35.00		0.00	0	0				35.00
36.00		0.00	0	0				36.00
37.00		0.00	0	0				37.00
38. 00 39. 00		0.00 0.00	0	0 0				38.00 39.00
40.00		0.00	0	0				40.00
41.00		0.00	0	0				41.00
42.00		0.00 0.00	0	0 0				42.00
43.00 44.00		0.00	0	0				43.00 44.00
45.00		0.00	0	0				45.00
46.00		0.00	0	0				46.00
47.00 48.00		0.00 5.00	0	0 0				47.00 48.00
48.00 49.00	ADMI NI STRATI VE & GENERAL	0.00	18, 600 0	0				48.00
	TOTALS		18, 600	23, 824, 704				
	Q - PROPERTY TAXES	0.00		100 501				1.00
1.00 2.00	CAP REL COSTS-MVBLE EQUIP	2.00 0.00	0	128, 534 0				1.00 2.00
2.00	TOTALS	0.00	o	128, 534				2.00
	R – DI SABI LI TY							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	928, 165				1.00
2.00 3.00		0.00 0.00	0	0 0				2.00 3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00 0.00	0	0 0				6.00
7.00 8.00		0.00	0	0				7.00 8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11. 00 12. 00		0.00 0.00	0	0 0				11.00 12.00
12.00		0.00	0	0				12.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16. 00 17. 00		0.00 0.00	0	0 0				16.00 17.00
18.00		0.00	0	0				18.00
19.00		0.00	0	0				19.00
20. 00 21. 00		0.00 0.00	0	0 0				20.00 21.00
21.00		0.00	0	0				21.00
23.00		0.00	0	0				23.00
25.00		0.00	0	0				25.00
26.00 27.00		0.00 0.00	0	0 0				26.00 27.00
28.00		0.00	0	0				28.00
29.00		0.00	0	0				29.00
30.00		0.00 0.00	0	0 0				30.00
31.00 32.00		0.00	0	0				31.00 32.00
33.00		0.00	0	0				33.00
34.00		0.00	0	0				34.00
35.00 36.00		0.00 0.00	0	0 0				35.00 36.00
37.00		0.00	0	0				37.00
38.00		0.00	0	0				38.00
39.00			•	0				39.00
	TOTALS S - SALARY IN NON-SALARY ACCO	UNTS	0	928, 165				-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	425	0				1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	7, 670	0				2.00
3.00	OPERATION OF PLANT	7.00	1, 337	0				3.00
4.00 5.00	LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG	8.00 9.00	1, 150 1, 250	0 0				4.00 5.00
6.00	DI ETARY	10.00	1, 900	0				6.00
7.00	NURSING ADMINISTRATION	13.00	7, 222	0				7.00
8.00 9.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	275 725	0 0				8.00 9.00
9.00 10.00	MEDICAL RECORDS & LIBRARY	16.00	725 1, 425	0				9.00
11.00	SOCI AL SERVI CE	17.00	225	0				11.00
12.00	ADULTS & PEDIATRICS	30.00	72, 611	0				12.00

In Lieu of Form CMS-2552-10

Provider CCN: 150082

Period: Worksheet A-6 From 10/01/2014 To 09/30/2015 Date/Time Prepared:

					lo 09/30/2015 Date/lime Pre 2/26/2016 11:	
		Increases				
	Cost Center	Line #	Sal ary	Other		
10.00	2.00	3.00	4.00	5.00		10.00
13.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31.00	5, 510	0		13.00
14. 00 15. 00	SUBPROVIDER - IPF	32.00 40.00	275 600	0		14.00 15.00
16.00	OPERATING ROOM	40.00 50.00	2, 295	0		16.00
17.00	RADI OLOGY-DI AGNOSTI C	54.00	3, 330	0		17.00
18.00	RADI OLOGY-THERAPEUTI C	55.00	375	0		18.00
19.00	CARDI AC CATHETERI ZATI ON	59.00	600	Ő		19.00
20.00	LABORATORY	60.00	1, 890	0		20.00
21.00	INTRAVENOUS THERAPY	64.00	50	0		21.00
22.00	RESPI RATORY THERAPY	65.00	225	0		22.00
24.00	CLINIC	90.00	600	0		24.00
25.00	FAMILY PRACTICE CLINIC	90.01	3, 690	0		25.00
26.00	OUTPATIENT PSYCH SERVICES	90.02	50	0		26.00
27.00	PRIMARY CARE FOR SENIORS	90.04	4, 080	0		27.00
28.00	PAIN MANAGEMENT	90.05	60	0		28.00
29.00	WOUND CARE CENTER	90.06	350	0		29.00
30.00	SLEEP CENTER	90.07	1, 490	0		30.00
31.00 32.00	EMERGENCY DURABLE MEDICAL EQUIP-RENTED	91.00	17, 150	0		31.00 32.00
32.00	PHYSICIANS' PRIVATE OFFICES	96.00 192.00	125 7, 060	0		33.00
34.00	FAMILY PRACTICE	192.00	106	0		34.00
35.00	MI SC NONREI MBURSABLE	192.03	100	0		35.00
36.00	OCCUPATI ONAL HEALTH	194.00	104	0		36.00
37.00	CHILD CARE CENTER	194.05	50	0		37.00
	TOTALS		146, 409	<u>_</u>		
	T - PART A PHYSICIANS					1
1.00	INTENSIVE CARE UNIT	31.00	45, 050	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	20, 460		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	<u>0</u>		4.00
	TOTALS		45, 050	20, 460		-
1.00	U - HEART SALARIES EMPLOYEE BENEFITS DEPARTMENT	4.00	4, 949	0		1.00
2.00	ADMINI STRATI VE & GENERAL	5.00	4, 949 506	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	6, 290	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	8, 872	0		4.00
5.00	OPERATING ROOM	50.00	19, 313	0		5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	3, 969	0		6.00
7.00	CARDI AC CATHETERI ZATI ON	59.00	2, 738	0		7.00
8.00	EMERGENCY		<u>5, 7</u> 58	— — — <u>0</u>		8.00
	TOTALS		52, 395	0		
	V - SLEEP EAST		011 501	-		
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	314, 504	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	95, 982		2.00
3.00 4.00		0.00 0.00	0	0		3.00 4.00
4.00	TOTALS		314, 504	95,982		4.00
	W - PHARMACY RESIDENCY		514, 504	,3, ,32		-
1.00	PARAMED ED PRGM-PHARMACY	23.00	36, 492	0		1.00
2.00		0.00	0			2.00
	TOTALS	T	36, 492	<u>0</u>		
	X – HEART SERVICES					
1.00	ELECTROCARDI OLOGY	69.00	0	1, 261, 741		1.00
2.00	<u> </u>	0.00	0	0		2.00
	TOTALS		0	1, 261, 741		_
1	Y - HSB BUILDING		-1	- · · · ·		1
1.00	CAP REL COSTS-BLDG & FIXT		0	<u>54,074</u>		1.00
	TOTALS		0	54, 074		-
1 00	Z - CARE TEAM ADULTS & PEDIATRICS	30.00	196, 745	~		1 00
1.00 2.00	OUTPATIENT PSYCH SERVICES	30.00 90.02	334, 352	0		1.00 2.00
2.00	EMERGENCY	90.02 91.00	554, 552 N	32, 916		3.00
0.00	TOTALS		531,097	32, 916		0.00
500.00	Grand Total: Increases		12, 622, 595	125, 083, 145		500.00
		1	1			•

ASSI FI CATI ONS				HOSPI TAL Provi de	r CCN: 150082	In Lie Period: From 10/01/2014	Worksheet A-6
						To 09/30/2015	Date/Time Prepare 2/26/2016 11:44 a
		Decreases		0.11		· ·	
Cost Cent 6.00	er	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00		
A - BUILDING DEPRE	CLATION	7.00	0.00	9.00	10.00		
)		0.00	0			9	1
ADMINISTRATIVE & C		5.00	0	17, 52	-	9	2
MI SC NONREI MBURSAE	LE	194.00	0	40 540 51		9	3
D OTHER FACILITIES TOTALS		1 <u>94.02</u>	0	<u>562, 5</u> 1 580, 44		9	4
B - EQUIPMENT DEPF	ECIATION			300, 44	T		
)		0.00	0		0	9	1
CAP REL COSTS-BLDC	& FIXT	1.00	0	1, 048, 21		9	2
EMPLOYEE BENEFITS		4.00	0	12, 43		9	3
D ADMINISTRATIVE & C		5.00	0	10, 477, 76		9	4
OPERATION OF PLANT		7.00	0	118, 57		9	5
<ul> <li>LAUNDRY &amp; LINEN SE</li> <li>HOUSEKEEPING</li> </ul>	RVICE	8.00 9.00	0	195, 34 56, 91		9	6
DI ETARY		10.00	0	132, 82		9	8
NURSING ADMINISTRA	TION	13.00	0	316, 79		9	9
DO CENTRAL SERVICES &		14.00	Ő	202, 88		9	10
DO PHARMACY		15.00	0	280, 91		9	11
00 MEDICAL RECORDS &	LI BRARY	16.00	0	104, 44		9	12
00 SOCIAL SERVICE		17.00	0	94		9	13
DO ADULTS & PEDIATRI (		30.00	0	1,038,39	-	9	14
DO INTENSIVE CARE UNI		31.00	0	397, 39		9	15
CORONARY CARE UNIT		32.00	0	65, 11		9	16
DO SUBPROVIDER - IPF DO OPERATING ROOM		40.00 50.00	0	72 2, 121, 98		9	17
00 RADI OLOGY-DI AGNOST	10	54.00	0	1, 361, 89	-	9	10
00 RADI OLOGY - THERAPEL		55.00	0	27, 14		9	20
DO CARDIAC CATHETERIZ		59.00	0	133, 05		9	21
DO LABORATORY		60.00	0	560, 10		9	22
DO INTRAVENOUS THERAF	Υ	64.00	0	4, 59		9	23
DO RESPIRATORY THERAF	Υ	65.00	0	79, 07		9	24
00 PHYSICAL THERAPY		66.00	0	33, 55		9	25
DO ELECTROCARDI OLOGY		69.00	0	6, 02		9	26
		90.00	0	5,87		9	27
DO FAMILY PRACTICE CL DO OUTPATIENT PSYCH S		90. 01 90. 02	0	16, 70 34		9	28
00 INFUSION CENTER	LKVICLS	90.02	0	3, 20	-	9	30
DO PRIMARY CARE FOR S	ENLORS	90.04	0	27, 19		9	31
DO PAIN MANAGEMENT		90.05	Ő	75, 92	-	9	32
WOUND CARE CENTER		90.06	0	10, 55		9	33
DO SLEEP CENTER		90.07	0	46, 32	-	9	34
DO EMERGENCY		91.00	0	390, 17		9	35
DURABLE MEDICAL EC		96.00	0	149, 11	· .	9	36
DO PHYSICIANS' PRIVAT DO HEARTCARE	E OFFICES	192.00 192.02	0 O	56, 40 1, 07		9	37
0 FAMILY PRACTICE		192.02	0	77, 17		9	39
00 MISC NONREIMBURSAE	LE	192.03	0	16, 75		9	40
00 OCCUPATIONAL HEALT		194.01	o	44		9	41
DO PUBLIC RELATIONS		194.04	0	5,45		9	42
00 CHILD CARE CENTER		194.05	0	9, 21		9	43
CENTER FOR LIFE BA	LANCE	194.06	0	1, 75		9	44
DO DEACONESS VNA		1 <u>94.</u> 07	0	46		2	45
TOTALS C - INTEREST EXPEN	ISE		0	19, 671, 28	4		
)		0.00	0		0 1	1	1
CAP REL COSTS-BLDO	& FIXT	1.00	0	266, 66		1	2
TOTALS			0	266, 66	+		
D - CAFETERIA	<u>r</u>						
)		0.00	0		-	0	1
D DI ETARY		0.00 10.00	0 2, 034, 639		0	0	2
		0.00	∠, U34, 039 ∩				3
)		0.00	0 0		ŏ	ol	5
DI ETARY		10.00	o	1, 725, 99	-	0	6
TOTALS			2, 034, 639	1, 725, 99		1	
E - INCENTIVE COMF	ENSATI ON				-1	-1	
)		0.00	0			0	1
)		0.00	0		0	0	2
		0.00	0				3
		0.00 0.00	U				4
)		0.00	0 O		0	0	6
		0.00	0		0	0	7
· · ·		0.00	0			0	

	Financial Systems		DEACONESS				u of Form CMS-	
RECLASS	SIFICATIONS			Provi der		Period: From 10/01/2014 To 09/30/2015	Worksheet A-6 Date/Time Pre	
		Decreases					2/26/2016 11:	44 am
	Cost Center	Line #	Salary		<u>Nkst. A-7 Ref.</u>	-		
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 40.00 40.00 40.00 39.00 40.	6.00	$\begin{array}{c} 7.\ 00\\ \hline 0.\ 00\\ 0.\ 00\ 0.\ 00\\ 0.\ 00\ 0.\ 00\\ 0.\ 00\ 0.\ 00\ 0.\ 00\ 0.\ 00\ 0.\ 0.\$	8.00 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0				9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 31.00 32.00 33.00 34.00 35.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00
42.00 43.00 44.00	ADMI NI STRATI VE & GENERAL TOTALS	0.00 0.00 5.00	0 0 <u>5, 587, 7</u> 63 5, 587, 763	0 0 0	( ( (			42.00 43.00 44.00
1.00 2.00 3.00 4.00 5.00	F - LEASES ADMI NI STRATI VE & GENERAL RADI OLOGY-DI AGNOSTI C DURABLE_MEDI CAL_EQUI P-RENTED TOTALS	0.00 0.00 5.00 54.00 <u>96.</u> 00		0 0 15, 042 613, 913 48, 048 677, 003	10 10 10 10 10			1.00 2.00 3.00 4.00 5.00
1.00 2.00	G - DRUGS PHARMACY	0.00	0 0	0 <u>38, 865, 224</u> <u>38, 865, 224</u>	(			1. 00 2. 00
1.00 2.00 3.00	CENTRAL_SERVICES_&_SUPPLY	0.00 0.00 14.00	0 0 0	0 0 <u>1, 950, 421</u> 1, 950, 421	( ( (			1.00 2.00 3.00
1.00 2.00 3.00 4.00 5.00 6.00	I - RESIDENTS FAMILY PRACTICE CLINIC FAMILY PRACTICE CLINIC PHYSICIANS' PRIVATE OFFICES TOTALS J - PASTORAL EDUCATION	0.00 0.00 90.01 90.01 <u>90.01</u> 1 <u>92.00</u>	0 0 2, 195, 627 0 0 2, 195, 627	0 0 0 91, 652 <u>16, 086</u> 107, 738				1.00 2.00 3.00 4.00 5.00 6.00
1.00 2.00 3.00 4.00	ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL TOTALS	0.00 0.00 5.00 <u>5.00</u>	0 0 198, 735 0 198, 735	0 0 	( ( ( ( (			1.00 2.00 3.00 4.00
1.00 2.00 3.00	K - I NSURANCE ADMI NI STRATI VE & GENERAL TOTALS	0.00 0.00 <u>5.</u> 00		0 0 51 <u>2, 5</u> 39 512, 539	12 12 12	2		1.00 2.00 3.00

	Financial Systems SIFICATIONS		DEACONESS		CCN: 150082	In Lie Period:	u of Form CMS-2552-1 Worksheet A-6
11202100						From 10/01/2014 To 09/30/2015	Date/Time Prepared:
		Decreases					2/26/2016 11: 44 am
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	-	
	L - PUBLIC RELATIONS	7.00	0.00	7.00	10.00		
1.00		0.00	0	0	(		1.0
2.00 3.00	PUBLIC RELATIONS	0.00 194.04	0 716	0			2.0
4.00	PUBLIC RELATIONS	194.04	o	65,855			4.0
	TOTALS M - NURSING EDUCATION		716	65, 855			
1.00	M - NURSING EDUCATION	0.00	0	0	(		1.0
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	20, 759	(		2.0
3.00 4.00	SOCIAL SERVICE ADULTS & PEDIATRICS	17.00 30.00	0	488 299, 261	(		3.0
4.00 5.00	INTENSIVE CARE UNIT	30.00	0	55, 987		-	4.0
6.00	CORONARY CARE UNIT	32.00	0	17, 174	(		6.0
7.00	OPERATING ROOM	50.00	0	23, 409			7.0
8.00 9.00	CARDIAC CATHETERIZATION	59.00 64.00	0	8, 347 1, 789			8. 0 9. 0
10.00	PRIMARY CARE FOR SENIORS	90.04	0	488	(		10.0
	WOUND CARE CENTER	90.06	0	433	(		11.0
12.00	EMERGENCY		<u>0</u>	1 <u>6, 3</u> 47 444, 482	·		12.0
	N - MEDI CAL SUPPLI ES CHARGED		-	,			
1.00		0.00	0	0	(		1.0
2.00 3.00	OPERATING ROOM	0.00 50.00	0	0 27, 823, 416	(		2.0
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 420, 519	(		4.0
5.00	CARDIAC CATHETERIZATION	59.00	0	2, 671, 396	(		5.0
6.00 7.00	RESPIRATORY THERAPY PAIN MANAGEMENT	65.00 90.05	0	479, 461 570, 764	(		6. 0 7. 0
8.00	WOUND CARE CENTER	90.05	0	51, 633	(		8.0
9.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	<u>307, 3</u> 01			9.0
	TOTALS 0 - SALARI ES		0	34, 324, 490			
1.00	U - SALARIES	0.00	0	0	(		1.0
2.00	MEDICAL RECORDS & LIBRARY	<u> </u>	0	1,000,000			2.0
	TOTALS P - BENEFITS		0	1,000,000			
1.00		0.00	0	0	(		1.0
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	4, 783, 605	(		2.0
3.00 4.00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7.00 8.00	0	319, 663 55, 210			3.0
5.00	HOUSEKEEPI NG	9.00	0	363, 813	(		5.0
6.00	DI ETARY	10.00	0	321, 095	(		6.0
7.00 8.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	0	250, 051 203, 890	(		7.0 8.0
	PHARMACY	15.00	0	1, 001, 666	(		9.0
	MEDICAL RECORDS & LIBRARY	16.00	0	405, 828	C		10. 0
	SOCIAL SERVICE	17.00	0	320, 476 12, 687	(		11.0
	PARAMED ED PRGM-PHARMACY ADULTS & PEDIATRICS	23.00 30.00	0	4, 659, 115			12. 0 13. 0
	INTENSIVE CARE UNIT	31.00	0	1, 108, 967	(		14.0
15.00	CORONARY CARE UNIT SUBPROVIDER - IPF	32.00	0	297, 345	(		15.0
	OPERATING ROOM	40.00 50.00	0	98, 136 1, 996, 981			16. 0 17. 0
	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 042, 674	0		18.0
	RADI OLOGY-THERAPEUTI C	55.00	0	71, 355	(		19.0
20.00 21.00	CARDIAC CATHETERIZATION	59.00 60.00	0	135, 136 1, 230, 105	(		20. 0 21. 0
	INTRAVENOUS THERAPY	64.00	0	69, 608	(		22.0
	RESPI RATORY THERAPY	65.00	0	359, 765	(		23.0
	ELECTROCARDI OLOGY RENAL DI ALYSI S	69.00 74.00	0	42, 284 17, 404			25. 0 26. 0
	CLINIC	90.00	0	152, 403	(		28.0
	FAMILY PRACTICE CLINIC	90.01	0	263, 773	(		29.0
	OUTPATIENT PSYCH SERVICES	90. 02 90. 03	0	76, 968 34, 671	(		30. 0 31. 0
	PRIMARY CARE FOR SENIORS	90. 03 90. 04	0	166, 365	(		31.0
33.00	PAIN MANAGEMENT	90.05	0	262, 074	(		33. 0
	WOUND CARE CENTER	90.06	0	38, 963	(		34.0
	SLEEP CENTER EMERGENCY	90.07 91.00	0	153, 013 1, 740, 147			35. 0 36. 0
	DURABLE MEDICAL EQUIP-RENTED	96.00	0	229, 406	(		37.0
	L	100.00	0	E24 210	0		20.0
38.00	PHYSICIANS' PRIVATE OFFICES HEARTCARE	192.00 192.02	0	524, 210 24, 030			38. 0 39. 0

	Financial Systems SIFICATIONS		DEACONESS H		CCN: 150082 Per	i od:	u of Form C Worksheet	
					Fro To	09/30/2015	Date/Time 2/26/2016	
		Decreases						
	Cost Center	Line #	Salary		Wkst. A-7 Ref.			
41.00	6.00 MI SC NONREI MBURSABLE	7.00	8.00	<u>9.00</u> 86,386	10.00			41.00
41.00	OCCUPATI ONAL HEALTH	194.00	0	37, 363				41.00
43.00	HEART HOSPITAL	194.03	0	76, 680				43.00
44.00	PUBLIC RELATIONS	194.04	0	66, 916				44.00
45.00	CHILD CARE CENTER	194.05	0	105, 348				45.00
46.00	CENTER FOR LIFE BALANCE	194.06	О	336	0			46.00
47.00	DEACONESS VNA	194.07	0	24	0			47.00
48.00		0.00	0	0	-			48.00
49.00	ADMI NI STRATI VE & GENERAL	5.00	0	1 <u>8,6</u> 00				49.00
	TOTALS		0	23, 843, 304				
1 00	Q – PROPERTY TAXES	0.00	ol	0	10			1.00
1.00 2.00		0.00 5.00	0	0 128, 534				1.00
2.00	ADMI NI STRATI VE & GENERAL			12 <u>8, 534</u> 128, 534				2.00
	R - DI SABI LI TY		U	120, 334				
1.00		0.00	0	0	0			1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	15, 333	0				2.00
3.00	ADMI NI STRATI VE & GENERAL	5.00	87, 759	0	0			3.00
4.00	OPERATION OF PLANT	7.00	10, 806	0	0			4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	2, 211	0	0			5.00
6.00	HOUSEKEEPI NG	9.00	32, 984	0	0			6.00
7.00	DI ETARY	10.00	16, 584	0				7.00
8.00	NURSING ADMINISTRATION	13.00	7, 939	0				8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	7, 147	0	-			9.00
10.00	PHARMACY	15.00	61, 391	0				10.00
11.00	MEDI CAL RECORDS & LI BRARY	16.00	5, 031	0				11.00
12.00	SOCIAL SERVICE	17.00	28, 278	0				12.00
13.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00	207, 573	0				13.00 14.00
14.00 15.00	CORONARY CARE UNIT	31.00 32.00	52, 423 24, 249	0				14.00
16.00	SUBPROVI DER – I PF	40.00	24, 249 2, 959	0				16.00
17.00	OPERATING ROOM	50.00	101, 160	0				17.00
18.00	RADI OLOGY-DI AGNOSTI C	54.00	45, 640	0				18.00
19.00	RADI OLOGY-THERAPEUTI C	55.00	704	0				19.00
20.00	CARDI AC CATHETERI ZATI ON	59.00	10, 764	0				20.00
21.00	LABORATORY	60.00	79, 576	0	0			21.00
22.00	INTRAVENOUS THERAPY	64.00	571	0	0			22.00
23.00	RESPI RATORY THERAPY	65.00	20, 137	0	0			23.00
25.00	CLINIC	90.00	1, 978	0	0			25.00
26.00	FAMILY PRACTICE CLINIC	90. 01	1, 956	0				26.00
27.00	OUTPATIENT PSYCH SERVICES	90. 02	1, 771	0				27.00
28.00	INFUSION CENTER	90.03	792	0				28.00
29.00	PRIMARY CARE FOR SENIORS	90.04	270	0				29.00
30.00	PAIN MANAGEMENT	90.05	6, 330	0	-			30.00
31.00	SLEEP CENTER	90.07	12, 390	0				31.00
32.00		91.00	57, 797	0 0				32.00
33.00 34.00	DURABLE MEDICAL EQUIP-RENTED PHYSICIANS' PRIVATE OFFICES	96.00 192.00	11, 198 6, 691	0				33.00 34.00
34.00	HEARTCARE	192.00	1, 340	0				34.00
36.00	FAMILY PRACTICE	192.03	245	0				36.00
37.00	MI SC NONREI MBURSABLE	194.00	1, 603	0				37.00
38.00	PUBLIC RELATIONS	194.04	1, 064	0				38.00
39.00	CHILD CARE CENTER	194.05	1, 521	0				39.00
	TOTALS		928, 165	0				
	S - SALARY IN NON-SALARY ACCC	DUNTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	425				1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	7,670				2.00
3.00	OPERATION OF PLANT	7.00	0	1, 337				3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	1, 150				4.00
5.00	HOUSEKEEPING	9.00	0	1, 250				5.00
6.00		10.00	0	1,900				6.00
7.00		13.00	0	7, 222				7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	U	275				8.00
9.00 10.00	PHARMACY MEDI CAL RECORDS & LI BRARY	15.00 16.00	U	725 1, 425				9.00 10.00
10.00	SOCIAL SERVICE	17.00	0	1, 425				10.00
12.00	ADULTS & PEDIATRICS	30.00	0	225 72, 611	0			12.00
12.00	INTENSIVE CARE UNIT	31.00	0	5, 510				12.00
14.00	CORONARY CARE UNIT	32.00	0	275				14.00
15.00	SUBPROVI DER – I PF	40.00	0	600				15.00
16.00	OPERATING ROOM	50.00	0	2, 295				16.00
17.00	RADI OLOGY-DI AGNOSTI C	54.00	ő	3, 330				17.00
18.00	RADI OLOGY-THERAPEUTI C	55.00	Ő	375				18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	600				19.00
-								

Heal th	Fi nanci al	Systems
RECLAS	SLELCATION	S

## DEACONESS HOSPITAL

Provider CCN: 150082

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 10/01/2014 To 09/30/2015 Date/Time Prepared:

					T	To 09/30/2015	Date/Time 2/26/2016	Prepared:
		Decreases					2/20/2010	
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.			
	6. 00	7.00	8.00	9.00	10.00			
20.00	LABORATORY	60.00	0	1, 890	0			20.00
21.00	INTRAVENOUS THERAPY	64.00	0	50	0			21.00
22.00	RESPI RATORY THERAPY	65.00	0	225	0			22.00
24.00	CLINIC	90.00	0	600	0			24.00
25.00	FAMILY PRACTICE CLINIC	90.01	0	3, 690	0			25.00
26.00	OUTPATIENT PSYCH SERVICES	90.02	0	50	0			26.00
27.00	PRIMARY CARE FOR SENIORS	90.04	0	4, 080	0			27.00
28.00	PAIN MANAGEMENT	90.05	0	60	0			28.00
29.00	WOUND CARE CENTER SLEEP CENTER	90.06	0	350	0			29.00
30.00		90.07	0	1,490	0			30.00
31.00 32.00	EMERGENCY	91.00 96.00	0	17, 150	0			31.00 32.00
32.00 33.00	DURABLE MEDICAL EQUIP-RENTED PHYSICIANS' PRIVATE OFFICES	98.00 192.00	0	125 7, 060	0			32.00
34.00	FAMILY PRACTICE	192.00	0	106	0			33.00
35.00	MI SC NONREI MBURSABLE	192.03	0	100	0			35.00
36.00	OCCUPATI ONAL HEALTH	194.01	0	104	0			36.00
37.00	CHILD CARE CENTER	194.05	0	50	0			37.00
07.00	TOTALS		— — — <del>o</del>	146, 409				07.00
	T - PART A PHYSICIANS	I	-1			I		
1.00		0.00	0	0	0			1.00
2.00		0.00	0	0	0			2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	45, 050	0	0			3.00
4.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	2 <u>0, 4</u> 60	0			4.00
	TOTALS		45, 050	20, 460				
	U – HEART SALARIES					I		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 949	0			1.00
2.00	ADMI NI STRATI VE & GENERAL ADULTS & PEDI ATRI CS	5.00	0	506	0			2.00
3.00 4.00	INTENSIVE CARE UNIT	30. 00 31. 00	0	6, 290 8, 872	0			3.00 4.00
4.00 5.00	OPERATING ROOM	50.00	0	8, 872 19, 313	0			5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 969	0			6.00
7.00	CARDI AC CATHETERI ZATI ON	59.00	0	2, 738	0			7.00
8.00	EMERGENCY	91.00	0	5, 758	0			8.00
	TOTALS			52, 395		-		
	V - SLEEP EAST			· ·		!		
1.00		0.00	0	0	0			1.00
2.00		0.00	0	0	0			2.00
3.00	SLEEP CENTER	90.07	314, 504	0	0			3.00
4.00	SLEEP CENTER	<u> </u>	0	<u> </u>	0	-		4.00
			314, 504	95, 982				
1.00	W – PHARMACY RESIDENCY	0.00	0	0	0			1.00
2.00	PHARMACY	15.00	36, 492	0	0			2.00
2.00	TOTALS		36, 492					2.00
	X - HEART SERVICES	I I	00, 172			1		_
1.00		0.00	0	0	0			1.00
2.00	HEART HOSPI TAL	194.03	0	1, 261, 741	0			2.00
	TOTALS		0	1, 261, 741				
	Y - HSB BUILDING							
1.00	CAP REL COSTS-BLDG & FIXT		<u>0</u>	54,074				1.00
	TOTALS		0	54, 074				
4 66	Z - CARE TEAM		Fot or-	-	-	1		
1.00		91.00	531, 097	0	0			1.00
2.00	ADULTS & PEDIATRICS OUTPATIENT PSYCH SERVICES	30. 00 90. 02	0	12, 194	0			2.00
3.00	TOTALS	90.02	531,097	<u> </u>	<u>0</u>	-		3.00
500 00	Grand Total: Decreases		11, 872, 788	125, 832, 952		-		500.00
555.00		I I	11,072,700	120,002,702		I		1 300.00

Health Financial Systems		DEACONESS HOSPI TAL			In Lieu of Form CMS-2552-10			
RECONO	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150082	Period: From 10/01/2014 To 09/30/2015		pared:	
				Acqui si ti on	S			
		Begi nni ng	Purchases	Donati on	Total	Disposals and		
		Bal ances				Retirements		
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	15, 932, 777	3, 219, 356		0 3, 219, 356	0	1.00	
2.00	Land Improvements	0	0		0 0	0	2.00	
3.00	Buildings and Fixtures	479, 910, 222	16, 302, 445		0 16, 302, 445	553, 037	3.00	
4.00	Building Improvements	0	0		0 0	0	4.00	
5.00	Fixed Equipment	0	0		0 0	0	5.00	
6.00	Movable Equipment	267, 484, 272	24, 902, 732		0 24, 902, 732	7, 342, 152	6.00	
7.00	HIT designated Assets	0	0		0 0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	763, 327, 271	44, 424, 533		0 44, 424, 533	7, 895, 189	8.00	
9.00	Reconciling Items	,00,02,72,1	0		0 0	0	9.00	
10.00	Total (line 8 minus line 9)	763, 327, 271	44, 424, 533		0 44, 424, 533	7, 895, 189		
10.00		Ending Balance	Fully		0 11, 121, 000	7,070,107	10.00	
		Ending barance	Depreci ated					
			Assets					
		6,00	7,00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		7100					
1.00	Land	19, 152, 133	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	495, 659, 630	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	285, 044, 852	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	799, 856, 615	0				8.00	
9.00	Reconciling Items	0	0				9.00	
	Total (line 8 minus line 9)	799, 856, 615	0				10.00	

Heal th	Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150082	Period: From 10/01/2014 To 09/30/2015		pared:
	SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	instructions)	
	1	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	17, 712, 268	0	7, 785, 3	13 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	5, 426, 527		0 0	0	2.00
3.00	Total (sum of lines 1-2)	17, 712, 268		7, 785, 3	13 0	0	3.00
	SUMMARY OF 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 WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	25, 497, 581				1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	5, 426, 527				2.00
3.00	Total (sum of lines 1-2)	0	30, 924, 108				3.00

Health Financial Systems	DEACONESS HOSPI TAL		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 10/01/2014 To 09/30/2015		
	COM	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)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS	_				
1.00 CAP REL COSTS-BLDG & FIXT	514, 811, 764	C	514, 811, 764	0. 643630	0	1.00
1.01 CAP REL COSTS-BLDG & FLXT	0	0	) (	0. 000000	0	1.01
2.00 CAP REL COSTS-MVBLE EQUIP	285, 044, 852	0	285, 044, 852			2.00
3.00 Total (sum of lines 1-2)	799, 856, 616		799, 856, 616			3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
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 CE	INTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	) (	18, 144, 107	434, 707	1.00
1.01 CAP REL COSTS-BLDG & FLXT	0	0	) (	54, 074	0	1.01
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	) (	19, 671, 284	5, 668, 823	2.00
3.00 Total (sum of lines 1-2)	0	C	) (	37, 869, 465	6, 103, 530	3.00
	SUMMARY OF CAPITAL					
Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT	7, 207, 976	504, 150	) (	) 0	26, 290, 940	1.00
1.01 CAP REL COSTS-BLDG & FIXT	0	8, 389	) (	0 0	62, 463	1.01
2.00 CAP REL COSTS-MVBLE EQUIP	266, 664	C	128, 534	0	25, 735, 305	2.00
3.00 Total (sum of lines 1-2)	7, 474, 640	512, 539	128, 534	0	52, 088, 708	3.00

	Financial Systems MENTS TO EXPENSES		DEACONESS	Provider CCN: 150082	Period: From 10/01/2014	u of Form CMS-2 Worksheet A-8	
					To 09/30/2015	Date/Time Prep 2/26/2016 11:4	pared: 44 am
				Expense Classification or To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
. 00	Investment income - CAP REL	1.00 B	2.00 -310,673	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 11	1.00
. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.01	0	1.01
. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00	0	
	COSTS-MVBLE EQUIP (chapter 2)		0	CAI REE COSTS-MUDEL ECOT			
00	Investment income - other (chapter 2)		0		0.00		
. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
00	Refunds and rebates of expenses (chapter 8)	В	-80, 028	ADMI NI STRATI VE & GENERAL	5.00	0	5.00
. 00	Rental of provider space by		0		0.00	0	6.00
00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		О		0.00	0	7.00
00	21) Tel evi si on and radi o servi ce		0		0.00	0	8.00
00	(chapter 21) Parking Lot (chapter 21)	В	-26-280	CAP REL COSTS-BLDG & FIXT	1.00	9	
D. 00	Provider-based physician	A-8-2	-41, 737, 898		1.00	Ó	
1.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
2. 00	(chapter 23) Related organization	A-8-1	-31, 722, 280			0	12.00
3. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
4.00 5.00	Cafeteria-employees and guests Rental of quarters to employee	В	-1, 026, 251 0	CAFETERI A	11.00 0.00	0	
5. 00	and others Sale of medical and surgical		0		0.00		
. 00	supplies to other than patients		0		0.00	0	10.00
7.00	Sale of drugs to other than patients		0		0.00	0	17.00
3. 00	Sale of medical records and		0		0.00	0	18.00
9. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19.00
0. 00	books, etc.) Vending machines	В	-47, 138	CAFETERI A	11.00	0	20.00
1.00	Income from imposition of interest, finance or penalty	В	-7, 552	ADMI NI STRATI VE & GENERAL	5.00	0	21.00
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
	repay Medicare overpayments		0		(5.00		
3. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	U	RESPI RATORY THERAPY	65.00		23.00
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
5. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
. 00	physicians' compensation		0	cost center bereted	114.00		25.00
6. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
5. 01	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.01	0	26. 0 <sup>-</sup>
7.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
8. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
9.00 0.00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0.00 67.00		29.00 30.00
	therapy costs in excess of		0	Sost contor bereted	07.00		
). 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
1.00	instructions) Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						

Health Financial Systems	S	DEACONESS	HOSPI TAL	In Lie	eu of Form CMS-:	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 150082	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8	pared:
			Expense Classification o To/From Which the Amount is			
Cost Center	Description Basis/Code (2	2) Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
32.00 CAH HIT Adjustmer		0		0.00	0 0	32.00
Depreciation and						
33.00 FI TNESS MEMBERSHI			EMPLOYEE BENEFITS DEPARTMEN			
33. 01 MI SCELLANEOUS	В		ADMI NI STRATI VE & GENERAL	5.00		
33.03 CALL CENTER	В		ADMI NI STRATI VE & GENERAL	5.00		
33.04 PRIMARY CARE SENI			PRIMARY CARE FOR SENIORS	90.04		
33.05 PROFESSI ONAL BILL			ADMI NI STRATI VE & GENERAL	5.00		33.05
33.06 WEIGHT LOSS PROGE			OPERATING ROOM	50.00		33.06
33.07 FINANCE CHARGES	A		ADMI NI STRATI VE & GENERAL	5.00		33.07
33.09 PROPERTY TAX - RI			ADMI NI STRATI VE & GENERAL	5.00		
33.10 FAMILY PRACTICE (			FAMILY PRACTICE CLINIC	90.01		
33.11 NURSING ADMIN GRA			NURSING ADMINISTRATION	13.00		
33. 13 MEDI CAL AFFAI RS			ADMI NI STRATI VE & GENERAL	5.00		33.13
33.14 DEFEASANCE	A		CAP REL COSTS-BLDG & FIXT	1.00		33.14
33.18 AMORT. PHASE II	A		CAP REL COSTS-BLDG & FIXT	1.00		33.18
33.19 AMORT. PHASE I	A		CAP REL COSTS-BLDG & FIXT	1.00		
33.20 1982 AMORT A & G			CAP REL COSTS-BLDG & FIXT	1.00		
33. 21 PHYSI CLAN RECRUI			ADMI NI STRATI VE & GENERAL	5.00		
42.00 AHA/IHA DUES	А		ADMI NI STRATI VE & GENERAL	5.00		
43.00 ADVERTI SEMENT	А		ADMI NI STRATI VE & GENERAL	5.00		
43. 01 ADVERTI SEMENT	A		RADI OLOGY-THERAPEUTI C	55.00		
44.00 DI ETARY EXPENSE F			DI ETARY	10.00		
45.02 LAUNDRY	В		LAUNDRY & LINEN SERVICE	8.00		
45.03 MEDI CAL RECORDS E RECOVERY	EXPENSE A	557, 868	MEDICAL RECORDS & LIBRARY	16.00	0	45.03
50.00 TOTAL (sum of lir	nes 1 thru 49)	-73, 835, 789				50.00
(Transfer to Worl	ksheet A,					
column 6, line 20	00.)					

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

Heal th	Financial Systems	DEACONESS	HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 150082	Peri od:	Worksheet A-8	
OFFICE	COSTS			From 10/01/2014		
				To 09/30/2015	Date/Time Pre 2/26/2016 11:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
	2.110 1101			Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (	ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			FACILITY RENT	127, 713		1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	FACILITY RENT	14, 839		2.00
3.00			FACILITY RENT	281, 334	518, 677	3.00
4.00	55.00	RADI OLOGY-THERAPEUTI C	FACILITY RENT	6, 253	0	4.00
4.01	60.00	LABORATORY	FACILITY RENT	0	41, 096	4.01
4.02			FACILITY RENT	102, 925	98, 214	4.02
4.03	90.00		FACILITY RENT	66, 034	47, 721	4.03
4.04			FACILITY RENT	651	0	4.04
4.05	90.04		FACILITY RENT	32,007	71, 310	4.05
4.06	90.05	PAIN MANAGEMENT	FACILITY RENT	160, 330	339, 187	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	FACILITY RENT	2,002	0	4.07
4.08	50.00	OPERATING ROOM	CONTRACT SERVICES	11, 063, 480		4.08
4.09			CONTRACT THERAPY	7, 444, 443	12, 943, 971	4.09
4.10			FACILITY RENT	128, 383		4.10
4.11			FACILITY RENT	2, 125		4.11
4.12			FACILITY RENT	220, 438		4.12
4.13			FACILITY RENT	455, 453		4.13
4.14			FACILITY RENT	106, 070	106, 070	4.14
4.15			FACILITY RENT	26, 457	26, 457	4.15
4.16			FACILITY RENT	45, 817	45, 817	4.16
4.17			CONTRACT SERVICES	2, 393, 157	7, 542, 450	4.17
4.18			CONTRACT SERVICES	0	110, 521	4. 18
4.19			CONTRACT SERVICES	525, 840	1, 180, 243	4.19
4.20		CARDI AC CATHETERI ZATI ON	CONTRACT SERVICES	52, 013	0	4.20
4.21			CONTRACT SERVICES	721, 418		4.21
4.22			CONTRACT SERVICES	1, 433, 167	1, 261, 741	4.22
4.23			CONTRACT SERVICES	160, 264		4.23
4.24		IMPL. DEV. CHARGED TO PATIEN		64, 153		4.24
4.25		OPERATING ROOM	CONTRACT SERVICES	2, 708, 444		4.25
4.26			CONTRACT SERVICES	1, 043, 430		4.26
4.27			CONTRACT SERVICES	465, 890		4.27
4.28	0.00			0	0	4.28
5.00	TOTALS (sum of lines 1-4).			29, 854, 530	61, 576, 810	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

6.00	В		100.00 DEACONESS HEALT	0.00	6.00
7.00	В		100.00 DEACONESS HEALT	0.00	7.00
8.00	В		100.00 DEACONESS HEALT	0.00	8.00
9.00	В		100.00 DEACONESS HEALT	0.00	9.00
10.00	В		100.00 DEACONESS HEALT	0.00	10.00
10. 01	В		100.00 DEACONESS HEALT	0.00	10.01
10. 02	В		100.00 DEACONESS HEALT	0.00	10. 02
10. 03	В		100.00 DEACONESS HEALT	0.00	10.03
10.04	В		100.00 DEACONESS HEALT	0.00	10.04
10.05	В		100.00 DEACONESS HEALT	0.00	10.05
10.06	С		100.00 DEACONESS HEALT	0.00	10.06
10. 07	С		0.00 EVANSVILLE SURG	50.00	10.07
10. 08	С		0.00 PROGRESSI VE HEA	51.00	10. 08
10.09	С		0. 00 PROGRESSI VE HEA	51.00	10.09
10. 10	С	DEACONESS HEALT	0. 00 PROGRESSI VE HEA	51.00	10. 10
		1	I I -		

Heal th	Financial Systems	DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
STATEME OFFI CE		I RELATED ORGANIZATIONS AND HO	ME Provider	CCN: 150082	Period: From 10/01/2014 To 09/30/2015		epared:
					nization(s) and/		
	Symbol (1)	Name	Percentage of Ownership		lame	Percentage of Ownership	
	1.00	2.00	3.00		. 00	5.00	
10. 11	A	DEACONESS HEALT		DEACONESS CLI		100.00	
10. 12	A	DEACONESS HEALT		DEACONESS CLI		100.00	
10. 13	A	DEACONESS HEALT		DEACONESS CLI		100.00	
10. 14	A	DEACONESS HEALT		DEACONESS CLI		100.00	
10. 15	A	DEACONESS HEALT		DEACONESS CLI		100.00	
10. 16	A	DEACONESS HEALT		DEACONESS CLI		100.00	
10. 17	A	DEACONESS HEALT		DEACONESS CLI		100.00	
10. 18	C			TRI-STATE RAD		51.00	
10. 19	С			HEART HOSPITA		51.00	
10. 20	С			HEART HOSPITA		51.00	10.20
10. 21	С			HEART HOSPITA		51.00	
10. 22	С			HEART HOSPITA		51.00	
10. 23	С			HEART HOSPITA		51.00	
10. 24	С			HEART HOSPITA		51.00	
10. 25	С			MAINSPRING MG	RS	51.00	
10. 26	С			VASCMED		51.00	
10. 27	С		0.00	VASCMED		51.00	
	G. Other (financial or non-financial) specify:						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. organi zati on.

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

Health Financial Systems	DEACONESS HOSPI	TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES F	ROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 150082	Period: From 10/01/2014	Worksheet A-8-1
011102 00010			To 09/30/2015	Date/Time Prepared:

	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			ENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO					
1.00	18, 352					1.00
2.00	14, 839					2.00
3.00	-237, 343					3.00
4.00	6, 253					4.00
4.01	-41,096	0				4. 01
4.02	4, 711	0				4. 02
4.03	18, 313	0				4.03
4.04	651	0				4.04
4.05	-39, 303	0				4.05
4.06	-178, 857	0				4.06
4.07	2,002	0				4.07
4.08	-16, 821, 949	0				4.08
4.09	-5, 499, 528					4.09
4.10	0	0				4.10
4.11	0	0				4. 11
4.12	0	0				4. 12
4.13	0	0				4.13
4.14	0	0				4.14
4.15	0	0				4. 15
4.16	0	0				4. 16
4.17	-5, 149, 293					4. 17
4.18	-110, 521	0				4. 18
4.19	-654, 403	0				4. 19
4.20	52, 013	0				4.20
4.21	-16, 907	0				4. 21
4.22	171, 426	0				4. 22
4.23	160, 264	0				4.23
4.24	64, 153					4.24
4.25	-2, 958, 062	0				4.25
4.26	-365,016					4.26
4.27	-162, 979					4.27
4.28	0	Ŭ				4.28
5.00	-31, 722, 280		aninto oc annonriato) are trancf			5.00

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

nas	not been posted to worksheet A,		2, th	e anount	allowable sh	nui cateu	or this p	Jar L.	
	Related Organization(s)								
	and/or Home Office								
	Type of Business								
	6.00								
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION	(S) AND	/OR HOME	OFFLCE:				

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.

Termbur Semerre under		
6.00 HEALTH SYSTEM		6.00
7.00 HEALTH SYSTEM	1	7.00
8.00 HEALTH SYSTEM	1	8.00
9.00 HEALTH SYSTEM	1	9.00
10.00 HEALTH SYSTEM	1	10.00
10.01 HEALTH SYSTEM	1	10.01
10.02 HEALTH SYSTEM	1	10.02
10.03 HEALTH SYSTEM	1	10.03
10.04 HEALTH SYSTEM	1	10.04
10.05 HEALTH SYSTEM	1	10.05
10.06 HEALTH SYSTEM	1	10.06
10.07 SURGERY		10.07
10.08 THERAPY SERVI	CE	10.08
10.09 THERAPY SERVI	CE	10.09
10.10 THERAPY SERVI	CE	10. 10
10.11 CLINIC		10. 11
10.12 CLINIC		10. 12
10.13 CLINIC		10. 13

Heal th	Financial Systems	DEACONESS HOSP	In Lieu of Form CMS-2552-10			
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 150082	Peri od:	Worksheet A-	8-1
OFFI CE	COSTS			From 10/01/2014	Data /Tima Dr	onorod.
				To 09/30/2015	Date/Time Pr 2/26/2016 11	
	Related Organization(s)			1.	2,20,2010 11	
	and/or Home Office					
	Type of Business	-				
	Type of Busiliess					
	6.00					
10.14	CLINIC					10.14
10. 15	CLINIC					10.15
10. 16	CLINIC					10.16
10. 17	CLINIC					10.17
10. 18	RADIATION THRPY					10. 18
10. 19	HOSPI TAL					10.19
10.20	HOSPI TAL					10.20
10. 21	HOSPI TAL					10.21
10. 22	HOSPI TAL					10. 22
10. 23	HOSPI TAL					10. 23
10. 24	HOSPI TAL					10.24
10. 25	SURGERY MGMT					10. 25
10. 26	SURGERY MGMT					10.26
10. 27	SURGERY MGMT					10. 27
100.00						100.00

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

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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.

	Financial Syste ER BASED PHYSIC		DEACONESS	HOSPI TAL Provi der		Period:	eu of Form CMS- Worksheet A-8	
						From 10/01/2014 To 09/30/2015	Date/Time Pre 2/26/2016 11:	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMINISTRATIVE & GENERAL	146, 473			171, 400	1, 770	1.00
2.00		SOCIAL SERVICE	205, 031	205, 031	0	171,400	0	2.00
3.00 4.00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	14, 252, 981 65, 360	13, 264, 731	988, 250 65, 360	171, 400 171, 400	4, 869 162	3.00 4.00
5.00		OPERATI NG ROOM	11, 493, 349		878, 995	200, 300	760	4.00 5.00
6.00		RADI OLOGY-DI AGNOSTI C	234,000		234,000	171, 400	936	6.00
7.00	59.00	CARDIAC CATHETERIZATION	38, 524			171, 400	614	7.00
8.00		LABORATORY	739, 117			219, 500	1, 029	8.00
9.00		ELECTROCARDI OLOGY	183, 680			171,400		9.00
10. 00 11. 00		RENAL DI ALYSI S CLI NI C	3, 387 13, 058	0 9, 373	-,	171, 400 171, 400	23 34	10. 00 11. 00
12.00		FAMILY PRACTICE CLINIC	231, 146		0	171,400	0	12.00
13.00		INFUSION CENTER	1, 236		0	171, 400	0	13.00
14.00		PRIMARY CARE FOR SENIORS	1, 395, 093		102, 248	171, 400	746	14.00
15.00		PAIN MANAGEMENT	246, 903		14,656	171,400	116	15.00
16. 00 17. 00		WOUND CARE CENTER SLEEP CENTER	76, 257			171, 400 171, 400	32 122	16. 00 17. 00
18.00		EMERGENCY	16, 579, 136					
200.00			46, 506, 313					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		Identi fi er	Limit	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
					Education	12	mourance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	145, 855	7, 293	0	0	0	1.00
2.00 3.00		SOCIAL SERVICE ADULTS & PEDIATRICS	401, 224	-	0	0	0	2.00 3.00
4.00		I NTENSI VE CARE UNI T	13, 349		0	0	0	4.00
5.00	50.00	OPERATING ROOM	73, 187	3, 659		0	0	5.00
6.00		RADI OLOGY-DI AGNOSTI C	77, 130		0	0	0	6.00
7.00 8.00		CARDI AC CATHETERI ZATI ON LABORATORY	50, 596 108, 589			0	0	7.00 8.00
8.00 9.00		ELECTROCARDI OLOGY	100, 509	5, 429		0	0	8.00 9.00
10.00		RENAL DIALYSIS	1, 895		-	0	0	10.00
11.00		CLINIC	2, 802	140		0	0	11.00
12.00		FAMILY PRACTICE CLINIC	0	0		0	0	12.00
13.00 14.00		INFUSION CENTER PRIMARY CARE FOR SENIORS	61, 473	0 3, 074	0	0	0	13. 00 14. 00
15.00		PAIN MANAGEMENT	9, 559		-	0	0	15.00
16.00	90.06	WOUND CARE CENTER	2, 637	132	0	0	0	16.00
17.00		SLEEP CENTER	10, 053			0	0	17.00
18.00 200.00	91.00	EMERGENCY	3, 822, 138		0	0	0	18.00 200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
		Identifier	Component	Limit	Di sal I owance	5		
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00		
1.00	5.00	ADMI NI STRATI VE & GENERAL	0	145, 855	618	618		1.00
2.00		SOCIAL SERVICE	0			205, 031		2.00
3.00 4.00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	401, 224 13, 349	587, 026 52, 011	13, 851, 757 52, 011		3.00 4.00
4.00 5.00		OPERATI NG ROOM						4.00 5.00
6.00		RADI OLOGY-DI AGNOSTI C	0	77, 130				6.00
7.00		CARDIAC CATHETERIZATION	0	50, 596		0		7.00
8.00			0	108, 589		630, 528		8.00
9. 00 10. 00		ELECTROCARDI OLOGY RENAL DI ALYSI S		0 1, 895	0 1, 492	183, 680 1, 492	1 1	9.00 10.00
11.00		CLINIC		2, 802	883	10, 256		11.00
12.00		FAMILY PRACTICE CLINIC	0	0		231, 146		12.00
13.00		INFUSION CENTER	0	0	-	1,236		13.00
14. 00 15. 00		PRIMARY CARE FOR SENIORS PAIN MANAGEMENT		61, 473 9, 559		1, 333, 620 237, 344		14. 00 15. 00
16.00		WOUND CARE CENTER		2,637	1, 840			16.00
17.00	90. 07	SLEEP CENTER	0	10, 053	4, 557	591, 529		17.00
18.00		EMERGENCY	0					18.00
200.00	I	1	0	4, 780, 487	4, 334, 594	41, 737, 898	I	200. 00

Heal th COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	DEACONESS		CCN: 150082	eriod:	u of Form CMS-: Worksheet B	2552-10
					rom 10/01/2014 o 09/30/2015	Part I Date/Time Pre	
			CAP	TAL RELATED CO	OSTS	2/26/2016 11:	44 am
	Cost Center Description	Net Expenses	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	
		for Cost Allocation				BENEFI TS DEPARTMENT	
		(from Wkst A col. 7)					
	AFNERAL CERVILOF ADOT AFNTERS	0	1.00	1.01	2.00	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	26, 290, 940	26, 290, 940				1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT	62, 463	0	62, 463			1.01
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	25, 735, 305 63, 845, 189	218, 410	4, 471	25, 735, 305 16, 619	64, 084, 689	2.00 4.00
5.00	00500 ADMINISTRATIVE & GENERAL	77, 419, 243	2, 380, 752	39, 819		9, 790, 942	
7.00	00700 OPERATION OF PLANT	11, 818, 713	3, 636, 685	0		950, 170	7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	1, 061, 443 4, 678, 227	500, 141 250, 497	0		174, 041 1, 147, 099	8.00 9.00
10.00	01000 DI ETARY	2, 773, 103	552, 071	0	177, 559	397, 015	
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	961, 862	192, 255	0		320, 985	11.00 13.00
13.00	01400 CENTRAL SERVICES & SUPPLY	2, 662, 358 2, 306, 703	71, 053 538, 406	0		604, 233 603, 114	14.00
15.00	01500 PHARMACY	7, 131, 565	238, 519	0	366, 301	2, 301, 179	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	3, 684, 792	198, 908	0		1, 177, 679	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	3, 099, 420 1, 237, 769	100, 487 0	0		904, 222 360, 811	17.00 21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 065, 596	0	0	0	283, 906	22.00
23.00	02300 PARAMED ED PRGM-PHARMACY 02301 PARAMED ED PRGM-CHAPLAIN	221, 548	5, 856	0	., == -	60, 794	23.00
23. 01 23. 03	02303 PARAMED ED PRGM-CHAPLAIN	203, 732	31, 386 47, 514	1, 777 0	14, 159 11, 667	57, 931 129, 567	23. 01 23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS			-			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	39, 266, 588	5, 685, 671	0		13, 940, 168 3, 007, 409	30.00 31.00
31.00	03200 CORONARY CARE UNIT	11, 269, 926 2, 781, 528	1, 072, 415 186, 683	0		3, 007, 409 730, 685	31.00
40.00	04000 SUBPROVIDER - IPF	993, 321	92, 868			288, 582	40.00
F0.00	ANCI LLARY SERVI CE COST CENTERS	20 7/0 400	2 1/0 0/7	0	2 024 504	( 201 ( 00	
50.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	28, 760, 489 15, 650, 840	2, 169, 847 862, 932	0		6, 391, 680 2, 678, 833	
55.00	05500 RADI OLOGY-THERAPEUTI C	3, 283, 710	329, 776	0		180, 740	55.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 140, 746	220, 078			360, 934	
60.00 64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	28, 626, 399 1, 785, 257	931, 711 24, 165	0		3, 481, 624 189, 801	60.00 64.00
65.00	06500 RESPI RATORY THERAPY	3, 323, 658	121, 524	0	105, 700	917, 688	65.00
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	8, 020, 308 2, 082, 673	146, 655 75, 602	0		0 110, 907	66.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 530, 590	0	0		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	20, 968, 738	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	38, 865, 224 1, 819, 561			-	0 69, 304	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 819, 501	11, 144 0	0		09, 304	76.00
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC 09001 FAMILY PRACTICE CLINIC	1, 956, 674 1, 316, 686	198, 320 287, 303	0		466, 040 286, 178	90. 00 90. 01
90.01	09002 OUTPATIENT PSYCH SERVICES	916, 649	112, 029	0	459	219, 964	90.01
90.03	09003 INFUSION CENTER	961, 211	73, 271	0	4, 283	114, 842	90. 03
90. 04 90. 05	09004 PRI MARY CARE FOR SENI ORS 09005 PAI N MANAGEMENT	1, 117, 328 2, 534, 581	0	0	36, 353 101, 489	606, 447 681, 580	90. 04 90. 05
90.05 90.06	09006 WOUND CARE CENTER	348, 751	9, 002	0	14, 112	109, 806	
90.07	09007 SLEEP CENTER	1, 411, 611	132, 403	0		477, 421	90.07
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 123, 407	944, 693	0	521, 566	5, 767, 437	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
	09600 DURABLE MEDI CAL EQUI P-RENTED	6, 839, 367	346, 966			723, 435	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
	11600 HOSPI CE	0	0	0	-		116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	494, 400, 274	22, 997, 998	46, 067	25, 509, 749	61, 065, 193	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 725, 384	122, 851	0	0	272, 115	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	7, 125, 164	173, 379	0	75, 403	1, 673, 205	192.00
	19201 DEACONESS URGENT CARE 19202 HEARTCARE	0 1, 133, 349		0	0 1, 437	0 63, 016	192.01
	19202 FAMILY PRACTICE	9, 129, 973	34, 456	0	103, 158	169, 774	
194.00	07950 MI SC NONREI MBURSABLE	2, 122, 236	165, 381	16, 396	22, 395	229, 345	194.00
	07951 OCCUPATIONAL HEALTH 07952 OTHER FACILITIES	527, 300 2, 986, 980	206, 167 1, 035, 893	0	600	111, 681	194. 01 194. 02
	07953 HEART HOSPI TAL	2, 980, 980	1, 005, 095		-	0	194.03
194.04	07954 PUBLIC RELATIONS	1, 647, 858			7, 288	172, 296	194.04

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 10/01/2014	Worksheet B Part I	
				To 09/30/2015	Date/Time Pre	pared:
					2/26/2016 11:	44 am
		CAPI	TAL RELATED C	OSTS		
Cost Center Description	Net Expenses	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	
	for Cost				BENEFI TS	
	Allocation				DEPARTMENT	
	(from Wkst A					
	col. 7)					
	0	1.00	1.01	2.00	4.00	
194. 05 07955 CHI LD CARE CENTER	1, 304, 095	296, 419	(	0 12, 318	326, 251	194.05
194.0607956CENTER FOR LIFE BALANCE	27, 892	0	(	2, 341	1, 359	194.06
194.0707957 DEACONESS VNA	631, 510	136, 212	(	0 616	454	194.07
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)	523, 006, 446	26, 290, 940	62, 46	3 25, 735, 305	64, 084, 689	202.00

Health Financial Syste COST ALLOCATION - GEN		DEACONESS			In Lieu eriod: rom 10/01/2014	u of Form CMS- Worksheet B Part I	2552-10
				T		Date/Time Pre	pared:
Cost Cent	er Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	2/26/2016 11: HOUSEKEEPI NG	44 am
	·		& GENERAL	PLANT	LINEN SERVICE	0.00	
GENERAL SERVICE	COST CENTERS	4A	5.00	7.00	8.00	9.00	
	OSTS-BLDG & FIXT						1.00
	OSTS-BLDG & FIXT						1.01
	OSTS-MVBLE EQUI P						2.00
	BENEFITS DEPARTMENT ATIVE & GENERAL	103, 657, 098	103, 657, 098				4.00 5.00
7.00 00700 OPERATI ON		16, 564, 073	4, 094, 407	20, 658, 480			7.00
8.00 00800 LAUNDRY &	LINEN SERVICE	1, 996, 749	493, 568		3, 025, 035		8.00
9.00 00900 HOUSEKEEP	'I NG	6, 151, 905	1, 520, 665		0	7, 940, 385	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A		3, 899, 748 1, 475, 102	963, 963 364, 625	590, 239 205, 547	24, 399 0	236, 036 82, 198	•
13.00 01300 NURSING A		3, 761, 120	929, 696		0	30, 379	
	ERVICES & SUPPLY	3, 719, 426	919, 390		26, 528	230, 194	
15.00 01500 PHARMACY		10, 037, 564	2, 481, 145		0	101, 978	•
	ECORDS & LI BRARY	5, 201, 001	1, 285, 615		0	85, 042	•
17.00 01700 SOCIAL SE 21.00 02100 I&R SERVI	CES-SALARY & FRINGES APPRVD	4, 105, 395 1, 598, 580	1, 014, 796 395, 147	107, 434 0	0	42, 963 0	17.00
	CES-OTHER PRGM COSTS APPRVD	1, 349, 502	333, 578		0	0	22.00
	D PRGM-PHARMACY	297, 418	73, 518		0	2, 504	
	D PRGM-CHAPLAIN	308, 985	76, 377	62, 005	0	24, 796	
23. 03 02303 PARAMED E	D PRGM-NURSING NE SERVICE COST CENTERS	633, 230	156, 526	50, 799	0	20, 315	23.03
30. 00 03000 ADULTS &		60, 259, 242	14, 895, 050	6, 079, 245	1, 444, 562	2, 431, 086	30.00
31.00 03100 I NTENSI VE		15, 876, 417	3, 924, 428		246, 458	458, 508	•
32.00 03200 CORONARY		3, 785, 935	935, 830		68, 360	79, 816	•
40.00 04000 SUBPROVID	ER - I PF CE COST CENTERS	1, 375, 741	340, 064	99, 288	8, 436	39, 705	40.00
50. 00 05000 OPERATI NG		40, 158, 600	9, 926, 644	2, 319, 862	347, 860	927, 712	50.00
54.00 05400 RADI OLOGY		21, 833, 789	5, 397, 007	922, 591	145, 864	368, 944	•
55.00 05500 RADI OLOGY		3, 830, 518	946, 850		0	140, 995	•
59.00 05900 CARDI AC C 60.00 06000 LABORATOR		2, 899, 622	716, 746		89, 405	94, 094	
60.00 06000 LABORATOR 64.00 06400 I NTRAVENO		33, 788, 459 2, 005, 371	8, 352, 034 495, 700		2, 271 0	398, 350 10, 331	
65. 00 06500 RESPI RATO		4, 468, 570	1, 104, 568		502	51, 957	65.00
66. 00 06600 PHYSI CAL		8, 211, 823	2, 029, 848		36, 968	62, 702	
69.00 06900 ELECTROCA		2, 277, 237	562, 901	80, 829	5, 645	32, 323	
	UPPLIES CHARGED TO PATIENTS . CHARGED TO PATIENTS	15, 530, 590 20, 968, 738	3, 838, 944 5, 183, 178		0	0	71.00 72.00
	RGED TO PATIENTS	38, 865, 224	9, 606, 939		0	0	73.00
74.00 07400 RENAL DIA		1, 900, 009	469, 656	11, 915	0	4, 765	
	I C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76.00
90. 00 09000 CLINIC	I CE COST CENTERS	2, 628, 882	649, 823	212, 031	3, 093	84, 791	90.00
90. 01 09001 FAMILY PR	ACTICE CLINIC	1, 912, 498	472, 743		3, 025	122, 835	
	T PSYCH SERVICES	1, 249, 101	308, 760	119, 774	0	47, 898	•
90. 03 09003 I NFUSI ON		1, 153, 607	285, 155		5, 210	31, 327	•
90. 04 09004 PRI MARY C 90. 05 09005 PAI N MANA	ARE FOR SENIORS	1, 760, 128 3, 317, 650	435, 079 820, 077	0	522 22, 724	0	90.04 90.05
90. 06 09006 WOUND CAR		481, 671	119, 062	9, 625	3, 701	3, 849	•
90.07 09007 SLEEP CEN		2, 083, 362	514, 978		3, 263	56, 609	90.07
91.00 09100 EMERGENCY 92.00 09200 0BSERVATI		22, 357, 103 0	5, 526, 363	1, 010, 006	347, 783	403, 901	
	ON BEDS (NON-DISTINCT PART) ABLE COST CENTERS	0					92.00
	EDI CAL EQUI P-RENTED	8, 109, 101	2, 004, 456	370, 953	0	148, 344	
101.00 10100 HOME HEAL		0	0	0	0	0	101.00
SPECIAL PURPOSE 116.00 11600 HOSPICE	COST CENTERS	0	0	0	0	0	116.00
	(SUM OF LINES 1-117)	487, 845, 884	94, 965, 899		2, 836, 579	6, 857, 247	
NONREI MBURSABLE	COST CENTERS						
	WER, COFFEE SHOP & CANTEEN	2, 120, 350	524, 121	131, 344	6, 558		190.00
192. 00 19200 PHYSI CI AN 192. 01 19201 DEACONESS		9, 047, 151	2, 236, 329	185, 365	16, 264 2, 297		192. 00 192. 01
192. 02 19202 HEARTCARE		1, 197, 802	296, 080	0	2, 297		192.01
192.03 19203 FAMILY PR		9, 437, 361	2, 332, 784		0		192.03
194.00 07950 MI SC NONR		2, 555, 753	631, 746		31, 127	175, 684	•
194.01079510CCUPATIO		845, 748	209, 057	220, 420	6, 549		194.01
194.02079520THER FAC 194.0307953 HEART HOS		4, 022, 873 1, 249, 526	994, 398 308, 865		0 108, 622	442, 893 0	194.02 194.03
194. 04 07954 PUBLI C RE		1, 944, 531	480, 661	125, 184	0		194.04
194. 05 07955 CHI LD CAR		1, 939, 083	479, 314		9, 977	126, 733	
194.0607956CENTER F0 194.0707957DEACONESS		31, 592 768, 792	7,809				194. 06 194. 07
	t Adjustments	108, 192	190, 035	145, 630	7, 062	50, 237	200.00
1 1	Cost Centers	0	0	0	0	0	201.00

Health Financial Systems	DEACONESS HOSPI TAL			In Lieu of Form CMS-2552-1		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 10/01/2014	Date/Time Pre	pared:
					2/26/2016 11:	
Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	PLANT	LINEN SERVICE		
	4A	5.00	7.00	8.00	9.00	
202.00 TOTAL (sum lines 118-201)	523, 006, 446	103, 657, 098	20, 658, 480	3, 025, 035	7, 940, 385	202.00

Health Financial Systems	DEACONESS		0011 150000 5		u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		riod: om 10/01/2014 09/30/2015	Worksheet B Part I Date/Time Pre	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	2/26/2016 11: PHARMACY	44 am
	10.00	11.00	13.00	SUPPLY 14.00	15.00	
GENERAL SERVICE COST CENTERS						
1.00       00100       CAP       REL       COSTS-BLDG       & FIXT         1.01       00101       CAP       REL       COSTS-BLDG       & FIXT         2.00       00200       CAP       REL       COSTS-BLDG       & FIXT         2.00       00200       CAP       REL       COSTS-MVBLE       EQUIP         4.00       00400       EMPLOYEE       BENEFITS       DEPARTMENT         5.00       00500       ADMI NI STRATI VE       & GENERAL         7.00       00700       OPERATION OF       PLANT         8.00       00800       LAUNDRY       & LI NEN       SERVICE         9.00       00900       HOUSEKEEPING       10.00       01000       DI ETARY         11.00       01100       CAFETERIA       SUIPLY       SUIPLY	5, 714, 385 0 0	2, 127, 472 31, 005 42, 261	4, 828, 166	5 512 428		1.00 1.01 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
14.00       01400       CENTRAL SERVICES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDICAL RECORDS & LIBRARY         17.00       01700       SOCIAL SERVICE         21.00       02100       I & SERVICES-SALARY & FRINGES APPRVD         22.00       02200       I & SERVICES-OTHER PRGM COSTS APPRVD         23.00       02300       PARAMED ED PRGM-PHARMACY         23.01       02301       PARAMED ED PRGM-CHAPLAIN         23.03       DARAMED ED PRGM-NURSING         INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0 0	42, 261 75, 673 77, 796 41, 482 14, 653 2, 478 1, 840 4, 389 5, 168	0 0 0 0 0 0 21, 804	5, 513, 428 0 45 0 0 0 0 0 0 0	12, 951, 369 0 612 0 0 0 0 0 0	16.00 17.00 21.00
30.00         03000         ADULTS & PEDIATRICS           31.00         03100         INTENSIVE CARE UNIT           32.00         03200         CORONARY CARE UNIT           40.00         04000         SUBPROVIDER - IPF	4, 093, 026 620, 860 146, 808 117, 638	562, 982 133, 648 30, 297 15, 786	127, 835	171, 493 83, 400 23, 056 0	5, 342 1, 896 649 0	31.00 32.00
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM           54.00         05400         RADI OLOGY-DI AGNOSTI C           55.00         05500         RADI OLOGY-THERAPEUTI C           59.00         05500         CARDI AC CATHETERI ZATI ON           60.00         06000         LABORATORY           64.00         06400         INTRAVENOUS THERAPY           65.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY           66.00         06900         ELECTROCARDI OLOGY           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS	0 0 0 0 0 0 0 0 0	134, 639 118, 429 7, 716 12, 954 207, 834 6, 654 41, 553 0 4, 884 0	0	38, 971 182, 338 416 6, 858 925, 392 61, 534 20, 312 15, 724 8, 049 1, 447, 192 1, 968, 448	9, 593 2, 819 10 166 561 60 0 1, 947 15 0 0	54.00 55.00 59.00 60.00 64.00 65.00 66.00 69.00 71.00
72.00 07200 TIMEL DEV. CHARGED TO PATTENTS 73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DI ALYSI S 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0UTPATTENT SERVI CE COST CENTERS	0	0 0 2, 619 0	0 0 11, 051 0	1, 908, 448 109, 926 11, 882 0	0 10, 501, 056 136 0	73.00 74.00
90.00       09000       CLINIC         90.01       09001       FAMILY PRACTICE CLINIC         90.02       09002       OUTPATIENT PSYCH SERVICES         90.03       09003       INFUSION CENTER         90.04       09004       PRIMARY CARE FOR SENIORS         90.05       09005       PAIN MANAGEMENT         90.06       09006       WOUND CARE CENTER         90.07       09007       SLEEP CENTER         91.00       09100       EMERGENCY	0 0 0 0 0 0 0 0 0 105, 665	20, 599 14, 582 11, 892 5, 309 15, 432 30, 439 4, 955 16, 777 136, 338	61, 528 50, 178 22, 401 65, 112 128, 433 20, 908 0	13, 941 3, 020 0 14, 202 510 2, 204 0 3, 048 87, 680	0 20, 516 0 45 15, 902 0 3, 854 22 597	90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07
92.00     09200     OBSERVATION BEDS (NON-DISTINCT PART)       0THER     REI MBURSABLE     COST CENTERS       96.00     09600     DURABLE     MEDI CAL     EQUI P-RENTED       101.00     10100     HOME     HEALTH     AGENCY	0	43, 747	0	276, 318		92.00 96.00 101.00
SPECIAL PURPOSE COST CENTERS           116. 00         HOSPI CE           118. 00         SUBTOTALS (SUM OF LINES 1-117)           NONREI MBURSABLE COST CENTERS	0 5, 083, 997	0 1, 876, 810	0	0 5, 475, 967		116. 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 DEACONESS URGENT CARE 192. 02 19202 HEARTCARE	0 0 0 0	26, 687 53, 941 0 4, 743	0 0 0	0 2, 269 0 0	19, 342 0 0	190. 00 192. 00 192. 01 192. 02
192. 03 19203 FAMILY PRACTICE 194. 00 07950 MISC NONREIMBURSABLE 194. 01 07951 OCCUPATIONAL HEALTH 194. 02 07952 OTHER FACILITIES	0 356, 270 0 0	6, 371 14, 795 5, 663 0	0 0 0 0	23, 243 5, 944 4, 069 0	1, 638 0	194. 00 194. 01 194. 02
194. 03 07953 HEART HOSPITAL 194. 04 07954 PUBLIC RELATIONS 194. 05 07955 CHILD CARE CENTER 194. 06 07956 CENTER FOR LIFE BALANCE 194. 07 07957 DEACONESS VNA	245, 025 0 0 29, 093	99, 670 7, 716 31, 076 0 0	0 0 0 0	0 0 1, 053 0 883	0 0 0	194. 03 194. 04 194. 05 194. 06 194. 07
200.00 Cross Foot Adjustments						200.00

Health Fina	ancial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Provi der		Period:	Worksheet B	
					From 10/01/2014 To 09/30/2015		pared.
						2/26/2016 11:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI O	N SERVICES &		
					SUPPLY		
		10.00	11.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118-201)	5, 714, 385	2, 127, 472	4, 828, 16	6 5, 513, 428	12, 951, 369	202.00

Health Financial Systems	DEACONESS				u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	veriod: rom 10/01/2014 o 09/30/2015	Date/Time Pre	pared:
			I NTERNS &	RESI DENTS	2/26/2016 11:	44 am
Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	SERVICES-SALAR Y & FRINGES	SERVI CES-OTHER PRGM COSTS	PARAMED ED PRGM-PHARMACY	
	LI BRARY 16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS	1	1	1	1		1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.01 00101 CAP REL COSTS-BLDG & FLXT						1.00 1.01
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINI STRATIVE & GENERAL						4.00 5.00
7. 00 00700 OPERATI ON OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY						10.00
						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
15. 00 01500 PHARMACY						15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	6, 862, 158					16.00 17.00
21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	5, 312, 690 0	2, 008, 380			21.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		1, 685, 558		22.00
23. 00   02300  PARAMED ED PRGM-PHARMACY 23. 01   02301  PARAMED ED PRGM-CHAPLAI N	0	0			381, 541	23.00 23.01
23. 03 02303 PARAMED ED PRGM-NURSI NG	0	24, 039				23.03
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         O3000 ADULTS & PEDI ATRI CS	407 510	4 251 110	920, 865	772 944	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	487, 518 179, 752		21, 364		0	31.00
32. 00 03200 CORONARY CARE UNI T	42, 443		C	0	0	32.00
40. 00 04000 SUBPROVI DER – I PF ANCI LLARY SERVI CE COST CENTERS	24, 526	0	C	0	0	40.00
50. 00 05000 OPERATI NG ROOM	911, 990	0			0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 078, 957 112, 357	0	8, 880	7,453	0	54.00 55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	128, 741	0	34, 772	Ŭ	0	59.00
60. 00 06000 LABORATORY	896, 994	0	C	0	0	60.00
64. 00  06400  I NTRAVENOUS THERAPY 65. 00  06500  RESPI RATORY THERAPY	14, 344 107, 403	0		0	0	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	215, 892	0	C	0	0	66.00
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	106, 500 107, 107	0		0	0	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	162, 495	0	C C	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	736, 950	0		0	381, 541	73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	28, 440	0		-	0	74.00 76.00
OUTPATIENT SERVICE COST CENTERS		_	-	-		
90. 00 09000 CLINIC 90. 01 09001 FAMILY PRACTICE CLINIC	18, 118		0 685, 901	0 0 575, 651	0	90.00 90.01
90. 02 09002 OUTPATI ENT PSYCH SERVICES	11, 265		C	0	0	90. 02
90. 03 09003 I NFUSI ON CENTER 90. 04 09004 PRI MARY CARE FOR SENI ORS	36, 564		C 24 914	0 29, 220	0	90. 03 90. 04
90. 05 09005 PALN MANAGEMENT	5, 389 106, 119		34, 816 C	0 29,220	0	90.04 90.05
90. 06 09006 WOUND CARE CENTER	6, 423		C	0	0	90.06
90. 07 09007 SLEEP CENTER 91. 00 09100 EMERGENCY	16, 057 611, 957		101, 239	0 0 84, 966	0	90.07 91.00
92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)						92.00
OTHER         REI MBURSABLE         COST         CENTERS           96.00         09600         DURABLE         MEDI CAL         EQUI P-RENTED	63, 660	0	C	0	0	96.00
101.00 10100 HOME HEALTH AGENCY	03,000	0	C C	0		101.00
SPECIAL PURPOSE COST CENTERS	0				0	114 00
116.00 11600 H0SPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117)	6, 227, 064	5, 312, 690	2, 008, 380	1, 685, 558		116.00 118.00
NONREI MBURSABLE COST CENTERS	-	-	-	1		
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0 3, 335	0		0		190. 00 192. 00
192.01 19201 DEACONESS URGENT CARE	0	0	C	0	0	192. 01
192. 02 19202 HEARTCARE 192. 03 19203 FAMI LY PRACTI CE	7,542	0	C	0		192. 02 192. 03
192. 03 19203 FAMILY PRACTICE 194. 00 07950 MISC NONREI MBURSABLE	42, 836	0		0		192.03 194.00
194. 01 07951 OCCUPATI ONAL HEALTH	0	0	C	0		194.01
194. 02 07952 0THER_FACILITIES 194. 03 07953 HEART_H0SPITAL	0 578, 319	0 0		0 0		194. 02 194. 03
194. 04 07954 PUBLIC RELATIONS	0	0	c c	0	0	194.04
194. 05 07955 CHILD CARE CENTER 194. 06 07956 CENTER FOR LIFE BALANCE	0	0		0		194. 05 194. 06
THE DELANCE	, U	1 U		u U	0	1, 14, 00

Health Financial Systems	DEACONESS HOSPI TAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 10/01/2014	Worksheet B Part I		
				o 09/30/2014		pared:	
			I NTERNS &	RESI DENTS			
Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	SERVICES-SALAF Y&FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-PHARMACY		
	LI BRARY						
	16.00	17.00	21.00	22.00	23.00		
194.0707957DEACONESS VNA	3, 061	0	0	0 0	0	194.07	
200.00 Cross Foot Adjustments			0	0 0	0	200.00	
201.00 Negative Cost Centers	0	0	0	0 0	0	201.00	
202.00 TOTAL (sum lines 118-201)	6, 862, 158	5, 312, 690	2, 008, 380	1, 685, 558	381, 541	202.00	

		DEACONESS		CON: 150000		u of Form CMS-	2552-10
CUST AL	LOCATION - GENERAL SERVICE COSTS		Provider	F	Period: From 10/01/2014 To 09/30/2015		pared:
	Cost Center Description	PARAMED ED PRGM-CHAPLAI N	PARAMED ED PRGM-NURSI NG	Subtotal	Intern & Residents Cost & Post Stepdown	2/26/2016 11: Total	44 am
		23.01	23.03	24.00	Adjustments 25.00	26.00	
	GENERAL SERVICE COST CENTERS	I	I	1	1		
1. 01       0         2. 00       0         4. 00       0         5. 00       0         7. 00       0         8. 00       0         9. 00       0         10. 00       0         11. 00       0         13. 00       0         16. 00       0         17. 00       0         21. 00       0         23. 00       0         23. 03       0	D0100       CAP       REL       COSTS-BLDG & FIXT         D0101       CAP       REL       COSTS-BLDG & FIXT         D0200       CAP       REL       COSTS-NVBLE       EQUIP         D0400       EMPLOYEE       BENEFITS       DEPARTMENT         D0500       ADMI NI STRATI VE & GENERAL       D0700       OPERATION OF PLANT         D0800       LAUNDRY & LINEN       SERVICE       D0900         D1000       DI ETARY       D1100       CAFETERIA         D1300       NURSI NG ADMI NI STRATI ON       D1400       CENTRAL         D1400       CENTRAL       SERVI CES & SUPPLY         D1500       PHARMACY       D1400       SERVI CES & SUPPLY         D1500       IAR SERVI CES-SALARY & FRI NGES       APPRVD         D2200       I & SERVI CES-OTHER       PRGM COSTS       APPRVD         D2200       I & SERVI CES-OTHER       PRGM COSTS       APPRVD         D2200       PARAMED ED       PRGM-PHARMACY       D2301       PARAMED ED         D2300       PARAMED ED       PRGM-CHAPLAIN       D2303       PARAMED ED       PRGM-NURSI NG	476, 552	911, 881				$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 01\\ 23. \ 03\\ \end{array}$
	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT	476, 552	641, 700 122, 143			98, 274, 320 23, 694, 525	
	D3200 CORONARY CARE UNI T	0	35, 395			5, 692, 368	
	D4000 SUBPROVI DER – I PF	0	C	2, 087, 790	0 0	2, 087, 790	40.00
	ANCILLARY SERVICE COST CENTERS	0	49, 863	3 55, 762, 676	- 368, 852	55, 393, 824	50.00
	D5400 RADI OLOGY-DI AGNOSTI C	0	49, 803			30, 050, 738	
	05500 RADI OLOGY-THERAPEUTI C	0	C			5, 391, 437	
	D5900 CARDI AC CATHETERI ZATI ON	0	19, 126			4, 257, 663	
		0	0	10,000,020		45, 568, 020	1
	D6400 I NTRAVENOUS THERAPY D6500 RESPI RATORY THERAPY	0	4, 098			2, 652, 003	
	D6600 PHYSICAL THERAPY	0				5, 924, 791 10, 731, 699	
	D6900 ELECTROCARDI OLOGY	0		3, 078, 383		3, 078, 383	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	20, 923, 833		20, 923, 833	
	D7200 IMPL. DEV. CHARGED TO PATIENTS	0	C	28, 282, 859	9 0	28, 282, 859	72.00
	D7300 DRUGS CHARGED TO PATIENTS	0	C	00/201/000		60, 201, 636	
	07400 RENAL DI ALYSI S	0	0			2, 440, 473	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES DUTPATI ENT SERVI CE COST CENTERS	0	C	) (	0 0	0	76.00
	DODO CLINIC	0	0	3, 718, 194	1 0	3, 718, 194	90.00
	D9001 FAMILY PRACTICE CLINIC	0	C	4, 188, 568		2, 927, 016	90.01
	09002 OUTPATI ENT PSYCH SERVI CES	0	C	1, 798, 868		1, 798, 868	
	09003 INFUSION CENTER	0	0	1, 632, 156		1, 632, 156	
	D9004 PRIMARY CARE FOR SENIORS D9005 PAIN MANAGEMENT	0	1, 118	2, 363, 228 4, 427, 646		2, 299, 192 4, 427, 646	
	09006 WOUND CARE CENTER	0	994			655, 042	
	D9007 SLEEP CENTER	0	0	2, 835, 673		2, 835, 673	
91.00	D9100 EMERGENCY	0	37, 444	31, 770, 929	-186, 205	31, 584, 724	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS	0	C	11 104 100	0 0	11, 104, 190	04 00
	10100 HOME HEALTH AGENCY	0					101.00
	SPECIAL PURPOSE COST CENTERS			<u> </u>			
	11600 HOSPI CE	0	C	) (	0 0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	476, 552	911, 881	471, 323, 001	-3, 693, 938	467, 629, 063	118.00
	NONREI MBURSABLE COST CENTERS				-		1.00.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0		2, 861, 585 11, 638, 123		2, 861, 585 11, 638, 123	
	19201 DEACONESS URGENT CARE	0		2, 297			192.00
	19202 HEARTCARE	0		1, 506, 167		1, 506, 167	
	19203 FAMILY PRACTICE	0	( C	14, 168, 644		14, 168, 644	
	07950 MI SC NONREI MBURSABLE	0	( C	4, 212, 737		4, 212, 737	1
	07951 OCCUPATIONAL HEALTH	0		1, 381, 290		1, 381, 290	1
	07952 OTHER FACILITIES 07953 HEART HOSPITAL	0		6, 567, 675 2, 590, 432		6, 567, 675 2, 590, 432	1
	07953 HEART HOSPITAL 07954 PUBLIC RELATIONS	0		2, 590, 432		2, 590, 432 2, 608, 153	
	07955 CHILD CARE CENTER	0		2, 904, 148		2, 904, 148	
	07956 CENTER FOR LIFE BALANCE	0	c	39, 401			194.06
-							

Health Financial Systems	DEACONESS	HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B		
				From 10/01/2014	Part I		
				To 09/30/2015		ared:	
					2/26/2016 11:4	4 am	
Cost Center Description	PARAMED ED	PARAMED ED	Subtotal	Intern &	Total		
	PRGM-CHAPLAI N	PRGM-NURSING		Residents Cost			
				& Post			
				Stepdown			
				Adjustments			
	23.01	23.03	24.00	25.00	26.00		
194.0707957 DEACONESS VNA	0	0	1, 202, 79	3 0	1, 202, 793 1	94.07	
200.00 Cross Foot Adjustments	0	0		0 0	0 2	200.00	
201.00 Negative Cost Centers	0	0		0 0	0 2	201.00	
202.00 TOTAL (sum lines 118-201)	476, 552	911, 881	523, 006, 44	6 -3, 693, 938	519, 312, 508 2	202.00	

	Financial Systems TION OF CAPITAL RELATED COSTS	DEACONESS		F	eriod: rom 10/01/2014 o 09/30/2015	u of Form CMS-2 Worksheet B Part II Date/Time Pre 2/26/2016 11:	pared:
			CAP	TAL RELATED CO	OSTS	2/20/2010 11.	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	Subtotal	
		0	1.00	1.01	2.00	2A	
	GENERAL SERVICE COST CENTERS			1			
1.00 1.01 2.00 4.00 5.00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL	0	218, 410 2, 380, 752	4, 471 39, 819		239, 500 16, 446, 913	1.00 1.01 2.00 4.00 5.00
7.00 8.00 9.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	3, 636, 685 500, 141 250, 497	0		3, 795, 190 761, 265 326, 579	7.00 8.00 9.00
9.00 10.00	01000 DI ETARY	0	552, 071	0		729, 630	
11.00	01100 CAFETERI A	0	192, 255			192, 255	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	71, 053 538, 406	0		494, 529 809, 609	13.00 14.00
15.00	01500 PHARMACY	0	238, 519			604, 820	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	198, 908 100, 487	0	139, 622 1, 266	338, 530 101, 753	16.00 17.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	-	0	21.00 22.00
23.00	02300 PARAMED ED PRGM-PHARMACY	0	5, 856	0	9, 220	15, 076	
23.01	02301 PARAMED ED PRGM-CHAPLAIN	0	31, 386			47, 322	23.01
23. 03	02303 PARAMED ED PRGM-NURSI NG I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	47, 514	0	11, 667	59, 181	23.03
30.00	03000 ADULTS & PEDI ATRI CS	0	5, 685, 671	0	1, 366, 815	7, 052, 486	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	1, 072, 415	0		1, 599, 082	31.00
32.00 40.00	03200 CORONARY CARE UNI T 04000 SUBPROVI DER – I PF	0	186, 683 92, 868			273, 722 93, 838	32.00 40.00
40.00	ANCI LLARY SERVICE COST CENTERS	0	92,000	0	970	93, 030	40.00
50.00	05000 OPERATI NG ROOM	0		0		5, 006, 431	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	862, 932			3, 504, 116	
55.00 59.00	05500 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON	0	329, 776 220, 078		36, 292 177, 864	366, 068 397, 942	55.00 59.00
60.00	06000 LABORATORY	0	931, 711	0		1, 680, 436	
64.00	06400 I NTRAVENOUS THERAPY	0	24, 165	0		30, 313	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	121, 524 146, 655			227, 224 191, 515	65.00 66.00
69.00	06900 ELECTROCARDI OLOGY	0	75, 602	0		83, 657	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0 11, 144	0		0 11, 144	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		-	-	0	
	OUTPATIENT SERVICE COST CENTERS			-			
90. 00 90. 01	09000 CLINIC 09001 FAMILY PRACTICE CLINIC	0	198, 320 287, 303			206, 168 309, 634	90.00 90.01
90.02	09002 OUTPATI ENT PSYCH SERVICES	0	112, 029			112, 488	
90. 03	09003 INFUSION CENTER	0	73, 271	0		77, 554	
90. 04 90. 05	09004 PRI MARY CARE FOR SENI ORS 09005 PAI N MANAGEMENT	0	0	0	36, 353	36, 353 101, 489	
90.03 90.06	09006 WOUND CARE CENTER	0	9, 002	0	101, 489 14, 112	23, 114	
90.07	09007 SLEEP CENTER	0	132, 403	0	61, 927	194, 330	
91.00	09100 EMERGENCY	0	944, 693	0	521, 566	1, 466, 259	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	346, 966			546, 299	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
116 00	SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	116.00
118.00		0				48, 553, 814	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	122, 851	0		122, 851	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	173, 379			248, 782	
	19201 DEACONESS URGENT CARE	0	0	0	0 1, 437		192.01 192.02
	19203 FAMILY PRACTICE	0	34, 456			137, 614	
	07950 MI SC NONREI MBURSABLE	0	165, 381	16, 396		204, 172	
	07951 OCCUPATI ONAL HEALTH 207952 OTHER FACI LI TI ES	0	206, 167		600 0	206, 767 1, 035, 893	
		0	1, 035, 893		-		
	3 07953 HEART HOSPI TAL	0	1,005,095	0	0	1,005,095	194.03
194.03 194.04	307953 HEART HOSPITAL 107954 PUBLIC RELATIONS 107955 CHILD CARE CENTER	0	1, 005, 095 117, 089 296, 419	0	7, 288	124, 377	194.04

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 10/01/2014	Worksheet B Part II	
				09/30/2015		pared: 44 am
		CAPI TAL RELATED COSTS				
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	Subtotal	
	0	1.00	1.01	2.00	2A	
194.06 07956 CENTER FOR LIFE BALANCE	0	0	(	2, 341	2, 341	194.06
194.0707957 DEACONESS VNA	0	136, 212	(	616	136, 828	194. 07
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	(	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	26, 290, 940	62, 463	3 25, 735, 305	52, 088, 708	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	DEACONESS			eriod:	u of Form CMS-2 Worksheet B	2552-10
					rom 10/01/2014 o 09/30/2015	Part II Date/Time Pre	pared:
	Cost Center Description	EMPLOYEE BENEFITS	ADMI NI STRATI VE & GENERAL	OPERATI ON OF PLANT	LAUNDRY & LINEN SERVICE	2/26/2016 11: HOUSEKEEPI NG	44 am
		DEPARTMENT 4.00	5.00	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.00	00101 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	239, 500 36, 577					4.00 5.00
7.00	00700 OPERATI ON OF PLANT	3, 550					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	650					8.00
9.00	00900 HOUSEKEEPI NG	4, 285			0	630, 364	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 483 1, 199	153, 287 57, 982	127, 137 44, 275	7, 707 0	18, 738 6, 525	
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 257	147, 838			2, 412	
	01400 CENTRAL SERVICES & SUPPLY	2, 253				18, 274	
	01500 PHARMACY	8, 597	394, 547	54, 929		8,096	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	4, 400 3, 378		45, 807 23, 141	0	6, 751 3, 411	16.00 17.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	1, 348		23, 141	0	3,411	
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 061		0	0	0	
23.00	02300 PARAMED ED PRGM-PHARMACY	227	11, 691	1, 349		199	
	02301 PARAMED ED PRGM-CHAPLAIN 02303 PARAMED ED PRGM-NURSING	216		13, 356 10, 942	0	1, 968 1, 613	
23.03	INPATIENT ROUTINE SERVICE COST CENTERS	404	24, 890	10, 942	0	1,013	23.03
30.00	03000 ADULTS & PEDIATRI CS	52, 169	2, 368, 737	1, 309, 465	456, 319	192, 998	30.00
	03100 I NTENSI VE CARE UNI T	11, 235				36, 400	
	03200 CORONARY CARE UNI T	2,730				6, 336	
40.00	04000 SUBPROVIDER - IPF ANCILLARY SERVICE COST CENTERS	1,078	54,076	21, 387	2, 665	3, 152	40.00
50.00	05000 OPERATI NG ROOM	23, 878	1, 578, 514	499, 697	109, 886	73, 648	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 008		198, 726		29, 289	
55.00	05500 RADI OLOGY-THERAPEUTI C	675				11, 193	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 348 13, 007	113, 975 1, 328, 123			7, 470 31, 624	
64.00	06400 I NTRAVENOUS THERAPY	709	78, 825			820	
65.00	06500 RESPI RATORY THERAPY	3, 428				4, 125	
66.00	06600 PHYSI CAL THERAPY	0	322, 782	33, 773		4, 978	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	414	89, 511 610, 461	17, 410 0	1, 783 0	2, 566 0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0				0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0			0	0	73.00
	07400 RENAL DI ALYSI S	259	74, 684			378	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.00
90.00	09000 CLINIC	1, 741	103, 333	45, 671	977	6, 731	90.00
	09001 FAMILY PRACTICE CLINIC	1, 069				9, 752	
	09002 OUTPATIENT PSYCH SERVICES	822				3, 802	
	09003 I NFUSI ON CENTER 09004 PRI MARY CARE FOR SENI ORS	429 2, 266			1, 646 165	2, 487 0	
	09005 PALN MANAGEMENT	2, 200		0		0	
	09006 WOUND CARE CENTER	410				306	
	09007 SLEEP CENTER	1, 784		30, 491	1, 031	4, 494	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	21, 546	878, 791	217, 555	109, 861	32, 064	
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	2, 703	318, 744	79, 903	0	11, 777	96.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00 118.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117)	0 228, 219				0 544, 377	116.00
118.00	NONREI MBURSABLE COST CENTERS	220, 219	15, 101, 433	3, 800, 409	890, 045	544, 577	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 017	83, 345	28, 291	2, 072	4, 170	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	6, 251	355, 616				192.00
	19201 DEACONESS URGENT CARE 19202 HEARTCARE	0 235	0 47,082	0	726 0		192. 01 192. 02
	19202 HEARTCARE 19203 FAMILY PRACTICE	634		-	-		192.02
	07950 MI SC NONREI MBURSABLE	857	100, 459			13, 947	
	07951 OCCUPATI ONAL HEALTH	417	33, 244	47, 478		6, 998	194.01
	07952 OTHER FACILITIES	0	158, 127	238, 557	0	35, 160	
194.02			49, 115	0	34, 313	0	194. 03
194. 02 194. 03	07953 HEART HOSPI TAL	611		26 065	0	2 07/	194 04
194.02 194.03 194.04	07953 HEART HOSPI TAL 07954 PUBLI C RELATI ONS 07955 CHI LD CARE CENTER	644 1, 219	76, 434			3, 974 10, 061	194. 04 194. 05
194. 02 194. 03 194. 04 194. 05 194. 06	07954 PUBLIC RELATIONS 07955 CHILD CARE CENTER 07956 CENTER FOR LIFE BALANCE		76, 434 76, 220 1, 242	68, 263 0	3, 152 0	10, 061 0	194. 05 194. 06
194. 02 194. 03 194. 04 194. 05 194. 06	07954 PUBLIC RELATIONS 07955 CHILD CARE CENTER 07956 CENTER FOR LIFE BALANCE 07957 DEACONESS VNA	1, 219	76, 434 76, 220	68, 263 0	3, 152 0	10, 061 0 4, 623	194. 05

Health Financial Systems	DEACONESS	DEACONESS HOSPI TAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B			
				rom 10/01/2014				
				o 09/30/2015				
					2/26/2016 11:	<u>44 am</u>		
Cost Center Description	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG			
	BENEFITS	& GENERAL	PLANT	LINEN SERVICE				
	DEPARTMENT							
	4.00	5.00	7.00	8.00	9.00			
201.00 Negative Cost Centers	C	0 0	C	0	0	201.00		
202.00 TOTAL (sum lines 118-201)	239, 500	16, 483, 490	4, 449, 824	955, 579	630, 364	202.00		

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS				eriod: 	Worksheet B Part II	
			To		Date/Time Pre	pared:
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	2/26/2016 11: PHARMACY	44 am
	10.00	11.00	13.00	SUPPLY 14.00	15.00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT						1.01
2.00 00200 CAP REL COSTS-MVBLE EQUI P 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	1, 037, 982					9.00 10.00
11. 00 01100 CAFETERIA	0	302, 236				11.00
13.00 01300 NURSING ADMINISTRATION	0	4, 405				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	0	6,004		1, 114, 709 0	1, 081, 739	14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	10, 750 11, 052		9	1,081,739	16.00
17.00 01700 SOCIAL SERVICE	0	5, 893		2	51	17.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	2, 082		0	0	21.00
22.00 02200 I & SERVI CES-OTHER PRGM COSTS APPRVD 23.00 02300 PARAMED ED PRGM-PHARMACY	0	352		0	0	22.00 23.00
23. 01 02301 PARAMED ED PRGM-CHAPLAIN	0	623		0	0	23.00
23. 03 02303 PARAMED ED PRGM-NURSING	0	734		0	0	23.03
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	740 474	70.001	220 552	24 (72)		20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSIVE CARE UNIT	743, 474 112, 775	79, 981 18, 987		34, 672 16, 862	446 158	
32. 00 03200 CORONARY CARE UNIT	26, 667	4, 304		4, 661	54	32.00
40. 00 04000 SUBPROVI DER - I PF	21, 368	2, 243	9, 213	0	0	40.00
ANCI LLARY SERVI CE COST CENTERS	0	19, 127	78, 575	7, 879	801	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	16, 824		36, 865	235	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 096		84	1	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1, 840		1, 387	14	59.00
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0	29, 526 945		187, 095 12, 441	47 5	60.00 64.00
65. 00 06500 RESPIRATORY THERAPY	0	5, 903		4, 107	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	3, 179	163	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	694		1, 627	1	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	J J	292, 592 397, 986	0	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	-	22, 225	877, 082	
74.00 07400 RENAL DI ALYSI S	0	372		2, 402	11	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	0	0 0	0	0	76.00
90. 00 09000 CLINIC	0	2, 926	12, 022	2, 819	0	90.00
90.01 09001 FAMILY PRACTICE CLINIC	0	2, 072	8, 510	611	1, 714	
90. 02 09002 0UTPATI ENT PSYCH SERVICES 90. 03 09003 I NFUSI ON CENTER	0	1, 689 754		0 2, 871	0	90. 02 90. 03
90. 04 09004 PRIMARY CARE FOR SENIORS	0	2, 192		2, 871	1, 328	
90. 05 09005 PALN MANAGEMENT	0	4, 324		446	0	90.05
90. 06 09006 WOUND CARE CENTER	0	704		0	322	
90. 07 09007 SLEEP CENTER 91. 00 09100 EMERGENCY	0 19, 193	2, 383 19, 369		616 17, 727	2 50	90. 07 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	17, 170	17,007	, , , , , , , , , , , , , , , , , , , ,	11,121		92.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	6, 215 0		55, 866	7, 317	96.00 101.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	<u>1</u> 0	<u> </u>	0	101.00
116. 00 11600 HOSPI CE	0	0	0 0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	923, 477	266, 626	667, 804	1, 107, 134	889, 806	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 791	0		0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	7, 663		459		192.00
192.01 19201 DEACONESS URGENT CARE	0	0	0	О	0	192. 01
192. 02 19202 HEARTCARE	0	674		0		192.02
192. 03 19203 FAMI LY PRACTI CE 194. 00 07950 MI SC NONREI MBURSABLE	0 64, 714	905 2, 102		4, 699 1, 202	189, 971 175	192.03 194.00
194. 01 07951 OCCUPATI ONAL HEALTH	0	805		823		194.00
194. 02 07952 OTHER FACILITIES	0	0	0	О		194.02
194. 03 07953 HEART HOSPI TAL 194. 04 07954 PUBLI C RELATI ONS	44, 507	14, 159		0		194. 03 194. 04
194. 05 07955 CHI LD CARE CENTER	0	1, 096 4, 415		213		194.04 194.05
194.0607956 CENTER FOR LIFE BALANCE	0	0		0	0	194. 06
194.0707957 DEACONESS VNA	5, 284	0	0	179	0	194.07
200.00 Cross Foot Adjustments						200.00

Health Fina	ancial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der		Period: From 10/01/2014	Worksheet B Part II	
					To 09/30/2015		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	N SERVICES &		
					SUPPLY		
		10.00	11.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	) (	0 0	0	201.00
202.00	TOTAL (sum lines 118-201)	1, 037, 982	302, 236	667, 804	4 1, 114, 709	1, 081, 739	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	DEACONESS			Period: From 10/01/2014	u of Form CMS-: Worksheet B Part II	2002 10
					o 09/30/2015		
				I NTERNS &	RESI DENTS	12/20/2010 111	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	SERVICES-SALAF Y&FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-PHARMACY	
	GENERAL SERVICE COST CENTERS	16.00	17.00	21.00	22.00	23.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 2.00 4.00 5.00 7.00 8.00 9.00	00101 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						1. 01 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00
10.00 11.00 13.00 14.00 15.00 16.00 17.00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	610, 985 0	299, 000	(( 20			10.00 11.00 13.00 14.00 15.00 16.00 17.00
21.00 22.00 23.00 23.01 23.03	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-PHARMACY 02301 PARAMED ED PRGM-CHAPLAI N 02303 PARAMED ED PRGM-NURSI NG		0 0 0 1, 353	66, 265	54, 458	28, 803	21.00 22.00 23.00 23.01 23.03
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	43, 342	244, 883				30.00
31.00 32.00 40.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 04000 SUBPROVI DER - I PF	15, 980 3, 773 2, 180	18, 941 12, 176				31.00 32.00 40.00
10.00	ANCILLARY SERVICE COST CENTERS	T	1	1			10.00
50.00 54.00 55.00 59.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05900 CARDI AC. CATHETERI ZATI ON	81, 078 96, 845 9, 989 11, 445	0 0 0				50.00 54.00 55.00 59.00
60.00 64.00 65.00 66.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	79, 745 1, 275 9, 548 19, 193					60.00 64.00 65.00 66.00
69.00 71.00 72.00 73.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	9, 468 9, 522 14, 446 65, 517	0 0 0 0				69.00 71.00 72.00 73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES OUTPAȚI ENT SERVI CE COST CENTERS	2, 528 0	0				74.00 76.00
90. 00 90. 01	09000 CLINIC 09001 FAMILY PRACTICE CLINIC	1, 611 809	0				90.00
90. 02 90. 03	09002 OUTPATIENT PSYCH SERVICES 09003 INFUSION CENTER 09004 PRIMARY CARE FOR SENIORS	1, 001 3, 251 479					90.02 90.03 90.04
90. 05 90. 06	09005 PAI N MANAGEMENT 09006 WOUND CARE CENTER 09007 SLEEP CENTER	9, 434 571 1, 428					90.05 90.06 90.07
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	54, 405					91.00 92.00
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	5, 660 0	0				96. 00 101. 00
116.00 118.00	11600 HOSPI CE	0 554, 523	0 299, 000		0 0	0	116. 00 118. 00
192.00 192.01	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 DEACONESS URGENT CARE 19202 HEARTCARE	0 297 0 671	0 0 0 0				190. 00 192. 00 192. 01 192. 02
192.03 194.00 194.01	19203 FAMILY PRACTICE 07950 MISC NONREIMBURSABLE 07951 OCCUPATIONAL HEALTH	3, 808 0 0	000000000000000000000000000000000000000				192. 03 194. 00 194. 01
194.03 194.04	07952 OTHER FACILITIES 07953 HEART HOSPITAL 07954 PUBLIC RELATIONS 07955 CHILD CARE CENTER 07956 CENTER FOR LIFE BALANCE	0 51, 414 0 0					194. 02 194. 03 194. 04 194. 05 194. 06

Health Financial Systems	DEACONESS HOSPI TAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B		
				rom 10/01/2014			
				o 09/30/2015	Date/Time Pre 2/26/2016 11:	pared: 44 am	
			I NTERNS &	RESI DENTS	272072010 11.		
Cost Center Description	MEDI CAL	SOCI AL SERVI CE	SERVI CES-SALAF	SERVI CES-OTHER	PARAMED ED		
	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM-PHARMACY		
	LI BRARY						
	16.00	17.00	21.00	22.00	23.00		
194.0707957DEACONESS VNA	272	0				194.07	
200.00 Cross Foot Adjustments			66, 265	5 54, 458	28, 803	200.00	
201.00 Negative Cost Centers	0	0	(	0 0	0	201.00	
202.00 TOTAL (sum lines 118-201)	610, 985	299, 000	66, 265	54, 458	28, 803	202.00	

Heal th	Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 10/01/2014	Worksheet B Part II	
					09/30/2015	Date/Time Pre 2/26/2016 11:	pared: 44 am
	Cost Center Description	PARAMED ED	PARAMED ED	Subtotal	Intern &	Total	
		PRGM-CHAPLAI N	PRGM-NURSING		Residents Cost & Post		
					Stepdown		
		23.01	23.03	24.00	Adjustments 25.00	26.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT						1.00 1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
9.00 10.00	01000 DI ETARY						10.00
11.00							11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
15.00	01500 PHARMACY						15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16.00 17.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23. 00 23. 01	02300 PARAMED ED PRGM-PHARMACY 02301 PARAMED ED PRGM-CHAPLAIN	75, 630					23.00 23.01
23.03	02303 PARAMED ED PRGM-NURSING		102, 21	3	-		23.03
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS			12, 907, 524	0	12, 907, 524	30.00
31.00	03100 I NTENSI VE CARE UNI T			2, 857, 293		2, 857, 293	
32.00	03200 CORONARY CARE UNIT			565, 504		565, 504	
40.00	04000 SUBPROVIDER - IPF ANCILLARY SERVICE COST CENTERS			211, 200	0	211, 200	40.00
50.00	05000 OPERATI NG ROOM			7, 479, 514		7, 479, 514	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C			4, 797, 206 615, 616		4, 797, 206 615, 616	
59.00	05900 CARDI AC CATHETERI ZATI ON			621, 905	0	621, 905	
60.00 64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY			3, 564, 886	0	3, 564, 886 134, 781	
65. 00	06500 RESPIRATORY THERAPY			134, 781 458, 126	-	458, 126	
66.00	06600 PHYSI CAL THERAPY			587, 261	0	587, 261	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS			207, 131 912, 575	0	207, 131 912, 575	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			1, 236, 650	0	1, 236, 650	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS			2, 492, 499 95, 873		2, 492, 499 95, 873	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			93, 073			76.00
00.00	OUTPATIENT SERVICE COST CENTERS			202.000		202.000	
90. 00 90. 01	09000 CLINIC 09001 FAMILY PRACTICE CLINIC			383, 999 476, 465		383, 999 476, 465	
90.02	09002 OUTPATI ENT PSYCH SERVI CES			201, 639	0	201, 639	90. 02
90. 03 90. 04	09003 INFUSION CENTER 09004 PRIMARY CARE FOR SENIORS			154, 313 121, 077		154, 313 121, 077	
	09005 PAIN MANAGEMENT			273, 588		273, 588	
90. 06 90. 07	09006 WOUND CARE CENTER 09007 SLEEP CENTER			50, 494		50, 494 318, 450	
	09100 EMERGENCY			318, 450 2, 938, 033		2, 938, 033	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
96.00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED			1, 034, 484	0	1, 034, 484	96.00
	10100 HOME HEALTH AGENCY			0			101.00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE			0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0		0 45, 698, 086		45, 698, 086	
100.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			245, 537	o	245, 537	100 00
	19200 PHYSI CLANS' PRI VATE OFFICES			671, 635		671, 635	
	19201 DEACONESS URGENT CARE			726			192.01
	19202 HEARTCARE 19203 FAMI LY PRACTI CE			50, 099 717, 689		50, 099 717, 689	
194.00	07950 MI SC NONREI MBURSABLE			492, 090	0	492, 090	194.00
	07951 OCCUPATIONAL HEALTH 07952 OTHER FACILITIES			298, 738 1, 467, 737		298, 738 1, 467, 737	
	07953 HEART HOSPITAL			1, 198, 637		1, 198, 637	
	07954 PUBLIC RELATIONS			233, 490		233, 490	
	07955 CHILD CARE CENTER 07956 CENTER FOR LIFE BALANCE			472, 280 3, 588		472, 280 3, 588	194.05 194.06
	· · · · · · · · · · · · · · · · · · ·						

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS				Peri od:	Worksheet B	
				From 10/01/2014		
			-	Fo 09/30/2015		pared:
					2/26/2016 11:	44 am
Cost Center Description	PARAMED ED	PARAMED ED	Subtotal	Intern &	Total	
	PRGM-CHAPLAI N	PRGM-NURSING		Residents Cost		
				& Post		
				Stepdown		
				Adjustments		
	23.01	23.03	24.00	25.00	26.00	
194.07 07957 DEACONESS VNA			211, 00	7 0	211, 007	194.07
200.00 Cross Foot Adjustments	75, 630	102, 213	327, 369	9 0	327, 369	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	75, 630	102, 213	52, 088, 708	3 0	52, 088, 708	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	DEACONESS		CCN: 150082	Period: From 10/01/2014	u of Form CMS-: Worksheet B-1	2552-10
				-	To 09/30/2015	Date/Time Pre 2/26/2016 11:	
		CAP	ITAL RELATED C	OSTS			
	Cost Center Description	BLDG & FIXT (SQUARE FEET - C)	BLDG & FIXT (SQUARE FEET - B)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconci I i ati on	
	r	1.00	1.01	2.00	4.00	5A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1, 387, 193					1.00
1.01 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00	00101 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 DI ETARY 01100 CAFETERIA	0 11, 524 125, 616 191, 883 26, 389 13, 217 29, 129 10, 144	49, 355 3, 533 31, 463 C C C C C C C C C C C C C C C C C C C	19, 252, 02 12, 43 10, 492, 80 118, 57 195, 34 56, 91 132, 82	2 219, 843, 612 33, 588, 021 4 3, 259, 576 5 5, 935, 147 8 1, 361, 967 0 1, 101, 144	-103, 657, 098 0 0 0 0 0 0	$\begin{array}{c} 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00 \end{array}$
15.00 16.00 17.00 21.00 22.00 23.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-PHARMACY 02300 PARAMED ED PRGM-PHARMACY	3,749 28,408 12,585 10,495 5,302 0 0 309		202, 88 274, 02 104, 44 94 6, 89	1         2, 068, 994           2         7, 894, 239           8         4, 040, 053           7         3, 101, 950           0         1, 237, 769           9         973, 944           7         208, 555	0 0 0 0 0 0 0 0	13.00 14.00 15.00 16.00 17.00 21.00 22.00 23.00
	02301 PARAMED ED PRGM-CHAPLAIN 02303 PARAMED ED PRGM-NURSING	1, 656 2, 507				0	23.01 23.03
30. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 INTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 04000 SUBPROVI DER - IPF ANCI LLARY SERVI CE COST CENTERS	299, 994 56, 584 9, 850 4, 900	- C - C	1, 022, 48 393, 98 65, 11	4 47, 821, 832 8 10, 316, 978 2 2, 506, 630	000000000000000000000000000000000000000	30. 00 31. 00 32. 00
73.00 74.00 76.00	05000 OPERATING ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 RENAL DI ALYSI S 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0UTPATI ENT SERVI CE COST CENTERS	114, 488 45, 531 17, 400 11, 612 49, 160 1, 275 6, 412 7, 738 3, 989 0 0 0 0 0 588 0		1, 975, 81 27, 14 133, 05 560, 10 4, 59 79, 07 33, 55 6, 02	2 9, 189, 789 9 620, 033 6 1, 238, 193 5 11, 943, 779 9 651, 117 2 3, 148, 146 9 0 6 380, 468 0 0 0 0 0 0 237, 749 0 0	0	74.00 76.00
90.01 90.02 90.03 90.04 90.05 90.06 90.07 91.00	09000 CLINIC 09001 FAMILY PRACTICE CLINIC 09002 OUTPATIENT PSYCH SERVICES 09003 INFUSION CENTER 09004 PRIMARY CARE FOR SENIORS 09005 PAIN MANAGEMENT 09006 WOUND CARE CENTER 09007 SLEEP CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 464 15, 159 5, 911 3, 866 0 0 475 6, 986 49, 845		16, 70 34 3, 20 27, 19 75, 92 10, 55 46, 32	5         981, 740           3         754, 591           4         393, 968           5         2, 080, 429           2         2, 338, 173           7         376, 693           6         1, 637, 803		90.00 90.01 90.02 90.03 90.04 90.05 90.06 90.07 91.00 92.00
	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	18, 307 0			7 2, 481, 758 0 0	0	96. 00 101. 00
116. 00 118. 00		0 1, 213, 447	) C 36, 400		0 0 8 209, 485, 169		116. 00 118. 00
192.00 192.01 192.02 192.03 194.00 194.01	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFICES 19201 DEACONESS URGENT CARE 19202 HEARTCARE 19203 FAMILY PRACTICE 07950 MI SC NONREI MBURSABLE 07951 OCCUPATI ONAL HEALTH	6, 482 9, 148 0 0 1, 818 8, 726 10, 878	C C C C C C 12, 955	56, 40 1, 07 77, 17	0 0 5 216, 176 0 582, 414 3 786, 773	0 0 0 0 0	190. 00 192. 00 192. 01 192. 02 192. 03 194. 00 194. 01
194. 02 194. 03	07952 OTHER FACILITIES 07953 HEART HOSPITAL 07954 PUBLIC RELATIONS	54, 657 53, 032 6, 178			0 0 0 0	0 0	194. 02 194. 03 194. 04

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 10/01/2014 To 09/30/2015		pared: 44 am
	CAPI	TAL RELATED CO	OSTS			
Cost Center Description	BLDG & FIXT (SQUARE FEET - C)	BLDG & FI XT (SQUARE FEET - B)	MVBLE EQUIP (DOLLAR VALUE		Reconciliation	
	1.00	1.01	2.00	4.00	5A	
194. 05 07955 CHI LD CARE CENTER	15, 640	0	9, 21	5 1, 119, 212		194.05
194.06 07956 CENTER FOR LIFE BALANCE	0	0	1, 75	61 4, 663	0	194.06
194. 07 07957 DEACONESS VNA	7, 187	0	46	1, 558	0	194.07
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	26, 290, 940	62, 463	25, 735, 30	64, 084, 689		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	18. 952619	1. 265586	1. 33675	0. 291501		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				239, 500		204. 00
205.00 Unit cost multiplier (Wkst. B, Part				0. 001089		205.00

	IFINANCIAL SYSTEMS ALLOCATION - STATISTICAL BASIS	DEACONESS			Period:	u of Form CMS-2 Worksheet B-1	
					From 10/01/2014 To 09/30/2015	Date/Time Pre 2/26/2016 11:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET - C)		HOUSEKEEPI NG (SQUARE FEET - C)	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{c} 1. \ 01 \\ 2. \ 00 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 8. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \\ 17. \ 00 \\ 21. \ 00 \\ 22. \ 00 \end{array}$	00101 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 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I & SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM COSTS APPRVD	419, 349, 348 16, 564, 073 1, 996, 749 6, 151, 905 3, 899, 748 1, 475, 102 3, 761, 120 3, 719, 426 10, 037, 564 5, 201, 001 4, 105, 395 1, 598, 580 1, 349, 502	1,019,521           26,389           13,217           29,129           10,144           3,749           28,408           12,585           10,495           5,302           6,5,302           6,302	5, 051, 335 40, 742 40, 742 44, 298 6 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	979,915           2         29,129           0         10,144           3,749           8         28,408           0         12,585           0         10,495           0         5,302           0         0           0         0           0         0	514, 033 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 01 \\ 2. \ 00 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \\ 17. \ 00 \\ 21. \ 00 \\ 22. \ 00 \end{array}$
23. 00 23. 01	02300 PARAMED ED PRGM-PHARMACY 02301 PARAMED ED PRGM-CHAPLAI N	297, 418 308, 985			0 309 0 3,060	0	23.00 23.01
23.03	02303 PARAMED ED PRGM-NURSING	633, 230			2, 507	0	23.03
30. 00 31. 00 32. 00 40. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 04000 SUBPROVI DER - I PF	60, 259, 242 15, 876, 417 3, 785, 935 1, 375, 741	56, 584 9, 850	411, 546 114, 15	56, 584 1 9, 850	368, 185 55, 849 13, 206 10, 582	
50.00	ANCI LLARY SERVI CE COST CENTERS	40, 158, 600	114, 488	580, 87	1 114, 488	0	50.00
50.00 54.00 55.00 59.00 60.00 64.00 65.00 65.00 69.00 71.00 72.00 73.00 74.00 76.00	OSJOOI OPERATING ROOM O5400 RADI OLOGY-DI AGNOSTI C O5500 RADI OLOGY-THERAPEUTI C O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY O6400 I NTRAVENOUS THERAPY O6500 RESPI RATORY THERAPY O6600 PHYSI CAL THERAPY O6600 PHYSI CAL THERAPY O6600 ELECTROCARDI OLOGY O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS O7200 I MPL. DEV. CHARGED TO PATI ENTS O7300 DRUGS CHARGED TO PATI ENTS O7400 RENAL DI ALYSI S O3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	40, 158, 600 21, 833, 789 3, 830, 518 2, 899, 622 33, 788, 459 2, 005, 371 4, 468, 570 8, 211, 823 2, 277, 237 15, 530, 590 20, 968, 738 38, 865, 224 1, 900, 009	45, 531 17, 400 11, 612 49, 160 1, 275 6, 412 7, 738 3, 989 0 C 0 C 58 588	243, 57( 149, 293 3, 795 ( 838 61, 73 9, 427 ( ( ( ( ( ( ( ( ( ( ( ( (	45, 531           17, 400           11, 612           49, 160           1, 275           6, 412           7, 738           7, 3, 989           0           0           0           0           1           0           1           0           0           0           0           0           0           0		50.00 54.00 55.00 59.00 60.00 64.00 65.00 66.00 69.00 71.00 72.00 73.00 74.00 76.00
90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 91. 00 92. 00	09000 CLINIC 09001 FAMILY PRACTICE CLINIC 09002 OUTPATIENT PSYCH SERVICES 09003 INFUSION CENTER 09004 PRIMARY CARE FOR SENIORS 09005 PAIN MANAGEMENT 09006 WOUND CARE CENTER 09007 SLEEP CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	2, 628, 882 1, 912, 498 1, 249, 101 1, 153, 607 1, 760, 128 3, 317, 650 481, 671 2, 083, 362 22, 357, 103	8 15, 159 5, 911 3, 866 8 0 0 0 475 2 6, 986	5, 052 ( 8, 700 87 37, 945 6, 180 5, 449	2 15, 159 5, 911 0 3, 866 1 0 5 0 9 475 9 6, 986	0 0 0 0 0 0 9, 505	90.00 90.01 90.02 90.03 90.04 90.05 90.06 90.07 91.00 92.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	8, 109, 101			18, 307	0	
	DIO100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	) C	) (	0 0		101.00
116.00 118.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 384, 188, 786	-		0 2 846, 246	0 457, 327	116. 00 118. 00
192.00 192.0 192.0 192.0 194.0 194.0 194.0 194.0 194.0 194.0 194.0 194.0	19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFICES 19201 DEACONESS URGENT CARE 212021 HEARTCARE 31203 FAMI LY PRACTI CE 07950 MI SC NONREI MBURSABLE 107951 OCCUPATI ONAL HEALTH 207952 OTHER FACI LI TI ES 307953 HEART HOSPI TAL 407954 PUBLI C RELATI ONS 507955 CHI LD CARE CENTER 507956 CENTER FOR LI FE BALANCE 707957 DEACONESS VNA	2, 120, 350 9, 047, 151 0 1, 197, 802 9, 437, 361 2, 555, 753 845, 748 4, 022, 873 1, 249, 526 1, 944, 531 1, 939, 083 31, 592 768, 792	9, 148 0 2 3 4 5 5 5 5 5 5 5 5 5 5 6 5 6 7 6 7 7 6 7 7 8 6 7 7 8 5 7 6 7 7 8 7 7 8 7 7 8 7 7 8 7 8 7 8 7 8	27, 15 3, 83 5 5 5 10, 93 181, 38 6 16, 660 0 16, 660	9     9, 148       6     0       0     1, 818       3     21, 681       5     10, 878       0     54, 657       2     0       0     6, 178       0     15, 640       0     0	0 0 32, 048 0 22, 041 0 0 0 0	190.00 192.00 192.01 192.02 194.02 194.00 194.01 194.03 194.03 194.04 194.05 194.06 194.07

Health Fir	ancial Systems	DEACONESS HOSPI TAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS			Provi der		Period:	Worksheet B-1	
					rom 10/01/2014 o 09/30/2015	Date/Time Pre 2/26/2016 11:	pared: 44 am
	Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	(SQUARE FEET -	(MEALS SERVED)	
		(ACCUM. COST)	(SQUARE FEET -	(POUNDS OF	C)		
			C)	LAUNDRY)			
		5.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	103, 657, 098	20, 658, 480	3, 025, 035	7, 940, 385	5, 714, 385	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 247186	20. 262927	0. 598859	8. 103136	11. 116767	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	16, 483, 490	4, 449, 824	955, 579	630, 364	1, 037, 982	204. 00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 039307	4. 364622	0. 189174	0. 643284	2. 019291	205.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	DEACONESS			Peri od:	u of Form CMS-: Worksheet B-1	
				From 10/01/2014 To 09/30/2015	Date/Time Pre 2/26/2016 11:	
Cost Center Description	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (FTE' S - NRSG)	CENTRAL SERVICES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS	44 аш
	11.00	13.00	REQUIS.) 14.00	15.00	REVENUE) 16.00	
GENERAL         SERVI CE         COST         CENTERS           1. 00         00100         CAP         REL         COSTS-BLDG & FIXT           1. 01         00101         CAP         REL         COSTS-BLDG & FIXT           2. 00         00200         CAP         REL         COSTS-MVBLE         EQUI P           4. 00         00400         EMPLOYEE         BENEFI TS         DEPARTMENT           5. 00         00500         ADMI NI STRATI VE         & GENERAL           7. 00         00700         OPERATI ON OF         PLANT           8. 00         00800         LAUNDRY         & LI NEN         SERVI CE           9. 00         00900         HOUSEKEEPI NG         0         01000         DI ETARY           11. 00         01100         CAFETERI A         13. 00         01300         NURSI NG         ADMI NI STRATI ON	30, 054 438					1.00 1.01 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00
14. 00       01400       CENTRAL SERVI CES & SUPPLY         15. 00       01500       PHARMACY         16. 00       01600       MEDI CAL RECORDS & LI BRARY         17. 00       01700       SOCI AL SERVI CE         21. 00       02100       I &R SERVI CES-SALARY & FRI NGES APPRVD         22. 00       02200       I &R SERVI CES-OTHER PRGM COSTS APPRVD         23. 00       02300       PARAMED ED PRGM-PHARMACY         23. 01       02301       PARAMED ED PRGM-CHAPLAI N         23. 03       02303       PARAMED ED PRGM-NURSI NG         INPATI ENT ROUTI NE SERVI CE COST CENTERS	438 597 1,069 1,099 586 207 35 26 62 73		58, 551, 482 ( 48 <sup>-</sup> 88 ( ( ( ( ( ( ( ( ( ( ( (	46, 658, 686 46, 658, 686 2, 205 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 133, 011, 419 0 0 0 0 0 0 0 0	14.00 15.00
30.00         03000         ADULTS & PEDI ATRICS           31.00         03100         I NTENSI VE CARE UNI T           32.00         03200         CORONARY CARE UNI T           40.00         SUBPROVI DER - I PF           ANCI LLARY SERVI CE COST CENTERS	7, 953 1, 888 428 223	1, 888 428	1, 821, 214 885, 69 244, 85 (	1 6, 830 1 2, 338	151, 544, 431 55, 875, 691 13, 193, 296 7, 623, 752	30.00 31.00 32.00 40.00
50.00         05000         0PERATING ROM           54.00         05400         RADI OLOGY-DI AGNOSTI C           55.00         05500         RADI OLOGY-THERAPEUTI C           59.00         05900         CARDI AC CATHETERI ZATI ON           60.00         06000         LABORATORY           64.00         06400         INTRAVENOUS THERAPY           65.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY           69.00         06600         PHYSI CAL THERAPY           69.00         06900         ELECTROCARDI OLOGY           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         07200 I MPL.         DEV.           73.00         07300         DRUGS CHARGED TO PATI ENTS           74.00         07400         RENAL DI ALYSI S           76.00         03550         PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES           0UTPATI ENT SERVI CE COST CENTERS         0UTPATI ENT SERVI CE	1,902 1,673 109 183 2,936 94 587 0 69 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3 0 0 183 0 94 9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	413, 864 1, 936, 388 4, 422 72, 83 9, 827, 448 653, 478 215, 700 166, 98 <sup>-</sup> 85, 482 15, 368, 84 <sup>-</sup> 20, 904, 588 1, 167, 388 126, 184 (	3     10, 154       2     36       4     599       3     2, 021       3     215       3     0       1     7, 016       2     53       9     0       5     0       3     37, 831, 185	283, 490, 838 335, 311, 250 34, 926, 173 40, 018, 928 278, 829, 325 4, 458, 668 33, 386, 034 67, 109, 756 33, 105, 274 33, 294, 084 50, 511, 430 229, 079, 760 8, 840, 501 0	54.00 55.00 59.00 60.00 64.00 65.00 66.00 69.00 71.00 72.00 73.00
90.00         000001         CLI NI C           90.01         090001         FAMI LY         PRACTI CE         CLI NI C           90.01         09001         FAMI LY         PRACTI CE         CLI NI C           90.02         09002         OUTPATI ENT         PSYCH         SERVI CES           90.03         09003         I NFUSI ON         CENTER           90.04         09004         PRI MARY         CARE         FOR         SENI ORS           90.05         09005         PAI N         MANAGEMENT         90.06         09006         WOUND CARE         CENTER           90.07         09007         SLEEP         CENTER         91.00         09100         EMERGENCY           92.00         092000         DSERVATI ON         BEDS         (NON-DI STI NCT         PART)           0THER         REI MBURSABLE         COST         CENTERS	291 206 168 75 218 430 70 237 1, 926	206 168 75 218 0 430 70 70 0 0	148, 050 32, 072 150, 824 5, 412 23, 409 0 32, 365 931, 149	2 73, 912 2 0 4 163 3 57, 287 5 0 13, 883 7 80	5, 631, 923 2, 829, 626 3, 501, 649 11, 365, 854 1, 675, 216 32, 987, 014 1, 996, 524 4, 991, 401 190, 226, 062	90. 02 90. 03 90. 04
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS	618 C		2, 934, 434	4 315, 626 0 0	19, 788, 696 0	96.00 101.00
116. 00 11600 HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	C 26, 513		( 58, 153, 648	0 3 38, 380, 049	0 1, 935, 593, 156	116. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 DEACONESS URGENT CARE 192. 02 19202 HEARTCARE 192. 03 19203 FAMI LY PRACTI CE 194. 00 07950 MI SC NONREI MBURSABLE 194. 01 07951 OCCUPATI ONAL HEALTH 194. 02 07952 OTHER FACI LI TI ES 194. 03 07953 HEART HOSPI TAL	377 762 67 90 209 80 0 1,408		24, 09 ( 246, 83 63, 12 43, 20 ( (	0 0 5 8, 194, 046 3 7, 550	1, 036, 731 0 2, 344, 420 13, 315, 516 457 0	192. 01 192. 02 192. 03 194. 00 194. 01 194. 02
194. 04 07954 PUBLIC RELATIONS 194. 05 07955 CHILD CARE CENTER 194. 06 07956 CENTER FOR LIFE BALANCE	109 439 C	0 0	( 11, 186 (	0 0	0 0	194. 04 194. 05 194. 06

Health Fir	nancial Systems	DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Period: From 10/01/2014	Worksheet B-1	
			_		To 09/30/2015	Date/Time Pre 2/26/2016 11:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTE'S)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
				SUPPLY	REQUIS.)	LI BRARY	
			(FTE'S - NRSG)	(COSTED		(GROSS	
				REQUIS.)		REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
194.07079	57 DEACONESS VNA	0	0	9, 38	2 0	951, 440	194.07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	2, 127, 472	4, 828, 166	5, 513, 42	8 12, 951, 369	6, 862, 158	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	70. 788314	298. 680235	0. 09416	4 0. 277577	0.003217	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	302, 236	667, 804	1, 114, 70	9 1, 081, 739	610, 985	204.00
205.00	Unit cost multiplier (Wkst. B, Part   )	10. 056432	41. 311723	0. 01903	8 0. 023184	0. 000286	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	DEACONESS			<u>In Lie</u> eriod: rom 10/01/2014	u of Form CMS-: Worksheet B-1	
					09/30/2015	Date/Time Pre 2/26/2016 11:	
	Cost Center Description		SERVI CES-SALAR Y & FRI NGES	PRGM COSTS	PRGM-PHARMACY	PARAMED ED PRGM-CHAPLAI N	
		(HOURS - A) 17.00	(HOURS - B) 21.00	(HOURS - B) 22.00	(HOURS - C) 23.00	(HOURS - D) 23.01	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1			1 00
$\begin{array}{c} 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 23.\ 01\\ \end{array}$	00101 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 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-CHAPLAIN	221 0 0 0 0		45, 687	100	100	
23.03	02303 PARAMED ED PRGM-NURSI NG I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>					23.03
31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	181 14		486	0	100 0	30. 00 31. 00
	03200 CORONARY CARE UNIT 04000 SUBPROVIDER - IPF	9	0	0	0 0	0	32.00 40.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	4, 562	4, 562	0	0	50.00
55. 00 59. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON	000000000000000000000000000000000000000	202 0 791	0 791	0 0 0	0 0 0	54.00 55.00 59.00
64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 0 0	0 0 0	0 0 0	0 0 0	60.00 64.00 65.00
66.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	0	0	0	0	66. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
	07400 RENAL DI ALYSI S 03550 PSYCHLATRI CZPSYCHOLOGI CAL SERVI CES	0	0	0		0	74.00 76.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09001 FAMILY PRACTICE CLINIC	0	0 15, 603	0 15, 603	0	0	90.00 90.01
	09002 OUTPATIENT PSYCH SERVICES	0	0	0	0	0	90.02
	09003 I NFUSI ON CENTER 09004 PRI MARY CARE FOR SENI ORS	0	792	0 792	0	0 0	90. 03 90. 04
	09005 PAIN MANAGEMENT 09006 WOUND CARE CENTER	0	0	0	0	0 0	90. 05 90. 06
	09007 SLEEP CENTER	0	0	0	0	0	90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	16	2, 303	2, 303	0	0	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS						92.00
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	0				0	96.00 101.00
116.00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	221			100		118.00
190.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	19201 DEACONESS URGENT CARE 19202 HEARTCARE	0	0	0	0		192. 01 192. 02
	19203 FAMILY PRACTICE	0	0	0	0		192.03
	07950 MI SC NONREI MBURSABLE 07951 OCCUPATI ONAL HEALTH		0	0	0		194. 00 194. 01
194.02	07952 OTHER FACILITIES	0	0	0	0	0	194. 02
	07953 HEART HOSPI TAL 07954 PUBLI C RELATI ONS		0 0	0 0	0		194. 03 194. 04
194.05	07955 CHILD CARE CENTER	0	0	0	0	0	194.05
194.06	07956 CENTER FOR LIFE BALANCE	0	0	0	0	0	194.06

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 10/01/2014 To 09/30/2015	Date/Time Pre 2/26/2016 11:	
		INTERNS &	RESI DENTS			
Cost Center Description	SOCI AL SERVI CE				PARAMED ED	
		Y & FRI NGES	PRGM COSTS	PRGM-PHARMACY	PRGM-CHAPLAIN	
	(HOURS - A)	(HOURS - B)	(HOURS - B)	(HOURS - C)	(HOURS - D)	
	17.00	21.00	22.00	23.00	23.01	101.07
194. 07 07957 DEACONESS VNA	0	0		0 0		194.07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	5, 312, 690	2,008,380	1, 685, 55	8 381, 541	476, 552	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	24, 039. 321267	43. 959551	36. 89360	2 3, 815. 410000	4, 765. 520000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	299, 000	66, 265	54, 45	8 28, 803	75, 630	204.00
205.00 Unit cost multiplier (Wkst. B, Part	1, 352. 941176	1. 450413	1. 19198	0 288.030000	756. 300000	205. 00
	· ·				-	

Heal th Financi COST ALLOCATI	ial Systems ON - STATISTICAL BASIS	DEACONESS H	OSPI TAL Provi der CCN: 150082	Period: From 10/01/2014	of Form CMS-2552-10 Worksheet B-1
				To 09/30/2015	Date/Time Prepared: 2/26/2016 11:44 am
C	Cost Center Description	PARAMED ED PRGM-NURSING (HOURS - E)			
GENERAL	_ SERVICE COST CENTERS	23.03			
1.00         00100         0           1.01         00101         0           2.00         00200         0           4.00         00400         E           5.00         00500         A           7.00         00700         C           8.00         00800         L           9.00         00900         F           10.00         01000         C	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL DPERATION OF PLANT CAUNDRY & LINEN SERVICE HOUSEKEEPING				1.00 1.01 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00
13.00 01300 M 14.00 01400 C 15.00 01500 F	JURSI NG ADMI NI STRATI ON SENTRAL SERVI CES & SUPPLY PHARMACY MEDI CAL RECORDS & LI BRARY				13.00 14.00 15.00 16.00
21.00 02100 I 22.00 02200 I 23.00 02300 F	SOCI AL SERVI CE &R SERVI CES-SALARY & FRI NGES APPRVD &R SERVI CES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-PHARMACY PARAMED ED PRGM-CHAPLAI N				17. 00 21. 00 22. 00 23. 00 23. 01
	PARAMED ED PRGM-NURSING ENT ROUTINE SERVICE COST CENTERS	14, 685			23. 03
30. 00 03000 A 31. 00 03100 I 32. 00 03200 0	ADULTS & PEDIATRICS NTENSIVE CARE UNIT CORONARY CARE UNIT SUBPROVIDER - IPF	10, 334 1, 967 570 0			30. 00 31. 00 32. 00 40. 00
	ARY SERVICE COST CENTERS	803			50.00
54.00 05400 F 55.00 05500 F 59.00 05900 0	ADI OLOGY-DI AGNOSTI C ADI OLOGY-THERAPEUTI C SARDI AC CATHETERI ZATI ON LABORATORY	0 0 308			54.00 55.00 59.00 60.00
64.00 06400 I	NTRAVENOUS THERAPY RESPI RATORY THERAPY	66 0			64. 00 65. 00
66.00 06600 F	PHYSI CAL THERAPY ELECTROCARDI OLOGY	0			66. 00 69. 00
71.00 07100 M 72.00 07200 I 73.00 07300 D	MEDICAL SUPPLIES CHARGED TO PATIENTS MPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0 0 0			71.00 72.00 73.00
1 1	RENAL DI ALYSI S PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 0			74. 00 76. 00
0UTPATI 90.00 09000 0	LENT SERVICE COST CENTERS	0			90.00
90.01 09001 F 90.02 09002 0	AMILY PRACTICE CLINIC DUTPATIENT PSYCH SERVICES NFUSION CENTER	0 0 0			90. 01 90. 02 90. 03
90.05 09005 F	PRIMARY CARE FOR SENIORS PAIN MANAGEMENT	18 0			90. 04 90. 05
90.07 09007 S		16 0			90.06 90.07
OTHER F	DBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	603			91.00 92.00
101.00 <u>10100</u> H	DURABLE MEDICAL EQUIP-RENTED HOME HEALTH AGENCY _ PURPOSE COST CENTERS	0			96. 00
	HOSPICE SUBTOTALS (SUM OF LINES 1-117) MBURSABLE COST CENTERS	0 14, 685			116. 00 118. 00
192.00 19200 F	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES DEACONESS URGENT CARE HEARTCARE	0 0 0			190. 00 192. 00 192. 01 192. 02
192.03 19203 F 194.00 07950 M	AMILY PRACTICE AISC NONREI MBURSABLE DCCUPATIONAL HEALTH	0			192. 03 194. 00 194. 01
194.02079520	ITHER FACILITIES IEART HOSPITAL	0			194. 02 194. 03
194.05079550	PUBLIC RELATIONS CHILD CARE CENTER	0			194. 04 194. 05
194.0707957 C	CENTER FOR LIFE BALANCE DEACONESS VNA Cross Foot Adjustments	0			194. 06 194. 07 200. 00

Health Fir	ancial Systems	DEACONESS HO	IOSPI T	AL			In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		F	Provi der	CCN:	150082	Peri od:	Worksheet B-7	
							From 10/01/2014 To 09/30/2015	Date/Time Pre	epared:
								2/26/2016 11:	44 am
	Cost Center Description	PARAMED ED							
		PRGM-NURSI NG							
		(HOURS - E)							
		23.03							
201.00	Negative Cost Centers								201.00
202.00	Cost to be allocated (per Wkst. B,	911, 881							202.00
	Part I)								
203.00	Unit cost multiplier (Wkst. B, Part I)	62.096084							203.00
204.00	Cost to be allocated (per Wkst. B,	102, 213							204.00
	Part II)								
205.00	Unit cost multiplier (Wkst. B, Part	6. 960368							205.00
, i									

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150082	Peri od:	Worksheet C	
				From 10/01/2014 To 09/30/2015	Part I Date/Time Pre	narod
				10 09/30/2013	2/26/2016 11:	
		Ti tl	e XVIII	Hospi tal	PPS	<u></u>
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
'	(from Wkst. B,			Di sal I owance		
	Part I, col.	-				
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	98, 274, 320		98, 274, 32	20 587, 026	98, 861, 346	30.00
31. 00 03100 I NTENSI VE CARE UNI T	23, 694, 525		23, 694, 52	25 52, 011	23, 746, 536	31.00
32. 00 03200 CORONARY CARE UNI T	5, 692, 368		5, 692, 30	68 0	5, 692, 368	32.00
40. 00 04000 SUBPROVIDER - IPF	2,087,790		2, 087, 79	90 0	2, 087, 790	40.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	55, 393, 824		55, 393, 82	24 805, 808		
54.00 05400 RADI OLOGY-DI AGNOSTI C	30, 050, 738		30, 050, 73		30, 207, 608	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	5, 391, 437		5, 391, 43	37 0	5, 391, 437	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 257, 663		4, 257, 60	53 0	4, 257, 663	59.00
60. 00 06000 LABORATORY	45, 568, 020		45, 568, 02	20 443, 832	46, 011, 852	60.00
64.00 06400 INTRAVENOUS THERAPY	2, 652, 003		2, 652, 00	03 0	2, 652, 003	64.00
65. 00 06500 RESPI RATORY THERAPY	5, 924, 791	0	5, 924, 79	91 0	5, 924, 791	65.00
66. 00 06600 PHYSI CAL THERAPY	10, 731, 699	0	10, 731, 69	99 0	10, 731, 699	66.00
69. 00 06900 ELECTROCARDI OLOGY	3, 078, 383		3, 078, 38	33 0	3, 078, 383	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 923, 833		20, 923, 83	33 0	20, 923, 833	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	28, 282, 859		28, 282, 8	59 0	28, 282, 859	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	60, 201, 636		60, 201, 63	36 0	60, 201, 636	73.00
74.00 07400 RENAL DIALYSIS	2, 440, 473		2, 440, 4	73 1, 492	2, 441, 965	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		_				
90. 00 09000 CLINIC	3, 718, 194		3, 718, 19	94 883	3, 719, 077	90.00
90.01 09001 FAMILY PRACTICE CLINIC	2, 927, 016		2, 927, 0	16 0	2, 927, 016	90.01
90. 02 09002 OUTPATI ENT PSYCH SERVICES	1, 798, 868		1, 798, 80	68 0	1, 798, 868	90.02
90. 03 09003 INFUSION CENTER	1, 632, 156		1, 632, 1	56 0	1, 632, 156	90.03
90.04 09004 PRIMARY CARE FOR SENIORS	2, 299, 192		2, 299, 19	92 40, 775	2, 339, 967	90.04
90. 05 09005 PALN MANAGEMENT	4, 427, 646		4, 427, 64	46 5, 097	4, 432, 743	90.05
90.06 09006 WOUND CARE CENTER	655, 042		655, 04	42 1, 840	656, 882	90.06
90. 07 09007 SLEEP CENTER	2, 835, 673		2, 835, 6	73 4, 557	2, 840, 230	90.07
91. 00 09100 EMERGENCY	31, 584, 724		31, 584, 72	24 2, 233, 785	33, 818, 509	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 985, 620		11, 985, 62	20	11, 985, 620	92.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	11, 104, 190		11, 104, 19	90 0	11, 104, 190	96.00
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS	_	1				
116. 00 11600 HOSPI CE	0			0		116.00
200.00 Subtotal (see instructions)	479, 614, 683					•
201.00 Less Observation Beds	11, 985, 620		11, 985, 62		11, 985, 620	•
202.00 Total (see instructions)	467, 629, 063	0	467, 629, 00	63 4, 333, 976	471, 963, 039	

COMPLIE	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	DEACONESS H		CCN: 150082	Peri od:	Worksheet C	2552-1
COMPUT	ATTON OF RATIO OF COSTS TO CHARGES		Provider	CCN. 150062	From 10/01/2014	Part I	
					To 09/30/2015		pared:
						2/26/2016 11:	
			Ti tl	e XVIII	Hospi tal	PPS	
			Charges	_			
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
	·			+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					•	
30.00	03000 ADULTS & PEDIATRICS	134, 329, 223		134, 329, 2	23		30. 0
31.00	03100 INTENSIVE CARE UNIT	56, 191, 303		56, 191, 3	03		31.00
32.00	03200 CORONARY CARE UNI T	13, 291, 376		13, 291, 3			32.0
	04000 SUBPROVI DER – I PF	7, 698, 896		7, 698, 8			40.0
	ANCI LLARY SERVICE COST CENTERS					I	
	05000 OPERATI NG ROOM	118, 497, 941	173, 035, 677	291, 533, 6	18 0. 190008	0.00000	50.0
	05400 RADI OLOGY-DI AGNOSTI C	91, 139, 794	250, 554, 583				
	05500 RADI OLOGY-THERAPEUTI C	1,803,053	33, 949, 406				
	05900 CARDI AC CATHETERI ZATI ON	26, 370, 686	13, 839, 633				
	06000 LABORATORY	147, 516, 046	135, 222, 125			0. 000000	
	06400 I NTRAVENOUS THERAPY	4, 410, 439	84, 474			0.000000	
	06500 RESPIRATORY THERAPY	31, 436, 387	2, 164, 793			0.000000	
	06600 PHYSI CAL THERAPY	49, 697, 448	17, 637, 489				
	06900 ELECTROCARDI OLOGY	20, 218, 104	13, 267, 449				
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 218, 104	12, 678, 897			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	38, 774, 106	12, 566, 126			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	130, 597, 682	102, 408, 550				
	07400 RENAL DI ALYSI S	8, 265, 556	615, 589				
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0.00000	0.00000	76.0
	OUTPATIENT SERVICE COST CENTERS	00.704	F 704 005	5 754 0	70 0 ( 4 ( 404	0.00000	
	09000 CLINIC	20, 784	5, 731, 095			0.00000	
	09001 FAMILY PRACTICE CLINIC	8, 587	2,833,236				
	09002 OUTPATIENT PSYCH SERVICES	1, 502	3, 669, 234				
	09003 INFUSION CENTER	147, 924	11, 444, 763				
	09004 PRIMARY CARE FOR SENIORS	5, 150	1, 670, 492				
	09005 PAIN MANAGEMENT	30, 357	33, 702, 044				
	09006 WOUND CARE CENTER	16, 664	1, 981, 335				
	09007 SLEEP CENTER	13, 407	5, 995, 734				
	09100 EMERGENCY	78, 213, 848	114, 310, 452	192, 524, 3	00 0. 164056	0.000000	91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 266, 124	14, 040, 202	18, 306, 3	26 0. 654726	0.00000	92.00
	OTHER REIMBURSABLE COST CENTERS				-		
	09600 DURABLE MEDICAL EQUIP-RENTED	0	19, 788, 696	19, 788, 6	96 0. 561138	0.00000	96.0
	10100 HOME HEALTH AGENCY	0	0		0		101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPI CE	0	0		0		116. 0
200.00	Subtotal (see instructions)	984, 384, 345	983, 192, 074	1, 967, 576, 4	19		200. 0
201.00	Less Observation Beds						201.0
202.00	Total (see instructions)	984, 384, 345		1, 967, 576, 4		1	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CON: 150082         Period: From 10/01/2014         Period: To 09/30/2015         Period: Part (-1) Period: 09/30/2015         Period: Part (-1) Period: 09/30/2015         Period: Period: Part (-1) Period: 09/30/2015         Period: Period: Period: 09/30/2015         Period: Period: Period: 09/30/2015         Period: Period: Period: Period: Period: Period: 00/3200         Period: Peri	Health Financial Systems	DEACONESS HOS	PI TAL	In Lie	u of Form CMS-2	552-10
Cost Center Description         PPS Inpatient           New Cost Center Description         PPS Inpatient           11.00         11.00           11.00         11.00           11.00         33.00           10.00         33000 ADULTS & PEDIATRICS           30.00         03000 CORONARY CARE UNIT           30.00         03200 CORONARY CARE UNIT           30.00         03200 CORONARY CARE UNIT           30.00         05400 CPERATINE ROOM           0.010200 OPERATINE ROOM         0.192772           50.00         5500 DESCO DENDICO PERATINE ROOM           50.00         05400 CARDIAL CATHERAPEUTIC           0.00 OS900 CARDIAL CATHERAPEUTIC         0.192772           50.00         05500 CARDIAL CATHERAPEUTIC           0.105895         05500           0.00 OS900 CARDIAL CATHERAPEUTIC         0.192737           0.00 OS900 CARDIAL CATHERAPEY         0.156373           0.00 OS900 CARDIAL CATHERAPY         0.15737           0.00 OS900 CLECTROCARD PHERAPY         0.15737           0.00 OS900 CLECTROCARD PHILENTS         0.613887           0.7000 WED CLECTROCARD POTIENTS         0.580891           0.7200 DRUSS CHARGED TO PATIENTS         0.580891           0.7200 DRUSS CHARGED TO PATIENTS         0.580891	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 10/01/2014 To 09/30/2015	Part I Date/Time Prep 2/26/2016 11:4	
Ratio         Ratio           INPATIENT ROUTINE SERVICE COST CENTERS         30.00           00         03000 INTENSIVE CARE UNIT         31.00           20.00         03000 CROMARY CARE UNIT         32.00           040.00         00000 CROMARY CARE UNIT         32.00           050.00         05000 CROMARY CARE UNIT         32.00           060.00         SUBPROVIDER - LIPF         40.00           MOLILARY SERVICE COST CENTERS         50.00           50.00         D5000 OPERATING ROOM         0.192772           50.00         D5000 CRABIA CARIETERIZATION         0.192737           50.00         D5000 CRABIA CARIETERIZATION         0.102737           60.00         064000 INTRAVENOUS THERAPY         0.152737           61.00         D6600 RESPIRATORY THERAPY         0.153737           66.00         06400 INTRAVENOUS THERAPY         0.153737           66.00         D6400 PHYSICAL THERAPY         0.153887           71.00         D159378         66.00           72.00         T20.00         T20.00           73.00         D7300 RUGS CHARGED TO PATIENTS         0.558091           72.00         T20.00         T20.00         T20.00           73.00         D7300 RUGS CHARGED TO PATIENTS			Title XVIII	Hospi tal	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS         30.00           00000000UDUTS & PEDIATRICS         31.00           31.00         03100         NETRSIVE CARE UNIT         31.00           32.00         03200         CORONARY CARE UNIT         32.00           00.00         03200         CORONARY CARE UNIT         32.00           00.00         04000         SUBPROVIDER - IFF         40.00           ANCLILLARY SERVICE COST CENTERS         50.00         56.00           00         05000 CPERATING ROM         0.192772         50.00           50.00         05500 CRADIALC CATHERAPEUTIC         0.088405         54.00           55.00         05500 CARDIAL CCATHERAPEUTIC         0.152737         66.00           60.00         D6600 INTRAVENOUS THERAPEY         0.590001         64.00           65.00         06500 RESPIRATORY THERAPY         0.159378         66.00           60.00         06600 PHYSICAL THERAPY         0.159378         66.00           71.00         07000 IMEDICAL SUPLIES CHARGED TO PATIENTS         0.258369         71.00           71.00         07000 IMELCAL SUPLIES CHARGED TO PATIENTS         0.258369         73.00           73.00         07300 ORUS CHARGED TO PATIENTS         0.258389         74.00	Cost Center Description	1 1				
30.00         300.00         JULTS & PEDIATRICS         30.00           31.00         03000         INTERSIVE CARE UNIT         31.00           32.00         03200         CORDNARY CARE UNIT         31.00           40.00         04000         SUBPROVIDER - IPF         90.00           ANCILLARY SERVICE COST CENTERS         50.00         Status         54.00           50.00         OSS00 OPERATING ROOM         0.192772         50.00           51.00         OSS00 ORADIOLOGY-THERAPEUTIC         0.088405         55.00           50.00         OSS00 CARDIACCATHETERIZATION         0.105885         59.00           60.00         OGMOO LABORATORY         0.122737         60.00           64.00         OGMOO PHYSICAL THERAPY         0.159378         66.00           65.00         OGS00 PHYSICAL THERAPY         0.159378         66.00           64.00         OMOO PHYSICAL THERAPY         0.159378         67.00           72.00         MALLARY DEPLIES CHARGED TO PATIENTS         0.258369         77.00           73.00         O7300 DRUSS CHARGED TO PATIENTS         0.258369         74.00           74.00         OFAND REACE TO TENTERS         0.274961         74.00           74.00         OFAND REACED TO PATIENTS		11.00				
31.00       03100       INTENSIVE CARE UNIT       31.00         200       03200       CORONARY CARE UNIT       32.00         40.00       SUBPOVIDER - IPF       40.00         MACILLARY SERVICE COST CENTERS       40.00         50.00       DS000       OPERATING ROOM       0.192772         50.00       DS000       RADIOLOGY-DIAGNOSTIC       0.088405         50.00       DS000       RADIOLOGY-DIAGNOSTIC       0.150799         50.00       DS000       RADIOLOGY-DIAGNOSTIC       0.162737         60.00       Adooo ILABORATORY       0.1023737       60.00         61.00       D6400       INTRAVENOUS THERAPY       0.590001       66.00         65.00       DS600       RESPI RATORY       0.176327       65.00         66.00       DR400 INTRAVENOUS THERAPY       0.189378       66.00         67.00       DR400 IRSPI RATORKED TO PATIENTS       0.613857       71.00         71.00       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.258369       73.00         73.00       T30.00       T30.00       73.00       74.00       PRACIL DIALYSIS       0.229978         70.00       POLOU INFLIC CLINIC       1.029978       90.02       90.02       90.02       90.02						
32.00         03200         CORONARY CARE UNIT         32.00           40.00         04000         05000         SUBPROVIDER - 1PF         40.00           ANCILLARY SERVICE COST CENTERS         50.00         50.00         Costool OPEATING ROM         0.192772         50.00           50.00         05000         RADIOLOGY-THERAPEUTIC         0.1962772         50.00         55.00           50.00         OSO00         CARDIA CATHETERI ZATION         0.105885         59.00         59.00           60.00         CABORATORY         0.162737         66.00         66.00         66.00         INTRAVENDS THERAPY         0.176327         65.00           66.00         0.6000         INTRAVENDIS THERAPY         0.176327         66.00         66.00           71.00         MCICAL SUPPLIES CHARGED TO PATIENTS         0.51387         71.00         71.00         71.00         71.00         72.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         72.00         73.00         72.00         73.00         72.00         73.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00						
40.00         040000         SUBPROVIDER - 1 PF         40.00           ANCILLARY SERVICE COST CENTERS         50.00         05000         OPERATING ROOM         0.192772         50.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         65.00         65.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         72.00         73.00         73.00         73.00         73.00         73.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
ARCILLARY SERVICE COST CENTERS						
50.00         05000         054.00         05400         0400         RADI 0LOGY-DI AGNOSTI C         0.088405         54.00           51.00         05500         RADI 0LOGY-THERAPEUTI C         0.150799         55.00           59.00         05900         CARDI AC CATHETERI ZATI ON         0.105885         59.00           00.00         06000         LB0RATORY         0.162737         60.00           06.00         06500         RESPI RATORY THERAPY         0.159378         65.00           06.00         06600         PHYSI CAL THERAPY         0.159378         66.00           06000         06000         Deptote LECTROCARDI OLOGY         0.09132         69.00           071.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.550891         72.00           0.00         07400         RENAGED TO PATI ENTS         0.258369         73.00           0.00         07400         ORENAL DI ALYSIS         0.274961         74.00           0.00         09000 FAULL VP RACTI CE CLINIC         0.2446585         90.01           0.01         09000 FAULLY PRACTI CE CLINIC         0.249078         90.02           0.01         09000 FAULLY PRACTICE CLINIC         0.246585         90.01           0.02         09						40.00
54.00       05400       RADI OLOGY-DI ARNOSTI C       0.088405       54.00         55.00       05500       RADI OLOGY-THERAPEUTI C       0.150799       55.00         59.00       05000       CARDI AC CATHETERI ZATI ON       0.105885       59.00         60.00       06000       INTRAVENUS THERAPY       0.162737       60.00         64.00       06000       INTRAVENUS THERAPY       0.176327       66.00         65.00       06500       RESPI RATORY THERAPY       0.193278       66.00         69.00       06000 ELECTROCARDI LOGY       0.091932       67.00         71.00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.50891       71.00         72.00       07200 IMPL DEV. CHARGED TO PATI ENTS       0.258369       73.00         73.00       07300 DRUGS CHARGED TO PATI ENTS       0.258369       73.00         74.00       074000 RENAL DI ALYSI S       0.274961       74.00         74.00       074000 RENAL DI ALYSI S       0.249978       90.01         90.01       09001 CLIN C       0.46655       90.02         90.02       09002 OUTPATI ENT SEVICE CS COST CENTERS       90.01       90.02         90.02       09000 CLIN C       0.340605       90.02         90.03<						
55 00         05500         ADI OLOGY -THERAPEUTI C         0.15079         55.00           59.00         05900         CARDI AC CATHETERI ZATI ON         0.105885         59.00           60.00         06000         LABORATORY         0.162737         60.00           64.00         06400         INTRAVENOUS THERAPY         0.590001         64.00           65.00         06500         RESPI RATORY THERAPY         0.176327         65.00           66.00         06400         INTRAVENOUS THERAPY         0.176327         65.00           66.00         06600         ELECTROCARDI OLOGY         0.091932         66.00           67.00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.550891         71.00           71.00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.550891         73.00           73.00         07300 PRUSC CHARGED TO PATI ENTS         0.274961         74.00           76.00         03500 JPSVCH ATRI C/PSYCHOLOGI CAL SERVI CES         0.000000         76.00           70.00         07300 IFAMI LY PRACTI CE CLINI C         0.274961         90.01           90.01         09000 IFAMI LY PRACTI CE CLINI C         0.264585         90.02           90.02         007000 IFAMI LY PRACTI CE CLINI C         0.20070	50.00 05000 OPERATI NG ROOM	0. 192772				50.00
59.00       0500       CARDI AC CATHETERI ZATI ON       0.105885       59.00         60.00       06000       LABORATORY       0.162737       60.00         64.00       06400       INTRAVENUUS THERAPY       0.176327       65.00         65.00       06500       RESPI RATORY THERAPY       0.176327       65.00         66.00       06000       ELECTROCARDI OLOGY       0.091932       66.00         67.00       06000       ELECTROCARDI OLOGY       0.091932       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.550891       72.00         73.00       07300       RRUGS CHARGED TO PATI ENTS       0.258369       74.00         74.00       07400       RENAL DI ALYSI S       0.274961       74.00         70.00       0700       RUGS CHARGED TO PATI ENTS       0.2474961       90.00         90.00       09000 CLI NC       0.466585       90.00       90.00         90.00       09000 CLI NC       0.466585       90.01       90.02         90.01       90000 LIPATI ENT SERVI CE COST CENTER       0.440792       90.03         90.02       09000 LIPATI ENT SERVI CE SIN ORS       1.396460       90.04         90.04       90004 PRI MARY CARE		0. 088405				
60.00       06000       LABORATORY       0.162737       60.00         64.00       06400       INTRAVENOUS THERAPY       0.590001       64.00         65.00       06500       RSPI RATORY THERAPY       0.159378       66.00         66.00       06600       PLYSI CAL THERAPY       0.159378       66.00         67.00       06000       LECTROCARDIOLOGY       0.091932       69.00         71.00       07100       MPL. DEV. CHARGED TO PATIENTS       0.15387       71.00         73.00       07300       RUGS CHARED TO PATIENTS       0.258369       73.00         74.00       07400       RENAL DI ALYSIS       0.274961       74.00         76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       74.00         70.01       09000       CLINI C       0.646585       90.00         90.02       09002       OUTACI TENT PSYCH SERVI CES       0.490056       90.02         90.03       19001       FAMILLY PRACTI CE CLINI C       1.40792       90.04         90.04       90004       PRI MARY CARE FOR SENI ORS       1.396460       90.07         90.05       9010       FAMIL SALE CONTER       0.472652       90.06         90.06       9	55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 150799				55.00
64.00         06400         INTRAVENUUS THERAPY         0.500001         64.00           65.00         06500         RESPI RATORY THERAPY         0.176327         65.00           66.00         06600         PHYSI CAL THERAPY         0.159378         66.00           69.00         06700         ELECTROCABDIOLOGY         0.091932         69.00           71.00         07100         MPL. SUPPLIES CHARGED TO PATIENTS         0.550891         72.00           73.00         07300         RNUGS CHARGED TO PATIENTS         0.258369         73.00           74.00         70400         RTAL DIALYSI S         0.274961         74.00           74.00         70400         RNAL DIALYSI S         0.274961         74.00           70.00         09000 CLINIC         0.646585         90.00         90.00           09000 CLINIC         0.646585         90.00         90.02         90002         007001 FMAIL LINT PSYCHOLOGICAL SERVICES         0.400056         90.01           90.01         90001 FAIM LY PRACTICE CLINIC         1.029978         90.03         90.03         90.04         90.04         90.05         90.06         90.06         90.06         90.07         90.07         90.07         90.07         90.06         90.06	59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 105885				59.00
65.00       06500       RESPI RATORY THERAPY       0.176327       65.00         66.00       06600       PHYSI CAL THERAPY       0.159378       66.00         71.00       7100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.613587       71.00         72.00       07300       DRUC CHARGED TO PATIENTS       0.50891       72.00         73.00       07400       RENAL DI ALYSI S       0.274961       73.00         74.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       76.00         0017600       INPL. DEV. CHARGED TO PATIENTS       0.274961       76.00         003550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       76.00         0011       90001       FAMILY PRACTICE CLINIC       1.029978       90.00         90.01       90002       OUTPATIENT PSYCH SERVI CES       0.4490056       90.02         90.02       09003       INFUSI ON CENTER       0.140792       90.03         90.03       90005       PAIN MANAGEMENT       0.131409       90.05         90.04       90004       PRI MARY CARE FOR SEN UORS       1.396460       90.06         90.05       90005       PAIN MANAGEMENT       0.328770       90.06         90.06 <td>60. 00 06000 LABORATORY</td> <td>0. 162737</td> <td></td> <td></td> <td></td> <td>60.00</td>	60. 00 06000 LABORATORY	0. 162737				60.00
66.00       06600       PHYSI CAL THERAPY       0.159378       66.00         69.00       06900       ELECTROCARDI OLOGY       0.091932       69.00         71.00       70100       MDICAL SUPPLIES CHARGED TO PATIENTS       0.153887       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.258369       72.00         73.00       DRUGS CHARGED TO PATIENTS       0.274961       73.00         74.00       7400       RANA DIALYSIS       0.274961       76.00         00100       DUTPATIENT SERVICE COST CENTERS       0.000000       76.00         00.01       09001       FAMILY PRACTICE CLINIC       1.029978       90.00         90.01       09001       FAMILY PRACTICE CLINIC       1.029978       90.02         90.02       090001       LINIC       0.140792       90.02         90.03       NPOUSI NO CENTER       0.140792       90.02         90.04       09004       PRI MARY CARE FOR SENI ORS       1.396460       90.04         90.05       PAIN MANAGEMENT       0.131409       90.05       90.05         90.06       09006       WINN CARE CENTER       0.472652       90.07         91.00       09100       EMERGENCY       0.175658 <td>64.00 06400 INTRAVENOUS THERAPY</td> <td>0. 590001</td> <td></td> <td></td> <td></td> <td>64.00</td>	64.00 06400 INTRAVENOUS THERAPY	0. 590001				64.00
69:00       06900       ELECTROCARDIOLOGY       0.091932       69:00         71:00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.61387       71:00         72:00       72:00       INPL. DEV. CHARGED TO PATIENTS       0.550891       73:00         73:00       07300       DRUGS CHARGED TO PATIENTS       0.258369       73:00         74:00       07400       RENAL DI ALYSIS       0.274961       74:00         70:00       UTPATIENT SERVICE COST CENTERS       0.000000       76:00         00:01       09001       FAMILY PRACTICE CLINIC       0.646585       90:01         90:02       09002       UTPATIENT PSYCH SERVICES       0.440056       90:02         90:03       09001       FAMILY PRACTICE CLINIC       1.029978       90:03         90:04       09004 PRI MARY CARE FOR SENI ORS       1.396460       90:04         90:05       09005 PAIN MANAGEMENT       0.131409       90:05         90:06       090004 WOUND CARE CENTER       0.375652       90:07         90:07       09007 SLEEP CENTER       0.375658       90:07         91:00       09100       EMERGENCY       0.175658       91:00         92:00       092000       OBSERVATION BEDS (NON-DI STINCT PART)	65. 00 06500 RESPI RATORY THERAPY	0. 176327				65.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.613587       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.550891       72.00         73.00       07000       RENAL DI ALYSIS       0.258369       74.00         74.00       07400       RENAL DI ALYSIS       0.274961       74.00         76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0.000000       74.00         90.00       09000       CLINIC       0.646585       90.00         90.01       09001       FAMI LY PRACTICE CLINIC       1.029978       90.02         90.02       09002       UTPATIENT SERVICES       0.440056       90.02         90.03       99031       INUSION CENTER       0.140792       90.03         90.04       09004       PRI MARY CARE FOR SENI ORS       1.396460       90.04         90.05       9005       PAIN MANAGEMENT       0.131409       90.05         90.06       09000 / ENTER       0.328770       90.05         90.07       90200       OBERGENCY       0.175658       90.07         91.00       9200       OBERGENCY       0.564726       90.07         91.00       90200       DURABLE MEDI CAL EQUI	66. 00 06600 PHYSI CAL THERAPY	0. 159378				66.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.550891       72.00         73.00       DRUGS CHARGED TO PATIENTS       0.258369       73.00         74.00       ORACE       DIALYSIS       0.274961       74.00         76.00       03550       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0.000000       76.00         00TPATIENT SERVICE COST CENTERS       0.046585       90.00       90.00         00.01       FAMILY PRACTICE CLINIC       1.029978       90.00         90.02       09002       OUTPATIENT PSYCH SERVICES       0.440792       90.02         90.03       90031       INFUSION CENTER       0.1410792       90.03         90.04       PRI MARY CARE FOR SENIORS       1.396460       90.04         90.05       09005       PAI N MANAGEMENT       0.131409       90.06         90.06       09006       WOUND CARE CENTER       0.328770       90.07         90.10       OP100       ELEPC CENTER       0.472652       90.07         91.00       09100       BERGENCY       0.175658       91.00         91.00       09100       EMERGENCY       0.561138       92.00         07HER RELIMBURSABLE COST CENTERS       96.00       90.00       90.00       90	69. 00 06900 ELECTROCARDI OLOGY	0. 091932				69.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0.258369       73.00         74.00       07400       RENAL DIALYSIS       0.274961       74.00         76.00       00550       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0.000000       76.00         0UTPATIENT SERVICE COST CENTERS       90.00       90.01       FAMILY PRACTICE CLINIC       0.646585       90.01         90.00       09000       CLINIC       0.646585       90.01       90.01         90.02       007PATIENT PSYCH SERVICES       0.490056       90.02         90.03       09003       INFUSION CENTER       0.140792       90.03         90.04       09004       PRI MARY CARE FOR SENI ORS       1.396460       90.05         90.05       0905       PAIN MANAGEMENT       0.131409       90.05         90.06       09006       WOUND CARE CENTER       0.328770       90.06         90.07       90.08       NUND CARE CENTER       0.175658       90.07         91.00       OPLOE MERGENCY       0.175658       92.00       91.00         91.00       09000       DURABLE MEDI CAL EQUI P-RENTED       0.561138       10.00         91.00       OPGOD       DURABLE MEDI CAL EQUI P-RENTED       0.561138       10.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 613587				71.00
74.00       07400       RENAL DI ALYSI S       0.274961       74.00         76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       76.00         0017PATI ENT SERVI CE COST CENTERS       0.646585       90.00       90.01         90.00       09000       CLI NI C       1.029978       90.01         90.02       09002       OUTPATI ENT PSYCH SERVI CES       0.490056       90.02         90.03       09003       INFUSI ON CENTER       0.140792       90.03         90.04       09004       PRI MARY CARE FOR SENI ORS       1.396460       90.03         90.05       09005       PAI N MANAGEMENT       0.131409       90.05         90.06       09006       KURR CENTER       0.328770       90.06         90.07       09007       SLEEP CENTER       0.328770       90.07         91.00       09100       EMERGENCY       0.175658       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI ST INCT PART)       0.654726       92.00         92.00       OHOOD       INBURSABLE COST CENTERS       90.00       90.00       90.00         92.00       OBSERVATI ON BEDS (NON-DI ST INCT PART)       0.654726       92.00       92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 550891				72.00
76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       76.00         0UTPATI ENT SERVI CE COST CENTERS       0.646585       90.00         90.01       09001       FAMI LY PRACTI CE CLINI C       1.029978       90.00         90.02       09002       OUTPATI ENT PSYCH SERVI CES       0.440056       90.02         90.03       09003       INFUSI ON CENTER       0.140792       90.03         90.04       09004       PRI MARY CARE FOR SENI ORS       1.396460       90.04         90.05       09005       PAI N MANAGEMENT       0.131409       90.05         90.06       090006       WOUND CARE CENTER       0.472652       90.07         90.07       09007       SLEEP CENTER       0.472652       90.07         91.00       09100       EMERGENCY       0.175658       91.00         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.561138       96.00         94.00       HBURSABLE COST CENTERS       96.00       90.00       96.00         90.01       OPAGO       JURABLE MEDI CAL EQUI P-RENTED       0.561138       96.00         91.00       9400       HOURABLE MEDI CAL EQUI P-RENTED       0.561138       96.00         901.00       HAURABLE M	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 258369				73.00
OUTPATI ENT SERVICE COST CENTERS         90.00           90.00         090000         CLINIC         0.646585         90.01           90.01         FAMILY PRACTICE CLINIC         1.029978         90.01           90.02         00PATH ENT PSYCH SERVICES         0.490056         90.02           90.03         09003 INFUSION CENTER         0.140792         90.03           90.04         09004 PRI MARY CARE FOR SENIORS         1.396460         90.04           90.05         09005 PAIN MANAGEMENT         0.131409         90.05           90.07         09006 WUND CARE ENTER         0.328770         90.06           90.07         09007 SLEEP CENTER         0.472652         90.07           91.00         09100 EMERGENCY         0.175658         91.00           92.00         092000 OBSERVATION BEDS (NON-DI STINCT PART)         0.654726         92.00           92.00         092000 DURABLE MEDICAL EQUIP-RENTED         0.561138         96.00           90.100         HER REI MBURSABLE COST CENTERS         96.00         101.00           90.100         HEALTH AGENCY         0.561138         96.00           90.010         HEALTH AGENCY         0.561138         96.00           101.00         SPECIAL PURPOSE COST CENTERS	74.00 07400 RENAL DIALYSIS	0. 274961				74.00
90.00       09000       CLINIC       0.646585       90.00         90.01       09001       FAMILY PRACTICE CLINIC       1.029978       90.01         90.02       09002       0UTPATIENT PSYCH SERVICES       0.490056       90.02         90.03       09003       INFUSION CENTER       0.140792       90.03         90.04       09004       PRI MARY CARE FOR SENIORS       1.396460       90.04         90.05       09005       PAIN MANAGEMENT       0.131409       90.05         90.06       09006       WUND CARE CENTER       0.328770       90.06         90.07       09007       SLEEP CENTER       0.472652       90.07         91.00       09100       EMERGENCY       0.175658       91.00         92.00       0BSERVATION BEDS (NON-DI STINCT PART)       0.654726       92.00         011.00       10100       HOME HEALTH AGENCY       0.561138       96.00         101.00       I0100       HOME HEALTH AGENCY       0.561138       96.00         101.00       I0100       HOME HEALTH AGENCY       0.561138       96.00         101.00       I0100       HOME HEALTH AGENCY       101.00       101.00         101.00       Less Observation Beds       200.00	76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000				76.00
90.01       09001       FAMI LY PRACTI CE CLINIC       1.029978       90.01         90.02       09002       0UTPATI ENT PSYCH SERVI CES       0.490056       90.02         90.03       09003       INFUSI ON CENTER       0.140792       90.03         90.04       09004       PRI MARY CARE FOR SENI ORS       1.396460       90.04         90.05       09005       PAI N MANAGEMENT       0.131409       90.05         90.06       09006       WOUND CARE CENTER       0.472652       90.07         90.07       09007       SLEEP CENTER       0.175658       90.07         91.00       09100       EMERGENCY       0.175658       91.00         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.654726       92.00         92.00       OP3000       DURABLE MEDI CAL EQUI P-RENTED       0.561138       96.00         101.00       HOME HEALTH AGENCY       0.561138       96.00       96.00         101.00       HOME HEALTH AGENCY       0.561138       96.00       90.00         101.00       HOME HEALTH AGENCY       0.561138       96.00       90.00         101.00       HOME HEALTH AGENCY       0.561138       90.00       90.00         200.00       Subtotal (see	OUTPATIENT SERVICE COST CENTERS					
90.02       09002       0UTPATI ENT PSYCH SERVICES       0.490056       90.02         90.03       09003       INFUSION CENTER       0.140792       90.03         90.04       09004       PRI MARY CARE FOR SENIORS       1.396460       90.04         90.05       09005       PAIN MANAGEMENT       0.131409       90.05         90.06       09006       WOUND CARE CENTER       0.328770       90.06         90.07       0907       SLEEP CENTER       0.472652       90.07         91.00       O9100       EMERGENCY       0.175658       90.07         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.654726       92.00         92.00       09200       DURABLE MEDI CAL EQUI P-RENTED       0.561138       96.00         101.00       HOME HEALTH AGENCY       0.561138       90.002         200.00 <td>90. 00 09000 CLI NI C</td> <td>0. 646585</td> <td></td> <td></td> <td></td> <td>90.00</td>	90. 00 09000 CLI NI C	0. 646585				90.00
90.03       09003       INFUSION CENTER       0.140792       90.03         90.04       09004       PRIMARY CARE FOR SENIORS       1.396460       90.04         90.05       09005       PAIN MANAGEMENT       0.131409       90.05         90.06       09006       WOUND CARE CENTER       0.328770       90.06         90.07       09007       SLEP CENTER       0.472652       90.07         91.00       09100       EMERGENCY       0.175658       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.654726       92.00         07HER       REI MBURSABLE COST CENTERS       96.00       90.07         94.00       09600       DURABLE MEDI CAL EQUI P-RENTED       0.561138       96.00         101.00       HOME HEALTH AGENCY       0.561138       96.00       101.00         SPECIAL PURPOSE COST CENTERS       96.00       101.00       HOSPI CE       116.00       200.00       201.00       200.00       201.00       200.00         200.100       Less Observation Beds       Less Observation Beds       201.00       201.00       201.00       201.00	90.01 09001 FAMILY PRACTICE CLINIC	1. 029978				90.01
90.04       09004       PRI MARY CARE FOR SENIORS       1.396460       90.04         90.05       09005       PAI N MANAGEMENT       0.131409       90.05         90.06       09006       WOUND CARE CENTER       0.328770       90.06         90.07       09007       SLEEP CENTER       0.472652       90.07         91.00       09100       EMERGENCY       0.175658       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.654726       92.00         01HER REIMBURSABLE COST CENTERS       96.00       96.00       90.04       96.00         101.00       HOMB LE MEDI CAL EQUI P-RENTED       0.561138       96.00       91.00         111.00       10100 HOME HEALTH AGENCY       0.561138       96.00       101.00         101.00       HOSPI CE       116.00       200.00       201.00       200.00       200.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00       201.00	90. 02 09002 OUTPATI ENT PSYCH SERVICES	0. 490056				90.02
90.05       09005       PAI N MANAGEMENT       0.131409       90.05         90.06       09006       WOUND CARE CENTER       0.328770       90.06         90.07       09007       SLEP CENTER       0.472652       90.07         91.00       09100       EMERGENCY       0.175658       91.00         92.00       09200 (DBSERVATI ON BEDS (NON-DI STI NCT PART)       0.654726       92.00         01100       OP400 EMERGENCY       0.561138       96.00         90.00       09600 DURABLE MEDI CAL EQUI P-RENTED       0.561138       96.00         101.00       HOME HEALTH AGENCY       0.561138       101.00         101.00       HOME HEALTH AGENCY       101.00       1010         920.00       Subtotal (see instructions)       200.00       201.00         200.00       Subtotal (see instructions)       200.00       201.00	90. 03 09003 INFUSION CENTER	0. 140792				90.03
90.06         09006         WOUND CARE CENTER         0.328770         90.07           90.07         09007         SLEP CENTER         0.472652         90.07           91.00         09100         EMERGENCY         0.175658         91.00           92.00         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0.654726         92.00           07000         DURABLE MEDI CAL EQUI P-RENTED         0.561138         96.00           01000         HOME HEALTH AGENCY         0.561138         96.00           101.00         HOME HEALTH AGENCY         101.00         10100           SPECIAL PURPOSE COST CENTERS         116.00         10500 HOSPI CE         116.00           200.00         Subtotal (see instructions)         200.00         201.00         201.00	90. 04 09004 PRI MARY CARE FOR SENI ORS	1. 396460				90.04
90.06         09006         WOUND CARE CENTER         0.328770         90.07           90.07         09007         SLEP CENTER         0.472652         90.07           91.00         09100         EMERGENCY         0.175658         91.00           92.00         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0.654726         92.00           07000         DURABLE MEDI CAL EQUI P-RENTED         0.561138         96.00           01000         HOME HEALTH AGENCY         0.561138         96.00           101.00         HOME HEALTH AGENCY         101.00         10100           SPECIAL PURPOSE COST CENTERS         116.00         10500 HOSPI CE         116.00           200.00         Subtotal (see instructions)         200.00         201.00         201.00	90. 05 09005 PALN MANAGEMENT	0. 131409				90.05
91.00       09100       EMERGENCY       0.175658       91.00         92.00       0BSERVATI ON BEDS (NON-DI STI NCT PART)       0.654726       92.00         0THER REIMBURSABLE COST CENTERS       96.00       00700       DURABLE MEDI CAL EQUI P-RENTED       0.561138       96.00         101.00       HOME HEALTH AGENCY       0.561138       101.00       10100         SPECI AL PURPOSE COST CENTERS         116.00       11600       HOSPI CE       116.00         200.00       Subtotal (see instructions)       200.00       201.00	90.06 09006 WOUND CARE CENTER					90.06
91.00       09100       EMERGENCY       0.175658       91.00         92.00       0BSERVATI ON BEDS (NON-DI STI NCT PART)       0.654726       92.00         0THER REIMBURSABLE COST CENTERS       96.00       00700       DURABLE MEDI CAL EQUI P-RENTED       0.561138       96.00         101.00       HOME HEALTH AGENCY       0.561138       101.00       10100         SPECI AL PURPOSE COST CENTERS         116.00       11600       HOSPI CE       116.00         200.00       Subtotal (see instructions)       200.00       201.00	90. 07 09007 SLEEP CENTER	0. 472652				90.07
OTHER         REI MBURSABLE         COST         CENTERS         96.00         OURABLE         MEDI CAL         EQUIP-RENTED         0.561138         96.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         200.00         SUBTORIAL (see instructions)         116.00         200.00         201.00         Subtorial (see instructions)         201.00         <	91. 00 09100 EMERGENCY	0. 175658				91.00
OTHER         REI MBURSABLE         COST         CENTERS         96.00         OURABLE         MEDI CAL         EQUIP-RENTED         0.561138         96.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         200.00         SUBTORIAL (see instructions)         116.00         200.00         201.00         Subtorial (see instructions)         201.00         <						92.00
96.00         09600         DURABLE         MEDI CAL         EQUI P-RENTED         0.561138         96.00           101.00         10100         HOME         HEALTH         AGENCY         101.00         101.00           SPECIAL         PURPOSE         COST         CENTERS         116.00         11600         HOSPI CE         116.00         200.00         200.00         Subtotal         (see instructions)         200.00         201.00						
101.00         HOME HEALTH AGENCY         101.00           SPECIAL PURPOSE COST CENTERS         116.00           116.00         11600         HOSPI CE         116.00           200.00         Subtotal (see instructions)         200.00         201.00         201.00		0. 561138				96.00
SPECIAL PURPOSE COST CENTERS         116.00       11600         200.00       Subtotal (see instructions)         201.00       Less Observation Beds						
116.00         HOSPI CE         116.00           200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00		<u> </u>				
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00						116.00
201.00 Less Observation Beds 201.00						

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150082	Period: From 10/01/2014	Worksheet C Part I	
				To 09/30/2015	Date/Time Pre 2/26/2016 11:	
		Tit	le XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,			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	98, 274, 320		98, 274, 32	20 587, 026	98, 861, 346	30.00
31.00 03100 INTENSIVE CARE UNIT	23, 694, 525		23, 694, 52	25 52, 011	23, 746, 536	31.00
32. 00 03200 CORONARY CARE UNI T	5, 692, 368		5, 692, 36	0 8	5, 692, 368	32.00
40. 00 04000 SUBPROVIDER - IPF	2,087,790		2, 087, 79	90 0	2, 087, 790	40.00
ANCI LLARY SERVI CE COST CENTERS	r					
50. 00 05000 OPERATI NG ROOM	55, 393, 824		55, 393, 82			
54.00 05400 RADI OLOGY-DI AGNOSTI C	30, 050, 738		30, 050, 73		30, 207, 608	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 391, 437		5, 391, 43		5, 391, 437	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 257, 663		4, 257, 66	53 0	4, 257, 663	1
60. 00 06000 LABORATORY	45, 568, 020		45, 568, 02	443, 832	46, 011, 852	
64.00 06400 INTRAVENOUS THERAPY	2, 652, 003		2, 652, 00		2, 652, 003	
65. 00 06500 RESPI RATORY THERAPY	5, 924, 791	0	5, 924, 79	91 0	5, 924, 791	
66. 00 06600 PHYSI CAL THERAPY	10, 731, 699				10, 731, 699	
69. 00 06900 ELECTROCARDI OLOGY	3, 078, 383		3, 078, 38		3, 078, 383	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 923, 833		20, 923, 83		20, 923, 833	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	28, 282, 859		28, 282, 85		28, 282, 859	1
73.00 07300 DRUGS CHARGED TO PATIENTS	60, 201, 636		60, 201, 63		60, 201, 636	
74. 00 07400 RENAL DI ALYSI S	2, 440, 473		2, 440, 47	73 1, 492	2, 441, 965	
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLINIC	3, 718, 194		3, 718, 19		3, 719, 077	90.00
90.01 09001 FAMILY PRACTICE CLINIC	2, 927, 016		2, 927, 01		2, 927, 016	
90. 02 09002 OUTPATI ENT PSYCH SERVI CES	1, 798, 868		1, 798, 86		1, 798, 868	
90. 03 09003 INFUSION CENTER	1, 632, 156		1, 632, 15		1, 632, 156	
90. 04 09004 PRIMARY CARE FOR SENIORS	2, 299, 192		2, 299, 19		2, 339, 967	
90. 05 09005 PALN MANAGEMENT	4, 427, 646		4, 427, 64		4, 432, 743	
90.06 09006 WOUND CARE CENTER	655, 042		655, 04		656, 882	
90. 07 09007 SLEEP CENTER	2, 835, 673		2, 835, 67		2, 840, 230	
91.00 09100 EMERGENCY	31, 584, 724		31, 584, 72		33, 818, 509	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 985, 620		11, 985, 62	20	11, 985, 620	92.00
OTHER REI MBURSABLE COST CENTERS	1	1	1			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	11, 104, 190		11, 104, 19		1	
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS	-	1				
116.00 11600 HOSPI CE	0			0		116.00
200.00 Subtotal (see instructions)	479, 614, 683				483, 948, 659	
201.00 Less Observation Beds	11, 985, 620		11, 985, 62		11, 985, 620	
202.00  Total (see instructions)	467, 629, 063	0	467, 629, 06	4, 333, 976	471, 963, 039	202.00

COMPLITATI	nancial Systems ON OF RATIO OF COSTS TO CHARGES	DEACONESS I		CCN: 150082	Pe	eri od:	Worksheet C	2552-1
CONTUTATI	ON OF RATTO OF COSTS TO CHARGES		riovider	CCN. 130002		om 10/01/2014	Part I	
					To		Date/Time Pre	
							2/26/2016 11:	44 am
				le XIX		Hospi tal	PPS	
			Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6	Cost or Other	TEFRA	
				+ col. 7)		Ratio	Inpati ent	
							Ratio	
		6.00	7.00	8.00		9.00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS			101.000.0				
	000 ADULTS & PEDIATRICS	134, 329, 223		134, 329, 2				30.0
	100 I NTENSI VE CARE UNI T	56, 191, 303		56, 191, 3				31.0
	200 CORONARY CARE UNI T	13, 291, 376		13, 291, 3				32.0
	000 SUBPROVIDER - IPF	7, 698, 896		7, 698, 8	396			40.0
	CILLARY SERVICE COST CENTERS	1 1		1				
	000 OPERATING ROOM	118, 497, 941	173, 035, 677			0. 190008	0.00000	50.0
	400 RADI OLOGY-DI AGNOSTI C	91, 139, 794	250, 554, 583			0. 087946	0.00000	54.0
	500 RADI OLOGY-THERAPEUTI C	1, 803, 053	33, 949, 406			0. 150799	0.00000	55.0
	900 CARDI AC CATHETERI ZATI ON	26, 370, 686	13, 839, 633			0. 105885	0.00000	59.0
	000 LABORATORY	147, 516, 046	135, 222, 125	282, 738, 1	71	0. 161167	0.00000	60.0
64.00 064	400 I NTRAVENOUS THERAPY	4, 410, 439	84, 474	4, 494, 9	913	0. 590001	0.00000	64.0
65.00 06!	500 RESPI RATORY THERAPY	31, 436, 387	2, 164, 793	33, 601, 1	80	0. 176327	0.000000	65.0
66.00 06	600 PHYSI CAL THERAPY	49, 697, 448	17, 637, 489	67, 334, 9	937	0. 159378	0.00000	66.0
69.00 06	900 ELECTROCARDI OLOGY	20, 218, 104	13, 267, 449	33, 485, 5	53	0. 091932	0.00000	69.0
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 421, 958	12, 678, 897	34, 100, 8	355	0. 613587	0.00000	71.0
	200 IMPL. DEV. CHARGED TO PATIENTS	38, 774, 106	12, 566, 126	51, 340, 2	232	0. 550891	0.00000	72.0
73.00 073	300 DRUGS CHARGED TO PATIENTS	130, 597, 682	102, 408, 550	233, 006, 2	232	0. 258369	0.00000	73.0
74.00 074	400 RENAL DIALYSIS	8, 265, 556	615, 589	8, 881, 1	45	0. 274793	0.00000	74.0
76.00 03	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0. 000000	0.000000	76.0
OU	TPATIENT SERVICE COST CENTERS							1
90.00 090	000 CLINIC	20, 784	5, 731, 095	5, 751, 8	379	0. 646431	0.00000	90.0
90.01 090	001 FAMILY PRACTICE CLINIC	8, 587	2, 833, 236	2, 841, 8	323	1.029978	0.000000	90.0
90. 02 090	002 OUTPATI ENT PSYCH SERVICES	1, 502	3, 669, 234	3, 670, 7	36	0. 490056	0.000000	90.0
90. 03 090	003 INFUSION CENTER	147, 924	11, 444, 763	11, 592, 6	87	0. 140792	0.000000	90.0
90.04 090	004 PRIMARY CARE FOR SENIORS	5, 150	1, 670, 492	1, 675, 6	42	1.372126	0.000000	90.0
90.05 090	005 PALN MANAGEMENT	30, 357	33, 702, 044	33, 732, 4	01	0. 131258	0.000000	90.0
90.06 090	006 WOUND CARE CENTER	16, 664	1, 981, 335	1, 997, 9	999	0. 327849	0.000000	90.0
	007 SLEEP CENTER	13, 407	5, 995, 734			0. 471893	0.000000	
	100 EMERGENCY	78, 213, 848	114, 310, 452			0.164056	0.000000	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 266, 124	14, 040, 202			0.654726	0.000000	92.0
	HER REIMBURSABLE COST CENTERS							
	600 DURABLE MEDICAL EQUIP-RENTED	0	19, 788, 696	19, 788, 6	96	0. 561138	0.000000	96.0
	100 HOME HEALTH AGENCY	0	0		0			101.0
	ECIAL PURPOSE COST CENTERS			1	-	I		1
	600 H0SPI CE	0	0		0			116. 0
200.00	Subtotal (see instructions)	984, 384, 345	983, 192, 074	1, 967, 576, 4	19			200. 0
201.00	Less Observation Beds							201.0
	Total (see instructions)	1 1		1	19			202.0

Heal th	Financial Systems	DEACONESS HOS	PI TAL	In Lie	u of Form CMS-	2552-10
COMPUT	FATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150082	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Pre 2/26/2016 11:	
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio				
	INDATIENT DOUTINE CEDVICE COST CENTERS	11.00				
20.00	INPATIENT ROUTINE SERVICE COST CENTERS					20.00
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
32.00 40.00	03200 CORONARY CARE UNIT					32.00
40.00	04000 SUBPROVIDER - IPF ANCILLARY SERVICE COST CENTERS					40.00
F0 00		0 100770				50.00
50.00	05000 OPERATING ROOM	0. 192772				50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 088405				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 150799				55.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 105885				59.00
60.00	06000 LABORATORY	0. 162737				60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 590001				64.00
65.00	06500 RESPI RATORY THERAPY	0. 176327				65.00
66.00	06600 PHYSI CAL THERAPY	0. 159378				66.00
69.00	06900 ELECTROCARDI OLOGY	0. 091932				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 613587				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 550891				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 258369				73.00
74.00	07400 RENAL DI ALYSI S	0. 274961				74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000				76.00
	OUTPATIENT SERVICE COST CENTERS	1 1				
90.00	09000 CLI NI C	0. 646585				90.00
90. 01	09001 FAMILY PRACTICE CLINIC	1. 029978				90.01
90. 02	09002 OUTPATI ENT PSYCH SERVI CES	0. 490056				90.02
90. 03	09003 INFUSION CENTER	0. 140792				90.03
90.04	09004 PRIMARY CARE FOR SENIORS	1. 396460				90.04
90.05	09005 PAIN MANAGEMENT	0. 131409				90.05
90.06	09006 WOUND CARE CENTER	0. 328770				90.06
90.07	09007 SLEEP CENTER	0. 472652				90.07
91.00	09100 EMERGENCY	0. 175658				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 654726				92.00
	OTHER REIMBURSABLE COST CENTERS					_
	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 561138				96.00
101.00	0 10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPI CE					116.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	) Total (see instructions)					202.00

	ancial Systems		HOSPI TAL			u of Form CMS-2	2552-1
	DN OF OUTPATIENT SERVICE COST TO CHARGE RA S FOR MEDICAID ONLY	ATIOS NET OF	Provi der	CCN: 150082	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part II Date/Time Pre 2/26/2016 11:-	pared: 44 am
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part			Reducti on	
		I, col. 26)	II col. 26)		-	Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	I LLARY SERVICE COST CENTERS					_	
	OO OPERATING ROOM	55, 393, 824				0	
	00 RADI OLOGY-DI AGNOSTI C	30, 050, 738				0	
	00 RADI OLOGY-THERAPEUTI C	5, 391, 437				0	55.0
	00 CARDI AC CATHETERI ZATI ON	4, 257, 663				0	59. C
	00 LABORATORY	45, 568, 020				0	60.0
	00 I NTRAVENOUS THERAPY	2, 652, 003				0	64.0
	00 RESPI RATORY THERAPY	5, 924, 791				0	65.0
	00 PHYSI CAL THERAPY	10, 731, 699				0	66.0
9.00 069	00 ELECTROCARDI OLOGY	3, 078, 383	207, 131	2, 871, 2	52 0	0	69.0
1.00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 923, 833	912, 575	20, 011, 2	58 0	0	71.0
2.00 072	00 IMPL. DEV. CHARGED TO PATIENTS	28, 282, 859	1, 236, 650	27, 046, 2	09 0	0	72.0
3.00 073	00 DRUGS CHARGED TO PATIENTS	60, 201, 636				0	73.0
4.00 074	00 RENAL DI ALYSI S	2, 440, 473	95, 873	2, 344, 6	00 0	0	74. (
6. 00 035	50 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C		0 0	0	76.0
OUT	PATIENT SERVICE COST CENTERS						1
0.00 090	OO CLINIC	3, 718, 194	383, 999	3, 334, 1	95 0	0	90.0
0.01 090	01 FAMILY PRACTICE CLINIC	2, 927, 016	476, 465	2, 450, 5	51 0	0	90.0
0. 02 090	02 OUTPATIENT PSYCH SERVICES	1, 798, 868	201, 639	1, 597, 2	29 0	0	90.0
0.03 090	03 INFUSION CENTER	1, 632, 156	154, 313	1, 477, 8	43 0	0	90. (
0.04 090	04 PRIMARY CARE FOR SENIORS	2, 299, 192	121, 077	2, 178, 1	15 0	0	90.0
0.05 090	05 PALN MANAGEMENT	4, 427, 646	273, 588	4, 154, 0	58 0	0	90.0
0.06 090	06 WOUND CARE CENTER	655,042		604, 5	48 0	0	90.0
0. 07 090	07 SLEEP CENTER	2,835,673	318, 450	2, 517, 2	23 0	0	90.0
	OO EMERGENCY	31, 584, 724				0	91.0
	00 OBSERVATION BEDS (NON-DISTINCT PART)	11, 985, 620				0	92.0
	ER REIMBURSABLE COST CENTERS						1
	OO DURABLE MEDICAL EQUIP-RENTED	11, 104, 190	1,034,484	10, 069, 7	06 0	0	96. (
	OO HOME HEALTH AGENCY	0			0 0	0	101.0
	CIAL PURPOSE COST CENTERS	· · ·					1
	00 HOSPI CE	0	C		0 0	0	1116. (
200.00	Subtotal (sum of lines 50 thru 199)	349, 865, 680	-				200. (
	Less Observation Beds	11, 985, 620					201. (
201.00							

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY         Provider CCN: 150082         Period: From 10/01/2014 To 09/30/2015         Worksheet C Pattern Devitient (Ourphatient)           Cost Center Description         Cost Net of Capital and Operating CostPatt. Reduction         Total Charges Outpatient (Ourphate)         Outpatient Cost to Charges         Worksheet C Pattern Pattern         Hospital         PPS           MICLLARY SERVICE COST CENTERS         Cost Net of Capital and Operating CostPatt. So. 00 (5000 OPERATINE ROOM 50. 00 (5000 OPERATINE ROPPUTIC 50. 00 (5000 OPERATINE ROOM 50. 00 (50	Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2552
Cost Center Description         Cost Net of Capital and Operating CostPart I, column Ratio (col. 6 Reduction 8)         Cost to Charge (col. 7)           4NCILLARY SERVICE COST CENTERS         6.00         7.00         8.00           50.00         05000 (PERATING R00M         55, 393, 824         291, 533, 618         0.190008           50.00         05000 (Rabi Locey-Di AGNOSTIC         30, 050, 738         341, 694, 377         0.087946           50.00         05000 (Rabi Locey-THERAPEUTIC         5, 391, 437         35, 752, 459         0.150799           59.00         05000 (ARDD LOCY-THERAPEUTIC         5, 589, 202         282, 738, 171         0.161167           60.00         06000 (ARDO LACEYT THERAPEUTIC         5, 5924, 791         3, 601, 180         0.199378           64.00         06400 (INTRAVENOUS THERAPY         2, 652, 003         4, 494, 913         0.590001           64.00         064000 (INTRAVENOUS THERAPY         3, 078, 383         34, 455, 553         0.91932           71.00         07100 (MEDI CAL SUPPLIES CHARGED TO PATIENTS         28, 282, 859         51, 340, 322         0.550891           72.00         07200 (JRUCE CHARGED TO PATIENTS         20, 206, 33, 34, 100, 855         0.50387         71.0           73.00         07300 (DRUGS CHARGED TO PATIENTS         28, 282, 859         51, 340, 3		ATIOS NET OF			From 10/01/2014 To 09/30/2015	Part II Date/Time Prepare 2/26/2016 11:44 a
Capital and (Poerstaning Cost for Line Cost for Charge Operating Cost Part I, colum, Ratio (col. 6) (col. 7)         Sector (Charge Autor)         Sector (Charge Reduction)         Sector (Col. 7)         Sector (Charge Reduction)         Sector (Charge Redu						PPS
Operating Cost Part I., Cost Part I., Colum, Ratio (col. 5 Reduction         Kolum	Cost Center Description					
Image: Production         B)         / coi. 7)           ANCILLARY SERVICE COST CENTERS         6.00         7.00         8.00           50.00         05000 (PAPERATING ROOM)         55, 393, 824         291, 533, 618         0.190008           54.00         05400 (RADIOLOGY-DIAGNOSTIC         30, 050, 738         341, 694, 377         0.087946         54.0           55.00         05500 (RADIOLOGY-THERAPEUTIC         5, 393, 824         291, 533, 618         0.190008         55.0           50.00         05000 (ARDIOLOGY-THERAPEUTIC         5, 391, 437         35, 752, 459         0.150799         55.0           60.00         06000 (ABDRATORY         45, 568, 020         282, 738, 171         0.161167         60.0           64.00         06400 INTRAVENDUS THERAPY         2, 652, 003         4, 494, 913         0.590001         64.0           65.00         065000 PHYSICAL THERAPY         5, 924, 791         33, 601, 180         0.176327         65.0           71.00         07100 MEDICAL SUPPLIES CHARGED TO PATIENTS         20, 923, 833         34, 405, 53         0.091932         66.0           72.00         07200 INPL. ECV. CHARGED TO PATIENTS         20, 923, 833         34, 405, 53         0.091932         72.0           73.00         07300 DRUGS CHARED TO PATIENTS<						
6.00         7.00         8.00           50.00         05000         0PERATI NO ROOM         55, 393, 824         291, 533, 618         0.190008         50.0           54.00         05000         RATI NO ROOM         55, 393, 824         291, 533, 618         0.190008         55.0           55.00         05500         RADI LOGY-DI AKNOSTI C         30, 050, 738         341, 694, 377         0.087946         55.0           55.00         05500         RADI LOGY-DI AKNOSTI C         5.91, 437         35, 752, 459         0.150799         55.0           59.00         D5900         CARDI AC CATHETERI ZATI ON         4, 257, 663         40, 210, 319         0.105885         59.0           60.00         06000         LABORATORY         45, 568.020         282, 738, 171         0.161167         66.0           66.00         06600         PH RATORY THERAPY         5, 924, 791         33, 601, 180         0.175327         66.0           69.00         MOOD MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         20, 923, 833         34, 100, 855         0.613587         71.0           73.00         07300         DRUA L BEV, CHARGED TO PATI ENTS         28, 282, 859         51, 800, 632         0.2505091         73.0           73.00         07300         <					6	
ANCI LLARY SERVICE COST CENTERS         -         -         -           0.00         OSDOO OPERATI NG ROM         55, 393, 824         291, 533, 618         0. 190008         55, 00         500         55, 00         500, 00         560, 00         560, 00         560, 00         560, 00         560, 00         560, 00         560, 00         571, 370, 00         570, 374, 03						
50.00         05000         05000         05000         05400         70008         50.00         150.799         55.6         50.00         50.00         50.00         150.799         50.00         50.00         150.799         50.00         50.00         150.799         50.00         50.00         150.799         50.00         60.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00		6.00	7.00	8.00		
54.00       05400       RADI OLOCY-DI AGNOSTI C       30, 050, 738       341, 694, 377       0.087946       54.0         55.00       05500       RADI OLOCY-THERAPEUTI C       5, 391, 437       35, 752, 459       0. 150799       55.0         60.00       06000       LABORATORY       4, 257, 663       40, 210, 319       0. 105885       59.0         64.00       06400       INTRAVENUS THERAPY       2, 652, 003       4, 494, 913       0. 59000       66.0         65.00       06500       RESPI RATORY THERAPY       5, 924, 791       33, 601, 180       0. 176327       65.0         66.00       06600       PUSI CAL THERAPY       10, 731, 699       67, 334, 937       0. 159378       66.0         67.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       20, 923, 833       34, 485, 553       0. 019392       69.0         73.00       07300       DRUGS CHARGED TO PATIENTS       20, 923, 833       34, 100, 855       0. 558891       73.0         74.00       07400       RENAL DI ALYSI S       2, 440, 473       8, 881, 145       0. 214793       74.0         74.00       09001       CHARGED TO PATIENTS       60, 201, 636       233, 006, 232       0. 258369       73.0       73.0       73.00       73.00			1	1		
55.00       0500       CARDI AC OXY -THERAPEUTIC       5, 391, 437       35, 752, 459       0. 150799         59.00       05000       CARDI AC CATHETERI ZATI ON       4, 257, 663       40, 210, 319       0. 105885       59.0         60.00       06000       LABORATORY       2, 652, 003       4, 494, 913       0. 590001       64.0         64.00       06400       INTRAVENUS THERAPY       2, 652, 003       4, 494, 913       0. 590001       64.0         65.00       06500       RESPI RATORY THERAPY       2, 652, 003       4, 494, 913       0. 590001       64.0         66.00       06600       FLEXERADRY THERAPY       10, 731, 699       67, 334, 937       0. 176327       65.0         67.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       20, 923, 833       34, 100, 855       0. 613587       71.0         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       20, 823, 836       30, 62, 322       0. 550891       73.0         73.00       07300       DRUS CHARGED TO PATI ENTS       20, 823, 836       1.00, 62, 2240, 5369       73.0       73.0       73.0       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.						
59.00       CARDI AC CATHETERI ZATI ON       4, 257, 663       40, 210, 319       0. 105885       59.0         60.00       06000       LABORATORY       45, 568, 020       282, 738, 171       0. 161167       60.0         64.00       06400       INTRAVENUUS THERAPY       2, 652, 003       4, 494, 913       0. 590001       64.0         65.00       06500       RESPI RATORY THERAPY       5, 924, 791       33, 601, 180       0. 176327       65.0         66.00       06000       PHSI CAL THERAPY       10, 731, 699       67, 334, 937       0.159378       66.0         69.00       0900 ELECTROCARDI OLOGY       3, 078, 383       33, 485, 553       0.091932       69.0         71.00       07100       MEUS CHARGED TO PATI ENTS       20, 923, 833       34, 100, 855       0.613587       71.0         72.00       07200       IPKL DEV. CHARGED TO PATI ENTS       28, 282, 859       51, 340, 232       0.258369       73.0         74.00       07400       REVAL DI ALYSI S       2, 440, 473       8, 81, 145       0.274793       74.0         0.00       09000       CHNIC       3, 718, 194       5, 751, 879       0.646431       90.0         90.01       09000       INFLI ST SERVICE COST CENTER       1, 798, 868						
60.00       06000       LABORATORY       45, 568, 020       282, 738, 171       0. 161167       60.0         64.00       06400       INTRAVENOUS THERAPY       2, 652, 003       4, 494, 913       0. 590001       64.0         65.00       06500       RESPI RATORY THERAPY       5, 924, 791       33, 601, 180       0. 176327       65.0         66.00       06600       PLSI CAL THERAPY       10, 731, 699       67, 334, 937       0. 159378       66.0         67.00       06000       LECTROCARDIOLOGY       3, 078, 383       33, 485, 553       0.091932       69.0         71.00       07100       MEDL CAL SUPPLIES CHARGED TO PATIENTS       28, 282, 859       51, 340, 232       0.550891       72.0         73.00       07300       RENG CHARGED TO PATIENTS       60, 201, 636       233, 006, 232       0.550891       73.0         74.00       07400       RENGE DTO PATIENTS       60, 201, 636       233, 006, 232       0.550859       73.0         76.00       03550       PSYCHIATRIC CE CLINIC       3, 718, 194       5, 751, 879       0. 646431       90.0         90.01       FAMILY PRACTICE CLINIC       3, 718, 194       5, 751, 879       0. 4646431       90.0       0.0       0.000000       0.0       0.0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
64.00       06400       INTRAVENOUS THERAPY       2, 652, 003       4, 494, 913       0. 590001       64.0         65.00       06500       RESPI RATORY THERAPY       5, 224, 791       33, 601, 180       0. 176327       65.0         66.00       06600       PHYSI CAL THERAPY       10, 731, 699       67, 334, 937       0. 159378       66.0         69.00       06900       ELECTROCARDI OLOGY       3, 078, 383       33, 485, 553       0. 091932       69.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       20, 923, 833       4, 100, 855       0. 613587       71.0         73.00       07300       DRUGS CHARGED TO PATI ENTS       28, 282, 859       51, 340, 232       0. 550891       72.c         74.00       07400       RENAL DI ALYSI S       2, 440, 473       8, 881, 145       0. 274793       74.0         70.00       07000       IFML ENT SERVICE COST CENTERS       0       0       0.0000000       76.0         90.01       09001       FAMI LY PRACTICE CLINIC       2, 927, 016       2, 841, 823       1. 029978       90.0         90.02       09002       ITATI ENT SERVICES       1, 788, 868       3, 670, 736       0. 400056       90.0         90.04       09004       PR	59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 257, 663	40, 210, 319			59.
65.00       06500       RESPI RATORY THERAPY       5, 924, 791       33, 601, 180       0.176327       65.0         66.00       06600       PHYSI CAL THERAPY       10, 731, 699       67, 334, 937       0.159378       66.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       20, 923, 833       34, 100, 855       0.091932       69.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       28, 282, 859       51, 340, 232       0.550891       73.0         73.00       07300       DRUS CHARGED TO PATIENTS       60, 201, 636       233, 006, 232       0.258369       73.4         74.00       03550       PSYCHI ATRIC/PSYCHOLOGI CAL SERVICES       0       0       0.000000       73.0         00100       00000       CLINIC       2, 927, 016       2, 841, 823       1.029978       90.0         00.01       090001       FAMILY PRACTICE CLINIC       2, 927, 016       2, 841, 823       1.029978       90.0         00.02       09002       OUTPATIENT SERVICE COST CENTER       1, 632, 156       11, 592, 687       0.4400762       90.0         00.03       09003       INFUSION CENTER       1, 632, 156       1, 592, 687       0.140792       90.0       90.0       90.00       90.00		45, 568, 020	282, 738, 171	0. 1611	67	
66.00       06600       PHYSI CAL THERAPY       10, 731, 699       67, 334, 937       0. 159378       66.0         69.00       06900       ELECTROCARDIOLOGY       3, 078, 383       33, 445, 553       0.091932       69.0         71.00       07100       MPL. DEV. CHARGED TO PATIENTS       20, 923, 833       34, 400, 855       0.613587       71.0         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       28, 282, 859       51, 340, 232       0.258369       73.0         73.00       07300       DRUGS CHARGED TO PATIENTS       60, 201, 636       233, 006, 232       0.258369       73.0         74.00       7400       RAND IALX'SIS       2, 440, 473       8, 881, 145       0.274793       74.0         76.00       003550       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0       0       0.0000000       0.0000000       76.0         90.01       09001       FAMILY PRACTICE COST CENTERS       1, 788, 868       3, 670, 736       0.440056       90.0       90.00       90.00       90.00       90.01       90.01       90.01       90.01       90003       INFUSION CENTER       1, 632, 156       1, 1592, 687       0.140792       90.0       90.0       90.00       90.00       90.00       90000       PIN MA	64.00 06400 INTRAVENOUS THERAPY					
69.00       06900       ELECTROCARDIOLOGY       3,078,383       33,485,553       0.091932       69.0         71.00       WEDI CAL SUPPLIES CHARGED TO PATIENTS       20,923,833       34,100,855       0.613587       71.0         72.00       7700       MEDI CAL SUPPLIES CHARGED TO PATIENTS       28,282,859       51,340,232       0.550891       72.0         73.00       07400       RENAL DI ALYSIS       2,440,473       8,881,145       0.274793       74.0         0.03550       PSYCHI ATRIC/PSYCHOLOGI CAL SERVICES       0       0.0000000       76.0         0017400       RENAL DI ALYSIS       3,718,194       5,751,879       0.646431       90.0         90.01       09000       IVIC       2,927,016       2,841,823       1.029978       90.0         90.02       09002 OUTPATI ENT SERVICES       1,798,868       3,670,736       0.440431       90.0         90.03       09003 INFUSION CENTER       1,632,156       11,592,687       0.140792       90.0         90.04       09004 PRI MARY CARE FOR SENIORS       2,299,192       1,675,642       1.372126       90.0         90.05       09005 PAIN MANAGEMENT       4,427,646       33,732,401       0.131258       90.0       90.0       90.0       90.00       9		5, 924, 791	33, 601, 180	0. 1763	27	65.
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       20,923,833       34,100,855       0.613587       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       28,282,859       51,340,232       0.550891       73.0         73.00       07000       RENAL DI ALYSI S       60,201,636       233,006,322       0.258369       73.0         74.00       07400       RENAL DI ALYSI S       2,440,473       8,881,145       0.274793       74.0         76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       0       0.000000       76.0         007000       CUIN C       3,718,194       5,751,879       0.646431       90.0         90.01       09001       FAMI LY PRACTICE CLINIC       2,927,016       2,841,823       1.029978       90.0         90.02       09002       OUTPATI ENT SERVI CES       1,798,868       3,670,736       0.490056       90.0       90.0         90.03       09003       INFUSION CENTER       1,632,156       11,592,687       0.140792       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0	66. 00 06600 PHYSI CAL THERAPY	10, 731, 699	67, 334, 937	0. 1593	78	66.
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       28,282,859       51,340,232       0.550891       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       60,201,636       233,006,232       0.258369       73.0         74.00       O7400       RENAL DI ALYSI S       2,440,473       8,881,145       0.274793       74.0         76.00       03550       PSYCHI ATRIC/PSYCHOLOGI CAL SERVICES       0       0       0.000000       76.0         0017041       ENT SERVICE COST CENTERS       0       0.646431       90.0       90.0       90.00       90.00       900.00       900.00       900.00       90.00	69.00 06900 ELECTROCARDI OLOGY	3, 078, 383	33, 485, 553	0. 0919	32	69.
73.00       07300       DRUGS CHARGED T0 PATIENTS       60, 201, 636       233, 006, 232       0. 258369       73.0         74.00       07400       RENAL DI ALYSI S       2, 440, 473       8, 881, 145       0. 274793       74.0         76.00       0350       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       0.00000       76.00         0UTPATIENT SERVICE COST CENTERS       0       0       0.00000       76.00         90.01       09001       CLINIC       3, 718, 194       5, 751, 879       0. 646431       90.0         90.02       00002       OUTPATIENT SERVICE CLINIC       2, 927, 016       2, 841, 823       1.029978       90.0         90.03       09003       INFUSION CENTER       1, 632, 156       11, 592, 687       0. 140792       90.0         90.04       09004       PRI MARY CARE FOR SENI ORS       2, 299, 192       1, 675, 642       1. 372126       90.0         90.05       09005       PAIN MANAGEMENT       4, 427, 646       33, 732, 401       0. 131258       90.0         90.06       09006       WOUND CARE CENTER       2, 835, 673       6, 009, 141       0. 471893       90.0         90.07       09020       DESERVATION BEDS (NON-DI STINCT PART)       11, 985, 620 <td< td=""><td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td><td>20, 923, 833</td><td>34, 100, 855</td><td>0. 6135</td><td>87</td><td>71.</td></td<>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 923, 833	34, 100, 855	0. 6135	87	71.
74.00       07400       RENAL DI ALYSI S       2,440,473       8,881,145       0.274793       74.0         76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       0.000000       76.0         0017PATI ENT SERVI CE COST CENTERS       3,718,194       5,751,879       0.646431       90.0         90.00       09000       CLI NI C       2,927,016       2,841,823       1.029978       90.0         90.01       09001       FAMI LY PRACTI CE CLI NI C       2,927,016       2,841,823       1.029978       90.0         90.02       09002       OUTPATI ENT PSYCH SERVI CES       1,798,868       3,670,736       0.490056       90.0         90.03       09003       INFUSI ON CENTER       1,632,156       11,592,687       0.140792       90.0         90.05       09005       PAI N MANAGEMENT       4,427,646       33,732,401       0.131258       90.0         90.06       09006       WOUND CARE CENTER       2,835,673       6,009,141       0.471893       90.0         91.00       09100       EMERGENCY       31,584,724       192,524,300       0.164056       91.0         92.00       09200       OBSERVATI ON BEDS (NON-DI ST INCT PART)       11,985,620       18,306,326       0.	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	28, 282, 859	51, 340, 232	0. 5508	91	72.
74.00       07400       RENAL DI ALYSI S       2,440,473       8,881,145       0.274793       74.0         76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       0.000000       74.0         90.01       09000       CLI NI C       3,718,194       5,751,879       0.646431       90.0         90.01       09001       FAMI LY PRACTI CE CLI NI C       2,927,016       2,841,823       1.029978       90.0         90.02       09002       OUTPATI ENT PSYCH SERVI CES       1,798,868       3,670,736       0.490056       90.0         90.03       09003       INFUSI ON CENTER       1,632,156       11,592,687       0.140792       90.0         90.04       09004       PRI MARY CARE FOR SENI ORS       2,299,192       1,675,642       1.372126       90.0         90.05       09005       PAI N MANAGEMENT       4,427,646       33,732,401       0.131258       90.0       90.0         90.07       09007       SLEEP CENTER       2,835,673       6,009,141       0.471893       90.0       90.0       90.0       90.0       9200       DBSERVATI ON BEDS (NON-DI STI NCT PART)       11,985,620       18,306,326       0.654726       91.0       92.0       92.00       002000       DBURABLE M	73.00 07300 DRUGS CHARGED TO PATIENTS	60, 201, 636	233, 006, 232	0. 2583	69	73.
76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       0.000000       76.00         0UTPATI ENT SERVI CE COST CENTERS       90.00       09000       CLI NI C       3,718,194       5,751,879       0.646431       90.0         90.01       FAMI LY PRACTI CE CLI NI C       2,927,016       2,841,823       1.029978       90.0         90.02       09001       FAMI LY PRACTI CE S       1,798,868       3,670,736       0.490056       90.0         90.03       09003       INFUSION CENTER       1,632,156       11,592,687       0.140792       90.0         90.04       09004       PAI MARY CARE FOR SENI ORS       2,299,192       1,675,642       1.372126       90.0         90.05       09005       PAI N MANAGEMENT       4,427,646       33,732,401       0.131258       90.0         90.06       09006       WOUND CARE CENTER       655,042       1.979,999       0.327849       90.0         91.00       09100       EMERGENCY       31,584,724       192,524,300       0.164056       91.0         92.0       092000       OBZRVATI ON BEDS (NON-DI STI NCT PART)       11,985,620       18,306,326       0.561138       90.0         91.00       092000       DBRABLE MEDI CAL EQUI P-RENTED </td <td>74.00 07400 RENAL DIALYSIS</td> <td>2, 440, 473</td> <td></td> <td></td> <td>93</td> <td>74.</td>	74.00 07400 RENAL DIALYSIS	2, 440, 473			93	74.
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC         3,718,194         5,751,879         0.646431         90.0           90.01         09001         FAMILY PRACTICE CLINIC         2,927,016         2,841,823         1.029978         90.0           90.02         0UTPATIENT PSYCH SERVICES         1,798,868         3,670,736         0.490056         90.0           90.03         09003         INFUSION CENTER         1,632,156         11,592,687         0.140792         90.0           90.04         09006         WUTPATIENT         4,427,646         33,732,401         0.131258         90.0           90.05         09005         PAIN MANAGEMENT         4,427,646         33,732,401         0.131258         90.0           90.06         09006         WOUND CARE CENTER         2,835,673         6,009,141         0.471893         90.0           90.07         09200         DESERVATION BEDS (NON-DISTINCT PART)         11,985,620         18,306,326         0.654726         91.0           91.00         092000         DURABLE MEDICAL EQUIP-RENTED         111,104,190         19,788,696         0.561138         96.0         92.0           092000         DURABLE MEDICAL EQUIP-RENTED         111,104,190         19,788,6	76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			0.0000	00	76.
90.00       09000       CLINIC       3,718,194       5,751,879       0.646431       90.0         90.01       09001       FAMILY PRACTICE CLINIC       2,927,016       2,841,823       1.029978       90.0         90.02       09002       0UTPATIENT PSYCH SERVICES       1,798,868       3,670,736       0.490056       90.0         90.03       09003       INFUSION CENTER       1,632,156       11,592,687       0.140792       90.0         90.04       09004       PRI MARY CARE FOR SENIORS       2,299,192       1,675,642       1.372126       90.0         90.05       09005       PAIN MANAGEMENT       4,427,646       33,732,401       0.131258       90.0         90.07       09007       SLEEP CENTER       655,042       1,997,999       0.327849       90.0         90.00       09000       BERGENCY       31,584,724       192,524,300       0.164056       91.0         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       11,985,620       18,306,326       0.561138       96.0         94.00       09000       URABLE MEDICAL EQUIP-RENTED       11,104,190       19,788,696       0.561138       96.0         90.100       BEDE CAST CENTERS       0       0       0.000000       0.0000000	OUTPATIENT SERVICE COST CENTERS					
90.01       09001       FAMILY PRACTICE CLINIC       2,927,016       2,841,823       1.029978       90.0         90.02       09002       0UTPATIENT PSYCH SERVICES       1,798,868       3,670,736       0.490056       90.0         90.03       09003       INFUSION CENTER       1,632,156       11,592,687       0.140792       90.0         90.04       09004       PRI MARY CARE FOR SENIORS       2,299,192       1,675,642       1.372126       90.0         90.05       09005       PAI N MANAGEMENT       4,427,646       33,732,401       0.131258       90.0         90.07       09007       SLEEP CENTER       2,835,673       6,009,141       0.471893       90.0         90.00       09007       SLEEP CENTER       2,835,673       6,009,141       0.471893       90.0         91.00       09100       EMERGENCY       31,584,724       192,524,300       0.164056       91.0         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       11,985,620       18,306,326       0.654726       92.0         96.00       092000       DURABLE MEDICAL EQUI P-RENTED       11,104,190       0       0.000000       101.0         10100       HOME HEALTH AGENCY       0       0.0000000       0.0000000       0		3, 718, 194	5, 751, 879	0. 6464	31	90.
90.02       09002       0UTPATI ENT PSYCH SERVICES       1,798,868       3,670,736       0.490056       90.0         90.03       09003       INFUSION CENTER       1,632,156       11,592,687       0.140792       90.0         90.04       09004       PRIMARY CARE FOR SENIORS       2,299,192       1,675,642       1.372126       90.0         90.05       09005       PAIN MANAGEMENT       4,427,646       33,732,401       0.131258       90.0         90.06       09006       WOUND CARE CENTER       655,042       1,997,999       0.327849       90.0         90.07       09007       SLEP CENTER       2,835,673       6,009,141       0.471893       90.0         91.00       09100       EMERGENCY       31,584,724       192,524,300       0.164056       92.0         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       11,985,620       18,306,326       0.654726       92.0         96.00       090000       DURABLE MEDI CAL EQUI P-RENTED       11,104,190       0       0.000000       101.0       96.0         97.10       10100       HOME HEALTH AGENCY       0       0       0.000000       101.0       10.0       10.0       90.0       0.0000000       10.00       0.0000000	90.01 09001 FAMILY PRACTICE CLINIC			1.0299	78	90.
90.03       09003       INFUSION CENTER       1, 632, 156       11, 592, 687       0.140792       90.0         90.04       09004       PRIMARY CARE FOR SENIORS       2, 299, 192       1, 675, 642       1.372126       90.0         90.05       09005       PAI N MANAGEMENT       4, 427, 646       33, 732, 401       0.131258       90.0         90.06       09006       WOUND CARE CENTER       655, 042       1, 997, 999       0.327849       90.0         90.07       09007       SLEEP CENTER       2, 835, 673       6, 009, 141       0.471893       90.0         91.00       09100       EMERGENCY       31, 584, 724       192, 524, 300       0.164056       91.0         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       11, 985, 620       18, 306, 326       0.654726       92.0         96.00       090600       DURABLE MEDI CAL EQUI P-RENTED       11, 104, 190       19, 788, 696       0.561138       96.0         101.00       HOME HEALTH AGENCY       0       0       0.000000       101.00       101.00       1000       10.00       0.000000       101.00       200.00       200.00000       101.00       200.00       200.00000       201.00       200.00       200.00       200.00000       200.00000	90. 02 09002 OUTPATIENT PSYCH SERVICES				56	90.
90. 04       09004       PRI MARY CARE FOR SENIORS       2, 299, 192       1, 675, 642       1. 372126       90. 0         90. 05       09005       PAI N MANAGEMENT       4, 427, 646       33, 732, 401       0. 131258       90. 0         90. 06       09006 WOUND CARE CENTER       655, 042       1, 997, 999       0. 327849       90. 0         90. 07       09007       SLEEP CENTER       2, 835, 673       6, 009, 141       0. 471893       90. 0         91. 00       09100       EMERGENCY       31, 584, 724       192, 524, 300       0. 164056       91. 0         92. 00       0BSERVATI ON BEDS (NON-DI STI NCT PART)       11, 985, 620       18, 306, 326       0. 654726       92. 0         96. 00       09000       DURABLE MEDI CAL EQUI P-RENTED       11, 104, 190       19, 788, 696       0. 561138       96. 0         101.00       HOME HEALTH AGENCY       0       0       0.000000       101.0       101.0       91. 0         90. 00       Subtotal (sum of Lines 50 thru 199)       349, 865, 680       1, 756, 065, 621       200. 0       200. 0         201. 00       Less Observati on Beds       11, 985, 620       0       0       0.000000       201. 0	90. 03 09003 INFUSION CENTER				92	90.
90.05       09005       PAI N MANAGEMENT       4, 427, 646       33, 732, 401       0.131258       90.0         90.06       09006       WOUND CARE CENTER       655, 042       1, 997, 999       0.327849       90.0         90.07       09007       SLEEP CENTER       2, 835, 673       6, 009, 141       0.471893       90.0         91.00       09100       EMERGENCY       31, 584, 724       192, 524, 300       0.164056       91.0         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       11, 985, 620       18, 306, 326       0.654726       92.0         96.00       090600       DURABLE MEDICAL EQUIP-RENTED       11, 104, 190       19, 788, 696       0.561138       96.0         101.00       HOME HEALTH AGENCY       0       0       0.000000       101.0         10100       HOME HEALTH AGENCY       0       0       0.000000       101.0         116.00       J1060       HOSPI CE       0       0       0.000000       116.0         200.00       Subtotal (sum of lines 50 thru 199)       349, 865, 680       1, 756, 065, 621       200.0         201.00       Less Observation Beds       11, 985, 620       0       0       201.00						
90.06       09006       WOUND CARE CENTER       655,042       1,997,999       0.327849       90.0         90.07       09007       SLEEP CENTER       2,835,673       6,009,141       0.471893       90.0         91.00       09100       EMERGENCY       31,584,724       192,524,300       0.164056       91.0         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART)       11,985,620       18,306,326       0.654726       92.0         01.00       09600       DURABLE MEDICAL EQUIP-RENTED       11,104,190       19,788,696       0.561138       96.0         01.00       HOME HEALTH AGENCY       0       0       0.000000       101.0         10100       HOSPI CE       0       0       0.000000       116.0         200.00       Subtotal (sum of lines 50 thru 199)       349,865,680       1,756,065,621       200.0         201.00       Less Observation Beds       11,985,620       0       0       20.00						
90. 07       09007       SLEEP CENTER       2,835,673       6,009,141       0.471893       90.0         91. 00       09100       EMERGENCY       31,584,724       192,524,300       0.164056       91.0         92. 00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART)       11,985,620       18,306,326       0.654726       92.0         01.00       OTHER       REI MBURSABLE COST CENTERS       96.0       0       0.000000       96.00       97.00         01.00       HOME       HEALTH       AGENCY       0       0       0.000000       96.00         101.00       HOME       HEALTH       AGENCY       0       0       0.000000       101.0         101.00       HOSPI CE       0       0       0.000000       116.0       200.00       201.00						
91.00       09100       EMERGENCY       31, 584, 724       192, 524, 300       0. 164056       91.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART)       11, 985, 620       18, 306, 326       0. 654726       92.00         0THER       REIMBURSABLE       COST CENTERS       96.00       006000       DURABLE       MEDI CAL       EQUI P-RENTED       11, 104, 190       19, 788, 696       0. 561138       96.00         101.00       HOME       HEALTH       AGENCY       0       0       0       0       101.00         10100       HOME       HEALTH       AGENCY       0       0       0.000000       101.00         116.00       HOSPI CE       0       0       0.000000       116.00       200.00       Subtotal (sum of lines 50 thru 199)       349, 865, 680       1, 756, 065, 621       200.00       201.00       201.00       201.00       0       0       0       201.00       201.00       201.00       0       0       0       0       201.00       201.00       201.00       201.00       0       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00						
92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         11,985,620         18,306,326         0.654726         92.0           OTHER         REI MBURSABLE         COST CENTERS         96.00         OPG000         DURABLE MEDI CAL         EQUI P-RENTED         11,104,190         19,788,696         0.561138         96.0         96.00           10100         HOME         HEALTH AGENCY         0         0         0.000000         101.0         100.000000         101.00         1000         HOSPI CE         11,00,190         19,788,696         0.0000000         101.00         101.00         101.00         1000         HOME HEALTH AGENCY         0         0         0.000000         101.00         101.00         1000         1000         1000         1000         100.000000         101.00         100.000000         101.00         100.000000         100.0000000         101.00         100.0000000         116.00         100.0000000         116.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
OTHER         REIMBURSABLE         COST         CENTERS           96.00         09600         DURABLE         MEDICAL         EQUIP-RENTED         11, 104, 190         19, 788, 696         0. 561138         96.0           101.00         10100 HOME         HEALTH         AGENCY         0         0         0.000000         101.0           SPECIAL PURPOSE COST CENTERS           116.00         11600 HOSPI CE         0         0.000000         116.0           200.00         Subtotal (sum of lines 50 thru 199)         349, 865, 680         1, 756, 065, 621         200.0           201.00         Less Observation Beds         11, 985, 620         0         201.0         201.00						
96.00         09600         DURABLE         MEDI CAL         EQUI P-RENTED         11, 104, 190         19, 788, 696         0. 561138         96.0           101.00         10100         HOME         HEALTH         AGENCY         0         0         0.000000         101.0           SPECIAL PURPOSE COST CENTERS           116.00         11600         HOSPI CE         0         0         0.000000         116.0           200.00         Subtotal (sum of lines 50 thru 199)         349, 865, 680         1, 756, 065, 621         200.0         201.00         201.00         201.00         0         0         0         0         201.00         0		11,700,020	10,000,020	0.0017	20	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
101.00       10100       HOME HEALTH AGENCY       0       0       0.000000       101.00         SPECIAL PURPOSE COST CENTERS       116.00       11600       HOSPI CE       0       0.0000000       116.00       116.00         200.00       Subtotal (sum of lines 50 thru 199)       349, 865, 680       1, 756, 065, 621       200.00       201.00       201.00       201.00       201.00       0       0       0       201.00       0       0       201.00       0       0       0       0       201.00       0 <td></td> <td>11 104 190</td> <td>19 788 696</td> <td>0 5611</td> <td>38</td> <td>96</td>		11 104 190	19 788 696	0 5611	38	96
SPECIAL PURPOSE COST CENTERS           116.00         11600         HOSPI CE         0         0         0.000000         116.0           200.00         Subtotal (sum of lines 50 thru 199)         349, 865, 680         1, 756, 065, 621         200.0         201.00         201.00         201.00         201.00         201.00         201.00         0         0         0         201.00         0         0         201.00         0         0         201.00         0         0         201.00         201.00         0						
116.00       11600       HOSPICE       0       0       0.000000       116.0         200.00       Subtotal (sum of lines 50 thru 199)       349,865,680       1,756,065,621       200.0         201.00       Less Observation Beds       11,985,620       0       201.0					I	
200.00         Subtotal (sum of lines 50 thru 199)         349,865,680         1,756,065,621         200.0           201.00         Less Observation Beds         11,985,620         0         201.0		0		0,0000	00	116.
201.00 Less Observation Beds 11,985,620 0 201.0						
				1		
	202.00 Total (line 200 minus line 201)					201.

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der		Period: From 10/01/2014 To 09/30/2015		nared
				10 077 307 2013	2/26/2016 11:	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	12, 907, 524	0	12, 907, 52	120, 954	106. 71	30.00
31.00 INTENSIVE CARE UNIT	2, 857, 293		2, 857, 29	3 18, 350	155.71	31.00
32.00 CORONARY CARE UNI T	565, 504		565, 50	4, 339	130.33	32.00
40. 00 SUBPROVIDER - IPF	211, 200	0	211, 20	3, 477	60.74	40.00
200.00 Total (lines 30-199)	16, 541, 521		16, 541, 52	147, 120		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	50, 558	5, 395, 044	Ļ			30.00
31.00 INTENSIVE CARE UNIT	7, 531					31.00
32.00 CORONARY CARE UNI T	2,062					32.00
40.00 SUBPROVIDER - IPF	1, 353					40.00
200.00 Total (lines 30-199)	61, 504					200.00

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150082	Peri od:	Worksheet D	
				From 10/01/2014	Part II	
				To 09/30/2015	Date/Time Pre 2/26/2016 11:	pared:
		Ti †I	e XVIII	Hospi tal	PPS	<u>44 alli</u>
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)	U U		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 05000 OPERATI NG ROOM	7, 479, 514					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 797, 206					
55. 00 05500 RADI OLOGY-THERAPEUTI C	615, 616					
59. 00 05900 CARDI AC CATHETERI ZATI ON	621, 905					1
60. 00 06000 LABORATORY	3, 564, 886					
64.00 06400 I NTRAVENOUS THERAPY	134, 781					64.00
65. 00 06500 RESPI RATORY THERAPY	458, 126				194, 366	
66.00 06600 PHYSI CAL THERAPY	587, 261				230, 703	
69. 00 06900 ELECTROCARDI OLOGY	207, 131					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	912, 575					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 236, 650					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 492, 499					73.00
74.00 07400 RENAL DIALYSIS	95, 873				47, 141	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.0000	000	0	76.00
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLINIC	383, 999					
90.01 09001 FAMILY PRACTICE CLINIC	476, 465				630	
90. 02 09002 OUTPATIENT PSYCH SERVICES	201, 639				27	90.02
90. 03 09003 I NFUSI ON CENTER	154, 313				710	
90. 04 09004 PRI MARY CARE FOR SENI ORS	121,077				349	90.04
90. 05 09005 PAIN MANAGEMENT	273, 588		0.0081		15	90.05
90. 06 09006 WOUND CARE CENTER	50, 494					90.06
90. 07 09007 SLEEP CENTER	318, 450				450	
91.00 09100 EMERGENCY	2, 938, 033					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1, 564, 867	18, 306, 326	0. 08548	32 2, 439, 117	208, 501	92.00
OTHER REI MBURSABLE COST CENTERS	1 004 404	10 700 (0)	0.0500	17		04 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	1,034,484					
200.00  Total (lines 50-199)	30,721,432	1, 756, 065, 621	I	354, 456, 274	5, 538, 957	∠UU. UU

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH O Cost Center Description Nursing Sch 1.00 1.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 40.00 V4000 SUBPROVIDER - IPF 200.00 Total (lines 30-199)		Title Ilied Health Cost	e XVIII AII Other Medical Education Cost		Date/Time Prep 2/26/2016 11:4 PPS Total Costs (sum of cols.	
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS           31. 00         03100 I NTENSI VE CARE UNI T           32. 00         03200 CORONARY CARE UNI T           40. 00         04000 SUBPROVI DER - I PF		llied Health Cost	AII Other Medical Education Cost	09/30/2015 Hospital Swing-Bed Adjustment Amount (see	Date/Time Prep 2/26/2016 11:4 PPS Total Costs (sum of cols.	
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000 ADULTS & PEDI ATRI CS           31.00         03100 I NTENSI VE CARE UNI T           32.00         03200 CORONARY CARE UNI T           40.00         04000 SUBPROVI DER - I PF		llied Health Cost	e XVIII All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see	2/26/2016 11: PPS Total Costs (sum of cols.	
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000 ADULTS & PEDI ATRI CS           31.00         03100 I NTENSI VE CARE UNI T           32.00         03200 CORONARY CARE UNI T           40.00         04000 SUBPROVI DER - I PF		llied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see	PPS Total Costs (sum of cols.	
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000 ADULTS & PEDI ATRI CS           31.00         03100 I NTENSI VE CARE UNI T           32.00         03200 CORONARY CARE UNI T           40.00         04000 SUBPROVI DER - I PF		Cost	Medical Education Cost	Adjustment Amount (see	(sum of cols.	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         I NTENSI VE CARE UNI T           32. 00         03200         CORONARY CARE UNI T           40. 00         04000         SUBPROVI DER - I PF			Education Cost	Amount (see		1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         I NTENSI VE CARE UNI T           32. 00         03200         CORONARY CARE UNI T           40. 00         04000         SUBPROVI DER - I PF						
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         I NTENSI VE CARE UNI T           32. 00         03200         CORONARY CARE UNI T           40. 00         04000         SUBPROVI DER - I PF		2,00			1 through 3,	1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         I NTENSI VE CARE UNI T           32. 00         03200         CORONARY CARE UNI T           40. 00         04000         SUBPROVI DER - I PF		2.00		instructions)	minus col. 4)	
30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         I NTENSI VE CARE UNI T           32. 00         03200         CORONARY CARE UNI T           40. 00         04000         SUBPROVI DER - I PF			3.00	4.00	5.00	
31.00         03100         I NTENSI VE CARE UNI T           32.00         03200         CORONARY CARE UNI T           40.00         04000         SUBPROVI DER - I PF						1
32. 00 03200 CORONARY CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	0	1, 118, 252	C	0 0	1, 118, 252	30.00
40. 00 04000 SUBPROVIDER - IPF	0	122, 143	C	)	122, 143	31.00
	0	35, 395	C	)	35, 395	32.00
200.00 Total (lines 30-199)	0	0	C	0	0	40.00
	0	1, 275, 790	C	)	1, 275, 790	200. 00
Cost Center Description Total Patie	ent Per	er Diem (col.	Inpatient	Inpati ent		1
Days	5	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		1
				Cost (col. 7 x		
				col. 8)		1
6.00		7.00	8.00	9.00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						1
30. 00 03000 ADULTS & PEDIATRICS 120,		9. 25				30.00
	350	6.66	7, 531	50, 156		31.00
32.00 03200 CORONARY CARE UNIT 4,	339	8. 16	2, 062	16, 826		32.00
40. 00 04000 SUBPROVIDER - IPF 3,	477	0.00	1, 353	0		40.00
200.00 Total (lines 30-199) 147,			61, 504	534, 644		200.00

Health Financial Systems	DEACONESS HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150082	Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2014	Part IV	
				To 09/30/2015	Date/Time Pre 2/26/2016 11:	pared: 44 am
		Titl	e XVIII	Hospi tal	PPS	44 alli
Cost Center Description	Non Physician Nur	rsing School	Allied Healt	h All Other	Total Cost	
•	Anestheti st	U		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	,					
50.00 05000 OPERATI NG ROOM	0	0	49, 8		49, 863	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	19, 12	26 0	19, 126	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	4, 0	78 0	4, 098	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	381, 54	41 0	381, 541	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
90.01 09001 FAMILY PRACTICE CLINIC	0	0		0 0	0	90.01
90. 02 09002 OUTPATI ENT PSYCH SERVI CES	0	0		0 0	0	90. 02
90. 03 09003 INFUSION CENTER	0	0		0 0	0	90. 03
90. 04 09004 PRI MARY CARE FOR SENI ORS	0	0	1, 1	18 0	1, 118	90.04
90. 05 09005 PALN MANAGEMENT	0	0		0 0	0	90.05
90.06 09006 WOUND CARE CENTER	0	0	99	94 0	994	90.06
90. 07 09007 SLEEP CENTER	0	0		0 0	0	90.07
91. 00 09100 EMERGENCY	0	0	37, 4		37, 444	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	135, 50	69 0	135, 569	92.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	96.00
200.00  Total (lines 50-199)	0	0	629, 7	53 0	629, 753	200. 00

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2014		
				To 09/30/2015	Date/Time Pre 2/26/2016 11:	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cos		I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50.00 05000 OPERATI NG ROOM	49, 863				46, 542, 618	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0					
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	19, 126					
60. 00 06000 LABORATORY	0	,,				60.00
64.00 06400 I NTRAVENOUS THERAPY	4,098					
65. 00 06500 RESPI RATORY THERAPY	0					65.00
66. 00 06600 PHYSI CAL THERAPY	0					
69. 00 06900 ELECTROCARDI OLOGY	0	33, 485, 553				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					
73.00 07300 DRUGS CHARGED TO PATIENTS	381, 541					
74.00 07400 RENAL DIALYSIS	0					74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	(	0.0000	0. 000000	0	76.00
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLINIC	0					
90.01 09001 FAMILY PRACTICE CLINIC	0					90.01
90. 02 09002 OUTPATI ENT PSYCH SERVI CES	0					90.02
90. 03 09003 INFUSION CENTER	0					90.03
90. 04 09004 PRIMARY CARE FOR SENIORS	1, 118				4, 830	90.04
90. 05 09005 PALN MANAGEMENT	0					90.05
90.06 09006 WOUND CARE CENTER	994					
90. 07 09007 SLEEP CENTER	0					90.07
91. 00 09100 EMERGENCY	37, 444					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	135, 569	18, 306, 326	0.00740	0. 007406	2, 439, 117	92.00
OTHER REIMBURSABLE COST CENTERS	1	T	1			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0. 000000		
200.00  Total (lines 50-199)	629, 753	1, 756, 065, 621	II.		354, 456, 274	200. 00

Health Financial Systems	DEACONESS H	IOSPI TAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der	CCN: 150082	Peri od:	Worksheet D
THROUGH COSTS				From 10/01/2014	Part IV
				To 09/30/2015	Date/Time Prepared: 2/26/2016 11:44 am
		Ti †I	e XVIII	Hospi tal	PPS
Cost Center Description	I npati ent	Outpatient	Outpatient	licopi tui	
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug	n l	
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS				-	
50. 00 05000 OPERATI NG ROOM	7, 959	27, 575, 613			50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	62, 278, 028		0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	13, 174, 650		0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 167	5, 333, 431		39	59.00
60. 00 06000 LABORATORY	0	17, 390, 040		0	60.00
64.00 06400 I NTRAVENOUS THERAPY	1, 854	12, 315		11	64.00
65.00 06500 RESPI RATORY THERAPY	0	460, 221		0	65.00
66.00 06600 PHYSI CAL THERAPY	0	84, 762		0	66.00
69.00 06900 ELECTROCARDI OLOGY	0	3, 066, 165		0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	3, 675, 126		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,032,989		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	93, 338	37, 211, 259			73.00
74.00 07400 RENAL DIALYSIS	0	422, 080		0	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	76.00
OUTPATIENT SERVICE COST CENTERS		4 7/4 040			
90. 00 09000 CLINIC	0	1, 761, 240		0	90.00
90. 01 09001 FAMILY PRACTICE CLINIC	0	249, 072		0	90.01
90. 02 09002 0UTPATI ENT PSYCH SERVI CES 90. 03 09003 I NFUSI ON CENTER	0	294, 104		0	90.02 90.03
90. 03 109003 THEOSTON CENTER 90. 04 109004 PRIMARY CARE FOR SENIORS	0	4, 387, 323 994, 417		63	90.03
90. 04 109004 PRIMART CARE FOR SENTORS 90. 05 109005 PALN MANAGEMENT	0	13, 241, 876		0	90.04
90. 05   09005   PATN MANAGEMENT 90. 06   09006   WOUND CARE CENTER	0	889, 237		42	90.05
90. 07 09007 SLEEP CENTER	4	2, 058, 263		0	90.07
91. 00 09100 EMERGENCY	6, 401	21, 038, 601		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	18,064	2, 056, 417		-	92.00
OTHER REIMBURSABLE COST CENTERS	10,004	2,030,417	10,2		72.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	96.00
200.00 Total (lines 50-199)	133, 790	221, 687, 229		-	200.00
				1	

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150082	Period:	Worksheet D	
				From 10/01/2014 To 09/30/2015	Part V Date/Time Pre	nared
				10 07/30/2013	2/26/2016 11:	44 am
		Titl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.)	(see inst.) 4.00	F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 190008	27, 575, 613		0 0	5, 239, 587	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 087946			30 19,056	5, 477, 103	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 150799			0 19,030	1, 986, 724	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 105885			10 0	564, 730	
60. 00 06000 LABORATORY	0. 161167				2, 802, 701	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 590001			0 0	7, 266	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 176327			0 0	81, 149	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 159378			0 0	13, 509	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 091932			0 0	281, 879	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 613587				2, 255, 010	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 550891			0 0	2, 221, 737	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 258369			32 298, 419	9, 614, 236	73.00
74.00 07400 RENAL DIALYSIS	0. 274793	422, 080		0 0	115, 985	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLINIC	0. 646431	1, 761, 240		0 0	1, 138, 520	90.00
90.01 09001 FAMILY PRACTICE CLINIC	1. 029978	249, 072		0 2	256, 539	90.01
90. 02 09002 OUTPATI ENT PSYCH SERVI CES	0. 490056			0 0	144, 127	90. 02
90. 03 09003 INFUSION CENTER	0. 140792			0 0	617, 700	90.03
90. 04 09004 PRIMARY CARE FOR SENIORS	1. 372126			0 14	1, 364, 465	90.04
90. 05 09005 PAIN MANAGEMENT	0. 131258			0 0	1, 738, 102	90.05
90.06 09006 WOUND CARE CENTER	0. 327849			0 0	291, 535	
90. 07 09007 SLEEP CENTER	0. 471893			0 0	971, 280	
91. 00 09100 EMERGENCY	0. 164056			46 9	3, 451, 509	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 654726	2, 056, 417	1, 34	41 4	1, 346, 390	92.00
OTHER REI MBURSABLE COST CENTERS	0.5(1100	1	1		-	
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 561138			0 0	0	96.00
200.00 Subtotal (see instructions)		221, 687, 229	9, 40		41, 981, 783	
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 +/- line 201)		221, 687, 229	9, 40	317, 504	41, 981, 783	202.00
	I	1 22.1, 00.1, 22.7	1 7, 10	3, 001	,,	

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS.	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150082	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Pro 2/26/2016 11	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	4			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			_
50.00 05000 OPERATING ROOM	0	C				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	16	1, 676				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C				55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1	C				59.00
60. 00 06000 LABORATORY	892	C				60.00
64.00 06400 INTRAVENOUS THERAPY	0	C				64.00
65. 00 06500 RESPI RATORY THERAPY	0	C				65.00
66. 00 06600 PHYSI CAL THERAPY	0	C				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	C				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 204	C	•			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	34	77, 102				73.00
74.00 07400 RENAL DIALYSIS	0	C	•			74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	)			76.00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0	C				90.00
90.01 09001 FAMILY PRACTICE CLINIC	0	2				90.01
90. 02 09002 OUTPATIENT PSYCH SERVICES	0	C				90. 02
90. 03 09003 INFUSION CENTER	0	C				90.03
90. 04 09004 PRIMARY CARE FOR SENIORS	0	19	•			90.04
90. 05 09005 PALN MANAGEMENT	0	C				90.05
90.06 09006 WOUND CARE CENTER	0	C				90.06
90. 07 09007 SLEEP CENTER	0	C				90.07
91.00 09100 EMERGENCY	40	1				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	878	3				92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C				96.00
200.00 Subtotal (see instructions)	3, 065	78, 803				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	3, 065	78, 803				202.00

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150082	Period:	Worksheet D	
		Component	t CCN: 15S082	From 10/01/2014 To 09/30/2015	Part II Date/Time Pre	nared
		component	L CON. 155002	10 0773072013	2/26/2016 11:	
		Ti tl	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		5	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ co	I. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	7, 479, 514	291, 533, 618	0. 0256	56 29, 001	744	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 797, 206				1,012	
55. 00 05500 RADI OLOGY-THERAPEUTI C	615, 616				0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	621, 905				0	59.00
60. 00 06000 LABORATORY	3, 564, 886					60,00
64. 00 06400 I NTRAVENOUS THERAPY	134, 781				0	64.00
65. 00 06500 RESPI RATORY THERAPY	458, 126				2	65.00
66. 00 06600 PHYSI CAL THERAPY	587, 261				0	66.00
69. 00 06900 ELECTROCARDI OLOGY	207, 131			86 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	912, 575	34, 100, 855	0. 0267	61 1, 959	52	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 236, 650	51, 340, 232	0. 0240	87 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 492, 499	233, 006, 232	0. 0106	97 325, 735	3, 484	73.00
74.00 07400 RENAL DIALYSIS	95, 873	8, 881, 145	0. 0107	95 0	0	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.0000	00 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLINIC	383, 999					
90.01 09001 FAMILY PRACTICE CLINIC	476, 465				0	90. 01
90. 02 09002 OUTPATIENT PSYCH SERVICES	201, 639				0	90. 02
90. 03 09003 INFUSION CENTER	154, 313				0	
90. 04 09004 PRI MARY CARE FOR SENI ORS	121, 077				0	90.04
90. 05 09005 PAI N MANAGEMENT	273, 588				0	90.05
90. 06 09006 WOUND CARE CENTER	50, 494				0	90.06
90. 07 09007 SLEEP CENTER	318, 450				0	90.07
91.00 09100 EMERGENCY	2, 938, 033					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	18, 306, 326	0.0000	00 0	0	92.00
	1 004 404	10 700 (0)	0.0500	77		
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	1,034,484					
200.00  Total (lines 50-199)	29, 100, 505	1, 756, 065, 621	I	1, 098, 557	14, 426	∠UU. UU

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	S Provider	CCN: 150082	Peri od:	Worksheet D	
THROUGH COSTS		Component	+ CON. 155000	From 10/01/2014 To 09/30/2015		norod.
		componen	t CCN: 15S082	10 09/30/2015	2/26/2016 11:	44 am
		Ti tl	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost		
	1.00	2.00	3.00	4.00	4)	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0	C	49, 80	03	49, 863	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		19, 12	26 0	19, 126	
60. 00 06000 LABORATORY	0	C		0 0	0	
64.00 06400 INTRAVENOUS THERAPY	0	C	4,04	98 0	4, 098	64.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	c c		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	381, 54	11 0	381, 541	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	)	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		1	1			
90. 00 09000 CLINIC	0	C	D.	0 0	0	
90.01 09001 FAMILY PRACTICE CLINIC	0	C	D	0 0	0	90.01
90. 02 09002 OUTPATIENT PSYCH SERVICES	0	C	0	0 0	0	90.02
90. 03 09003 INFUSION CENTER	0	C		0 0	0	90.03
90. 04 09004 PRI MARY CARE FOR SENI ORS	0	C	) 1, 1 <sup>-</sup>	18 0	1, 118	
90. 05 09005 PALN MANAGEMENT	0			0 0	0	
90. 06 09006 WOUND CARE CENTER	0		90	0	994	90.06
90. 07 09007 SLEEP CENTER	0		27.4	0 0	0	90.07
91.00 09100 EMERGENCY	0		37, 44	14 0	37, 444	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0		/	0 0	0	92.00
96.00 09600 DURABLE MEDICAL EQUI P-RENTED	0	C		0 0	0	96.00
200.00 Total (lines 50-199)	0	-			-	
	1 0	1 0	1 -74, 10		1 77,104	200.00

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS		Componen	t CCN: 15S082	From 10/01/2014 To 09/30/2015		narod
		component	CCN. 155002	10 077 307 2013	2/26/2016 11:	
		Ti tl	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and 4)	8)	7)	(col. 6 ÷ col.		
	6.00	7.00	8.00	7)	10.00	
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
50. 00 05000 OPERATI NG ROOM	49, 863	291, 533, 618	0.0001	0. 000171	29,001	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					•
59. 00 05900 CARDI AC CATHETERI ZATI ON	19, 126					
60. 00 06000 LABORATORY	0	282, 738, 171	0.0000	0. 000000	409, 955	60.00
64.00 06400 INTRAVENOUS THERAPY	4,098	4, 494, 913	0.00091	2 0.000912	0	
65. 00 06500 RESPI RATORY THERAPY	0	33, 601, 180	0.0000	0. 000000	138	65.00
66. 00 06600 PHYSI CAL THERAPY	0	67, 334, 937				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	33, 485, 553	0.0000	0. 000000		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34, 100, 855				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					
73.00 07300 DRUGS CHARGED TO PATIENTS	381, 541					
74.00 07400 RENAL DIALYSIS	0					
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	0.0000	0.00000	0	76.00
OUTPATIENT SERVICE COST CENTERS		5 754 070				
90. 00 09000 CLINIC	0					
90. 01 09001 FAMILY PRACTICE CLINIC	0					
90. 02 09002 0UTPATI ENT PSYCH SERVICES 90. 03 09003 INFUSION CENTER		-,,				
90. 03 09003 TNF0STON CENTER 90. 04 09004 PRIMARY CARE FOR SENIORS	-				0	
90. 05 09005 PALN MANY CARE FOR SENTORS	1, 118				-	
90. 05 09005 PATR MANAGEMENT 90. 06 09006 WOUND CARE CENTER	994					90.05
90. 07 09007 SLEEP CENTER	994				-	
91. 00 09100 EMERGENCY	37, 444					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	37, 444					
OTHER REIMBURSABLE COST CENTERS	. 0	10, 500, 520	0.0000	0.00000	0	72.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	19, 788, 696	0.0000	0.00000	0	96.00
200.00 Total (lines 50-199)		1, 756, 065, 621		0.00000	1, 098, 557	
		, , , , 02.	1	1	.,,,	

Health Financial Systems	DEACONESS I	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provi der	CCN: 150082	Period: From 10/01/2014	Worksheet D Part IV	
		Component	t CCN: 15S082		Date/Time Pre 2/26/2016 11:	
		Ti tl	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10) 11.00	12.00	x col. 12) 13.00			
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00			
50. 00 05000 OPERATING ROOM	5	0		0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60. 00 06000 LABORATORY	0	0		0		60,00
64.00 06400 INTRAVENOUS THERAPY	0	0	)	0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	)	0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	)	0		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	)	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	)	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	533	0	)	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		0		74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		76.00
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLINIC	0	0		0		90.00
90. 01 09001 FAMILY PRACTICE CLINIC	0	0		0		90.01
90. 02 09002 OUTPATIENT PSYCH SERVICES	0	0		0		90.02
90. 03 09003 I NFUSI ON CENTER 90. 04 09004 PRI MARY CARE FOR SENI ORS	0	0		0		90. 03 90. 04
90. 05 09005 PALN MANY CARE FOR SENTORS	0	0		0		90.04 90.05
90. 05 09005 PATN MANAGEMENT 90. 06 09006 WOUND CARE CENTER	0	0		0		90.05
90. 07 09007 SLEEP CENTER	0	0		0		90.08
91. 00 09100 EMERGENCY	50	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	1			/2.00
96. 00 09600 DURABLE MEDICAL EQUI P-RENTED	0	0		0		96.00
200.00 Total (lines 50-199)	588	0		0		200.00

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 10/01/2014 To 09/30/2015		
	_	Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	12, 907, 524	0	12, 907, 52	4 120, 954	106. 71	30.00
31.00 INTENSIVE CARE UNIT	2, 857, 293		2, 857, 29	3 18, 350	155.71	31.00
32.00 CORONARY CARE UNIT	565, 504		565, 50	4, 339	130.33	32.00
40. 00 SUBPROVIDER - IPF	211, 200	0	211, 20	0 3, 477	60.74	40.00
200.00 Total (lines 30-199)	16, 541, 521		16, 541, 52	1 147, 120		200.00
Cost Center Description	I npati ent	Inpati ent				
'	Program days	Program				
	5 5	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	7, 477	797, 871				30.00
31.00 INTENSIVE CARE UNIT	1, 696					31.00
32. 00 CORONARY CARE UNIT	471					32.00
40.00 SUBPROVIDER - IPF	494					40.00
200.00 Total (lines 30-199)	10, 138					200.00

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150082	Period:	Worksheet D	
				From 10/01/2014		
				To 09/30/2015	Date/Time Pre 2/26/2016 11:	pared:
		Ti t	le XIX	Hospi tal	272672016 TT: PPS	44 alli
Cost Center Description	Capi tal	Total Charges			Capital Costs	
oust center beschiption		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		$(col \cdot 1 + col$		column 4)	
	Part II, col.	8)	2)			
	26)		,			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		•	•		•	
50.00 05000 OPERATI NG ROOM	7, 479, 514	291, 533, 618	0. 0256	56 12, 520, 263	321, 220	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 797, 206	341, 694, 377	0.01403	9, 954, 560	139, 752	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	615, 616			19 194, 462	3, 348	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	621, 905	40, 210, 319	0.0154	56 2, 488, 198	38, 482	59.00
60. 00 06000 LABORATORY	3, 564, 886	282, 738, 171	0. 0126	20, 120, 847	253, 684	60.00
64.00 06400 INTRAVENOUS THERAPY	134, 781					64.00
65. 00 06500 RESPI RATORY THERAPY	458, 126					65.00
66. 00 06600 PHYSI CAL THERAPY	587, 261					
69. 00 06900 ELECTROCARDI OLOGY	207, 131				10, 977	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	912, 575					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 236, 650	51, 340, 232			83, 414	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 492, 499					
74.00 07400 RENAL DIALYSIS	95, 873	8, 881, 145			10, 865	
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.0000	0 00	0	76.00
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	383, 999					
90.01 09001 FAMILY PRACTICE CLINIC	476, 465					90.01
90. 02 09002 OUTPATI ENT PSYCH SERVI CES	201, 639					90.02
90. 03 09003 INFUSION CENTER	154, 313					90.03
90. 04 09004 PRI MARY CARE FOR SENI ORS	121,077				Ű	90.04
90. 05 09005 PALN MANAGEMENT	273, 588					90.05
90.06 09006 WOUND CARE CENTER	50, 494					90.06
90. 07 09007 SLEEP CENTER	318, 450					90.07
91. 00 09100 EMERGENCY	2, 938, 033					1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 564, 867	18, 306, 326	0.0854	32 285, 280	24, 386	92.00
OTHER REIMBURSABLE COST CENTERS		40.700.171	0.0	-	-	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	1,034,484				-	
200.00   Total (lines 50-199)	30, 721, 432	1, 756, 065, 621	I	93, 779, 523	1, 441, 595	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I						2552-10
	PASS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 10/01/2014		
				To 09/30/2015	Date/Time Pre 2/26/2016 11:	
		Ti +	le XIX	Hospi tal	PPS	44 dili
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
cost center bescription	Nul Sing School	Cost	Medi cal	Adj ustment	(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	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	1, 118, 252		0 0	1, 118, 252	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	122, 143			122, 143	
32. 00 03200 CORONARY CARE UNIT	0	35, 395		0	35, 395	
40. 00 04000 SUBPROVI DER - 1 PF	0	35, 375		0 0	0	
200.00 Total (lines 30-199)	0	1, 275, 790		0	1, 275, 790	
Cost Center Description	Total Patient		Inpati ent	Inpati ent	1, 273, 790	200.00
cost center bescription	Days	$5 \div col.$ (col.	Program Days			
	Days	5 ÷ COL 0)	Program Days	Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6,00	7.00	8.00	9,00	-	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
30. 00 03000 ADULTS & PEDI ATRI CS	120, 954	9, 25	7,47	7 69, 162		30.00
31. 00 03100 I NTENSI VE CARE UNI T	18, 350					31.00
32. 00 03200 CORONARY CARE UNIT	4, 339					31.00
40. 00 04000 SUBPROVIDER - 1 PF	3, 477					40.00
						•
200.00  Total (lines 30-199)	147, 120	1	10, 13	8 84, 300	1	200. 00

Health Financial Systems	DEACONESS HOSE	PI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS		CCN: 150082	Period: From 10/01/2014 To 09/30/2015	Date/Time Pre 2/26/2016 11:	pared: 44 am
			le XIX	Hospi tal	PPS	
Cost Center Description	Non Physician Nurs	sing School	Allied Healt	h All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	49, 8	53 0	49, 863	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	19, 12	26 0	19, 126	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	4, 0	98 0	4, 098	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	381, 54	41 0	381, 541	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90.01 09001 FAMILY PRACTICE CLINIC	0	0		0 0	0	90.01
90. 02 09002 OUTPATI ENT PSYCH SERVI CES	0	0		0 0	0	90.02
90. 03 09003 INFUSION CENTER	0	0		0 0	0	90.03
90. 04 09004 PRIMARY CARE FOR SENIORS	0	0	1, 1	18 0	1, 118	90.04
90. 05 09005 PALN MANAGEMENT	0	0		0 0	0	90.05
90.06 09006 WOUND CARE CENTER	0	0	9	94 0	994	90.06
90. 07 09007 SLEEP CENTER	0	0		0 0	0	90.07
91.00 09100 EMERGENCY	0	0	37, 4	44 0	37, 444	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1 1		1			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0		
200.00  Total (lines 50-199)	0	0	494, 18	34 0	494, 184	200. 00

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2014		
				To 09/30/2015	Date/Time Pre 2/26/2016 11:	
		Tit	tle XIX	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50.00 OPERATING ROOM	49, 863				12, 520, 263	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0					
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	19, 126					
60. 00 06000 LABORATORY	0	,,				60.00
64.00 06400 INTRAVENOUS THERAPY	4, 098					64.00
65. 00 06500 RESPI RATORY THERAPY	0					
66. 00 06600 PHYSI CAL THERAPY	0					
69. 00 06900 ELECTROCARDI OLOGY	0	33, 485, 553				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					
73.00 07300 DRUGS CHARGED TO PATIENTS	381, 541					
74.00 07400 RENAL DIALYSIS	0					74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	(	0.0000	0. 000000	0	76.00
OUTPATIENT SERVICE COST CENTERS	-	1	1			
90. 00 09000 CLINIC	0					90.00
90.01 09001 FAMILY PRACTICE CLINIC	0					90.01
90. 02 09002 OUTPATIENT PSYCH SERVICES	0					90.02
90. 03 09003 I NFUSI ON CENTER	0					90.03
90. 04 09004 PRI MARY CARE FOR SENI ORS	1, 118				0	90.04
90. 05 09005 PALN MANAGEMENT	0					90.05
90.06 09006 WOUND CARE CENTER	994					90.06
90. 07 09007 SLEEP CENTER	0					
91. 00 09100 EMERGENCY	37, 444					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	18, 306, 326	0.0000	0. 000000	285, 280	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	1			
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0. 000000		96.00
200.00  Total (lines 50-199)	494, 184	1, 756, 065, 62	II.		93, 779, 523	200. 00

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2552-10	0
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150082	Peri od:	Worksheet D	-
THROUGH COSTS				From 10/01/2014	Part IV	
				To 09/30/2015	Date/Time Prepared: 2/26/2016 11:44 am	
		Tit	le XIX	Hospi tal	PPS	-
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)	40.00	x col. 12)			
	11.00	12.00	13.00			_
ANCI LLARY SERVI CE COST CENTERS	2, 141	0		0	50.00	~
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2,141	0		0	54.00	
55. 00 05500 RADI OLOGY-DI AGNOSTI C	0	0		0	55.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 184	0		0	59.00	
60. 00 06000 LABORATORY	1, 104	0		0	60.00	
64. 00 06400 I NTRAVENOUS THERAPY	596	0		0	64.00	
65. 00 06500 RESPI RATORY THERAPY	0,0	0		0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0		0	66.00	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71.00	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72.00	0
73.00 07300 DRUGS CHARGED TO PATIENTS	30, 808	0		0	73.00	0
74.00 07400 RENAL DIALYSIS	0	0		0	74.00	0
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	76.00	0
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0	90.00	
90.01 09001 FAMILY PRACTICE CLINIC	0	0		0	90.01	
90. 02 09002 OUTPATI ENT PSYCH SERVI CES	0	0		0	90. 02	
90. 03 09003 I NFUSI ON CENTER	0	0		0	90.03	
90. 04 09004 PRI MARY CARE FOR SENI ORS	0	0		0	90.04	
90. 05 09005 PALN MANAGEMENT	0	0		0	90.05	
90. 06 09006 WOUND CARE CENTER	0	0		0	90.06	
90. 07 09007 SLEEP CENTER	0	0		0	90.07	
91.00 09100 EMERGENCY	1, 991	0		0	91.00	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REIMBURSABLE COST CENTERS	0	0		0	92.00	J
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	96.00	0
200.00 Total (lines 50-199)	36, 720	0		0	200.00	
	00,720	0	I	<b>9</b>	1200.00	-

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150082	Period:	Worksheet D	
				From 10/01/2014 To 09/30/2015	Part V Date/Time Pre	narod
				10 09/30/2013	2/26/2016 11:	44 am
		Ti t	le XIX	Hospi tal	PPS	
			Charges	•	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		-	1		-	
50.00 05000 OPERATING ROOM	0. 190008			0 13, 987, 726	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 087946			0 32, 485, 163	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 150799			0 3, 328, 750	0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 105885			0 1, 243, 276	0	59.00
60. 00 06000 LABORATORY	0. 161167	0		0 22, 585, 350	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 590001	0		0 29,084	0	64.00
65.00 06500 RESPI RATORY THERAPY	0. 176327			0 495, 302	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 159378			0 446, 590	0	66.00
69.00 06900 ELECTROCARDI OLOGY	0. 091932	0		0 1, 532, 948	0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 613587	0		0 2, 596, 097	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 550891	0		0 1, 848, 843	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 258369			0 10, 051, 634	0	73.00
74.00 07400 RENAL DIALYSIS	0. 274793			0 60, 040	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.00000	0		0 0	0	76.00
	0 (4(4)1	0	1	0 (52.72)	0	
90. 00 09000 CLINIC	0. 646431 1. 029978			0 652, 726	0	
90. 01 09001 FAMILY PRACTICE CLINIC 90. 02 09002 OUTPATIENT PSYCH SERVICES	0. 490056			0 1, 951, 658	0	90.01
90. 02 09002 0UTPATIENT PSYCH SERVICES 90. 03 09003 INFUSION CENTER	0. 490056			0 126, 557	-	90. 02 90. 03
90. 03 09003 THEOSTON CENTER 90. 04 09004 PRIMARY CARE FOR SENIORS	1. 372126			0 953, 433 0 516	0	90.03
90. 05 09005 PALN MANAGEMENT	0. 131258			0 3, 012, 783	0	90.04
90. 05 109005 PATN MANAGEMENT 90. 06 109006 WOUND CARE CENTER	0. 327849			0 3, 012, 783	0	90.05
90. 07 09007 SLEEP CENTER	0. 327849			0 674, 738	0	90.00
91. 00 09100 EMERGENCY	0. 164056			0 29, 599, 446	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 654726			0 29, 599, 440	0	92.00
OTHER REIMBURSABLE COST CENTERS	0.034720	0		0 3,030,320	0	72.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 561138	0		0 0	0	96.00
200.00 Subtotal (see instructions)	0. 301130			0 131, 573, 191		200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ		0 131, 373, 171	0	201.00
Only Charges				- 0		
202.00 Net Charges (line 200 +/- line 201)		o		0 131, 573, 191	0	202.00
			•		-	

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS.	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der	CCN: 150082	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Pro 2/26/2016 11	
		Tit	le XIX	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	2, 657, 780				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 856, 940				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	501, 972				55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	131, 644				59.00
60. 00 06000 LABORATORY	0	3, 640, 013				60,00
64. 00 06400 I NTRAVENOUS THERAPY	0	17, 160				64.00
65. 00 06500 RESPIRATORY THERAPY	0	87, 335				65.00
66. 00 06600 PHYSI CAL THERAPY	0	71, 177	1			66.00
69. 00 06900 ELECTROCARDI OLOGY	0	140, 927				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 592, 931				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 018, 511	•			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 597, 031				73.00
74.00 07400 RENAL DI ALYSI S	0	16, 499				74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	421, 942				90.00
90.01 09001 FAMILY PRACTICE CLINIC	0	2, 010, 165				90.01
90. 02 09002 OUTPATI ENT PSYCH SERVICES	0	62, 020				90.02
90. 03 09003 INFUSION CENTER	0	134, 236				90.03
90. 04 09004 PRIMARY CARE FOR SENIORS	0	708				90.04
90. 05 09005 PALN MANAGEMENT	0	395, 452				90.05
90.06 09006 WOUND CARE CENTER	0	91, 799				90.06
90. 07 09007 SLEEP CENTER	0	318, 404				90.07
91.00 09100 EMERGENCY	0	4, 855, 967	•			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 377, 001				92.00
OTHER REI MBURSABLE COST CENTERS			1			
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96.00
200.00 Subtotal (see instructions)	0	25, 997, 614				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
0nly Charges 202.00 Net Charges (line 200 +/- line 201)		2E 007 /14				202 00
202.00  Net Charges (line 200 +/- line 201)	0	25, 997, 614	1			202.00

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150082	Peri od:	Worksheet D	
			CCN: 15S082	From 10/01/2014 To 09/30/2015	Part II Date/Time Pre	pared:
					2/26/2016 11:	
		Tit	le XIX	Subprovider - IPF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,		(col. 1 ÷ co	L. Charges	column 4)	
	Part II, col.	8)	2)	0	, , , , , , , , , , , , , , , , , , ,	
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 OPERATING ROOM	7, 479, 514				0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 797, 206				792	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	615, 616				0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	621, 905				0	59.00
60. 00 06000 LABORATORY	3, 564, 886				6, 081	60.00
64.00 06400 INTRAVENOUS THERAPY	134, 781				0	64.00
65. 00 06500 RESPI RATORY THERAPY	458, 126				0	65.00
66. 00 06600 PHYSI CAL THERAPY	587, 261				0	66.00
69. 00 06900 ELECTROCARDI OLOGY	207, 131					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	912, 575				51	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 236, 650				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 492, 499				1, 548	73.00
74.00 07400 RENAL DIALYSIS	95, 873				0	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.0000	0 00	0	76.00
OUTPATIENT SERVICE COST CENTERS		5 754 070				
90. 00 09000 CLINIC	383, 999					90.00
90. 01 09001 FAMILY PRACTICE CLINIC	476, 465				0	90.01
90. 02 09002 OUTPATIENT PSYCH SERVICES	201, 639				0	90.02
90. 03 09003 I NFUSI ON CENTER	154, 313				0	90.03
90. 04 09004 PRI MARY CARE FOR SENI ORS	121,077				0	90.04
90. 05 09005 PALN MANAGEMENT	273, 588				U U	90.05
90. 06 09006 WOUND CARE CENTER	50, 494				0	90.06
90. 07 09007 SLEEP CENTER 91. 00 09100 EMERGENCY	318, 450				0 7 040	90. 07 91. 00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 938, 033				7, 040	91.00
OTHER REIMBURSABLE COST CENTERS	0	10, 300, 320	0.0000	1, 147	0	72.00
96. 00 09600 DURABLE MEDICAL EQUI P-RENTED	1,034,484	19, 788, 696	0.0522	77 0	0	96.00
200.00 Total (lines 50-199)		1, 756, 065, 621		1, 150, 220		
			•			•

Heal th	Financial Systems	DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPOR	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provi der	CCN: 150082	Peri od:	Worksheet D	
THROUG	GH COSTS		Componer	t CCN: 15S082	From 10/01/2014 To 09/30/2015		narad
			Componer	11 CCN. 155062	10 09/30/2013	2/26/2016 11:	
			Ti	tle XIX	Subprovider -	PPS	
					I PF		
	Cost Center Description	Non Physician	Nursing Schoo	Allied Healt		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	0.00	
50.00	05000 OPERATING ROOM	0		0 49,8	63 C	49, 863	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0	0 0	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0		o	0 0	0	55.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0 19, 1	26 C	19, 126	59.00
60.00	06000 LABORATORY	0		o	0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0		0 4,0	98 C	4, 098	64.00
65.00	06500 RESPI RATORY THERAPY	0		o	0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0		o	0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0		o	0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0 381, 5	41 C	381, 541	73.00
74.00	07400 RENAL DI ALYSI S	0		0	0 0	0 0	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0	0 0	0 0	76.00
	OUTPATIENT SERVICE COST CENTERS		i	1		1	-
	09000 CLI NI C	0		0	0 0	0	
90.01	09001 FAMILY PRACTICE CLINIC	0		0	0 0	0 0	
90.02	09002 OUTPATIENT PSYCH SERVICES	0		0	0 0	0	10102
90.03	09003 INFUSION CENTER	0		0	0 0	0	
	09004 PRI MARY CARE FOR SENI ORS	0		0 1, 1	18 0	1, 118	
90.05	09005 PAIN MANAGEMENT	0		0	0 0	0	
90.06	09006 WOUND CARE CENTER	0		9 9	94 0	994	
90.07	09007 SLEEP CENTER	0		0	0 (	0	
91.00	09100 EMERGENCY	0		0 37, 4		37, 444	•
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0		0	0 0	0 0	92.00
04 00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0 0	0	96.00
96.00 200.00		0		0 494, 1			•
200.00		1 0	I	Y 474, I		'l 474, 104	1200.00

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der	CCN: 150082	Peri od:	Worksheet D	
THROUGH COSTS		Componen	t CCN: 15S082	From 10/01/2014 To 09/30/2015		narod
		Componen	L CON. 155062	10 09/30/2013	2/26/2016 11:	
		Ti t	le XIX	Subprovider -	PPS	
				I PF		
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
	col. 2, 3 and 4)	8)	7)	(col. 6 ÷ col.		
	6.00	7.00	8.00	7)	10.00	
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
50. 00 05000 OPERATI NG ROOM	49, 863	291, 533, 618	0.0001	0. 000171	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					•
59. 00 05900 CARDI AC CATHETERI ZATI ON	19, 126					
60. 00 06000 LABORATORY	0	282, 738, 171	0.0000	0. 000000	482, 331	60.00
64.00 06400 INTRAVENOUS THERAPY	4,098	4, 494, 913	0.0009	0. 000912	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	33, 601, 180	0.0000	0. 000000	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	67, 334, 937				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	33, 485, 553	0.0000	0. 000000	2, 448	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34, 100, 855				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	,				
73.00 07300 DRUGS CHARGED TO PATIENTS	381, 541					
74.00 07400 RENAL DIALYSIS	0					
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.0000	0. 000000	0	76.00
OUTPATIENT SERVICE COST CENTERS		5 754 070	0.0000	0 00000		
90. 00 09000 CLINIC	0					
90. 01 09001 FAMILY PRACTICE CLINIC	0					
90. 02 09002 0UTPATI ENT PSYCH SERVICES 90. 03 09003 INFUSI ON CENTER		-,,				
90. 03 09003 TNF0STON CENTER 90. 04 09004 PRIMARY CARE FOR SENIORS	1, 118					
90. 05 09005 PALN MANY CARE FOR SENTORS	1, 118				-	
90. 06 09006 WOUND CARE CENTER	994				0	90.05
90. 07 09007 SLEEP CENTER	0				-	
91. 00 09100 EMERGENCY	37, 444					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	37,444					
OTHER REIMBURSABLE COST CENTERS		.0,000,020		0.00000	., ,	1 2.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	19, 788, 696	0.0000	0. 000000	0	96.00
200.00 Total (lines 50-199)		1, 756, 065, 621			1, 150, 220	
						•

Health Financial Systems	DEACONESS H	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS		CCN: 150082 t CCN: 15S082	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Pre 2/26/2016 11:	
		Ti t	le XIX	Subprovider - IPF	PPS	<u>44 dili</u>
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. x col. 12)	h		
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS	· · · · · ·					_
50.00 05000 OPERATI NG ROOM	0	0		0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60. 00 06000 LABORATORY	0	0		0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	237	0		0		73.00
74.00 07400 RENAL DIALYSIS	0	0		0		74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		76.00
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	0		0		90.00
90. 01 09001 FAMILY PRACTICE CLINIC	0	0		0		90.01
90. 02 09002 OUTPATIENT PSYCH SERVICES	0	0		0		90.02
90. 03 09003 I NFUSI ON CENTER	0	0		0		90.03
90. 04 09004 PRI MARY CARE FOR SENI ORS	0	0		0		90.04
90. 05 09005 PAIN MANAGEMENT	0	0		0		90.05
90. 06 09006 WOUND CARE CENTER	0	0		0		90.06
90. 07 09007 SLEEP CENTER	0	0		0		90.07
91.00 09100 EMERGENCY	89	0		0		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0	1	0		92.00
OTHER REI MBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0		96.00
200.00   Total (lines 50-199)	326	0	1	0		200.00

	Financial Systems DEACONESS HOSE ATION OF INPATIENT OPERATING COST	Provider CCN: 150082	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 10/01/2014 To 09/30/2015	Date/Time Pre 2/26/2016 11:	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days,			120, 954	1
00 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days do not complete this line.		ivate room days,	120, 954 0	2
00	Semi-private room days (excluding swing-bed and observation bec	days)		106, 290	4
00	Total swing-bed SNF type inpatient days (including private room reporting period		r 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	50, 558	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent	y (including private r	oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			0	13
	Medically necessary private room days applicable to the Program			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	s through December 31 o	f the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	s after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing period (line	98, 861, 346 0	
	Sx line 17) Swing-bed cost applicable to SNF type services after December 3			0	
	Swing-bed cost applicable to NF type services through December	•		0	
	$7 \times 1$ ine 19) Swing-bed cost applicable to NF type services after December 31	•			25
	x line 20) Total swing-bed cost (see instructions)	e. the cost reporting		0	
. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		98, 861, 346	
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)	- 1	+:>	0.00	
	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		tions)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
	General inpatient routine service cost net of swing-bed cost ar 27 minus line 36)	nd private room cost di	fferential (line	98, 861, 346	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3			817. 35 41, 323, 581	
	Medically necessary private room cost applicable to the Program			41, 323, 581	
0,00		( ····= · · · · · · · · · · · · · · · ·		0	

	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2014	Worksheet D-1	- <u>2552</u> 1
					o 09/30/2015		
	Cost Center Description	Total	Ti tl Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription		Inpatient Days	Diem (col. 1 ÷		(col. 3 x col.	
		1.00	2.00	<u>col. 2)</u> 3.00	4.00	4) 5.00	-
. 00	NURSERY (title V & XIX only)						42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	23, 746, 536	18, 350	1, 294. 09	7, 531	9, 745, 792	2 43
00	CORONARY CARE UNI T	5, 692, 368		1, 311. 91			3 44
00	BURN INTENSIVE CARE UNIT						45
	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECI FY)						46
00	Cost Center Description						
00	Program inpatient ancillary service cost (Wk	st D 2 col 2	2 Lino 200)			1.00 73,747,395	5 48
00	Total Program inpatient costs (sum of lines			ns)		127, 521, 926	
	PASS THROUGH COST ADJUSTMENTS		•			1	
00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	7, 371, 080	50
00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillar	v services (fr	om Wkst. D. su	m of Parts II	5, 672, 747	51
	and IV)		j i i i i i i i i i i i i i i i i i i i	,			
00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non stor	cician anasti-	tict and	13, 043, 827	
. 00	medical education costs (line 49 minus line		ateu, non-phy	sician anesthe	ust, and	114, 478, 099	7 33
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
00 00	Program di scharges					0.00	
00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus l	ine 53)	0	
00	Bonus payment (see instructions)					0	
00	Lesser of lines 53/54 or 55 from the cost re market basket	pounded by the	0.00	) 59			
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of line					C	61
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% of	the target		
. 00	Relief payment (see instructions)	riisti detrons)				0	62
00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	) 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reportir	a period (See	0	64
	instructions) (title XVIII only)	to the ough book		0001 i opoi i i	.g poi i ou (000		
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the c	ost reporting	period (See	0	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66
	CAH (see instructions)		- p	-,(			
. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31 o	f the cost rep	orting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	December 31 of	the cost repor	ting period	C	68
	(line 13 x line 20)				0.1		
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	) 69
. 00	Skilled nursing facility/other nursing facil						70
00	Adjusted general inpatient routine service c	ost per diem (l					71
00	Program routine service cost (line 9 x line Medically necessary private room cost applic		line 14 v H	ne 35)			72
. 00	Total Program general inpatient routine serv			10 337			74
. 00	Capital -related cost allocated to inpatient			orksheet B, Pa	rt II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu	s line 77)					78
00	Aggregate charges to beneficiaries for exces	• •		· · · · · · · · · · · · · · · · · · ·	(a, b, b, a, 70)		79
00 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		JUST TIMETATION	(ine /δ minu	IS ITTIE /Y)		80
00	Inpatient routine service cost per dreim rimitation (I		)				82
00	Reasonable inpatient routine service costs (	see instruction					83
. 00	Program inpatient ancillary services (see in		nc)				84
. 00 . 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	/				
	Tatal shares at an had days (as in the state	)				14, 664	1 87
. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2			817.35	

Health Financial Systems	DEACONESS HOSPI TAL			In Lieu of Form CMS-255			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1		
				From 10/01/2014 To 09/30/2015	Date/Time Pre 2/26/2016 11:4		
		Titl	e XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST						
90.00 Capital-related cost	12, 907, 524	98, 861, 346	0. 13056	2 11, 985, 620	1, 564, 867	90.00	
91.00 Nursing School cost	0	98, 861, 346	0.00000	0 11, 985, 620	0	91.00	
92.00 Allied health cost	1, 118, 252	98, 861, 346	0. 01131	1 11, 985, 620	135, 569	92.00	
93.00 All other Medical Education	0	98, 861, 346	0.00000	0 11, 985, 620	0	93.00	

MPUT	TATION OF INPATIENT OPERATING COST From 10/0 Component CCN: 150082 To 09/3	1/2014 0/2015	Worksheet D-1 Date/Time Pre	
	Title XVIII Subprovid		2/26/2016 11: PPS	
	Cost Center Description	-	1.00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
~ ~	INPATIENT DAYS			
00 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)		3, 477 3, 477	1. 2.
00	Private room days (excluding swing-bed and observation bed days). If you have only private room do not complete this line.	days,	0	3.
00 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	e cost	3, 477 0	4. 5.
00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the or reporting period (if calendar year, enter 0 on this line)	cost	0	6.
00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the reporting period		0	
00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the correporting period (if calendar year, enter 0 on this line)	ost	0	8.
00	Total inpatient days including private room days applicable to the Program (excluding swing-bed newborn days)	and	1, 353	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) a	after	0	
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)			
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days		0	
	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)	5)	0	
. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)		0 0	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	
. 00 . 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0. 00 2, 087, 790	
. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period 5 x line 17)	(I i ne	2,087,790	
. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (I x line 18)		0	
. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period ( 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (li		0	
. 00 . 00	x line 20) Total swing-bed cost (see instructions)	0 311	0	
. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		2, 087, 790	27
. 00 . 00	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)		0	
. 00	Semi -private room charges (excluding swing bed charges)		0	30
00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)		0.00	
00 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	
00	Average per diem private room cost differential (line 34 x line 31)		0.00	
00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential	(line	0 2, 087, 790	36
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			
<u> </u>	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
	Adjusted general inpatient routine service cost per diem (see instructions)		600.46 812.422	
	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)		812, 422 0	
	1 $1$ $1$ $1$ $1$ $1$ $1$ $1$ $1$ $1$		0	1 70

MPUT	Financial Systems ATION OF INPATIENT OPERATING COST	DEACONESS		CCN: 150082	Peri od:	eu of Form CMS- Worksheet D-1	
			Componen	t CCN: 15S082	From 10/01/2014 To 09/30/2015	Date/Time Pre	
			Titl	e XVIII	Subprovider -	2/26/2016 11: PPS	44
	Cost Contor Description	Tatal			. I PF		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1	5	Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	-
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	4
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	C	0.1			4
. 00	CORONARY CARE UNIT	0	C				
00	BURN INTENSIVE CARE UNIT						4
00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						4
	Cost Center Description					1.00	
00	Program inpatient ancillary service cost (Wks	t. D-3, col. 3	, line 200)			1.00	4
00	Total Program inpatient costs (sum of lines 4	1 through 48)(	see instructio	ons)		1, 022, 099	4
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tient routine	services (from	n Wkst. D, sur	n of Parts I and	82, 181	5
00	III)	tiont oncillor	v constant (fr	am Wkat D	our of Dorto II	15 014	_
00	Pass through costs applicable to Program inpa and IV)	trent and Har	y services (Tr	UNI WKSL. D, S	SUN OF PALES II	15, 014	5
. 00	Total Program excludable cost (sum of lines 5		lated are -'		actict and	97, 195	
. 00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5		nateu, non-phy	sician anesti	ietist, and	924, 904	5
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	5
00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0	
00 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
00	Lesser of lines 53/54 or 55 from the cost rep	orting period	ending 1996, ι	pdated and co	ompounded by the		
00	market basket Lesser of lines 53/54 or 55 from prior year c	ost report up	dated by the m	arket basket		0.00	6
. 00	If line 53/54 is less than the lower of lines	55, 59 or 60	enter the less	er of 50% of		0	
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	f the target		
. 00	Relief payment (see instructions)					0	
00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	nt (see instru	ictions)			0	6
00	Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of the	e cost reporti	ng period (See	0	6
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the c	ost reportin	n period (See	0	6
	instructions)(title XVIII only)						
00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	e costs (line	64 plus line 6	5)(title XVI	ll only). For	0	6
. 00	Title V or XIX swing-bed NF inpatient routine	costs through	December 31 c	of the cost re	eporting period	0	6
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	costs after D	ecember 31 of	the cost rep	orting period	0	6
	(line 13 x line 20)				bi ting period		
. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	6
. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	tine service o	cost (line 37)	)		7
00 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ine /U ÷ line	2)			7
00	Medically necessary private room cost applica	ble to Program					7
00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•			Part II column		7
	26, line 45)			ISTRUCTED, I	artir, corunni		
00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						7
00	Inpatient routine service cost (line 74 minus						7
00	Aggregate charges to beneficiaries for excess				aug Ling 70)		7
00 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		SUST IIMITATION	i (iine /8 mii	ius line /9)		8
00	Inpatient routine service cost limitation (li	ne 9 x line 81					8
00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		s)				8
. 00	Utilization review - physician compensation (	see instructio					8
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				8
. 00	Total observation bed days (see instructions)					0	8
. 00	Adjusted general inpatient routine cost per d	iem (line 27 ÷				0.00	8
	Observation bed cost (line 87 x line 88) (see	INSTRUCTIONS)				1 0	8   1

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2014	Worksheet D-1	
		Componer		To 09/30/2015		pared: 44 am
		Tit	le XVIII	Subprovider -	PPS	
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	COST	•				
90.00 Capital-related cost	211, 200	2,087,79	0 0. 10116	0 0	0	90.00
91.00 Nursing School cost	0	2,087,79	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2,087,79	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2,087,79	0. 00000	0 0	0	93.00

	Financial Systems DEACONESS HOSE ATION OF INPATIENT OPERATING COST	Provi der CCN: 150082	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 10/01/2014 To 09/30/2015	Date/Time Prep 2/26/2016 11:4	
		Title XIX	Hospi tal	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			120, 954	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivate room days,	120, 954 0	2.00 3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	l days)		106, 290	4.00
5.00	Total swing-bed SNF type inpatient days (including private roor reporting period		r 31 of the cost	0	5.00
5.00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	0	6. 0
7.00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7.00
3. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	7, 477	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructi		oom days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	y (including private r	oom days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13.00
14.00 15.00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only)			0	
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	s through December 31 c	f 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
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.00
21.00	reporting period Total general inpatient routine service cost (see instructions)			98, 861, 346	
22.00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	31 of the cost report	ing period (line	0	22.0
23.00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reportin	g period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	of the cost reporting	period (line 8	0	25.00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 98, 861, 346	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28.00
	Private room charges (excluding swing-bed charges)		ai ges)	0	
	Semi-private room charges (excluding swing-bed charges)	Lipo 29)		0	30.00
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	rine 28)		0. 000000 0. 00	
33.00	Average semi-private room per diem charge (line 27 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minu		tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line	e 31)		0.00	
36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line	0 98, 861, 346	36.00 37.00
	27 minus line 36)			, 3, 361, 340	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	STMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see i			817.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 3			6, 111, 326	1
	Medically necessary private room cost applicable to the Program	n (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 -	ling (0)		6, 111, 326	1 11 00

OMPUT	TATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2014	Worksheet D-1	1
					Fo 09/30/2015		
	Cost Center Description	Total	Ti t Total	le XIX Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription		Inpatient Days			(col. 3 x col.	
		1.00	2.00	3.00	4.00	4) 5.00	
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42
00	INTENSIVE CARE UNIT	23, 746, 536	18, 350	1, 294. 0	9 1, 696		
00	CORONARY CARE UNIT	5, 692, 368	4, 339	1, 311. 9	471	617, 910	
00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	+
00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			19, 629, 399	9 48
00	Total Program inpatient costs (sum of lines			ns)		28, 553, 412	2 49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	Wkst D sum	of Parts L and	1, 207, 640	50
. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (fr	om Wkst. D, sı	um of Parts II	1, 478, 315	51
00	Total Program excludable cost (sum of lines	50 and 51)				2, 685, 955	5 52
. 00	Total Program inpatient operating cost exclu		elated, non-phy	sician anesthe	etist, and	25, 867, 457	/ 53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
00	Program discharges					C	
00 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus l	ine 53)		
00	Bonus payment (see instructions)	0	0			C	
00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996, u	pdated and cor	npounded by the	0.00	59
00	Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of line					C	61
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (Tines 54 x	60), or 1% or	the target		
. 00	Relief payment (see instructions)					C	
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			C	) 63
. 00		ts through Dece	ember 31 of the	cost reportir	ng period (See	C	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	to ofter Decomb	oor 21 of the e	act conarting	partial (Saa	C	) 65
. 00	instructions) (title XVIII only)	ts after becenic		UST TEPOTITING	perrou (see		
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For	C	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 o	f the cost rem	porting period	c c	67
	(line 12 x line 19)	U U			0.1		
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [	December 31 of	the cost repor	ting period	C	68
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	(line 67 + line	68)		C	) 69
00	PART III - SKILLED NURSING FACILITY, OTHER N						1 70
00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70
00	Program routine service cost (line 9 x line	71)		,			72
. 00 . 00	Medically necessary private room cost applic Total Program general inpatient routine serv			ne 35)			73
. 00	Capital -related cost allocated to inpatient			orksheet B, Pa	art II, column		75
	26, line 45)		-				
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
00	Inpatient routine service cost (line 74 minu	s line 77)					78
00	Aggregate charges to beneficiaries for exces	• •		· · ·	$r = 1 \cdot p = 70$		79
00 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		Jost inmitation	(IIIe /8 MINU	13 11110 /9)		80
00	Inpatient routine service cost limitation (I	ine 9 x line 81					82
00	Reasonable inpatient routine service costs (		ns)				83
. 00 . 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84
. 00	Total Program inpatient operating costs (sum	of lines 83 th					86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS					14, 664	87
. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		÷line 2)			817.35	
. 00							1

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2014	Worksheet D-1	
				To 09/30/2015	Date/Time Pre 2/26/2016 11:	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	12, 907, 524	98, 861, 346	0. 13056	2 11, 985, 620	1, 564, 867	90.00
91.00 Nursing School cost	0	98, 861, 346	0.00000	0 11, 985, 620	0	91.00
92.00 Allied health cost	1, 118, 252	98, 861, 346	0. 01131	1 11, 985, 620	135, 569	92.00
93.00 All other Medical Education	0	98, 861, 346	0.00000	0 11, 985, 620	0	93.00

OMPUT		ovider CCN: 150082	Period: From 10/01/2014	u of Form CMS-2 Worksheet D-1	
	Сс	mponent CCN: 15S082	To 09/30/2015	Date/Time Prep 2/26/2016 11: 4	
		Title XIX	Subprovider - IPF	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
. 00	Inpatient days (including private room days and swing-bed days, ex			3, 477	1.(
. 00 . 00	Inpatient days (including private room days, excluding swing-bed a Private room days (excluding swing-bed and observation bed days). do not complete this line.	nd newborn days) If you have only pr	vate room days,	3, 477 0	2. ( 3. (
. 00 . 00	Semi-private room days (excluding swing-bed and observation bed da Total swing-bed SNF type inpatient days (including private room da		r 31 of the cost	3, 477 0	4. ( 5. (
. 00	reporting period Total swing-bed SNF type inpatient days (including private room da reporting period (if calendar year, enter 0 on this line)	ys) after December :	31 of the cost	0	6.
. 00	Total swing-bed NF type inpatient days (including private room day reporting period	s) through December	31 of the cost	0	7.
. 00	Total swing-bed NF type inpatient days (including private room day reporting period (if calendar year, enter 0 on this line)	s) after December 3	l of the cost	0	8. (
. 00	Total inpatient days including private room days applicable to the newborn days)	0 1 0	5	494	
0.00	Swing-bed SNF type inpatient days applicable to title XVIII only ( through December 31 of the cost reporting period (see instructions	)	3 ,	0	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII only ( December 31 of the cost reporting period (if calendar year, enter	0 on this line)	5,	0	
2.00 3.00	Swing-bed NF type inpatient days applicable to titles V or XIX onl through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX onl		5 ,	0	
4. 00	after December 31 of the cost reporting period (if calendar year, Medically necessary private room days applicable to the Program (e	enter 0 on this line	e)	0	
5.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	Xer during Swring bed	lays)	0	15.
	SWING BED ADJUSTMENT			-	
7.00 8.00	Medicare rate for swing-bed SNF services applicable to services th reporting period Medicare rate for swing-bed SNF services applicable to services af	0		0.00	
9.00	reporting period Medicaid rate for swing-bed NF services applicable to services thr			0.00	
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to services aft	er December 31 of t	ne cost	0.00	20.
1. 00	reporting period Total general inpatient routine service cost (see instructions)			2, 087, 790	21.
2.00	Swing-bed cost applicable to SNF type services through December 31 5 x line 17)	•		0	
3.00	Swing-bed cost applicable to SNF type services after December 31 o x line 18)			0	
4.00	Swing-bed cost applicable to NF type services through December 31 7 x line 19)		51	0	
5.00	Swing-bed cost applicable to NF type services after December 31 of x line 20) Total swing bed cost (see instructions)	the cost reporting	perioa (line 8	0	25.
6.00 7.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	21 minus line 26)		0 2, 087, 790	
8. 00	General inpatient routine service charges (excluding swing-bed and	observation bed ch	arges)	0	28.
9.00	Private room charges (excluding swing-bed charges)			0	29.
0.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ lin	e 28)		0 0. 000000	30. 31.
2.00	Average private room per diem charge (line 29 ÷ line 3)	0 20)		0.000000	
3.00	Average semi-private room per diem charge (line 20 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 minus l	ine 33)(see instruc	tions)	0.00	
5.00	Average per diem private room cost differential (line 34 x line 31			0.00	
6.00	Private room cost differential adjustment (line 3 x line 35)			0	36.
7.00	General inpatient routine service cost net of swing-bed cost and p 27 minus line 36)	rivate room cost di	fferential (line	2, 087, 790	37.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	NTC			-
8.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTME Adjusted general inpatient routine service cost per diem (see inst		I	600.46	38.
	Program general inpatient routine service cost per diem (see fist Program general inpatient routine service cost (line 9 x line 38)			296, 627	
9.00				2,0,021	1
	Medically necessary private room cost applicable to the Program (I	ine 14 x line 35)		0	40.

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	DEACONESS	10311		CCN: 150082	Peri od:	eu of Form CMS- Worksheet D-1	
				Component	t CCN: 15S082	From 10/01/2014 To 09/30/2015	Date/Time Pre	
				Ti t	le XIX	Subprovider -	2/26/2016 11: PPS	44 ar
	Cost Center Description	Total Inpatient Cost		otal ent Davs	Average Per Diem (col 1	5	Program Cost (col. 3 x col.	
		•			col. 2)		4)	
2.00	NURSERY (title V & XIX only)	1.00		2.00	3.00	4.00	5.00	42.0
	Intensive Care Type Inpatient Hospital Units							
13.00 14.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0		0				
5.00	BURN INTENSIVE CARE UNIT	0		0				45.
6.00	SURGICAL INTENSIVE CARE UNIT							46.
17.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47.
8.00	Program inpatient ancillary service cost (Wks	st D-3 col 3	3 lin	e 200)			1.00	48.
9.00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS				ons)		500, 663	
0. 00	Pass through costs applicable to Program inpa	atient routine	servi	ces (from	n Wkst. D, su	m of Parts I and	30, 006	50.
51.00	Pass through costs applicable to Program inpa	atient ancillar	ry ser	vices (fr	om Wkst. D,	sum of Parts II	15, 853	51.0
2.00	and IV) Total Program excludable cost (sum of lines {	50 and 51)					45, 859	52.
53.00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	elated	, non-phy	vsician anest	hetist, and	454, 804	
4.00	Program di scharges						0	
5.00	Target amount per discharge Target amount (line 54 x line 55)						0.00	
7.00	Difference between adjusted inpatient operati	ng cost and ta	arget	amount (I	ine 56 minus	line 53)		
8.00	Bonus payment (see instructions)						0	
9.00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period	endi n	g 1996, u	pdated and c	ompounded by the	0.00	59.
0. 00	Lesser of lines 53/54 or 55 from prior year of						0.00	60.
1.00	If line 53/54 is less than the lower of lines						0	61.
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		LS (II	nes 54 x	60), OF 1% 0	i the target		
2.00	Relief payment (see instructions)						0	
3. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Enstru	JCTION	s)			0	63.
4.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Dece	ember	31 of the	e cost report	ing period (See	C	64.
5. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	oer 31	of the c	ost reportin	g period (See	0	65.
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 pl	us line 6	5)(title XVI	II only). For	C	66.
57 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	Dece	mber 31 c	of the cost r	eporting period		67.
	(line 12 x line 19)	0						
58.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after [	Decemb	er 31 of	the cost rep	orting period	C	68.
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU		<u>`</u>		,		C	69.
0.00	Skilled nursing facility/other nursing facili					)		70.
1.00 2.00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ine /	0 ÷ line	2)			71.
3.00	Medically necessary private room cost applica	,	m (lin	e 14 x li	ne 35)			73.
4.00	Total Program general inpatient routine servi							74.
5. 00	Capital-related cost allocated to inpatient r 26, line 45)	routine service	e cost	s (from W	lorksheet B,	Part II, column		75.
6.00	Per diem capital-related costs (line 75 ÷ lin							76.
7.00 8.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus							77.
9.00	Aggregate charges to beneficiaries for excess		orovi d	er record	ls)			79.
0.00	Total Program routine service costs for compa		cost I	imitation	n (line 78 mi	nus line 79)		80.
1.00 2.00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		1)					81. 82.
32.00 33.00	Reasonable inpatient routine service cost (							82.
34.00	Program inpatient ancillary services (see ins		.0)					84.
35.00	Utilization review - physician compensation			05)				85.
36.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		nrough	85)				86.
37.00	Total observation bed days (see instructions)						C	87.
38. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷		2)			0.00	88.
	Observation bed cost (line 87 x line 88) (see	e instructions)	)				1 0	89.

Health Financial Systems	DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2014	Worksheet D-1	
		Componer		To 09/30/2015		pared: 44 am
		Ti	tle XIX	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27	) column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•				
90.00 Capital-related cost	211, 200	2, 087, 79	0 0. 10116	0 0	0	90.00
91.00 Nursing School cost	0	2,087,79	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2,087,79	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 087, 79	0. 00000	0 0	0	93.00

	Financial Systems DEACONESS HOSPIT		001 450000		u of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	rovi der	CCN: 150082	Period: From 10/01/2014	Worksheet D-3	
				To 09/30/2015	Date/Time Pre	pared.
				10 07/00/2010	2/26/2016 11:	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			58, 525, 901		30.00
31.00	03100 I NTENSI VE CARE UNI T			23, 681, 393		31.00
32.00	03200 CORONARY CARE UNI T			6, 289, 640		32.00
40.00	04000 SUBPROVI DER – I PF			0		40.00
	ANCI LLARY SERVI CE COST CENTERS			1	-	
50.00	05000 OPERATING ROOM		0. 1927		8, 972, 114	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 0884		3, 939, 688	
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 1507		89, 609	
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1058			
60.00	06000 LABORATORY		0. 1627		11, 826, 263	
64.00	06400 I NTRAVENOUS THERAPY		0. 5900		1, 199, 627	64.00
65.00	06500 RESPI RATORY THERAPY		0. 1763		2, 513, 709	65.00
66.00	06600 PHYSI CAL THERAPY		0. 1593		4, 216, 139	
69.00	06900 ELECTROCARDI OLOGY		0.0919	32 10, 961, 172	1, 007, 682	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6135	87 10, 315, 686	6, 329, 571	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5508	91 16, 195, 503	8, 921, 957	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 2583			
74.00	07400 RENAL DI ALYSI S		0. 2749	61 4, 366, 894	1, 200, 726	74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000	00 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0. 6465	85 13, 415	8, 674	90.00
90.01	09001 FAMILY PRACTICE CLINIC		1.0299	78 3, 756	3, 869	90.01
90.02	09002 OUTPATI ENT PSYCH SERVICES		0.4900	56 491	241	90.02
90.03	09003 INFUSION CENTER		0. 1407	92 53, 338	7, 510	90.03
90.04	09004 PRIMARY CARE FOR SENIORS		1. 3964	60 4, 830	6, 745	90.04
90.05	09005 PALN MANAGEMENT		0. 1314	09 1, 816	239	90.05
90.06	09006 WOUND CARE CENTER		0. 3287	70 8, 090	2, 660	90.06
90.07	09007 SLEEP CENTER		0. 4726	52 8, 491	4, 013	90.07
91.00	09100 EMERGENCY		0. 1756		5, 796, 007	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6547	26 2, 439, 117	1, 596, 953	92.00
	OTHER REIMBURSABLE COST CENTERS		-		-	
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED		0. 5611	38 0	0	
200.00				354, 456, 274	73, 747, 395	200.00
201.00		ne 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1	354, 456, 274	1	202.00

Health Financial Systems DEACONESS H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150082	Peri od:	Worksheet D-3	
	Component	t CCN: 15S082	From 10/01/2014 To 09/30/2015	Date/Time Pre	narod
	Component	L CCN. 155062	10 09/ 30/ 2015	2/26/2016 11:	
	Ti tl	e XVIII	Subprovider -	PPS	
		•	I PF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
32. 00 03200 CORONARY CARE UNI T			0		32.00
40. 00 04000 SUBPROVI DER – I PF			2, 979, 216		40.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1927		5, 591	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0884		6, 375	1
55. 00 O5500 RADI OLOGY-THERAPEUTI C		0.1507		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1058		0	
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY		0. 1627 0. 5900		66, 715 0	1
65. 00 06500 RESPIRATORY THERAPY		0. 3900		24	
66. 00 06600 PHYSI CAL THERAPY		0. 1703		0	66.00
69. 00 06900 ELECTROCARDI OLOGY		0.0919		0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6135			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5508		0	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2583	69 325, 735	84, 160	73.00
74. 00 07400 RENAL DI ALYSI S		0. 2749	61 0	0	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000	0 00	0	76.00
OUTPATIENT SERVICE COST CENTERS		1			
90. 00 09000 CLINIC		0. 6465		-	
90. 01 09001 FAMILY PRACTICE CLINIC		1.0299			
90. 02 09002 0UTPATIENT PSYCH SERVICES 90. 03 09003 INFUSION CENTER		0.4900		0	
90. 03 09003 INFUSION CENTER 90. 04 09004 PRIMARY CARE FOR SENIORS		0. 1407 1. 3964		0	
90. 05  09005  PALN MANAGEMENT		0. 1314			90.04
90. 06 09006 WOUND CARE CENTER		0. 1314		0	
90. 07 09007 SLEEP CENTER		0. 4726		0	90.07
91. 00 09100 EMERGENCY		0. 1756		-	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6547			1
OTHER REIMBURSABLE COST CENTERS					
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 5611	38 0	0	96.00
200.00 Total (sum of lines 50-94 and 96-98)			1, 098, 557	209, 677	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			1, 098, 557		202.00

	Financial Systems DEACONESS HOSPI ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150082	Peri od:	eu of Form CMS-2 Worksheet D-3	
	ENT ANGLEEART SERVICE COST AFFORTIONMENT	riovidei	CCN. 150002	From 10/01/2014	worksneet D-5	
				To 09/30/2015		
					2/26/2016 11:	44 am
		Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			23, 015, 428		30.0
31.00	03100 I NTENSI VE CARE UNI T			9, 105, 136		31.0
32.00	03200 CORONARY CARE UNIT			2, 438, 032		32.0
40.00	04000 SUBPROVIDER - IPF			0		40.0
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 1927			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0.08840		880, 033	
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 1507		29, 325	
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1058			
60.00	06000 LABORATORY		0. 1627		3, 274, 406	
64.00	06400 I NTRAVENOUS THERAPY		0. 5900		385, 607	64.0
65.00	06500 RESPI RATORY THERAPY		0. 1763		896, 861	65.0
66.00	06600 PHYSI CAL THERAPY		0. 1593		734, 918	
69.00	06900 ELECTROCARDI OLOGY		0. 09193	32 1, 774, 412	163, 125	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6135			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5508	91 3, 463, 018	1, 907, 745	72.0
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 2583		4, 862, 511	73.0
74.00	07400 RENAL DIALYSIS		0. 2749		276, 732	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000	0 00	0	76.0
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0. 6465		1, 703	90.0
90. 01	09001 FAMILY PRACTICE CLINIC		1.0299	78 3, 958	4, 077	90.0
90. 02	09002 OUTPATIENT PSYCH SERVICES		0.4900	56 87	43	90.0
90. 03	09003 INFUSION CENTER		0. 1407	92 9, 545	1, 344	90.0
90. 04	09004 PRIMARY CARE FOR SENIORS		1. 3964	60 0	0	90.0
90.05	09005 PALN MANAGEMENT		0. 1314	3, 863	508	90.0
90.06	09006 WOUND CARE CENTER		0. 3287	70 568	187	90.0
90. 07	09007 SLEEP CENTER		0. 4726	52 260	123	90.0
91.00	09100 EMERGENCY		0. 1756	58 10, 264, 905	1, 803, 113	91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 65472	26 285, 280	186, 780	92.0
	OTHER REIMBURSABLE COST CENTERS			-	-	
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED		0. 5611	38 0	0	96.0
200.00				93, 779, 523	19, 629, 399	200. 0
201.00	Less PBP Clinic Laboratory Services-Program only charges (	line 61)		0		201.0
202.00	Net Charges (line 200 minus line 201)			93, 779, 523		202.0

Health Financial Systems	DEACONESS HOSPI TAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150082	Peri od:	Worksheet D-3	
	Component	CCN: 15S082	From 10/01/2014 To 09/30/2015	Date/Time Pre	narod
	component	CON. 155062	10 09/30/2015	2/26/2016 11:	
	Tit	le XIX	Subprovider -	PPS	
			IPF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
32. 00 03200 CORONARY CARE UNI T			0		32.00
40. 00 04000 SUBPROVIDER - IPF			2, 525, 048		40.00
ANCI LLARY SERVI CE COST CENTERS				-	
50. 00 05000 OPERATING ROOM		0. 1927		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.08840		4, 985	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1507		0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY		0. 1058 0. 1627		0 78, 493	59.00 60.00
64. 00 06400 INTRAVENOUS THERAPY		0. 5900		10,493	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 1763		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 1593		0	66.00
69. 00 06900 ELECTROCARDI OLOGY		0.0919		225	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6135			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5508	91 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2583	59 144, 725	37, 392	73.00
74.00 07400 RENAL DIALYSIS		0. 2749		0	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000	0 00	0	76.00
OUTPATIENT SERVICE COST CENTERS		0.445			
90. 00 09000 CLINIC 90. 01 09001 FAMILY PRACTICE CLINIC		0. 6465		-	90.00 90.01
90. 01 09001 FAMILY PRACTICE CLINIC 90. 02 09002 0UTPATIENT PSYCH SERVICES		1. 0299		0	90.01
90. 03 09003 INFUSION CENTER		0. 1407		0	90.02
90. 04 09004 PRI MARY CARE FOR SENI ORS		1. 3964		0	90.04
90. 05 09005 PALN MANAGEMENT		0. 1314		0	90.05
90. 06 09006 WOUND CARE CENTER		0. 3287		0	90.06
90. 07 09007 SLEEP CENTER		0. 4726		0	90.07
91.00 09100 EMERGENCY		0. 1756	58 461, 284	81, 028	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 65472	26 1, 147	751	92.00
OTHER REIMBURSABLE COST CENTERS					
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 56113		-	96.00
200.00 Total (sum of lines 50-94 and 96-98)			1, 150, 220	204, 036	•
201.00 Less PBP Clinic Laboratory Services-Program	m only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		I	1, 150, 220		202.00

ALCUL	Financial Systems DEACONESS HO ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150082	Peri od:	u of Form CMS Worksheet E	
				From 10/01/2014 To 09/30/2015	Part A Date/Time Pr 2/26/2016 1	
		Titl	e XVIII	Hospi tal	272672016 T PPS	1:44 am
			before 1/1	on/after 1/1		
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	0	1.00	1.01	2.00	_
. 00	DRG Amounts Other than Outlier Payments			0		1.0
. 01	DRG amounts other than outlier payments for discharges			0		1.0
. 02	occurring prior to October 1 (see instructions) DRG amounts other than outlier payments for discharges		93, 563, 22	22		1.0
. 02	occurring on or after October 1 (see instructions)		75, 505, 2.			1.0.
. 03	DRG for federal specific operating payment for Model 4			0		1.0
	BPCI for discharges occurring prior to October 1 (see instructions)					
. 04	DRG for federal specific operating payment for Model 4			0		1.0
	BPCI for discharges occurring on or after October 1 (see					
. 00	instructions) Outlier payments for discharges. (see instructions)		2, 473, 2	16		2.0
. 01	Outlier reconciliation amount		2, 473, 2	0		2.0
. 02	Outlier payment for discharges for Model 4 BPCI (see			0		2.0
. 00	instructions)		24 027 7	20		3.0
. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost		24, 827, 73 456. (			4.0
	reporting period (see instructions)					
	Indirect Medical Education Adjustment		45			
. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before		15.3	30		5.0
	12/31/1996. (see instructions)					
. 00	FTE count for all opathic and osteopathic programs which		0.0	00		6.0
	meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)					
. 00	MMA Section 422 reduction amount to the IME cap as		0.0	00		7.0
0.1	specified under 42 CFR §412.105(f)(1)(iv)(B)(1)					7.0
. 01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the		0.0	00		7.0
	cost report straddles July 1, 2011 then see instructions.					
. 00	Adjustment (increase or decrease) to the FTE count for		0.0	00		8.0
	allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b),					
	413. 79(c) (2) (i v), 64 FR 26340 (May 12, 1998), and 67 FR					
. 01	50069 (August 1, 2002).		0.0			8.0
. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report		0.0	00		0.0
	straddles July 1, 2011, see instructions.					
. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506		0.0	00		8. 0
	of ACA. (see instructions)					
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		15.3	30		9.0
0. 00	lines (8, 8,01 and 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the		20.4	14		10.0
0.00	current year from your records		20.	**		10.0
1. 00	FTE count for residents in dental and podiatric programs.		0.0			11.0
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.		15.3			12.0
4.00	Total allowable FTE count for the penultimate year if that		15.			14.0
	year ended on or after September 30, 1997, otherwise enter					
5.00	zero. Sum of lines 12 through 14 divided by 3.		15.3	30		15.0
6.00	Adjustment for residents in initial years of the program		0.0			16.0
7.00	Adjustment for residents displaced by program or hospital		0.0	00		17.0
8. 00	closure Adjusted rolling average FTE count		15.3	30		18.0
9.00	Current year resident to bed ratio (line 18 divided by		0. 03350			19.0
	line 4).					
0.00	Prior year resident to bed ratio (see instructions)		0.0421			20.0
1.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)		0. 03350			21.0
	IME payment adjustment - Managed Care (see instructions)		450, 3			22. 0
2 00	Indirect Medical Education Adjustment for the Add-on for Sect	ion 422 of t				
3. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		2.3	<u> </u>		23.0
4.00	IME FTE Resident Count Over Cap (see instructions)		5.	14		24.0
5.00	If the amount on line 24 is greater than -O-, then enter		2.3	22		25.0
6. 00	the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4)		0. 0048	52		26.0
6.00 7.00	IME payments adjustment factor. (see instructions)		0.0048			26.0
8. 00	IME add-on adjustment amount (see instructions)		121, 4	45		28.0
8. 01	IME add-on adjustment amount - Managed Care (see		32, 23	26		28. 0
0 00	instructions) Total IME payment ( sum of lines 22 and 28)		1, 818, 6	32		29.0

30. 00 31. 00 32. 00 33. 00	Total IME payment - Managed Care (sum of lines 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Me A patient days (see instructions) Percentage of Medicaid patient days (see instr Sum of lines 30 and 31 Allowable disproportionate share percentage (s instructions) Disproportionate share adjustment (see instruct	edicare Part	0 Ti tl	e XVIII before 1/1 1.00 482,60	Hospi tal on/after 1/1 1.01	2/26/2016 11: PPS 2.00	
30. 00 31. 00 32. 00 33. 00	28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Me A patient days (see instructions) Percentage of Medicaid patient days (see instr Sum of lines 30 and 31 Allowable disproportionate share percentage (s instructions)	edicare Part	0	1.00	1.01	2 00	
30. 00 31. 00 32. 00 33. 00	28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Me A patient days (see instructions) Percentage of Medicaid patient days (see instr Sum of lines 30 and 31 Allowable disproportionate share percentage (s instructions)	edicare Part	0			2 00	
30.00 31.00 32.00 33.00	Percentage of SSI recipient patient days to Me A patient days (see instructions) Percentage of Medicaid patient days (see instr Sum of lines 30 and 31 Allowable disproportionate share percentage (s instructions)			· · · · · · · · · · · · · · · · · · ·	1	2.00	29.01
31.00 32.00 33.00	Percentage of Medicaid patient days (see instr Sum of lines 30 and 31 Allowable disproportionate share percentage (s instructions)	ructions)		5.5	5		30. 00
34.00	· · · · · · · · · · · · · · · · · · ·	see		16. 2 21. 7 7. 1	6		31.00 32.00 33.00
		ctions)		1, 677, 12	.1		34.00
				Prior to		On/After	
	-	0		0ctober 1 1.00	1.01	0ctober 1 2.00	
	Uncompensated Care Adjustment	0		1.00	1.01	2.00	
	Total uncompensated care amount (see				0	7, 647, 644, 885	35.00
	instructions) Factor 3 (see instructions) Hospital uncompensated care payment (If			0.0000000	0	0. 000565663 4, 325, 990	
35 03	line 34 is zero, enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated				0	4, 325, 990	35.03
	Total uncompensated care (sum of columns 1			4, 325, 99		4, 323, 990	36.00
	and 2 on line 35.03)						
	Additional payment for high percentage of ESRE Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652,	<u>D beneficiary d</u>	il scharges (TT	nes 40 throug	0		40.00
	682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				0 0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				0 0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			0.0	0		42.00
	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)			0. 00000	0		44.00
	Average weekly cost for dialysis treatments (see instructions)			0.0			45.00
	Total additional payment (line 45 times line 44 times line 41.01)				0		46.00
48.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)			103, 858, 23	0		47.00 48.00
	Total payment for inpatient operating costs (see instructions)			104, 340, 83	2		49.00
	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			8, 300, 34	5		50.00
	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)				0		51.00
	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			866, 49			52.00
	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			384, 73			53.00 54.00
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			2,42	0		54.00
	Cost of physicians' services in a teaching hospital (see intructions)				0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			534, 64	4		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			133, 79	0		58.00
59. 00	Total (sum of amounts on lines 49 through 58)			114, 563, 26	2		59.00
61.00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries			25, 17 114, 538, 08 10, 774, 11	5		60.00 61.00 62.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 150082	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Pro 2/26/2016 11:	
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
	_	0		October 1	1.01	0ctober 1 2.00	
63.00	Coinsurance billed to program beneficiaries	0		1.00 378,5	1.01	2.00	63.00
64.00	Allowable bad debts (see instructions)			866, 8			64.00
65.00	Adjusted reimbursable bad debts (see			563, 4			65.00
00.00	instructions)			000, 1			
66.00	Allowable bad debts for dual eligible			609, 5	60		66.00
	beneficiaries (see instructions)						
67.00	Subtotal (line 61 plus line 65 minus lines			103, 948, 9	16		67.00
	62 and 63)						
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
07.00	lines 93, 95 and 96). (For SCH see				0		09.00
	instructions)						
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)				0		70.00
	(SPECI FY)						
70. 50	RURAL DEMONSTRATION PROJECT				0		70.50
70. 89	Pioneer ACO demonstration payment adjustment				0		70.89
	amount (see instructions)						
70. 90	HSP bonus payment HVBP adjustment amount				0		70.90
70. 91	(see instructions) HSP bonus payment HRR adjustment amount (see				0		70.91
70. 71	instructions)				0		10. 1
70. 92	Bundled Model 1 discount amount (see				0		70.92
	instructions)						
70. 93	HVBP payment adjustment amount (see			-409, 6	48		70.93
	instructions)						
70.94	HRR adjustment amount (see instructions)			-374, 2			70.94
70. 95 70. 96	Recovery of accelerated depreciation		0		0		70.95
70.90	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the		0		0		10.90
	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)						70.00
70. 98 70. 99	Low Volume Payment-3 HAC adjustment amount (see instructions)				0		70.98
70. 99	Amount due provider (line 67 minus lines 68			103, 164, 9	0		71.00
/1.00	plus/minus lines 69 & 70)			103, 104, 9	77		11.00
71.01	Sequestration adjustment (see instructions)			2,063,3	00		71.01
72.00	Interim payments			101, 953, 5	01		72.00
73.00	Tentative settlement (for contractor use				0		73.00
	only)						
74.00	Balance due provider (Program) (line 71			-851, 8	02		74.00
75 00	minus lines 71.01, 72, and 73) Protested amounts (nonallowable cost report			2, 094, 3	00		75.00
75.00	items) in accordance with CMS Pub. 15-2,			2,094,3	98		/5.00
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR (lines 90 throug	ıh 96)					
90.00	Operating outlier amount from Wkst. E, Pt.				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
93.00	amount (see instructions) Capital outlier reconciliation adjustment				0		93.00
93.00	amount (see instructions)				0		93.00
94.00	The rate used to calculate the time value of			0.	00		94.00
	money (see instructions)						
95.00	Time value of money for operating expenses				0		95.00
	(see instructions)						
96.00	Time value of money for capital related				0		96.00
	expenses (see instructions)						1

Health Financial Systems	DEACONESS HOSPI	TAL			In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 150082		i od:	Worksheet E	
				To	m 10/01/2014 09/30/2015		pared.
					077 007 2010	2/26/2016 11:4	44 am
		Ti tl	e XVIII		Hospi tal	PPS	
			Prior 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	100.00
HVBP Adjustment for HSP Bonus Payment							
101.00 HVBP adjustment factor (see instructions)						0	101.00
102.00 HVBP adjustment amount for HSP bonus payment (se	ee instructions)					0	102.00
HRR Adjustment for HSP Bonus Payment							
103.00 HRR adjustment factor (see instructions)						0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see	e instructions)					0	104.00

W VO	Financial Systems LUME CALCULATION EXHIBIT 4		DEACONESS	Provi der		Period: From 10/01/2014 To 09/30/2015	Date/Time Pre 2/26/2016 11:	t 4 pared
			Amounts (from	Titl Pre/Post Entitlement	e XVIII Period Prior		PPS Total (Col 2	
		line 0	<u>E, Part A)</u> 1.00	2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
00	DRG amounts other than outlier	1.00	0	0		0 0	0	1.
01	payments DRG amounts other than outlier payments for discharges	1.01	О	0		o o	0	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	93, 563, 222	0		0 93, 563, 222	93, 563, 222	1.
03	I DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0 0	0	1.
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	O	0		o o	0	1.
00	Outlier payments for discharges (see instructions)	2.00	2, 473, 216	0		0 2, 473, 216	2, 473, 216	2.
01	Outlier payments for	2.02	0	0		0 0	0	2.
00	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	0	0		0 0	0	3
00	Managed care simulated payments	3.00	24, 827, 730	0		0 24, 827, 730	24, 827, 730	4
00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 033507	0. 033507	0. 03350	7 0. 033507		5
0	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	1, 697, 237	0		0 1, 697, 237	1, 697, 237	6
)1	IME payment adjustment for managed care (see instructions)	22.01	450, 375	0		0 450, 375	450, 375	6
0	Indirect Medical Education Adju IME payment adjustment factor	<u>stment for the</u> 27.00	e Add-on for Se 0.001298			8 0. 001298	F	   _
)0 )0	(see instructions) IME adjustment (see	27.00	121, 445	0.001298		0 121, 445		8
)1	instructions) IME payment adjustment add on for managed care (see	28.01	32, 226	0		0 32, 226	32, 226	8
00	instructions) Total IME payment (sum of	29.00	1, 818, 682	0		0 1, 818, 682	1, 818, 682	9
)1	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	482, 601	0		0 482, 601	482, 601	9
00	Disproportionate Share Adjustme			0.0715	0.071			
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0717	0. 0717	0. 071	7 0. 0717		10
00	Disproportionate share adjustment (see instructions)	34.00	1, 677, 121	0		0 1, 677, 121		
01	Uncompensated care payments Additional payment for high per	<u>36.00</u> centage of FSE	4, 325, 990 D beneficiary	0 di scharges	1	0 4, 325, 990	4, 325, 990	1 11
00	Total ESRD additional payment	46.00	0	0		0 0	0	12
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	103, 858, 231 0	0		0 103, 858, 231 0 0	103, 858, 231 0	
00	(completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see	49.00	104, 340, 832	0		0 104, 340, 832	104, 340, 832	
00	instructions) Payment for inpatient program	50.00	8, 300, 345	0		0 8, 300, 345	8, 300, 345	16
00	capital Special add-on payments for new tochaologies	54.00	2, 425	0		0 2, 425	2, 425	17
01 02	new technologies Net organ aquisition cost Credits received from manufacturers for replaced	55.00 68.00	0 0	0 0		0 0 0 0	0	17 17
00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18

Health Financial Systems		DEACONESS	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
LOW VOLUME CALCULATION EXHIBIT 4			Provi der		Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Exhibi Date/Time Pre 2/26/2016 11:	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	W/S E, Part A	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		0 112, 643, 602	112, 643, 602	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	7, 389, 503	0		0 7, 389, 503	7, 389, 503	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	473, 383	0		0 473, 383	473, 383	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. 0141	0. 0141	0. 014	1 0. 0141		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	104, 192	0		0 104, 192	104, 192	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0451	0. 0451	0. 045	1 0. 0451		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	333, 267	0		0 333, 267	333, 267	25.00
26.00 Total prospective capital payments (see instructions)	12.00	8, 300, 345	0		0 8, 300, 345	8, 300, 345	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 0. 000000		27.00
28.00 Low volume adjustment (transfer amount to Wkst. E,	70. 96				0	0	28.00
Pt. A, line) 29.00 (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

Heal th	Financial Systems	DEACONESS	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA			CCN: 150082	Period: From 10/01/2014	Worksheet E Part A Exhibi	
					To 09/30/2015	Date/Time Pre 2/26/2016 11:4	
				e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	A) 1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	1.00	2.00	0.00	1.00	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0		0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	93, 563, 222		93, 563, 222	93, 563, 222	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		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	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	2, 473, 216		0 2, 473, 216	2, 473, 216	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	24, 827, 730		0 24, 827, 730	24, 827, 730	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, Line 21	21.00	0. 033507	0. 03350	07 0. 033507		5.00
( 00	(see instructions)	22.00	1 (07 007		1 (07 007	1 (07 007	( 00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	1, 697, 237 450, 375		0 1, 697, 237 0 450, 375		6. 00 6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 001298	0. 00129	0. 001298		7.00
8.00	IME adjustment (see instructions)	28.00	121, 445		0 121, 445		8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	32, 226		0 32, 226	32, 226	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1, 818, 682		0 1, 818, 682		9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	482, 601		0 482, 601	482, 601	9. 01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 0717	0. 071	7 0. 0717		10.00
11.00	(see instructions) Disproportionate share adjustment (see	34.00	1, 677, 121		0 1, 677, 121	1, 677, 121	11.00
11.01	instructions) Uncompensated care payments Additional payment for high percentage of ESF	36.00	4, 325, 990		0 4, 325, 990	4, 325, 990	11.01
12.00	Total ESRD additional payment (see instructions)	46.00	0 O		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	103, 858, 231		0 103, 858, 231	103, 858, 231	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0		
15.00	Total payment for inpatient operating costs (see instructions)	49.00	104, 340, 832		0 104, 340, 832	104, 340, 832	15.00
16.00	Payment for inpatient program capital	50.00	8, 300, 345		0 8, 300, 345	8, 300, 345	16.00
17.00	Special add-on payments for new technologies	54.00	2, 425		0 2, 425	2, 425	17.00
17.01	Net organ aquisition cost	55.00	0		0 0	0	17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
19.00	SUBTOTAL				0 112, 643, 602	112, 643, 602	19.00

Heal th	Financial Systems	DEACONESS	HOSPI TAL			In Lie	u of Form CMS-	2552-10
HOSPI	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		CCN: 150082		iod: m 10/01/2014 09/30/2015	Date/Time Pre 2/26/2016 11:	epared:
				e XVIII		Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00		3.00	4.00	
20.00	Capital DRG other than outlier	1.00	7, 389, 503		0	7, 389, 503	7, 389, 503	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0	0	0	20.01
21.00		2.00	473, 383		0	473, 383	473, 383	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0	0	0	
22.00	Indirect medical education percentage (see	5.00	0. 0141	0. 01	41	0. 0141	-	22.00
	instructions)							
23.00	,	6.00	104, 192		0	104, 192	104, 192	23.00
	instructions)							
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0451	0.04	51	0. 0451		24.00
25.00		11.00	333, 267		0	333, 267	333, 267	25.00
23.00	instructions)	11.00	333, 207		0	555, 207	555, 207	23.00
26.00		12.00	8, 300, 345		0	8, 300, 345	8, 300, 345	26.00
	This full tons)	Wkst. E, Pt.	(Amt. from					
		A, line	Wkst. E, Pt.					
		A, THE	A)					
		0	1.00	2.00		3.00	4,00	
27.00		0	1.00	2.00		3.00	4.00	27.00
28.00	Low volume adjustment prior to October 1	70, 96	0		0		0	
29.00	Low volume adjustment on or after October 1	70.97			0	0	0	
30.00	HVBP payment adjustment (see instructions)	70.93	-409, 648		0	-409,648	-409,648	
30.00	HVBP payment adjustment for HSP bonus	70.93	-409, 040		0	-409, 040	-409, 048	
30.01	payment (see instructions)	70.90	0		0	0	0	30.01
31, 00	HRR adjustment (see instructions)	70, 94	-374, 269		0	-374, 269	-374, 269	21 00
31.00	HRR adjustment for HSP bonus payment (see	70.91	-374, 207		0	-374,209	-374, 209	
51.01	instructions)	70. 71			0	0	0	51.01
							(Amt. to Wkst.	
							E, Pt. A)	
		0	1.00	2.00		3.00	4.00	
32.00		70.99			0	0	0	32.00
100.00	instructions)		N					100 00
100.00	Transfer HAC Reduction Program adjustment to		N					100.00
	Wkst. E, Pt. A.	l						1

Heal th	Financial Systems DEACONESS HOSE	PI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150082	Period: From 10/01/2014	Worksheet E	
			To 09/30/2015	Part B   Date/Time Pre	pared:
		T: 11 - 20/1-1-	· · · · ·	2/26/2016 11:	44 am
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)		1	81, 868	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ions)		41, 893, 187	•
3.00	PPS payments			43, 167, 115	
4.00	Outlier payment (see instructions)			48, 315	4.00
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	•
6.00	Line 2 times line 5			0	
7.00 8.00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	•
9.00	Ancillary service other pass through costs from Wkst. D, Pt. 1	V. col. 13. line 200		88, 596	•
	Organ acquisitions	.,,		0	•
11.00	Total cost (sum of lines 1 and 10) (see instructions)			81, 868	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable charges		1	224 010	1 12 00
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ne 69)		326, 910 0	1
	Total reasonable charges (sum of lines 12 and 13)	lie 07)		326, 910	•
	Customary charges				1
15.00	Aggregate amount actually collected from patients liable for pa	ayment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16.00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)	)		0,000000	17 00
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 326, 910	•
	Excess of customary charges over reasonable cost (complete only	vifline 18 exceeds li	ne 11) (see	245, 042	
17.00	instructions)	y i i i i i co coccus i i		210,012	
20.00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		81, 868 0	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	uctions)		0	
	Total prospective payment (sum of lines 3, 4, 8 and 9)			43, 304, 026	•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (for CAH, see instructions)			416	•
	Deductibles and Coinsurance relating to amount on line 24 (for			9, 010, 636	•
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl instructions)	lus the sum of lines 22	and 23] (see	34, 374, 842	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, lin	ne 50)		283, 497	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			34, 658, 339	30.00
	Primary payer payments			15, 246	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	-67		34, 643, 093	32.00
	Composite rate ESRD (from Wkst. I-5, line 11)	_5)		0	33.00
	Allowable bad debts (see instructions)			838, 786	•
	Adjusted reimbursable bad debts (see instructions)			545, 211	•
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		719, 812	
	Subtotal (see instructions)			35, 188, 304	•
	MSP-LCC reconciliation amount from PS&R			- 384	•
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	
	Partial or full credits received from manufacturers for replace		tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			35, 188, 688	40.00
	Sequestration adjustment (see instructions)			703, 774	•
	Interim payments			34, 554, 626	1
	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 -69, 712	
	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2.	chapter 1.	402, 080	1
	§115. 2		and the second s		
1	TO BE COMPLETED BY CONTRACTOR				
				0	
90.00	Original outlier amount (see instructions)		l l		1 01 00
90. 00 91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
90. 00 91. 00 92. 00	5			-	92.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150082	Period: From 10/01/2014 To 09/30/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
		I npati en	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		101, 908, 8	01 0	34, 554, 626 0	1.00 2.00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					3.00
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	04/27/2015	44, 7	00	0	3. 01
3.02		04/2//2013	44,7	0	0	3.02
3.03				0	0	3.03
3.04				0	0	3. 04
3.05				0	0	3.05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.50	ADJUSTINIENTS TO PROGRAM			0	0	3.50
3.52				0	0	3. 52
3.53				0	0	3.53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		44, 7		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		101, 953, 5	UT	34, 554, 626	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
5.01	TENTATI VE TO PROVIDER			0	0	5. 01
5.02				0	0	5.02
5.03				0	0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.51				0	0	5.50
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		851, 8	0	0 69, 712	6. 01 6. 02
6.02 7.00	Total Medicare program liability (see instructions)		101, 101, 6		34, 484, 914	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1.00	2.00	
8.00	Name of Contractor					8.00

IALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150082 CCN: 15S082	Period: From 10/01/2014 To 09/30/2015		pare
		Ti tl	e XVIII	Subprovider - IPF	PPS	<u> </u>
		I npati en	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
0.0		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		829, 92	0	0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER		1	0	0	3.
01	ADJUSTWILINTS TO FROM DER			0	0	
03				0	0	
04				0	0	
05				0	0	3
	Provider to Program			-	1	
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	-
52				0	0	-
53 54				0	0	
99 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
, ,	3. 50-3. 98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as (appropriate)		829, 92	28	0	4
	TO BE COMPLETED BY CONTRACTOR		1		1	
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	
)3				0	0	5
	Provider to Program				1	
50	TENTATIVE TO PROGRAM			0	0	
51				0	0	
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
7	5. 50-5. 98)				0	່ ີ
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		8, 34	11	0	
)2	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		838, 20		0 NPR Date	7
				Contractor Number	(Mo/Day/Yr)	
				NUMBER		1

Heal th	Financial Systems DEACONESS HOS	PI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150082	Period: From 10/01/2014	Worksheet E-1 Part II	
			To 09/30/2015		pared:
				2/26/2016 11:	44 am
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	26, 962	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	-12		60, 151	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	10		16, 969	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	-12		128, 979	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	20		1, 967, 576, 419	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li			40, 842, 199	
7.00	CAH only - The reasonable cost incurred for the purchase of ce	ertified HII technology	WKST. S-2, PT. I	0	7.00
8.00	line 168 Calculation of the HIT incentive payment (see instructions)			0	8,00
9,00	Sequestration adjustment amount (see instructions)			0	9.00
9.00 10.00	Calculation of the HIT incentive payment after sequestration (	soo instructions)		0	10.00
10.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			0	10.00
30, 00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
30.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ne 31) (see instruction	s)	0	32.00
52.00			5)	0	52.00

	Financial Systems DEACONESS HOSE			u of Form CMS-2	
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150082	Period: From 10/01/2014	Worksheet E-3 Part II	
		Component CCN: 15S082			
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and media	cal education payments)		986, 478	1.00
2.00	Net IPF PPS Outlier Payments			2, 782	2.00
3.00	Net IPF PPS ECT Payments			7, 516	
4.00	Unweighted intern and resident FTE count in the most recent cost	st report filed on or b	efore November	0.00	4.00
4.01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE count	for recidents that wer	o dicplaced by	0.00	4.01
4.01	program or hospital closure, that would not be counted without CFR §412. 424(d) (1) (iii) (F) (1) or (2) (see instructions)			0.00	4.01
5.00	New Teaching program adjustment. (see instructions)			0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in th	ne new program growth p	eriod of a "new	0.00	
	teaching program" (see instuctions)				
7.00	Current year's unweighted I&R FTE count for residents within the teaching program" (see instuctions)	ne new program growth p	eriod of a "new	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjust	ment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)			9. 526027	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the second	ne power of .5150 -1}.		0. 000000	
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0	
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			996, 776	1
13.00 14.00	Nursing and Allied Health Managed Care payment (see instruction	1)		0	13.00 14.00
14.00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see instru	(ctions)		0	
16.00				996, 776	
17.00				0	
18.00	Subtotal (line 16 less line 17).			996, 776	18.00
19.00	Deducti bl es			128, 284	19.00
20.00	Subtotal (line 18 minus line 19)			868, 492	20.00
21.00	Coinsurance			21, 603	
22.00				846, 889	
23.00	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		12, 154	
24.00 25.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		7, 900 6, 025	
26.00	5			854, 789	
27.00	Direct graduate medical education payments (from Wkst. E-4, lin	ne 49)		004,707	1
28.00	Other pass through costs (see instructions)			588	
29.00	Outlier payments reconciliation			0	
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	)		0	30.50
30.99	Recovery of Accelerated Depreciation			0	
31.00				855, 377	
31.01	Sequestration adjustment (see instructions)			17, 108	
32.00	Interim payments			829, 928	
33.00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32 and	4 33)		0	
34.00 35.00	Protested amounts (nonallowable cost report items) in accordance		chapter 1.	8, 341 0	1
	§115. 2 TO BE COMPLETED BY CONTRACTOR		1		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			2 782	50.00
51.00	5			2,782	1
52.00	The rate used to calculate the Time Value of Money				52.00
	Time Value of Money (see instructions)				53.00

DIRECT	Financial Systems DEACONESS HOSE GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	PI TAL Provi der	CCN: 150082	Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS	i i ovi dei		From 10/01/2014 To 09/30/2015	Date/Time Pre	pared:
		Title	e XVIII	Hospi tal	2/26/2016 11: PPS	44 am
				nospi tui	113	
					1.00	
1 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT	<b></b>		n en en en el en el en	10.00	1 1 00
1.00	Unweighted resident FTE count for allopathic and osteopathic p ending on or before December 31, 1996.	rograms tor	cost reporti	ng periods	18.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR	413.79(e)(	1) (see instr	uctions)	0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			,	1.40	
3.01	Direct GME cap reduction amount under ACA §5503 in accordance	with 42 CFR	§413.79 (m).	(see	0.00	3.0
	instructions for cost reporting periods straddling 7/1/2011)					
4.00	Adjustment (plus or minus) to the FTE cap for all opathic and o		programs due	to a Medicare	0.00	4.00
4.01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)) ACA Section 5503 increase to the Direct GME FTE Cap (see instr		cost reporti	na neriods	0.00	4.0
4.01	straddling 7/1/2011)		0031 1000111	ng per lous	0.00	7.0
4.02	ACA Section 5506 number of additional direct GME FTE cap slots	(see inst	ructions for	cost reporting	0.00	4.02
	periods straddling 7/1/2011)					
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plu	s or minus	line 4 plus l	ines 4.01 and	16.60	5.00
6.00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic p	rograms for	the current	waar from wour	20.51	6.00
0.00	records (see instructions)	rograms ror	the current	year rronn your	20. 51	0.00
7.00	Enter the lesser of line 5 or line 6				16.60	7.00
			Primary Care	Other	Total	
			1.00	2.00	3.00	
3.00	Weighted FTE count for physicians in an allopathic and osteopa	thic	20. 5	1 0.00	20. 51	8.0
9.00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwi	50	16.6	0 0.00	16.60	9.0
7.00	multiply line 8 times the result of line 5 divided by the amou		10.0	0.00	10.00	7.00
	6.					
10. 00	Weighted dental and podiatric resident FTE count for the curre	nt year		0.00		10.00
11.00	Total weighted FTE count		16.6			11.00
12.00	Total weighted resident FTE count for the prior cost reporting instructions)	year (see	16.6	0 0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost rep	ortina	16.6	0 0.00		13.00
	year (see instructions)	or tring	1010	0,00		
14.00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	16.6	0 0.00		14.0
	Adjustment for residents in initial years of new programs		0.0			15.0
16.00	Adjustment for residents displaced by program or hospital clos	ure	0.0			16.0
17.00 18.00	Adjusted rolling average FTE count Per resident amount		16. 6 120, 498. 9			17.00
19.00	Approved amount for resident costs		2, 000, 28		2, 000, 283	•
17.00			2,000,20	0	2,000,200	17.00
					1.00	
20. 00	Additional unweighted allopathic and osteopathic direct GME FT	E resident (	cap slots rec	eived under 42	0.00	20.00
01 00	Sec. 413.79(c)(4)	+:)			2.01	21 0
21.00	Direct GME FTE unweighted resident count over cap (see instruc Allowable additional direct GME FTE Resident Count (see instru				3.91	21.0
23.00	Enter the locally adjustment national average per resident amo		structions)			23.0
	Multiply line 22 time line 23					24.0
	Total direct GME amount (sum of lines 19 and 24)				2, 000, 283	
			Inpatient Par	t Managed care		
			A 1.00	2.00	2.00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
26. 00	Inpatient Days (see instructions)		61, 50	4 17,057		26.0
27.00	Total Inpatient Days (see instructions)		132, 45			27.0
	Ratio of inpatient days to total inpatient days		0. 46433			28.00
28.00						29.00
	Program direct GME amount		928, 80	1 257, 586		29.00
28.00 29.00 30.00	Program direct GME amount Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount		928, 80	36, 397	1, 149, 990	30.00

Heal th	Financial Systems	DEACONESS HOSP	I TAL	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATI	ENT DIRECT	Provider CCN: 150082	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 10/01/2014 To 09/30/2015	Date/Time Pre	nared
				10 07/30/2013	2/26/2016 11:	
			Title XVIII	Hospi tal	PPS	
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSI EDUCATION COSTS)	TE RATE - TITLE	XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
32.00	Renal dialysis direct medical education costs (	from Wkst. B, Pt	. I, sum of col. 20 an	d 23, lines 74	0	32.00
	and 94)					
33.00	Renal dialysis and home dialysis total charges	(Wkst. C, Pt. I,	col. 8, sum of lines	74 and 94)	8, 881, 145	33.00
34.00	Ratio of direct medical education costs to tota	l charges (line	32 ÷ line 33)		0.00000	34.00
35.00	Medicare outpatient ESRD charges (see instruction				0	35.00
36.00	Medicare outpatient ESRD direct medical education				0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST	- TITLE XVIII O	NLY			
	Part A Reasonable Cost			1		
	Reasonable cost (see instructions)				128, 544, 025	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, co				0	38.00
	Cost of physicians' services in a teaching hosp	ital (see instru	ctions)		0	39.00
40.00	Primary payer payments (see instructions)				25, 177	40.00
41.00	Total Part A reasonable cost (sum of lines 37 t	hrough 39 minus	line 40)		128, 518, 848	41.00
42.00	Part B Reasonable Cost				42.0(2.(51	40.00
42.00	Reasonable cost (see instructions) Primary payer payments (see instructions)				42, 063, 651	
43.00 44.00	Total Part B reasonable cost (line 42 minus lin	. (2)			15, 246 42, 048, 405	
44.00	Total reasonable cost (sum of lines 41 and 44)	le 43)			170, 567, 253	
45.00	Ratio of Part A reasonable cost to total reason	able cost (line	41 · Lipo 45)		0. 753479	
40.00	Ratio of Part B reasonable cost to total reason				0. 246521	40.00
÷7.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN				0. 240321	47.00
48.00			5		1, 149, 990	48 00
49.00	Part A Medicare GME payment (line 46 x 48) (tit	le XVIII only) (	see instructions)		866, 493	
50,00	Part B Medicare GME payment (line 47 x 48) (tit				283, 497	
				1		

LANCE	inancial Systems DEACONESS SHEET (If you are nonproprietary and do not maintain	Provi der		Peri od:	u of Form CMS-: Worksheet G	2
ind-typ	be accounting records, complete the General Fund column on	l y)		From 10/01/2014 To 09/30/2015	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	2/26/2016 11: Plant Fund	44 8
		1.00	Purpose Fund 2.00	3.00	4.00	
CI	URRENT ASSETS	1.00	2.00	3.00	4.00	
	ash on hand in banks	84, 419, 547		0 0	0	] 1
	emporary investments	33, 754	1	0 0	0	2
	lotes recei vabl e	0		0 0	0	
	ccounts receivable	102, 536, 399		0 0	0	
	ther receivable Ilowances for uncollectible notes and accounts receivable				0	
	nventory	6, 858, 270		0 0	0	
	repaid expenses	7, 028, 211		0 0	0	
00 0	ther current assets	15, 468, 480	)	o o	0	9
. 00 D	ue from other funds	0		0 0	0	10
	otal current assets (sum of lines 1-10)	216, 344, 661		0 0	0	11
	I XED ASSETS	40.054.507				
	and	13, 251, 527		0 0 0 0	0	12
	and improvements ccumulated depreciation	5, 900, 605		0 0	0	14
	uildings	495, 659, 631			0	15
	ccumulated depreciation	-274, 853, 345		0 0	0	16
	easehold improvements	0		o o	0	17
	ccumulated depreciation	0		0 0	0	18
. 00 F	ixed equipment	285, 044, 852		0 0	0	19
	ccumulated depreciation	-224, 642, 359		0 0	0	20
	utomobiles and trucks	0		0 0	0	21
	ccumulated depreciation	0		0 0	0	22
	lajor movable equipment	0		0 0	0	23
	ccumulated depreciation				0	24
	linor equipment depreciable .ccumulated depreciation				0	20
	IT designated Assets			0 0	0	2
	ccumul ated depreciation			0 0	0	28
	li nor equi pment-nondepreci abl e			0 0	0	29
	otal fixed assets (sum of lines 12-29)	296, 056, 775		0 0	0	30
0	THER ASSETS					
	nvestments	506, 544, 022	12, 263, 19		0	31
	eposits on leases	0		0 0	0	32
	ue from owners/officers	0		0 0	0	33
	ither assets	49, 560, 455		0 0	0	34
1	otal other assets (sum of lines 31-34)	556, 104, 477			0	35
	otal assets (sum of lines 11, 30, and 35) URRENT LIABILITIES	1,068,505,913	12, 263, 19		0	1 30
	ccounts payable	37,004,719		0 0	0	37
	al aries, wages, and fees payable	31, 899, 544		0 0	0	
	ayroll taxes payable	1, 469, 299		0 0	0	
	lotes and I oans payable (short term)	6, 105, 639		0 0	0	40
	eferred income	0		0 0	0	41
1	ccelerated payments	0				42
	ue to other funds	0		0 0	0	
	ther current liabilities	14, 174, 139		0 0	0	44
	otal current liabilities (sum of lines 37 thru 44) ONG TERM LIABILITIES	90, 653, 340	1	0 0	0	45
	lortgage payable			0 0	0	46
	lot tyage payable lotes payable	207, 056, 700		0 0	0	
	Insecured Loans			0 0	0	
	ther long term liabilities	89, 645, 617		0 0	0	
. 00   T	otal long term liabilities (sum of lines 46 thru 49	296, 702, 317		0 0	0	50
	otal liabilites (sum of lines 45 and 50)	387, 355, 657		0 0	0	51
	API TAL ACCOUNTS					
	eneral fund balance	681, 150, 256	1	_		52
	pecific purpose fund		12, 263, 19			53
	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		5!
1	overning body created - endowment fund balance lant fund balance - invested in plant			0	0	5
	lant fund balance - reserve for plant improvement,				0	58
	eplacement, and expansion				0	50
	otal fund balances (sum of lines 52 thru 58)	681, 150, 256	12, 263, 19	7 0	0	59
	otal liabilities and fund balances (sum of lines 51 and	1,068,505,913			0	
			1	- i		1

Heal th	Financial Systems	DEACONESS H	HOSPI TAL				In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provi	der	CCN: 150082		riod: om 10/01/2014 09/30/2015		pared:
		General	Fund		Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2.00		3.00		4.00	5.00	
1.00	Fund balances at beginning of period		625, 479,				12, 453, 541		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		138, 261,				10 450 541		2.00
3.00 4.00	Total (sum of line 1 and line 2) NET UNREALIZED GAIN ON INVESTMENTS	-18, 797, 983	763, 741,	645	-458, 3	201	12, 453, 541	l c	3.00 4.00
4.00 5.00	BENEFIT RELATED CHANGES	-38, 019, 360			-430, 3	0			
6.00	FOUNDATION NET INCOME	0			267, 9	-			
7.00		0				0		0	7.00
8.00		0				0		C	
9.00		0				0		0	1.00
10.00	Total additions (sum of line 4-9)		-56, 817,				-190, 343		10.00
11.00	Subtotal (line 3 plus line 10)	25 774 047	706, 924,	302			12, 263, 198	c c	11.00 12.00
12.00 13.00	CHANGES IN UNRESTRICTED ASSETS (TRAN ROUNDING (CORRECT VARIANCE IN REV)	25, 774, 047 -1				0			
14.00	ROUNDING (CORRECT VARIANCE IN REV)	0				0			
15.00		0				Ö			
16.00		0				0		C	16.00
17.00		0				0		C	17.00
18.00	Total deductions (sum of lines 12-17)		25, 774,				1		18.00
19.00	Fund balance at end of period per balance		681, 150,	256			12, 263, 197		19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI	ant	Fund	_			
					T und	_			
	r	6.00	7.00		8.00				
1.00	Fund balances at beginning of period	0				0			1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29)	0				0			2.00 3.00
3.00 4.00	Total (sum of line 1 and line 2) NET UNREALIZED GAIN ON INVESTMENTS	0		0		0			3.00 4.00
4.00 5.00	BENEFIT RELATED CHANGES			0					5.00
6.00	FOUNDATION NET INCOME			0					6.00
7.00				0					7.00
8.00				0					8.00
9.00				0					9.00
10.00	Total additions (sum of line 4-9)	0				0			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10)	0		_		0			11.00 12.00
12.00	CHANGES IN UNRESTRICTED ASSETS (TRAN ROUNDING (CORRECT VARIANCE IN REV)			0					12.00
14.00	CONDING (CONNECT VARIANCE IN NEV)			0					14.00
15.00				0					15.00
16.00				0					16.00
17.00				0					17.00
18.00	Total deductions (sum of lines 12–17)	0				0			18.00
19.00	Fund balance at end of period per balance	0				0			19.00
	sheet (line 11 minus line 18)			I		I			I

Heal th	Financial Systems DEACONESS HOSP	TAL			In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150082		riod: om 10/01/2014 09/30/2015	Worksheet G-2 Parts I & II Date/Time Prep 2/26/2016 11:4	
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services						
1.00	Hospi tal		160, 846, 7	00		160, 846, 799	1.00
2.00	SUBPROVIDER - IPF		7, 698, 8			7, 698, 896	2.00
3.00	SUBPROVIDER - IRF		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1,070,070	3.00
4.00	SUBPROVIDER						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)		168, 545, 6	95		168, 545, 695	10.00
11 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT			04			11 00
11.00 12.00	CORONARY CARE UNIT		56, 565, 6 13, 403, 0			56, 565, 604 13, 403, 006	11. 00 12. 00
12.00	BURN INTENSIVE CARE UNIT		13, 403, 0	00		13, 403, 000	12.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes	69, 968, 6	10		69, 968, 610	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		238, 514, 3	05		238, 514, 305	17.00
18.00	Ancillary services		708, 092, 1		773, 833, 755	1, 481, 925, 895	18.00
19.00	Outpatient services		80, 029, 4		288, 158, 129	368, 187, 620	19.00
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00 23.00	HOME HEALTH AGENCY AMBULANCE SERVICES				0	0	22. 00 23. 00
23.00	CMHC						23.00
24.00	AMBULATORY SURGICAL CENTER (D. P. )						24.00
26.00	HOSPICE			0	0	0	26.00
27.00	OTHER (SPECIFY)			0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	1, 026, 635, 9	36	1, 061, 991, 884	2, 088, 627, 820	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES		1				
29.00	Operating expenses (per Wkst. A, column 3, line 200)			~	596, 842, 235		29.00
30.00 31.00	ADD (SPECI FY)			0 0			30. 00 31. 00
31.00				0			31.00
32.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECIFY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0	_		41.00
42.00	Total deductions (sum of lines 37-41)	(tran-f-			0 504 042 225		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42) to Wkst. G-3, line 4)	(transfer			596, 842, 235		43.00
			I	I	I	I	

Heal th	Financial Systems	EACONESS HOSPI	TAL			In Lie	u of Form CMS-2	552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider (	CCN: ´	150082	Peri od:	Worksheet G-3	
						From 10/01/2014 To 09/30/2015	Date/Time Prep	arad
						10 09/ 30/ 2013	2/26/2016 11:4	l4 am
							2/20/2010 111	
							1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, co	olumn 3, line 2	8)				2, 088, 627, 820	1.00
2.00	Less contractual allowances and discounts on patie	ents' accounts					1, 407, 657, 887	2.00
3.00	Net patient revenues (line 1 minus line 2)						680, 969, 933	3.00
4.00	Less total operating expenses (from Wkst. G-2, Par	rt II, line 43)					596, 842, 235	4.00
5.00	Net income from service to patients (line 3 minus	line 4)					84, 127, 698	5.00
	OTHER INCOME							
6.00	Contributions, donations, bequests, etc						0	6.00
7.00	Income from investments						6, 012, 669	7.00
8.00	Revenues from telephone and other miscellaneous co	ommunication se	rvi ces				0	8.00
9.00	Revenue from television and radio service						0	9.00
10.00	Purchase di scounts						0	10.00
11.00	Rebates and refunds of expenses						0	11.00
12.00	Parking lot receipts						0	12.00
13.00	Revenue from laundry and linen service						0	13.00
14.00	Revenue from meals sold to employees and guests						0	14.00
15.00	Revenue from rental of living quarters						0	15.00
16.00	Revenue from sale of medical and surgical supplies	s to other than	pati ents				0	16.00
17.00	Revenue from sale of drugs to other than patients						0	17.00
18.00	Revenue from sale of medical records and abstracts	6					0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)						0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and car	nteen					0	20.00
21.00	Rental of vending machines						0	21.00
22.00	Rental of hospital space						0	22.00
23.00	Governmental appropriations						0	23.00
24.00	OTHER OPERATING REVENUE						48, 121, 448	24.00
25.00	Total other income (sum of lines 6-24)						54, 134, 117	25.00
26.00	Total (line 5 plus line 25)						138, 261, 815	26.00
27.00	ROUNDING						2	27.00
28.00	Total other expenses (sum of line 27 and subscript						2	28.00
29.00	Net income (or loss) for the period (line 26 minus	s line 28)					138, 261, 813	29.00

ALCULA	Financial Systems DEACONE ATION OF CAPITAL PAYMENT	ESS HOSPITAL Provider CCN: 150082	Peri od:	u of Form CMS-: Worksheet L	
			From 10/01/2014	Parts I-III	
			To 09/30/2015	Date/Time Pre	
		Title XVIII	Hospi tal	2/26/2016 11: PPS	44 ai
			nospi tai	115	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				-
	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			7, 389, 503	1 1.
	Model 4 BPCI Capital DRG other than outlier			7, 369, 503	
	Capital DRG outlier payments			473, 383	
	Model 4 BPCI Capital DRG outlier payments			473, 303	
	Total inpatient days divided by number of days in the co	ost reporting period (see inst	ructions)	353.37	
	Number of interns & residents (see instructions)	ust reporting period (see that		17.52	
	Indirect medical education percentage (see instructions)	)		1.41	
	Indirect medical education adjustment (multiply line 5		columns 1 and	104, 192	
	1.01) (see instructions)			101,172	
00	Percentage of SSI recipient patient days to Medicare Pa	rt A patient days (Worksheet E	, part A line	5.55	7.
	30) (see instructions)				
	Percentage of Medicaid patient days to total days (see	instructions)		16.21	
	Sum of lines 7 and 8			21.76	
	Allowable disproportionate share percentage (see instru	ctions)		4.51	
	Disproportionate share adjustment (see instructions)			333, 267	
. 00	Total prospective capital payments (see instructions)			8, 300, 345	12
				1.00	
	PART II – PAYMENT UNDER REASONABLE COST				
	Program inpatient routine capital cost (see instructions			0	1.
00	Program inpatient ancillary capital cost (see instruction	ons)		0	2.
00	Total inpatient program capital cost (line 1 plus line 2	2)		0	3.
00	Capital cost payment factor (see instructions)			0	4.
00	Total inpatient program capital cost (line 3 x line 4)			0	5
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)			0	
	Program inpatient capital costs for extraordinary circu			0	
	Net program inpatient capital costs (line 1 minus line )	2)		0	-
	Applicable exception percentage (see instructions)			0.00	
	Capital cost for comparison to payments (line 3 x line			0	
	Percentage adjustment for extraordinary circumstances (			0.00	
	Adjustment to capital minimum payment level for extraord	dinary circumstances (line 2 x	line 6)	0	
	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as	applicable)		0	-
	Current year capital payments (from Part 1, fine 12, as Current year comparison of capital minimum payment leve		Less line 0)	0	
	Carryover of accumulated capital minimum payment level			0	
	Worksheet L, Part III, line 14)	ere. Suprial payment (from pri-	s. your	0	' '
	Net comparison of capital minimum payment level to capit	tal payments (line 10 plus lin	e 11)	0	12.
	Current year exception payment (if line 12 is positive,			0	
	Carryover of accumulated capital minimum payment level			0	14
	(if line 12 is negative, enter the amount on this line)		5,		
					1
. 00	Current year allowable operating and capital payment (se	ee instructions)		0	15.
. 00	Current year allowable operating and capital payment (se Current year operating and capital costs (see instruction Current year exception offset amount (see instructions)	,		0	