Health Financia	al Systems	FRANCI SCAN ST.	ELI ZABETH	HEALTH - CR		In Lieu	u of Form CMS	-2552-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	re to report ca	an resul	t in all interim	FORM APPROVE	D
payments made	since the beginning of the cost	reporting perio	d being d	eemed overpayme	ents (42	USC 1395g).	OMB NO. 0938	3-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST SUMMARY	REPORT CERTIFI	CATION	Provider CCN:	150022	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Pr 5/27/2015 9:	
PART I – COST	REPORT STATUS							
Provi der	1. [X] Electronically filed cos	st report				Date: 5/27/20	15 Time:	9:37 am
use only	2. [] Manually submitted cost	report						
	3. [0] If this is an amended r 4. [F] Medicare Utilization. E				vider re	submitted this co	ost report	
Contractor use only	(2) Settled without Audit 8.	Contractor No.	port for ort for th	this Provider is Provider CC	11. C CCN 12. [PR Date: ontractor's Vendc O]If line 5, co number of tim	lumn 1 is 4:	
PART II - CERT	I FI CATI ON							
MI SREPRESENTAT	ION OR FALSIFICATION OF ANY INFO	ORMATION CONTAIN	ED IN THI	S COST REPORT N	MAY BE P	UNISHABLE BY CRIM	INAL, CIVIL	AND
ADMI NI STRATI VE	ACTION, FINE AND/OR IMPRISONMEN	NT UNDER FEDERAL	LAW. FU	RTHERMORE, IF S	SERVI CES	IDENTIFIED IN TH	IS REPORT WE	RE
PROVIDED OR PR	OCURED THROUGH THE PAYMENT DIREC	CTLY OR INDIRECT	LY OF A K	ICKBACK OR WERE	E OTHERW	ISE ILLEGAL, CRIM	INAL, CIVIL	AND

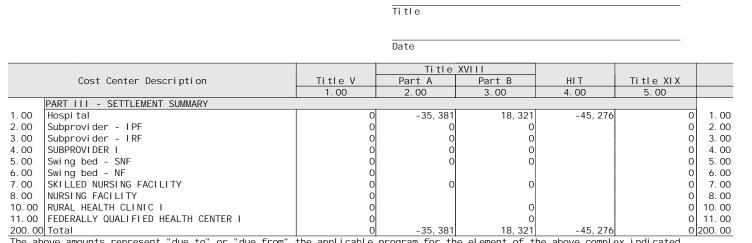
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN ST. ELIZABETH HEALTH - CR (150022) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)

Officer or Administrator of Provider(s)



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

	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	A Contraction of the second se	Provi de	er CCN:	150022	Period: From 01/01/	/2014	Part I	et S-2	
							To 12/31		Date/Ti		
	1.00	2.0	0	3.	00			4.00	5/27/20	15 9:3	
	Hospital and Hospital Health Care Co	mplex Address:									
C	Street: 1710 LAFAYETTE RD.	PO Box:		<u> </u>				-			1.
)	City: CRAWFORDSVILLE	State: IN Component Nam		p Code: CCN	47933 CBSA	Provi der	ty: MONTGOME ^ Date		nt Syste	om (D	2.
					lumber	Type	Certi fi ed		0, or		
								V	XVIII	XIX	1
		1.00	2	. 00	3.00	4.00	5.00	6.00	7.00	8.00	
)	Hospital and Hospital-Based Componen Hospital	FRANCI SCAN ST.	15	0022	99915	1	01/01/1966	N	Р	0	3
, ,		ELIZABETH HEALTH -		0022	,,,,,,						
)	Subprovider - IPF	FRANCI SCAN ST.	15	S022	99915	4	01/01/1995	N	Р	0	4.
)	Subprovider - IRF	ELIZABETH - PSYCH									5
)	Subprovider - (Other)							1		1	6.
)	Swing Beds - SNF									1	7.
)	Swing Beds - NF										8
)	Hospital-Based SNF										9.
)0)1	Hospital-Based NF ICF/MR									1	10
00	Hospi tal -Based OLTC									1	11
00	Hospital-Based HHA									1	12.
00	Separately Certified ASC										13
)0)0	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14 15
0	Hospital -Based Health Clinic - FQHC										16
0	Hospital-Based (CMHC) I									1	17
0	Hospital-Based (CORF) I										17
	Renal Dialysis										18
00	Other					<u> </u>	From:		To:		19
							1.00		2.0		1
0	Cost Reporting Period (mm/dd/yyyy)						01/01/2		12/31/	2014	20
00	Type of Control (see instructions)							2			21.
00	Inpatient PPS Information Does this facility qualify and is it	currently receivi	na payment	ts for d	ispropo	ortionate	e N		N		22.
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil				06(c)(2	?) (Pi ckl e	1			l	
)1	amendment hospital?) In column 2, en Did this hospital receive interim un				cost re	porting	N		Ν		22
, ,	period? Enter in column 1, "Y" for y						IN		IN		22
	reporting period occurring prior to									l	
	for no for the portion of the cost r	eporting period oc	curring or	n or aft	er Octo	ber 1.					
12	(see instructions)	roquiros final un	component	od cara	novmont	to to bo	N		N		22
)2	Is this a newly merged hospital that determined at cost report settlement		•				N		N		22.
	or "N" for no, for the portion of th										
	in column 2, "Y" for yes or "N" for	no, for the portion	n of the o	cost rep	orting	period o	n			l	
12	or after October 1. Did this hospital receive a geograph	ic reclassification	n from ur	han to m	ural co	a recul	t N		Ν		22.
5	of the OMB standards for delineating								IN	l	22
	in column 1, "Y" for yes or "N" for	no for the portion	of the co	ost repo	rting p	peri od					
	prior to October 1. Enter in column						e			l	
	cost reporting period occurring on o hospital contain at least 100 but no						h				
	42 CFR 412.105)? Enter in column 3,			ancou i li		ando wit				l	
00	Which method is used to determine Me	dicaid days on line	es 24 and/					2	Ν		23.
	1, enter 1 if date of admission, 2 i method of identifying the days in th									l	
	used in the prior cost reporting per										
			n-State	In-Sta	te Ou	ut-of	Out-of M	ledi cai		ther	
			Medicaid	Medi cai		tate		HMO day	·	i cai d	
		þ	aid days	el i gi bl unpai d			Medicaid eligible		d	ays	
				days		a days	unpaid				
			1.00	2.00	:	3. 00	4.00	5.00	6	. 00	
0	If this provider is an IPPS hospital		0		0	0	0		0	0	24
	in-state Medicaid paid days in colum										
	Medicaid eligible unpaid days in col									l	
	IOUL-OF-STATE MEDICALD DATO DAVS TO C						1		1		1
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai									1	
		d days in column t unpaid days in									

	Financial Systems FRANCISCAN S TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA			CCN: 150022	Peri od:			eet S-2	
						1/2014 1/2014	5/27/2	015 9:3	
		In-State Medicaid paid days	Medi cai d	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	iys Mee	ither di cai d days	
		1.00	2.00	3.00	4.00	5.00		6.00	
. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0 0	0 0	0		0		25.
					Urban/R		2.		1
. 00	Enter your standard geographic classification (not wa		s at the beg	ginning of th	ne	2			26.
. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status - "2" for n	rural. If ap		t	2			27.
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	f periods SC	CH status in		0			35.
					Begi ni		Endi 2.		-
. 00	Enter applicable beginning and ending dates of SCH st		script line	36 for number			۷.	00	36.
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		er of period	ds MDH status	5	1			37.
. 00	in effect in the cost reporting period. Enter applicable beginning and ending dates of MDH st of periods in excess of one and enter subsequent date	tatus. Subs	•			/2014	12/31	/2014	38.
					Y/		Y/ 2.		-
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage red 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)? Enter i quirements or "N" for adjustmer	in column 1 in accordar r no. (see i nt? Enter "Y	"Y" for yes nce with 42 nstructions) (" for yes on	ne Y) ~ N			1	39. 40.
	no in column 2, for discharges on or after October 1.					V 1.00	XVIII 2.00	XI X 3.00	
. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for dism	proporti onat	te share in a	accordance	N	N	N	45.
00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1					N	N	N	46.
00	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment					N N	N N	N N	47. 48.
	Teaching Hospitals			2 Enton "V	' for ves	N			
. 00	Is this a hospital involved in training residents in	approved (JME programs	s? Enter r	101 903				56.
00	or "N" for no. 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 for yes or "N" for no in column 2. If column 2 is "N	beriod duri yes or "M th of this (", complet	ing which re N" for no ir cost report te Worksheet	esidents in a n column 1. l ting period?	approved f column f Enter "Y				57.
00	or "N" for no. 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 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 If line 56 is yes, did this facility elect cost reimb	period duri yes or "M th of this (", complet , if appli pursement f	ing which re N" for no ir cost report te Worksheet icable.	esidents in a column 1. l ting period? t E-4. lf col	approved fcolumn Enter "Y' umn 2 is				
00 00 00	or "N" for no. 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 for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, § 2148? If yes, complete Wk	period duri yes or "N th of this (", complet , if appli oursement f (st. D-5. s, complete costs for	ing which re N" for no ir cost report te Worksheet icable. for physicia e Wkst. D-2, a program t	esidents in a n column 1. I ting period? t E-4. If col ans' services Pt. I. that meets th	approved f column Enter "Y' umn 2 is s as				57.
00 00 00 00 00	or "N" for no. 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 for yes or "N" for no in column 2. If column 2 is "N "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, § 2148? If yes, complete WK Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health	period duri yes or "N th of this (", complet , if appli oursement f (st. D-5. s, complete costs for	ing which re N" for no ir cost report te Worksheet icable. for physicia e Wkst. D-2, a program t	esidents in a n column 1. I ting period? t E-4. If col ans' services Pt. I. that meets th	approved f column Enter "Y" umn 2 is s as ne cuctions)	N N N	Direc	t GME	57 58 59
00 00 00 00 00	or "N" for no. 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 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 If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, § 2148? If yes, complete Wk Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	beriod duri yes or "h th of this (", complet , if appli bursement 1 (st. D-5. s, complete costs for for yes or Y/N 1.00	ing which re N" for no ir cost report te Worksheet icable. for physicia e Wkst. D-2, a program t r "N" for no	esidents in a n column 1. 1 ting period? t E-4. If col ans' services Pt. 1. that meets th o. (see instr	approved f column Enter "Y" umn 2 is s as ne cuctions)	N N N N N DO	5.	00	57. 58. 59. 60.
00 00 00 00 00 00	or "N" for no. 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 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 If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, § 2148? If yes, complete Wk Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	beriod duri yes or "I th of this ", complet , if appli bursement 1 kst. D-5. s, complete costs for for yes or Y/N	ing which re N" for no ir cost report te Worksheet icable. for physicia e Wkst. D-2, a program t r "N" for no IME 2.00	esidents in a n column 1. 1 ting period? t E-4. If col ans' services Pt. 1. that meets th Direct GME 3.00	approved f column Enter "Y" umn 2 is s as ructions) E IN 4.	N N N	5.		57 58 59 60
00 00 00 00 00 00	or "N" for no. 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 for yes or "N" for no in column 2. If column 2 is "N "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, § 2148? If yes, complete Wk Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	beriod duri yes or "h th of this (", complet , if appli bursement 1 (st. D-5. s, complete costs for for yes or Y/N 1.00	ing which re N" for no ir cost report te Worksheet icable. for physicia e Wkst. D-2, a program t <u>r "N" for no</u> IME	esidents in a n column 1. 1 ting period? t E-4. If col ans' services Pt. 1. that meets th Direct GME 3.00	approved f column ⁷ Enter "Y" umn 2 is s as he ructions) E IN	N N N N N DO	5.	00	57 58 59 60

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION I	ATA	Provi der		Period: From 01/01/2014	Worksheet S-2 Part I	
				To 12/31/2014		
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	1
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.0	00		61.03
 D4 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 		0.00	0.0	OO		61.0
1.05 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 (lin	e	0.00	0.0	00		61.0
 61.04 minus line 61.03). (see instructions) 1.06 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) 		0.00	0.0	00		61.0
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.10
 special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded 				0.00		61. 20
1.20 of the FTLS in FTHe of 0.03, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00		01.2
					1.00	
ACA Provisions Affecting the Health Resources and S 2.00 Enter the number of FTE residents that your hospita				iod for which	0.00	62.0
your hospital received HRSA PCRE funding (see instr 2.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pr Teaching Hospitals that Claim Residents in Nonprovi	a Teachi ogram. (s	see instructior		your hospital	0.00	62.0
3.00 Has your facility trained residents in nonprovider			ost reporting	period? Enter	N	63.0
"Y" for yes or "N" for no in column 1. If yes, comp	lete line	es 64-67. (see	instructions) Unweighted	Unweighted	Ratio (col. 1/	,
			FTEs Nonprovi der Si te	FTEsin	(col . 1 + col . 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in period that begins on or after July 1, 2009 and bef	•	0	This base year	ris your cost n	reporting	
4. 00 Enter in column 1, if line 63 is yes, or your facil in the base year period, the number of unweighted n resident FTEs attributable to rotations occurring i settings. Enter in column 2 the number of unweight resident FTEs that trained in your hospital. Enter of (column 1 divided by (column 1 + column 2)). (se	ity trair on-primar n all nor ed non-pr in columr	ned residents ry care nprovider rimary care n 3 the ratio	0. 0	0 0.00	0. 000000	64.0
Program Name		ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		2.00	3.00	4.00	5.00	1

alth Financial Systems)SPITAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION DA	ATA Provi der		eriod:	Worksheet S	-2
			FI Te	rom 01/01/2014 p 12/31/2014		repared
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
			FTEs	FTEsin	(col. 3 + co	
			Nonprovi der Si te	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	-
.00 Enter in column 1, if line 63	1.00	2.00	0.00			00 65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. (col. 1 + co	
			Nonprovi der Si te	Hospi tal	2))	
			1.00	2.00	3.00	_
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settin				
			0.00	0.0	0 0.0000	000 66.
.00 Enter in column I the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	occurring in all nonp unweighted non-prima tal. Enter in column	rovider settings. ry care resident 3 the ratio of	Unweighted FTEs Nonprovider	0.00 Unweighted FTEs in Hospital	0 0.0000 Ratio (col. (col. 3 + co 4))	3/
FTEs attributable to rotations c Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in:	rovider settings. ry care resident 3 the ratio of structions)	Unweighted FTEs	Unweighted FTEs in Hospital 4.00	Ratio (col. (col. 3 + co 4)) 5.00	3/ ol .
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 + column	occurring in all nonp unweighted non-prima tal. Enter in column ← column 2)). (see in: Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. (col. 3 + co 4)) 5.00	
 FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 2)))) OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3) 	occurring in all nonp unweighted non-prima tal. Enter in column ← column 2)). (see in: Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. (col. 3 + co 4)) 5.00 0 0.0000	3/ ol .
 FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 2 divided by (column 1 + (column 2 divided by (column 2 divided by (column 2 divided by (column 3 divided by (column 3	occurring in all nonp unweighted non-prima tal. Enter in column : ← column 2)). (see in: Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. (col. 3 + co 4)) 5.00 0 0.0000	3/ pl.
 FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 2 divided divided by (column 2 divided primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 	poccurring in all nonp unweighted non-prima tal. Enter in column column 2)). (see in Program Name 1.00	Provi der settings. ry care resident 3 the ratio of structions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospital 4.00 0.00	Ratio (col. (col. 3 + co 4)) 5.00 0 0.0000	3/)1. 000 67.1
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Heal th	Financial Systems FRANCISCAN ST. ELLZ	ZABETH HEALTH -	CR	In L	ieu of Form	n CMS-25	52-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150022	Period: From 01/01/20 To 12/31/20		ne Prepa	
				1	00 2 00	2.00	
	If line 75 yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 1 no. Column 2: Did this facility train residents in a new te CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no 1, 2, or 3, in column 3. (see instructions) If this cost re of the fourth year, enter 4 in column 3, or if the fifth or teaching program in existence, enter 5. (see instructions) on or after October 1, 2012, if this cost reporting period any subsequent academic year of the new teaching program ir instructions)	15, 2004? Enter eaching program 5. Column 3: If eporting period - subsequent ac For cost repor covers the beg	"Y" for yes in accordanc column 2 is covers the b ademic years ting periods inning of the	e most or "N" for e with 42 Y, enter eginning of the new beginning sixth or	. 00 2. 00	3.00	76.00
					1.00	C	
	Long Term Care Hospital PPS						
80. 00 81. 00	Is this a long term care hospital (LTCH)? Enter "Y" for ye Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no. TEFRA Providers	es and "N" for or all of the	no. cost reportin	g period? Ente	er N		80. 00 81. 00
86.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i Did this facility establish a new Other subprovider (exclud §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			on	D. N		85. 00 86. 00
				V 1.00	2.00		
	Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospit yes or "N" for no in the applicable column.	al services? E	nter Y Tor	N	Y		90.00
	Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	Y		91.00
	Are title XIX NF patients occupying title XVIII SNF beds (c	dual certificat			N		92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applic Does this facility operate an ICF/MR facility for purposes		XIX? Enter	N	N		93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N		94.00
95.00	applicable column. If line 94 is "Y", enter the reduction percentage in the ap	oplicable colum	n.	0.	00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.	es or "N" for n	o in the	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the ap	oplicable colum	n.	0.	00	0.00	97.00
	Rural Providers Does this hospital qualify as a Critical Access Hospital (C If this facility qualifies as a CAH, has it elected the all		hod of paymen	t N			05. 00 06. 00
107.00	for outpatient services? (see instructions) Column 1: If this facility qualifies as a CAH, is it eligi for I &R training programs? Enter "Y" for yes or "N" for r			Ν		1	07. 00
	instructions) If yes, the GME elimination would not be on W the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I&Rs in an approved medical educ CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or	Wkst. B, Pt. I, D-2, Pt. II. cation program	col. 25 and Column 2: If train in the				
108.00	instructions) Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e CRNA fee sche	dul e? See 42	Ν		1	08. 00
		Physi cal	Occupationa		Respi ra		
109.00	lf 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.	1.00 e N	2.00 N	3.00 N	4.00 N		09.00
					1.00	<u></u>	
110.00	Did this hospital participate in the Rural Community Hospit		on project (4	10A Demo)for	N		10.00
	the current cost reporting period? Enter "Y" for yes or "N"	TOP NO.		1	. 00 2. 00	3.00	
	Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes c	nr "N" for no i	n column 1 l	f column 1	N	0 1	15.00
110.00	is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208.1.	2. If column 2 ent for long te	is "E", enter rm care (incl	in column udes			10.00
	Is this facility classified as a referral center? Enter "Y" Is this facility legally-required to carry malpractice insu no.			"N" for	N N		16. 00 17. 00
	Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1	if the policy	is	2	1	18. 00

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Addition structure contain end therein and sequence of the sequ					2.00	
120. 00[15 this a SOH or EACH that qualifies for the Outpatient Hold Hamiless provision in AGA N Y 120. 00[15 this a crual hospital with < 100 bods that qualifies for the Outpatient	Administrative and General? If yes, submit supporting and amounts contained therein.			N		
patients? Enter 'Yr for yes or 'N' for no. 1	120.00 Is this a SCH or EACH that qualifies for the Outpatient §3121 and applicable amendments? (see instructions) Ent "N" for no. Is this a rural hospital with < 100 beds th Hold Harmless provision in ACA §3121 and applicable ame	er in column 1, "Y nat qualifies for t	" for yes or he Outpatient		Y	
125.00Dees this facility operate a transplant center? Fitter 'Y' for yes and 'N' for no. If N 125.00 126.00T this is a Medicare certified Kidney transplant center, enter the certification date 126.00 126.00 127.00D the this is a Medicare certified Kidney transplant center, enter the certification date 127.00 127.00 127.00D the this is a Medicare certified Kidney transplant center, enter the certification date 127.00 127.00 128.00T this is a Medicare certified Kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 128.00 128.00 128.00T this is a Medicare certified Kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 131.00 for this is a Medicare certified Kie, if applicable, in column 2. 133.00 133.00 132.00 for this is a Medicare certified Kie, if applicable, in column 2. 133.00 133.00 132.00 for this is a Medicare certified Kie, if applicable, in column 2. 133.00 133.00 133.00 for this is a Medicare certified Kie, if applicable, in column 2. 133.00 133.00 133.00 for this is a Medicare certified Kie, if applicable, in column 2. 133.00 134.00 134.00 for this is a Medicare certified Kie, if applicable, in column 3. 134.00 138.00	patients? Enter "Y" for yes or "N" for no.	implantable device	s charged to	Y		121.00
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127 00 If this is a Medicare certification if applicable, in column 2. 127.00 128 00 If this is a Medicare certification date in a poly column 1 and termination date. If applicable, in column 2. 128.00 129 00 If this is a Medicare certification date. In column 2. 129.00 130 00 If this is a Medicare certification date. In column 2. 130.00 130 00 If this is a Medicare certification date. If applicable, in column 2. 130.00 131 00 If this is a Medicare certification date. If applicable, in column 2. 131.00 131 00 If this is a Medicare certification date. If applicable, in column 2. 131.00 132 00 If this is a Medicare certification date. If applicable, in column 2. 131.00 141 00 Umm 1 and termination date. If applicable, in column 2. 132.00 132 00 If this is a Medicare certification date. If applicable, in column 2. 133.00 141 00 Umm 1 and termination date. If applicable, in column 2. 134.00 141 00 Umm 1 and termination date. If applicable, in column 2. 134.00 141 00 Umm 1 and termination date. If applicable, in column 2. 134.00 141 00 Umm 1 and termination date. If applicable, in column 2. 134.00 141 00 Umm 1 and termination date. If applicable, in column 2. 144.00 142 00 Umm 1 and termination date. If applicable, in column 2. 134.00	126.00 If this is a Medicare certified kidney transplant center		fication date			126. 00
128.00 If this is a Medicare cartified liver irransplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.00 129.00 If this is a Medicare cartified lung transplant center, enter the certification date in colum 1 and termination date, if applicable, in column 2. 130.00 131.00 If this is a Medicare cartified intestinal transplant center, enter the certification date in colum 1. 131.00 132.00 If this is a Medicare certified intestinal transplant center, enter the certification date in colum 1. 131.00 132.00 If this is a Medicare certified to ther transplant center, enter the certification date in colum 1. 131.00 132.00 If this is a Medicare certified to ther transplant center, enter the certification date in colum 1. 133.00 133.00 If this is a Medicare certified to ther transplant center, enter the certification date in colum 1. 133.00 133.00 If this is a Medicare certified to ther transplant center, enter the certification date in colum 1. 134.00 134.00 If this is a and gan precursent organization or home office costs as defined in CMS Pub. 15-1. Y 158014 140.00 Mare: Frakel SAM ALLIAKC, IKC. Contractor's Number: 08101 141.00 142.00 Mare: Frakel SAM ALLIAKC, IKC. Contractor's Number: 08101 141.00 143.00 Vare: Frakel SA Frakel SAM ALLIAKC, IKC. Contractor's Number: 08101 141.00 144.00 Are provid			ication date			127.00
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130.00 If this is a Medicare certified pancreas transplant center, enter the certification date if applicable, in column 2. 130.00 If this is a Medicare certified intestinal transplant center, enter the certification date if applicable, in column 2. 130.00 If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in colum 2. 133.00 If this is a medicare certified other transplant center, enter the certification date in colum 1 and termination date, if applicable, in colum 2. 133.00 If this is a medicare certified other transplant center, enter the certification date in colum 1 and termination date. If applicable, in colum 2. 133.00 If this is a medicare certified other transplant center, enter the certification date in colum 1 and termination date. If applicable, in colum 2. 133.00 If this is a medicare certified other transplant center, enter the certification date in colum 1 and termination date. If applicable, in colum 2. 133.00 If this is a medicare certified organization or home office costs as defined in CMS Pub. 15-1. Y 140.00 If this is a medicare certified on transplant center, entructions 134.00 If this facility is part of a chain organization, enter on lines 114 through 143 the name and address of the home office costs and contractor number.<			cation date i	n		129.00
131.00 f this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in colum 2. 131.00 132.00 f this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date. if applicable, in colum 2. 132.00 133.00 f this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date. if applicable, in colum 2. 133.00 134.00 f this is an organ procurement organization (OPD), enter the OPD number in column 1 and termination date. if applicable, in column 2. 134.00 134.00 f this is an organ procurement organization (OPD), enter the OPD number in column 1 and termination date. if applicable, in column 2. 134.00 140.00 /re there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 107 Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in colum 2. 3.00 140.00 141.00 Name FEANCISCAN ALLIANCE, INC. Contractor's Nameer. Contractor's Number. 08101 141.00 142.00 Street: 1515 DRAGOON TRAL P0 Box: 1290 Contractor's Number: 08101 142.00 145.00 re derived organi tastic call worksheet A? N N N 145.00 144.00 Are provider based physici ans' costs included in Worksheet A? N N N 146.00 145.00 re derived organi netodo	130.00 If this is a Medicare certified pancreas transplant cer	iter, enter the cer	tification			130. 00
132.00 If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 133.00 If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. 134.00 140.00 Fethere any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2. 158014 140.00 140.00 Fethere any related organization, or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter the home office contractor name and contractor number. 3.00 141.00 141.00 Costs for relate P0 Box: 1200 2:0 3.00 141.00 142.00 Street: 1515 0RAGOON TRALL 143.00 Street: 1515 0RAGOON TRALL 143.00 Street: 1510 RAGOON TRALL 150 OFfice and enter the home office costs included In Worksheet A? 1.00 143.00 144.00 Are provider based physicians' costs included In Worksheet A? 1.00 2.00 1.44.00 145.00 If Starts or methodology changed from the previously filed cost repation N N 145.00 145.00 If Stas there a change in the start sticial basis? Enter "Y"	131.00 If this is a Medicare certified intestinal transplant c	enter, enter the c	erti fi cati on			131.00
133.00 f this is a Medicare certified ther transplant center, enter the certification date 133.00 133.00 f this is a norgan procurement organization (OPD), enter the OPD number in column 1 134.00 134.00/Are thermination date, if applicable, in column 2. 134.00 140.00/Are there any related organization or home office costs as defined in CMS Pub. 15-1, Y 158014 140.00 140.00/Are there any related organization, or home office costs as defined in CMS Pub. 15-1, I Y 158014 140.00 16 this fact lity is part of a chain organization, enter on lines 141 through 143 the name and address of the home office contractor name and contractor number. 3.00 141.00 141.00Name: FRANCISCAN ALLIANCE, INC. Contractor's Name: WPS Contractor's Number: 08101 141.00 142.00Stree provider based physicians' costs included in Worksheet A? Ine 74, are the costs for inpatient services N 145.00 144.00/Ha error wider based physicians' costs included in Worksheet A? Ine 74, are the costs for inpatient services N 145.00 144.00/Ha ther achage in the statistical basis? Enter 'Y' for yes or 'N' for no. N 146.00 142.00 144.00/Ha there achange in the statistical basis? Enter 'Y' for yes or 'N' for no. N 146.00 142.00 144.00/Ha there achange in the statistical basis? Enter 'Y	132.00 If this is a Medicare certified islet transplant center	, enter the certif	ication date			132.00
134.00 f this is an organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2. All Providers 134.00 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs Y 158014 140.00 150.00 Are there any related organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor number. 3.00 3.00 141.00Name: FRANCISCAN ALLIANCE, INC. Contractor's Name: WPS Contractor's Number: 08101 142.00 142.00Stree: 1515 DRAGODN TRAIL PO Box: 1290 Contractor's Number: 08101 142.00 144.00Are provider based physicians' costs included in Worksheet A? 1.00 Y Y 144.00 144.00Are provider based physicians' costs included in Worksheet A? 1.00 1.00 140.00 144.00Are provider based physicians' costs included in Worksheet A? 1.00 1.00 146.00 144.00Are provider based physicians' costs included in Worksheet A? 1.00 2.00 146.00 146.00Are provider based physicians' costs included in Worksheet A? 1.00 1.00 1.00 144.00Are provider based physicians' costs included in Worksheet A? 1.00 1.00 1.00	133.00 If this is a Medicare certified other transplant center	, enter the certif	ication date			133. 00
140.00Are there any related organization or home ofFice costs as defined in CMS Pub. 15-1. Chapter 10? Enter "V" for yes or "N" for no in column 1. If yes, and home ofFice costs Y 158014 140.00 are claimed, enter in column 2 the home ofFice chain number. (see instructions) 3.00 3.00 3.00 if this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home ofFice and enter the home ofFice contractor number. 3.00 141.00 141.00V.00Street: 1515 DRAG00N TRAIL Contractor's Name: WS Contractor's Number: 08101 141.00 143.00City: MISHAWAKA State: IN Zip Code: 46546-1290 143.00 144.00Are provider based physicians' costs included in Worksheet A? IN Y 144.00 Y 144.00 145.00 If costs for renal services are claimed on Worksheet A, Line 74, are the costs for inpatient services N 145.00 144.00DHas the cost allocation methodology changed from the previously filed cost report? N 146.00 2.00 1.00 2.00 146.00 N N 146.00 144.00DHas the cost allocation methodology changed from the previously filed cost report? N 146.00 146.00 2.00 1.00 2.00 1.00 146.	134.00 If this is an organ procurement organization (OPO), ent and termination date, if applicable, in column 2.		in column 1			134.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 141.00\Name: FRANCISCAN ALLIANCE, INC. Contractor's Name: WPS Contractor's Number: 08101 141.00 142.00\Street: 1515 DRAGON TRAIL PO Box: 1290 Contractor's Number: 08101 142.00 143.00\City: MISHAWAKA State: IN Zip Code: 46546-1290 143.00 144.00\Are provider based physicians' costs included in Worksheet A? Ino Y 144.00 145.00\If costs for renal services are claimed on Worksheet A? Ino Y 144.00 146.00\Has the cost allocation methodology changed from the previously filed cost report? N 145.00 146.00\Has there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 148.00 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 150.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	140.00 Are there any related organization or home office costs chapter 10? Enter "Y" for yes or "N" for no in column 1 are claimed, enter in column 2 the home office chain nu	. If yes, and home imber. (see instruc	office costs	5 · · · ·	158014	140. 00
141.00 Name: FRANCI SCAN ALLIANCE, INC. Contractor's Name: Contractor's Number: 08101 141.00 142.00 Strete: 1190 Box: 1290 142.00 143.00[City: MISHAWAKA State: IN Zip Code: 46546-1290 143.00 144.00 Are provider based physicians' costs included in Worksheet A? Inco Y 144.00 144.00 Are provider based physicians' costs included in Worksheet A? Inco Y 144.00 145.00 If costs for renal services are claimed on Worksheet A? Inco Y 144.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 145.00 146.00 Has there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 144.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N 144.00 149.00 N N N 149.00 149.00 No N N 144.00 149.00 <t< td=""><td>If this facility is part of a chain organization, enter</td><td>on lines 141 thro</td><td></td><td></td><td>of the</td><td></td></t<>	If this facility is part of a chain organization, enter	on lines 141 thro			of the	
143.00 City: MISHAWAKA State: IN Zip Code: 46546-1290 143.00 144.00 Are provider based physicians' costs included in Worksheet A? Image: Costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no. Y 144.00 145.00 If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no. Y 145.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 146.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 147.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N 149.00 149.00 149.00 2.00 3.00 4.00 49.00 149.00 0.00 2.00 3.00 4.00 149.00 N N N N 149	141.00 Name: FRANCISCAN ALLIANCE, INC. Contractor's Nam	ne: WPS		or's Number: 0810)1	
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145.00 If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services N 145.00 Indext and the cost allocation methodology changed from the previously filed cost report? N 1.00 2.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in colum 2. N 146.00 144.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N 149.00 149.00 100 2.00 3.00 4.00 4.00 100 2.00 3.00 4.00 4.00 155.00 Host facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 155.00 N N N N 155.00 155.00 Subprovider - IPF					1.00	
146.00 Has the cost all ocation methodol ogy changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00 147.00 147.00 was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N N 149.00 149.00 was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N N 149.00 149.00 no. N N 149.00 149.00 was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N N 149.00 149.00 no. N N N N 149.00 155.00 Hospital N N N N N N 149.00 155.00 Hospital N N N N N N N N N 155.00 156.00 Subprovid	145.00 If costs for renal services are claimed on Worksheet A,		costs for inp	atient services		
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.N147.00147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.N147.00148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.N148.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for NN149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N149.00149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N149.00149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N149.00149.00150.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N149.00149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N149.00149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N149.00149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N149.00149.00149.00 Was there a change to the simplified cost finding method?1002.003.004.00149.00 Was there a change to the simplified cost finding method?1.002.003.004.00149.00 Was there a change to the simplified cost finding method?1.001.001.001.00155.00 HospitalNNNN </td <td></td> <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td></td>				1.00	2.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.N147.00148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.N148.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for NN148.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for NN148.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N148.00148.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N149.00149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for NN149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for NNN149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" forNN149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" forNN149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for149.00149.00149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for149.00149.00155.00 HospitalNNNN155.00156.00 Subprovider - IPFNNNN158.00158.00 SubProvi DERNNNN158.00159.00 SNFNNNN160.00	Enter "Y" for yes or "N" for no in column 1. (See CMS F					146.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for N 149.00 Indext Constant of the simplified cost finding method? Enter "Y" for yes or "N" for Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 155.00 Hospital N N N 155.00 156.00 Subprovider - IPF N N N 156.00 158.00 Subprovider - IRF N N N 157.00 159.00 SNF N N N 159.00 160.00 HOME HEALTH AGENCY N N N N 161.00 CMHC N N N 161.00	147.00 Was there a change in the statistical basis? Enter "Y"	for yes or "N" for	no.			
Loc2.003.004.00Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)155.00 HospitalNNNN155.00156.00 Subprovider - IPFNNNN156.00157.00 Subprovider - IRFNNN157.00158.00 SUBPROVIDERNNN157.00159.00 SNFNNN159.00160.00 HOME HEALTH AGENCYNNN159.00161.00 CMHCNNN161.00	149.00 Was there a change to the simplified cost finding method					
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155.00 Hospital N N N 155.00 156.00 Subprovider - IPF N N N N 156.00 157.00 Subprovider - IRF N N N N 157.00 158.00 SUBPROVIDER N N N 157.00 159.00 SNF N N N 159.00 160.00 CMHC N N N 160.00		or an exemption fro	m the applica	ation of the lowe	er of costs	
157.00 Subprovider - IRF N N N 157.00 158.00 SUBPROVIDER N N 158.00 159.00 SNF N N N N 160.00 HOME HEALTH AGENCY N N N 160.00 161.00 CMHC N N N 161.00	155.00 Hospi tal	N	N	N	N	
159.00 SNF N N N N 159.00 160.00 HOME HEALTH AGENCY N N N 160.00 161.00 CMHC N N N 161.00	157.00 Subprovi der – IRF					157.00
161.00 CMHC N N 161.00		N	N	N	N	
		N	1			
			•			

Health Financial Systems	FRANCI SCAN ST.	ELI ZABETH	HEALTH - C	R		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	L.	Provider CC	CN: 15002		od: 01/01/2014 12/31/2014		epared:
							572772015 9.	
							1.00	
Multicampus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that ha	as one or	more campus	es in di	fferent	CBSAs?	N	165.00
	Name		ounty	State	Zip Co		FTE/Campus	
	0	1	. 00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10	under Section §1886(D5 is "Y") and is a me	(n)? Ente eaningful	er "Y" for ye	es or "N	l" for no	D.	1.00 Y	0 166. 00 167. 00 167. 00 0168. 00
reasonable cost incurred for the H								
169.00 If this provider is a meaningful u transition factor. (see instruction) and is r	not a CAH (li	ine 105	is "N"),			5169.00
					_	Begi nni ng	Endi ng	
						1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy)	beginning date and end	ding date	for the rep	orting		01/01/2014	12/31/2014	170.00
							1.00	174.05
171.00 If line 167 is "Y", does this prov	ider have any days fo	or individ	iuals enrolle	ed in se	ection 18	376	N	171.00

171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)

FRANCI SCAN ST. ELI ZABETH HEALTH - CR

		CISCAN ST. ELIZABETH			<u>In L</u> ie	u of Form CMS	-2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 150022	Period: From 01/01/2014 To 12/31/2014		epared:
		i			Y/N	Date	
					1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for	all NO re	esponses. Ente	er all dates in t	the	_
	Provider Organization and Operation Has the provider changed ownership immediatel	ly prior to the boai	nning of	the cost	N		1.00
. 00	reporting period? If yes, enter the date of t						1.00
			21 (000	Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.			N			2.00
. 00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions)	., chain home office d to the provider or l, or members of the	es, drug its board	N			3. 00
				Y/N	Туре	Date	
				1.00	2.00	3.00	
	Financial 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	Audited, "C" for Co enter date availabl ructions.	mpiled, e in	Y	A	04/24/2015	4.00
5.00	Are the cost report total expenses and total			N			5.00
	those on the filed financial statements? If y	yes, submit reconcin	ration.		Y/N	Legal Oper.	
					1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ool?Column 2: If y	ves, is th	ne provider is			6. 00
	the legal operator of the program? Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog			during the	N N		7.00 8.00
9. 00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program yes, see instructions.		irrent cos	st report? If	N		9.00
0. 00	Was an Intern-Resident program been initiated period? If yes, see instructions.				g N		10. 00
1.00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		in an App	proved	N	Y/N	11.00
						1.00	
	Bad Debts						
2.00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy.	d debts? If yes, see bt collection policy	e instruct change c	ions. Huring this co	ost reporting	Y N	12.00 13.00
4.00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments w	aived? If	°yes, see ins	structions.	Ν	14.00
15.00	Did total beds available change from the pric	or cost reporting pe	riod?lf	yes, see inst	tructions.	N	15.00
					art A	Part B	
		Description	1	Y/N	Date	Y/N	
	PS&R Data	0		1.00	2.00	3.00	_
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see			N		N	16.00
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			Y	04/22/2014	Ν	17.00
8. 00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional			N		Ν	18.00
	claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments			N		Ν	19.00
9. 00	made to PS&R Report information? If yes, see						

Heal th	Financial Systems FRANC	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		eriod:	Worksheet S-2	
					rom 01/01/2014 o 12/31/2014	Part II Date/Time Pre	pared:
						5/27/2015 9:3	
					rt A	Part B	
			iption	Y/N	Date	Y/N	
21 00	Was the cost report prepared only using the	(0	1.00 N	2.00	3.00 N	21.00
21.00	provider's records? If yes, see instructions.			IN IN		N	21.00
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			-
22.00	Capital Related Cost Have assets been relifed for Medicare purpose	as2 If yes see	ainstructions			N	22.00
	Have changes occurred in the Medicare depreci			als made durin	a the cost	N	23.00
20.00	reporting period? If yes, see instructions.	att off onpolice	ado to appraio		g the boot		20100
24.00	Were new leases and/or amendments to existing If yes, see instructions	g leases entere	ed into during	this cost repo	rting period?	Ν	24.00
25.00	Have there been new capitalized leases entere instructions.	ed into during	the cost repor	ting period? I	f yes, see	Ν	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquinstructions.	uired during th	ne cost reporti	ng period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy char copy.	nged during the	e cost reportin	ng period?lfy	es, submit	Ν	27.00
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit er	ntered into dur	ing the cost r	eporti ng	Ν	28.00
29.00	Did the provider have a funded depreciation a treated as a funded depreciation account? If			bt Service Res	erve Fund)	Y	29.00
30.00	Has existing debt been replaced prior to its instructions.	scheduled matu	urity with new	debt? If yes,	see	Ν	30.00
31.00	Has debt been recalled before scheduled matur instructions.	rity without is	ssuance of new	debt? If yes,	see	Ν	31.00
	Purchased Servi ces						
32.00	Have changes or new agreements occurred in pa			d through cont	ractual	Ν	32.00
33.00	arrangements with suppliers of services? If y If line 32 is yes, were the requirements of S no, see instructions.			g to competiti	ve bidding? If	Ν	33.00
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili	ty under an ar	rrangement with	provi der-base	d physi ci ans?	Y	34.00
	If yes, see instructions.						
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			its with the pr	ovi der-based	Ν	35.00
					Y/N	Date	
	Home Office Costs				1.00	2.00	
36.00	Were home office costs claimed on the cost re	eport?			Y		36.00
	If line 36 is yes, has a home office cost sta If yes, see instructions.		repared by the	home office?	Ý		37.00
38.00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the 1				Ν		38.00
39.00	If line 36 is yes, did the provider render se see instructions.				Ν		39.00
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lfyes, see	Ν		40.00
	instructions.						
			1.	00	2.	00	-
	Cost Report Preparer Contact Information		b				
41.00	Enter the first name, last name and the title held by the cost report preparer in columns	•	DAVI D		OSTHEI MER		41.00
42.00	respectively. Enter the employer/company name of the cost r preparer.	report	FSEH - CRAWFOR	DSVI LLE			42.00
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv		765-428-5925		DAVI D. OSTHEI MER	R@FRANCI SCANAL	43.00
		5	1			'	

	Financial Systems FRANC		BETH HEALTH - CR Provider CCN: 150022		of Form CMS-2552 orksheet S-2
		511 Oliver HE		From 01/01/2014 Pa	art II
					ate/Time Prepare /27/2015 9:37 am
		Part B			2772013 7.37 am
		Date			
		4.00			
	PS&R Data				
5.00	Was the cost report prepared using the PS&R				16.
	Report only? If either column 1 or 3 is yes,				
	enter the paid-through date of the PS&R				
	Report used in columns 2 and 4 . (see				
	instructions)				
7.00	Was the cost report prepared using the PS&R	04/22/2014			17.
	Report for totals and the provider's records				
	for allocation? If either column 1 or 3 is				
	yes, enter the paid-through date in columns				
	2 and 4. (see instructions)				
3. 00	If line 16 or 17 is yes, were adjustments				18.
	made to PS&R Report data for additional				
	claims that have been billed but are not				
	included on the PS&R Report used to file				
	this cost report? If yes, see instructions.				
9 00	If line 16 or 17 is yes, were adjustments				19.
	made to PS&R Report data for corrections of				' '.
	other PS&R Report information? If yes, see				
	instructions.				
	If line 16 or 17 is yes, were adjustments				20.
5.00	made to PS&R Report data for Other? Describe				20.
	the other adjustments:				
1 00	Was the cost report prepared only using the				21.
1.00	provider's records? If yes, see				21.
	instructions.				
		_	3.00		
	Cost Report Preparer Contact Information	I			
	Enter the first name, last name and the title	e/position D	IRECTOR OF ACCOUNTING		41.
	held by the cost report preparer in columns 1				
	respectively.	, _,			
2.00	Enter the employer/company name of the cost r	report			42.
	preparer.				12.
3 00	Enter the telephone number and email address	of the cost			43.
	report preparer in columns 1 and 2, respectiv				40.

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Pr	rovi der	CCN: 150022		eriod: fom 01/01/2014 o 12/31/2014	Worksheet S-3 Part I Date/Time Pre 5/27/2015 9:3	pare
								I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of	F Beds	Bed Days Avai I abl e		CAH Hours	Title V	
		1.00	2.		3.00		4.00	5.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00		25	9, 12	25	0.00	0	1
00 00	HMO I PF Subprovi der HMO I RF Subprovi der								3
00	Hospital Adults & Peds. Swing Bed SNF							0	5
00 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			25	9, 12	25	0.00	0	6
	beds) (see instructions)	21.00						0	
00 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31. 00 32. 00		6 0		90	0.00 0.00	0	
. 00	BURN INTENSIVE CARE UNIT	32.00		0		0	0.00	0	10
00	SURGICAL INTENSIVE CARE UNIT	34.00		0		0	0.00	0	1
00	OTHER SPECIAL CARE (SPECIFY)	34.00		0		0	0.00	0	
00	NURSERY	43.00						0	1:
00	Total (see instructions)	43.00		31	11, 31	15	0, 00	0	
00	CAH visits			51	11, 5	13	0.00	0	1
00	SUBPROVIDER - IPF	40.00		11	4, 01	15		0	1
00	SUBPROVI DER – I RF	41.00		0		0		0	1
00	SUBPROVIDER	42.00		0		0		0	1
00	SKILLED NURSING FACILITY	44.00		0		0		0	1
00	NURSING FACILITY	45.00		0		0		0	2
01	I CF/MR	45.01		0		0	0.00	0	2
00	OTHER LONG TERM CARE	46.00		0		0			2
00	HOME HEALTH AGENCY								22
00	AMBULATORY SURGICAL CENTER (D. P.)	115.00							2
00	HOSPI CE	116.00		0		0			2
10	HOSPICE (non-distinct part)	30.00							2
00	CMHC - CMHC								2
10	CMHC - CORF	99.10						0	2
00	RURAL HEALTH CLINIC	88.00						0	2
25	FEDERALLY QUALIFIED HEALTH CENTER	89.00		40				0	2
00 00	Total (sum of lines 14-26)			42				0	2
00	Observation Bed Days Ambulance Trips							0	20
00	Employee discount days (see instruction)								30
. 00	Employee discount days (see fistraction) Employee discount days - IRF								3
. 00	Labor & delivery days (see instructions)			0		0			32
. 00	Total ancillary labor & delivery room			0		U			32
. 01	LTCH non-covered days								33

iospi 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	1	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part I Date/Time Pre 5/27/2015 9:3	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	
I. 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)	2, 006	180	3, 18	3		1.00
2.00	HMO and other (see instructions)	443	0				2.00
3.00	HMO IPF Subprovider	137	0				3.00
1.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		C		5.00
5.00	Hospital Adults & Peds. Swing Bed NF		0		C		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 006	180				7.00
3.00	INTENSIVE CARE UNIT	226	43	403	3		8.00
9.00	CORONARY CARE UNI T	0	0	(C		9.00
0.00	BURN INTENSIVE CARE UNIT	0	0		C		10.00
1.00	SURGI CAL I NTENSI VE CARE UNI T	0	0		C		11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY		0	(C		13.00
4.00	Total (see instructions)	2, 232	223	3, 58	6 0.00	175.31	14.00
5.00	CAH visits	0	0	(C		15.00
6.00	SUBPROVIDER - IPF	1, 473	6	1, 70	9 0.00	10. 20	16.0
7.00	SUBPROVIDER - IRF	0	0	(0.00	0.00	17.0
8.00	SUBPROVI DER	0	0	(0.00	0.00	18.0
9.00	SKILLED NURSING FACILITY	0	0	(0.00	0.00	19.0
0.00	NURSING FACILITY		0	(0.00	0.00	20.0
0. 01	I CF/MR	0	0	(0.00	0.00	20.0
1.00	OTHER LONG TERM CARE			(0.00	0.00	21.0
2.00	HOME HEALTH AGENCY			1			22.0
3. 00	AMBULATORY SURGICAL CENTER (D. P.)			1	0.00	0.00	23.0
4.00	HOSPI CE	0	0	(0.00	0.00	24.0
4. 10	HOSPICE (non-distinct part)	0	0	(C		24.1
5.00	CMHC - CMHC						25.0
5.10	CMHC - CORF	0	0	(0.00	0.00	25.1
6.00	RURAL HEALTH CLINIC	0	0	(0.00	0.00	26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	0.00	26.2
7.00	Total (sum of lines 14-26)				0.00	185. 51	27.0
8.00	Observation Bed Days		85	80	7		28.0
9.00	Ambulance Trips	0					29.0
0.00	Employee discount days (see instruction)	-			D		30. C
1.00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	o	0		0		32.0
2.00	Total ancillary labor & delivery room outpatient days (see instructions)	Ŭ	0				32.0
2 00	LTCH non-covered days	о					33.0

HOSPI T.	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	AL DATA	Provi der	CCN: 150022	Period: From 01/01/2014 To 12/31/2014		pared
		Full Time		Di se	charges		
	Component	Equi val ents 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	65	53 59	1, 020	1. (
2.00	HMO and other (see instructions)			11	4 0		2.
. 00	HMO I PF Subprovider						3.
1.00	HMO I RF Subprovider						4.
5.00	Hospital Adults & Peds. Swing Bed SNF						5.
5.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						6. 7.
. 00	INTENSIVE CARE UNIT						8.
. 00	CORONARY CARE UNIT						9.
0.00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY						13.
4.00	Total (see instructions)	0.00	0	65	53 59	1, 020	
5.00	CAH visits						15.
6.00	SUBPROVIDER - IPF	0.00	0		1	145	
7.00	SUBPROVIDER - IRF	0.00	0		0 0	0	17.
8.00	SUBPROVIDER	0.00	0		0 0	0	18.
9.00 0.00	SKILLED NURSING FACILITY	0.00					19. 20.
D. 00 D. 01	NURSING FACILITY	0. 00 0. 00	0		0 0	0	20.
1.00	ICF/MR OTHER LONG TERM CARE	0.00	0		0 0	0	20.
2.00	HOME HEALTH AGENCY	0.00				0	21.
3.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					22.
4.00	HOSPICE	0.00					23.
4.10	HOSPICE (non-distinct part)	0.00					24.
5.00	CMHC - CMHC						25.
5. 10	CMHC - CORF	0, 00					25.
6.00	RURAL HEALTH CLINIC	0.00					26.
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.
7.00	Total (sum of lines 14-26)	0.00					27.
3. 00	Observation Bed Days						28.
9.00	Ambul ance Tri ps						29.
0. 00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF						31.
2.00	Labor & delivery days (see instructions)						32.
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32.
3.00	LTCH non-covered days						33.

FRANCI SCAN	ST.	ELI ZABETH	HEALTH	-	CR

2.0 Instructions) Instructions) 0 0.00 <th></th> <th>Financial Systems</th> <th>FRANC</th> <th>ISCAN ST. ELIZ</th> <th>ZABETH HEALTH -</th> <th></th> <th></th> <th>u of Form CMS-2</th> <th>2552-10</th>		Financial Systems	FRANC	ISCAN ST. ELIZ	ZABETH HEALTH -			u of Form CMS-2	2552-10
Non-there Monetal Properties In cart in Market Stater in the Market Stater in State in Stater in Stater in Stater in Stater in Stater in Stater in State in Stater in State in St	HOSPI T	AL WAGE INDEX INFORMATION			Provi der	F	rom 01/01/2014	Part II Date/Time Pre	pared:
Image: Determinant of the section of the sectin of the section of the section of the section of the sec					on of Salaries (from	Salaries (col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷	
Subtract S Subtrac			1.00	2.00	/			6.00	
1.00 Intal static less (see 200.00 9.193,889 0 9.193,889 364.8/P.00 25.2 1.0 2.00 Man physic lan anesthetist Part B. 0 0 0 0.00									-
2.0 Instructions) Instructions) 0 0.00 <td>1 00</td> <td></td> <td>200_00</td> <td>0 103 580</td> <td></td> <td>0 103 580</td> <td>364 639 00</td> <td>25.21</td> <td>1.00</td>	1 00		200_00	0 103 580		0 103 580	364 639 00	25.21	1.00
3.0.0 An-prysicilan anesthetist Part Administrative Admi	1.00		200.00	7, 175, 507		, 173, 307	304, 037. 00	20.21	1.00
4.00 Physician-Part A - Administrative 0 0 0.00 <t< td=""><td>2.00</td><td>Non-physician anesthetist Part</td><td></td><td>C</td><td>0</td><td>C</td><td>0.00</td><td>0.00</td><td>2.00</td></t<>	2.00	Non-physician anesthetist Part		C	0	C	0.00	0.00	2.00
4.00 Physician-Part A - Administrative 0 0 0.00 <t< td=""><td>3 00</td><td>A Non-physician anesthetist Part</td><td></td><td>C</td><td>0</td><td></td><td>0.00</td><td>0.00</td><td>3 00</td></t<>	3 00	A Non-physician anesthetist Part		C	0		0.00	0.00	3 00
Adding strative Adding str	3.00	B		Ĺ			0.00	0.00	3.00
4.01 Physic Lam Part & - Teaching 0 0 0 0.0	4.00			C	0	C	0.00	0.00	4.00
5.00 Physic lan-Part B 0 0 0.000	4 01			C			0.00	0.00	1 01
6.00 Mon-physiclan-Part 6 0 0 0.00									•
approved program) residents (in an approved program) presidents (in an approved program) president (in an		3		C	0	C			•
7.01 Contracted inferens and programs) 0 0 0 0.00 0	7.00		21.00	C	0	C	0.00	0.00	7.00
residents (in an approved progras) residents (in appr	7 01			C	0		0.00	0.00	7.01
8.00 blow Itom office personnel 0 blow 0	7.01			C C			0.00	0.00	1 7.01
9.00 SNF 44.00 0 0 0 0.00 <td></td> <td>1 5 /</td> <td></td> <td></td> <td>_</td> <td></td> <td></td> <td></td> <td></td>		1 5 /			_				
10. 00 Excluded area salaries (see 655, 419 0 655, 419 23, 137, 00 28, 33 10. 0 Other MACES & RELATED 00STS			44.00	0					
OTHER WAGES & RELATED COSTS O State Stat		-	44.00	655, 419	0	655, 419			
11.00 Contract Labor: Direct Patient Care 53,251 0 53,251 348.00 153.02 11.0 12.00 Contract Labor: Top Level management and dafin Istrative services 0 0 0 0 0.00		instructions)							
Care Care <th< td=""><td>11 00</td><td></td><td></td><td>E2 251</td><td>0</td><td>52 251</td><td>249.00</td><td>152.02</td><td>1 1 1 00</td></th<>	11 00			E2 251	0	52 251	249.00	152.02	1 1 1 00
management and other management and other management and other management and other 13. 00 Contract 1 abor: Physician Part A 53, 251 0 53, 251 348.00 153.02 13.02 14. 00 Home Office salaries & 1, 823, 067 0 1, 823, 067 39, 700.00 45.92 14.0 15. 00 Office and Contract 0 0 0 0.00 0.00 16.0 16. 00 Home Office and Contract 0 0 0 0.00 0.00 16.0 17. 00 Home Office and Contract 0 0 0 0 0.00	11.00			55, 251	0	55, 251	346.00	155.02	
nanagement and administrative services nanagement and administrative Contract labor: Physician-Part A - Administrative 53,251 0 53,251 348.00 153.02 13.00 14.00 Home office salaries & wage-related costs 1,823,067 0 1,823,067 39,700.00 45.92 14.0 15.00 Home office: Physician Part A - Administrative 0 0 0 0.00 0.00 0.00 16.00 16.00 Home office: and Contract 0 0 0 0 0.00 0.00 0.00 16.00 17.00 Wage-related costs (core) (see instructions) 4,713,776 4,713,776 17.0 17.0 18.00 10.00 Excluded areas 325,430 0 325,430 19.00 20.00 21.00 Non-physician anesthetist Part Administrative 0 0 0 20.00 20.00 22.00 22.00 Physician Part A 0 0 0 20.00 22.00 20.00 22.00 20.00 22.00 20.00 20.00 20.00 <td< td=""><td>12.00</td><td></td><td></td><td>C</td><td>0</td><td>c</td><td>0.00</td><td>0.00</td><td>12.00</td></td<>	12.00			C	0	c	0.00	0.00	12.00
services services services same same <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
13.00 Contract labor: Physician-Part A 53.251 0 53.251 348.00 153.02 13.0 14.00 Home office salaries & 1,823.067 0 1,823.067 39,700.00 45.92 14.0 15.00 Home office: Physician Part A 0 0 0 0.00									
14.00 Home office salaries & model of the second secon	13.00			53, 251	0	53, 251	348.00	153.02	13.00
wage-related costs o	4.4.00			4 000 0/-		1 000 0/7	00 700 00	45.00	11.00
15.00 Home office: Physician Part A 0 0 0 0.00 0.00 0.00 15.0 16.00 Home office and Contract 0 0 0 0.00 0.00 0.00 16.00 Physicians Part A - Teaching -	14.00			1, 823, 067	0	1, 823, 067	39, 700. 00	45.92	14.00
16.00 Home offices and Contract PNOE-RELATED COSTS 0 0 0.00 0.00 0.00 0.00 16.0 WAGE-RELATED COSTS	15.00			C	o	C	0.00	0.00	15.00
Physicians Part A - Teaching - - - - Wage-related costs (core) (see instructions) 4,713,776 0 4,713,776 17.00 18.00 Wage-related costs (other) (see instructions) 0 0 0 18.00 19.00 Excluded areas 325,430 0 325,430 19.00 20.00 Non-physician anesthetist Part A 0 0 0 0 20.00 21.00 Non-physician Part A - A 0 0 0 0 22.00 22.01 Physician Part A - Administrative 0 0 0 0 23.00 23.00 Physician Part B 0 0 0 23.00 23.00 24.00 Wage-related costs (RHC/FOHC) 0 0 0 23.00 25.00 Interns & residents (in an approved program) 0 0 0 0 0 27.00 28.00 Admin istrative & General 5.00 1,038,677 0 1,038,677 0 0.00 0.00									
WAGE-RELATED COSTS WAGE-related costs (core) (see instructions) 4,713,776 0 4,713,776 0 4,713,776 17.0 18.00 Wage-related costs (other) (see related costs (other) 0 0 0 0 0 18.0 19.00 Excluded areas 325,430 0 325,430 0 20.0 20.00 Non-physician anesthetist Part A 0 0 0 0 20.0 21.00 Physician Part A - Administrative 0 0 0 0 22.00 22.01 Physician Part A - Teaching 0 0 0 22.00	16.00			Ĺ	0		0.00	0.00	16.00
instructions) instructions instructions instructions 18.00 Wage-related costs (other) (see instructions) 0 0 0 0 0 0 0 0 0 18.00 (see instructions) 19.00 Excluded areas 325,430 0 325,430 19.00 0						I			1
18.00 Wage-related costs (other) (see instructions) 0 0 0 0 18.00 19.00 Excluded areas 325,430 325,430 325,430 19.00 20.00 Non-physician anesthetist Part A 0 0 0 0 20.00 19.00 22.00 10.00 20.	17.00			4, 713, 776	0	4, 713, 776			17.00
(see instructions) 325,430 325,430 325,430 325,430 325,430 325,430 19.00 20.00 Non-physician anesthetist Part A 0 0 0 0 0 20.00	18 00			ſ					18.00
20.00 Non-physician anesthetist Part A 0 0 0 0 0 0 20.00	10.00								
A O				325, 430	0				19.00
B C	20.00	Non-physician anesthetist Part		C	0	C			20.00
Admin is strative Admin is strative 22.01 Physic ian Part A - Teaching 0 0 0 22.01 21.00 Physic ian Part B 0 0 0 0 23.02 Physic ian Part B 0 0 0 23.02 24.00 Wage-related costs (RHC/FQHC) 0 0 0 0 0 24.00 24.00 24.00 24.00 24.00 0 0 0 0 0 0 0 24.00 24.00 24.00 24.00 0 0 0 0 0 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 27.00 24.10 27.00 24.10 27.00 28.00 27.00 28.00 27.00 23.15 30.00 29.00 20.00 20.00 20.00	21.00	Non-physician anesthetist Part		C	0	C			21.00
Admin is strative Admin is strative 22.01 Physic ian Part A - Teaching 0 0 0 22.01 21.00 Physic ian Part B 0 0 0 0 23.02 Physic ian Part B 0 0 0 23.02 24.00 Wage-related costs (RHC/FQHC) 0 0 0 0 0 24.00 24.00 24.00 24.00 24.00 0 0 0 0 0 0 0 24.00 24.00 24.00 24.00 0 0 0 0 0 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 27.00 24.10 27.00 24.10 27.00 28.00 27.00 28.00 27.00 23.15 30.00 29.00 20.00 20.00 20.00	~~ ~~	B							
22.01 Physician Part A - Teaching 0 0 0 0 0 22.02 23.00 Physician Part B 0 0 0 0 0 23.02 24.00 Wage-related costs (RHC/FOHC) 0 0 0 0 23.02 24.00 Interns & residents (in an approved program) 0 0 0 0 25.00 OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 0 0 0 0.00 0.00 25.00 27.00 Administrative & General 5.00 1,038,677 0 1,038,677 58,294.00 17.82 27.02 28.00 Administrative & General under contract (see inst.) 0 0 0 0 0.00 23.02 29.00 Uaundry & Linen Service 8.00 91,570 9175,892 7,597.00 23.15 30.02 31.00 Laundry & Linen Service 8.00 91,570 0 91,570 6,582.00 13.59 34.02 33.00 Dietary 10.00 248,970 -111,921	22.00			C	0	C			22.00
23.00 Physician Part B 0 0 0 23.00 24.00 Wage-related costs (RHC/FQHC) 0 0 0 0 24.00 25.00 Interns & residents (in an approved program) 0 0 0 0 25.00 0 OVERHEAD COSTS - DIRECT SALARIES 0 0 0 0 0.00 26.00 26.00 Employee Benefits Department 4.00 0 0 0 0.00 0.00 26.00 28.00 Administrative & General under contract (see inst.) 0 0 0 0.00 0.00 28.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 23.00 29.00 Maintenance & Repairs 6.00 0 0 0.00 0.00 23.15 30.00 100 Departion of Plant 7.00 175,892 7,597.00 23.15 30.00 30.00 Housekeeping 9.00 0 0 0.00 0.00 30.00 30.00 Housekeeping under contract 0 0 0 0.00 <	22. 01			C	o	c)		22.01
25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 25.00 approved program) 26.00 Contract (see lenst : Department is the sequence of the s				C	0	, s			23.00
approved program) All				0					
26.00 Employee Benefits Department 4.00 0 0 0 0.00 0.00 26.00 27.00 Administrative & General 5.00 1,038,677 0 1,038,677 58,294.00 17.82 27.00 28.00 Administrative & General under contract (see inst.) 0 0 0 0 0.00 0.00 28.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 28.00 30.00 Operation of Plant 7.00 175,892 0 175,892 7,597.00 23.15 30.00 31.00 Laundry & Linen Service 8.00 91,570 0 91,570 6,582.00 13.91 31.00 2.00 Housekeeping 9.00 0 0 0 0 0.00 0.00 32.00 Housekeeping 9.00 0 0 0 0 0.00 0.00 33.00 34.00 Dietary 10.00 248,970 -111,921 <td< td=""><td>23.00</td><td></td><td></td><td>C</td><td></td><td></td><td>, </td><td></td><td>25.00</td></td<>	23.00			C			, 		25.00
27.00 Admini strative & General under contract (see inst.) 5.00 1,038,677 0 1,038,677 58,294.00 17.82 27.00 28.00 Admini strative & General under contract (see inst.) 0 0 0 0 0 0.00 28.00 0							1		1
28.00 Administrative & General under contract (see inst.) 0 0 0 0.00 0.00 28.0 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 29.00 30.00 Operation of Plant 7.00 175,892 0 175,892 7,597.00 23.15 30.0 31.00 Laundry & Linen Service 8.00 91,570 0 91,570 6,582.00 13.91 31.0 32.00 Housekeeping 9.00 0 0 0 0.00 0.00 32.0 33.00 Housekeeping 10.00 248,970 -111,921 137,049 10,084.00 13.59 34.00 35.00 Dietary 10.00 248,970 -111,921 137,049 10,084.00 13.59 34.00 36.00 Cafeteria 11.00 0 111,921 137,049 0.00 0.00 0.00 0.00 35.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00				-					•
contract (see inst.) contract (see instructions) contral services and Supply contract (s			5.00	1, 036, 077		1, 030, 077			
30.00 Operation of Plant 7.00 175,892 0 175,892 7,597.00 23.15 30.0 31.00 Laundry & Linen Service 8.00 91,570 0 91,570 6,582.00 13.91 31.0 32.00 Housekeeping 9.00 0 0 0 0 0.00 32.0 33.00 Housekeeping 9.00 0 0 0 0 0.00 32.0 34.00 Dietary 10.00 248,970 -111,921 137,049 10,084.00 13.59 34.0 35.00 Dietary under contract (see instructions) 0 0 0 0 0.00 35.00 36.00 Cafeteria 11.00 0 111,921 111,921 8,679.00 12.90 36.00 37.00 Maintenance of Personnel 12.00 0 0 0.00 0.00 37.00 38.00 Nursing Administration 13.00 5,512 0 5,512 230.00 23.97 38.00 39.00 Central Services and Supply 14.00 83,724		contract (see inst.)		-		_			
31.00 Laundry & Linen Service 8.00 91,570 0 91,570 6,582.00 13.91 31.00 32.00 Housekeeping 9.00 0 0 0 0.00 0.00 32.00 33.00 Housekeeping under contract (see instructions) 0 0 0 0 0.00 33.00 34.00 Dietary 10.00 248,970 -111,921 137,049 10,084.00 13.59 34.00 35.00 Dietary under contract (see instructions) 0 0 0 0 0.00 0.00 35.00 36.00 Cafeteria 11.00 0 111,921 111,921 8,679.00 12.90 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 0.00 37.00 38.00 Nursing Administration 13.00 5,512 0 5,512 230.00 23.97 38.00 39.00 Central Services and Supply 14.00 83,724 0 83,724 6,290.00 13.31 39.00				175 000	0	0			
32.00 Housekeeping 9.00 0 0 0 0.00 32.00 33.00 Housekeeping under contract (see instructions) 0 0 0 0 0 0 0.00 33.00 34.00 Dietary 10.00 248,970 -111,921 137,049 10,084.00 13.59 34.00 35.00 Dietary under contract (see instructions) 0 0 0 0 0 0 35.00 0 0.000 35.00 34.00 35.00 0 0.000 0.00 35.00 34.00 0 0 0 0 0 0 0 0 35.00 34.00 35.00 34.00 35.00 35.00 0 0 0 0 0 0 0 35.00 35.00 35.00 35.00 35.00 35.00 36.00 35.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 0.00 35.00 37.00 38.00 38.00 Nursing Administration 13.00 5,512 0 5,512 230.00									
33.00 Housekeeping under contract (see instructions) 0 0 0 0.00 33.0 34.00 Dietary 10.00 248,970 -111,921 137,049 10,084.00 13.59 34.0 35.00 Dietary under contract (see instructions) 0 0 0 0 0.00 35.0 36.00 Cafeteria 11.00 0 111,921 111,921 8,679.00 12.90 36.0 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 5,512 0 5,512 230.00 23.97 38.0 39.00 Central Services and Supply 14.00 83,724 0 83,724 6,290.00 13.31 39.00				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	C			
34.00 Di etary 10.00 248,970 -111,921 137,049 10,084.00 13.59 34.0 35.00 Di etary under contract (see instructions) 0 0 0 0 0.00 35.0 36.00 Cafeteria 11.00 0 111,921 111,921 8,679.00 12.90 36.0 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 0.00 37.00 38.00 Nursing Administration 13.00 5,512 0 5,512 230.00 23.97 38.0 39.00 Central Services and Supply 14.00 83,724 0 83,724 6,290.00 13.31 39.00	33.00			C	0	C	0.00	0.00	33.00
35.00 Dietary under contract (see instructions) 0 0 0 0.00 35.00 36.00 Cafeteria 11.00 0 111,921 111,921 8,679.00 12.90 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 5,512 0 5,512 230.00 23.97 38.00 39.00 Central Services and Supply 14.00 83,724 0 83,724 6,290.00 13.31 39.00	34 00		10.00	210 070	_111_021	127 040	10 004 00	12 50	34 00
i nstructions)i nstructions)i nstructions)36.00Cafeteria11.000111,921111,9218,679.0012.9036.0037.00Maintenance of Personnel12.000000.000.0037.0038.00Nursing Administration13.005,51205,512230.0023.9738.0039.00Central Services and Supply14.0083,724083,7246,290.0013.3139.00			10.00	240, 9/(0	137,049			
37. 00 Maintenance of Personnel 12. 00 0 0 0.00 37. 00 38. 00 Nursing Administration 13. 00 5, 512 0 5, 512 230. 00 23. 97 38. 00 39. 00 Central Services and Supply 14. 00 83, 724 0 83, 724 6, 290. 00 13. 31 39. 00		instructions)		-		-			
38.00 Nursing Administration 13.00 5,512 0 5,512 230.00 23.97 38.00 39.00 Central Services and Supply 14.00 83,724 0 83,724 6,290.00 13.31 39.00				C	111, 921	111, 921			
39.00 Central Services and Supply 14.00 83,724 0 83,724 6,290.00 13.31 39.0				5 512		5 512			
40. 00 Pharmacy 15. 00 384, 483 0 384, 483 9, 213. 00 41. 73 40. 0							6, 290. 00	13. 31	
	40.00	Pharmacy	15.00	384, 483	8 0	384, 483	9, 213. 00	41.73	40.00

Health Financial Systems	eu of Form CMS-2	2552-10					
HOSPITAL WAGE INDEX INFORMATION			Provi der	Provider CCN: 150022 Pe		Worksheet S-3	
					From 01/01/2014		
					Го 12/31/2014	Date/Time Pre 5/27/2015 9:3	
	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	16.00	94, 656	0	94, 656	5, 121. 00	18.48	41.00
Records Library							
42.00 Social Service	17.00	C	0	(0.00	0.00	42.00
43.00 Other General Service	18.00	C	0	(0.00	0.00	43.00

Health Financial Systems FRANCISCAN ST. ELIZABETH HEALTH - CR In Lieu of Form CMS-2552-10								
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3		
					From 01/01/2014 To 12/31/2014		oared [.]	
						5/27/2015 9:3		
	Worksheet A		Recl assi fi cati	, J		Average Hourly		
	Line Number	Reported	on of Salaries			Wage (col. 4 ÷		
			(from	(col.2 ± col.		col. 5)		
			Worksheet A-6)		col. 4			
	1.00	2.00	3.00	4.00	5.00	6.00		
PART III - HOSPITAL WAGE INDE>	SUMMARY		1		- 1	-		
1.00 Net salaries (see		9, 193, 589	0	9, 193, 58	9 364, 639. 00	25. 21	1.00	
instructions)			-					
2.00 Excluded area salaries (see		655, 419	0	655, 41	9 23, 137. 00	28. 33	2.00	
instructions)			-					
3.00 Subtotal salaries (line 1		8, 538, 170	0	8, 538, 17	0 341, 502. 00	25.00	3.00	
minus line 2)		4 000 5/0		1 000 5/		47.77	4 00	
4.00 Subtotal other wages & related	2	1, 929, 569	0	1, 929, 56	9 40, 396. 00	47.77	4.00	
costs (see inst.)		4 740 77/		4 740 77		FF 04	F 00	
5.00 Subtotal wage-related costs		4, 713, 776	0	4, 713, 77	6 0.00	55. 21	5.00	
(see inst.)		15 101 515		15 101 51	E 201 000 00	20.75	4 00	
6.00 Total (sum of lines 3 thru 5)		15, 181, 515		15, 181, 51				
7.00 Total overhead cost (see		2, 123, 484	0	2, 123, 48	4 112, 090. 00	18.94	7.00	
instructions)	1				1			

	Financial Systems FRANCISCAN ST. ELIZA			In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provider C	CN: 150022	Peri od: From 01/01/2014 To 12/31/2014	Date/Time Prep 5/27/2015 9:3	oared:
					Amount	
					Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETIREMENT COST				-	
1.00	401K Employer Contributions				0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution				0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)				2, 831, 788	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)					
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan				0	6.00
7.00	Employee Managed Care Program Administration Fees				0	7.00
	HEALTH AND INSURANCE COST					
8.00	Health Insurance (Purchased or Self Funded)				979, 516	8.00
9.00	Prescription Drug Plan				0	9.00
10.00	Dental, Hearing and Vision Plan				63, 279	
11.00	Life Insurance (If employee is owner or beneficiary)				0	11. OC
12.00	Accident Insurance (If employee is owner or beneficiary)				0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)				17, 975	
14.00	Long-Term Care Insurance (If employee is owner or beneficiar	y)			432	14.OC
15.00	'Workers' Compensation Insurance				46, 231	15.00
16.00	Retirement Health Care Cost (Only current year, not the extr	aordi nary accr	ual require	ed by FASB 106.	0	16.00
	Non cumulative portion)					
	TAXES					
17.00	FICA-Employers Portion Only				1, 099, 985	17.00
18.00	Medicare Taxes - Employers Portion Only				0	18.00
19.00	Unemployment Insurance				0	19.00
20.00					0	20.00
	OTHER					
21.00	Executive Deferred Compensation (Other Than Retirement Cost instructions))	Reported on li	nes 1 throu	igh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances				0	22.00
23.00	Tuition Reimbursement				0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)				5, 039, 206	
	Part B - Other than Core Related Cost				., ,	
	OTHER WAGE RELATED COSTS (SPECIFY)				0	25.00

Heal th	Financial Systems	FRANCI SCAN ST. EL	IZABETH HEALTH - CR	In Lie	u of Form CMS-2	2552-10
HOSPI TA	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150022	Period:	Worksheet S-3	
				From 01/01/2014 To 12/31/2014	Part V	narodi
				10 12/31/2014	Date/Time Pre 5/27/2015 9:3	
	Cost Center Description			Contract Labor	Benefit Cost	
	· .			1.00	2.00	
	PART V - Contract Labor and Benefit Co	st				
	Hospital and Hospital-Based Component	I denti fi cati on:				
1.00	Total facility's contract labor and be	enefit cost		0	0	1.00
	Hospi tal			0	0	2.00
	Subprovider - IPF			0	0	3.00
	Subprovider - IRF			0	0	4.00
	Subprovider - (Other)			0	0	5.00
	Swing Beds - SNF			0	0	6.00
	Swing Beds - NF			0	0	7.00
	Hospital-Based SNF			0	0	0.00
	Hospital-Based NF			0	0	
	Hospital-Based NF			0	0	9.01
	Hospital-Based OLTC					10.00
	Hospital-Based HHA					11.00
	Separately Certified ASC			0	0	
	Hospital-Based Hospice			0	0	
	Hospital-Based Health Clinic RHC			0	0	
	Hospital-Based Health Clinic FQHC			0	0	
	Hospital-Based-CMHC					16.00
	Hospital-Based-CMHC 10			0	0	
	Renal Dialysis			0	0	
18.00	Other			0	0	18.00

Heal th	Financial Systems FRANCISCAN ST. ELIZABETH HEALTH -	CR	In Lie	eu of Form CMS-	2552-10
		CCN: 150022	Peri od:	Worksheet S-	
			From 01/01/2014		nored.
			To 12/31/2014	Date/Time Pro 5/27/2015 9:3	apareu: 37 am
				1.00	
	Uncompensated and indigent care cost computation			1	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by li	ne 202 columr	1 8)	0. 244904	1.00
0 00	Medicaid (see instructions for each line)			0.007.0(1 0 00
2.00 3.00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?			2, 237, 064 N	2.00
3.00 4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments	from Medicaid	2	IN IN	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			(
6.00	Medi cai d charges			14, 238, 114	
7.00	Medicaid cost (line 1 times line 6)			3, 486, 97	•
8.00	Difference between net revenue and costs for Medicaid program (line 7 min	nus sum of lir	es 2 and 5; if	1, 249, 907	8.00
	< zero then enter zero)				
	State Children's Health Insurance Program (SCHIP) (see instructions for e	ach line)		•	
9.00	Net revenue from stand-al one SCHIP			(
10.00	Stand-al one SCHIP charges			(
11.00	Stand-alone SCHIP cost (line 1 times line 10)			(
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 m enter zero)	inus ine 9;	IT < Zero then		12.00
	Other state or local government indigent care program (see instructions f	or each line)			1
13.00	Net revenue from state or local indigent care program (Not included on li			(13.00
14.00	Charges for patients covered under state or local indigent care program ((14.00
	10)				
15.00	State or local indigent care program cost (line 1 times line 14)			(
16.00	Difference between net revenue and costs for state or local indigent care	e program (lir	e 15 minus line	(16.00
	13; if < zero then enter zero)				-
17.00	Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding char	ity caro		(17.00
17.00	Government grants, appropriations or transfers for support of hospital op				
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent		s (sum of lines		
.,	8, 12 and 16)	our o program		1,21,,00	
		Uni nsured	Insured	Total (col. 1	
		patients	pati ents	+ col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full	8, 105, 84	13 0	8, 105, 843	20.00
21.00	charges excluding non-reimbursable cost centers) for the entire facility Cost of initial obligation of patients approved for charity care (line 1	1, 985, 15	53 O	1, 985, 153	21 00
21.00	times line 20)	1, 705, 10		1, 200, 100	21.00
22.00	Partial payment by patients approved for charity care		0 0		22.00
	Cost of charity care (line 21 minus line 22)	1, 985, 15	53 0	1, 985, 153	
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyo	ond a length o	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care program?				
25.00	If line 24 is "yes," charges for patient days beyond an indigent care pr		h of stay limit		
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2, 051, 855	
27.00 28.00	Medicare bad debts for the entire hospital complex (see instructions) Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minu	is line 27)		151, 325 1, 900, 530	
28.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 20 minute cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 20 minute cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 20 minute cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 20 minute cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 20 minute cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 20 minute cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 20 minute cost of non-Medicare bad debt expense (line 20 minute		28)	465, 447	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		. 20)	2, 450, 600	

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (TTOVIDEI	CCN: 150022 Pe	eriod: rom 01/01/2014 o 12/31/2014		
						5/27/2015 9:3	
	Cost Center Description	Sal ari es	Other	lotal (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		3, 545, 150 67, 569	3, 545, 150 67, 569	1, 171, 769	4, 716, 919 67, 569	1.00
00	00300 OTHER CAP REL COSTS		07, 309	07, 509	0	07, 509	3.00
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 793, 322	2, 793, 322	-78	2, 793, 244	4.00
00	00500 ADMINISTRATIVE & GENERAL	1, 038, 677	9, 483, 462	10, 522, 139	-1, 162, 123	9, 360, 016	
00 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 175, 892	0 1, 057, 527	0 1, 233, 419	0 -1, 789	0 1, 231, 630	6.00 7.00
00	00800 LAUNDRY & LINEN SERVICE	91, 570	38, 420	1, 233, 419	-633	1, 231, 830	8.00
00	00900 HOUSEKEEPI NG	0	501, 060	501, 060	-21, 713	479, 347	9.00
0. 00	01000 DI ETARY	248, 970	188, 216	437, 186	-199, 232	237, 954	
1.00	01100 CAFETERIA	0	0	0	196, 531	196, 531	11.00
2.00 3.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	5, 512	0 105, 890	111, 402	0 -532	0 110, 870	12.00 13.00
4.00	01400 CENTRAL SERVICES & SUPPLY	83, 724	88, 143	171, 867	-60, 585	111, 282	14.00
5.00	01500 PHARMACY	384, 483	795, 850	1, 180, 333	-728, 412	451, 921	15.00
5.00	01600 MEDI CAL RECORDS & LI BRARY	94, 656	44, 410	139, 066	0	139, 066	16.00
). 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 119, 701	68, 269	1, 187, 970	-55, 065	1, 132, 905	30.00
1.00	03100 I NTENSI VE CARE UNI T	435, 237	15, 497	450, 734	-9, 517	441, 217	31.00
2.00	03200 CORONARY CARE UNI T	0	0	0	0	0	32.00
3.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
4.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
D. 00 1. 00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	628, 488	250, 905	879, 393	-11, 803	867, 590 0	40.00
2.00	04200 SUBPROVI DER	0	0	0	0	0	41.00
3.00	04300 NURSERY	0	0	0	0	0	43.00
4.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
5.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
5.01 5.00	04510 I CF/MR 04600 OTHER LONG TERM CARE	0	0	0	0	0	45.01 46.00
5. 00	ANCI LLARY SERVICE COST CENTERS		0	0	0	0	40.00
0. 00	05000 OPERATI NG ROOM	1, 131, 843	2, 104, 680	3, 236, 523	-1, 532, 923	1, 703, 600	50.00
1.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
2.00 3.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	52.00 53.00
4.00	05400 RADI OLOGY -DI AGNOSTI C	1, 049, 578	549, 662	1, 599, 240	-76, 438	1, 522, 802	
4.01	05401 ULTRASOUND	53, 010	6, 285	59, 295	0	59, 295	
5.00	05500 RADI OLOGY-THERAPEUTI C	393, 124	4, 676, 337	5, 069, 461	-4, 095, 077	974, 384	55.00
5.00	05600 RADI OI SOTOPE	74, 238	156, 309	230, 547	-95, 208	135, 339	
7.00 3.00	05700 CT SCAN 05800 MRI	0	0	0	0	0	
9.00 9.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
0.00	06000 LABORATORY	0	2, 078, 542	2, 078, 542	0	2, 078, 542	60.00
D. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 0 ⁴
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	61.00
2.00 3.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62.00 63.00
4.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
5.00	06500 RESPI RATORY THERAPY	279, 072	80, 382	359, 454	-21, 755	337, 699	65.00
5.00	06600 PHYSI CAL THERAPY	441, 056	24, 629	465, 685	-6, 074	459, 611	66.00
7.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
3.00 9.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	156, 314	0 13, 803	0 170, 117	0 -9, 644	0 160, 473	68.00 69.00
9.00 D.00	07000 ELECTROCARDI OLOGI	0	13, 003	0	- 7, 044	160, 473	70.00
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1, 125, 679	1, 125, 679	
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	783, 771	783, 771	72.00
3.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	4, 916, 796	4, 916, 796	
4.00 5.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)		0	0	0	0	74.00
5.00	03020 ONCOLOGY	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS	· · ·					
3.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	120 004	0 1E 0/1	0 155 747	0 1 7 7 7 4	0 152 003	89.00
D. 00 1. 00	09000 CLINIC 09100 EMERGENCY	139, 906 1, 141, 607	15, 841 202, 105	155, 747 1, 343, 712	2, 754- 103, 035-	152, 993 1, 240, 677	90.00 91.00
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 141, 007	202, 103	1, 545, 712	103, 033	1, 240, 077	92.00
	OTHER REIMBURSABLE COST CENTERS	· · ·					1
9. 10	09910 CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS	0	0	0	0		109.00
$\sim \sim \sim$							

Health Financial Systems FRANC	CISCAN ST. ELIZA	BETH HEALTH -	CR	In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 9:3	pared: 7 am
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	
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0 C		111.00
113.00 11300 INTEREST EXPENSE		0	(0 0	0	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	(0 0	0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(0 0	0	115.00
116. 00 11600 HOSPI CE	0	0	(0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	9, 166, 658	28, 952, 265	38, 118, 92	3 156	38, 119, 079	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190. 00
191. 00 19100 RESEARCH	0	0	(0 0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	26, 931	109, 897	136, 82	B -156	136, 672	192.00
193.00 19300 NONPALD WORKERS	0	0	(0 0	0	193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0 0	0	194.00
194. 01 07951 SPORTS MEDI CI NE	0	0	(0 0	0	194.01
194.0207952 COMMUNITY IND HEALTH	0	0	(0 0	0	194. 02
200.00 TOTAL (SUM OF LINES 118-199)	9, 193, 589	29, 062, 162	38, 255, 75	1 0	38, 255, 751	200.00

	Financial Systems FRAM SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	ICI SCAN ST. ELIZ OF EXPENSES		CCN: 150022 Period: Workst	orm CMS-2552-1 neet A
				From 01/01/2014 To 12/31/2014 Date/1	Time Prepared:
	Cost Center Description	Adjustments	Net Expenses	5/27/2	2015 9:37 am
		(See A-8) 6.00	For Allocation 7.00	<u>1</u>	
	GENERAL SERVICE COST CENTERS	0.00	1 7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-656, 029			1.00
2.00 3.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS) 67,569		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	265, 951		-	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-3, 900, 697			5.00
6.00	00600 MAINTENANCE & REPAIRS	C			6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-26, 979	1/201/000		7.0
8.00 9.00	00900 HOUSEKEEPING	-20, 979	479, 347		9.0
10.00	01000 DI ETARY	-53, 773			10.0
11. 00	01100 CAFETERI A	-61, 955			11.0
12.00	01200 MAINTENANCE OF PERSONNEL	0		-	12.0
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	-83			13.0
15.00		6, 356			15.0
16.00		C	139,066		16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1 1 2 2 00	-	20.00
30.00 31.00					30.00
32.00		0			32.0
33.00	03300 BURN INTENSIVE CARE UNIT	C			33.0
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	017 007			34.0
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	-217, 927	649,663	3	40.0
42.00	04200 SUBPROVI DER				42.0
43.00		C			43.0
44.00		0		2	44.0
45.00 45.01	04500 NURSING FACILITY 04510 I CF/MR				45. 0 45. 0
46.00	04600 OTHER LONG TERM CARE				45.0
	ANCILLARY SERVICE COST CENTERS				
50.00		-445, 299			50.00
51.00 52.00					51.0 52.0
53.00					53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	-66, 108	1, 456, 694	1	54.0
54.01	05401 ULTRASOUND	C	59, 295		54.0
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C	-182, 308			55. 0 56. 0
57.00	05600 RADI 0I SOTOPE 05700 CT SCAN) 135, 339		57.0
58.00	05800 MRI	0			58.0
59.00		C			59.0
60. 00 60. 01		-5,043	2,073,499		60. 0 60. 0
61.00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				61.0
62.00		C			62.0
63.00		C			63. 0
64.00	06400 I NTRAVENOUS THERAPY			-	64.0
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY) 337, 699 459, 611		65. 0 66. 0
67.00		0			67.0
68.00		0		2	68.0
69.00 70.00		-1, 188	159, 285		69.0
70.00			1, 125, 679		70.0
72.00			783, 77		72.0
73.00		C	4, 916, 796	b	73.0
74.00 75.00	07400 RENAL DIALYSIS			2	74. 0 75. 0
76.00	07500 ASC (NON-DI STINCT PART) 03020 ONCOLOGY			-	75.0
	OUTPATIENT SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·	·	,0.0
88. 00	08800 RURAL HEALTH CLINIC	C		-	88. 0
89.00		0) (-	89.0
90.00 91.00		-13, 433) 152, 993 3 1, 227, 244		90. 0 91. 0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	-15,455	, , , , , , , , , , , , , , , , , , , ,		91.0
	OTHER REIMBURSABLE COST CENTERS				
99. 10	09910 CORF	C) (99.10
100 00	SPECIAL PURPOSE COST CENTERS	0		si	100.0
	D 11000 I NTESTI NAL ACQUI SI TI ON				109. 00 110. 00
111.00	11100 ISLET ACQUISITION				111.0
113.00	11300 INTEREST EXPENSE	C		D	113.00

Health Financial Systems FRANC	CISCAN ST. ELIZ	ABETH HEALTH - CR	In Lieu	」of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN:	Peri od:	Worksheet A
			From 01/01/2014 To 12/31/2014	Data /Tima Draparadi
			10 12/31/2014	Date/Time Prepared: 5/27/2015 9:37 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7.00		
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115.00
116. 00 11600 H0SPI CE	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-5, 358, 515	32, 760, 564		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191. 00 19100 RESEARCH	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	136, 672		192.00
193.00 19300 NONPALD WORKERS	0	0		193.00
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0		194.00
194. 01 07951 SPORTS MEDI CI NE	0	0		194. 01
194.0207952 COMMUNITY IND HEALTH	0	0		194. 02
200.00 TOTAL (SUM OF LINES 118-199)	-5, 358, 515	32, 897, 236		200.00

Health Financial Systems RECLASSIFICATIONS

FRANCI SCAN ST.	ELIZABETH HEALTH - CR	

In Lieu of Form CMS-2552-10 Provi der CCN: 150022 Period: From Worksheet A-6

				TTOVICET	From 01/01/2014	Data (Time Dranam
					 To 12/31/2014	Date/Time Prepare 5/27/2015 9:37 an
	Cost Center	lncreases Line #	Salary	Other		
	2.00	3.00	Salary 4.00	5.00		
Δ	A - CAPITAL	3.00	4.00	3.00	 	
	CAP REL COSTS-BLDG & FIXT	1.00	0	26, 499		1
		0.00	0	0		2
		0.00	0	0		3
		0.00	0	0		4
		0.00	0	0		5
		0.00	0	0		6
		0.00	0	0		7
		0.00	0	0		8
		0.00	0	0		9
00		0.00	0	0		10
00		0.00	0	0		11
00		0.00	0	0		12
00		0.00	0	0		13
Т	TOTALS			26, 499		
E	B - INTEREST EXPENSE					
0 0	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 145, 270		1
	TOTALS		0	1, 145, 270		
	C - DIETARY					
	CAFETERI A		11 <u>1, 9</u> 21	8 <u>4, 6</u> 10		1
	TOTALS		111, 921	84, 610	 	
	D - CHARGEABLE SUPPLIES					
	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 125, 679		1
	PATIENT					
		0.00	0	0		2
		0.00	0	0		3
		0.00	0	0		4
		0.00	0	0		5
		0.00	0	0		6
		0.00	0	0		7
		0.00	0	0		8
)		0.00	0	0		9
00		0.00	0	0		10
00		0.00	0	0		11
00		0.00	0	0		12
00		0.00	0	0		13
00		0.00	0	0		14
00		0.00	0	0		15
00		0.00	0	0		16
00		0.00	0	0		17
00		0.00	0	0		18
00		0.00	0	0		19
00		0.00	0	0		20
		0.00	0	0		21
-	TOTALS		U	1, 125, 679		
	E - DRUGS CHARGED TO PATIENTS	72 00	0	4, 916, 796		1
	DRUGS CHARGED TO PATIENTS	73.00 0.00	0	4, 910, 790		1
		0.00	0	0		3
		0.00	0	0		4
		0.00	0	0		5
		0.00	0	0		6
		0.00	0	0		7
		0.00	0	0		8
		0.00	0	0		9
		0.00	0	0		10
		0.00	0	0		11
		0.00	0	0		12
		0.00	0	0		13
		0.00	0	0		14
	TOTALS		— — — 0	4, 916, 796		
	F - IMPLANTABLE DEVICES		5	., , 10, 770		
	IMPL. DEV. CHARGED TO	72.00	0	783, 771		1
	PATIENTS	/2.00	5	,00,771		
b ľ		0.00	0	0		2
	TOTALS			783, 771		-
	Grand Total: Increases		111, 921	8, 082, 625		500

						From 01/01/2014 To 12/31/2014	Date/Time Prepared:
		Decreases					5/27/2015 9:37 am
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A – CAPITAL ADMINISTRATIVE & GENERAL	5.00	0	187	ç	1	1.0
2.00	OPERATION OF PLANT	7.00	0	1, 768	Ċ		2.0
3.00	DI ETARY	10.00	0	624	C)	3. 0
4.00	ADULTS & PEDIATRICS	30.00	0	1, 226	C		4.0
5.00	INTENSIVE CARE UNIT	31.00	0	59	C		5.0
6.00 7.00	SUBPROVIDER - IPF OPERATING ROOM	40.00 50.00	0	3, 754	C		6.0
8.00	RADI OLOGY-THERAPEUTI C	55.00	0	13, 207 395			8.0
9.00	RESPI RATORY THERAPY	65.00	0	632	C		9.0
10.00	PHYSICAL THERAPY	66.00	0	181	C		10. 0
11.00	ELECTROCARDI OLOGY	69.00	0	448	C		11. 0
12.00	CLINIC	90.00	0	7	C		12.0
13.00	EMERGENCY	<u>91.00</u>	0		<u>C</u>		13.0
	B - INTEREST EXPENSE		U	26, 499			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 145, 270	11		1.0
	TOTALS		o	1, 145, 270			
	C – DIETARY					1	
1.00	DI ETARY	<u>10.00</u>	-111,921	84,610	C	-	1.0
	TOTALS D - CHARGEABLE SUPPLIES		111, 921	84, 610			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	78	C		1.0
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	8, 327	C		2.0
3.00	OPERATION OF PLANT	7.00	0	21	C		3. 0
4.00	LAUNDRY & LINEN SERVICE	8.00	0	633	C		4.0
5.00	HOUSEKEEPING	9.00	0	21, 713	C		5.0
6.00 7.00	DI ETARY NURSI NG ADMI NI STRATI ON	10.00 13.00	0	2, 077 532	C		6.0
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	60, 461			8.0
9.00	PHARMACY	15.00	0	22, 147	C		9.0
10.00	ADULTS & PEDIATRICS	30.00	0	51, 698	C)	10. 0
11.00	INTENSIVE CARE UNIT	31.00	0	9, 286	C		11. 0
12.00	SUBPROVIDER - IPF	40.00	0	8, 032	C		12.0
13.00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	731, 398	C		13.0
14.00 15.00	RADI OLOGY-DI AGNOSTI C	55.00	0	66, 899 5, 317			14.0
16.00	RESPI RATORY THERAPY	65.00	0	21, 122	0		16.0
17.00	PHYSI CAL THERAPY	66.00	0	5, 861	C		17.0
18.00	ELECTROCARDI OLOGY	69.00	0	9, 137	C		18.0
19.00	CLINIC	90.00	0	2, 745	C		19.0
20.00		91.00	0	98, 039	C		20.0
21.00	PHYSICIANS' PRIVATE OFFICES TOTALS	<u> </u>	0	<u>156</u> 1, 125, 679		-	21.0
	E - DRUGS CHARGED TO PATIENTS	<u> </u>		1, 120, 077		1	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	8, 339	C		1.0
2.00	PHARMACY	15.00	0	706, 265	C		2.0
3.00	ADULTS & PEDIATRICS	30.00	0	2, 141	C		3.0
4.00 5.00		31.00	0	172			4.0
5.00 6.00	SUBPROVIDER - IPF OPERATING ROOM	40.00 50.00	0	17 4, 671			5.0
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	9, 539			7.0
8.00	RADI OLOGY-THERAPEUTI C	55.00	0	4,089,365	C		8.0
9.00	RADI OI SOTOPE	56.00	0	95, 208	C		9.0
10.00	RESPI RATORY THERAPY	65.00	0	1	C		10.0
11.00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00	0	32 59			11.0
12. 00 13. 00	CLINIC	69.00 90.00	0	59 2			12.0
14.00	EMERGENCY	90.00	0	985			14. 0
	TOTALS			4, 916, 796		1	
	F - IMPLANTABLE DEVICES					1	
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	124	C		1.0
2.00	OPERATING_ROOM	<u> </u>	0		<u> </u>	1	2.0
500.00	Grand Total: Decreases		111, 921	8, 082, 625		-	500.0
		· I		.,,	1	I	1

Heal th	Fi nanci al	Systems	
RECONC	LI ATLON C	E CAPITAL	COSTS C

Heal th	Financial Systems FRAN	CISCAN SI. ELIZ	ABEIH HEALIH -	CR		In Lie	eu of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150022	Perio	d: 01/01/2014	Worksheet A-7 Part I	
						12/31/2014		nared
					10	12/ 51/ 2014	5/27/2015 9:3	
			·	Acqui si ti or	าร			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	1, 000, 120	0		0	0	30, 000	1.00
2.00	Land Improvements	1, 656, 033	43, 560		0	43, 560	0	2.00
3.00	Buildings and Fixtures	29, 052, 933	1, 725, 949		0	1, 725, 949	0	3.00
4.00	Building Improvements	517, 681	0		0	0	0	4.00
5.00	Fixed Equipment	19, 623	0		0	0	0	5.00
6.00	Movable Equipment	25, 071, 297	0		0	0	5, 652, 805	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	57, 317, 687	1, 769, 509		0	1, 769, 509	5, 682, 805	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	57, 317, 687	1, 769, 509		0	1, 769, 509	5, 682, 805	10.00
		Endi ng Bal ance	Fully					
		_	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	970, 120	0					1.00
2.00	Land Improvements	1, 699, 593	0					2.00
3.00	Buildings and Fixtures	30, 778, 882	0					3.00
4.00	Building Improvements	517, 681	0					4.00
5.00	Fixed Equipment	19, 623	0					5.00
6.00	Movable Equipment	19, 418, 492	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	53, 404, 391	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	53, 404, 391	0					10.00
								•

Heal th	Financial Systems FRANC	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150022	Peri od:	Worksheet A-7	
					From 01/01/2014 To 12/31/2014		narod
					10 12/31/2014	5/27/2015 9:3	7 am
			SI	JMMARY OF CAP	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORE			ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	3, 545, 150	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	67, 569	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	3, 612, 719	C)	0 0	0	3.00
		SUMMARY C	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORH	KSHEET A, COLUN	IN 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 545, 150				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	67, 569				2.00
3.00	Total (sum of lines 1-2)	0	3, 612, 719	1			3.00
		1					

RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Prep 5/27/2015 9:37	pared:
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	T	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS						
. 00	CAP REL COSTS-BLDG & FIXT	3, 545, 150		3, 545, 15		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	67, 569		67, 56		0	2.0
3.00	Total (sum of lines 1-2)	3, 612, 719	TION OF OTHER (3, 612, 71	9 1.000000 SUMMARY 0	0	3.0
		ALLUCA	TION OF OTHER (APITAL	SUMMARY U	F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Rel ate		Depreciation	Lease	
		(00	d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS	6.00	7.00	8.00	9.00	10.00	
. 00	CAP REL COSTS-BLDG & FIXT	0	0		0 3, 979, 052	500, 217	1.0
2.00	CAP REL COSTS-MVBLE EQUIP	0	-		0 67, 569	0	2.0
. 00	Total (sum of lines 1-2)	0	o o		4, 046, 621	500, 217	3.0
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	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		12.00	13.00	14.00	13.00	
. 00	CAP REL COSTS-BLDG & FIXT	-418, 379	0		0 0	4, 060, 890	1.0
. 00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	67, 569	2.0
. 00	Total (sum of lines 1-2)	-418, 379	0		0 0	4, 128, 459	3.0

Health Financial Systems

In Lieu of Form CMS-2552-10

DD021	MENTS TO EXPENSES		1		Period: From 01/01/2014 To 12/31/2014		pared:
				Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 Ref. 5.00	
. 00	Investment income - CAP REL	B		CAP REL COSTS-BLDG & FIXT	4.00		1.0
. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
	COSTS-MVBLE EQUIP (chapter 2)			SAN REE COSTS MUBLE EQUIT			
. 00	Investment income - other (chapter 2)		0		0.00	0	3.0
. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.0
. 00	Refunds and rebates of	В	-148, 046	ADMI NI STRATI VE & GENERAL	5.00	0	5.0
. 00	expenses (chapter 8) Rental of provider space by		О		0.00	0	6.0
	suppliers (chapter 8)						
. 00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.0
. 00	Television and radio service (chapter 21)		0		0.00	0	8.0
. 00	Parking lot (chapter 21)		0		0.00		
0. 00	Provider-based physician adjustment	A-8-2	-922, 110			0	10. (
1. 00	Sale of scrap, waste, etc.		0		0.00	0	11.
2.00	(chapter 23) Related organization	A-8-1	221, 699			0	12.
3. 00	transactions (chapter 10) Laundry and linen service	В	- 26 979	LAUNDRY & LINEN SERVICE	8.00	0	13.
4. 00	Cafeteria-employees and guests	В	-61, 955	CAFETERIA	11.00	0	14.
6. 00	Rental of quarters to employee and others	В	-56, 131	ADMI NI STRATI VE & GENERAL	5.00	0	15.
6. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.
7.00	patients Sale of drugs to other than		О		0.00	0	17.
3. 00	patients Sale of medical records and	В	-22, 446	ADMI NI STRATI VE & GENERAL	5.00	0	18.
	abstracts		0				
9.00	Nursing school (tuition, fees, books, etc.)		_		0.00		19.
D. 00 1. 00	Vending machines Income from imposition of	В	-7, 183 I 0	DI ETARY	10.00 0.00		
	interest, finance or penalty charges (chapter 21)		0		0.00		21.
2.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.
3. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
	therapy costs in excess of						
4.00	limitation (chapter 14) Adjustment for physical	A-8-3	o	PHYSI CAL THERAPY	66.00		24.
	therapy costs in excess of limitation (chapter 14)						
5.00	Utilization review -		o	UTILIZATION REVIEW-SNF	114.00		25.
	physicians' compensation (chapter 21)						
5.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
7.00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
3. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.
9.00	Physicians' assistant		0		0.00	0	29.
0. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	U(OCCUPATI ONAL THERAPY	67.00		30.
). 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.
1. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.
2. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.
	MI SC I NCOME	В		ADMI NI STRATI VE & GENERAL	5.00		
3. 01	MI SC I NCOME	В	-83	CENTRAL SERVICES & SUPPLY	14.00	0	33.

Heal th	Financial Systems	FRANC	CISCAN ST. ELIZ	ABETH HEALTH - CR	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2014 Fo 12/31/2014	Date/Time Prep 5/27/2015 9:3	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3,00	4.00	5. 00	
33.02	MI SC I NCOME	В		PHARMACY	15.00		33.02
	MI SC I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00		33.03
	MI SC I NCOME	В		RADI OLOGY-THERAPEUTI C	55.00		33.04
	MI SC I NCOME	В		ELECTROCARDI OLOGY	69.00		33.05
33.06	MI SC I NCOME	В	-32	DI ETARY	10.00	0	33.06
33.07	HOME DELIVERED MEALS	В	-46, 558	DI ETARY	10.00	0	33.07
33.08	APPLICATION PROCESS FEES	В	-27, 400	ADMI NI STRATI VE & GENERAL	5.00	0	33.08
33.09	PROPERTY TAX	A	-1, 603	ADMI NI STRATI VE & GENERAL	5.00	0	33.09
33.10	ADVERTISING EXPENSE	A	-225, 598	ADMI NI STRATI VE & GENERAL	5.00	0	33. 10
33.11	HAF ASSESSMENT	A	-2, 728, 001	ADMINISTRATIVE & GENERAL	5.00	0	33. 11
33. 12	INTEREST EXPENSE	A	-1, 541, 221	CAP REL COSTS-BLDG & FIXT	1.00	11	33. 12
	PENSION ADJ	A	265, 951	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 13
50.00	TOTAL (sum of lines 1 thru 49)		-5, 358, 515				50.00
	(Transfer to Worksheet A,						

(Iransfer to Worksheet A, column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions). A. Costs - if cost, including applicable overhead, can be determined. B. Amount Received - if cost cannot be determined. (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	FRANCISCAN ST. ELI	ZABETH HEALTH - CR	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 150022	Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2014 To 12/31/2014		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-INT	1, 645, 487	1, 145, 270	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-NEW CAP	407, 403	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	FA-A&G	2, 576, 894	3, 267, 106	3.00
4.00	15.00	PHARMACY	FA-COEP	52, 231	43, 840	4.00
4.01	91.00	EMERGENCY	FA-AIS	0	4, 100	4.01
5.00	TOTALS (sum of lines 1-4).			4, 682, 015	4, 460, 316	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 RELAT	ED ORGANIZATION(S) AND/OR HO	ME 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

1 CT IIIDUT						
6.00	В	FRANCISCAN ALLI	100.00	FRANCI SCAN ALLI	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

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

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

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

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

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

Health Financial Systems	FRANCI SCAN ST. ELI ZABET	H HEALTH - CR	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM I OFFICE COSTS	RELATED ORGANIZATIONS AND HOME	Provider CCN: 150022	From 01/01/2014	Worksheet A-8-1 Date/Time Prepared:

	_								5/27/2015 9:3	37 am
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6.00	7.00								
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED	AS A RESULT C	F TRANSAC	TIONS WIT	H RELATED C	RGANIZATIONS OF	CLAI MED	
	HOME OFFICE CO	STS:								
1.00	500, 217	10								1.00
2.00	407, 403	9								2.00
3.00	-690, 212	0								3.00
4.00	8, 391	0								4.00
4.01	-4, 100	0								4.01
5.00	221, 699									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.

1103 110	t been posted to worksheet A,	condining i and/or 2, the amount arrowable should be indicated in condining of this part.	
	Rel ated Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
-	B INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE	

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 HOME OFFICE	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
9. 00 10. 00 100. 00	100.00

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

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

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

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

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

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

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

Heal th Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

FRANCI SCAN ST.	ELI ZABETH	HEALTH -	CR	
		Provi der	CCN: 150022	Peri od.

In Lieu of Form CMS-2552-10 Worksheet A-8-2

2. 00 50. 00 OPERATI NG ROOM 289, 921 276, 971 12, 950 182, 900 51 2. 3. 00 50. 00 OPERATI NG ROOM 109, 050 109, 050 0 182, 900 0 3. 4. 00 50. 00 OPERATI NG ROOM 50, 813 50, 813 0 182, 900 0 4. 5. 00 54. 00 RADI OLOGY-DI AGNOSTI C 64, 294 64, 294 0 217, 600 0 5.	
Wkst. A Line # Cost Center/Physician Identifier Total Remuneration Professional Component Provider Component RCE Amount Physician/Provider Identifier Physician/Provider Hours 1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 40.00 SUBPROVIDER - IPF 229, 374 205, 486 23,888 159,800 149 1. 2.00 50.00 OPERATING ROOM 289,921 276,971 12,950 182,900 51 2. 3.00 50.00 OPERATING ROOM 109,050 109,050 0 182,900 0 3. 4.00 50.00 OPERATING ROOM 50,813 50,813 0 182,900 0 3. 5.00 54.00 RADI OLOGY-DI AGNOSTIC 64,294 64,294 0 217,600 0 5.	
Identifier Remuneration Component Component ider Component Hours 1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 40.00 SUBPROVI DER - IPF 229, 374 205, 486 23, 888 159, 800 149 1. 2.00 50.00 OPERATI NG ROOM 289, 921 276, 971 12, 950 182, 900 51 2. 3.00 50.00 OPERATI NG ROOM 109, 050 109, 050 0 182, 900 0 3. 4.00 50.00 OPERATI NG ROOM 50, 813 50, 813 0 182, 900 0 3. 5.00 54.00 RADI OLOGY-DI AGNOSTI C 64, 294 64, 294 0 217, 600 0 5.	
Image: Note of the image of the image. The image of the imag	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 40.00 SUBPROVI DER - IPF 229, 374 205, 486 23, 888 159, 800 149 1. 2.00 50.00 OPERATI NG ROOM 289, 921 276, 971 12, 950 182, 900 51 2. 3.00 50.00 OPERATI NG ROOM 109, 050 109, 050 0 182, 900 0 3. 4.00 50.00 OPERATI NG ROOM 50, 813 50, 813 0 182, 900 0 4. 5.00 54.00 RADI OLOGY-DI AGNOSTI C 64, 294 64, 294 0 217, 600 0 5.	
1. 0040. 00SUBPROVI DER - IPF229, 374205, 48623, 888159, 8001491.2. 0050. 00OPERATI NG ROOM289, 921276, 97112, 950182, 900512.3. 0050. 00OPERATI NG ROOM109, 050109, 0500182, 90003.4. 0050. 00OPERATI NG ROOM50, 81350, 8130182, 90004.5. 0054. 00RADI OLOGY-DI AGNOSTI C64, 29464, 2940217, 60005.	
2. 00 50. 00 OPERATI NG ROOM 289, 921 276, 971 12, 950 182, 900 51 2. 3. 00 50. 00 OPERATI NG ROOM 109, 050 109, 050 0 182, 900 0 3. 4. 00 50. 00 OPERATI NG ROOM 50, 813 50, 813 0 182, 900 0 4. 5. 00 54. 00 RADI OLOGY-DI AGNOSTI C 64, 294 64, 294 0 217, 600 0 5.	1.00
3. 00 50. 00 OPERATI NG ROOM 109, 050 109, 050 0 182, 900 0 3. 4. 00 50. 00 OPERATI NG ROOM 50, 813 50, 813 0 182, 900 0 4. 5. 00 54. 00 RADI OLOGY-DI AGNOSTI C 64, 294 64, 294 0 217, 600 0 5.	2.00
4. 00 50. 00 OPERATI NG ROOM 50, 813 50, 813 0 182, 900 0 4. 5. 00 54. 00 RADI OLOGY-DI AGNOSTI C 64, 294 64, 294 0 217, 600 0 5.	3.00
5. 00 54. 00 RADI OLOGY - DI AGNOSTI C 64, 294 64, 294 0 217, 600 0 5.	4.00
	5.00
	5.00
7. 00 55. 00 RADI OLOGY - THERAPEUTI C 179, 654 179, 654 0 217, 600 0 7.	7.00
	3.00
	9.00 9.00
). 00). 00
200.00 949, 412 896, 161 53, 251 348 200.	
200.00 949,412 896,101 55,251 348,200. Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provider Physician Cost). 00
Identifier Limit Unadjusted RCE Memberships & Component of Malpractice	
Limit Continuing Share of col. Insurance	
Ethin t Contributing Share of Cor. This mance	
1.00 2.00 8.00 9.00 12.00 13.00 14.00	
	1.00
	2.00
	2.00 3.00
	4.00
	+. 00 5. 00
	5.00
	7.00
	3.00
	9.00
	0.00
200.00 27,302 1,365 0 0 0 200.). 00
Wkst. A Line # Cost Center/Physician Provider Adjusted RCE RCE Adjustment	
Identifier Component Limit Disallowance	
Share of col.	
<u> </u>	
	1.00
	2.00
	3.00
	4.00
	4.00 5.00
	5.00
	7.00
	3.00
	9.00
	0.00
200. 00 0 27, 302 25, 949 922, 110 200.	0. 00

In Lieu	u of Form CMS-2552-10
ri od:	Worksheet B
om 01/01/2014	Part I

				F	rom 01/01/2014 o 12/31/2014		epared: 7 am
				LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		col. 7) 0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	4,060,890	4, 060, 890				1.0
2.00	00200 CAP REL COSTS-BEDG & TTXT	4,000,890	4, 000, 890	67, 569			2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 059, 195	27, 804	463	3, 087, 462		4.0
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	5, 459, 319	617, 491	10, 275		6, 435, 902 0	
7.00	00700 OPERATION OF PLANT	1, 231, 630	305, 495	-	-	1, 601, 277	
8.00	00800 LAUNDRY & LINEN SERVICE	102, 378	118, 983			254, 093	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	479, 347 184, 181	9, 499 118, 483			489, 004 350, 660	
11.00	01100 CAFETERIA	134, 576	64, 991			238, 234	
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	, v	-	0	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	110, 870 111, 199	38, 956 217, 700			152, 325 360, 638	
15.00	01500 PHARMACY	458, 277	11, 537			599, 126	
16.00	01600 MEDICAL RECORDS & LIBRARY	139, 066	74, 413	1, 238	31, 788	246, 505	16. 0
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 132, 905	604, 838	10, 064	376, 027	2, 123, 834	30.0
31.00	03100 I NTENSI VE CARE UNI T	441, 217	72, 259	1, 202	146, 165	660, 843	31.0
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	-	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	
40.00	04000 SUBPROVIDER - IPF	649, 663	165, 746	2, 758	211, 064	1, 029, 231	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0	0	0	
43.00	04300 NURSERY	0	0	0	0	0	
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	
45.00 45.01	04500 NURSING FACILITY 04510 ICF/MR	0	0	0	0	0	
46.00	04600 OTHER LONG TERM CARE	0	0	-	-	0	
	ANCI LLARY SERVI CE COST CENTERS						1
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	1, 258, 301	241, 235	4, 014		1, 883, 655 0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	-	0	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	1, 456, 694 59, 295	595, 224 10, 806			2, 414, 300 88, 083	
55.00	05500 RADI OLOGY-THERAPEUTI C	792, 076	0	0		924, 098	
56.00	05600 RADI OI SOTOPE	135, 339	10, 268			170, 709	
57.00 58.00	05700 CT SCAN 05800 MRI	0	0		-	0	
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60.00		2,073,499	207, 125	3, 446	0	2, 284, 070	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.0
53.00 54.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	0	0	-	0	
65.00	06500 RESPIRATORY THERAPY	337, 699	15, 613	-	-	447, 292	
66.00	06600 PHYSI CAL THERAPY	459, 611	89, 564			698, 784	
57.00 58.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	-	0	
58.00 59.00	06900 ELECTROCARDI OLOGY	159, 285	12, 421	-	-	224, 408	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.0
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 125, 679 783, 771	54, 300	903		1, 180, 882 783, 771	
73.00	07200 TMPL. DEV. CHARGED TO PATIENTS	4, 916, 796	164, 246	, v	0	5, 083, 775	
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.0
75.00	07500 ASC (NON-DI STINCT PART) 03020 ONCOLOGY	0	0	0	0	0	
,0.00	OUTPATIENT SERVICE COST CENTERS	0	0	1 0	0	0	70.0
38.00	08800 RURAL HEALTH CLINIC	0	0	0	-	0	
39.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 152, 993	0 32, 726	0 545	-	0 233, 248	
90.00		1, 227, 244				233, 248 1, 715, 558	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	
99 10	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	99.1
, ,. 10		ı O	0	1 0	, U	0	1 2 7. 1

Health Financial Systems FRANC	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014		
		CAPI TAL REL	_ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
SPECIAL PURPOSE COST CENTERS	-	-	1	-	-	
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 I NTEREST EXPENSE	0	0		0 0	0	111.00
114. 00/11400/UTI LI ZATI ON REVI EW-SNF						113.00 114.00
115. 00/11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0	114.00
116. 00 11600 H0SPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	32, 760, 564	3, 984, 939	66, 30	3, 078, 418		
NONREI MBURSABLE COST CENTERS	32,700,304	3, 704, 737	00, 30	5, 070, 410	32, 074, 303	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 498	22	5 0	13, 723	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	136, 672	0		0 9, 044	145, 716	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
194. 01 07951 SPORTS MEDI CI NE	0	0		0 0		194.01
194.0207952COMMUNITY IND HEALTH	0	62, 453	1, 03	9 0		194. 02
200.00 Cross Foot Adjustments		_		_		200.00
201.00 Negative Cost Centers	00 007 007	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	32, 897, 236	4, 060, 890	67, 56	3, 087, 462	32, 897, 236	202.00

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Heal th	Financial Systems FRA	NCISCAN ST. ELIZ	ZABETH HEALTH -	CR	In Lie	u of Form CMS-	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part I Date/Time Pre 5/27/2015 9:3	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATI ON OF PLANT	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS		Т	1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT	4 425 002					4.00
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS	6, 435, 902					5.00
7.00	00700 OPERATION OF PLANT	389, 461		1, 990, 738			6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	61, 800		76, 160			8.00
9.00	00900 HOUSEKEEPI NG	118, 935		6, 080	43, 465		
10.00	01000 DI ETARY	85, 287		75, 840			
11.00	01100 CAFETERI A	57, 943	3 C	41, 600	0	14, 331	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	C		0 0	0	C	12.00
13.00	01300 NURSING ADMINISTRATION	37, 048	3 C	24, 935	0	8, 590	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	87, 714		139, 347	1, 449		
15.00	01500 PHARMACY	145, 719			0	2, 544	
16.00	01600 MEDI CAL RECORDS & LI BRARY	59, 955	5 C	47, 631	0	16, 409	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	E14 EE2	7	207 140	110,000	100.075	1 20 00
30.00 31.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	516, 557 160, 730			118, 889 11, 151	133, 375 15, 934	
31.00	03200 CORONARY CARE UNIT	100,730		40, 252	11, 151	15, 934	
32.00	03300 BURN INTENSIVE CARE UNIT				0		
34.00	03400 SURGICAL INTENSIVE CARE UNIT			0	0	0	
40.00	04000 SUBPROVIDER - IPF	250, 329		106, 092	36, 572	36, 549	
41.00	04100 SUBPROVIDER - IRF	C		0	0	C	
42.00	04200 SUBPROVI DER	C	o c	0	0	C	42.00
43.00	04300 NURSERY	C	oj c	0	0	C	43.00
44.00	04400 SKILLED NURSING FACILITY	C	o c	0 0	0	C	44.00
45.00	04500 NURSING FACILITY	C) C	0	0	0	
45.01	04510 I CF/MR	C) C	0	0	0	
46.00	04600 OTHER LONG TERM CARE	C) <u> </u>	0 0	0	0	46.00
F0 00	ANCI LLARY SERVICE COST CENTERS	450 141		154 410	F0 07/	F2 10F	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	458, 141		154, 412 0	52, 376 0	53, 195 0	
52.00	05200 DELIVERY ROOM & LABOR ROOM			0	0		
53.00	05300 ANESTHESI OLOGY			0	0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	587, 204		380, 996	14, 575		
54.01	05401 ULTRASOUND	21, 423		6, 917	0	2, 383	
55.00	05500 RADI OLOGY-THERAPEUTI C	224, 758		0	0		
56.00	05600 RADI OI SOTOPE	41, 520		6, 572	0	2, 264	56.00
57.00	05700 CT SCAN	C	o c	0	0	C	57.00
58.00	05800 MRI	C) C	0	0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	C		0 0	0	C	
60.00	06000 LABORATORY	555, 529		132, 578	0	45, 674	
60.01	06001 BLOOD LABORATORY	C		0	0	C	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS.				0		
64.00	06400 I NTRAVENOUS THERAPY				0		
65.00	06500 RESPI RATORY THERAPY	108, 790		9,994	2,019		
66.00	06600 PHYSI CAL THERAPY	169, 958		57, 329	10, 186		
67.00	06700 OCCUPATI ONAL THERAPY	0		0	0	0	1
68.00	06800 SPEECH PATHOLOGY	0) c	0	0	C	
69.00	06900 ELECTROCARDI OLOGY	54, 580) c	7, 951	0	2, 739	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0) C	0	0	C	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	287, 213		34, 757	0	11, 974	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	190, 628		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 236, 473	S C	105, 132	0	36, 218	
74.00	07400 RENAL DIALYSIS	0		0	0	0	
75.00	07500 ASC (NON-DI STINCT PART)			0	0		
76.00	03020 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	(0	0		76.00
88.00	08800 RURAL HEALTH CLINIC	0		0	0	C	88.00
88.00 89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			0	0		
90.00	09000 CLINIC	56, 730		20, 948	0	7, 217	
91.00	09100 EMERGENCY	417, 256		66, 067	98, 737	22, 760	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	C) C) 0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS			1			4
	10900 PANCREAS ACQUISITION	0			0		109.00
	11000 INTESTINAL ACQUISITION	C) C	0	0		110.00
	11100 I SLET ACQUI SI TI ON	0	C IC	0	0	C	111.00
	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF		1				114.00

Health Financial Systems

FRANCI SCAN ST. ELIZABETH HEALTH - CR In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Pre 5/27/2015 9:3	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6.00	7.00	8.00	9.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	6, 381, 681	0	1, 942, 12	3 392, 053	640, 736	118.00
NONREI MBURSABLE COST CENTERS			_			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 338	0	8, 64	0 0	2, 976	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	35, 441	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.00
194. 01 07951 SPORTS MEDI CI NE	0	0		0 0	0	194.01
194.0207952 COMMUNITY IND HEALTH	15, 442	0	39, 97	5 0	13, 772	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	6, 435, 902	0	1, 990, 73	8 392, 053	657, 484	202.00

	Financial Systems FRANG	CISCAN ST. ELIZA		CCN: 150022 P F T	eriod: rom 01/01/2014 o 12/31/2014	u of Form CMS-2 Worksheet B Part I Date/Time Prep 5/27/2015 9:3	pared:
	Cost Center Description	DI ETARY	CAFETERI A		ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	540, 548 0 0 0 0 0 0 0	352, 108 C 297 8, 152 11, 957 6, 640	0 0 0 0	223, 195 5, 179 7, 585 4, 216	650, 485 0 0	1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 31. 00 32. 00 33. 00 34. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	324, 937 41, 146 0 0	53, 309 14, 953 C C	0	33, 823 9, 489 0 0	0 0 0 0	30.00 31.00 32.00 33.00 34.00
40. 00 41. 00 42. 00 43. 00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER 04300 NURSERY	174, 465 0 0 0	27, 532 C C C	0	17, 461 0 0 0	0 0 0 0	40. 00 41. 00 42. 00 43. 00
44. 00 45. 00 45. 01 46. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04510 ICF/MR 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0 0	C C C C	-	0 0 0	0 0 0	44.00 45.00 45.01 46.00
50.00 51.00 52.00 53.00 54.00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C		55, 764 C C C 45, 940	0 0 0	35, 381 0 0 0 29, 140	0 0 0 0	50.00 51.00 52.00 53.00 54.00
54. 01 55. 00 56. 00 57. 00 58. 00	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI	0 0 0 0	2, 051 24, 401 2, 753 0	0 0 0 0 0	1, 295 15, 480 1, 738 0 0	0 0 0 0	54.01 55.00 56.00 57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	000000000000000000000000000000000000000				0 0 0 0	59.00 60.00 60.01 61.00 62.00 63.00
64.00 65.00 66.00 67.00 68.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0 0 0 0	C 13, 928 20, 568 C C		0 8, 831 13, 049 0 0	0 0 0 0	64.00 65.00 66.00 67.00 68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0 0 0	7, 234 C C C C	0 0 0 0	4, 596 0 0 0 0	0 0 383, 786 266, 699 0	69.00 70.00 71.00 72.00 73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03020 ONCOLOGY OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC					0 0 0	74.00 75.00 76.00 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	000000000000000000000000000000000000000	C 5, 938 50, 691	0	0 3, 766 32, 166	0 0 0	89.00 90.00 91.00 92.00
99. 10	OTHER REIMBURSABLE COST CENTERS	0	C	0	0	0	99.10
109.00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	0	C	0	0	0	109.00
111. OC	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE	0	C C	0	0		110. 00 111. 00 113. 00

Health Financial Systems FRAN	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part I		
				To 12/31/2014			
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O		CENTRAL		
			PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY		
	10.00	11.00	12.00	13.00	14.00		
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00	
116. 00 11600 H0SPI CE	0	0		0 0	0	116.00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	540, 548	352, 108		0 223, 195	650, 485	118.00	
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00	
191. 00 19100 RESEARCH	0	0		0 0	0	191.00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00	
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00	
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.00	
194. 01 07951 SPORTS MEDI CI NE	0	0		0 0	0	194.01	
194.0207952COMMUNITY IND HEALTH	0	0		0 0	0	194.02	
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118-201)	540, 548	352, 108		0 223, 195	650, 485	202.00	

LOST Center Description PMMRMACY MILLIONL RECORDS LIBOWY Subtotal Records LIBOWY Interval Subtotal Records and subtotal Records Steption Interval Steption Interval Steption 0 SUBDAL SERVICE DOST-CENTERS Steption 15.00 16.00 24.00 26.00 26.00 0 OPDIOL/AP RELOTS-RULE COST-SHORE Steption 15.00 16.00 24.00 26.00 26.00 0 OPDIOL/AP REPENTS FORMEL STEPTION Steption 24.00 26.00 26.00 0 OPDIOL/AP REPENTS FORMEL STEPTION FORMER STEPTION FORMER STEPTION 24.00 26.00 0 OPDIOL/AP REPENTS FORMEL STEPTION FORMER STEPTION FORMER STEPTION 26.00 0 OPDIOL/AP REPENTS FORMEL STEPTION FORMER STEPTION FORMER STEPTION 281.256 774.31 281.256 0 OPDIOL/AP REPENTS FORMEL STEPTION STEPTION 0 3.706.600 3.706.600 3.706.600 0 OPDIOL/AP REPENTS FORMEL STEPTION STEPTION 0 3.706.600 3.706.600 3.706.600 3.706.600 3.706.600 3.706.600 3.706.600					To 12/31/2014	Date/Time Pre 5/27/2015 9:3	epare
CHERAL SERVICE COST CENTERS 15.00 16.00 24.00 25.00 26.00 DEDUCE OF REL COST CENTERS 0	Cost Center Description	PHARMACY	RECORDS &	Subtotal	Residents Cost & Post Stepdown	Total	
00 DOTO CAP_PETL COSTS NUME E COST_PENEE EQUIP 1 00 DOTO CAP_PETL COSTS_NUME E EQUIP 1 00 DOTO CAP_PETL COSTS_NUME E EQUIP 1 00 DOTO CAP_PETL COSTS_NUME E EQUIP 1 00 DOTO CAP_PETL TWARE & DEPARTMENT 1 00 DOTO CAP_PETL TWARE & DEPARTMENT NO 1 00 DOTO CAP_PETL TWARE & DEPARTMENT NO 1 00 DOTO CAP_PETL TWARE & DEPARTMENT NO 1 00 DOTO CAP_PETL NOT NE SUPCRAFT NO NO 1 00 DOTO CAP_PETL NOT NE SUPCRAFT NO NO 1 00 DOTO CAP_PETL NOT NE SUPCRAFT NO		15.00	16.00	24.00		26.00	
00 00200 CAP. PEL: COSTS.NVRUE. EXCUTS PORATEENT 0<							
00 00-0000 EMPLOYE ENERT IS DEPARTMENT 4 00 00500 AUM INTENANCE & REPAINS 5 00 00500 AUM INTENANCE & REPAINS 5 00 00500 AUM INTENANCE & REPAINS 7 00 00500 AUM INTENANCE AND INSTANT IO 0 00 011000 AUM INTENANCE AND INSTANT IO 0 00 011000 AUM INTENANCE AND INSTANT IO 1 00 011000 AUM INTENANCE AND INSTANT IO 1 00 011000 AUM INTENANCE COP PENSONREL 1 00 011000 AUM INTENANCE COP PENSONREL 1 00 011000 AUM INTENANCE AUM INSTANT IO 3.700, 650 00 01100 AUM INTENANCE AUM							1.
00 00000 ADMINISTRATIVE & CREMERAL 5 00 00000 AMINISTRATIVE & CREMERAL 7 00 00000 ADMINISTRATIVE & CREMERAL 7 00 00000 ADMINISTRATIVE & CREMERAL 7 00 00000 ADMINISTRATIVE & CREMERAL 7 00 01000 ADMINISTRATIVE & CREMERAL 7 00 01000 ADMINISTRATIVE & CREMERAL 7 00 01000 ADMINISTRATIVE & CREMERAL 11 00 01000							2.
00 00000 MARTENNICE A REPAIRS 6 00 00000 FARAL STATUS OF PLANTS 6 00 00000 FARAL STATUS OF PLANTS 7 00 00000 FARAL STATUS OF PLANTS 7 00 01000 MARSERFORM 7 00 00000 0100 1 1 00 00000 0100 1 1 1 00 0000 0100 1 1 1 1 00 0000 0100 1 1 1 1							4.
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000 DOUD HOUSEKEEPING 9 00 01000 DETRAY 11 00 1100 CAFFTERIA 11 11 00 1100 CAFFTERIA 0 310 111 00 1100 CAFFTERIA 0 310 111 11 00 3030 DIRIN TERS IVE CARE UNIT 0 3.706, 650 0 3.706, 650 00 3030 DIRIN TERS IVE CARE UNIT 0 3.676 964, 174 964, 174 00 3030 DIRIN TERS IVE CARE UNIT 0 0 0 0 0							7.
000000000000000000000000000000000000							8.
00 0100 CAFETERIA 11 00 01200 MURS NEA AMM INSTRATION 11 00 01300 MURS NEA AMM INSTRATION 11 00 01400 CENTRAL SERVICES & SUPPLY 774,316 11 00 01300 MURS NEA AMM INSTRATION 11 11 00 01400 CENTRAL SERVICES & SUPPLY 774,316 11 00 01300 AMULTS & FEDIATRICE COST CENTERS 0 14.778 3.706,600 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>9.</td>							9.
0:0 01200 MAINTENANCE OF PERSONNEL. 1130 0:0 01300 MAINTENANCE OF PERSONNEL. 131 0:0 01300 MAINTENANCE OF PERSONNEL. 131 0:0 01300 MAINTRA SADAN INSTANTON 131 0:0 01300 MAINTRALSERVICES & SUPPLY 0 0:0 03200 CRANKY CARE UNIT 0 14.778 0:0 03200 CRANKY CARE UNIT 0 0 0 0:0 03200 CRANKY CARE UNIT 0 0 0 0 0:0 03200 CRANKY CARE UNIT 0 0 0 0 0 0:0 04100 SUBPROVI DER - 1 PF 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
CO D1200 NURSI NG JABUM NI STRATION 11 00 01400 CINTRAL SERVICES SUPPLY 774,316 11 01500 NURABLESEVICES SUPPLY 774,316 11 01500 NURABLESEVICES SUPPLY 0 381,366 01500 NURABLESEVICES ALLIBRARY 0 3.676 0 3.706,630 0 3.706,630 0 3.706,630 0 3.706,630 0 0.9230 0.9240 0.9440 0 0 0 0.9240 0.9440 0 0 0 0 0 0 0.9330 0.9490 0							
DID COND COND <thc< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></thc<>							
DOI DISCOD PHARMACY T/4 31 Constraints Total state Total state <thtotal state<="" th=""> Total state <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>14.</td></t<></thtotal>							14.
OND Discol MEDICAL, ECCRORDS & LIERARY O 381,356 16 INMART INT MOUTINE SERVICE COST CENTERS 0 14,778 3,706,650 0 3,706,650 0 3,706,650 0 0 0 0 0 0,706,650 0 <td></td> <td>774 316</td> <td></td> <td></td> <td></td> <td></td> <td>15.</td>		774 316					15.
INPART ENT. ROUTINE SERVICE COST CENTERS Image: Control of the service			381 356				16.
00 02000 ADULTS & PEDIATRICS 0 14,778 3,706,650 0 3,706,650 2 00 03300 FURTISH VE CARE UNIT 0 3,677 964,174 0 964,174 0 964,174 0 330 964,174 0 964,174 0		V	301, 330			·	- 10.
00 03200 CORONARY CARE UNIT 0 3.676 964.174 0 .964.174 0 00 03200 CORONARY CARE UNIT 0 <			14 778	3 706 65		3 706 650	30.
0.00 0.200 CORONARY CARE UNIT 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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000 0000 SUBPROVIDER - INFF 0 8,555 1,686,786 0		0	0		0 0	-	
O O		0	8, 555	1, 686, 78		-	
00 020 0200 SUBPROVIDER 0		0		.,,			
OD OD OD OD OD <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>		0	0		0 0		
00 0400 SKILLED NURSI NG FACILITY 0		0	0		0 0	(c	
CO Description Description <thdescription< th=""> <thdesc< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td></td></thdesc<></thdescription<>		0	0		0 0		
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00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 5200 0 5200 0 0 0 0 0 5200 0 5200 0 0 0 0 0 0 0 5200 0				_			
00 5200 DELIVERY ROOM & LABOR ROOM 0 0 0 5200 00 05300 ANESTHESI OLGGY 0 0 0 5300 00 05401 ULTRASOUND 0 7,050 129,202 0 129,202 54 00 05500 RADI OLGGY-THERAPEUTI C 0 11,173 1.200,450 55 00 05500 RADI OLGGY-THERAPEUTI C 0 11,173 1.200,450 55 00 05500 RADI OLGY-THERAPEUTI C 0 7,343 232,899 0 232,899 56 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 56 00 05900 CARDI AC CATHETERI ZATI ON 0	. 00 05000 OPERATING ROOM	0	27, 905	2, 720, 82	9 0	2, 720, 829	9 50.
00 05300 ANESTHESIOLOGY 0	. 00 05100 RECOVERY ROOM	0	0		0 0	(D 51.
0:00 05400 RADI OLOGY - DI AGNOSTI C 0 0 3, 663, 869 0 3, 663, 869 0 3, 663, 869 5, 60 3, 663, 869 0 129, 202 50 0:00 0 0 7, 050 129, 202 0 129, 202 50 0:00 0 0 0 7, 343 232, 899 0 232, 899 50 0:00 0 0 0 0 0 0 0 0 57 0:00 05500 RADI OLOGY - THERAPEUTI C 0 11, 713 1, 200, 450 0 232, 899 0 232, 899 0 232, 899 0 232, 899 0 232, 899 0		0	0		0 0	-	
01 05401 ULTRASOUND 0 7,050 129,202 0 129,202 5 00 05500 RADIOLOGY-THERAPEUTIC 0 11,713 1,200,450 55 00 05500 RADIOLOGY-THERAPEUTIC 0 7,343 232,899 0 232,899 56 00 05500 RADIOLSOTOPE 0		0	0		0 0	(C	
100 05500 RADI OLGY-THERAPEUTI C 0 11,713 1,200,450 55 00 05600 RADI OLGY-THERAPEUTI C 0 7,343 232,899 0 232,899 55 00 05700 CT SCAN 0 0 0 0 0 0 57 00 05800 MRI 0 0 0 0 0 0 57 00 05800 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 57 00 06000 LABORATORY 0 45,889 3,063,740 0 <td< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>		0					
00 05600 RADI (1) SOTOPE 0 7, 343 232, 899 0 232, 899 65 00 05700 CT SCAN 0		0					
00 05700 CT SCAN 0 <t< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></t<>		0					
00 05800 MRI 0		0					
00 05900 CARDIAC CATHETERI ZATION 0 0 0 0 0 55 00 06000 LABORATORY 0 45,889 3,063,740 0 3,063,740 60 00 06000 LABORATORY 0		0			-	-	
00 06000 LABORATORY 0 45,889 3,063,740 0 3,063,740 60 01 06001 BLOOD LABORATORY 0<		0	0		0 0		00
01 06001 BLOOD LABORATORY 0 0 0 0600 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>		0	0		0 0	-	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 6200 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 620 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 640 00 06500 RESPIRATORY THERAPY 0 4,835 599,132 0 597,312 65 00 06600 PHYSI CAL THERAPY 0 5,747 995,371 0 67 00 06600 SPEECH PATHOLOGY 0 0 0 0 66 00 06600 SPEECH PATHOLOGY 0 11,429 312,937 69 70 00 07000 ELECTROCARDI OLOGY 0 11,429 312,937 69 70 70 00 07000 ELECTROCARDI OLOGY 0 11,429 312,937 69 73 73 73 73,99,139 73 73 74,946 74 74 74 76 <td></td> <td>0</td> <td>45, 889</td> <td>3,063,74</td> <td>0 0</td> <td></td> <td></td>		0	45, 889	3,063,74	0 0		
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 6200 0		0	0		0 0		
00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 6330 00 06400 INTRAVENOUS THERAPY 0		0	0		0		
00 06400 INTRAVENOUS THERAPY 0 0 0 0 6400 00 06500 RESPI RATORY THERAPY 0 4,835 599,132 0 599,132 65 00 06600 PHYSI CAL THERAPY 0 5,747 995,371 0 995,371 66 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 67 00 06600 PHYSI CAL THERAPY 0 0 0 0 67 00 06600 SPECH PATHOLOGY 0 11,429 312,937 0 312,937 69 00 06900 ELECTROCARDIOLOGY 0 11,429 312,937 0 710 80 1,919,698 1,919,698 71 710 710 710 7300 7300 7300 739 0 7,309,139 0 7,309,139 73		0	0			-	
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00 06600 PHYSI CAL THERAPY 0 5,747 995,371 0 995,371 66 00 06700 0CUPATI ONAL THERAPY 0 0 0 0 66 00 06800 SPEECH PATHOLOGY 0 0 0 66 00 06800 SPEECH PATHOLOGY 0 0 0 66 00 06900 ELECTROCARDI OLOGY 0 11,429 312,937 0 312,937 66 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 8,706 1,249,804 0 1,249,804 72 00 07300 DRUGS CHARGED TO PATI ENTS 774,316 73,225 7,309,139 0 7,309,137 73 00 07300 DRUGS CHARGED TO PATI ENTS 774,316 73,225 7,309,139 0 7,309,139 0 7 7309,137 73 00 07500 ASC (NON-DI STI NCT PART) 0 0 0		0	4 835	500 13			
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00 07000 ELECTROENCEPHALOGRAPHY 0		0	11 429	312 93	37 0		
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 21,086 1,919,698 0 1,919,698 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 8,706 1,249,804 0 1,249,804 72 00 07300 DRUGS CHARGED TO PATIENTS 774,316 73,225 7,309,139 0 7,309,139 73 00 07400 RENAL DI ALYSI S 0 0 0 0 74 00 07400 RENAL DI ALYSI S 0 0 0 0 74 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75 01 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75 02 0800 RURAL HEALTH CLINIC 0 0 0 0 89 00 09000 CLINIC 0 0 0 0 329,915 0 329,915 90 329,915 90 92 91 <td></td> <td>0</td> <td>0</td> <td>0.2,70</td> <td>0 0</td> <td></td> <td></td>		0	0	0.2,70	0 0		
00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 8, 706 1, 249, 804 0 1, 249, 804 72 00 07300 DRUGS CHARGED TO PATIENTS 774, 316 73, 225 7, 309, 139 0 7, 309, 139 73 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74 73 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 75 00 03020 ONCOLOGY 0 0 0 0 0 0 75 01 0000 0 0 0 0 0 75 02 0NCOLOGY 0 0 0 0 0 0 76 017PATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 89 00 09000 CLINIC 0 0 0 2,068 329,915 0 329,915 90		0	21.086	1, 919, 69	v8 0	-	
00 07300 DRUGS CHARGED TO PATIENTS 774,316 73,225 7,309,139 0 7,309,139 73 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74 00 07400 RENAL DI ALYSI S 0 0 0 0 74 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75 00 03020 ONCOLOGY 0 0 0 0 0 76 00 03020 ONCOLOGY 0 0 0 0 0 76 00 03020 ONCOLOGY 0 0 0 0 0 76 0179471 ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 2, 450, 126 0 2, 450, 126 0 2, 450, 126 0 2, 450, 126 </td <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
00 07400 RENAL DI ALYSI S 0 0 0 0 74 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75 00 03020 ONCOLOGY 0 0 0 0 76 00 03020 ONCOLOGY 0 0 0 0 76 00 00000 0 0 0 0 0 76 000 00000 0 0 0 0 0 76 000 00000 0 0 0 0 0 76 000 000000 0 0 0 0 0 76 000 00000 0 0 0 0 0 88 000 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89 00 09000 CLINIC 0 2,068 329,915 0 329,915 0 00 09100 EMERGENCY 0 46,891 2,450,126 0		774.316					
00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75 00 03020 ONCOLOGY 0 0 0 0 76 00 03020 ONCOLOGY 0 0 0 0 76 00 03020 ONCOLOGY 0 0 0 0 76 00 0400 0 0 0 0 0 76 00 08000 RURAL HEALTH CLINIC 0 0 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89 00 09000 CLINIC 0 2,068 329,915 0 329,915 90 00 09100 EMERGENCY 0 46,891 2,450,126 0 2,450,126 91 01 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 0 0 0 92 01 09910 CORF		0					
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OUTPATI ENT SERVICE COST CENTERS 00 08800 RURAL HEALTH CLINIC 0 0 0 0 880 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 880 00 09000 CLINIC 0 0 0 0 890 00 09000 CLINIC 0 2,068 329,915 0 329,915 90 00 09100 EMERGENCY 0 46,891 2,450,126 0 2,450,126 91 00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 0 92 0THER REIMBURSABLE COST CENTERS 0 0 0 99 SPECIAL PURPOSE COST CENTERS 0 0 0 99		0	0		-	-	
00 08800 RURAL HEALTH CLINIC 0							
00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89 00 09000 CLINIC 0 2,068 329,915 0 329,915 90 00 09100 EMERGENCY 0 46,891 2,450,126 0 2,450,126 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92 01HER REI MBURSABLE COST CENTERS 0 0 0 92 09910 CORF 0 0 0 0 99 SPECIAL PURPOSE COST CENTERS		0	0		0 0	(3 88.
00 09000 CLINIC 0 2,068 329,915 0 329,915 90 00 09100 EMERGENCY 0 46,891 2,450,126 0 2,450,126 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92 0THER REI MBURSABLE COST CENTERS 0 0 0 94 10 09910 CORF 0 0 0 0 94 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 94		0	0		0 0	0	
.00 09100 EMERGENCY 0 46, 891 2, 450, 126 0 2, 450, 126 91 .00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 92 0THER REI MBURSABLE COST CENTERS 0 0 0 0 99 .10 09910 CORF 0 0 0 0 0 99 SPECIAL PURPOSE COST CENTERS		0	2,068	329, 91	5 0	-	
.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 92 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 92 10 09910 CORF 0 0 0 0 99 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0		0					
OTHER REI MBURSABLE COST CENTERS .10 09910 CORF 0 0 0 0 99 SPECIAL PURPOSE COST CENTERS			-, -, -, -,	,,			92
. 10 09910 CORF 0 0 0 0 0 99 SPECIAL PURPOSE COST CENTERS						1	1 1
SPECIAL PURPOSE COST CENTERS		0	0		0 0	(0 99
	10 09910 CORF						-

Health Financial Systems FRAN	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part I
				To 12/31/2014	
Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intern &	Total
		RECORDS &		Residents Cost	
		LI BRARY		& Post	
				Stepdown	
	15.00	16.00	24.00	Adjustments 25.00	26.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	24.00	0 0	0 111.00
113.00 11300 INTEREST EXPENSE				-	113.00
114.00 11400 UTILIZATION REVIEW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0 115.00
116. 00 11600 HOSPI CE	0	0		0 0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	774, 316	381, 356	32, 554, 72	1 0	32, 554, 721 118. 00
NONREI MBURSABLE COST CENTERS			00.47	-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	28, 67	/ 0	28, 677 190. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	181, 15		0 191.00 181.157 192.00
192. 00 19200 PHISICIANS PRIVATE OFFICES	0	0	101, 13		0 193.00
194. 00 07950 OTHER NONRELMBURSABLE COST CENTERS	0	0			0 194, 00
194. 01 07951 SPORTS MEDI CI NE	0	0		0 0	0 194. 01
194. 02 07952 COMMUNITY IND HEALTH	0	0	132, 68	1 0	132, 681 194. 02
200.00 Cross Foot Adjustments				0 0	0 200. 00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118-201)	774, 316	381, 356	32, 897, 23	6 0	32, 897, 236 202. 00

Heal th	Fi na	inci	al	Syste	ems		
		OF	CΔ	ρι ται	REI	ATED	CC

		icial Systems FRAN DF CAPITAL RELATED COSTS	CISCAN ST. ELIZ		CCN: 150022 P	eriod: rom 01/01/2014	u of Form CMS-2 Worksheet B Part II Date/Time Pre 5/27/2015 9:3	pared:
		Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REI BLDG & FI XT	LATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		AL SERVICE COST CENTERS	1	1	1			
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	27, 804		28, 267	28, 267	4.00
5.00		ADMINISTRATIVE & GENERAL	0	617, 491	10, 275	627, 766	3, 194	
6.00		MAINTENANCE & REPAIRS	0	0	U F 000	210 570	0	
7.00 8.00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	305, 495 118, 983		310, 578 120, 963	541 282	7.00 8.00
9.00		HOUSEKEEPING	0	9, 499		9,657	202	
10.00		DIETARY	0	118, 483		120, 454	421	10.00
11.00		CAFETERIA	0	64, 991	1, 081	66, 072	344	
12.00		MAINTENANCE OF PERSONNEL	0	0	0	0	0	
13.00		NURSING ADMINISTRATION	0	38, 956	648	39, 604	17	13.00
14.00		CENTRAL SERVICES & SUPPLY	0	217, 700	3, 622	221, 322	257	14.00
15.00		PHARMACY	0	11, 537	192	11, 729	1, 182	
16.00		MEDICAL RECORDS & LIBRARY	0	74, 413	1, 238	75, 651	291	16.00
		I ENT ROUTI NE SERVI CE COST CENTERS	-					
30.00		ADULTS & PEDIATRICS	0			614, 902	3, 443	
31.00 32.00			0	72, 259		73, 461	1, 338	
32.00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0	0	0	32.00 33.00
33.00		SURGICAL INTENSIVE CARE UNIT	0		0	0	0	
40.00	1	SUBPROVIDER - IPF	0	165, 746	2, 758	168, 504	1, 933	1
41.00		SUBPROVIDER - IRF	0	0	0	100,001	0	1
42.00		SUBPROVIDER	0	0	0	o	0	
43.00		NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00		NURSING FACILITY	0	0	0	0	0	45.00
45.01	04510	I CF/MR	0	0	0	0	0	45.01
46.00		OTHER LONG TERM CARE	0	0	0	0	0	46.00
		LARY SERVICE COST CENTERS	-					
50.00		OPERATING ROOM	0	241, 235		245, 249	3, 480	
51.00		RECOVERY ROOM	0	0	0	0	0	
52.00 53.00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00 53.00
54.00		RADI OLOGY-DI AGNOSTI C	0	595, 224	9, 904	605, 128	3, 227	
54.00 54.01		ULTRASOUND	0	10, 806		10, 986	163	1
55.00		RADI OLOGY-THERAPEUTI C	0	0	0	0	1, 209	
56.00		RADI OI SOTOPE	0	10, 268	171	10, 439	228	
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00		CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60.00		LABORATORY	0	207, 125	3, 446	210, 571	0	60.00
60.01		BLOOD LABORATORY	0	0	0	0	0	60.01
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0	61.00
62.00 63.00	1	WHOLE BLOOD & PACKED RED BLOOD CELL BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64.00	1	INTRAVENOUS THERAPY	0		0	0	0	63.00 64.00
65.00		RESPIRATORY THERAPY	0	15, 613	260	15, 873	858	
66. 00		PHYSI CAL THERAPY	0	89, 564		91, 054	1, 356	
67.00		OCCUPATIONAL THERAPY	0	0	0	0	0	1
		SPEECH PATHOLOGY	0	0	0	0	0	1
69.00	06900	ELECTROCARDI OLOGY	0	12, 421	207	12, 628	481	69.00
		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
		MEDICAL SUPPLIES CHARGED TO PATIENT	0	54, 300	903	55, 203	0	71.00
		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
		DRUGS CHARGED TO PATIENTS	0	164, 246	2, 733	166, 979	0	73.00
		RENAL DIALYSIS	0		0	0	0	
75.00		ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00		ONCOLOGY TIENT SERVICE COST CENTERS	0	0	0	0	0	76.00
88.00		RURAL HEALTH CLINIC	0	0	0	0	0	88.00
		FEDERALLY QUALIFIED HEALTH CENTER	0	n	0	0	0	
90.00		CLINIC	0	32, 726		33, 271	430	1
91.00		EMERGENCY	0	103, 216		104, 933	3, 509	1
		OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER	REIMBURSABLE COST CENTERS		1				
99.10			0	0	0	0	0	99.10
100.07		AL PURPOSE COST CENTERS	-	-	-	-1	_	100.00
109 00	i 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00

Heal th	Fina	nci a	I Syst	ems	
ALL OCA	TION	OF (API TAI	RELATED	COST

ALLOCATION OF CAPITAL RELATED COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014			
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	3, 984, 939	66, 30	5 4, 051, 244	28, 184	118.00
NONREI MBURSABLE COST CENTERS					-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 498	22	5 13, 723		190.00
191.00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		193.00 194.00
194. 01 07950 OTHER NONRETMBORSABLE COST CENTERS	0	0		0 0		194.00
194. 02 07952 COMMUNITY IND HEALTH	0	62, 453	1, 03	9 63, 492		194.01
200.00 Cross Foot Adjustments	0	02,403	1,03	03,492	0	200.00
201.00 Negative Cost Centers		0		0 0	0	200.00
202.00 TOTAL (sum Lines 118-201)	0	4, 060, 890	67, 56	9 4, 128, 459		201.00

Heal th	Fina	nci	al S	Syste	ems		
	TLON			TAL	DEL	ATED	~

ALLOC	ATION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 01/01/2014 o 12/31/2014		epareo 37 am
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAI RS	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	-
I. 00	00100 CAP REL COSTS-BLDG & FIXT						1 1.
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
5.00	00500 ADMI NI STRATI VE & GENERAL	630, 960					5.
5.00	00600 MAI NTENANCE & REPAI RS	0	0				6.
7.00	00700 OPERATION OF PLANT	38, 182	0	349, 301			7.
3.00	00800 LAUNDRY & LINEN SERVICE	6, 059	0	13, 363	140, 667		8.
. 00	00900 HOUSEKEEPI NG	11,660	0	1, 067	15, 595		
0.00		8, 361	0	13, 307	945		
1.00		5, 681	0	7, 299	0	828	
2.00		3,632		4, 375	0	0 496	
4.00		8, 599	-	24, 450	520	2, 773	
5.00		14, 286				147	
6.00		5, 878	0		0	948	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		50, 643			42, 658		
1.00		15, 758		8, 116	4, 001	920	
2.00		0	0	0	0	0	
3.00		0	0	0	0	0	
4.00 0.00		24, 542	0	18, 615	0 13, 122	0 2, 111	
1.00		24, 342		0	13, 122	2, 111	
2.00		0	0	0	0	0	
3.00		0	0	0	0	0	
4.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.
5.00		0	0	0	0	0	45.
5. 01		0	0	0	0	0	
6.00		0	0	0	0	0) 46.
~ ~~	ANCI LLARY SERVICE COST CENTERS	44.01/		27.004	10 700	2.072	
0.00		44, 916 0	0		18, 792 0	3, 073 0	
51.00 52.00		0		0	0	0	
3.00		0	0	0	0	0	
4.00		57, 569	0	66, 851	5, 229		
4. 01		2,100	0	1, 214	0	138	
5.00	05500 RADI OLOGY-THERAPEUTI C	22, 035	0	0	0	0	55.
6.00		4,071	0	1, 153	0	131	56.
7.00		0	0	0	0	0	
8.00		0	0	0	0	0	
9.00		0	0	23, 263	0	0	
0.00		54, 464		23, 203	0	2, 638 0	
1.00		0		0	0		61.
2.00		0	0	0	0	o	
3.00		0	0	0	0	0	
4.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.
5.00		10, 666		1, 754	724		
6.00		16, 663	0	10, 059			
7.00		0	0	0	0	0	
8.00 9.00		U E 251		0 1, 395	0	0	
0.00		5, 351		1, 395	0	158 0	
0.00 1.00		28, 158		6, 099	0	692	
1.00 2.00		18, 689		0,077	0	072	
	07300 DRUGS CHARGED TO PATIENTS	121, 212	0	18, 447	0	2, 092	
4.00		0	0	0	0	0	
5.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.
6. 00		0	0	0	0	0	76.
	OUTPATIENT SERVICE COST CENTERS						1
3.00		0	0	0	0	0	
9.00).00		0		0	0	0	
). 00 1. 00		5, 562 40, 907		3, 676 11, 592	0 35, 426	417 417 1, 315	
1.00 2.00		40, 907	0	11, 392	JJ, 420	1, 313	91
00	OTHER REIMBURSABLE COST CENTERS		1	1		1	1 12
9. 10	09910 CORF	0	0	0	0	0	99
	SPECIAL PURPOSE COST CENTERS						
	0 10900 PANCREAS ACQUI SI TI ON	0	0	0	0		109
	0 11000 INTESTINAL ACQUISITION	0	0	0	0		110
	0 11100 I SLET ACQUI SI TI ON	0	0	0	0	0) 111
	0 11300 INTEREST EXPENSE 0 11400 UTILIZATION REVIEW-SNF						113
	NULLANDULLELE ZALLAN DEVIEW SNE	1	1	1		1	114

Health Financial Systems

FRANCI SCAN ST. ELIZABETH HEALTH - CR In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014 Fo 12/31/2014	Worksheet B Part II Date/Time Pre 5/27/2015 9:3	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6.00	7.00	8.00	9.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	625, 644	0	340, 77	1 140, 667	37, 011	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	327	0	1, 51	5 0	172	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 475	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.00
194. 01 07951 SPORTS MEDI CI NE	0	0		0 0	0	194.01
194.0207952 COMMUNITY IND HEALTH	1, 514	0	7, 01	4 0	796	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	630, 960	0	349, 30	1 140, 667	37, 979	202.00

1.00 00 2.00 00	Cost Center Description	DI ETARY			Го 12/31/2014	Date/Time Pre 5/27/2015 9:3	
1.00 00 2.00 00		10.00	CAFETERI A	MAINTENANCE OI PERSONNEL	ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
1.00 00 2.00 00	NERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
5.00 00 6.00 00 7.00 00 8.00 00 9.00 00 10.00 01 11.00 01 13.00 01 14.00 01 15.00 01	100 CAP REL COSTS-BLOG & FIXT 200 CAP REL COSTS-BLOG & FIXT 200 CAP REL COSTS-MVBLE EQUI P 400 EMPLOYEE BENEFI TS DEPARTMENT 500 ADMI NI STRATI VE & GENERAL 600 MAI NTENANCE & REPAI RS 700 OPERATI ON OF PLANT 800 LAUNDRY & LI NEN SERVI CE 900 HOUSEKEEPI NG 000 DI ETARY 100 CAFETERI A 200 MAI NTENANCE OF PERSONNEL 300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY	144, 997 0 0 0 0 0 0 0 0 0	80, 224 0 68 1, 857 2, 724 1, 513		0 0 48, 192 0 1, 118 0 1, 638 0 910	260, 896 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
	PATIENT ROUTINE SERVICE COST CENTERS	r		l.	I		
31.00 03 32.00 03 33.00 03	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 200 CORONARY CARE UNIT 300 BURN INTENSIVE CARE UNIT 400 SURGICAL INTENSIVE CARE UNIT	87, 161 11, 037 0 0 0	12, 146 3, 407 0 0 0		0 7, 303 0 2, 049 0 0 0 0 0 0 0 0	0 0 0 0	30.00 31.00 32.00 33.00 34.00
40.00 04 41.00 04 42.00 04 43.00 04	000 SUBPROVI DER - I PF 100 SUBPROVI DER - I RF 200 SUBPROVI DER 300 NURSERY	46, 799 0 0 0	6, 273 0 0 0		3,770 0 0 0 0 0 0 0 0	0 0 0 0	40. 00 41. 00 42. 00 43. 00
45.00 04 45.01 04 46.00 04	400 SKILLED NURSING FACILITY 500 NURSING FACILITY 510 ICF/MR 600 OTHER LONG TERM CARE	0 0 0	0 0 0		0 0 0 0 0 0 0 0	0 0 0	44.00 45.00 45.01 46.00
50.00 05	CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 100 RECOVERY ROOM	0	12, 707 0		D 7, 640 D 0	0 0	50. 00 51. 00
53.00 05. 54.00 05. 54.01 05. 55.00 05. 56.00 05. 57.00 05.	200 DELIVERY ROOM & LABOR ROOM 300 ANESTHESIOLOGY 400 RADIOLOGY-DIAGNOSTIC 401 ULTRASOUND 500 RADIOLOGY-THERAPEUTIC 600 RADIOLOGY-THERAPEUTIC 600 RADIOLSOTOPE 700 CT SCAN 800 MRI	0 0 0 0 0 0 0 0	0 0 10, 467 467 5, 559 627 0 0		D 0 D 0 D 6, 292 D 280 D 3, 342 D 375 D 0 D 0	0 0 0 0 0 0 0 0 0 0	52.00 53.00 54.00 54.01 55.00 56.00 57.00 58.00
60.00 06 60.01 06 61.00 06 62.00 06 63.00 06	 900 CARDI AC CATHETERI ZATI ON 000 LABORATORY 001 BLOOD LABORATORY 100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 200 WHOLE BLOOD & PACKED RED BLOOD CELL 300 BLOOD STORI NG, PROCESSI NG & TRANS. 	0 0 0 0	0 0 0 0 0			0 0 0 0 0	60. 01 61. 00 62. 00 63. 00
65.00 06 66.00 06 67.00 06 68.00 06	400 NTRAVENOUS THERAPY 500 RESPI RATORY THERAPY 600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY 800 SPEECH PATHOLOGY 900 ELECTROCARDI OLOGY		0 3, 173 4, 686 0 0 1, 648		0 0 0 1,907 0 2,818 0 0 0 0 0 992	0 0 0 0 0	64.00 65.00 66.00 67.00 68.00 69.00
70.00 07 71.00 07 72.00 07 73.00 07 74.00 07 75.00 07	000 ELECTROENCEPHALOGRAPHY 100 MEDICAL SUPPLIES CHARGED TO PATIENT 200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS 400 RENAL DIALYSIS 500 ASC (NON-DISTINCT PART)		0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 153, 929 106, 967 0 0 0	70.00 71.00 72.00 73.00 74.00 75.00
	020 ONCOLOGY TPATI ENT SERVICE COST CENTERS	0	0	(0 0	0	76.00
88.00 08 89.00 08 90.00 09 91.00 09	19ATENT SERVICE COST CENTERS 800 RURAL HEALTH CLINIC 900 FEDERALLY QUALIFIED HEALTH CENTER 000 CLINIC 100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0 0	0 0 1, 353 11, 549		D 0 D 0 D 813 D 6, 945	0 0 0 0	88.00 89.00 90.00 91.00 92.00
0TI 99. 10 09	HER REIMBURSABLE COST CENTERS 910 CORF	0	0	(0	99. 10
109.0010 110.0011	ECIAL PURPOSE COST CENTERS 900 PANCREAS ACQUISITION 000 INTESTINAL ACQUISITION 100 ISLET ACQUISITION	0	0			0	109.00 110.00 111.00

Health Financial Systems FRANC	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/27/2015 9:3	
Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE O	F NURSI NG	CENTRAL	
cost center bescription	DILIAN		PERSONNEL	ADMI NI STRATI ON		
			TERSONNEL	ADMINI STRATION	SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	144, 997	80, 224		0 48, 192	260, 896	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.00
194. 01 07951 SPORTS MEDICINE	0	0		0 0	0	194.01
194.0207952 COMMUNITY IND HEALTH	0	0		0 0	0	194. 02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	144, 997	80, 224		0 48, 192	260, 896	202.00

Heal th	Fina	nci	al	Syste	ems		
		OF	CA		DEL	ATED	0

OCATION OF CAPITAL RELATED COSTS		TTOVICE		Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Pre 5/27/2015 9:3	
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
CENEDAL SEDVICE COST CENTEDS	15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS 0 00100 CAP REL COSTS-BLDG & FIXT						1 1
0 00200 CAP REL COSTS-BEBG & TEXT						2
0 00400 EMPLOYEE BENEFITS DEPARTMENT						4
0 00500 ADMI NI STRATI VE & GENERAL						5
0 00600 MAI NTENANCE & REPAI RS						6
0 00700 OPERATION OF PLANT						7
0 00800 LAUNDRY & LINEN SERVICE						8
0 00900 HOUSEKEEPI NG						9
00 01000 DI ETARY						10
						11
00 01200 MAINTENANCE OF PERSONNEL 00 01300 NURSING ADMINISTRATION						12
00 01400 CENTRAL SERVICES & SUPPLY						14
00 01500 PHARMACY	33, 002					15
00 01600 MEDICAL RECORDS & LIBRARY	0	93, 548				16
INPATIENT ROUTINE SERVICE COST CENT	ERS			· · · · · · · · · · · · · · · · · · ·		
00 03000 ADULTS & PEDI ATRI CS	0	3, 626	897, 51		897, 514	
00 03100 I NTENSI VE CARE UNI T	0	902	120, 98		120, 989	
00 03200 CORONARY CARE UNIT	0	0		0 0	0	
00 03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	
00 03400 SURGI CAL INTENSI VE CARE UNIT 00 04000 SUBPROVI DER – I PF	0	2,099	287, 76		0 287, 768	
00 04100 SUBPROVIDER - IRF	0	2,099		0 0	207,708	
00 04200 SUBPROVI DER	0	0		0 0	0	
00 04300 NURSERY	0	0	(0 0	0	
00 04400 SKILLED NURSING FACILITY	0	0	(0 0	0	44
00 04500 NURSING FACILITY	0	0	(0 0	0	45
01 04510 I CF/MR	0	0		0 0	0	
00 04600 OTHER LONG TERM CARE	0	0	(0 0	0	46
ANCI LLARY SERVICE COST CENTERS	0	6, 847	369, 79	8 0	369, 798	50
00 05100 RECOVERY ROOM	0	0, 847		0 0	309, 798	
00 05200 DELIVERY ROOM & LABOR ROOM	Ő	0		0 0	0	
00 05300 ANESTHESI OLOGY	0	0	(0 0	0	53
00 05400 RADI OLOGY-DI AGNOSTI C	0	19, 717	782, 06	2 0	782, 062	54
01 05401 ULTRASOUND	0	1, 730	17, 07		17, 078	
00 05500 RADI OLOGY-THERAPEUTI C	0	2, 874	35, 01		35, 019	
00 05600 RADI 0I SOTOPE 00 05700 CT SCAN	0	1, 802	18, 82		18, 826 0	
00 05800 MRI	0	0		0 0	0	
00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
00 06000 LABORATORY	0	11, 260	302, 19	-	302, 196	
01 06001 BLOOD LABORATORY	0	0	. (0 0	0	
00 06100 PBP CLINICAL LAB SERVICES-PRG	M ONLY					61
00 06200 WHOLE BLOOD & PACKED RED BLOO		0	(0 0	0	
00 06300 BLOOD STORING, PROCESSING & T	RANS. 0	0	(0	0	
00 06400 INTRAVENOUS THERAPY		0	24 24		0	
00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY		1, 186 1, 410	36, 34(132, 84)		36, 340 132, 842	
00 06700 OCCUPATIONAL THERAPY		1, 410	132, 64.		132, 842	
00 06800 SPEECH PATHOLOGY		0	(0 0	0	
00 06900 ELECTROCARDI OLOGY	0	2, 804	25, 45	7 0	25, 457	
00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0 0	0	
00 07100 MEDICAL SUPPLIES CHARGED TO P		5, 174	249, 25		249, 255	
00 07200 I MPL. DEV. CHARGED TO PATIENT	1	2, 136	127, 79		127, 792	
00 07300 DRUGS CHARGED TO PATIENTS	33, 002	17, 968	359, 70		359, 700	
00 07400 RENAL DIALYSIS 00 07500 ASC (NON-DISTINCT PART)		0			0	
00 03020 ONCOLOGY		0		0	0	
OUTPATIENT SERVICE COST CENTERS		0			0	1
00 08800 RURAL HEALTH CLINIC	0	0		0 C	0	88
00 08900 FEDERALLY QUALIFIED HEALTH CE	NTER 0	0		0 C	0	89
00 09000 CLINIC	0	507	46, 02		46, 029	
00 09100 EMERGENCY	0	11, 506	227, 68		227, 682	
00 09200 OBSERVATI ON BEDS (NON-DI STI NC	I PART			0		92
OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	99
SPECIAL PURPOSE COST CENTERS	0	0		0	0	1 35
. 00 10900 PANCREAS ACQUISITION	0	0	(0 0	0	109
	°	0	(110

Health Financial Systems FRANC	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B
				From 01/01/2014 To 12/31/2014	
				10 12/31/2014	Date/Time Prepared: 5/27/2015 9:37 am
Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intern &	Total
		RECORDS &		Residents Cost	
		LI BRARY		& Post	
				Stepdown	
				Adjustments	
	15.00	16.00	24.00	25.00	26.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0 111.00
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0 115.00
116. 00 11600 HOSPI CE	0	0		0 0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	33, 002	93, 548	4, 036, 34	7 0	4, 036, 347 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15, 73	в О	15, 738 190. 00
191. 00 19100 RESEARCH	0	0		0 0	0 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	3, 55	в О	3, 558 192. 00
193.00 19300 NONPALD WORKERS	0	0		0 0	0 193.00
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0		0 0	0 194.00
194. 01 07951 SPORTS MEDI CI NE	0	0		0 0	0 194.01
194.0207952COMMUNITY IND HEALTH	0	0	72, 81	6 0	72, 816 194. 02
200.00 Cross Foot Adjustments				0 0	0 200. 00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118-201)	33, 002	93, 548	4, 128, 45	9 0	4, 128, 459 202. 00

In Lieu of Form CMS-2552-10 Worksheet B-1

	LLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
					From 01/01/2014 Fo 12/31/2014		pared
		CAPI TAL REL	ATED COSTS			5/27/2015 9:3	
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci l i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS			1			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	105, 598	105, 598				1.0 2.0
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	723	723		2		4.0
5.00	00500 ADMI NI STRATI VE & GENERAL	16, 057	16, 057			26, 461, 334	
6.00	00600 MAINTENANCE & REPAIRS	0	0		0 0	0	6.0
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	7,944	7, 944 3, 094			1, 601, 277 254, 093	
8.00 9.00	00900 HOUSEKEEPING	247	247			489,004	
10.00	01000 DI ETARY	3, 081	3, 081		9 0	350, 660	
11.00	01100 CAFETERI A	1,690	1, 690	111, 92	0	238, 234	
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	1,013	0 1, 013	5, 512		0 152, 325	
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 661	5, 661			360, 638	
15.00	01500 PHARMACY	300				599, 126	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 935	1, 935	94, 656	6 0	246, 505	16.0
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	15, 728	15, 728	1, 119, 70	1 0	2, 123, 834	30. 0
31.00	03100 I NTENSI VE CARE UNI T	1,879	1, 879			660, 843	
32.00	03200 CORONARY CARE UNI T	0	0		0 0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	(0	0	
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	4, 310	4, 310	628, 488		0 1, 029, 231	
1.00	04100 SUBPROVIDER - IRF	0	0	(0 0	0	
12.00	04200 SUBPROVI DER	0	0	(0 0	0	
13.00 14.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	0			0	
15.00	04400 SKILLED NORSING FACILITY	0	0				
45.01	04510 CF/MR	0	0		0 0	0	
46.00	04600 OTHER LONG TERM CARE	0	0	(0 0	0	46.0
50.00	ANCI LLARY SERVI CE COST CENTERS	6, 273	6, 273	1, 131, 843	3 0	1, 883, 655	50. 0
51.00	05100 RECOVERY ROOM	0,2,0	0,2,0	(0 0	0	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 15, 478	0 15, 478	1, 049, 578		0 2, 414, 300	
54.00 54.01	05401 ULTRASOUND	281	281			88, 083	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0			924, 098	
56.00	05600 RADI OI SOTOPE	267	267			170, 709	
57.00	05700 CT SCAN 05800 MRI	0	0			0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60.00	06000 LABORATORY	5, 386	5, 386		0 0	2, 284, 070	
50.01 51.00	06001 BLOOD LABORATORY	0	0	(0 0	0	
52.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			0	61.0
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0 0	0	
4.00	06400 I NTRAVENOUS THERAPY	0	0)	0	0	
5.00 6.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	406				447, 292 698, 784	
57.00	06700 OCCUPATI ONAL THERAPY	0	2, 327	(0 0	0,00,704	1
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.0
9.00		323	323	156, 314	4 0	224, 408	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 412	0 1, 412		0 וע ס (כ	0 1, 180, 882	70.0
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			783, 771	
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 271	4, 271	0	0 0	5, 083, 775	73.0
74.00	07400 RENAL DIALYSIS	0	0			0	
75.00 76.00	07500 ASC (NON-DISTINCT PART) 03020 ONCOLOGY				ט וי ח (כ	0	
5.00	OUTPATIENT SERVICE COST CENTERS					. 0] , 0. (
38.00	08800 RURAL HEALTH CLINIC	0	0	(0 0	0	
39.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 851	0 851	(139, 906		0 233, 248	
		2, 684				1, 715, 558	
	O9100 EMERGENCY	Z. 004					
90. 00 91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	2,004	2,004				92.0

 FRANCI SCAN ST. ELI ZABETH HEALTH - CR
 In Lieu of Form CMS-2552-10

 Provider CCN: 150022
 Period: From 01/01/2014
 Worksheet B-1

 To 12/31/2014
 Date/Time Prepared:

				T	0 12/31/2014	Date/Time Pre 5/27/2015 9:3	pared: 7 am
		CAPI TAL REL	ATED COSTS			0/2//2010 7.0	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	2.00	SALARI ES)	E A	F 00	
CDECL	AL PURPOSE COST CENTERS	1.00	2.00	4.00	5A	5.00	
	PANCREAS ACQUISITION	0	0	0	0	0	109.00
	INTESTINAL ACQUISITION	0	0	0	0		110,00
	I SLET ACQUI SI TI ON	0	0	0	0		111.00
	INTEREST EXPENSE	0	0	0	0		113.00
	UTI LI ZATI ON REVI EW-SNF						114.00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
116.00 11600		0	0	0	0		116.00
	SUBTOTALS (SUM OF LINES 1-117)	103, 623	103, 623	9, 166, 658	-6, 435, 902		
	MBURSABLE COST CENTERS		· · · ·	· · · · ·			
190.0019000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	351	0	0	13, 723	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
	PHYSICIANS' PRIVATE OFFICES	0	0	26, 931	0	145, 716	192.00
	NONPAID WORKERS	0	0	0	0		193.00
	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
	SPORTS MEDICINE	0	0	0	0		194. 01
	COMMUNITY IND HEALTH	1, 624	1, 624	0	0	63, 492	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		17 5 10				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 060, 890	67, 569	3, 087, 462		6, 435, 902	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	38. 456126	0. 639870	0. 335828		0. 243219	203.00
204.00	Cost to be allocated (per Wkst. B,			28, 267		630, 960	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0. 003075		0. 023845	205.00
	11)		l		I	l	I

Heal th Financial	Systems	
COST ALLOCATION		-

Heal th	Financial Systems FRAN	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der		eriod:	Worksheet B-1	
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	nared
						5/27/2015 9:3	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	
		(SUUARE ILLI)	(SUDARE TELT)	LAUNDRY)			
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	1	1	1	ŀ	r	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS	0					6.00
7.00	00700 OPERATION OF PLANT	0	80, 874				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	3, 094				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	247 3, 081			19, 916	9.00 10.00
11.00	01100 CAFETERI A	0	1, 690		1, 690		11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	1, 013		1, 013		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0				0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0			300 1, 935	0	15.00 16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	1, 755	0	1, 755	0	10.00
30.00	03000 ADULTS & PEDIATRICS	0	15, 728			11, 972	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	1, 879	7, 744	1, 879		31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF		4, 310	25, 398	4, 310		40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0, 120	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0		44.00 45.00
45.00 45.01	04510 I CF/MR		0		0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50.00	05000 OPERATING ROOM	0					50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	15, 478	10, 122	15, 478	0	54.00
54.01	05401 ULTRASOUND	0	281	0	281	0	54.01
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0 267	0	0 267	0	55.00 56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60.00		0	5, 386	0	5, 386		60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00		0	406				65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	2, 329	7,074	2, 329	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	323	0	323	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	-	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 412	0	1, 412		71.00 72.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 271		4, 271	0	72.00
74.00	07400 RENAL DI ALYSI S	0	9,2,1	0	9,271	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020 ONCOLOGY	0	0	0	0	0	76.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	88.00
88.00 89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89.00
90.00	09000 CLINIC	0	851		851	0	90.00
91.00	09100 EMERGENCY	0	2, 684			0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
99 10	OTHER REI MBURSABLE COST CENTERS 09910 CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0			0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0			-		110. 00 111. 00
111.00	ITTOUTSET ACQUISTIUN	0	1 U	0	0	0	111.00

Health Financial Systems FRAM	ICI SCAN ST. ELI Z	ABETH HEALTH -	CR	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eriod:	Worksheet B-1	
				rom 01/01/2014 o 12/31/2014	Date/Time Pre	nared
				0 12/31/2014	5/27/2015 9: 3	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
	(7.00	LAUNDRY)	0.00	10.00	
	6.00	7.00	8.00	9.00	10.00	110.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0	78, 899	272, 270			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	78, 899	272, 270	75, 558	19,910	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	351		351	0	190.00
191. 00 19100 RESEARCH	0	0		0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0		193.00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0		194.00
194. 01 07951 SPORTS MEDI CI NE	0	0		0	0	194.01
194.0207952 COMMUNITY IND HEALTH	0	1, 624	l c	1, 624	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	0	1, 990, 738	392, 053	657, 484	540, 548	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	24. 615303	1. 439942	8. 480054	27. 141394	203.00
204.00 Cost to be allocated (per Wkst. B,	0	349, 301	140, 667	37, 979	144, 997	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	4. 319077	0. 516645	0. 489843	7. 280428	205.00
11)		I	l			l

IST A	LLOCATION - STATISTICAL BASIS			Provi der	CCN: 1500	F	Period: From 01/01/2014	Worksheet B-	
		0155555			-		o 12/31/2014	Date/Time Pre 5/27/2015 9:3	
	Cost Center Description	CAFETERI A (FTES)	PE (H	FENANCE O RSONNEL NUMBER OUSED)	ADMI NI STR (DI RE NRSI N	ATION CT G)	CENTRAL I SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	
	GENERAL SERVICE COST CENTERS	11.00		12.00	13.0	2	14.00	15.00	
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATION OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	13, 045 0 11 302 443 246			0 0 27 0 0 0	1, 087 6, 290 9, 213 5, 121	100 100 0	100	1 2 4 5 6 7 8 9 10 11 12 13 14 0 15 0 16
	INPATIENT ROUTINE SERVICE COST CENTERS	1.075							
. 00 . 00 . 00 . 00 . 00 . 00 . 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	1,975 554 0 0 0 1,020 0 0 0 0 0 0 0			0 1 0 0	1, 080 1, 525 0 0 1, 208 1, 208 0 0 0) 31) 32) 33) 34) 40) 41) 42) 43
00	04400 SKILLED NURSING FACILITY	0			0	C	0	(
. 00 . 01	04500 NURSING FACILITY 04510 ICF/MR				0	C	-	(
. 00	04600 OTHER LONG TERM CARE	0			0	C		(
	ANCI LLARY SERVICE COST CENTERS		1						
. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	2,066			0 4 0	2, 972		(
. 00 . 00	05200 DELIVERY ROOM & LABOR ROOM				0	C	-	(
	05300 ANESTHESI OLOGY	0			0	C	0	(
00	05400 RADI OLOGY-DI AGNOSTI C	1,702				5, 393		(
	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	76				1, 573 8, 802		(
. 00	05600 RADI OLOGI - THERAPEOTIC	102				2, 111		(
	05700 CT SCAN	0			0	_, C		(
	05800 MRI	0			0	C	0 0	(
. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0			0	C	0	(
. 00	06001 BLOOD LABORATORY				0	C	0	(
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY								61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	C	0	(
. 00 . 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY				0	C		(
. 00	06500 RESPI RATORY THERAPY	516			0 1	0, 726	0	(
. 00	06600 PHYSI CAL THERAPY	762	2		0 1	5,849	0	(1 00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0			0	C	0	(
	06900 ELECTROCARDI OLOGY	268			0	5, 582	-	(
	07000 ELECTROENCEPHALOGRAPHY	0			o	C	, i	(
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0			0	C	59	(
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS						41	0 100	
	07400 RENAL DIALYSIS	0			0	C	0	(
	07500 ASC (NON-DISTINCT PART)	0			o	C	0 0	() 75
. 00	03020 ONCOLOGY	0			0	0	0 0	(<u> </u>
. 00	OUTPATIENT SERVICE COST CENTERS	0			0	0		(88 0
	08900 FEDERALLY QUALIFIED HEALTH CENTER				o	C	-	(
	09000 CLINIC	220			0	4, 574	, v	(
	09100 EMERGENCY	1, 878			0 3	9, 068	0	C	
. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART								92
. 10	OTHER REIMBURSABLE COST CENTERS	0			0	C	0	(0 99
			1		-1		ч Ч		Η ΄΄
	SPECIAL PURPOSE COST CENTERS		-						

Health Financial Systems FRANC	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 01/01/2014 0 12/31/2014	Date/Time Pre	norod.
				12/31/2014	5/27/2015 9:3	
Cost Center Description	CAFETERIA	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
	(FTES)		ADMI NI STRATI ON	SERVICES &	(COSTED	
	. ,	(NUMBER		SUPPLY	REQUIS.)	
		HOUSED)	(DI RECT	(COSTED		
			NRSING)	REQUIS.)		
	11.00	12.00	13.00	14.00	15.00	
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(0 0		115.00
116. 00 11600 HOSPI CE	0	0	(0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	13, 045	0	271, 08	7 100	100	118.00
NONREI MBURSABLE COST CENTERS						1.00.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0		190.00
	0	0	(0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0		192.00
193. 00 19300 NONPALD WORKERS	0	0	l	0		193.00 194.00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 194. 01 07951 SPORTS MEDICINE	0	0				194.00
194. 02 07952 COMMUNITY_IND_HEALTH	0	0				194.01
200.00 Cross Foot Adjustments	0	0	(0	0	200.00
201.00 Negative Cost Centers						200.00
201.00 Negative cost centers 202.00 Cost to be allocated (per Wkst. B,	352, 108	0	223, 195	650, 485	774, 316	
Part 1)	352, 100	0	223, 193	000, 400	114, 310	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	26, 991798	0. 000000	0. 823333	6, 504, 850000	7, 743. 160000	203 00
204.00 Cost to be allocated (per Wkst. B,	80, 224		48, 192			204.00
Part II)	00,221	Ŭ	10, 172	200,070	00,002	
205.00 Unit cost multiplier (Wkst. B, Part	6. 149789	0. 000000	0, 177773	2, 608. 960000	330. 020000	205.00
		•				

alth Financial Systems DST ALLOCATION - STATISTICAL BASIS	FRANCISCAN ST. ELI	Provider CCN: 150022	In Lieu of Form CMS- Period: Worksheet B-	
ST ALLOCATION - STATISTICAL DASIS			From 01/01/2014 To 12/31/2014 Date/Time Pro	
			5/27/2015 9:	
Cost Center Description	MEDI CAL RECORDS & LI BRARY (GROSS <u>CHARGES)</u> 16.00	_		
GENERAL SERVICE COST CENTERS				
00 00100 CAP REL COSTS-BLDG & FIXT 00 00200 CAP REL COSTS-MVBLE EQUIP				1
00 00400 EMPLOYEE BENEFITS DEPARTMENT				4
00500 ADMINI STRATI VE & GENERAL				5
00600 MAINTENANCE & REPAIRS				6
				1
00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING				
00 01000 DI ETARY				10
00 01100 CAFETERIA				11
00 01200 MAINTENANCE OF PERSONNEL				12
00 01300 NURSI NG ADMI NI STRATI ON				13
00 01400 CENTRAL SERVICES & SUPPLY 00 01500 PHARMACY				14
. 00 01600 MEDI CAL RECORDS & LI BRARY	132, 928, 69	2		16
INPATIENT ROUTINE SERVICE COST CENTERS	102/ /20/ 0/	-		
. 00 03000 ADULTS & PEDIATRICS	5, 150, 89	7		30
00 03100 INTENSIVE CARE UNIT	1, 281, 24			31
. 00 03200 CORONARY CARE UNI T				32
. 00 03300 BURN INTENSIVE CARE UNIT . 00 03400 SURGICAL INTENSIVE CARE UNIT				33
. 00 04000 SUBPROVIDER - IPF	2, 981, 90	1		40
.00 04100 SUBPROVIDER - IRF	2, 701, 70			41
00 04200 SUBPROVI DER		D		42
. 00 04300 NURSERY				43
00 04400 SKILLED NURSING FACILITY		0		44
. 00 04500 NURSING FACILITY . 01 04510 CF/MR		מ		45
. 01 04510 ICF/MR . 00 04600 OTHER LONG TERM CARE				45
ANCI LLARY SERVICE COST CENTERS		5		
. 00 05000 OPERATI NG ROOM	9, 726, 51	7		50
. 00 05100 RECOVERY ROOM				51
. 00 05200 DELIVERY ROOM & LABOR ROOM				52
. 00 05300 ANESTHESI OLOGY . 00 05400 RADI OLOGY-DI AGNOSTI C	28, 049, 84			53
. 01 05401 ULTRASOUND	2, 457, 34			54
. 00 05500 RADI OLOGY-THERAPEUTI C	4, 082, 53	6		55
. 00 05600 RADI OI SOTOPE	2, 559, 57			56
. 00 05700 CT SCAN				57
00 05800 MRI 00 05900 CARDI AC CATHETERI ZATI ON				58
. 00 06000 LABORATORY	15, 994, 67	7		60
01 06001 BLOOD LABORATORY		D		60
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONL				61
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CEL	L			62
00 06300 BLOOD STORING, PROCESSING & TRANS. 00 06400 INTRAVENOUS THERAPY				63
00 06500 RESPI RATORY THERAPY	1, 685, 34	7		65
00 06600 PHYSI CAL THERAPY	2,003,28			66
. 00 06700 OCCUPATI ONAL THERAPY				67
00 06800 SPEECH PATHOLOGY				68
	3, 983, 52	7		69
00 07000 ELECTROENCEPHALOGRAPHY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	IT 7, 349, 76	0 1		70
.00 07100 MEDICAL SUPPLIES CHARGED TO PATTER .00 07200 IMPL. DEV. CHARGED TO PATTENTS	3, 034, 66			72
00 07300 DRUGS CHARGED TO PATIENTS	25, 522, 86			73
. 00 07400 RENAL DIALYSIS		D		74
. 00 07500 ASC (NON-DI STI NCT PART)				75
00 03020 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS		0		76
. 00 08800 RURAL HEALTH CLINIC				88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89
. 00 09000 CLINIC	720, 66	o		90
. 00 09100 EMERGENCY	16, 344, 05	6		91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	?T			92
OTHER REIMBURSABLE COST CENTERS				
. 10 09910 CORF SPECIAL PURPOSE COST CENTERS		0		99
9. 00 10900 PANCREAS ACQUISITION				109
				110

Heal th Financial	Systems
COST ALLOCATION	- STATISTICAL BASIS

In Lieu of Form CMS-2552-10 Worksheet B-1

In on Date/Time Prepared: 5/27/2015 Date/Time	COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150022	Period: From 01/01/2014	Worksheet B-	1
Cost Center Description MEDICAL RECORDS & LIBRARY (GROSS CHARGES) 111.00 111.00 11100 ISLET ACQUISITION 16.00 111.00 INTEREST EXPENSE 111.00 113.00 INTEREST EXPENSE 114.00 116.00 INTEREST EXPENSE 114.00 116.00 INTEREST EXPENSE 114.00 115.00 I1600 HOSPICE 0 116.00 UBTOTALS (SUM OF LINES 1-117) 132,928,692 118.00 SUBTOTALS (SUM OF LINES 1-117) 132,928,692 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 191.00 ISESARCH 0 191.00 192.00 IY3CI ANS' PRI VATE OFFICES 0 192.00 193.00 19300 NONREI MBURSABLE COST CENTERS 193.00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194.00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194.00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194.00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS					Date/Time Pr	epared:
RECORDS & LI BRARY RECORDS & LI BRARY 111. 00 11100 I SLET ACOULSI TI 0N 0 111. 00 11300 I SLET ACOULSI TI 0N 0 114. 00 11120 I SLET ACOULSI TI 0N 0 114. 00 I SLET ACOULSI TI 0N 0 113. 00 114. 00 I SLET ACOULSI TI 0N 0 113. 00 114. 00 I SLET ACOULSI TI 0N 0 114. 00 114. 00 I SUB TOTALS (SUM OF LINES STER 114. 00 116. 00 SUBBTOTALS (SUM OF LINES 1-117) 0 0 118. 00 SUB TOTALS (SUM OF LINES 1-117) 132, 928, 692 118. 00 NONRE IMBURSABLE COST CENTERS 0 119. 00 118. 00 190. 00 19000 GIFT, FLOWER, COFFE SHOP & CANTEEN 0 191. 00 191. 00 192. 00 192. 00 192. 00 193. 00 193. 00 193. 00 19300 NONREI MBURSABLE COST CENTERS 0 194. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 01					5/27/2015 9:	<u>37 am</u>
LIBRARY (GROSS CHARGES) LIBRARY (GROSS 111.00 11100 ISLET ACQUISITION 0 113.00 11100 ISLET ACQUISITION 0 113.00 11100 INTEREST EXPENSE 113.00 114.00 114.00 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 116.00 1050 PICE 0 116.00 109.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 118.00 190.00 106 T, FLOWER, COFFEE SHOP & CANTEEN 0 191.00 190.00 107, FLOWER, COFFEE SHOP & CANTEEN 0 192.00 190.00 107, FLOWER, COFFEE SHOP & CANTEEN 0 192.00 190.00 107, FLOWER, COFFEE SHOP & CANTEEN 0 192.00 191.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 192.00 193.00 194.00 O7950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 194.02 07952 COMMUNI TY IND HEALTH 0 194.02 194.02	Cost Center Description					
Image: Constraint of the second sec						
CHARGES) 16.00 111.00 113.00 111.00 113.00 111.00 113.00 114.00 116.00 115.00 116.00 115.00 116.00 116.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 119.00 191.00 191.00 191.00 191.00 192.00 192.00 193.00 193.00 193.00 193.00 193.00						
16.00 16.00 111:00 11100 ISET ACQUISITION 0 113:00 INTEREST EXPENSE 113.00 114:00 UILIZATION REVIEW-SNF 114.00 115:00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 116:00 11600 HOM PLATEST EXPENSE 114.00 115:00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 118:00 SUBTOTALS (SUM OF LINES 1-117) 132, 928, 692 118.00 NONREI MBURSABLE COST CENTERS 0 190.00 190.00 190:00 RESEARCH 0 192.00 191:00 19300 NONREI MBURSABLE COST CENTERS 0 192:00 PHYSICIANS' PRIVATE OFFICES 0 193.00 193:00 19300 NONREI MBURSABLE COST CENTERS 0 194:01 07951 SPORTS MEDICINE 0 194:02 07952 COMUNITY IND HEALTH 0 200:00 Cross Foot Adjustments 200.00 202:00 Coss to be allocated (per Wkst. B, Part I) 0.002869 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
111.00 11100 I SLET ACQUI SI TI ON 0 111.00 11300 INTEREST EXPENSE 113.00 114.00 114.00 III LION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 116.00 11600 HORNEL MBURSABLE COST CENTER (D. P.) 0 NOREE IMBURSABLE COST CENTERS 118.00 118.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 191.00 RESEARCH 0 192.00 192000 PHSICI CANS' PRI VATE OFFI CES 0 193.00 19300 NONREI MBURSABLE COST CENTERS 192.00 194.00 07950 OTHER NORREI MBURSABLE COST CENTERS 0 194.00 07951 SPORTS MEDI CINE 0 194.00 07952 COMUNI TY IND HEALTH 0 194.00 Cross Foot Adj ustments 200.00 201.00 202.00 Coss to be al located (per Wkst. B, Part I) 0.002869 203.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002869 203.00 204.00 Cost to be al located (per Wkst. B, Part I)		· · · · · · · · · · · · · · · · · · ·				
113.00 11300 INTEREST EXPENSE 113.00 114.00 UTI LI ZATI ON REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 116.00 11600 HOSPI CE 0 118.00 SUBTOTALS (SUM OF LINES 1-117) 132,928,692 118.00 NONRET MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 191.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 193.00 19300 NONREI MBURSABLE COST CENTERS 0 194.00 17950 OTHER NONREI MBURSABLE COST CENTERS 0 194.01 07951 SPORTS MEDI CI NE 0 194.02 07952 COMMUNI TY I ND HEALTH 0 194.01 194.02 07952 COMMUNI TY I ND HEALTH 0 194.02 200.00 Cross Foot Adj ustments 200.00 201.00 202.00 201.00 Negative Cost Centers 201.00 202.00 202.00 203.00 Unit cost multiplier (Wkst. B		16.00				
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191.00 19100 RESEARCH 0 191.00 192.00 19200 PHYSI CLANS' PRIVATE OFFICES 0 192.00 193.00 19300 NONPAID WORKERS 0 193.00 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 194.00 194.01 07951 SPORTS MEDI CLNE 0 194.00 194.01 194.02 07952 COMMUNI TY IND HEALTH 0 194.02 200.00 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 381,356 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002869 203.00 204.00 Cost to be allocated (per Wkst. B, 93,548 93,548 204.00						
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193.00 19300 NONPAID WORKERS 0 193.00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00 194.01 07951 SPORTS MEDICINE 0 194.01 194.02 07952 COMMUNITY IND HEALTH 0 194.02 200.00 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 381,356 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002869 203.00 204.00 Cost to be allocated (per Wkst. B, 93,548 93,548		0				
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 194.01 07951 SPORTS MEDICINE 0 194.01 194.02 07952 COMMUNITY IND HEALTH 0 194.02 200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 201.00 Negative Cost Centers 201.00 202.00 202.00 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002869 203.00 203.00 204.00 Cost to be allocated (per Wkst. B, 93,548 93,548 204.00		0				
194.01 07951 SPORTS MEDICINE 0 194.01 194.02 07952 COMMUNITY IND HEALTH 0 194.02 200.00 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 0.002869 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002869 204.00 Cost to be allocated (per Wkst. B, P3, 548		0				
194.02 07952 COMMUNITY IND HEALTH 0 194.02 200.00 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 381,356 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002869 204.00 Cost to be allocated (per Wkst. B, 93,548 204.00		0				
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 381,356 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002869 204.00 Cost to be allocated (per Wkst. B, 93,548 203.00		0				
201.00 Negative Cost Centers 201.00 202.00 202.00 Cost to be allocated (per Wkst. B, Part I) 381,356 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002869 203.00 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 93,548 204.00 204.00		0				
202.00 Cost to be allocated (per Wkst. B, Part I) 381,356 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002869 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 93,548 204.00	3					
203.00 Part I) 0.002869 203.00 204.00 Cost to be allocated (per Wkst. B, 93,548 203.00 Part II) 0.002869 204.00	5					
203.00 Unit cost multiplier (Wkst. B, Part I) 0.002869 203.00 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 93,548 204.00 204.00		381, 356				202.00
204.00 Cost to be allocated (per Wkst. B, 93, 548 204.00 204.00						
Part II)						
		93, 548				204.00
205.00 Unit cost multiplier (Wkst. B, Part 0.000704 205.00						
		0. 000704				205.00
	11)					1

Health Financial Systems FRAM	NCISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet C Part I Date/Time Pre	epared:
		Ti tl	e XVIII	Hospi tal	5/27/2015 9:3 PPS	
			[Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	3, 706, 650		3, 706, 650	0	3, 706, 650	
31.00 03100 I NTENSI VE CARE UNI T	964, 174		964, 174	0	964, 174	
32.00 03200 CORONARY CARE UNIT	0		0	0	0	
33. 00 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	1 404 704		1 404 704	12 441	1 400 227	
40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF	1, 686, 786		1, 686, 786	12, 441	1, 699, 227 0	
41.00 04100 SUBPROVIDER - TRP 42.00 04200 SUBPROVIDER	0		0	0	0	
43. 00 04300 NURSERY	0		0	0	0	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0			0	0	
45. 00 04500 NURSING FACILITY	0		0	0	0	
45. 01 04510 I CF/MR	0		0	0	0	
46.00 04600 OTHER LONG TERM CARE	0		0	0	0	
ANCI LLARY SERVICE COST CENTERS			1 0	0		101.00
50. 00 05000 OPERATING ROOM	2, 720, 829		2, 720, 829	8, 465	2, 729, 294	50.00
51.00 05100 RECOVERY ROOM	0		0	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 683, 869		3, 683, 869	0	3, 683, 869	54.00
54. 01 05401 ULTRASOUND	129, 202		129, 202	0	129, 202	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 200, 450		1, 200, 450	0	1, 200, 450	55.00
56. 00 05600 RADI OI SOTOPE	232, 899		232, 899	0	232, 899	56.00
57.00 05700 CT SCAN	0		0	0	0	57.00
58. 00 05800 MRI	0		0	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	
60. 00 06000 LABORATORY	3, 063, 740		3, 063, 740	5, 043	3, 068, 783	
60. 01 06001 BLOOD LABORATORY	0		0	0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0	0	
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY	0		0	0	0	
65. 00 06500 RESPIRATORY THERAPY	599, 132		599, 132	0	599, 132	
66. 00 06600 PHYSI CAL THERAPY	995, 371		995, 371	0	995, 371	
67. 00 06700 OCCUPATI ONAL THERAPY	993, 371		, 775, 571 0	0	995, 571	1
68. 00 06800 SPEECH PATHOLOGY	0			0	0	
69. 00 06900 ELECTROCARDI OLOGY	312, 937		312, 937	0	312, 937	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	012,707	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 919, 698		1, 919, 698	0	1, 919, 698	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 249, 804		1, 249, 804	0	1, 249, 804	
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 309, 139		7, 309, 139	0	7, 309, 139	73.00
74.00 07400 RENAL DIALYSIS	0		0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76. 00 03020 ONCOLOGY	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0		0	0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	
90. 00 09000 CLINIC	329, 915		329, 915		329, 915	
91.00 09100 EMERGENCY	2, 450, 126		2, 450, 126	0	2, 450, 126	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	749, 687		749, 687		749, 687	92.00
OTHER REIMBURSABLE COST CENTERS	1	1		1	-	0.0.10
99. 10 09910 CORF	0		0		0	99.10
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUI SI TI ON	0		0		0	109.00
110. 00 11000 PANCREAS ACQUISITION 110. 00 11000 NTESTINAL ACQUISITION						1109.00
111. 00 11100 I SLET ACQUI SI TI ON						111.00
113. 00 11300 I NTEREST EXPENSE	0				0	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0		0	115.00
116. 00 11600 HOSPI CE	0					116.00
200.00 Subtotal (see instructions)	33, 304, 408	c	33, 304, 408	25, 949	33, 330, 357	
201.00 Less Observation Beds	749, 687		749, 687		749, 687	
202.00 Total (see instructions)	32, 554, 721					
	= .	,				

	CISCAN ST. ELIZA	ABETH HEALTH -	CR	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150022 P	eriod:	Worksheet C	
				rom 01/01/2014 o 12/31/2014	Part I Date/Time Pre	nared
				0 12/31/2014	5/27/2015 9:3	7 am
		Titl	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6		TEFRA	
			+ col. 7)	Ratio	Inpati ent	
	(00	7.00	0.00	0.00	Ratio	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	4, 184, 705		4, 184, 705			30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 281, 241		1, 281, 241			31.00
32. 00 03200 CORONARY CARE UNI T	1,201,211		0			32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		0			33.00
34.00 03400 SURGI CAL INTENSI VE CARE UNI T	0		0			34.00
40. 00 04000 SUBPROVI DER – I PF	2, 981, 901		2, 981, 901			40.00
41.00 04100 SUBPROVIDER – IRF	0		0			41.00
42. 00 04200 SUBPROVI DER	0		0			42.00
43. 00 04300 NURSERY	0		0			43.00
44.00 04400 SKILLED NURSING FACILITY	0		0			44.00
45. 00 04500 NURSING FACILITY	0		0			45.00
45. 01 04510 I CF/MR	0		0			45.01
46. 00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0		0			46.00
50. 00 05000 OPERATI NG ROOM	2, 394, 342	7, 332, 175	9, 726, 517	0. 279733	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	2, 374, 342	7, 332, 173	9, 720, 517	0. 279733	0. 000000	•
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0. 000000	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0	0	0. 000000	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 103, 431	24, 946, 418	28, 049, 849		0. 000000	
54. 01 05401 ULTRASOUND	240, 638	2, 216, 702			0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	11, 175	4,071,361			0. 000000	
56. 00 05600 RADI OI SOTOPE	95, 396	2, 464, 179			0. 000000	56.00
57.00 05700 CT SCAN	0	0	0	0. 000000	0. 000000	57.00
58. 00 05800 MRI	0	0	0	0. 000000	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0. 000000	0. 000000	
60. 00 06000 LABORATORY	4, 124, 680	11, 869, 997	15, 994, 677	0. 191547	0.00000	•
60. 01 06001 BLOOD LABORATORY	0	0	0	0.000000	0.00000	•
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.00000	0.00000	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	0.000000	•
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0	0	0.00000	0.00000	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	1, 207, 792	477, 555	1, 685, 347	0. 000000 0. 355495	0. 000000 0. 000000	
66. 00 06600 PHYSI CAL THERAPY	272, 877	1, 730, 405		0. 335495	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	272,077	1, 730, 403	2,003,202	0. 000000	0. 000000	
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0. 000000	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	752, 268	3, 231, 259	3, 983, 527		0.000000	•
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0. 000000	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 499, 138	4, 850, 623	7, 349, 761	0. 261192	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 069, 623	965, 042	3, 034, 665	0. 411842	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 655, 426	19, 867, 435	25, 522, 861	0. 286376	0. 000000	
74.00 07400 RENAL DIALYSIS	0	0	0	0. 000000	0. 000000	
75. 00 07500 ASC (NON-DI STINCT PART)	0	0			0.00000	
76.00 03020 ONCOLOGY	0	0	0	0.00000	0. 000000	76.00
		0	0			
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			88.00 89.00
90. 00 09000 CLINIC	0	720, 660	-		0. 000000	
91. 00 09100 EMERGENCY	1, 663, 797	14, 680, 259			0. 000000	•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,003,777	966, 192				•
OTHER REIMBURSABLE COST CENTERS		700, 172	700,172	0.770717	0.00000	72.00
99. 10 09910 CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS				I		
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0			111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00 11600 HOSPI CE	0	0	0			116.00
200.00 Subtotal (see instructions)	32, 538, 430	100, 390, 262	132, 928, 692			200.00
201.00 Less Observation Beds	22 520 420	100 200 2/2	122 020 (02			201.00
202.00 Total (see instructions)	32, 538, 430	100, 390, 262	132, 928, 692	l	l	202.00

Heal th	Financial Systems FRAN	CISCAN ST. ELIZAB	ETH HEALTH - CR	In Lie	u of Form CMS-2552-1	10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150022	Period:	Worksheet C	_
				From 01/01/2014 To 12/31/2014	Part I Date/Time Prepared:	ŀ
				10 12/01/2011	5/27/2015 9:37 am	
			Title XVIII	Hospi tal	PPS	_
	Cost Center Description	PPS Inpatient				
		Rati o 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	11100				_
30.00	03000 ADULTS & PEDIATRICS				30. 0	00
31.00	03100 I NTENSI VE CARE UNI T				31.0	
32.00	03200 CORONARY CARE UNIT				32.0	
33.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT				33.0	
34.00 40.00	04000 SUBPROVIDER - IPF				34. 0 40. 0	
41.00	04100 SUBPROVIDER - IRF				41.0	
42.00	04200 SUBPROVI DER				42.0	
43.00	04300 NURSERY				43.0	00
44.00	04400 SKILLED NURSING FACILITY				44.0	
45.00	04500 NURSING FACILITY				45.0	
45.01	04510 I CF/MR				45.0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS				46.0	JU
50.00		0. 280603			50.0	00
51.00	05100 RECOVERY ROOM	0. 000000			51.0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0	
53.00	05300 ANESTHESI OLOGY	0. 000000			53.0	00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 131333			54.0	
54.01	05401 ULTRASOUND	0. 052578			54.0	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0. 294045 0. 090991			55. 0 56. 0	
57.00	05700 CT SCAN	0. 000000			57.0	
58.00	05800 MRI	0. 000000			58.0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.0	
60.00	06000 LABORATORY	0. 191863			60.0	00
60. 01	06001 BLOOD LABORATORY	0. 000000			60. 0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62.0	
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0.000000			63. 0 64. 0	
65.00	06500 RESPI RATORY THERAPY	0. 355495			65.0	
66.00	06600 PHYSI CAL THERAPY	0. 496870			66.0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.0	00
68.00	06800 SPEECH PATHOLOGY	0. 000000			68.0	00
69.00	06900 ELECTROCARDI OLOGY	0. 078558			69.0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.00000			70.0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 261192			71. 0 72. 0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0. 411842 0. 286376			72.0	
74.00	07400 RENAL DIALYSIS	0. 000000			74.0	
75.00	07500 ASC (NON-DI STINCT PART)	0. 000000			75.0	
76.00		0. 000000			76. 0	00
00.05	OUTPATIENT SERVICE COST CENTERS	1				
88.00					88.0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0. 457796			89. 0 90. 0	
90.00 91.00		0. 149909			91.0	
		0. 775919			92.0	
	OTHER REIMBURSABLE COST CENTERS					
99. 10	09910 CORF				99. 1	10
	SPECIAL PURPOSE COST CENTERS					
	10900 PANCREAS ACQUISITION				109.0	
	11000 INTESTINAL ACQUISITION				110.0	
) 11100 ISLET ACQUI SI TI ON) 11300 INTEREST EXPENSE				111. 0 113. 0	
	11400 UTILIZATION REVIEW-SNF				113.0	
	11500 AMBULATORY SURGICAL CENTER (D. P.)				115.0	
	11600 HOSPI CE				116. 0	00
200.00					200. 0	
201.00					201.0	
202.00) Total (see instructions)				202.0	JÜ

Health Financial Systems FRA COMPUTATION OF RATIO OF COSTS TO CHARGES	NCISCAN ST. ELIZ		CCN: 150022 P F	veriod: from 01/01/2014 fo 12/31/2014		pared:
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	3, 706, 650		3, 706, 650	0	3, 706, 650	30.00
31. 00 03100 I NTENSI VE CARE UNI T	964, 174		964, 174		964, 174	
32.00 03200 CORONARY CARE UNI T	C		0	0	0	
33.00 03300 BURN INTENSIVE CARE UNIT	C		0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	C	D	0	0	0	
40. 00 04000 SUBPROVIDER - IPF	1, 686, 786		1, 686, 786	12, 441	1, 699, 227	40.00
41. 00 04100 SUBPROVIDER - IRF			0	0	0	
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY				0	0	
44. 00 04400 SKI LLED NURSI NG FACI LI TY				0	0	
45. 00 04500 NURSING FACILITY				0	0	
45.01 04510 I CF/MR	C		0	0	0	
46.00 04600 OTHER LONG TERM CARE	0		0	0	0	46.00
ANCI LLARY SERVI CE COST CENTERS		1	1			
50. 00 05000 OPERATING ROOM	2, 720, 829		2, 720, 829	8, 465	2, 729, 294	
51.00 05100 RECOVERY ROOM	0		0	0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY				0	0	
54. 00 05500 ANESTHEST 0LOGY 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	3, 683, 869		3, 683, 869		3, 683, 869	
54. 01 05401 ULTRASOUND	129, 202		129, 202		129, 202	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 200, 450		1, 200, 450		1, 200, 450	
56. 00 05600 RADI OI SOTOPE	232, 899		232, 899		232, 899	
57.00 05700 CT SCAN	C		0	0	0	
58. 00 05800 MRI	C		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C		0	0	0	
	3, 063, 740		3, 063, 740	5, 043	3, 068, 783	
60. 01 06001 BLOOD LABORATORY			0	0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.				0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY			0	0	0	
65. 00 06500 RESPI RATORY THERAPY	599, 132	2 0	599, 132	0	599, 132	
66. 00 06600 PHYSI CAL THERAPY	995, 371	0	995, 371	0	995, 371	66.00
67.00 06700 OCCUPATI ONAL THERAPY	C	0 0	0	0	0	
68.00 06800 SPEECH PATHOLOGY	C	0 0	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	312, 937		312, 937	0	312, 937	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1 010 409		1, 919, 698	0	0 1 010 409	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 919, 698		1, 249, 804		1, 919, 698 1, 249, 804	
73. 00 07300 DRUGS CHARGED TO PATIENTS	7, 309, 139		7, 309, 139		7, 309, 139	
74.00 07400 RENAL DI ALYSI S	C		0		0	
75.00 07500 ASC (NON-DISTINCT PART)	C		0	0	0	75.00
76. 00 03020 ONCOLOGY	C		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS		J	1			
88.00 08800 RURAL HEALTH CLINIC	0		0	-	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	220.015)	0	-	0	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	329, 915 2, 450, 126		329, 915 2, 450, 126		329, 915 2, 450, 126	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	749, 687		749, 687		2, 430, 128 749, 687	
OTHER REIMBURSABLE COST CENTERS	747,007	1	147,007		747,007	/2.00
99. 10 09910 CORF	C)	0)	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	C		0			109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0		0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0		0		0	111.00
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)			_		0	114.00
116. 00 11600 HOSPICE						116.00
200.00 Subtotal (see instructions)	33, 304, 408		33, 304, 408	25, 949		
201.00 Less Observation Beds	749, 687		749, 687		749, 687	
202.00 Total (see instructions)	32, 554, 721					

		CISCAN ST. ELIZA	ABETH HEALTH -	CR	In Lie	u of Form CMS-	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150022 P	eriod:	Worksheet C	
					rom 01/01/2014 o 12/31/2014		nared
					0 12/31/2014	5/27/2015 9:3	7 am
				le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6		TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		6.00	7.00	8.00	9.00	Ratio 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
30.00	03000 ADULTS & PEDIATRICS	4, 184, 705		4, 184, 705			30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 281, 241		1, 281, 241			31.00
32.00	03200 CORONARY CARE UNI T	0		0			32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0			33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0		0			34.00
40.00	04000 SUBPROVI DER – I PF	2, 981, 901		2, 981, 901			40.00
41.00	04100 SUBPROVI DER – I RF	0		0			41.00
42.00	04200 SUBPROVI DER	0		0			42.00
43.00	04300 NURSERY	0		0			43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0		0			44.00
45.00	04500 NURSING FACILITY	0		0			45.00
45. 01 46. 00	04510 I CF/MR 04600 OTHER LONG TERM CARE	0		0			45.01 46.00
40.00	ANCI LLARY SERVICE COST CENTERS	0		0			40.00
50.00	05000 OPERATI NG ROOM	2, 394, 342	7, 332, 175	9, 726, 517	0. 279733	0.00000	50.00
51.00	05100 RECOVERY ROOM	0	002/ 1/0	0	0.000000		1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000		
53.00	05300 ANESTHESI OLOGY	0	0	0	0.000000		
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 103, 431	24, 946, 418	28, 049, 849	0. 131333	0. 000000	54.00
54.01	05401 ULTRASOUND	240, 638	2, 216, 702		0. 052578	0.000000	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	11, 175	4, 071, 361		0. 294045	0. 000000	
56.00	05600 RADI OI SOTOPE	95, 396	2, 464, 179	2, 559, 575	0. 090991	0. 000000	
57.00	05700 CT SCAN	0	0	0	0.00000	0.000000	
58.00	05800 MRI	0	0	0	0.00000	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	11 0/0 007		0.00000	0. 000000	
60.00		4, 124, 680	11, 869, 997	15, 994, 677	0. 191547	0.000000	
60. 01 61. 00	06001 BLOOD LABORATORY	0	0	0	0. 000000 0. 000000		
62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0. 000000		1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0. 000000	0. 000000	1
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0. 000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	1, 207, 792	477, 555	1, 685, 347	0. 355495		
66.00	06600 PHYSI CAL THERAPY	272, 877	1, 730, 405		0. 496870		
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0.000000	0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	752, 268	3, 231, 259	3, 983, 527	0. 078558		1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.00000		1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 499, 138	4, 850, 623		0. 261192		1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2,069,623	965, 042		0. 411842		
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 655, 426	19, 867, 435	25, 522, 861	0. 286376		
74.00 75.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	
76.00	03020 ONCOLOGY	0	0				1
70.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0.000000	0.000000	70.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0.00000	0.00000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.000000		
90.00	09000 CLINIC	0	720, 660	720, 660	0. 457796		
91.00	09100 EMERGENCY	1, 663, 797	14, 680, 259	16, 344, 056	0. 149909	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	966, 192	966, 192	0. 775919	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	11					
99.10	09910 CORF	0	0	0			99.10
100.00	SPECIAL PURPOSE COST CENTERS			0		1	100.00
	0 10900 PANCREAS ACQUISITION 0 11000 INTESTINAL ACQUISITION	0	0	0			109. 00 110. 00
	11100 I SLET ACQUI SI TI ON	0	0				111.00
	11300 INTEREST EXPENSE	0	0	0			113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115.00
	11600 HOSPI CE	0	0	0			116.00
200.00		32, 538, 430	100, 390, 262	132, 928, 692			200. 00
201.00							201.00
202.00) Total (see instructions)	32, 538, 430	100, 390, 262	132, 928, 692			202.00

Heal th	Financial Systems FRAN	CISCAN ST. ELIZABE	ETH HEALTH – CR	In Lie	u of Form CMS-	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150022	Period: From 01/01/2014	Worksheet C Part I	
				To 12/31/2014	Date/Time Pre 5/27/2015 9:3	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Rati o 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T					31.00
	03300 BURN I NTENSI VE CARE UNI T					33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT					34.00
	04000 SUBPROVIDER - IPF					40.00
	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER					41.00
	04300 NURSERY					43.00
	04400 SKILLED NURSING FACILITY					44.00
	04500 NURSING FACILITY					45.00
	04510 I CF/MR					45.01
	04600 OTHER LONG TERM CAREAND CONTRESAND CONTRES					46.00
	05000 OPERATI NG ROOM	0.000000				50.00
	05100 RECOVERY ROOM	0. 000000				51.00
1	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	05300 ANESTHESI OLOGY	0. 000000				53.00
1	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0. 000000				54.00 54.01
	05500 RADI OLOGY-THERAPEUTI C	0.000000				55.00
	05600 RADI OI SOTOPE	0. 000000				56.00
	05700 CT SCAN	0. 000000				57.00
		0. 000000				58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0. 000000				59.00 60.00
	06001 BLOOD LABORATORY	0. 000000				60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0. 000000 0. 000000				64.00 65.00
	06600 PHYSI CAL THERAPY	0. 000000				66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
	06800 SPEECH PATHOLOGY	0. 000000				68.00
		0. 000000				69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	07400 RENAL DI ALYSI S	0. 000000				74.00
	07500 ASC (NON-DI STINCT PART)	0.000000				75.00
	03020 0NCOLOGY DUTPATIENT SERVICE COST CENTERS	0. 000000				76.00
	08800 RURAL HEALTH CLINIC	0. 000000				88.00
1	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
		0.000000				90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	0.000000				/2.00
	09910 CORF					99.10
	SPECIAL PURPOSE COST CENTERS					1.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION					109.00 110.00
	11100 I SLET ACQUISITION					111.00
	11300 I NTEREST EXPENSE					113.00
	11400 UTILIZATION REVIEW-SNF					114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)					115.00
	11600 HOSPI CE					116.00
200.00 201.00	Subtotal (see instructions) Less Observation Beds					200.00 201.00
201.00	Total (see instructions)					201.00
						•

	Financial Systems TONMENT OF INPATIENT ROUTINE SERVICE CAR	FRANCI SCAN ST. ELIZ		CCN: 150022	Peri od:	u of Form CMS- Worksheet D	2552-10
APPURI	TONMENT OF INPATIENT ROUTINE SERVICE CAP	PITAL CUSIS	Provider	CCN: 150022	From 01/01/2014		
					To 12/31/2014	Date/Time Pre	pared:
						5/27/2015 9:3	7 am
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swing Bed	Reduced	Total Pati ent		
		Related Cost (from Wkst. B,	Adjustment	Capi tal Rel ated Cos [.]	Days	3 / col. 4)	
		Part II, col.		(col. 1 - col			
		26)		2)	•		
		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	ADULTS & PEDI ATRI CS	897, 514	0	897, 5	14 3, 990	224, 94	30.00
31.00	INTENSIVE CARE UNIT	120, 989		120, 9		300.22	
32.00	CORONARY CARE UNIT	0		,	0 0	0.00	
33.00	BURN INTENSIVE CARE UNIT	0			0 0	0.00	•
34.00	SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	•
40.00	SUBPROVIDER - IPF	287, 768	C	287, 7	58 1, 709	168.38	40.00
41.00	SUBPROVIDER - IRF	0	C		0 0	0.00	41.00
12.00	SUBPROVI DER	0	C		0 0	0.00	42.00
13.00	NURSERY	0			0 0	0.00	43.00
4.00	SKILLED NURSING FACILITY	0			0 0	0.00	44.00
45.00	NURSING FACILITY	0			0 0	0.00	45.00
45.01	I CF/MR	0			0 0	0.00	45.01
200.00	Total (lines 30-199)	1, 306, 271		1, 306, 2	71 6, 102		200.00
	Cost Center Description	Inpati ent	Inpatient				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
		(6)	-			
	INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00				
30.00	ADULTS & PEDIATRICS	2,006	451, 230				30.00
31.00	INTENSIVE CARE UNIT	2,008					31.00
32.00	CORONARY CARE UNIT	220	07, 850				32.00
33.00	BURN INTENSIVE CARE UNIT	0					33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0					34.00
10.00	SUBPROVIDER - IPF	1,473	248, 024				40.00
11.00	SUBPROVIDER - IRF	1, 1, 3	210,021				41.00
12.00	SUBPROVI DER	0	0				42.00
13.00	NURSERY	0	0				43.00
4.00	SKILLED NURSING FACILITY	0	0				44.00
45.00	NURSING FACILITY	0					45.00
	I CF/MR	0	0				45.01
	Total (lines 30-199)	3, 705		1			200.00

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	NCISCAN ST. ELIZ AL COSTS		CCN: 150022	Peri od:	u of Form CMS- Worksheet D	
				From 01/01/2014	Part II	
				To 12/31/2014		
					5/27/2015 9:3	7 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
D. 00 05000 OPERATI NG ROOM	369, 798	9, 726, 517				
1.00 05100 RECOVERY ROOM	0	0	0.0000		0	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		0	
3. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	782,062	28, 049, 849	0. 02788	31 1, 757, 113	48, 990	54.0
4. 01 05401 ULTRASOUND	17,078	2, 457, 340	0.00695	50 135, 929	945	54.0
5. 00 05500 RADI OLOGY - THERAPEUTI C	35, 019	4, 082, 536	0.00857	78 6, 675	57	55.0
5. 00 05600 RADI OI SOTOPE	18, 826	2, 559, 575	0.00735	63, 584	468	56.0
7.00 05700 CT SCAN	0	C	0.0000	0 0	0	57.0
3. 00 05800 MRI	0	C	0.0000	0 0	0	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	c c	0.0000	0 0	0	59.0
D. 00 06000 LABORATORY	302, 196	15, 994, 677			44, 833	60.0
D. 01 06001 BLOOD LABORATORY	0	0	0.0000		0	
1. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	-				-	61.0
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0. 00000	0	0	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0.00000		0	
4. 00 06400 I NTRAVENOUS THERAPY	0		0.00000		0	
5. 00 06500 RESPI RATORY THERAPY	36, 340	1, 685, 347			-	
5. 00 06600 PHYSI CAL THERAPY	132, 842				10, 513	
7. 00 06700 OCCUPATI ONAL THERAPY	132,042	2,003,202	0.0000		0, 513	
3. 00 06800 SPEECH PATHOLOGY	0		0.00000		0	
	25 457				-	
7. 00 06900 ELECTROCARDI OLOGY D. 00 07000 ELECTROENCEPHALOGRAPHY	25, 457	3, 983, 527	0.00639		3, 060	
	240.055	7 240 7/1			-	
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	249, 255					
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	127, 792					
3. 00 07300 DRUGS CHARGED TO PATIENTS	359, 700				46, 657	
4.00 07400 RENAL DIALYSIS	0	0	0.00000		0	1
5. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000		0	
5. 00 03020 ONCOLOGY	0	0	0.0000	0 0	0	76.0
OUTPATIENT SERVICE COST CENTERS				1		
3. 00 08800 RURAL HEALTH CLINIC	0	-			0	
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	, s			0	
D. 00 09000 CLINIC	46, 029				0	
1. 00 09100 EMERGENCY	227, 682	16, 344, 056			11, 746	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	181, 526	966, 192	0. 1878	78 0	0	92.0
00.00 Total (lines 50-199)	2, 911, 602	124, 480, 845		13, 519, 708	322, 524	1200 C

Health Financial Systems FF	RANCISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	TS Provi der	CCN: 150022	Period: From 01/01/2014 To 12/31/2014		pared: 7 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adj ustment	(sum of cols.	
			Education Cos	st Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
32.00 03200 CORONARY CARE UNI T	0	0		0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0			0 0	0	
41. 00 04100 SUBPROVI DER – I RF	0			0 0	0	
42. 00 04200 SUBPROVI DER	0				0	
43. 00 04300 NURSERY	0			0	0	1
44. 00 04400 SKI LLED NURSING FACILITY	0			0	0	1
44:00 04400 SKIELED NOKSING FACILITY	0			0		
45. 01 04510 I CF/MR	0			0		
	0			0	Ű	
200.00 Total (lines 30-199)	U			0	0	200.00
Cost Center Description	Total Patient			Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
	(00	7.00	0.00	col . 8)		
INDATIONT DOUTING CODVICE COCT CENTERC	6.00	7.00	8.00	9.00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	3, 990	0.00	2,00)6 0	1	30,00
31.00 03100 INTENSIVE CARE UNIT	403					31.00
32.00 03200 CORONARY CARE UNIT	0	0.00		0 0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0.00		0 0		33.00
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	0	0.00		0 0		34.00
40. 00 04000 SUBPROVIDER - IPF	1, 709			73 0		40.00
41.00 04100 SUBPROVIDER - IRF	0	0.00		0 0		41.00
42.00 04200 SUBPROVI DER	0	0.00		0 0		42.00
43.00 04300 NURSERY	0	0.00		0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		0 0		44.00
45.00 04500 NURSING FACILITY	0	0.00		0 0		45.00
45.01 04510 I CF/MR	0	0.00		0 0		45.01
200.00 Total (lines 30-199)	6, 102		3, 70	05 0		200.00

Health Financial Systems FRAN	CISCAN ST. ELIZA	ABETH HEALTH -	CR	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150022	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014	Part IV	
				To 12/31/2014	Date/Time Pre 5/27/2015 9:3	
		Ti +1	e XVIII	Hospi tal	PPS	1 dili
Cost Center Description	Non Physician				Total Cost	
cost center bescription	Anesthetist	Nul Si ng School	Allieu neart	Medical	(sum of col 1	
	Cost			Education Cost		
	CUST			Luucation 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	5.00	-
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
	0	0		0 0		
51.00 05100 RECOVERY ROOM	-	0			0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
54. 01 05401 ULTRASOUND	0	0		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	
57.00 05700 CT SCAN	0	0		0 0	0	
58. 00 05800 MRI	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	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
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	1
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74. 00 07400 RENAL DIALYSIS	0	0		0 0	0	
	0	0		0 0		
75. 00 07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	
76.00 03020 ONCOLOGY	0	0		0 0	0	76.00
OUTPATI ENT SERVI CE COST CENTERS				0		00.00
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
90. 00 09000 CLINIC	0	0		0 0	0	
91. 00 09100 EMERGENCY	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	1
200.00 Total (lines 50-199)	0	0		0 0	0	200. 00

	CISCAN ST. ELIZ		CR	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der	CCN: 150022	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	narod
				10 12/31/2014	5/27/2015 9:3	7 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(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	-					
50. 00 05000 OPERATING ROOM	0	.,			1, 266, 426	50.00
51.00 O5100 RECOVERY ROOM	0	0			0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	28, 049, 849			1, 757, 113	
54. 01 05401 ULTRASOUND	0	2, 457, 340			135, 929	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	4, 082, 536			6, 675	
56. 00 05600 RADI OI SOTOPE	0	2, 559, 575			63, 584	
57.00 05700 CT SCAN	0	0			0	57.00
58. 00 05800 MRI	0	0			0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60. 00 06000 LABORATORY	0	15, 994, 677			2, 372, 852	
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0 0. 000000	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000		0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 685, 347			725, 059	
66. 00 06600 PHYSI CAL THERAPY	0	2, 003, 282			158, 531	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0			0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 983, 527	0.00000		478, 730	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 349, 761			1, 175, 558	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	3, 034, 665			1, 225, 436	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	25, 522, 861	0.00000		3, 310, 627	73.00
74.00 07400 RENAL DIALYSIS	0	0			0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	-			0	75.00
76. 00 03020 ONCOLOGY	0	0	0.00000	0 0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS	1	1				
88.00 08800 RURAL HEALTH CLINIC	0				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
90. 00 09000 CLINIC	0	,			0	90.00
91.00 09100 EMERGENCY	0				843, 188	
02 00 100200 ODCEDVATION DEDC (NON DICTINCT DADT		966, 192	0.00000	0 0.000000	0	92.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200. 00 Total (lines 50-199)				0.000000	13, 519, 708	

	FINANCIAL SYSTEMS FRAM TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		ABETH HEALTH -	CCN: 150022	Period:		u of Form CMS Worksheet D	-2002-10
	H COSTS	RVICE UTHER PASS			From 01,	/01/2014 /31/2014	Part IV	epared: 37 am
			Ti tl	e XVIII	Hosp	i tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent				
		Program	Program	Program				
		Pass-Through	Charges	Pass-Throug	h			
		Costs (col. 8		Costs (col.	9			
		x col. 10)		x col. 12)				
	1	11.00	12.00	13.00				
	ANCI LLARY SERVICE COST CENTERS			-				
50.00	05000 OPERATI NG ROOM	0	2, 955, 458		0			50.00
51.00	05100 RECOVERY ROOM	0	0		0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0			52.00
53.00	05300 ANESTHESI OLOGY	0	0)	0			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	7, 642, 073		0			54.00
54.01	05401 ULTRASOUND	0	713, 996		0			54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	1, 913, 151		0			55.00
56.00	05600 RADI OI SOTOPE	0	1, 415, 165		0			56.00
57.00	05700 CT SCAN	0	0	1	0			57.00
58.00	05800 MRI	0	0)	0			58,00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0			59.00
60.00	06000 LABORATORY	0	2, 425, 383		0			60,00
60.01	06001 BLOOD LABORATORY	0	_,,		0			60, 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	J. J	0		Ű			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0			63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0			64.00
65.00	06500 RESPI RATORY THERAPY	0	178, 674	,	0			65.00
66.00	06600 PHYSI CAL THERAPY	0	4, 058		0			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	4,038	1	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0			68.00
69.00	06900 ELECTROCARDI OLOGY	0	1 900 741		0			69.00
		0	1, 809, 741		0			70.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1 01(222		-			
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	1,016,323		0			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	383, 404	1	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8, 721, 724	1	0			73.00
74.00	07400 RENAL DI ALYSI S	0	0		0			74.00
75.00	07500 ASC (NON-DI STINCT PART)	0	0		0			75.00
76.00	03020 ONCOLOGY	0	0	1	0			76.00
	OUTPATIENT SERVICE COST CENTERS				-			_
88.00	08800 RURAL HEALTH CLINIC	0	0		0			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0			89.00
90.00	09000 CLINIC	0	23, 197		0			90.00
91.00	09100 EMERGENCY	0	2, 915, 576		0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	286, 507		0			92.00
200.00	Total (lines 50-199)	0	32, 404, 430					200.00

	INCI AL SYSTEMS FRAN ENT OF MEDICAL, OTHER HEALTH SERVICES ANI		ABETH HEALTH -	CCN: 150022	Peri od:	u of Form CMS-: Worksheet D	2332-10
APPORTIUNINE	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	J VACCINE CUST	Provider	CCN: 150022	From 01/01/2014	Part V	
					To 12/31/2014	Date/Time Pre	
						5/27/2015 9:3	7 am
				e XVIII	Hospi tal	PPS	
	Cast Captor Decariation	Cost to Charge	DDC Doimhurood	Charges	Cast	Costs	
	Cost Center Description	Ratio From	PPS Reimbursed Services (see		Cost Reimbursed	PPS Services (see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not	(See That.)	
		Part I, col. 9	· · ·	Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 279733	2, 955, 458		0 0	826, 739	50.00
	O RECOVERY ROOM	0. 000000			0 0	0	
	O DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	
	0 ANESTHESI OLOGY	0. 000000			0 0	0	
	0 RADI OLOGY-DI AGNOSTI C	0. 131333			0 0	1, 003, 656	
	1 ULTRASOUND	0. 052578			0 0	37, 540	
	0 RADI OLOGY-THERAPEUTI C	0. 294045			0 0	562, 552	
	0 RADI OI SOTOPE	0. 090991			0 0	128, 767	
	0 CT SCAN	0. 000000			0 0	0	
	0 MRI	0. 000000			0 0	0	
	O CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	
	O LABORATORY	0. 191547			0 0	464, 575	1
	1 BLOOD LABORATORY	0. 000000			0 0	0	1
	O PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000			0 0		61.00
	O WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			0 0	0	
	O BLOOD STORING, PROCESSING & TRANS.	0. 000000			0 0	0	
	0 I NTRAVENOUS THERAPY 0 RESPI RATORY THERAPY	0. 000000			0 0	0	
	O PHYSI CAL THERAPY	0. 355495		1	0 0	63, 518 2, 016	1
	0 OCCUPATIONAL THERAPY	0. 498870			0 0	2,018	1
	O SPEECH PATHOLOGY	0. 000000			0 0	0	1
	0 ELECTROCARDI OLOGY	0. 078558			0 0	142, 170	
	0 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	1
	O MEDICAL SUPPLIES CHARGED TO PATIENT	0. 261192			0 0	265, 455	
	O I MPL. DEV. CHARGED TO PATIENTS	0. 411842			0 0	157, 902	1
	O DRUGS CHARGED TO PATIENTS	0. 286376			0 8, 426	2, 497, 692	
	0 RENAL DI ALYSI S	0. 000000			0 0	0	1
	O ASC (NON-DISTINCT PART)	0.000000			0 0	0	
	O ONCOLOGY	0.000000)	0 0	0	76.00
OUTP	ATIENT SERVICE COST CENTERS						
88.00 0880	O RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 0890	O FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90.00 0900		0. 457796	23, 197		0 0	10, 619	90.00
91.00 0910	0 EMERGENCY	0. 149909	2, 915, 576	,	0 0	437, 071	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 775919	286, 507		0 0	222, 306	
200.00	Subtotal (see instructions)		32, 404, 430		0 8, 426	6, 822, 578	
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges					(000	000 00
202.00	Net Charges (line 200 +/- line 201)		32, 404, 430	1	0 8, 426	6, 822, 578	J202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der	CCN: 150022	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/27/2015 9:3	epared: 37 am
		Titl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
·	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS		I				_
50. 00 05000 OPERATI NG ROOM	0					50.00
51.00 05100 RECOVERY ROOM	0					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53. 00 05300 ANESTHESI OLOGY	0	0	1			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 05401 ULTRASOUND	0	0	1			54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0)			63.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 413				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
76.00 03020 ONCOLOGY	0	0				76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	2, 413				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	2, 413				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.		Componen	CCN: 150022 t CCN: 15S022	Period: From 01/01/2014 To 12/31/2014		
Cost Center Description	Conitol	•	t CCN: 15S022			
Cost Center Description	Conitol	Ti t		10 12/31/2014	Date/Time Pre 5/27/2015 9:3	
Cost Center Description	Conital		e XVIII	Subprovider - IPF	PPS	
	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					<u> </u>
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0 (0. 700	0.70/.54				
50.00 05000 OPERATING ROOM	369, 798				0	50.00
1.00 05100 RECOVERY ROOM	0		0.0000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0.0000		0	52.00
3.00 05300 ANESTHESI OLOGY	0		0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	782,062				2, 167	54.00
54. 01 05401 ULTRASOUND	17,078				17	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	35, 019	4, 082, 536			0	55.00
56. 00 05600 RADI OI SOTOPE	18, 826	2, 559, 575			0	56.00
57.00 05700 CT SCAN	0	(0. 00000	0 00	0	57.00
58. 00 05800 MRI	0	(0. 00000	0 00	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(0. 00000	0 00	0	59.00
0. 00 06000 LABORATORY	302, 196	15, 994, 67	0. 01889	94 294, 176	5, 558	60.00
0. 01 06001 BLOOD LABORATORY	0	(0. 00000	0 0	0	60.01
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	(0. 00000	0 0	0	62.00
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(0. 00000	0 0	0	63.00
4.00 06400 I NTRAVENOUS THERAPY	0	(0. 00000	0 00	0	64.00
5. 00 06500 RESPI RATORY THERAPY	36, 340	1, 685, 34	0. 02156	52 38, 319	826	65.00
6. 00 06600 PHYSI CAL THERAPY	132, 842	2,003,282	0. 0663	12 37, 248	2, 470	66.00
7.00 06700 OCCUPATI ONAL THERAPY	0		0. 00000	0 00	0	67.00
08.00 06800 SPEECH PATHOLOGY	0	(0. 00000	0 0	0	68.00
9. 00 06900 ELECTROCARDI OLOGY	25, 457	3, 983, 52	0. 00639	27, 507	176	69.00
0.00 07000 ELECTROENCEPHALOGRAPHY	0		0. 00000		0	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	249, 255	7, 349, 76	0. 0339	13 17, 200	583	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	127, 792	3, 034, 665	0. 0421	11 0	0	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	359, 700	25, 522, 86	0. 01409	419, 466	5, 912	73.00
4.00 07400 RENAL DIALYSIS	0		0. 00000	0 00	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0		0. 00000	0 00	0	75.00
76.00 03020 ONCOLOGY	0		0. 00000	0 00	0	76.00
OUTPATIENT SERVICE COST CENTERS						
38. 00 08800 RURAL HEALTH CLINIC	0	(0.0000	0 00	0	88. 00
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
20. 00 09000 CLINIC	46,029	720, 660			0	90.00
01. 00 09100 EMERGENCY	227, 682				-	91.00
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
200.00 Total (lines 50-199)	2, 730, 076			983, 480		•

Health Financial Systems FRAN	CISCAN ST. ELIZA	BETH HEALTH -	CR	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der	CCN: 150022	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15S022	From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Non Physician N	ursing School	Allied Healt		Total Cost	
	Anesthetist	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
50. 00 05000 OPERATING ROOM	0	0		0 0	0	
51.00 O5100 RECOVERY ROOM	0	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	0	0		0 0		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0		
56. 00 05600 RADI OLOGI - THERAPEUTIC	0	0		0 0		
57. 00 05700 CT SCAN	0	0		0 0		
58. 00 05800 MRI	0	0		0 0		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60. 00 06000 LABORATORY	0	0			0	
60. 01 06001 BLOOD LABORATORY	0	0			0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	
76. 00 03020 ONCOLOGY	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	1 1			-		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	Ű	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	Ű	
90. 00 09000 CLINIC	0	0		0 0	0	
91.00 09100 EMERGENCY	0	0		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	
200.00 Total (lines 50-199)	0	0	l	0 0	0	200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der	CCN: 150022	Peri od:	Worksheet D	
HROUGH COSTS		Componen	t CCN: 15S022	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	
				<u></u>	5/27/2015 9:3	7 am
		11 TI	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00		7)	10.00	
	6.00	7.00	8.00	9.00	10.00	-
ANCI LLARY SERVICE COST CENTERS		0 70/ 547		0 000000		1 50 /
0. 00 05000 OPERATING ROOM	C					
1.00 O5100 RECOVERY ROOM	C					
2.00 05200 DELIVERY ROOM & LABOR ROOM	C				0	
3. 00 05300 ANESTHESI OLOGY	C		0.00000			
4. 00 05400 RADI OLOGY-DI AGNOSTI C	C	28, 049, 849				
4. 01 05401 ULTRASOUND	C	2, 457, 340				
5. 00 05500 RADI OLOGY-THERAPEUTI C	C	4, 082, 536	1			
5. 00 05600 RADI 0I SOTOPE	C	2, 559, 575				
7. 00 05700 CT SCAN	C				0	
3. 00 05800 MRI	C	0 0				
9. 00 05900 CARDI AC CATHETERI ZATI ON	C		0.00000			
D. 00 06000 LABORATORY	C					
0.01 06001 BLOOD LABORATORY	C		0.00000	0.00000	0	
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C) (0	
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	0	0.00000		0	
4.00 06400 INTRAVENOUS THERAPY	C	0 0	0100000		0	
5. 00 06500 RESPI RATORY THERAPY	C	1, 685, 347				
6. 00 06600 PHYSI CAL THERAPY	C	2, 003, 282				
7.00 06700 OCCUPATI ONAL THERAPY	C) (
8.00 06800 SPEECH PATHOLOGY	C		0.00000		0	68.
9. 00 06900 ELECTROCARDI OLOGY	C	3, 983, 527			27, 507	
D. 00 07000 ELECTROENCEPHALOGRAPHY	C	0 0			0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	7, 349, 761			17, 200	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	3, 034, 665	0. 00000	0.00000	0	72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	C	25, 522, 861			419, 466	73.
4. 00 07400 RENAL DIALYSIS	C	0	0. 00000	0.00000	0	74.
5.00 07500 ASC (NON-DISTINCT PART)	C	0	0. 00000	0.00000	0	75.
6. 00 03020 ONCOLOGY	C	0 0	0.00000	0.00000	0	76.
OUTPATIENT SERVICE COST CENTERS	1					
8.00 08800 RURAL HEALTH CLINIC	C	0	0. 00000	0.00000	0	88.
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0 0	0. 00000	0.00000	0	89.
D. 00 09000 CLINIC	C	720, 660	0. 00000	0.00000	0	90.
1.00 09100 EMERGENCY	C	16, 344, 056	0. 00000	0.00000	69, 398	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C	966, 192	0. 00000	0.00000	0	92.
00.00 Total (lines 50-199)	C	124, 480, 845	5		983, 480	200.

	NCISCAN ST. ELIZ				u of Form CMS	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provi der	CCN: 150022	Period: From 01/01/2014	Worksheet D Part IV	
		Componen	t CCN: 15S022		Date/Time Pr 5/27/2015 9:	
		Ti tl	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Inpatient	Outpati ent	Outpati ent		1	
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	ih 🛛		
	Costs (col. 8		Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	0	(0		50.00
51.00 O5100 RECOVERY ROOM	0	(0		51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	(0		52.00
53. 00 05300 ANESTHESI OLOGY	0	(0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(0		54.00
54. 01 05401 ULTRASOUND	0	(0		54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(0		55.00
56. 00 05600 RADI 0I SOTOPE	0	(0		56.00
57. 00 05700 CT SCAN	0	(0		57.00
	0	(0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(0		59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	(0		60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	(0		60.01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	(0		61.00 62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(0		63.00
64. 00 06400 INTRAVENOUS THERAPY	0	(0		64.00
65. 00 06500 RESPIRATORY THERAPY	0	(0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	(0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(-	0		67.00
68. 00 06800 SPEECH PATHOLOGY	0	(0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	(0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	(-	0		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(-	0		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(-	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	(0		73.00
74. 00 07400 RENAL DI ALYSI S	0	(0		74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	(-	0		75.00
76. 00 03020 ONCOLOGY	0	(0		76.00
OUTPATIENT SERVICE COST CENTERS	· · · · · ·		· · · · · · · · · · · · · · · · · · ·			
88.00 08800 RURAL HEALTH CLINIC	0	(0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0		89.00
90. 00 09000 CLINIC	0	C		0		90.00
91.00 09100 EMERGENCY	0	C	b	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	(0		92.00
200.00 Total (lines 50-199)	0	(0		200.00

Health Financial Systems

FRANCI SCAN	ST.	ELI ZABETH	HEALTH	- CR	

In Lieu of Form CMS-2552-10

	ATION OF INPATIENT OPERATING COST	Provider CCN: 150022	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Pre	
				5/27/2015 9:3	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	·			1.00	
	PART I – ALL PROVIDER COMPONENTS				-
. 00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		3, 990	1.0
. 00	Inpatient days (including private room days, excluding swing-			3, 990	2.0
. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only p	rivate room days,	0	3.0
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ad dave)		3, 183	4.0
. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	3, 183	
	reporting period			-	
. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.0
. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m dave) through Decombo	a 21 of the east	0	7.0
. 00	reporting period	in days) thi ough becember	ST OF THE COST	0	/.0
. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December :	31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)	-			
. 00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	2, 006	9.0
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private i	coom days)	0	10.0
0.00	through December 31 of the cost reporting period (see instruc		com dayoy	0	
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11. (
2.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room days)	0	12. (
2.00	through December 31 of the cost reporting period	x only (meruding priva	te room uays)	0	12.0
3. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. (
	after December 31 of the cost reporting period (if calendar y			_	
4.00 5.00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
5.00 6.00	Nursery days (title V or XIX only)			0	
0.00	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	of the cost	0.00	17.0
8. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ac after December 21 of	the cost	0.00	10 /
0.00	reporting period		the cost	0.00	10.
9. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19. (
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 21 of	the cost	0.00	20.
0.00	reporting period	s al tel becember 31 01	the cost	0.00	20. 1
1. 00	Total general inpatient routine service cost (see instruction	is)		3, 706, 650	21.0
2.00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22.0
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	na period (line 6	0	23. (
5.00	x line 18)	ST OF the cost reportin	ig period (The U	0	25.0
4.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.0
F 00	7 x line 19)	21 of the east reporting	r pariod (Line O	0	25.0
5.00	Swing-bed cost applicable to NF type services after December x line 20)	Si oi the cost reporting	j per lou (The o	0	25.1
6.00	Total swing-bed cost (see instructions)			0	26.0
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 706, 650	27.0
8. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and obsorvation had a	pargos)	0	28.0
	Private room charges (excluding swing-bed charges)	a and observation bed ci	lai ges)	0	
7.00	Semi-private room charges (excluding swing-bed charges)			0	
		÷line 28)		0.00000	
). 00 I. 00	General inpatient routine service cost/charge ratio (line 27				32.
). 00 . 00 2. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
0.00 1.00 2.00 3.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	nus line 33)(see instru	ctions)	0.00	33.
0.00 1.00 2.00 3.00 4.00	Average private room per diem charge (line 29 ÷ line 3)		ctions)		33. 34.
0.00 1.00 2.00 3.00 4.00 5.00 6.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00 0.00 0.00 0	33. 34. 35. 36.
9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	Average private room per diem charge (line $29 \div$ line 3) Average semi-private room per diem charge (line $30 \div$ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line $34 \times$ li Private room cost differential adjustment (line $3 \times$ line 35) General inpatient routine service cost net of swing-bed cost	ne 31)		0.00 0.00 0.00	33. 34. 35. 36.
 00 	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	ne 31)		0.00 0.00 0.00 0	33. 34. 35. 36.
0.00 1.00 2.00 3.00 4.00 5.00 6.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	ne 31) and private room cost di		0.00 0.00 0.00 0	33. 34. 35. 36.
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	ne 31) and private room cost di USTMENTS		0.00 0.00 0.00 0	33. 34. 35. 36. 37.
0.00 1.00 2.00 3.00 4.00 5.00 6.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	ne 31) and private room cost di USTMENTS : instructions) : 38)		0.00 0.00 0.00 3,706,650	 33. 34. 35. 36. 37. 38. 39.

MPUT	ATION OF INPATIENT OPERATING COST		Provi der	1	Period: From 01/01/2014		
					To 12/31/2014	5/27/2015 9:3	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
		Inpatient Costl	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)	0		0.0) 42.
00	Intensive Care Type Inpatient Hospital Units	0(4.474				540 70	
. 00 . 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	964, 174 0	403	2, 392. 4 0 0. 0			
. 00	BURN INTENSIVE CARE UNIT	0		0.0			
. 00	SURGI CAL I NTENSI VE CARE UNI T	0	(C	
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	, line 200)			3, 316, 638	3 48.
. 00	Total Program inpatient costs (sum of lines 4	41 through 48)(s	see instructio	ons)		5, 720, 875	5 49.
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routing	convicos (fro	wket D. cum	of Parts L and	519,080	50.
. 00	(111)		services (IIO	II WKSL. D, SUIII	OF PAILS F ANU	519,060	50.
. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fi	rom Wkst. D, si	um of Parts II	322, 524	1 51.
00	and IV)	50 and 51				0/1 /0/	1 50
00 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclud		lated, non-ph	vsician anesth	etist. and	841, 604 4, 879, 271	
20	medical education costs (line 49 minus line 5					1, 577, 27	
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
00 00	Program discharges Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and tai	rget amount (I	line 56 minus	line 53)	0	
00	Bonus payment (see instructions)					0	
00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period (ending 1996, i	updated and cor	mpounded by the	0.00	59.
00	Lesser of lines 53/54 or 55 from prior year of	cost report, upo	dated by the r	market basket		0.00	60.
00	If line 53/54 is less than the lower of lines					C) 61.
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	the target		
00	Relief payment (see instructions)	histi deti olisj				0	62.
00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63.
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Docor	mbor 21 of the	o cost roportiu	a poriod (Soo		64.
00	instructions) (title XVIII only)	ts through becer		e cost reportin	ig period (see		04.
00	Medicare swing-bed SNF inpatient routine cost	ts after Decembe	er 31 of the d	cost reporting	period (See	(c	65.
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no coste (lino d	64 plus lipo d	65) (+i +l o XVIII	l only) For	c	66.
00	CAH (see instructions)		54 prus rine (i oniy). Toi		00.
00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost re	porting period	(c	67.
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	a anata aftar D	acombox 21 of	the east range	ating pariod		
00	(line 13 x line 20)		ecember 31 01	the cost repo	ting period) 68.
. 00	Total title V or XIX swing-bed NF inpatient i	routine costs (I	line 67 + line	e 68)		0	69.
~~	PART III - SKILLED NURSING FACILITY, OTHER NU					1	1 70
00 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	5					70.
00	Program routine service cost (line 9 x line 3			2)			72.
00	Medically necessary private room cost applica						73.
00 00	Total Program general inpatient routine servi	•			art II column		74.
00	Capital-related cost allocated to inpatient r 26, line 45)	outifie service		WULKSHEEL D, Pa	art II, corumn		/5.
00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.
00	Program capital-related costs (line 9 x line						77.
00 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	ds)			79.
00	Total Program routine service costs for compa	• •		· · ·	us line 79)		80
00	Inpatient routine service cost per diem limit						81.
00	Inpatient routine service cost limitation (li						82.
00 00	Reasonable inpatient routine service costs (see inspection of the service of the		5)				83.
00	Utilization review - physician compensation		ns)				85.
00	Total Program inpatient operating costs (sum	of lines 83 th					86.
00	PART IV - COMPUTATION OF OBSERVATION BED PASS					005	7 07
00	Total observation bed days (see instructions)					807 928.98	
00	Adjusted general inpatient routine cost per o	alem (line 27 ∸	line 2)			970 97	

Health Financial Systems FRAN	ealth Financial Systems FRANCISCAN ST. ELIZABETH HEALTH - CR In Lieu of Form CMS-2					
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014		
		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	897, 514	3, 706, 650	0. 24213	5 749, 687	181, 526	90.00
91.00 Nursing School cost	0	3, 706, 650	0.00000	749, 687	0	91.00
92.00 Allied health cost	0	3, 706, 650	0.00000	749, 687	0	92.00
93.00 All other Medical Education	0	3, 706, 650	0.00000	749, 687	0	93.00

MPUT		Tovider CCN: 150022 Component CCN: 15S022	Peri od: From 01/01/2014 To 12/31/2014 Subprovi der -	Worksheet D-1 Date/Time Pre 5/27/2015 9:3 PPS	pare
	Cost Contor Description		I PF	PP3	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, ex	cludina newborn)		1, 709	1 1
	Inpatient days (including private room days, excluding swing-bed a			1, 709	2
00	Private room days (excluding swing-bed and observation bed days).	If you have only pri	vate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed da	vc)		1, 709	4
00	Total swing-bed SNF type inpatient days (including private room da		31 of the cost	1, 704	5
	reporting period	<i>J</i> -		-	
00	Total swing-bed SNF type inpatient days (including private room da	ys) after December 3	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room day	s) through Docombor	21 of the cost	0	7
	reporting period	s) through becember	ST OF THE COST	0	'
00	Total swing-bed NF type inpatient days (including private room day	s) after December 3	1 of the cost	0	8
20	reporting period (if calendar year, enter 0 on this line)		and any land and	1 470	
00	Total inpatient days including private room days applicable to the newborn days)	Program (excluding	swing-bed and	1, 473	9
00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private ro	oom days)	0	10
	through December 31 of the cost reporting period (see instructions)			
00	Swing-bed SNF type inpatient days applicable to title XVIII only (December 31 of the cost reporting period (if calendar year, enter		oom days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XIX on		e room days)	0	12
	through December 31 of the cost reporting period		5 /	0	
00	Swing-bed NF type inpatient days applicable to titles V or XIX onl			0	13
00	after December 31 of the cost reporting period (if calendar year, Medically necessary private room days applicable to the Program (e			0	14
	Total nursery days (title V or XIX only)	xcruaring swring-bea	lays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		<u></u>		
00	Medicare rate for swing-bed SNF services applicable to services th reporting period	rough December 31 of	f the cost	0.00	17
00	Medicare rate for swing-bed SNF services applicable to services af	ter December 31 of	the cost	0.00	18
	reporting period				
00	Medicaid rate for swing-bed NF services applicable to services thr reporting period	ough December 31 of	the cost	0.00	19
00	Medicaid rate for swing-bed NF services applicable to services aft	er December 31 of th	ne cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions)			1, 699, 227	
00	Swing-bed cost applicable to SNF type services through December 31 5 x line 17)	or the cost report	ng period (line	0	22
00	Swing-bed cost applicable to SNF type services after December 31 o	f the cost reporting	period (line 6	0	23
	x line 18)				
00	Swing-bed cost applicable to NF type services through December 31	of the cost reportion	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of	the cost reporting	period (line 8	0	25
	x line 20)	5		-	
	Total swing-bed cost (see instructions)	01 minus (inc. 0/)		0	
1	General inpatient routine service cost net of swing-bed cost (line PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	21 minus line 26)		1, 699, 227	27
	General inpatient routine service charges (excluding swing-bed and	observation bed cha	arges)	0	28
	Private room charges (excluding swing-bed charges)		0	0	29
	Semi-private room charges (excluding swing-bed charges)	20)		0	30
	General inpatient routine service cost/charge ratio (line 27 ÷ lin Average private room per diem charge (line 29 ÷ line 3)	e 28)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minus l	ine 33)(see instruc [.]	tions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)	rivate room cost di	Fforential (line	0	
00	General inpatient routine service cost net of swing-bed cost and p 27 minus line 36)	TIVALE TUUM CUSE OF		1, 699, 227	3/
	PART II - HOSPITAL AND SUBPROVIDERS ONLY]
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTME				
	Adjusted general inpatient routine service cost per diem (see inst	ructions)		994.28 1 464 574	
	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (l	ine 14 x line 35)		1, 464, 574 0	
~~	Total Program general inpatient routine service cost (line 39 + li	-		1, 464, 574	

OMPUTATI ON	cial Systems FRA OF INPATIENT OPERATING COST	NCISCAN ST. ELIZA		CCN: 150022	Peri od:	eu of Form CMS- Worksheet D-1	
			Componen	t CCN: 15S022	From 01/01/2014 To 12/31/2014	Date/Time Pre	
			Titl	e XVIII	Subprovider -	5/27/2015 9:3 PPS	87 am
					I PF		-
	Cost Center Description	Total Inpatient Costl	Total npatient Days	col . 2)	÷	Program Cost (col. 3 x col. 4)	
. 00 NURSE	RY (title V & XIX only)	1.00	2.00	3.00	<u>4.00</u>	5.00	42.
	sive Care Type Inpatient Hospital Unit			0.0	50 0		1 72
	SIVE CARE UNIT ARY CARE UNIT	0	(0.0		-	
	NTENSIVE CARE UNIT	0	(0.0			
-	CAL INTENSIVE CARE UNIT	0	(0.0		0	
	SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
. 00 Progr	am inpatient ancillary service cost (W	kst. D-3, col. 3	line 200)			236, 088	48
	Program inpatient costs (sum of lines	41 through 48)(see instructio	ons)		1, 700, 662	49
	HROUGH COST ADJUSTMENTS through costs applicable to Program in	patient routine :	services (from	Wkst. D. sur	n of Parts L and	248, 024	50
						210,021	
	through costs applicable to Program in	patient ancillar	y services (fi	om Wkst. D, s	sum of Parts II	18, 676	51
and I' .00 Total	/) Program excludable cost (sum of lines	50 and 51)				266, 700	52
3.00 Total	Program inpatient operating cost excl	uding capital re	ated, non-phy	sician anestl	netist, and	1, 433, 962	
	al education costs (line 49 minus line AMOUNT AND LIMIT COMPUTATION	52)					
	am discharges					0	54
. 00 Targe	t amount per discharge					0.00	
	t amount (line 54 x line 55)					0	
	rence between adjusted inpatient opera payment (see instructions)	ting cost and ta	rget amount (I	ine 56 minus	line 53)	0	
	r of lines 53/54 or 55 from the cost r	eporting period	ending 1996, ι	updated and co	ompounded by the	-	
	t basket						
	r of lines 53/54 or 55 from prior year ne 53/54 is less than the lower of lin				the amount by	0.00	
	operating costs (line 53) are less th						
	t (line 56), otherwise enter zero (see	instructions)			Ū		
	f payment (see instructions)	mant (and instru	ati ana)			0	
	able Inpatient cost plus incentive pay M INPATIENT ROUTINE SWING BED COST	ment (see instru	strons)			0	03
. 00 Medic	are swing-bed SNF inpatient routine co	sts through Dece	mber 31 of the	cost reporti	ng period (See	0	64
	uctions)(title XVIII only) are swing-bed SNF inpatient routine co	sts after Decemb	ar 31 of the (cost reportin	a period (See	0	65
	uctions)(title XVIII only)	ISTS ATTEL DECEMB		νος τι εροιτιτής	j perioù (see		00
5.00 Total	Medicare swing-bed SNF inpatient rout	ine costs (line)	64 plus line 6	5)(title XVI	l only). For	0	66
	see instructions)	no costs through	Docombor 21	of the cost r	oporting poriod	0	67
	V or XIX swing-bed NF inpatient routi 12 x line 19)	The COSIS ITH OUGH	December 31 (I THE COST I	sporting period		
3.00 Title	V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost repo	orting period	0	68
	13 x line 20) title V or XIX swing-bed NF inpatient	routino costs (ino 67 Lin	. 60)		0	69
	11 - SKILLED NURSING FACILITY, OTHER						09
	ed nursing facility/other nursing faci						70
	ted general inpatient routine service		ne 70 ÷ line	2)			71
U U	am routine service cost (line 9 x line ally necessary private room cost appli	,	(line 14 x li	ne 35)			73
	Program general inpatient routine ser						74
	al-related cost allocated to inpatient	routine service	costs (from W	lorksheet B, F	°art II, column		75
	ne 45) em capital-related costs (line 75 ÷ l	ine 2)					76
	am capital-related costs (line 9 x lin						77
	ent routine service cost (line 74 min		and data t				78
	gate charges to beneficiaries for exce Program routine service costs for com				ous line 79)		80
1	ent routine service cost per diem lim	•					81
.00 Inpat	ent routine service cost limitation (line 9 x line 81					82
	nable inpatient routine service costs	•	5)				83
-	am inpatient ancillary services (see i zation review - physician compensation		ns)				84
1	Program inpatient operating costs (su						86
PART I	V - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COST					
7.00 Total	observation bed days (see instruction					0.00	
8.00 Adjus	ted general inpatient routine cost per						

Health Financial Systems FRAN	RANCI SCAN ST. ELI ZABETH HEALTH - CR In Lieu					2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014		
Title XVIII Subprovider - P						
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	287, 768	1, 699, 227	0. 16935	0	0	90.00
91.00 Nursing School cost	0	1, 699, 227	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	1, 699, 227	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 699, 227	0.00000	0 0	0	93.00

Health Financial Systems

FRANCI SCAN ST.	ELI ZABETH	HEALTH -	CR

In Lieu of Form CMS-2552-10

	Financial Systems FRANCISCAN ST. ELIZABET ATION OF INPATIENT OPERATING COST	Provi der CCN: 150022	Peri od:	u of Form CMS-2 Worksheet D-1	
		Title XIX	From 01/01/2014 To 12/31/2014 Hospi tal	Date/Time Pre 5/27/2015 9:3 Cost	
	Cost Center Description		10301 tui		
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed days,			3, 990	
2.00	Inpatient days (including private room days, excluding swing-be		sivete reem deve	3, 990	
3.00	Private room days (excluding swing-bed and observation bed days do not complete this line.	s). IT you have only pr	rvate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed		3, 183		
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	n days) through Decembe	er 31 of the cost	0	5.0
5.00	Total swing-bed SNF type inpatient days (including private room	n days) after December	31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	- 31 of the cost	0	7.0
3.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)			100	
9.00	Total inpatient days including private room days applicable to newborn days)	the program (excluding	g swing-bed and	180	9.00
0.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	room days)	0	10. 0
1.00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII on		coom dave) after	0	11.0
11.00	December 31 of the cost reporting period (if calendar year, ent		oom days) arter	0	11.0
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	te room days)	0	12.0
3.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	te room days)	0	13.0
5.00	after December 31 of the cost reporting period (if calendar yea			0	15.0
4.00	Medically necessary private room days applicable to the Program	n (excluding swing-bed	days)	0	
5.00 6.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
0.00	SWING BED ADJUSTMENT				1010
7.00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	of the cost	0.00	17.0
18.00	reporting period Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0.00	18.0
19.00	reporting period	through December 21 of	the east	0.00	10.0
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	through beceniber 31 of	the cost	0.00	19.0
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of 1	the cost	0.00	20.0
21.00	Total general inpatient routine service cost (see instructions))		3, 706, 650	21.00
22.00	Swing-bed cost applicable to SNF type services through December	- 31 of the cost report	ting period (line	0	22.0
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportir	na period (line 6	0	23.0
	x line 18)		51 (
24.00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	31 of the cost reporti	ng period (line	0	24.0
25.00	Swing-bed cost applicable to NF type services after December 31	l of the cost reporting	g period (line 8	0	25.0
	x line 20)			0	
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 3, 706, 650	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT				
8.00 9.00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)	0	
0.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	31.0
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
3.00 4.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	us line 33)(see instruc	ctions)	0.00 0.00	
5.00	Average per diem private room cost differential (line 34 x line	, (/	0.00	35.0
36.00	Private room cost differential adjustment (line 3 x line 35)	d privata ream cast -"	fforontial (list	0	
37.00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	iu private room cost di	TTERENTIAL (LINE	3, 706, 650	37.0
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
00 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			0.00 0.00	20 0
38.00 39.00	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3	-		928. 98 167, 216	
10.00	Medically necessary private room cost applicable to the Program	n (line 14 x line 35)		0	40.00
11 00	Total Program general inpatient routine service cost (line 39 +	⊦line 40)		167, 216	41.00

	ATION OF INPATIENT OPERATING COST		PIOVIU	er CCN: 150022	Period: From 01/01/2014	Worksheet D-1	l
					To 12/31/2014		
				Fitle XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per aysDiem (col. 1		Program Cost (col. 3 x col.	
		inpatrent cost			-	4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0		0 0.	00 00	0	42.
~~	Intensive Care Type Inpatient Hospital Units	0(4 174		0.000	40 40	100.077	1 42
00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	964, 174	2	103 2, 392.			
00 00	BURN INTENSIVE CARE UNIT	0		0 0. 0 0.		-	
00	SURGI CAL I NTENSI VE CARE UNI T	0		0 0.		0	
	OTHER SPECIAL CARE (SPECIFY)	-					47.
	Cost Center Description						
00	Program inpatient ancillary service cost (Wks	+ D 2 col 2	Line 200)			1.00	40
00 00	Total Program inpatient costs (sum of lines 4			tions)		319, 616 589, 709	
00	PASS THROUGH COST ADJUSTMENTS		see matrue			507,707	47
00	Pass through costs applicable to Program inpa	tient routine	services (fr	rom Wkst. D, su	m of Parts I and	0	50
	111)						
00	Pass through costs applicable to Program inpa	tient ancillar	y services ((from Wkst. D, s	sum of Parts II	0	51
00	and IV) Total Program excludable cost (sum of lines 5	0 and 51)				0	52
00	Total Program inpatient operating cost exclude		lated, non-	ohysi ci an anestl	netist, and	0	
	medical education costs (line 49 minus line 5	2)		5			
	TARGET AMOUNT AND LIMIT COMPUTATION					-	
00 00	Program di scharges					0	
00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and ta	raet amount	(line 56 minus	line 53)	0	
00	Bonus payment (see instructions)	5	5			0	58
00	Lesser of lines 53/54 or 55 from the cost rep	orting period	endi ng 1996,	updated and c	ompounded by the	0.00	59
~~	market basket					0.00	
00 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				the amount by	0.00	
00	which operating costs (line 53) are less than						101
	amount (line 56), otherwise enter zero (see i		- (
00	Relief payment (see instructions)					0	
00	Allowable Inpatient cost plus incentive payme	nt (see instru	ctions)			0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of t	the cost report	ing period (See	0	64
00	instructions) (title XVIII only)	5 thi bugh beec					
00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the	e cost reporting	g period (See	0	65
~~	instructions)(title XVIII only)						
00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	e costs (line	64 plus line	e 65)(title XVI	ll only). For	0	66
00	Title V or XIX swing-bed NF inpatient routine	costs through	December 31	1 of the cost r	eporting period	0	67
00	(line 12 x line 19)	oooto tiii ougii	beecenber e		opor tring por rou		
00	Title V or XIX swing-bed NF inpatient routine	costs after D	ecember 31 d	of the cost rep	orting period	0	68
~~	(line 13 x line 20)			(0)			
00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
00	Skilled nursing facility/other nursing facili						70
00	Adjusted general inpatient routine service co	3					71
00	Program routine service cost (line 9 x line 7		<i></i>				72
00	Medically necessary private room cost applica						73
00 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•			Part II column		74
00	26, line 45)	Satine Service	50513 (110	in mori Kaneet D, I	art II, COLUMN		'
00	Per diem capital-related costs (line 75 ÷ lir	e 2)					76
00	Program capital-related costs (line 9 x line	,					77
00	Inpatient routine service cost (line 74 minus	· ·	novi da				78
00 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			· · · · · · · · · · · · · · · · · · ·	nus line 70)		80
00	Inpatient routine service costs for compa				100 1110 $17)$		81
00	Inpatient routine service cost limitation (li)				82
00	Reasonable inpatient routine service costs (s		· .				83
00	Program inpatient ancillary services (see ins	,					84
00	Utilization review - physician compensation (85
00	Total Program inpatient operating costs (sum		rougn 85)				86
00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					807	87
	3 . ,						
00	Adjusted general inpatient routine cost per c	iem (line 27 ÷	line 2)			928.98	

Health Financial Systems FRAN	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014		oared: 7 am
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	897, 514	3, 706, 650	0. 24213	5 749, 687	181, 526	90.00
91.00 Nursing School cost	0	3, 706, 650	0.00000	749, 687	0	91.00
92.00 Allied health cost	0	3, 706, 650	0.00000	749, 687	0	92.00
93.00 All other Medical Education	0	3, 706, 650	0.00000	749, 687	0	93.00

MPUTA	TION OF INPATIENT OPERATING COST	Provider CCN: 150022 Component CCN: 15S022	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Pre 5/27/2015 9:3	pare
		Title XIX	Subprovider - IPF	Cost	
	Cost Center Description			1.00	
-	PART I – ALL PROVIDER COMPONENTS				
00	Inpatient days (including private room days and swing-bed days	. excluding newborn)		1, 709	1 1
	Inpatient days (including private room days, excluding swing-b			1, 709	2
00	Private room days (excluding swing-bed and observation bed day	s). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d dave)		1, 709	4
	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	1, 707	
	reporting period				
	Total swing-bed SNF type inpatient days (including private roo	m days) after December :	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
	reporting period	days) through becomber		0	1
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (oveluding	swing_bed and	6	9
	newborn days)	the riogram (excruding	swillg-bed alla	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10
00	through December 31 of the cost reporting period (see instruct			0	1 1 1
	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		bom days) arter	0	11
	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
	through December 31 of the cost reporting period				
	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13
	Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)	(0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	s through Docombor 21 o	f the cost	0.00	1 17
. 00	reporting period	s through becember 31 0	T the cost	0.00	''
	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18
	reporting period Madianid rate for awing had NE convises appliable to convise	through December 21 of	the east	0.00	10
	Medicaid rate for swing-bed NF services applicable to services reporting period	through becember 31 of	the cost	0.00	19
	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period	、			
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line)	1, 686, 786 0	
. 00	5 x line 17)	i si ui the cost repuit	ing period (ine	0	
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23
00	x line 18) Swing had apat applicable to NE type capyings through December	21 of the east reporting	ng ported (Line	0	1 .
	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reportin	ng period (inne	0	24
	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25
00	x line 20)				
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		0 1, 686, 786	
ł	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			1,000,700	1 - 1
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0 0. 000000	30
	Average private room per diem charge (line 29 ÷ line 3)	11110 20)		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
1	Average per diem private room charge differential (line 32 min		tions)	0.00	
1	Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35)	e 31)		0. 00 0	
	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	1, 686, 786	
	27 minus line 36)	·	•		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			1
	Adjusted general inpatient routine service cost per diem (see			987.00	38
	Program general inpatient routine service cost (line 9 x line			5, 922	
	Medically necessary private room cost applicable to the Progra	. ,		0	
00	Total Program general inpatient routine service cost (line 39	+ IINE 40)		5, 922	41

MPUT	Financial Systems FRANC	CISCAN ST. ELIZ		CCN: 150022	Period: From 01/01/2014	worksheet D-1	
			Componen	t CCN: 15S022		Date/Time Pre	
			Tit	le XIX	Subprovider -	5/27/2015 9:3 Cost	57 8
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	4
	Intensive Care Type Inpatient Hospital Units	· · ·		T		1	
. 00 . 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0				-	
. 00	BURN INTENSIVE CARE UNIT	0	C	0.0		0	
00	SURGICAL INTENSIVE CARE UNIT	0	C	0.0	0 00	0	1
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description					1.00	4
	Program inpatient ancillary service cost (Wk					1.00 2,812	
. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ons)		8, 734	4
00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	n of Parts I and	0	5
. 00) Pass through costs applicable to Program inpa	atient ancillar	y services (fr	rom Wkst. D, s	sum of Parts II	0	5
. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				0	5
. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line	ding capital re	lated, non-phy	/sician anesth	netist, and	0	-
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				1	
. 00 . 00	Program discharges Target amount per discharge					0 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	rget amount (I	ine 56 minus	line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endina 1996 i	updated and co	ompounded by the	0.00	
	market basket		0		singulated by the		
. 00 . 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	
. 00	which operating costs (line 53) are less that					0	0
00	amount (line 56), otherwise enter zero (see	instructions)					
. 00 . 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts 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 cos	ts after Decemb	er 31 of the d	cost reporting	period (See	0	6
	instructions)(title XVIII only)					-	
. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)				•	0	6
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 d	of the cost re	eporting period	0	6
. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	0	68
0. 00	Total title V or XIX swing-bed NF inpatient					0	6
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						7
. 00	Adjusted general inpatient routine service c	ost per diem (I					7
. 00 . 00	Program routine service cost (line 9 x line Medically necessary private room cost application	,	ı (line 14 x li	ne 35)			7
. 00	Total Program general inpatient routine service	0	•				7
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from V	Vorksheet B, F	Part II, column		7
. 00	Per diem capital-related costs (line 75 ÷ li						7
00 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu:						7
. 00	Aggregate charges to beneficiaries for excess	s costs (from p					7
. 00	Total Program routine service costs for compariant routine service cost per diam limit		ost limitation	n (line 78 mir	nus line 79)		8
. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				8
. 00	Reasonable inpatient routine service costs (see instructior					8
. 00 . 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		uns)				8
. 00	Total Program inpatient operating costs (sum						8
00	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
. 00 . 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per o		line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see	•					8

Health Financial Systems FRAN	CISCAN ST. ELIZ	ABETH HEALTH -	CR	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014		
		Tit	le XIX	Subprovider - IPF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	287, 768	1, 686, 786	0. 17060	0 1	0	90.00
91.00 Nursing School cost	0	1, 686, 786	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	1, 686, 786	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 686, 786	0.00000	0 0	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150022	Peri	i od:	Worksheet D-3	
				m 01/01/2014 12/31/2014	Date/Time Pre	pare
	T; +I	e XVIII		Hospi tal	5/27/2015 9:3 PPS	7 an
Cost Center Description	11 ti	Ratio of Co	st	Inpatient	Inpati ent	
		To Charges		Program	Program Costs	
					(col. 1 x col.	
				-	2)	
		1.00		2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		T		2 274 221		1 20
00 03000 ADULTS & PEDIATRICS 00 03100 INTENSIVE CARE UNIT				2, 276, 231 737, 886		30
00 03200 CORONARY CARE UNIT				/37,000		32
00 03300 BURN INTENSIVE CARE UNIT				0		33
00 03400 SURGICAL INTENSIVE CARE UNIT				0		34
00 04000 SUBPROVIDER - IPF				0		40
00 04100 SUBPROVI DER – I RF				0		41
00 04200 SUBPROVI DER				0		42
00 04300 NURSERY						43
ANCI LLARY SERVI CE COST CENTERS		•				1
. 00 05000 OPERATI NG ROOM		0. 2800	603	1, 266, 426	355, 363	50]
. 00 05100 RECOVERY ROOM		0.0000	000	0	0	51
. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	0	52
00 05300 ANESTHESI OLOGY		0.0000		0	0	53
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1313		1, 757, 113	230, 767	54
01 05401 ULTRASOUND		0. 0525		135, 929	7, 147	54
00 05500 RADI OLOGY-THERAPEUTI C		0. 2940		6, 675	1, 963	
00 05600 RADI OI SOTOPE		0.090		63, 584	5, 786	56
00 05700 CT SCAN		0.0000		0	0	57
		0.0000		0	0	58
00 05900 CARDI AC CATHETERI ZATI ON		0.0000		2 272 052		59
00 06000 LABORATORY 01 06001 BLOOD LABORATORY		0. 1918		2, 372, 852 0	455, 263 0	60
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	0	61
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	0	62
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	0	63
00 06400 I NTRAVENOUS THERAPY		0.0000		0	0	64
00 06500 RESPI RATORY THERAPY		0. 3554		725, 059	257, 755	65
00 06600 PHYSI CAL THERAPY		0. 4968		158, 531	78, 769	66
00 06700 OCCUPATI ONAL THERAPY		0.000		0	0	67
00 06800 SPEECH PATHOLOGY		0.0000		0	0	68
. 00 06900 ELECTROCARDI OLOGY		0. 078	558	478, 730	37, 608	69
00 07000 ELECTROENCEPHALOGRAPHY		0.0000	000	0	0	70
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 261	192	1, 175, 558	307, 046	71
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4118	842	1, 225, 436	504, 686	72
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2863		3, 310, 627	948, 084	73
00 07400 RENAL DIALYSIS		0.0000		0	0	74
00 07500 ASC (NON-DI STINCT PART)		0.0000		0	0	75
. 00 03020 ONCOLOGY		0.000	000	0	0	76
OUTPATIENT SERVICE COST CENTERS		0.000	000		-	1
00 08800 RURAL HEALTH CLINIC		0.0000			0	88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		~	0	89
		0.457		0 843, 188	124 401	90
00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1499		043, 188	126, 401	91 92
0.00 Total (sum of lines 50-94 and 96-98)		0.775	717	0 13, 519, 708	3, 316, 638	
1.00 Less PBP Clinic Laboratory Services-Program only	(Lino 61)			13, 319, 708	3, 310, 038	200
2.00 Net Charges (line 200 minus line 201)	y charges (The OT)			13, 519, 708		201

ATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150022	Peri od:	Worksheet D-3	
			From 01/01/2014		
	Componen	t CCN: 15S022	To 12/31/2014	Date/Time Pre 5/27/2015 9:3	
	Ti tl	e XVIII	Subprovider - IPF	PPS	
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	
00 03000 ADULTS & PEDI ATRI CS			0		30
00 03100 INTENSIVE CARE UNIT			0		31
00 03200 CORONARY CARE UNIT			0		32
00 03300 BURN INTENSIVE CARE UNIT			0		33
00 03400 SURGICAL INTENSIVE CARE UNIT			0		34
00 04000 SUBPROVIDER - IPF			2, 428, 716		40
00 04100 SUBPROVIDER - IRF			0		41
00 04200 SUBPROVI DER			0		42
				I	43
ANCI LLARY SERVI CE COST CENTERS 00 05000 OPERATI NG ROOM		0.2806	03 0	0	50
00 05100 RECOVERY ROOM		0. 00000		0	5
00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	52
00 05300 ANESTHESI OLOGY		0.0000		0	53
00 05400 RADI OLOGY-DI AGNOSTI C		0. 1313			
01 05401 ULTRASOUND		0. 0525			
00 05500 RADI OLOGY-THERAPEUTI C		0. 29404		0	55
00 05600 RADI 0I SOTOPE		0.0909		0	56
00 05700 CT SCAN		0.0000		0	5
00 05800 MRI		0.0000		0	58
00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	59
00 06000 LABORATORY		0. 1918		56, 441	60
01 06001 BLOOD LABORATORY		0.0000		0	60
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000	00 O	0	61
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000	00 0	0	62
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000	00 0	0	63
00 06400 I NTRAVENOUS THERAPY		0.0000	00 0	0	64
00 06500 RESPI RATORY THERAPY		0.3554	95 38, 319	13, 622	65
00 06600 PHYSI CAL THERAPY		0. 4968	70 37, 248	18, 507	60
00 06700 OCCUPATI ONAL THERAPY		0.0000	00 0	0	6
00 06800 SPEECH PATHOLOGY		0.0000		0	68
00 06900 ELECTROCARDI OLOGY		0. 0785		2, 161	
00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2611			
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4118		0	72
00 07300 DRUGS CHARGED TO PATIENTS		0. 2863			
00 07400 RENAL DI ALYSI S		0.0000		0	74
00 07500 ASC (NON-DI STINCT PART)		0.0000			75
00 03020 ONCOLOGY		0.0000	00 0	0	76
OUTPATIENT SERVICE COST CENTERS 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88
00 08800 FEDERALLY QUALIFIED HEALTH CENTER		0.0000			
00 009000 CLINIC		0. 4577		0	90
00 09100 EMERGENCY		0. 4377			
00 09100 EMERGENCI 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 14990		n 10, 403	92
.00 Total (sum of lines 50-94 and 96-98)		0.7759	983, 480	236, 088	
.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		703, 400	230,000	200
.00 Net Charges (Line 200 minus Line 201)	charges (The UT)	1	983, 480	1	202

IPATIENT ANCILLARY	tems FRANCISCAN S SERVICE COST APPORTIONMENT	Provi der	CCN: 150022	Peri od:	Worksheet D-	.3
				From 01/01/20 To 12/31/20		
		Tit	le XIX	Hospi tal	Cost	
Cost Cer	iter Description		Ratio of Co To Charges		Inpatient Program Costs (col. 1 x col 2)	
			1.00	2.00	3.00	
INPATIENT ROU	FINE SERVICE COST CENTERS					
0.00 03000 ADULTS 8	PEDI ATRI CS			214, 2	278	30
. 00 03100 I NTENSI	E CARE UNIT			120, 4	477	31
2. 00 03200 CORONAR	CARE UNIT				0	32
3.00 03300 BURN IN	ENSIVE CARE UNIT				0	33
. 00 03400 SURGI CAI	INTENSIVE CARE UNIT				0	34
0.00 04000 SUBPROV	DER – I PF				0	40
.00 04100 SUBPROV	DER – IRF				0	41
2. 00 04200 SUBPROV	DER				0	42
00 04300 NURSERY					o	43
	/I CE COST CENTERS					
0.00 05000 OPERATI	IG ROOM		0. 2797	733 101, 7	785 28, 47	3 50
. 00 05100 RECOVER	' ROOM		0.0000	000	0	0 51
2. 00 05200 DELI VER	' ROOM & LABOR ROOM		0.0000	000	0	0 52
3. 00 05300 ANESTHE	SI OLOGY		0.0000	000	0	0 53
. 00 05400 RADI OLO	GY-DI AGNOSTI C		0. 1313	333 233, 8	379 30, 71	6 54
. 01 05401 ULTRASO			0. 0525			
. 00 05500 RADI OLO			0. 2940			0 55
. 00 05600 RADI 0I S			0.0909			
.00 05700 CT SCAN			0.0000			0 57
3. 00 05800 MRI			0.0000		0	0 58
	CATHETERI ZATI ON		0.0000			0 59
0.00 06000 LABORAT			0. 1915			
0. 01 06001 BLOOD LA			0.0000			0 60
	II CAL LAB SERVI CES-PRGM ONLY		0.0000			0 61
	OOD & PACKED RED BLOOD CELL		0.0000			0 62
	ORING, PROCESSING & TRANS.		0.0000		-	0 63
. 00 06400 I NTRAVE			0.0000			0 64
5. 00 06500 RESPI RA			0. 3554			
00 06600 PHYSI CAI			0. 4968			
2.00 06700 0CCUPAT			0. 0000			0 67
3. 00 06800 SPEECH I			0.0000			0 68
0.00 06900 ELECTRO			0.0785			
	ENCEPHALOGRAPHY		0.0000			0 70
	SUPPLIES CHARGED TO PATIENT		0. 2611			
	V. CHARGED TO PATIENT					
	IARGED TO PATIENTS		0.4118		546 1, 50	
. 00 07300 DR0G3 CI			0. 2863			
	I-DI STINCT PART)		0.0000			
	<i>,</i>		0.0000			
0.00 03020 ONCOLOG			0.0000	000	0	0 76
	RVICE COST CENTERS		0.0000	000	0	0 00
8. 00 08800 RURAL HI	Y QUALIFIED HEALTH CENTER		0.0000			0 88
	I QUALIFIED HEALIH GENIEK		0.0000			0 89
0.00 09000 CLINIC	N/		0.4577			0 90
. 00 09100 EMERGEN			0. 1499			
	TON BEDS (NON-DISTINCT PART		0. 7759			0 92
0.00 Total (s	sum of lines 50–94 and 96–98) P Clinic Laboratory Services-Program onl			1, 410, 9	951 319, 61	6 200
1.00 Less PBI						

ATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150022	Period:	Worksheet D-3	
	Component	CCN: 15S022	From 01/01/2014 To 12/31/2014	Date/Time Pre	nar
	component	CCN. 155022	10 12/31/2014	5/27/2015 9:3	7 a
	Tit	le XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Ŭ	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
00 03000 ADULTS & PEDIATRICS			0		30
00 03100 I NTENSI VE CARE UNI T			0		31
00 03200 CORONARY CARE UNIT			0		32
00 03300 BURN INTENSIVE CARE UNIT			0		33
00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34
00 04000 SUBPROVIDER - IPF			1, 418		40
00 04100 SUBPROVI DER - I RF			0		41
00 04200 SUBPROVI DER 00 04300 NURSERY			0		42
00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			0		4
00 05000 OPERATI NG ROOM		0. 2797	33 1, 925	538	50
00 05100 RECOVERY ROOM		0.0000	00 0	0	51
00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	00 0	0	52
00 05300 ANESTHESI OLOGY		0.0000	00 0	0	53
00 05400 RADI OLOGY-DI AGNOSTI C		0. 1313	33 1, 546	203	54
01 05401 ULTRASOUND		0. 0525	78 114	6	54
00 05500 RADI OLOGY-THERAPEUTI C		0. 2940	45 51	15	55
00 05600 RADI OI SOTOPE		0. 0909		5	
00 05700 CT SCAN		0.0000		0	
00 05800 MRI		0.0000		0	
00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
00 06000 LABORATORY		0. 1915		381	
01 06001 BLOOD LABORATORY		0.0000		0	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
00 06400 I NTRAVENOUS THERAPY 00 06500 RESPI RATORY THERAPY		0.0000		0 266	
00 06600 PHYSI CAL THERAPY		0. 3554 0. 4968		200	
00 06700 OCCUPATI ONAL THERAPY		0. 0000		0	
00 06800 SPEECH PATHOLOGY		0.0000		0	
00 06900 ELECTROCARDI OLOGY		0.0785		32	
00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2611		20	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4118		405	
00 07300 DRUGS CHARGED TO PATIENTS		0. 2863		757	
00 07400 RENAL DI ALYSI S		0.0000		0	
00 07500 ASC (NON-DISTINCT PART)		0.0000		0	
00 03020 ONCOLOGY		0.0000		0	
OUTPATIENT SERVICE COST CENTERS		1			4
00 08800 RURAL HEALTH CLINIC		0.0000		0	
00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
00 09000 CLINIC		0. 4577		0	
00 09100 EMERGENCY		0. 1499		119	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7759			92
.00 Total (sum of lines 50-94 and 96-98)			11, 454	2, 812	200 201
.00 Less PBP Clinic Laboratory Services-Program only char					

		TTOVIGET	CCN: 150022	Period: From 01/01/2014	Worksheet E Part A	
				To 12/31/2014	Date/Time Pi 5/27/2015 9:	
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1.00	2.00	_
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0		1.00
1.01	DRG amounts other than outlier payments for discharges occurrin	g prior		2, 891, 813		1.01
1.02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	g on or		1, 076, 751		1.02
1.03	after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	-		0		1.03
	discharges occurring prior to October 1 (see instructions)			0		
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1.04
2.00	Outlier payments for discharges. (see instructions)			204, 953		2.00
2.01 2.02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0		2.01
3.00	Managed Care Simulated Payments			731, 167		3.00
4.00	Bed days available divided by number of days in the cost report period (see instructions)	ing		28.79		4.00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent	1	0.00		5.00
	cost reporting period ending on or before 12/31/1996. (see instr	uctions)				5.00
6.00	FTE count for allopathic and osteopathic programs which meet th criteria for an add-on to the cap for new programs in accordanc			0.00		6.00
	CFR 413.79(e)					
7.00	MMA Section 422 reduction amount to the IME cap as specified un CFR §412.105(f)(1)(iv)(B)(1)	der 42		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified u			0.00		7.01
	CFR $412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July then see instructions.	1, 2011				
8.00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8.00
	413. 75(b), 413. 79(c) (2) (iv), 64 FR 26340 (May 12, 1998), and 67					
8.01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8. 01
0.01	section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		
8.02	instructions. The amount of increase if the hospital was awarded FTE cap slot	s from a		0.00		8.02
0.00	closed teaching hospital under section 5506 of ACA. (see instru			0.00		9.00
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)			0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the curren from your records	t year		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00		11.00
12.00 13.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00 0.00		12.00
14.00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14.00
15.00	or after September 30, 1997, otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00		15.00
16. 00 17. 00	Adjustment for residents in initial years of the program			0.00		16.00 17.00
18.00	Adjusment for residents displaced by program or hospital closur Adjusted rolling average FTE count	e		0. 00 0. 00		17.00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000		19.00 20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000		21.00
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment – Managed Care (see instructions)			0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section		he MMA			
23.00	Number of additional allopathic and osteopathic IME FTE residen slots under 42 Sec. 412.105 (f)(1)(iv)(C).	t cap		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	c		0.00		24.00
25.00	If the amount on line 24 is greater than -O-, then enter the lo line 23 or line 24 (see instructions)	wer or		0.00		25.00
26.00 27.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26.00 27.00
28.00	IME add-on adjustment amount (see instructions)			0.000000		28.00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			0		28. 01 29. 00
29.00	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.00
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	ient davs		0.00		30.00
	(see instructions)	uuys				
31.00 32.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			0.00 0.00		31.00
33.00	Allowable disproportionate share percentage (see instructions)			0.00		33.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2014	Worksheet E Part A	
			To 12/31/2014		
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
		0	0ctober 1 1.00	<u>0ctober 1</u> 2.00	
	Uncompensated Care Adjustment			2100	
	Total uncompensated care amount (see instructions)		9, 046, 380, 143		
5.01	Factor 3 (see instructions)		0. 000011584	0. 000004440	
5. 02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.0
5. 03	Pro rata share of the hospital uncompensated care payment		0	0	35.0
	amount (see instructions)				
5. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.0
	Additional payment for high percentage of ESRD beneficiary (discharges (lines 40 throug	h 46)		
D. 00	Total Medicare discharges on Worksheet S-3, Part I		0		40.0
	excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.0
	682, 683, 684 an 685. (see instructions)				
1. 01	Total ESRD Medicare covered and paid discharges excluding		0		41.0
2.00	MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not		0.00		42. C
00	qualify for adjustment)		0.00		.2.0
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43. C
4.00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44. C
T. UU	divided by Line 41 divided by 7 days)		0.00000		44.0
5.00	Average weekly cost for dialysis treatments (see		0.00		45.0
5. 00	instructions)		0		46.0
5. 00	Total additional payment (line 45 times line 44 times line 41.01)		0		40.0
7.00	Subtotal (see instructions)		4, 173, 517		47.0
3. 00	Hospital specific payments (to be completed by SCH and		3, 918, 204		48. C
9.00	MDH, small rural hospitals only. (see instructions) Total payment for inpatient operating costs (see		4, 173, 517		49.0
7.00	instructions)		ч, 173, 317		
D. 00	Payment for inpatient program capital (from Wkst. L, Pt. I		366, 596		50.0
1.00	and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L,		0		51.0
1.00	Pt. III, see instructions)		0		51.0
2.00	Direct graduate medical education payment (from Wkst. E-4,		0		52. C
	line 49 see instructions).		0		E2 0
3.00 4.00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies		0		53.0 54.0
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.0
	line 69)				
5. 00	Cost of physicians' services in a teaching hospital (see intructions)		0		56. C
7.00	Routine service other pass through costs (from Wkst. D,		0		57. C
	Pt. III, column 9, lines 30 through 35).				
3.00	Ancillary service other pass through costs from Wkst. D,		0		58.0
9.00	Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58)		4, 540, 113		59.0
0. 00	Primary payer payments		0		60. C
1.00	Total amount payable for program beneficiaries (line 59		4, 540, 113		61.0
2. 00	minus line 60) Deductibles billed to program beneficiaries		595, 680		62.0
3.00	Coinsurance billed to program beneficiaries		1, 216		63.0
4.00	Allowable bad debts (see instructions)		84, 015		64.0
5.00	Adjusted reimbursable bad debts (see instructions)		54, 610		65.0
5. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		22, 656		66. (
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3, 997, 827		67.0
3. 00	Credits received from manufacturers for replaced devices		0		68. (
9.00	for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and		0		69. (
	96). (For SCH see instructions)				
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.0
). 50). 89	RURAL DEMONSTRATION PROJECT Pioneer ACO demonstration payment adjustment amount (see		0		70. 5
. 07	instructions)		0		, 0.1
0. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 9
0.01	instructions)				70 /
	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)		0		70. 9 70. 9
	HVBP payment adjustment amount (see instructions)		14, 817		70.
D. 94	HRR adjustment amount (see instructions)		-34, 170		70. 9 70. 9
	HRR adjustment amount (see instructions) Recovery of accelerated depreciation		-34,170		

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150022	Period: From 01/01/2014 To 12/31/2014	Date/Time Pr 5/27/2015 9:	
		Title XVIII	Hospi tal	PPS	
			Prior to October 1	On/After October 1	
		0	1.00	2.00	1
0.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		14 502, 478		70.96
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	20	15 186, 688	3	70. 97
0. 98	Low Volume Payment-3		(70.98
0. 99	HAC adjustment amount (see instructions)		(70.99
1. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4, 667, 640		71.00
1.01	Sequestration adjustment (see instructions)		93, 353	3	71.01
2.00	Interim payments		4, 609, 668	3	72.00
3.00	Tentative settlement (for contractor use only)		(D	73.00
4.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-35, 381		74.00
5.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		(75.00
0 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2 (see		(1	
0.00	instructions)		(90.00
1.00	Capital outlier from Wkst. L, Pt. I, line 2		(91.00
2.00	Operating outlier reconciliation adjustment amount (see		(92.00
2.00	instructions)				/2.0
3. 00	Capital outlier reconciliation adjustment amount (see instructions)		(93.00
4.00	The rate used to calculate the time value of money (see		0.00	þ	94.00
5.00	instructions) Time value of money for operating expenses (see		0	D	95.00
6.00	instructions) Time value of money for capital related expenses (see		(96.00
0.00	instructions)				70.00
			Prior to 10/1	0n/After 10/1	
	HSP Bonus Payment Amount		1.00	2.00	
00 00	HSP bonus amount (see instructions)		(0 100. 00
00.00	HVBP Adjustment for HSP Bonus Payment			ч ,	100.00
01.00	HVBP adjustment factor (see instructions)		(0 101. 00
	HVBP adjustment amount for HSP bonus payment (see instruction	าร)			0 102.00
20	HRR Adjustment for HSP Bonus Payment	,			
03.00	HRR adjustment factor (see instructions)		0.0000	0.000	0 103. 0
01 00	HRR adjustment amount for HSP bonus payment (see instructions	5)	(0 104. 0

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150022	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Pre 5/27/2015 9:3	
		Title XVIII	Hospi tal	PPS	/ dili
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	-
00	Medical and other services (see instructions)			2, 413	1 1.
00	Medical and other services reimbursed under OPPS (see instruct	i ons)		6, 822, 578	
00	PPS payments			6, 419, 532	3.
00	Outlier payment (see instructions)			17, 433	
00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	
00 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0.00	
00	Transitional corridor payment (see instructions)			0.00	
00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	
. 00	5			0	
. 00	Total cost (sum of lines 1 and 10) (see instructions)			2, 413	11
	COMPUTATION OF LESSER OF COST OR CHARGES				4
00	Reasonable charges			0.404	1 40
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, c			8, 426 0	
	Total reasonable charges (sum of lines 12 and 13)	.01. 4)		8, 426	
. 00	Customary charges			0, 120	1
. 00	Aggregate amount actually collected from patients liable for p	ayment for services on	a charge basis	0	15
. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16
~~	had such payment been made in accordance with 42 CFR §413.13(e	e)			
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete onl	vifling 18 exceeds li	no 11) (soo	8, 426 6, 013	
. 00	instructions)	y II IIIc To exceeds II		0,013	' '
. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20
	instructions)	5	, ,		
	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		2, 413	
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 8 and 9)	uctions)		0 6, 436, 965	1
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0, 430, 903	24
. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25
	Deductibles and Coinsurance relating to amount on line 24 (for			1, 408, 740	26
. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 22	and 23} (for	5, 030, 638	27
00	CAH, see instructions)	DC C C C C C C C C C		0	20
	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	
	Subtotal (sum of lines 27 through 29)			5, 030, 638	
	Primary payer payments			610	
. 00	Subtotal (line 30 minus line 31)			5, 030, 028	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)			4
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			148, 793 96, 715	
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		65, 108	
	Subtotal (see instructions)			5, 126, 743	
. 00	MSP-LCC reconciliation amount from PS&R			0	38
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions			0	
	Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see instruc	tions)	0	
	Subtotal (see instructions)			0 5, 126, 743	
	Sequestration adjustment (see instructions)			102, 535	
	Interim payments			5, 005, 887	
	Tentative settlement (for contractors use only)			0	
	Balance due provider/program (see instructions)			18, 321	
. 00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub. 15-2,	chapter 1,	0	44
	§115.2 TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount (see instructions)			0	90
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
. 00	Time Value of Money (see instructions)			0	
	Total (sum of lines 91 and 93)			0	94

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150022	Period: From 01/01/2014 To 12/31/2014		pare
		Ti tl	e XVIII	Hospi tal	PPS	
			nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4,00	
00	Total interim payments paid to provider		4, 609, 6		5, 005, 887	1.
00	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,			0	0	
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
	Program to Provider	1			1	
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3
03				0	0	3
)4				0	0	
)5				0	0	3
	Provider to Program		1	-	-	
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	-
52 53				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
	3. 50-3. 98)					-
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)		4, 609, 6	68	5, 005, 887	4
	TO BE COMPLETED BY CONTRACTOR				1	
0	List separately each tentative settlement payment after					15
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider		1	-		
)1)2	TENTATI VE TO PROVIDER			0	0	
,∠)3				0	0	
/5	Provider to Program		1	0	0	
0	TENTATI VE TO PROGRAM			0	0	1 5
51				0	0	5
52				0	0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER			0	18, 321	6
)2	SETTLEMENT TO PROGRAM		35, 3		0	
00	Total Medicare program liability (see instructions)		4, 574, 2		5, 024, 208	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1, 00	2.00	
0	Name of Contractor				2.00	8

NALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150022 CCN: 15S022	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part I Date/Time Prep 5/27/2015 9:37	pared: 7 am
		Ti tl	e XVIII	Subprovider - IPF	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
0.0		1.00	2.00	3.00	4.00	1.0
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 362, 4	0	0 0	1.0 2.0
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. 0
01	ADJUSTMENTS TO PROVIDER		I	0	0	3.0
02 03 04 05	AUSUSTINIENTS TO PROVIDER			0 0 0	0 0 0	3.0 3.0 3.0 3.0 3.0
00	Provider to Program			0		0.0
50	ADJUSTMENTS TO PROGRAM			0	0	3.5
51 52 53 54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0 0	0 0 0 0	3.5 3.5 3.5 3.5 3.5
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		1, 362, 4	51	0	4. (
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5. (
01	TENTATI VE TO PROVIDER			0	0	5.0
02 03				0 0	0 0	5. 5.
	Provider to Program					
50 51 52	TENTATI VE TO PROGRAM			0 0 0	0 0 0	5. 5. 5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.
00 01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6. 6.
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		1, 362, 4	0	0 0	6.
)	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	

Heal th	Financial Systems FRANCISCAN ST. ELIZABET	H HEALTH - CR	In Lie	u of Form CMS-2	2552-10
CALCU	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150022		Worksheet E-1	
			From 01/01/2014		
			To 12/31/2014	Date/Time Pre	
			Hocni tal	5/27/2015 9:3 PPS	
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PP5	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S	-3, Pt. I col. 15 li	ne 14	1, 020	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	2		2, 232	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			443	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		3, 586	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			132, 928, 692	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	e 20		8, 105, 843	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technolog	y Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			1, 191, 600	8.00
9.00	Sequestration adjustment amount (see instructions)			23, 832	9.00
10.00	Calculation of the HIT incentive payment after sequestration (s	ee instructions)		1, 167, 768	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1, 213, 044	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and lin	e 31) (see instructi	ons)	-45, 276	32.00

	Component CCN: 15S022	From 01/01/2014 To 12/31/2014	Part II Date/Time Pre 5/27/2015 9:3	
	Title XVIII	Subprovider - IPF	PPS	<u>/ alli</u>
			1.00	
T II - MEDICARE PART A SERVICES - IPF PPS				
Federal IPF PPS Payments (excluding outlier, ECT, and medi	cal education payments)		1, 429, 384	1.
IPF PPS Outlier Payments			46, 882	2.
IPF PPS ECT Payments			0	3.
eighted intern and resident FTE count in the most recent co	ost report filed on or be	efore November	0.00	4.
2004. (see instructions) increases for the unweighted intern and resident FTE count	for real dents that war	diaplaced by	0.00	
gram or hospital closure, that would not be counted without			0.00	4
§412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		ient under 42		
Teaching program adjustment. (see instructions)			0.00	5
rent year's unweighted FTE count of I&R excluding FTEs in t	the new program growth pe	eriod of a "new	0.00	
ching program" (see instuctions)				
rent year's unweighted I&R FTE count for residents within t	he new program growth pe	eriod of a "new	0.00	7
ching program" (see instuctions)				
ern and resident count for IPF PPS medical education adjust	ment (see instructions)		0.00	
rage Daily Census (see instructions)			4.682192	
ching Adjustment Factor {((1 + (line 8/line 9)) raised to t	the power of .5150 -1}.		0.00000	
ching Adjustment (line 1 multiplied by line 10).			0	11
usted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1, 476, 266	
sing and Allied Health Managed Care payment (see instruction	on)		0	
an acquisition (DO NOT USE THIS LINE) t of physicians' services in a teaching hospital (see instr	suctions)		0	14 15
total (see instructions)	uctions)		1, 476, 266	
mary payer payments			1, 470, 200	
itotal (line 16 less line 17).			1, 476, 266	
lucti bl es			82, 656	
total (line 18 minus line 19)			1, 393, 610	
nsurance			3, 344	21
total (line 20 minus line 21)			1, 390, 266	22
owable bad debts (exclude bad debts for professional servic	ces) (see instructions)		0	23
usted reimbursable bad debts (see instructions)			0	24
owable bad debts for dual eligible beneficiaries (see instr	ructions)		0	25
total (sum of lines 22 and 24)			1, 390, 266	
ect graduate medical education payments (from Wkst. E-4, li	ne 49)		0	
er pass through costs (see instructions)			0	
lier payments reconciliation			0	29
IER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) neer ACO demonstration payment adjustment (see instructions			0	30 30
every of Accel erated Depreciation	<i>)</i>		0	
al amount payable to the provider (see instructions)			1, 390, 266	
uestration adjustment (see instructions)			27, 805	
erim payments			1, 362, 461	
tative settlement (for contractor use only)			0	
ance due provider/program (line 31 minus lines 31.01, 32 ar	nd 33)		0	
	-	chapter 1,	0	
5. 2				1
BE COMPLETED BY CONTRACTOR				
ginal outlier amount from Worksheet E-3, Part II, line 2			46, 882	
lier reconciliation adjustment amount (see instructions)				51
rate used to calculate the Time Value of Money				
5.2 BEC gina Tier	COMPLETED BY CONTRACTOR al outlier amount from Worksheet E-3, Part II, line 2 reconciliation adjustment amount (see instructions) te used to calculate the Time Value of Money	COMPLETED BY CONTRACTOR al outlier amount from Worksheet E-3, Part II, line 2 reconciliation adjustment amount (see instructions) te used to calculate the Time Value of Money	al outlier amount from Worksheet E-3, Part II, line 2 r reconciliation adjustment amount (see instructions) te used to calculate the Time Value of Money	COMPLETED BY CONTRACTOR al outlier amount from Worksheet E-3, Part II, line 2 46,882 reconciliation adjustment amount (see instructions) 0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150022	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Pre 5/27/2015 9:3	pared
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIO	CES FOR TITLES V OR X	1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CESTOR TITLES V OR X	TX SERVICES		1
. 00	Inpatient hospital/SNF/NF services		589, 709		1.0
. 00	Medical and other services			0	2.0
. 00	Organ acquisition (certified transplant centers only)		0		3. (
. 00	Subtotal (sum of lines 1, 2 and 3)		589, 709	0	4. (
. 00	Inpatient primary payer payments		0		5.0
. 00	Outpatient primary payer payments			0	6.0
. 00	Subtotal (line 4 less sum of lines 5 and 6)		589, 709	0	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges				
. 00	Routine service charges Ancillary service charges		1, 410, 951	0	8. 9.
	Organ acquisition charges, net of revenue		1, 410, 951	0	10.
	Incentive from target amount computation		0		11.
	Total reasonable charges (sum of lines 8 through 11)		1, 410, 951	0	12.
2.00	CUSTOMARY CHARGES		1,410,731	0	12.
3.00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13.
	basi s			-	
4.00	Amounts that would have been realized from patients liable for patients	ayment for services o	n 0	0	14.
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15.
6.00	Total customary charges (see instructions)		1, 410, 951	0	16.
7.00	Excess of customary charges over reasonable cost (complete only	ifline 16 exceeds	821, 242	0	17.
	line 4) (see instructions)			_	
8.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	e 0	0	18.
0 00	16) (see instructions)		0	0	19.
	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	tions)	0	-	
	Cost of covered services (enter the lesser of line 4 or line 16)	trons)	589, 709	0	
1.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con	mplated for PDS provi		0	21.
2.00	Other than outlier payments		0	0	22.
	Outlier payments		0	0	23.
	Program capital payments		0		24.
	Capital exception payments (see instructions)		0		25.
	Routine and Ancillary service other pass through costs		0	0	26.
7.00	Subtotal (sum of lines 22 through 26)		0	0	27.
	Customary charges (title V or XIX PPS covered services only)		0	0	28.
9.00	Titles V or XIX (sum of lines 21 and 27)		589, 709	0	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	30.
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		589, 709	0	
	Deductibles		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review	2)		~	35.
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3.	3)	589, 709	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		589, 709	0	37. 38.
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		04, 709	0	38. 39.
	Total amount payable to the provider (sum of lines 38 and 39)		589, 709	0	
	Interim payments		589, 709 589, 709	0	
2.00	Balance due provider/program (line 40 minus line 41)		007,709	0	41.
2.00 3.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2	0	0	
J. UU	chapter 1, §115.2	with ows rub 15-2,	0	0	1 + 3.

CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150022 Component CCN: 15S022	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Pre	
		component con: 155022	10 12/31/2014	5/27/2015 9:3	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	/ICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
0	Inpatient hospital/SNF/NF services		8, 734] '
0	Medical and other services			0	
0	Organ acquisition (certified transplant centers only)		0		:
0	Subtotal (sum of lines 1, 2 and 3)		8, 734	0	4
0	Inpatient primary payer payments		0	-	1
0	Outpatient primary payer payments		0.70/	0	6
0	Subtotal (line 4 less sum of lines 5 and 6)		8, 734	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges		0		1.
0	Routine service charges Ancillary service charges		11, 454	0	
	Organ acquisition charges, net of revenue		n, 434	0	10
	Incentive from target amount computation		0		1
	Total reasonable charges (sum of lines 8 through 11)		11, 454	0	
	CUSTOMARY CHARGES				1
00	Amount actually collected from patients liable for payment for	services on a charge	0	0	1:
	basi s				
00	Amounts that would have been realized from patients liable for		ח 0	0	1
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.00000	
	Total customary charges (see instructions)		11, 454	0	1
00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	y IT ITHE 16 exceeds	2, 720	0	1
00	Excess of reasonable cost over customary charges (complete only	vifline 4 exceeds line	· 0	0	1
00	16) (see instructions)		0	0	
00	Interns and Residents (see instructions)		0	0	10
00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	20
00	Cost of covered services (enter the lesser of line 4 or line 1	6)	8, 734	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be a	completed for PPS provid	lers.		
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		2
	Capital exception payments (see instructions)		0		2!
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		8, 734	0	
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0,734	0	2
00	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		8, 734	0	
	Deducti bl es		0	0	
00	Coinsurance		0	0	3
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0		3
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	8, 734	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
00	Subtotal (line 36 ± line 37)		8, 734	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		3
00	Total amount payable to the provider (sum of lines 38 and 39)		8, 734	0	4
00	Interim payments Palance due provider (program (line 40 minus line 41)		8, 734	0	4
	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance	co with CMS Dub 15 0	0	0	
111	The steared amounts (nonarrowable cost report ritems) in accordance	US WITH OWS PUD 10-2,	0	0	43

	E SHEET (If you are nonproprietary and do not maintain			Period: From 01/01/2014	Worksheet G	
und-t	ype accounting records, complete the General Fund column onl	y)		To 12/31/2014	Date/Time Pre 5/27/2015 9:3	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS		1			
. 00	Cash on hand in banks	442,000		0 0	0	
. 00 . 00	Temporary investments Notes receivable	2, 204, 000		0 0	0	2.
. 00	Accounts receivable	6, 677, 000			0	4.
. 00	Other receivable	0,077,000		0 0	0	
. 00	Allowances for uncollectible notes and accounts receivable	0		0 0	0	
. 00	Inventory	1, 104, 000		0 0	0	7.
. 00	Prepaid expenses	0		0 0	0	
. 00	Other current assets	1, 009, 000		0 0	0	
0.00	Due from other funds	11 424 000		0 0	0	
1.00	Total current assets (sum of lines 1-10) FIXED ASSETS	11, 436, 000		0 0	0	11.
2.00	Land	0		0 0	0	12
3.00	Land improvements	0		0 0	0	13.
4.00	Accumulated depreciation	0		0 0	0	14.
5.00	Bui I di ngs	0		0 0	0	15
5.00	Accumulated depreciation	0		0 0	0	
7.00	Leasehold improvements	0		0 0	0	17
B. 00	Accumulated depreciation			0 0	0	18
9.00	Fixed equipment	27, 162, 000		0 0	0	19
0.00 1.00	Accumulated depreciation Automobiles and trucks	0			0	20
2.00	Accumulated depreciation			0 0	0	22
3.00	Major movable equipment	0		0 0	0	23
4.00	Accumulated depreciation	0		0 0	0	24
5.00	Minor equipment depreciable	0		0 0	0	25
5.00	Accumulated depreciation	0		0 0	0	26
7.00	HIT designated Assets	0		0 0	0	27
8.00	Accumulated depreciation	0		0 0	0	28
9.00	Minor equipment-nondepreciable	0		0 0	0	29
0. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	27, 162, 000		0 0	0	30
1.00	Investments	4, 648, 000		0 0	0	31
2.00	Deposits on Leases	0		0 0	0	32
3.00	Due from owners/officers	0		0 0	0	33
4.00	Other assets	0		0 0	0	34
5.00	Total other assets (sum of lines 31–34)	4, 648, 000		0 0	0	35
5.00	Total assets (sum of lines 11, 30, and 35)	43, 246, 000		0 0	0	36
	CURRENT_LIABILITIES	0 700 000			0	1
7.00 3.00	Accounts payable	2, 720, 000 1, 553, 000		0 0	0	37
9.00 9.00	Salaries, wages, and fees payable Payroll taxes payable	1, 555, 000		0 0	0	38
	Notes and Loans payable (short term)			0 0	0	
1.00	Deferred income	0		0 0	0	
2.00	Accel erated payments	0		-		42
3.00	Due to other funds	0		0 0	0	43
4.00	Other current liabilities	544, 000		0 0	0	44
5.00	Total current liabilities (sum of lines 37 thru 44)	4, 817, 000		0 0	0	45
< 00	LONG TERM LIABILITIES	0		0	0	
6.00 7.00	Mortgage payable Notes payable	0		0 0	0	
B. 00	Unsecured Loans			0 0	0	
7.00	Other long term liabilities	-2, 179, 000		0 0	0	
0. 00	Total long term liabilities (sum of lines 46 thru 49	-2, 179, 000		0 0	0	
. 00	Total liabilites (sum of lines 45 and 50)	2, 638, 000		0 0	0	51
	CAPI TAL ACCOUNTS			_		
2.00	General fund balance	40, 608, 000				52
3.00	Specific purpose fund			0		53
4.00	Donor created - endowment fund balance - restricted			0		54
5.00	Donor created - endowment fund balance - unrestricted			0		55
5.00	Governing body created - endowment fund balance			0	_	56
7.00	Plant fund balance - invested in plant				0	
8. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	⁵⁸
9. 00	Total fund balances (sum of lines 52 thru 58)	40, 608, 000		0 0	0	59
5.00 D.00	Total liabilities and fund balances (sum of lines 51 and	43, 246, 000		0 0	0	
	59)		1	Ŭ	Ű	1 22

Heal th	Financial Systems FRANC	CISCAN ST. ELIZA	ABETH HEALTH -	CR	In Lie	eu of Form CMS-2	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 150022	Peri od: From 01/01/2014 To 12/31/2014	Worksheet G-1 Date/Time Pre	pared:
		General	Fund	Speci al	Purpose Fund	5/27/2015 9:3 Endowment Fund	/ am
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00 5.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	41, 647, 000 5, 989, 358 47, 636, 358		0	0	1.00 2.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00 10.00	Total additions (sum of line 4-9)	000000000000000000000000000000000000000	0				6.00 7.00 8.00 9.00 10.00
11.00 12.00 13.00 14.00 15.00 16.00	Subtotal (line 3 plus line 10) ADJUST TO AFS	7, 028, 358 0 0 0 0	47, 636, 358		0 0 0 0 0	0 0 0 0 0	11.00 12.00 13.00 14.00 15.00 16.00
17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	7, 028, 358 40, 608, 000		0 0 0		17.00 18.00 19.00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0		1.00 2.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00 10.00 11.00 12.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ADJUST TO AFS	0 0	000000000000000000000000000000000000000		0 0		6.00 7.00 8.00 9.00 10.00 11.00 12.00
13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00		0 0			0 0		13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

AIEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	ovi der	CCN: 150022	Period: From 01/01/201 To 12/31/201		pared
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
00	Hospi tal		4, 184, 7		4, 184, 705	
00	SUBPROVIDER - IPF		2, 981, 9	01	2, 981, 901	2.0
00	SUBPROVIDER - IRF			0	0	3.0
00	SUBPROVI DER			0	0	4.0
00	Swing bed - SNF			0	0	
00	Swing bed - NF			0	0	6.0
00	SKILLED NURSING FACILITY			0	0	7.0
00	NURSING FACILITY			0	0	8.1
01	I CF/MR			0	0	8.0
00	OTHER LONG TERM CARE			0	0	9.
0. 00	Total general inpatient care services (sum of lines 1-9)		7, 166, 6	06	7, 166, 606	10.
	Intensive Care Type Inpatient Hospital Services					
I. 00	INTENSIVE CARE UNIT		1, 281, 2	41	1, 281, 241	
2.00	CORONARY CARE UNI T			0	0	
3.00	BURN INTENSIVE CARE UNIT			0	0	
1.00	SURGI CAL I NTENSI VE CARE UNI T			0	0	
5.00	OTHER SPECIAL CARE (SPECIFY)					15.
5.00	Total intensive care type inpatient hospital services (sum of line	S	1, 281, 2	41	1, 281, 241	16.
	11-15)					
7.00	Total inpatient routine care services (sum of lines 10 and 16)		8, 447, 8		8, 447, 847	
3.00	Ancillary services		22, 424, 6			
9.00	Outpatient services		1, 665, 9	02 16, 420, 07		
0. 00	RURAL HEALTH CLINIC			0	0 0	
1.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0 0	
2.00	HOME HEALTH AGENCY					22.
3.00	AMBULANCE SERVICES					23.
4.00	СМНС					24.
4.10	CORF			0	0 0	
5.00	AMBULATORY SURGICAL CENTER (D. P.)			0	0 0	
5.00	HOSPICE			0	0 0	
7.00	NON HOSPITAL - FPN (CORP 43)			0 15, 561, 36		
3. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to V	kst.	32, 538, 4	30 115, 951, 62	6 148, 490, 056	28.
	G-3, line 1) PART II - OPERATING EXPENSES					-
9.00	Operating expenses (per Wkst. A, column 3, line 200)		[38, 255, 75	1	29.
), 00	NON HOSPITAL - FPN (CORP 43)		14, 172, 4			30.
1.00	NON HOSFITAL - TEN (CORF 43)		14, 172, 4	0		31.
2.00				0		32.
. 00				0		33.
. 00				0		34.
. 00				0		35.
. 00	Total additions (sum of lines 30-35)			14, 172, 45	2	36.
. 00	DEDUCT (SPECIFY)			0 14, 172, 43	-	37.
. 00				0		38.
. 00				0		39.
. 00				0		40.
. 00				0		40.
. 00	Total deductions (sum of lines 37-41)			0	0	41.
. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tr	ancfor		52, 428, 20	°	42.
. 00	to Wkst. G-3, line 4)	ansrer		5Z, 4Z8, ZU	3	43.

STATEN	ENT OF REVENUES AND EXPENSES Provider CCN: 150022 Period:	Worksheet G-3	
	From 01/01/2014 To 12/31/2014		oared.
		5/27/2015 9:3	
		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	148, 490, 056	1.00
2.00	Less contractual allowances and discounts on patients' accounts	92, 593, 495	2.00
3.00	Net patient revenues (line 1 minus line 2)	55, 896, 561	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	52, 428, 203	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3, 468, 358	5.00
(00	OTHER I NCOME	0	1 00
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	19, 000	
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase di scounts	0	10.00 11.00
11.00 12.00	Rebates and refunds of expenses	-	12.00
12.00	Parking lot receipts Revenue from Laundry and Linen service	0	12.00
14.00	Revenue from meals sold to employees and guests	0	14.00
14.00	Revenue from rental of living quarters	0	14.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
17.00	Revenue from sale of medical records and abstracts	0	17.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
20.00	Rental of vending machines	0	20.00
22.00	Rental of hospital space	0	21.00
23.00	Governmental appropriations	0	23.00
23.00	OTHER OPERATING REVENUE	2, 564, 000	
24.00	LOSS ON SALE	-60, 000	
24.01	OTHER, NET	-2,000	
24.02	Total other income (sum of lines 6-24)	2, 521, 000	
26.00	Total (line 5 plus line 25)	5, 989, 358	
27.00		5, 707, 330	20.00
27.00	Total other expenses (sum of line 27 and subscripts)	0	27.00
		U U	_ ∠0. UU

CALCULATION OF CAPITAL PAYMENT Provider CCN: 150022 Period: From 01/01/201 To 12/31/201			narod		
				5/27/2015 9:3	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			313, 818	
. 01 . 00	Model 4 BPCI Capital DRG other than outlier			0	
. 00	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments			52, 778 0	
. 00	Total inpatient days divided by number of days in the cost repo	orting period (see inst	ructions)	9.82	
. 00	Number of interns & residents (see instructions)			0.00	
. 00	Indirect medical education percentage (see instructions)			0.00	5.0
. 00	Indirect medical education adjustment (multiply line 5 by the s			0	
. 00	Percentage of SSI recipient patient days to Medicare Part A pat 30) (see instructions)	5	, part A line	0.00	
. 00	Percentage of Medicaid patient days to total days (see instruct	ions)		0.00	-
. 00	Sum of lines 7 and 8			0.00	
0.00	Allowable disproportionate share percentage (see instructions)	ac 1 and 1 01)		0.00	
	Disproportionate share adjustment (line 10 times the sum of lin Total prospective capital payments (sum of lines 1, 1.01, 2, 2.			366, 596	
2.00				300, 370	12.
				1.00	
. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.0
. 00	Program inpatient ancillary capital cost (see instructions)			0	
. 00	Total inpatient program capital cost (line 1 plus line 2)			0	
. 00	Capital cost payment factor (see instructions)			0	4.
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1.00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances	(see instructions)		0	
00	Net program inpatient capital costs (line 1 minus line 2)			0	
	Applicable exception percentage (see instructions)			0.00	
. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5.
. 00 . 00				0.00	
. 00 . 00 . 00 . 00	Percentage adjustment for extraordinary circumstances (see inst				
. 00 . 00 . 00 . 00 . 00	Adjustment to capital minimum payment level for extraordinary c		line 6)	0	
00 00 00 00 00	Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7)	ircumstances (line 2 x	line 6)	0 0	8.
00 00 00 00 00 00 00	Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica	ircumstances (line 2 x ble)	·	0 0 0	8. 9.
00 00 00 00 00 00 00 00 00	Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica Current year comparison of capital minimum payment level to cap Carryover of accumulated capital minimum payment level over cap	ircumstances (line 2 x ble) ital payments (line 8	less line 9)	0 0	8. 9. 10.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00	Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica Current year comparison of capital minimum payment level to cap Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14)	ircumstances (line 2 x ble) bital payments (line 8 bital payment (from pri	less line 9) or year	0 0 0	8. 9. 10. 11.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00	Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica Current year comparison of capital minimum payment level to cap Carryover of accumulated capital minimum payment level over cap	ircumstances (line 2 x ble) bital payments (line 8 bital payment (from pri ments (line 10 plus lin	less line 9) or year e 11)	0 0 0 0	8. 9. 10. 11. 12.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica Current year comparison of capital minimum payment level to cap Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital paym	ircumstances (line 2 x ble) bital payments (line 8 bital payment (from pri ments (line 10 plus lin be amount on this line	less line 9) or year e 11))	0 0 0 0 0	8. 9. 10. 11. 12. 13.
2. 00 3. 00 5. 00 5. 00 5. 00 7.	Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica Current year comparison of capital minimum payment level to cap Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital paym Current year exception payment (if line 12 is positive, enter t Carryover of accumulated capital minimum payment level over cap	ircumstances (line 2 x ble) ital payments (line 8 ital payment (from pri ments (line 10 plus lin he amount on this line ital payment for the f	less line 9) or year e 11))	0 0 0 0 0 0 0	8. 9. 10. 11. 12. 13. 14. 15.