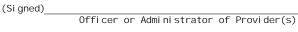
Heal th Financia	al Systems	ST. ELIZABETH CE	NTRAL	In Lieu	u of Form CMS-2552-10			
This report is	required by law (42 USC 1395g	; 42 CFR 413.20(b)). Failu	ire to report can resu	ult in all interim	FORM APPROVED			
payments made	since the beginning of the cos	t reporting period being d	leemed overpayments (4	42 USC 1395g).	OMB NO. 0938-0050			
AND SETTLEMENT		ST REPORT CERTIFICATION	Provider CCN: 150003	Period: From 01/01/2014 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 2/27/2015 7:18 am			
PART I - COST	REPORT STATUS							
Provi der	1. [X] Electronically filed c	cost report		Date: 2/27/20	15 Time: 7:18 am			
use only	2. [] Manually submitted cos	st report						
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [F] Medicare Utilization. Enter "F" for full or "L" for low.								
Contractor use only	 (1) As Submitted (2) Settled without Audit 	6. Date Received: 7. Contractor No. 3. [N] Initial Report for 9. [N] Final Report for th	this Provider CCN 12.					
PART II - CERT	I FI CATI ON							
MI SREPRESENTAT	ION OR FALSIFICATION OF ANY IN	FORMATION CONTAINED IN THI	S COST REPORT MAY BE	PUNI SHABLE BY CRIM	IINAL, CIVIL AND			
	ACTION, FINE AND/OR IMPRISONM							
	OCURED THROUGH THE PAYMENT DIR		ICKBACK OR WERE OTHER	RWISE ILLEGAL, CRIM	IINAL, CIVIL AND			
ADMI NI STRATI VE	ACTION, FINES AND/OR IMPRISON	MENT MAY RESULT.						

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. ELIZABETH CENTRAL (150003) for the cost reporting period beginning 01/01/2014 and ending 09/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.



Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	697, 055	50, 309	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	697, 055	50, 309	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Securi ty Boul evard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryl and 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.

		DENTIFICATION DA	ATA	PLOVIUE	er CCN:	150003	Period: From 01/0	1/2014	Part	ksheet t l	5-2	
								0/2014	Date	e/Time 7/2015		
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	share hospital adjustment, in accord											
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				J6(C)(2		e					
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. 00	<pre>period? Enter in column 1, "Y" for y reporting period occurring prior to no for the portion of the cost repor instructions) Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lin-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in lf this provider is an IRF, enter th Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-stat eligible but unpaid days in col. Medicaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 6.</pre>	es or "N" for no October 1. Enter ting period occur dicaid days on li f census days, of is cost reporting iod? In column : , enter the 1, in-state . 2, ol. 3, d days in col. t unpaid days in column 6. e in-state -state Medicaid of-state e Medicaid caid HMO paid 5, and other	payments f for the po in column rring on or ines 24 and r 3 if date g period di 2, enter "Y In-State Medicaid paid days 1.00 482	For this of the second	the cd r yes of ctober el ow? I harge. from th s or "h ce 0 d S e Me b pai	ost pr "N" fi 1. (see n column Is the me methor N" for mut-of State di cai d di cai d d days 3. 00 2 0	or n d 0. Out-of State Medicaid eligible unpaid 4.00 0 0 0 0	Medica HMO da 5.00	0 155 0	Othe Medica days 6.00	ai d 5 28	23. (
. 00	<pre>period? Enter in column 1, "Y" for y reporting period occurring prior to no for the portion of the cost repor instructions) Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per used in the prior cost reporting per lin-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid days in col out-of-state Medicaid eligible unpaid days in col. If this provider is an IRF, enter th Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-state ligible unpaid days in col. 4, Medi and eligible but unpaid days in col. Enter your standard geographic class cost reporting period. Enter "1" for</pre>	es or "N" for no October 1. Enter ting period occur dicaid days on li f census days, of is cost reporting iod? In column : , enter the 1, in-state . 2, ol. 3, d days in col. t unpaid days in column 6. e in-state -state Medicaid of-state e Medicaid caid HMO paid 5, and other ification (not we urban or "2" for	payments f for the po in column rring on or ines 24 and r 3 if date g period di 2, enter "Y In-State Medicaid paid days 1.00 482 ((())))))))))))))))	For this of ortion of 2 "Y" food of a fter of 2 "Y" food of a fter	the corryes of control of the corryes of control of the control of	n column Is the methor of the methor of tate di cai d d days 3.00 2 0 0	or h d Out-of State Medicaid eligible unpaid 4.00 0 0 0 0 0 0 0 0 0 0 0 0	Medi ca HMO da 5.00	0 155 0	Othe Medica days 6.00	ai d 5 28	23. (24. (25. (26. (
. 00	<pre>period? Enter in column 1, "Y" for y reporting period occurring prior to no for the portion of the cost repor instructions) Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per instate Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid paid days in col. 3, out-of-state eligible unpaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 3, out-of-state eligible unpaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 6.</pre>	es or "N" for no October 1. Enter ting period occur dicaid days on li f census days, ou is cost reporting iod? In column : , enter the 1, in-state 2, ol. 3, d days in col. t unpaid days in column 6. e in-state -state Medicaid of-state e Medicaid caid HMO paid 5, and other ification (not wa urban or "2" fou ification (not wa	payments f for the po in column rring on or ines 24 and r 3 if date g period di 2, enter "Y In-State Medicaid paid days 1.00 482 (((() () () () () () () ()	For this of ortion of 2 "Y" foo after 00 after 00 fferent of discl fferent of discl fferent of discl fferent of discl fferent of discl fferent of discl fferent of discl n-Stat Medicai eligibl unpaic days 2.00	the cd r yes of ctober el ow? I harge. from th s or "I d S e Me i pai 58 0 0 0	n column Is the method of is the method is the method of is the method is tate di cai d d days 3.00 2 0 0 0 0 0	or h d Out-of State Medicaid eligible unpaid 4.00 0 0 0 0 0 0 0 0 0 0 0 0	Medi ca HMO da 5.00	0 155 0	Othe Medica days 6.00	ai d 5 28	23. (24. (25. (
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. 00 . 00 . 00	period? Enter in column 1, "Y" for y reporting period occurring prior to no for the portion of the cost report instructions) Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per Medicaid eligible unpaid days in col. Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in lf this provider is an IRF, enter th Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-stat eligible unpaid days in col. 4, Medi and eligible bu unpaid days in col. Medicaid days in col. 6.	es or "N" for no October 1. Enter ting period occur dicaid days on li f census days, ou is cost reporting iod? In column : , enter the 1, in-state 2, ol. 3, d days in col. t unpaid days in column 6. e in-state -state Medicaid of-state e Medicaid caid HMO paid 5, and other i fication (not wa "1" for urban or raphic reclassifi	payments f for the po in column rring on or ines 24 and 3 if date g period di 2, enter "Y In-State Medicaid paid days 1.00 482 (((() () () () () () () ()	at the l	the cc r yes of ctober el ow? I harge. from the s or "1 d S e Me h pai 58 0 0 0 0	ng of ti the cost	or n d 0. Out-of State Medicaid eligible unpaid 4.00 0 0 0 0 0 0	Medi ca HMO da 5.00	0 155 0	Othe Medica days 6.00	ai d 5 28	23. (24. (25. (26. (

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	H CENTRAL Provider (F	eriod: rom 01/01 o 09/30	/2014	Workshe Part I Date/Ti 2/27/20	me Pre 015 7:0	pare
				Begi nni 1. 00		Endi 2. (-
00 Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1.00	,	2.1		36.
of periods in excess of one and enter subsequent date 00 [f this is a Medicare dependent hospital (MDH), enter		umber of period	s MDH status		0			37.
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		Subscript line	38 for number					38
or periods in excess of one and enter subsequent date	3.			Y/N		Y/	N	
00 Deep this facility mulify for the impetient benefited				1.00)	2. (N		20
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 req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ent∈ uiremer	er in column 1 nts in accordan	"Y" for yes ce with 42	IN				39
					V 1.00	2.00	XI X 3.00	-
Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
00 Does this facility qualify and receive Capital paymen	t for c	di sproporti onat	e share in acc	cordance	N	N	N	45
<pre>with 42 CFR Section §412.320? (see instructions) 00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Work</pre>			5		N	N	N	46
	+-10		"N"					47
00 Is this a new hospital under 42 CFR §412.300 PPS capi 100 Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47
00 Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y" 1	for yes	N			56
00 If line 56 is yes, is this the first cost reporting p					N			57
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 Worksheet D, Part III & IV and D-2, Par	h of th ", comp	nis cost report plete Worksheet	ing period? [Enter "Y"				
00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, section 2148? If yes, compl			ns' services a	as	N			58
00 Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Worksheet			Ν			59
00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"				stions)	Y			60
provider-operated critteria under 9413.03? Enter 1	Y/N		Direct GME	IME		Di rec	t GME	
	1.00							-
00 Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	0.00	5. (0.00	61
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	, N				0.00		0.00	
01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0. 00	0.00	¢				61
 instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of 		0. 00	0.00	D				61
 ACA). (see instructions) Bater the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see 		0.00	0.00	þ				61
instructions) 04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00	þ				61
current cost reporting period. (see instructions). 55 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0. 00	0.00	o				61
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary		0.00	0.00	D				61
care or general surgery. (see instructions)	Pro	ogram Name	Program Code	Unweighte FTE Co		Direct (GME FTE	
		1.00	2 00	2.00		Cou 4. (-
10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	0.00	4. (0.00	61
				1	00		0.00	

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPL		LI ZABETH CENTRAL TA Provi der		Period: From 01/01/2014 To 09/30/2014	Date/Time Pre	pared:
					2/27/2015 7:0	2 am
		Program Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	1
1.20 Of the FTEs in line 61.05, specif program specialty, if any, and th residents for each expanded progr instructions) Enter in column 1 t enter in column 2 the program coo 3 the IME FTE unweighted count ar direct GME FTE unweighted count.	e number of FTE ram. (see the program name, le, enter in column			0.00	0.00	61.2
			(1120.4)		1.00	
ACA Provisions Affecting the Heal 2.00 Enter the number of FTE residents				sight for which	0.00	62.0
your hospital received HRSA PCRE			reporting per	TOU TOT WHICH	0.00	02.0
2.01 Enter the number of FTE residents during in this cost reporting per	s that rotated from a riod of HRSA THC prog	n Teaching Health Cent Iram. (see instruction		o your hospital	0.00	62.0
Teaching Hospitals that Claim Res 3.00 Has your facility trained resider			act conacting	a pariod? Entar	N	42 0
"Y" for yes or "N" for no in colu	umn 1. If yes, comple	ete lines 64-67. (see	instructions)) periou? Enter	IN	63.0
			Unwei ghted	Unwei ghted	Ratio (col. 1/	r
			FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Base Year	- FTE Residents in No	onprovider settings				
period that begins on or after Ju 4.00 Enter in column 1, if line 63 is	ly 1, 2009 and befor	<u>re June 30, 2010.</u>	····· - ···· · ····	0 0.00		
resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	number of unweighted Ir hospital. Enter in	l non-primary care 1 column 3 the ratio	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovider Site	Hospi tal	4))	
-	1.00	2.00	3.00	4.00	5.00	-
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column			0. 0	0.00	0. 000000	
4)). (see instructions) Section 5504 of the ACA Current V beginning on or after July 1, 207		n Nonprovider setting:	Unweighted FTEs Nonprovider Site 1.00 sEffective	2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00 ng periods	-
6.00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	nweighted non-primar ccurring in all non-p nweighted non-primar nl. Enter in column 3	orovider settings. Ty care resident the ratio of	0. 0	0. 00	0. 000000	66. C

na yo wh En co no co uca to no co yo 5 di 4)	ater in column 1 the program ame associated with each of our primary care programs in hich you trained residents. hter in column 2 the program ode. Enter in column 3 the imber of unweighted primary are FTE residents attributable or ortations occurring in all on-provider settings. Enter in olumn 4 the number of weighted primary care esident FTEs that trained in our hospital. Enter in column the ratio of (column 3 vided by (column 3 + column). (see instructions)	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unweighte FTEs in Hospital 4.00	d R	Date/Tii 2/27/20 Patio (c col . 3 4)) 5.0 0.	15 7:0 :ol. 3/ + col.)	2 am
na yo wh En co no co uca to no co yo 5 di 4)	ame associated with each of our primary care programs in hich you trained residents. hter in column 2 the program ode. Enter in column 3 the umber of unweighted primary are FTE residents attributable orotations occurring in all on-provider settings. Enter in olumn 4 the number of weighted primary care esident FTEs that trained in our hospital. Enter in column the ratio of (column 3 vided by (column 3 + column	Ĵ	Ū.	FTĔs Nonprovi der Si te 3.00	FTES in Hospital 4.00	((col . 3 4)) 5.0	+ col .)	-
na yo wh En co no co uca to no co yo 5 di 4)	ame associated with each of our primary care programs in hich you trained residents. hter in column 2 the program ode. Enter in column 3 the umber of unweighted primary are FTE residents attributable orotations occurring in all on-provider settings. Enter in olumn 4 the number of weighted primary care esident FTEs that trained in our hospital. Enter in column the ratio of (column 3 vided by (column 3 + column	1.00	2.00	3.00		. 00			67.
na yo wh En co no co uca to no co yo 5 di 4)	ame associated with each of our primary care programs in hich you trained residents. hter in column 2 the program ode. Enter in column 3 the umber of unweighted primary are FTE residents attributable orotations occurring in all on-provider settings. Enter in olumn 4 the number of weighted primary care esident FTEs that trained in our hospital. Enter in column the ratio of (column 3 vided by (column 3 + column			0.00	0	. 00	0.	000000	67.
4) . 00 s				1					
00 I s									
00 I s							2.00	2 00	
00 I s	npatient Psychiatric Facility PF	Ś				. 00	2.00	3.00	
	this facility an Inpatient Psy		PF), or does it conta	ain an IPF subp	rovi der?	Ν			70
	nter "Y" for yes or "N" for no. Fline 70 yes: Column 1: Did the	facility have an an	proved GME teaching r	program in the	most			0	71
Co §4 or be th	ecent cost report filed on or be olumn 2: Did this facility train H12.424 (d)(1)(iii)(D)? Enter "Y or 3 respectively in column 3. (s eginning of the fourth year, ent he new teaching program in exist upatient Rehabilitation Facility	residents in a new " for yes or "N" for ee instructions) If er 4 in column 3, or ence, enter 5. (see i	teaching program in a no. Column 3: If col this cost reporting p if the 5th or subsec	accordance with umn 2 is Y, en period covers t	42 CFR ter 1, 2 he				-
	s this facility an Inpatient Reh		(IRF), or does it co	ontain an IRF		N			75
00 If re no CF 1, be	ubprovider? Enter "Y" for yes a f line 75 yes: Column 1: Did the ccent cost reporting period endi column 2: Did this facility t R §412.424 (d)(1)(ii)(D)? Enter 2 or 3 respectively in column eginning of the fourth year, ent he new teaching program in exist	facility have an app ng on or before Nover rain residents in a r "Y" for yes or "N" 3. (see instructions) er 4 in column 3, or	mber 15, 2004? Enter new teaching program for no. Column 3: If) If this cost report if the 5th or subsec	"Y" for yes or in accordance column 2 is Y ting period cov	"N" for with 42 , enter ers the			0	76.
						-	1.0	10	
	ong Term Care Hospital PPS						1.0		
	this a long term care hospital	(LTCH)? Enter "Y"	for yes and "N" for r	10.			N		80
00 Is 00 Di	FRA Providers this a new hospital under 42 C d this facility establish a new H13.40(f)(1)(ii)? Enter "Y" for	Other subprovider (r"N" for n	0.	N		85 86
134					V		XIX	X	
T :	the V and VIV Camil and				1.00		2.0	0	
	<u>tle V and XIX Services</u> bes this facility have title V a	nd/or XIX inpatient	hospital services? Er	nter "Y" for	N		Y		90
ye	es or "N" for no in the applicab	le column.	·						
	s this hospital reimbursed for t Ill or in part? Enter "Y" for ye				N		Y		91
00 Ar	e title XIX NF patients occupyi	ng title XVIII SNF b	eds (dual certificati				Ν		92
	nstructions) Enter "Y" for yes o Des this facility operate an ICF			XIX? Enter	Ν		Ν		93
" Y	" for yes or "N" for no in the bes title V or XIX reduce capita	applicable column.			N		N		94
ар	pplicable column.								
	fline 94 is "Y", enter the redu bes title V or XIX reduce operat				O N	. 00	N	0. 00	95 96
ар	pplicable column.						14		
	<u>°line 96 is "Y", enter the redu</u> µral Providers	ction percentage in	the applicable column	۱.	0	. 00		0.00	97
5. 00 Do	bes this hospital qualify as a C this facility qualifies as a C	•	, ,		N				105. 106.

Health Financial Systems	ST. ELI ZABETH	CENTRAL		١r	n Lieu	of Form	CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA	Provi der	F	eriod: rom 01/01/ o 09/30/	2014 2014	Workshee [.] Part I Date/Time	e Prepared:
				V		XI X	5 7:02 am
107.00 Column 1: If this facility qualifies as a for I &R training programs? Enter "Y" for instructions) If yes, the GME elimination w 25 and the program would be cost reimbursed Column 2: If this facility is a CAH, do I& train in the CAH's excluded IPF and/or IRF column 2. (see instructions)	yes or "N" for no Yould not be on Wor L. If yes complete Rs in an approved	in column 1. ksheet B, Par Worksheet D-2 medical educa	(see rt I, column 2, Part II. ation program	1.00		2.00	107.00
108.00 Is this a rural hospital qualifying for an CFR Section §412.113(c). Enter "Y" for yes				N			108.00
		Physi cal 1.00	Occupational 2.00	Speech 3.00		Respirat 4.00	
109.00 If this hospital qualifies as a CAH or a co therapy services provided by outside suppli for yes or "N" for no for each therapy.		Ν	N	N		N	109.00
					1.00	2.00	3.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Ent enter the method used (A, B, or E only) in either "93" percent for short term hospital psychiatric, rehabilitation and long term h 15-1, §2208.1.	column 2. If colum or "98" percent f	n 2 is "E", € or long term	enter in columr care (includes	1 3 5	N		0 115.00
116.00 Is this facility classified as a referral of 117.00 Is this facility legally-required to carry no.				'N" for	N Y		116. 00 117. 00
118.00 s the malpractice insurance a claims-made claim-made. Enter 2 if the policy is occurr		cy? Enter 1 i	f the policy i	s	2		118.00
			Premi ums	Losses	5	Insurar	nce
			1.00	2.00	1 001	3.00	
118.01 List amounts of malpractice premiums and pa	ind Tosses:		575, 934		7,001		0 118. 01
118.02 Are malpractice premiums and paid losses re Administrative and General? If yes, submit and amounts contained therein. 119.00DD NOT USE THIS LINE				1.00 N		2.00	118.02
120.00 Is this a SCH or EACH that qualifies for th §3121 and applicable amendments? (see instr "N" for no. Is this a rural hospital with < Hold Harmless provision in ACA §3121 and ap	uctions) Enter in 100 beds that qua plicable amendment	column 1 "Y" lifies for th	for yes or ne Outpatient	N		Ν	120. 00
Enter in column 2 "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for patients? Enter "Y" for yes or "N" for no.		table devices	s charged to	Y			121.00
Transplant Center Information 125.00 Does this facility operate a transplant cen	iter? Enter "Y" for	yes and "N"	for no. If	N			125.00
yes, enter certification date(s) (mm/dd/yyy 126.00 f this is a Medicare certified kidney tran		er the certif	fication date				126.00
in column 1 and termination date, if applic 127.00 If this is a Medicare certified heart trans		r the certifi	cation date				127.00
in column 1 and termination date, if applic 128.00 If this is a Medicare certified liver trans		r the certifi	cation date				128.00
in column 1 and termination date, if applic 129.00 If this is a Medicare certified lung transp	lant center, enter	the certific	cation date in				129.00
column 1 and termination date, if applicabl 130.00 If this is a Medicare certified pancreas tr date in column 1 and termination date, if a	ansplant center, e		tification				130. 00
131.00 If this is a Medicare certified intestinal	transplant center,	enter the ce	erti ficati on				131.00
date in column 1 and termination date, if a 132.00 If this is a Medicare certified islet trans in column 1 and termination date, if applic	plant center, ente		cation date				132.00
133.00 If this is a Medicare certified other trans	plant center, ente	r the certifi	cation date				133.00
in column 1 and termination date, if applic 134.00 If this is an organ procurement organization and termination date, if applicable, in col	n (OPO), enter the	OPO number i	n column 1				134.00
All Providers 140.00 Are there any related organization or home chapter 10? Enter "Y" for yes or "N" for no are claimed, enter in column 2 the home off	in column 1. If y	es, and home	office costs	Y	1	58014	140. 00

Health Financial Systems	ST. ELI	ZABETH C	ENTRAL				In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Ą	Provider (CCN: 1500			/01/2014 /30/2014		epared:
1.00		2.00					3.00	2/2//2013 /.	
If this facility is part of a chain	organization, ente		es 141 throu	iah 143 t	he name	e and		of the	
home office and enter the home offic	<u>e contractor name</u>	and contr	actor numbe	er.					
141.00 Name: FRANCISCAN ALLIANCE, INC.	Contractor's Na	me: WPS		Cont	ractor'	s Num	nber: 0810)1	141.00
142.00 Street: 1515 DRAGOON TRAIL	PO Box:	1290							142.00
143.00City: MISHAWAKA	State:	IN		Zip	Code:		4654	6-1290	143.00
									_
								1.00	
144.00 Are provider based physicians' costs 145.00 If costs for renal services are clai services only? Enter "Y" for yes or	med on Worksheet A		, are they	costs fo	r inpat	ient		Y Y	144.00 145.00
					-		1.00	2.00	-
146.00 Has the cost allocation methodology	changed from the n	revi ousl v	filed cost	report?			N	2.00	146.00
Enter "Y" for yes or "N" for no in c enter the approval date (mm/dd/yyyy)	olumn 1. (See CMS I						N.		
147.00 Was there a change in the statistica							Ν		147.00
148.00 Was there a change in the order of a							Ν		148.00
149.00 Was there a change to the simplified	cost finding metho	od? Enter	"Y" for ye	s or "N"	for		Ν		149.00
no.			Part A	Part	D	т	tle V	Title XIX	
			1.00	2.0			3.00	4.00	-
Does this facility contain a provide	r that qualifies f	or an exe							
or charges? Enter "Y" for yes or "N"									
155. 00 Hospi tal			N	N			N	N	155.00
156.00 Subprovi der – IPF			N	Ν			Ν	N	156.00
157.00 Subprovi der – IRF			N	Ν			Ν	N	157.00
158.00 SUBPROVI DER									158.00
159.00 SNF			N	Ν			Ν	N	159.00
160.00 HOME HEALTH AGENCY			N	N			Ν	N	160. 00
161.00 CMHC				N			N	N	161.00
161. 10 CORF				N			N	N	161.10
								1.00	-
Multicampus									
165.00 Is this hospital part of a Multicamp	us hospital that ha	as one or	more campu	ses in d	ifferen	nt CBS	SAs?	N	165.00
Enter "Y" for yes or "N" for no.									
	Name		County	State			CBSA	FTE/Campus	_
	0		1.00	2.00	3.0	00	4.00	5.00	01((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								0.0	0 166. 00
								1.00	_
Health Information Technology (HIT)	incentive in the A	merican F	Recoverv and	Rei nves	stment A	Act		1.00	
167.00 Is this provider a meaningful user u								Y	167.00
168.00 If this provider is a CAH (line 105			user (line	167 is	"Y"), e	enter	the		0168.00
reasonable cost incurred for the HIT 169.00 If this provider is a meaningful use transition factor. (see instructions	r (line 167 is "Y")		not a CAH (line 105	is "N"), er	nter the	0. 7	5169.00
						Beg	i nni ng	Endi ng	
							1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	inning date and en	ding date	e for the re	porting			01/2014	09/30/2014	170.00

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	Provider	F	Period: From 01/01/2014 To 09/30/2014		
				1	2/27/2015 7:0	02 am
				Y/N 1.00	Date 2.00	+
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	oonses. Enter N for all NO re	esponses. Enter	all dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
0	Has the provider changed ownership immediatel			Ν		1.
	reporting period? If yes, enter the date of t	ne change in column 2. (see	Y/N	Date	V/I	
			1.00	2.00	3.00	
0	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.		Y	09/30/2014	V	2.
0	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 offices, drug d to the provider or its , or members of the board	N			3.
			Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports		1.00	2.00	3.00	
0	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled, enter date available in	N		06/01/2015	4.
0	column 3. (see instructions) If no, see instr Are the cost report total expenses and total those on the filed financial statements? If y	revenues different from	N			5.
		····		Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
0	Column 1: Are costs claimed for nursing scho the legal operator of the program?		ne provider is	Y	Y	6.
0 0	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog cost reporting period? If yes, see instruction	grams approved and/or renewed	during the	Y N		8.
0	Are costs claimed for Intern-Resident program	ns claimed on the current cos	st report? If	Ν		9.
00	yes, see instructions. Was an Intern-Resident program been initiated	d or renewed in the current o	cost reporting	N		10.
~~	period? If yes, see instructions.			N		11
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		proved	N		11.
				·	Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bac	debts? If yes, see instruct	i ons.		Y	12.
00	If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	ot collection policy change c	luring this cos	t reporting	Ν	13.
00	If line 12 is yes, were patient deductibles a	and/or co-payments waived? If	⁻ yes, see inst	ructions.	N	14.
00	Bed Complement Did total beds available change from the pric	or cost reporting period? If	ves see instr	ructions	N	15.
			Par	rt A	Part B	
		Description 0	Y/N 1.00	Date 2.00	Y/N 3.00	_
	PS&R Data	0		2.00	1	
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	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	01/23/2015	Y	17.
	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments		N		N	18.
00	made to PS&R Report data for additional claims that have been billed but are not					
00	included on the PS&R Report used to file				N	19.
00	this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N			

Heal th	Financial Systems	ST. ELIZABE	TH CENTRAL		In Lie	u of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der				
							pared:
							2 am
		Deceri	inti on				
			-				
21.00	provider's records? If yes, see		5	N	2.00	N	21.00
			-	•			
						1.00	
		ALS ONLY (EXCE	PI CHILDRENS H	IOSPITALS)			-
22.00		es?lfves see	e instructions			N	22.00
				als made durin	g the cost	N	23.00
	reporting period? If yes, see instructions.				0		
24.00		g leases entere	ed into during	this cost repo	rting period?	Ν	24.00
25.00	Have there been new capitalized leases entere	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 acqu	uired during th	ne cost reporti	ng period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy char	nged during the	e cost reportin	ng period?lfy	es, submit	Ν	27.00
	Interest Expense						
28.00		rs of credit er	ntered into dur	ing the cost r	eporti ng	N	28.00
29.00	Did the provider have a funded depreciation a			ebt Service Res	erve Fund)	Ν	29.00
30.00				dobt2 If yos	500	N	30.00
30.00	instructions.	Schedul ed mate	an ty with new	debt: 11 yes,	366	N.	50.00
31.00	Has debt been recalled before scheduled matur instructions.	rity without is	ssuance of new	debt? If yes,	see	Ν	31.00
	Purchased Services						
32.00				ed through cont	ractual	N	32.00
33.00	If line 32 is yes, were the requirements of §			ng to competiti	ve bidding? If	Ν	33.00
	Provi der-Based Physi ci ans						
34.00		ty under an ar	rangement with	n provi der-base	d physi ci ans?	Y	34.00
35.00	3	or amondod ovi	sting agroomon	te with the pr	ovidor basod	N	35.00
35.00				its with the pi	ovi del -based	IN	35.00
					Y/N	Date	
					1.00	2.00	
36.00		port2			V		36.00
	If line 36 is yes, has a home office cost sta		repared by the	home office?	N		37.00
38.00	If line 36 is yes, was the fiscal year end o				Ν		38.00
39.00	If line 36 is yes, did the provider render se				N		39.00
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lf yes, see	Ν		40.00
	PT TAL_AND_HOSPITAL_REALTH_CARE_RELIMBURSIDENT_OUESTIONNALRE Provider_CCR: 150003 Provider_TCR: 150003						
			1.	00	2.	00	
			D M H D				
41.00	held by the cost report preparer in columns f		DAVI D		OSTHETMER		41.00
42.00	Enter the employer/company name of the cost r	report	FSEH -CENTRAL				42.00
43.00	Enter the telephone number and email address		765-428-5925			R@FRANCI SCANAL	43.00
		· - · J ·	1			1	

	Financial Systems	ST. ELIZABETH			u of Form CMS-	
iospi t	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE		Provider CCN: 150003	Period: From 01/01/2014 To 09/30/2014	Worksheet S-2 Part II Date/Time Pre 2/27/2015 7:0	epared
		Part B				
		Date				
		4.00				
	PS&R Data					
16.00	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		01/23/2015				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)					
8.00	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.					
19.00	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.					
20.00	If line 16 or 17 is yes, were adjustments					20.
	made to PS&R Report data for Other? Describe					
	the other adjustments:					
21.00	Was the cost report prepared only using the					21.
	provider's records? If yes, see					
	instructions.					
	T		3.00			
	Cost Report Preparer Contact Information					
41.00			RECTOR OF ACCOUNTING			41.
	held by the cost report preparer in columns '	1, 2, and 3,				
	respecti vel y.					
42.00		report				42.
	preparer.					
43.00	Enter the telephone number and email address					43.
	report preparer in columns 1 and 2, respectiv	vel y.				1

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ST. ELIZABET			CCN: 150003	Pe	ri od:	u of Form CN Worksheet S		
							om 01/01/2014 09/30/2014	Part I Date/Time I 2/27/2015	Pre 7: 0	
								I/P Days / (Visits / Tri		
	Component	Worksheet A	No. o	f Beds	Bed Days		CAH Hours	Title V	μs	
		Line Number			Avai I abl e					
		1.00	2.	00	3.00		4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		85	23, 2	05	0.00		0	1.00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2									
2 00	for the portion of LDP room available beds)									2.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider									2.00
3.00 4.00	HMO I RF Subprovi der									4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF								0	5.00
6.00	Hospital Adults & Peds. Swing Bed Ski Hospital Adults & Peds. Swing Bed NF								0	6.00
7.00	Total Adults and Peds. (exclude observation			85	23, 2	05	0.00		0	7.00
7.00	beds) (see instructions)			05	23, 2	05	0.00		0	7.00
8.00	INTENSIVE CARE UNIT	31.00		9	2, 4	57	0.00		0	8.00
9.00	CORONARY CARE UNIT	01100			_/	<i>.</i>	01.00		Ũ	9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13.00	NURSERY	43.00							0	13.00
14.00	Total (see instructions)			94	25, 6	62	0.00		0	14.00
15.00	CAH visits								0	15.00
16.00	SUBPROVIDER - IPF								-	16.00
17.00	SUBPROVIDER - IRF	41.00		0		0			0	17.00
18.00	SUBPROVI DER	42.00		0		0			0	18.00
19.00	SKILLED NURSING FACILITY				1					19.00
20.00	NURSING FACILITY				1					20.00
21.00	OTHER LONG TERM CARE									21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)									23.00
24.00	HOSPI CE	116.00		0		0				24.00
24. 10	HOSPICE (non-distinct part)	30.00								24.10
25.00	CMHC - CMHC									25.00
25. 10	CMHC - CORF	99. 10							0	25.10
26.00	RURAL HEALTH CLINIC	88.00							0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00							0	26. 25
27.00	Total (sum of lines 14-26)			94						27.00
28.00	Observation Bed Days								0	28.00
29.00	Ambul ance Trips									29.00
30.00	Employee discount days (see instruction)									30.00
31.00	Employee discount days - IRF			_						31.00
32.00	Labor & delivery days (see instructions)			0		0				32.00
32.01	Total ancillary labor & delivery room									32.01
22.00	outpatient days (see instructions)									22.00
33.00	LTCH non-covered days				I					33.0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	<u>ST. ELIZABETI</u> AL DATA		CCN: 150003		eriod: com 01/01/2014	u of Form CMS-: Worksheet S-3 Part I Date/Time Pre 2/27/2015 7:0	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2, 468	570	4, 2	79			1.00
2.00	HMO and other (see instructions)	426	155					2.00
3.00	HMO IPF Subprovider	0	0					3.00
4.00	HMO IRF Subprovider	0	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 468	570	4, 2	79			7.00
8.00	INTENSIVE CARE UNIT	565	0	1, 08	83			8.00
9.00	CORONARY CARE UNI T							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY		0		0			13.00
14.00	Total (see instructions)	3, 033	570	5, 3	62	0.00	350.29	14.00
15.00	CAH visits	0	0		0			15.00
16.00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVIDER - IRF	0	0		0	0.00	0.00	17.00
18.00	SUBPROVI DER	0	0		0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPICE	0	0		0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0		0			24.10
25.00	CMHC - CMHC							25.00
25.10	CMHC - CORF	0	0		0	0.00	0.00	
26.00	RURAL HEALTH CLINIC	0	0		0	0.00	0.00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	
27.00	Total (sum of lines 14-26)					0.00	350.29	
28.00	Observation Bed Days		94	4	15			28.00
29.00	Ambul ance Trips	0						29.00
30.00	Employee discount days (see instruction)				0			30.00
31.00	Employee discount days - IRF				0			31.00
32.00	Labor & delivery days (see instructions)	0	0		0			32.00
32.01	Total ancillary labor & delivery room				0			32.01
22.02	outpatient days (see instructions)							
33.UU	LTCH non-covered days	0						33.

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150003	Period: From 01/01/2014 To 09/30/2014	Worksheet S-3 Part I Date/Time Pre 2/27/2015 7:02	pared:
		Full Time Equivalents		Di s	charges	272772013 7.0.	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	0		47 140	1, 211	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)				95 0		2.00
3.00	HMO I PF Subprovi der						3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF						4.00 5.00
6.00	Hospital Adults & Peds. Swing Bed SNF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	7	47 140	1, 211	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0		0 0	0	
18.00	SUBPROVI DER	0.00	0		0 0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23.00
24.00 24.10	HOSPICE	0.00					24.00 24.10
24.10	HOSPICE (non-distinct part) CMHC - CMHC						24.10
25.00	CMHC - CORF	0.00					25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days	5. 50					28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33.00	LTCH non-covered days						33.00

ISPI T	Financial Systems AL WAGE INDEX INFORMATION		ST. ELI ZABE		F	eriod: rom 01/01/2014 o 09/30/2014		pared:
		Worksheet A Line Number	Reported	Reclassificati on of Salaries (from Worksheet A-6)	Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see	200.00	19, 674, 878	-3, 450, 405	16, 224, 473	728, 612. 00	22.27	1.00
~~	instructions)		0			0.00	0.00	2.00
00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	3.00
00	B Physician-Part A -		0	0	0	0.00	0. 00	4.00
00	Administrative		0			0.00	0.00	4.00
01	Physicians - Part A - Teaching		0	0	0	0.00		•
00 00	Physician-Part B Non-physician-Part B		0			0.00 0.00		•
00	Interns & residents (in an	21.00	0	0	0	0.00		
0.4	approved program)		0				0.00	7 01
01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
00	Home office personnel		0	0	0	0.00		
00	SNF Excluded area salaries (see	44.00	0 4, 532, 072	0 150, 833	0 4, 682, 905	0.00 165,574.00		
. 00	instructions)		4, 552, 072	150, 655	4,082,905	105, 574. 00	20.20	10.00
	OTHER WAGES & RELATED COSTS			_	-			
. 00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
. 00	Contract labor: Top level		0	0	0	0.00	0.00	12.00
	management and other management and administrative services							
. 00	Contract Labor: Physician-Part		0	0	0	0.00	0. 00	13.00
~~	A - Administrative		0 (54 007		0 (54 007	47 704 00		44.00
. 00	Home office salaries & wage-related costs		2, 651, 307	0	2, 651, 307	47, 721.00	55.56	14.00
. 00	Home office: Physician Part A		0	0	0	0.00	0.00	15.00
. 00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16.00
. 00	Physicians Part A - Teaching		0	0		0.00	0.00	10.00
	WAGE-RELATED COSTS		7 700 000		7 700 000	1		1 4 7 . 00
. 00	Wage-related costs (core) (see instructions)		7, 783, 882	0	7, 783, 882			17.00
. 00	Wage-related costs (other)		0	0	0			18.00
00	(see instructions) Excluded areas		1, 035, 436	0	1, 035, 436			19.00
	Non-physician anesthetist Part		1, 035, 430					20.00
	A		_	_	_			
. 00	Non-physician anesthetist Part B		0	0	0			21.00
. 00	Physician Part A -		0	0	0			22.00
. 01	Administrative Physician Part A - Teaching		0	0				22. 01
	Physician Part B		0	0	0			23.00
. 00	Wage-related costs (RHC/FQHC)		0	-	0			24.00
. 00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DI RECT SALARI E				1	1		
	Employee Benefits Department	4.00	0					26.00
. 00	Administrative & General Administrative & General under	5.00	2, 207, 121 68, 948		589, 348 68, 948			
				-				
. 00	contract (see inst.)			0	0	0.00		
. 00 . 00	contract (see inst.) Maintenance & Repairs	6.00	045 205	107 075	1 1/0 220		20.04	30.00
. 00	contract (see inst.)	6. 00 7. 00 8. 00	0 945, 395 110, 657	-497, 075 -79, 497				31.00
2.00 2.00 2.00 2.00 2.00	contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping	7.00	945, 395	-79, 497		1, 400. 00 40, 523. 00	22. 26 12. 63	32.00
2.00 2.00 2.00 .00	contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping Housekeeping under contract	7.00 8.00	945, 395 110, 657	-79, 497	31, 160	1, 400. 00	22. 26 12. 63	
2.00 2.00 2.00 2.00 2.00	contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping	7.00 8.00	945, 395 110, 657	-79, 497 0 0	31, 160 511, 646 0	1, 400. 00 40, 523. 00 0. 00	22. 26 12. 63 0. 00	32.00 33.00
2. 00 2. 00 0. 00 2. 00 2. 00 3. 00	contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping Housekeeping under contract (see instructions) Dietary Dietary under contract (see	7.00 8.00 9.00	945, 395 110, 657 511, 646 0	-79, 497 0 0	31, 160 511, 646 0	1, 400. 00 40, 523. 00 0. 00	22. 26 12. 63 0. 00 12. 24	32.00 33.00 34.00
2.00 2.00 2.00 2.00 2.00 3.00 3.00	contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping Housekeeping under contract (see instructions) Dietary Dietary under contract (see instructions)	7.00 8.00 9.00 10.00	945, 395 110, 657 511, 646 0 401, 164 0	-79, 497 0 0 -127, 008 0	31, 160 511, 646 0 274, 156 0	1, 400. 00 40, 523. 00 0. 00 22, 398. 00 0. 00	22. 26 12. 63 0. 00 12. 24 0. 00	32.00 33.00 34.00 35.00
 . 00 	contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping Housekeeping under contract (see instructions) Dietary Dietary under contract (see	7.00 8.00 9.00	945, 395 110, 657 511, 646 0	-79, 497 0 0 -127, 008 0	31, 160 511, 646 0 274, 156 0	1, 400. 00 40, 523. 00 0. 00 22, 398. 00 0. 00	22. 26 12. 63 0. 00 12. 24 0. 00 11. 34	32.00 33.00 34.00 35.00 36.00
 . 00 	contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping Housekeeping under contract (see instructions) Dietary Dietary Dietary under contract (see instructions) Cafeteria	7.00 8.00 9.00 10.00 11.00	945, 395 110, 657 511, 646 0 401, 164 0	-79, 497 0 -127, 008 0 127, 008 0 0	31, 160 511, 646 0 274, 156 0 266, 914 0	1, 400. 00 40, 523. 00 0. 00 22, 398. 00 0. 00 23, 528. 00 0. 00	22. 26 12. 63 0. 00 12. 24 0. 00 11. 34 0. 00 35. 57	32.00 33.00 34.00 35.00

Health Financial Systems		ST. ELI ZABE	TH CENTRAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
					rom 01/01/2014		
					o 09/30/2014		
						2/27/2015 7:0	
	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	45,885	56, 922	102, 807	7, 001. 00	14.68	41.00
Records Library							
42.00 Social Service	17.00	C	64, 077	64, 07	2, 618. 00	24.48	42.00
43.00 Other General Service	18.00	C	0		0.00	0.00	43.00

Heal th Fi	nancial Systems		ST. ELIZABE	TH CENTRAL		In Lie	eu of Form CMS-2	2552-10
HOSPI TAL	WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014 To 09/30/2014	Date/Time Pre	
							2/27/2015 7:02	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			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	
PA	ART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00 Ne	et salaries (see		19, 743, 826	-3, 450, 405	16, 293, 42	1 729, 132. 00	22.35	1.00
lir	nstructions)							
	xcluded area salaries (see		4, 532, 072	150, 833	4, 682, 90	5 165, 574. 00	28.28	2.00
	nstructions)							
	ubtotal salaries (line 1		15, 211, 754	-3, 601, 238	11, 610, 51	6 563, 558. 00	20.60	3.00
	nus line 2)							
	ubtotal other wages & related		2, 651, 307	0	2, 651, 30	7 47, 721. 00	55. 56	4.00
	osts (see inst.)		7 700 000		7 700 00		(7.04	F 00
	ubtotal wage-related costs see inst.)		7, 783, 882	0	7, 783, 88	2 0.00	67.04	5.00
	otal (sum of lines 3 thru 5)		25, 646, 943	-3, 601, 238	22, 045, 70	5 611, 279. 00	36.06	6,00
	otal overhead cost (see		4, 861, 166					
	nstructions)		., 551, 166					

	Financial Systems TAL WAGE RELATED COSTS	ST. ELIZABETH CE	Provider CCN	1 1 5 0 0 2	Period:	u of Form CMS-2 Worksheet S-3	
10321	AL WAGE RELATED CUSTS		PIOVIDEI CCM	1. 100003	From 01/01/2014		
					To 09/30/2014	Date/Time Pre	
						2/27/2015 7:0	<u>2 am</u>
						Amount	
						Reported	<u> </u>
						1.00	
	PART IV - WAGE RELATED COSTS						-
	Part A - Core List						-
00	RETIREMENT COST						
. 00	401K Employer Contributions					0	1
2.00	Tax Sheltered Annuity (TSA) Employer Contribut					0	
3.00	Nonqualified Defined Benefit Plan Cost (see in					-1, 139	
. 00	Qualified Defined Benefit Plan Cost (see instr					2, 730, 725	4.0
5.00	PLAN ADMINISTRATIVE COSTS (Paid to External Or 401K/TSA Plan Administration fees	gani zati on)				0	1 5.0
. 00	Legal /Accounting/Management Fees-Pension Plan						
. 00	Employee Managed Care Program Administration F	005					
. 00	HEALTH AND INSURANCE COST	665				0	/.'
. 00	Health Insurance (Purchased or Self Funded)					3, 146, 111	8.
. 00	Prescription Drug Plan					3, 140, 111	
0.00	Dental, Hearing and Vision Plan					138, 098	
1.00	Life Insurance (If employee is owner or benefi	ci arv)				12, 368	
2.00	Accident Insurance (If employee is owner or be					0	
3.00	Disability Insurance (If employee is owner or					0	
	Long-Term Care Insurance (If employee is owner					101, 302	
5.00	0	or benefit of dry)				218, 831	
6.00	Retirement Health Care Cost (Only current year	. not the extraor	di narv accrua	l require	ed by FASB 106.	0	
	Non cumulative portion)	,				-	
	TAXES						
7.00	FICA-Employers Portion Only					1, 454, 423	17. (
8.00	Medicare Taxes - Employers Portion Only					0	18.0
9.00	Unemployment Insurance					43, 023	19. (
0. 00	State or Federal Unemployment Taxes					0	20.
	OTHER						
1.00	Executive Deferred Compensation (Other Than Re	tirement Cost Rep	orted on line	s 1 throu	igh 4 above. (see	0	21.
	instructions))						
	Day Care Cost and Allowances					0	1
	Tuition Reimbursement					23, 050	
4.00	Total Wage Related cost (Sum of lines 1 -23)					7, 866, 792	24.0
	Part B - Other than Core Related Cost						
5.00	EMPLOYEE ASSI STANCE					245, 443	25.

Heal th	Financial Systems	ST. ELIZABETH C	ENTRAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150003	Peri od:	Worksheet S-3	
					From 01/01/2014 To 09/30/2014	Part V Date/Time Pre	nared
					10 077 307 2014	2/27/2015 7:0	
	Cost Center Description				Contract Labor	Benefit Cost	
				-	1.00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identia	fication:					
1.00	Total facility's contract labor and benefit	cost			0	0	
2.00	Hospi tal				0	0	2.00
3.00	Subprovider - IPF						3.00
4.00	Subprovider - IRF				0	0	
5.00	Subprovider - (Other)				0	0	
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	1.00
8.00	Hospital-Based SNF						8.00
9.00	Hospital-Based NF						9.00
10.00	Hospital-Based OLTC						10.00
11.00	Hospital-Based HHA						11.00
12.00	Separately Certified ASC					_	12.00
13.00	Hospi tal -Based Hospi ce				0	0	13.00
14.00	Hospital-Based Health Clinic RHC				0	0	
15.00	Hospital-Based Health Clinic FQHC				0	0	1 .0.00
16.00	Hospi tal -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		ST. ELIZABET	TH CENTRAL		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL IDENTIFICATION DATA			Provi der	CCN: 150003	Peri od:	Worksheet S-9	
					001 454540	From 01/01/2014		
				Component	CCN: 151563	To 09/30/2014	Date/Time Prep 2/27/2015 7:02	pared:
						Hospi ce I	2/2//2015 7.02	
		Unduplicated				nospree i		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursing		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility	5		,	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I – ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0		0 0	0	1.00
2.00	Routine Home Care	11, 470	405	0		0 243	12, 118	2.00
3.00	Inpatient Respite Care	38	2	0		0 0	40	3.00
4.00	General Inpatient Care	8	0	0		0 2	10	4.00
5.00	Total Hospice Days	11, 516	407	0		0 245	12, 168	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	253	12	0		0 20	285	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0.00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	45.52	33. 92	0.00	0.	20 12.25	42.69	8.00
	5/line 6)							
9.00	Unduplicated Census Count	228	0	0		0 0	228	9.00

Heal th	Financial Systems ST. ELIZABETH CENT	RAL		In Lie	u of Form CMS-:	2552-10
H0SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 1500			Worksheet S-1	0
				n 01/01/2014		
			То	09/30/2014	Date/Time Pre 2/27/2015 7:0	
					2/2//2013 7.0	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ed by line 202 c	olumn 8)		0. 314264	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				2, 838, 682	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p		i cai d?		Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from M	edi cai d			0	
6.00	Medicaid charges				16, 544, 948	
7.00	Medicaid cost (line 1 times line 6)				5, 199, 482	
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minus sum o	flines 2	2 and 5; if	2, 360, 800	8.00
	< zero then enter zero)	C 1.11				
0.00	State Children's Health Insurance Program (SCHIP) (see instruction	ns for each line)			0.00
9.00	Net revenue from stand-al one SCHLP				0	
10.00	Stand-allone SCHIP charges				0	
11. 00 12. 00	Stand-alone SCHIP cost (line 1 times line 10)	ing 11 minus lin	- 0. if	. Torse then	0	1 00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I enter zero)	ine ii minus iin	e 9; 11 <	< zero then	0	12.00
	Other state or local government indigent care program (see instru	ctions for each	line)			
13.00	Net revenue from state or local indigent care program (Not includ				0	13.00
14.00	Charges for patients covered under state or local indigent care p			ines 6 or	0	
	10)		adoa III I	11100 0 01	0	
15.00	State or local indigent care program cost (line 1 times line 14)				0	15.00
16.00	Difference between net revenue and costs for state or local indig	ent care program	(line 15	5 minus line	0	16.00
	13; if < zero then enter zero)	1 5				
	Uncompensated care (see instructions for each line)					
	Private grants, donations, or endowment income restricted to fund				0	
18.00	Government grants, appropriations or transfers for support of hos				0	
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local	indigent care pr	ograms (s	sum of lines	2, 360, 800	19.00
_	8, 12 and 16)	Unteres		I maxima al	Tatal (asl 1	
		Uninsu patie		Insured patients	Total (col. 1 + col. 2)	
		1.0		2.00	3, 00	
20,00	Total initial obligation of patients approved for charity care (a		017,764	2.00		20.00
20.00	charges excluding non-reimbursable cost centers) for the entire f		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	7,017,704	20.00
21.00	Cost of initial obligation of patients approved for charity care		33, 959	0	2, 833, 959	21.00
	times line 20)					
22.00	Partial payment by patients approved for charity care		0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2, 8	33, 959	0	2, 833, 959	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient d		gth of st	tay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care pr					
25.00	If line 24 is "yes," charges for patient days beyond an indigent		length of	r stay limit	0	
	Total bad debt expense for the entire hospital complex (see instr				5, 951, 732	
	Medicare bad debts for the entire hospital complex (see instructi		->		261, 628	
	Non-Medicare and non-reimbursable Medicare bad debt expense (line		·		5, 690, 104	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expen	se (line 1 times	iine 28))	1, 788, 195	
	Cost of uncompensated care (line 23 column 3 plus line 29)	20)			4, 622, 154	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	3U)			6, 982, 954	3 I. UU

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	ST. ELIZABETH		CCN: 150003 P	In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
1120210				F	rom 01/01/2014 o 09/30/2014	Date/Time Pre 2/27/2015 7:03	
	Cost Center Description	Sal ari es	Other	Total (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	I I I I I I I I I I I I I I I I I I I			00(()		1
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	286, 447 183, 416	286, 447 183, 416	1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	О	0	0	000,410	0	4.00
5.02	00550 DATA PROCESSING	0	0	0	0	0	5.02
5.03	00561 PURCHASING RECEIVING AND STORES	0	0	0	0	0	5.03
5.04 5.05	00580 CASHI ERING/ACCOUNTS RECEIVABLE	333, 131 679, 126	2, 182 3, 169, 133			335, 313 3, 848, 259	5.04 5.05
5.06	00560 ADMI NI STRATI VE AND GENERAL	1, 194, 864	2, 113, 144			3, 278, 949	5.06
7.00	00700 OPERATION OF PLANT	945, 395	795, 135			1, 740, 530	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	110, 657	455, 994		0	566, 651	•
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	511, 646 401, 164	172, 780 128, 266			684, 426 379, 763	9.00 10.00
11.00	01100 CAFETERI A	139, 906	82, 407	222, 313		371, 858	
13.00	01300 NURSING ADMINISTRATION	690	-800	-110	0	-110	
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	1 507 212	0	0	14.00
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	429, 754 45, 885	1, 167, 558 157, 231	1, 597, 312 203, 116	-957, 805 -191, 964	639, 507 11, 152	15.00 16.00
17.00	01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
20.00	02000 NURSI NG SCHOOL	1, 845, 032	135, 320			2, 223, 611	
23.00	02300 PARAMED ED PRGM	123, 487	9, 702	133, 189	63, 351	196, 540	23.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 745, 356	124, 577	1, 869, 933	-120, 637	1, 749, 296	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 876, 718	184, 448			1, 897, 732	31.00
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43.00
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	726, 116	400, 121	1, 126, 237		809, 614	•
56.00 56.02	05600 RADI 0I SOTOPE 05602 MRI	99, 436 20, 543	184, 603 5, 978		-5, 076 -3, 353	278, 963 23, 168	56.00 56.02
56.02	05603 ULTRASOUND	79, 720	4, 191	83, 911		81, 328	•
57.00	05700 CT SCAN	185, 562	59, 256			195, 450	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 3, 038, 784	3, 038, 784	-5, 629	0 3, 033, 155	59.00 60.00
60.00	06001 BLOOD LABORATORY	0	0,000,704	0,030,704	0,027	0,000,100	60.00
65.00	06500 RESPI RATORY THERAPY	474, 213	102, 590			540, 442	
66.00	06600 PHYSI CAL THERAPY	2, 395, 052	292, 234			2, 424, 824	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	312, 901 629, 842	4, 877 931, 508			317, 341 1, 557, 366	
70.00	07000 ELECTROENCEPHALOGRAPHY	027,042	0	1, 301, 330	0	1, 337, 300	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1, 040, 467	1, 040, 467	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	015 449	0 915, 448	72.00
73.00 74.00	07400 RENAL DIALYSIS	9, 284	389, 368	398, 652	915, 448 -2, 373	915, 448 396, 279	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	258, 208			256, 753	
	OUTPATIENT SERVICE COST CENTERS			-	-		
88.00 89.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00 89.00
89.00 91.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY	1, 034, 251	0 128, 624	1, 162, 875	-112, 723	0 1, 050, 152	
91.01	09101 WOUND CARE	761, 594	229, 437			809, 662	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1 617 717	576, 768	2, 094, 485	-149, 682	1, 944, 803	95.00
93.00 97.00	09700 DURABLE MEDICAL EQUIP SOLD	1, 517, 717	570, 708 0	2, 094, 465	- 149, 082	1, 944, 803	
	09910 CORF	0	0	0	0	0	
400.00	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	0		0		109.00 110.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
	11300 INTEREST EXPENSE		0	0	0	0	113.00
		782, 239	307, 876			954, 226	
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	19, 411, 281	15, 611, 500	35, 022, 781	0	35, 022, 781	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	Ó	0	0	0	0	192.00
	07950 PATIENT TRANSPORT	61, 275	158, 679			219, 954	
	07951 SETON LEASE 1 NORTH 07952 REHAB (FSEH-E)	202, 322	10, 892 0			213, 214 0	194.01 194.02
. / 1. 02		<u>ا</u>	0	. 0	0	0	1

Health Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period:	Worksheet A	
				From 01/01/2014 To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.0307953 HHA (FSEH-E)	0	0	(0 0	0	194.03
194.04 07956 PSYCH (FSEH-E)	0	0	(0 0	0	194.04
194. 05 07955 VACANT SPACE	0	0	(0 0	0	194.05
200.00 TOTAL (SUM OF LINES 118-199)	19, 674, 878	15, 781, 071	35, 455, 94	9 0	35, 455, 949	200. 00

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (ST. ELIZABE		CCN: 150003	In Lie Period:	u of Form CMS-255 Worksheet A	52-1
NLULA	STITCATION AND ADJUSTMENTS OF TREAD ADJUST		litovidei	CCN. 150005	From 01/01/2014 To 09/30/2014		red:
	Cost Center Description	Adjustments	Net Expenses			2/27/2015 7:02 a	
		(See A-8)	For Allocation				
	GENERAL SERVICE COST CENTERS	6.00	7.00				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	2, 340, 315					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	1, 363, 103					2.00
4.00 5.02	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING	7, 188, 373					4.00
5.02	00561 PURCHASING RECEIVING AND STORES	66, 953					5.0
5.04	00570 ADMI TTI NG	-300, 619					5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-3, 649, 454	198, 805			5	5.0
5.06	00560 ADMINI STRATI VE AND GENERAL	1, 544, 617					5.0
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-99, 971 -407, 086					7.0 8.0
8.00 9.00	00900 HOUSEKEEPING	-407, 080		1			8.0 9.0
10.00	01000 DI ETARY	-52, 773					0.0
11.00	01100 CAFETERI A	-192, 023		1			1.0
13.00	01300 NURSING ADMINISTRATION	350, 012					3.00
14.00	01400 CENTRAL SERVICES & SUPPLY	C					4.00
15.00		-48, 488					5.00 6.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	59, 334 64, 510		1			7.00
20.00	02000 NURSI NG SCHOOL	-1, 909					0.00
23.00	02300 PARAMED ED PRGM	166, 074		1		23	3. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1				
30.00	03000 ADULTS & PEDIATRICS	1 200 024		1			0.00
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	-1, 380, 834					1.00
42.00	04200 SUBPROVI DER						2.00
43.00	04300 NURSERY	C					3.00
	ANCI LLARY SERVICE COST CENTERS		1	1			
50.00	05000 OPERATING ROOM	C					0.00
51.00 54.00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C						1.00
56.00	05600 RADI OLOGI DI AGNOSTI C	-83					6. 00
56.02	05602 MRI	C					6. 02
56.03	05603 ULTRASOUND	C	81, 328			56	6. 03
57.00	05700 CT SCAN	C					7.00
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)		-				8.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	71, 484	-				9.00
60.01	06001 BLOOD LABORATORY	, i, ioi	0				0.01
65.00	06500 RESPI RATORY THERAPY	1, 153					5.00
66.00	06600 PHYSI CAL THERAPY	-856, 282					6.00
68.00		1 007 (04					8.00
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	-1, 087, 604 254, 196		1			9.00 0.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	516, 056		1			1.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	77, 298					2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C					3.00
74.00		-184, 660					4.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	C	256, 753			///	6. 98
88.00	08800 RURAL HEALTH CLINIC	C	0			88	8. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C		•			9.00
91.00	09100 EMERGENCY	-13, 892	1, 036, 260				1.00
91.01	09101 WOUND CARE	-1, 236	808, 426				1.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					92	2.00
95.00	09500 AMBULANCE SERVICES	1, 571	1, 946, 374			95	5. 00
97.00	09700 DURABLE MEDICAL EQUIP SOLD	C					7.00
99. 10	09910 CORF	C	0			99	9.10
100 0	SPECIAL PURPOSE COST CENTERS						0.0
) 10900 PANCREAS ACQUISITION) 11000 INTESTINAL ACQUISITION	0	0				9.00 0.00
	11100 I SLET ACQUI SI TI ON		0				1.00
	11300 I NTEREST EXPENSE		o o				3.00
116.00	11600 HOSPI CE	-111				116	6.00
118.00		5, 933, 330	40, 956, 111			118	8.00
100 00	NONREIMBURSABLE COST CENTERS	0	0			100	0. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						2.00
	07950 PATIENT TRANSPORT		219, 954				4.00
	07951 SETON LEASE 1 NORTH	C	213, 214				4.0
194.02	207952 REHAB (FSEH-E)	C	0				4. 02
	BO7953 HHA (FSEH-E)	C	0				4.03
194 04	IO7956 PSYCH (FSEH-E)	C	0			194	4.

Health Financial Systems	ST. ELI ZABE	TH CENTRAL	In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 150	0003 Period: From 01/01/2014	Worksheet A
				Date/Time Prepared: 2/27/2015 7:02 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7.00		
194. 05 07955 VACANT SPACE	0	0		194. 05
200.00 TOTAL (SUM OF LINES 118-199)	5, 933, 330	41, 389, 279		200.00

Financial Systems IFICATIONS		ST. ELI ZABET	Provi der CCN: 15		ieu of Form CMS-2552-1 Worksheet A-6
				To 09/30/201	
Cost Center	I ncreases Li ne #	Salary	Other		
2.00	3.00	4.00	5.00		
A – BUILDING RENTAL	1	-			
NEW CAP REL COSTS-BLDG & FIXT	1.00	0	286, 447		1.0
	0.00	О	0		2.0
	0.00	0	0		3.0
	0.00				4.0
B - EQUI PMENT RENTAL	<u> </u>	<u> </u>	200, 117		
NEW CAP REL COSTS-MVBLE	2.00	0	183, 416		1.0
EQUI P	0.00	0	0		2.0
	0.00	Ő	0		3. 0
	0.00	0	0		4.0
	0.00 0.00	0	0		5.0
	0.00	0	0		7.0
TOTALS		0	183, 416		
C – CAFETERIA CAFETERIA	11.00	127, 008	22, 659		1. (
TOTALS		127,008			1.0
D - MEDICAL SUPPLIES					
MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1, 040, 467		1. C
	0.00	0	0		2.0
	0.00	0	0		3. 0
	0.00 0.00	0	0		4. (
	0.00	0	0		6.0
	0.00	0	0		7.0
	0.00	0	0		8.
	0.00 0.00	0	0		9. 10.
	0.00	0	0		11.
	0.00	0	0		12.
	0.00 0.00	0	0 0		13. (
	0.00	0	0		15. (
	0.00	0	0		16. (
	0.00 0.00	0	0		17.0
	0.00	0	0		19.
	0.00	0	0		20.
TOTALS		0	<u> </u>		21.
E - DRUGS		U	1,040,407		
DRUGS CHARGED TO PATIENTS	73.00	0	915, 448		1.0
	0.00 0.00	0	0		2.
	0.00	0	0		4.0
	0.00	0	0		5.
	0.00 0.00	0	0		6. 7.
	0.00	0	0		8.
	0.00	0	0		9.
	0.00 0.00	0	0		10.
	0.00	0	0		12.
	0.00	0	0		13.
	0.00 0.00	0	0		14. 15.
TOTALS		0	915, 448		
F - FSEH - SHARED SERVICES	· · ·				
EMPLOYEE BENEFITS DEPARTMENT PURCHASING RECEIVING AND STORES	4.00 5.03	238, 762 48, 585	0 0		1. 2.
ADMINISTRATIVE AND GENERAL	5.06	339, 860	0		3.
OPERATION OF PLANT	7.00	251, 861	0		4.
NURSING ADMINISTRATION	13.00	342, 350	0		5.
MEDICAL RECORDS & LIBRARY	16.00 17.00	127, 071 64, 077	0		6. 7.
SOCIAL SERVICE					
SOCI AL SERVI CE RESPI RATORY THERAPY	65.00	2, 438	0		
					8. 9. 10.

Heal th	Financial Systems		ST. ELIZABE	TH CENTRAL		In Lie	u of Form CMS	5-2552-10
RECLASS	SIFICATIONS			Provi der	CCN: 150003	Peri od:	Worksheet A-	-6
						From 01/01/2014 To 09/30/2014	Date/Time Pr 2/27/2015 7:	repared: 02 am
		Increases						
	Cost Center	Line #	Sal ary	Other	-			
	2.00	3.00	4.00	5.00				
12.00	CASHI ERI NG/ACCOUNTS RECEI VABLE	5.05	0	608, 857				12.00
13.00	ADMINISTRATIVE AND GENERAL	5.06	0	1,071,233				13.00
14.00	OPERATION OF PLANT	7.00	0	748, 936				14.00
15.00	LAUNDRY & LINEN SERVICE	8.00	0	79, 497				15.00
16.00	MEDICAL RECORDS & LIBRARY	16.00	0	38, 030				16.00
17.00	ELECTROCARDI OLOGY	69.00	0	262, 497				17.00
	TOTALS		1, 487, 434	3, 162, 843				
	G - PURCHASED SERVICES							
1.00	ADULTS & PEDIATRICS	30.00	0	1, 257, 267				1.00
2.00	LABORATORY	60.00	15, 756	C				2.00
3.00	PHYSICAL THERAPY	66.00	0	864, 264				3.00
4.00	ELECTROCARDI OLOGY	69.00	40, 317	C				4.00
5.00	ELECTROENCEPHALOGRAPHY		227,033	<u>C</u>				5.00
	TOTALS		283, 106	2, 121, 531				_
	H - NURSING SCHOOL				1			_
1.00	NURSING SCHOOL	20.00	87, 404	160, 376				1.00
2.00		0.00	0	C				2.00
3.00		0.00	0	C				3.00
	TOTALS		87, 404	160, 376				_
	I - PARA MEDICAL EDUCATION				1			
1.00	PARAMED ED PRGM	23.00	41, 207	C				1.00
2.00	PARAMED ED PRGM	23.00	22, 222	Q	<u> </u>			2.00
500.00	TOTALS		63, 429	7 000 107				500.00
500.00	Grand Total: Increases		2, 048, 381	7, 893, 187	1			500.00

	Financial Systems		ST. ELI ZABET			n Lieu of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 150003 Period: From 01/01	Worksheet A-6 /2014
					To 09/30	/2014 Date/Time Prepared: 2/27/2015 7:02 am
		Decreases				
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - BUILDING RENTAL	7.00	8.00	9.00	10.00	
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	232, 133		1.00
2.00 3.00	LABORATORY PHYSI CAL THERAPY	60.00 66.00	0	5, 629 31, 360	10 10	2.00
4.00	AMBULANCE SERVICES	95.00	0	17, 325		4.00
	TOTALS		0	286, 447		
1.00	B - EQUI PMENT RENTAL ADMI NI STRATI VE AND GENERAL	5.06	0	990	10	1.00
2.00	CAFETERI A	11.00	0	122	10	2.00
3.00	PHARMACY	15.00	0	167, 364	10	3.00
4.00 5.00	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54.00 56.00	0	990 3, 000	10 10	4.00 5.00
6.00	PHYSICAL THERAPY	66.00	0	10, 455	10	6.00
7.00	ELECTROCARDIOLOGY	69.00	0	495		7.00
	TOTALS C - CAFETERIA		ō	183, 416		
1.00	DI ETARY	10.00	127, 008	22, 659	0	1.00
	TOTALS		127,008	22,659		
1.00	D - MEDI CAL SUPPLI ES PHARMACY	15.00	0	52, 289	0	1.00
1.00 2.00	MEDI CAL RECORDS & LI BRARY	16.00	0	52, 289 72	0	2.00
3.00	NURSING SCHOOL	20.00	0	4, 455	0	3. 00
4.00	PARAMED ED PRGM	23.00	0	78	0	4.00
5.00 6.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00 31.00	0	83, 795 150, 344	0	5.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	82, 584	0	7.00
8.00	RADI OI SOTOPE	56.00	0	2, 076	0	8.00
9.00 10.00	MRI ULTRASOUND	56.02 56.03	0	39 2, 556	0	9.00
11.00	CT SCAN	57.00	0	34, 769	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	36, 268	0	12.00
13.00 14.00	PHYSI CAL THERAPY SPEECH PATHOLOGY	66.00 68.00	0	220, 121 437	0	13.00
14.00	ELECTROCARDI OLOGY	69.00	0	3, 489	0	15.00
16.00	RENAL DI ALYSI S	74.00	0	2, 169	0	16.00
17.00 18.00	HYPERBARIC OXYGEN THERAPY EMERGENCY	76. 98 91. 00	0	1, 450 71, 516	0	17.00
18.00	WOUND CARE	91.00	0	177, 283	0	19.00
20.00	AMBULANCE SERVICES	95.00	0	90, 949	0	20.00
21.00	HOSPICE	1 <u>16.</u> 00	<u>o</u>	<u>23, 728</u> 1, 040, 467	0	21.00
	E - DRUGS		0	1, 040, 407		
1.00	PHARMACY	15.00	0	738, 152	0	1.00
2.00	NURSI NG SCHOOL ADULTS & PEDI ATRI CS	20.00 30.00	0	66 9, 023	0	2.00
3.00 4.00	INTENSIVE CARE UNIT	31.00	0	9, 023 13, 090		3.00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	916		5. 00
6.00		56.02	0	3, 314	0	6.00
7.00 8.00	ULTRASOUND CT SCAN	56.03 57.00	0	27 14, 599	0	7.00
9.00	RESPIRATORY THERAPY	65.00	0	93	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	526	0	10.00
11. 00 12. 00	RENAL DIALYSIS HYPERBARIC OXYGEN THERAPY	74.00 76.98	0	204 5	0	11.00
13.00	WOUND CARE	91.01	0	4, 086	0	13.00
14.00	AMBULANCE SERVICES	95.00	0	19, 186		14.00
15.00	HOSPICE	<u> </u>	<u>0</u> 0	<u>112, 161</u> 915, 448	0	15.00
	F - FSEH - SHARED SERVICES			710, 440		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	238, 762		1.00
2.00	PURCHASING RECEIVING AND STORES	5.03	0	48, 585	0	2.00
3.00	ADMI NI STRATI VE AND GENERAL	5.06	0	339, 860	0	3.00
4.00	OPERATION OF PLANT	7.00	0	251, 861	0	4.00
5.00 6.00	NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY	13.00 16.00	0	342, 350 127, 071	0	5.00
8.00 7.00	SOCIAL SERVICE	17.00	0	64, 077	0	7.00
8.00	RESPI RATORY THERAPY	65.00	0	2, 438	0	8.00
9. 00 10. 00	PHYSICAL THERAPY EMERGENCY	66.00 91.00	0 55, 131	72, 430 0		9.00 10.00
10.00	ADMI TTI NG	5.04	298, 662	0	0	11.00
12.00	CASHI ERI NG/ACCOUNTS	5.05	608, 857	0	Ö	12.00
13.00	RECEI VABLE ADMI NI STRATI VE AND GENERAL	5.06	1, 071, 233	0	0	13.00
13.00	UNI NI SINATI VE ANU GENERAL	J. 00	1, 0/1, 233	0	U	13.00

Heal th	Financial Systems		ST. ELI ZABE	TH CENTRAL		In Lie	u of Form CMS-2552-10	2
RECLASS	SEFECATIONS			Provi der	- CCN: 150003	Period:	Worksheet A-6	-
						From 01/01/2014 To 09/30/2014	Date/Time Prepared: 2/27/2015 7:02 am	_
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	OPERATION OF PLANT	7.00	748, 936	C)	0	14.00	
	LAUNDRY & LINEN SERVICE	8.00	79, 497	C)	0	15.00	
16.00	MEDICAL RECORDS & LIBRARY	16.00	38, 030	C)	0	16.00	
17.00	ELECTROCARDI OLOGY	69.00	<u> </u>	C)	0	17.00)
	TOTALS		3, 162, 843	1, 487, 434	Į.			
	G - PURCHASED SERVICES							
1.00	ADULTS & PEDIATRICS	30.00	1, 257, 267	C)	0	1.00)
2.00	LABORATORY	60.00	0	15, 756	5	0	2.00)
3.00	PHYSICAL THERAPY	66.00	864, 264	C)	0	3.00)
4.00	ELECTROCARDI OLOGY	69.00	0	40, 317	7	0	4.00)
5.00	ELECTROENCEPHALOGRAPHY	70.00	0	227, 033	3	0	5.00)
	TOTALS		2, 121, 531	283, 106	b			
	H - NURSING SCHOOL							
1.00	ADMI NI STRATI VE AND GENERAL	5.06	27, 466	603	3	0	1.00)
2.00	MEDICAL RECORDS & LIBRARY	16.00	32, 119	159, 773	3	0	2.00)
3.00	ADULTS & PEDIATRICS	30.00	27, 819	C)	0	3.00)
	TOTALS		87, 404	160, 376				
	I - PARA MEDICAL EDUCATION							
1.00	EMERGENCY	91.00	0	41, 207	1	0	1.00)
2.00	AMBULANCE SERVICES	95.00	0	22, 222	2	0	2.00)
	TOTALS			63, 429	· · · · · · · · · · · · · · · · · · ·	7		
500.00	Grand Total: Decreases		5, 498, 786	4, 442, 782	2		500.00)
		•						

Heal th	Financial Systems	ST. ELI ZABET	TH CENTRAL			Inlie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS	JT. LLIZADLI		CCN: 150003	Peri From To		Worksheet A-7 Part I	
				Acqui si ti on	s			
		Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	4, 191, 082	0		0	0	0	1.00
2.00	Land Improvements	3, 723, 866	55, 308		0	55, 308	0	2.00
3.00	Buildings and Fixtures	92, 814, 043	1, 396, 839		0	1, 396, 839	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	24, 251, 540	0		0	0	3, 730, 150	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	124, 980, 531	1, 452, 147		0	1, 452, 147	3, 730, 150	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	124, 980, 531	1, 452, 147		0	1, 452, 147	3, 730, 150	10.00
		Endi ng Bal ance	Fully					
		5	Depreciated					
			Assets					
		6.00	7.00	1				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	4, 191, 082	0	1				1.00
2.00	Land Improvements	3, 779, 174	0					2.00
3.00	Buildings and Fixtures	94, 210, 882	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	20, 521, 390	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	122, 702, 528	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	122, 702, 528	0					10.00

Heal th	n Financial Systems	ST. ELI ZABET	TH CENTRAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150003	Period: From 01/01/2014	Worksheet A-7	
					To 09/30/2014		pared:
						2/27/2015 7:0	
			SL	JMMARY OF CAF	PITAL		
	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 WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O					
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 01/01/2014 To 09/30/2014		
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1. 00 NEW CAP REL COSTS-BLDG & FIXT 2. 00 NEW CAP REL COSTS-MVBLE EQUIP 3. 00 Total (sum of lines 1-2)	0 0 0	O O O TION OF OTHER ((0 1.000000 0 0.000000 0 1.000000 SUMMARY 0		1.00 2.00 3.00
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				1	00/ //7	
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	-		1, 924, 344 1, 124, 437 3, 048, 781		1.00 2.00 3.00
	0	SL	JMMARY OF CAPI		407, 003	3.00
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 CE					0 (0) 7(0	1 00
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	415, 971 238, 666 654, 637	0	(2, 626, 762 1, 546, 519 4, 173, 281	1.00 2.00 3.00

	Financial Systems MENTS TO EXPENSES		ST. ELIZABE		In Lie eriod:	u of Form CMS-2 Worksheet A-8	
ADJ US I	MENTS TO EXPENSES			F	rom 01/01/2014 o 09/30/2014		pared:
				Expense Classification on To/From Which the Amount is		272772013 7.0.	2 0111
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	В		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter	В	-3, 214	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	2. 00
3.00	2) Investment income - other		C		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		C		0.00	0	7.00
8.00	21) Television and radio service (chapter 21)		O		0.00	0	8.00
9.00 10.00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -642, 821		0.00	0 0	9. 00 10. 00
11.00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	6, 939, 899			0	12. 00
13.00 14.00 15.00	Laundry and linen service Cafeteria-employees and guests Rental of quarters to employee	В	0 171, 970- 0	CAFETERI A	0.00 11.00 0.00	0 0 0	14.00
16.00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16. 00
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		C		0.00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19. 00
	books, etc.) Vending machines Income from imposition of interest, finance or penalty	В	-20, 053 0	CAFETERI A	11. 00 0. 00		20. 00 21. 00
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22. 00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24. 00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		C	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26. 00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28. 00 29. 00	Non-physician Anesthetist Physicians'assistant		0	*** Cost Center Deleted ***	19.00 0.00	0	28. 00 29. 00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		O	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		O		0.00	0	32. 00

Heal th	Financial Systems		ST. ELI ZABE	TH CENTRAL	In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES			Provider CCN: 150003	Peri od:	Worksheet A-8		
					From 01/01/2014 To 09/30/2014	Date/Time Prep 2/27/2015 7:03	pared: 2 am	
				Expense Classification o	n Worksheet A			
				To/From Which the Amount is	s 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		
33.00	MARKETING EXP	A		DI ETARY	10.00		33.00	
33.01	MARKETING EXP	А	-1,011	WOUND CARE	91.01	0	33.01	
33.02	MARKETING EXP	A	-111	HOSPI CE	116.00	0	33. 02	
33.03	SON ADVERTISING	A	-1, 909	NURSING SCHOOL	20.00	0	33.03	
33.04	DAY CARE FOOD SERVICE REV	В	-2, 255	DI ETARY	10.00	0	33.04	
33.05	DI SCOUNTS EARNED/REBATES	В	-50, 509	DI ETARY	10.00	0	33.05	
33.06	ATHLETIC TRAINING REV	В	-2,465	PHYSICAL THERAPY	66.00	0	33.06	
33.07	DI SCOUNTS EARNED/REBATES	В	-3, 010	LABORATORY	60.00	0	33.07	
33.08	DI SCOUNTS EARNED/REBATES	В	-1, 306	RESPI RATORY THERAPY	65.00	0	33.08	
33.09	MISC - OTHER REV	В		RADI OI SOTOPE	56.00	0	33.09	
33.10	MISC - OTHER REV	В		WOUND CARE	91.01	0	33.10	
33. 11	DI SCOUNTS EARNED/REBATES	В		PHARMACY	15.00		33. 11	
33. 12	BLDG RENTAL INCOME	В		NEW CAP REL COSTS-BLDG &	1.00	9	33. 12	
50.00				FLXT			50.00	
50.00	TOTAL (sum of lines 1 thru 49)		5, 933, 330				50.00	
	(Transfer to Worksheet A,							
	column 6, line 200.)							

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

Heal th	Financial Systems	ST. ELI ZABI	ETH CENTRAL	In Li	eu of Form CMS-:	2552-10
STATEME OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 150003	From 01/01/2014		
				To 09/30/2014	1 Date/Time Pre 2/27/2015 7:0	pared: 2 am
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	2.00	2.00	4.00	5	
	1.00 A. COSTS INCURRED AND ADJUSTM	2.00	3.00	4.00	5.00	
	HOME OFFICE COSTS:	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	URGANIZATIONS UR		
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	FRANCI SCAN DEPRECIATION	463, 534	0	1.00
2.00		NEW CAP REL COSTS-MVBLE EQUI		265, 956		2.00
3.00		NEW CAP REL COSTS-BLDG & FIX		421, 573	0	3.00
4.00		NEW CAP REL COSTS-MVBLE EQUI		241,880		4.00
4.01			FRANCI SCAN A&G	3, 963, 538		4.01
4.02		PHARMACY	FRANCI SCAN COEP	174, 165		4.02
4.03		CASHI ERI NG/ACCOUNTS RECEI VAB		C	1,007,020	4.03
4.04		CASHI ERI NG/ACCOUNTS RECEI VAB		C	07,007	4.04
4.05		PHARMACY	PHARMACY	0	158,072	4.05
4.06			FSEH-C SHARED SERVICES	34, 694		4.06
4.07		CASHI ERI NG/ACCOUNTS RECEI VAB		198, 805		4.07
4.08			FSEH-C SHARED SERVICES FSEH-C SHARED SERVICES	210, 470		4.08 4.09
4.09 4.10			FSEH-C SHARED SERVICES	348, 958 159, 565		4.09 4.10
4.10		MEDICAL RECORDS & LIBRARY	FSEH-C SHARED SERVICES	28, 120		4.10
4.11		ELECTROCARDI OLOGY	FSEH-C SHARED SERVICES	94, 906		4.11
4.12		NEW CAP REL COSTS-BLDG & FIX		1, 496, 245		4.12
4.13		NEW CAP REL COSTS-DEDU & TTX		858, 481		4.13
4.15		EMPLOYEE BENEFITS DEPARTMENT		7, 188, 373		4. 15
4.16			FSEH-E SHARED SERVICES	58, 910	1 1	4. 16
4.17		DATA PROCESSING	FSEH-E SHARED SERVICES	145, 306	1 1	4.17
4.18		PURCHASING RECEIVING AND STO		66, 953	1 1	4.18
4.19			FSEH-E SHARED SERVICES	619, 706		4.19
4.20			FSEH-E SHARED SERVICES	1, 291, 601		4.20
4.21	13.00	NURSING ADMINISTRATION	FSEH-E SHARED SERVICES	350, 012	0	4.21
4.22	16.00	MEDICAL RECORDS & LIBRARY	FSEH-E SHARED SERVICES	234, 329	0	4.22
4.23	17.00	SOCIAL SERVICE	FSEH-E SHARED SERVICES	64,510	0	4.23
4.24			FSEH-E SHARED SERVICES	2, 459	0	4.24
4.25		PHYSI CAL THERAPY	FSEH-E SHARED SERVICES	72, 890		4.25
4.26		EMERGENCY	FSEH-E SHARED SERVICES	C	001077	4.26
4.27		INTENSIVE CARE UNIT	FSEH PURCHASED SERVICES	C	1,000,001	4.27
4.28		LABORATORY	FSEH PURCHASED SERVICES	74, 494		4.28
4.29			FSEH PURCHASED SERVICES		926, 707	4.29
4.30		ELECTROCARDI OLOGY	FSEH PURCHASED SERVICES	50, 448		4.30
4.31			FSEH PURCHASED SERVICES	254, 196		4.31
4.32 4.33		MEDICAL SUPPLIES CHARGED TO IMPL. DEV. CHARGED TO PATIEN	FSEH PURCHASED SERVICES	516, 056 77, 298		4.32 4.33
4.33 4.34		RENAL DIALYSIS	FSEH PURCHASED SERVICES	11, 298	1	4.33
4.34			FSEH-PHARMACY PROGRAM	63, 759		4.34
4.35			FSEH-PHARMACY PROGRAM	41, 207	1 1	4.35
4.37		AMBULANCE SERVICES	FSEH-PARAMED PROGRAM	11, 966		4.37
4.38		PARAMED ED PRGM	FSEH-PHARMACY PROGRAM	102, 315	1	4.38
5.00	TOTALS (sum of lines 1-4).			20, 247, 678	1 1	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
* The	amounts on Lines 1-4 (and sub	scripts as appropriate) are t	ransferred in detail to W	rksheet Δ columr	n 6 lines as	

* 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
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.

6.00	G	FSEH	100.00 FSEH - EAST	100.00 6.00	
7.00	В	FRANCI SCAN ALLI	100.00 FRANCI SCAN ALLI	100.00 7.00	
8.00			0.00	0.00 8.00	
0.00			0.00	0.000 0.00	

	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	FSEH- SHARED SV				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.

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

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

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

	Financial Syste		ST. ELIZABETH			u of Form CMS-2552
		SERVICES FROM RE	ELATED ORGANIZATIONS AND HOME	Provider CCN: 150003	Period: From 01/01/2014	Worksheet A-8-1
DEFICE	COSTS				To 09/30/2014	Date/Time Prepare 2/27/2015 7:02 ar
	Net	Wkst. A-7 Ref.			1.	2/2//2010 /.02 u
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTMEN	NTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED	ORGANIZATIONS OR	CLAIMED
	HOME OFFICE CO	STS:				
. 00	463, 534					1
2.00	265, 956	9				2
. 00	421, 573	11				3
. 00	241, 880	11				4
. 01	3, 963, 538	0				4
. 02	174, 165	0				4
. 03	-1, 887, 525					4
04	-39, 339	0				4
05	-158, 072	0				4
. 06	-300, 619	0				4
. 07	-1, 722, 590	0				4
. 08	-3, 097, 537	0				4
09	-1, 391, 572	0				4
. 10	-407,086	0				4
. 11	-174, 995	0				4
. 12	-505, 626	0				4
. 13	1, 496, 245					4
. 14	858, 481	9				4
. 15	7, 188, 373	0				4
. 16	58, 910					4
. 17	145, 306					4
. 18	66, 953	-				4
. 19	619, 706	-				4
20	1, 291, 601	0				4
21	350, 012					4
22	234, 329					4
23	64, 510					4
24	2, 459					4
25	72, 890					4
26	-55, 099					4
27	-1, 380, 834					4
28	74, 494	0				4
29	-926, 707	0				4
30	50, 448	-				4
31	254, 196					4
32	516, 056	-				4
. 33	77, 298					4
. 33	-184, 660					4
. 34	63, 759					4
36	41, 207	0				4
. 30 . 37	11, 966					4
. 37	102, 315					4
. 30	102, 315	0				4

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropri ate.

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.

5.00

Related Organization(s) and/or Home Office		
Type of Business		
 6.00		
 B. INTERRELATIONSHIP TO RELAT	ED 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	SISTER FACILITY	6.00
7.00	HOME OFFICE	7.00
8.00		8.00
9.00		9.00
10. 00 100. 00		10.00
100.00		100.00

5.00

6, 939, 899

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

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

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

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

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

Health Financial Systems ST. ELIZABETH CENTRAL In Lieu of Form CMS-2552-10 PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 150003 Peri od: Worksheet A-8-2 From 01/01/2014 09/30/2014 Date/Time Prepared: То 2/27/2015 7:02 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 7.00 1.00 2.00 3.00 4.00 5.00 6.00 69. 00 ELECTROCARDI OLOGY 1.00 635, 499 6,000 1.00 159,800 0 40 11, 250 2.00 91.01 WOUND CARE 11, 250 0 159,800 180 2.00 3.00 95.00 AMBULANCE SERVICES 33, 750 0 33, 750 159,800 304 3.00 4.00 0.00 0 0 0 4.00 0 С 0.00 0 5.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 0 6.00 0 0 7.00 0.00 0 0 0 7.00 8.00 0.00 0 0 8.00 0 0 0 9.00 0.00 0 0 0 0 9.00 10.00 0.00 0 0 0 C 0 10.00 51,000 680, 499 524 200.00 200.00 0 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice . Limit Conti nui ng Share of col. Insurance Educati on 12 1.00 2.00 8.00 9.00 12.00 13.00 14.00 69. 00 ELECTROCARDI OLOGY 1.00 1.00 3,073 154 0 С 0 2.00 91.01 WOUND CARE 13, 829 691 0 0 0 2.00 3.00 95.00 AMBULANCE SERVICES 23, 355 0 0 0 3.00 1, 168 0 4.00 0.00 0 0 4.00 0 0 0.00 5.00 0 0 0 5 00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 0 0.00 0 0 8.00 0 8.00 0.00 0 0 0 9.00 0 9.00 10.00 0.00 0 0 0 10.00 0 0 200.00 40, 257 2,013 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adj ustment I denti fi er Component Limit Di sal I owance Share of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 69. 00 ELECTROCARDI OLOGY 1.00 1.00 3,073 0 2,927 632, 426 2.00 91.01 WOUND CARE 0 13, 829 2.00 С 3.00 95.00 AMBULANCE SERVICES 0 23, 355 10, 395 10, 395 3.00 4.00 0.00 0 4.00 0 0 0 0.00 5.00 0 0 0 0 5 00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 0.00 0 8.00 0 0 0 8.00 0.00 9.00 0 0 0 9.00 10.00 0.00 0 0 0 10.00 0 0

40, 257

13, 322

642, 821

200.00

200.00

	Financial Systems LLLOCATION - GENERAL SERVICE COSTS	ST. ELI ZABET		F	rom 01/01/2014 o 09/30/2014	u of Form CMS-: Worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		2/27/2015 7:0	2 am
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FI XT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSI NG	
		0	1.00	2.00	4.00	5.02	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-NUBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00561 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00560 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	2, 626, 762 1, 546, 519 7, 188, 373 145, 306 66, 953 34, 694 198, 805 4, 823, 566 1, 640, 559 159, 565 684, 426	2, 626, 762 6, 946 7, 791 62, 528 8, 916 40, 961 224, 364 711, 561 83, 053 47, 725	1, 546, 519 629 87, 549 68, 631 1, 687 4, 176 34, 978 97, 313 15, 419 6, 846	7, 195, 948 0 21, 870 15, 516 31, 632 196, 276 201, 811 14, 027	240, 646 1, 611 1, 244 2, 681 7, 414 5, 563 463 13, 399	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ \end{array}$
10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 20. 00 23. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02000 NURSI NG SCHOOL 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	326, 990 179, 835 349, 902 0 591, 019 70, 486 64, 510 2, 221, 702 362, 614	53, 254 31, 802 7, 432 25, 308 18, 638 19, 697 0 299, 069 2, 505	21, 578 5, 504 28, 285 23, 919 19, 272 1, 941 C 36, 779 C	123, 411 120, 151 154, 419 0 193, 453 46, 278 28, 844 869, 880	7, 406 7, 779 3, 188 0 4, 818 1, 854 866 19, 385 4, 184	10.00 11.00 13.00 14.00 15.00 16.00 17.00 20.00
30.00 31.00 41.00 42.00 43.00	03000 ADULTS & PEDI ATRI CS 03100 INTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 749, 296 516, 898 0 0 0	164, 440 26, 710 0 0	40, 672 53, 418 C C C	844, 803 0 0	22, 303 22, 403 0 0 0	30.00 31.00 41.00 42.00 43.00
50. 00 51. 00 54. 00 56. 02 56. 03 57. 00 58. 00 59. 00 60. 00 60. 01 65. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE 05602 MRI 05603 ULTRASOUND 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06900 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 809, 614 278, 880 23, 168 81, 328 195, 450 0 3, 104, 639 0 541, 595	0 109, 652 21, 639 9, 148 3, 548 10, 163 0 0 60, 068 0 16, 767	C 276, 313 96, 406 1, 826 17, 410 159, 632 C 0 1, 829 0 66, 055	0 326, 860 44, 761 9, 247 35, 886 83, 531 0 0 0 7, 093 0	0 0 10, 082 1, 046 240 664 2, 162 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	56.00 56.02 56.03 57.00 58.00 59.00 60.00
66. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 98	06600 PHYSICAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07698 HYPERBARIC OXYGEN THERAPY 0UTPATIENT SERVICE COST CENTERS	1, 568, 542 317, 341 469, 762 254, 196 1, 556, 523 77, 298 915, 448 211, 619 256, 753	62, 330 13, 540 25, 617 20, 486 0 0 76, 206 0	65, 743 17, 070 103, 965 41, 682 0 0 0 0 0 0 0	721, 687 140, 852 183, 509	28, 761 3, 099 4, 051 0 0 0 83 0	66.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00
88.00 89.00 91.00 91.01 92.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY 09101 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0 0 1, 036, 260 808, 426	0 0 98, 496 53, 629	C C 53, 482 6, 198		0 0 13, 999 9, 000	
95. 00 97. 00 99. 10	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP SOLD 09910 CORF SPECIAL PURPOSE COST CENTERS	1, 946, 374 0 0	19, 691 0 0	50, 453 C C	0	24, 545 0 0	95.00 97.00 99.10
110.00 111.00 113.00	10900 PANCREAS ACQUI SI TI ON 11000 I NTESTI NAL ACQUI SI TI ON 11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE 11600 HOSPI CE	0 0 0 954, 115 40, 956, 111	0 0 0 25, 904 2, 469, 584	C C C 1, 506, 660	0 0 352, 124	0 0	109.00 110.00 111.00 113.00 116.00 118.00
190.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	000	8, 386 0	646 C	0	0	190. 00 192. 00

Health Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014 To 09/30/2014		
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	DATA PROCESSING	
	0	1.00	2.00	4.00	5.02	
194. 00 07950 PATI ENT TRANSPORT	219, 954	0	36, 16	4 27, 583		194.00
194.01 07951 SETON LEASE 1 NORTH	213, 214	46, 136	3, 04	9 91, 075	2, 948	194.01
194.0207952 REHAB (FSEH-E)	0	58, 523		0 0	0	194.02
194.0307953 HHA (FSEH-E)	0	10, 284		0 0	0	194.03
194.0407956 PSYCH (FSEH-E)	0	33, 849		0 0	0	194.04
194. 05 07955 VACANT SPACE	0	0		0 0	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	41, 389, 279	2, 626, 762	1, 546, 51	9 7, 195, 948	240, 646	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ST. ELIZABET		Fr	riod: om 01/01/2014	u of Form CMS-: Worksheet B Part I	
				То	09/30/2014	Date/Time Pre 2/27/2015 7:0	pared: 2 am
	Cost Center Description	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	ADMI NI STRATI VE AND GENERAL	
		5.03	5.04	5. 05	5A. 05	5.06	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00550 DATA PROCESSI NG						5. 02
5.03	00561 PURCHASING RECEIVING AND STORES	221, 593					5.03
5.04 5.05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	7 182	62, 064 0	278, 437			5.04 5.05
5.06	00560 ADMI NI STRATI VE AND GENERAL	561	0	270,437	5, 287, 159	5, 287, 159	
7.00	00700 OPERATION OF PLANT	514	0	0	2, 657, 321	389, 165	
8.00	00800 LAUNDRY & LINEN SERVICE	81	0	0	272, 608	39, 923	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 653 1, 081	0	0	985, 366 533, 720	144, 307 78, 163	
11.00	01100 CAFETERI A	501	0	-	345, 572	50, 609	
13.00	01300 NURSING ADMINISTRATION	1	0	0	543, 227	79, 556	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 9, 589	0	0	49, 227 836, 789	7, 209 122, 548	
16.00	01600 MEDICAL RECORDS & LIBRARY	9, 309	0	0	140, 261	20, 541	
17.00	01700 SOCIAL SERVICE	0	0	0	94, 220	13, 799	
20.00	02000 NURSI NG SCHOOL	817	0	0	3, 447, 632	504, 907	
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	14	0	0	453, 457	66, 409	23.00
30.00	03000 ADULTS & PEDIATRICS	15, 367	11, 446	17, 729	2, 228, 443	326, 355	30.00
31.00	03100 INTENSIVE CARE UNIT	27, 571	5, 810		1, 505, 950	220, 546	
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0	0	0	0	
10.00	ANCI LLARY SERVICE COST CENTERS						10.00
	05000 OPERATI NG ROOM	0	0	-	0	0	
51.00	05100 RECOVERY ROOM	15 204	0	0	1 540 207	0	
54.00 56.00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	15, 286 381	962	19, 518 87	1, 568, 287 443, 200	229, 676 64, 907	
56.02	05602 MRI	7	1, 491	4, 150	49, 277	7, 217	
56.03	05603 ULTRASOUND	469	615		142, 654	20, 892	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	6, 376	3, 344	23, 265 0	483, 923 0	70, 871 0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60.00	06000 LABORATORY	12, 969	13, 361	58, 129	3, 258, 088	477, 147	
60.01	06001 BLOOD LABORATORY	10, 225	0	0	0	107 5(2)	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	18, 235 40, 365	3, 047 694	4, 895 19, 566	871, 025 2, 507, 688	127, 562 367, 251	
68.00	06800 SPEECH PATHOLOGY	80	635	2, 463	495, 080	72, 504	68.00
69.00	06900 ELECTROCARDI OLOGY	741	1, 524	5, 844	795, 013	116, 430	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	265 4, 955		423, 664 1, 576, 484	62, 046 230, 876	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	263		77, 995	11, 422	
	07300 DRUGS CHARGED TO PATIENTS	0	10, 330		946, 696	138, 644	73.00
	07400 RENAL DIALYSIS 07698 HYPERBARIC OXYGEN THERAPY	398	1, 089 445		295, 233	43, 237 38, 285	
70.90	OUTPATIENT SERVICE COST CENTERS	0	440	4, 221	261, 419	30, 203	76. 98
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
91.00 91.01	09100 EMERGENCY 09101 WOUND CARE	13, 115 32, 511	1, 695 93		1, 688, 074 1, 262, 184	247, 218 184, 847	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	52, 511	75	7,470	1, 202, 104	104, 047	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	17, 227	0		2, 759, 085	404, 068	
	09700 DURABLE MEDICAL EQUIP SOLD 09910 CORF	0	0	0	0	0	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	SPECIAL PURPOSE COST CENTERS					0	
	10900 PANCREAS ACQUISITION	0	0	0	0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	0	0	0		110.00 111.00
	11300 I NTEREST EXPENSE		0	0	0	0	113.00
116.00	11600 HOSPI CE	4, 351	0	7, 277	1, 351, 309	197, 899	116.00
118.00		221, 455	62, 064	278, 437	40, 637, 330	5, 177, 036	118.00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9, 032	1 323	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	0	0	⁷ , 032		192.00
	07950 PATIENT TRANSPORT	0	0	0	283, 701		194.00
		1					
194.01	07951 SETON LEASE 1 NORTH 07952 REHAB (FSEH-E)	138	0	0	356, 560 58, 523	52, 218	194.01 194.02

Health Financial Systems	u of Form CMS-:	2552-10				
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150003 F	Period:	Worksheet B	
				rom 01/01/2014		
			[]	o 09/30/2014		
				1	2/27/2015 7:0	
Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	ADMI NI STRATI VE	
	RECEIVING AND		OUNTS		AND GENERAL	
	STORES		RECEI VABLE			
	5.03	5.04	5.05	5A. 05	5.06	
194.0407956 PSYCH (FSEH-E)	0	C	(33, 849	4, 957	194.04
194. 05 07955 VACANT SPACE	0	C	0 0	0 0	0	194.05
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	0	0	0 0	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	221, 593	62, 064	278, 437	41, 389, 279	5, 287, 159	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	ST. ELIZABE		CCN: 150003 P	In Lie eriod:	u of Form CMS- Worksheet B	2552-10
031 7	ALLOCATION - GENERAL SERVICE COSTS		FIONICE		rom 01/01/2014	Part I Date/Time Pre 2/27/2015 7:0	pared:
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11:00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.02	00550 DATA PROCESSI NG						5. 02
5.03	00561 PURCHASING RECEIVING AND STORES						5.03
5.04 5.05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04 5.05
5.05	00560 ADMI NI STRATI VE AND GENERAL						5.05
7.00	00700 OPERATION OF PLANT	3, 046, 486					7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	161, 809					8.00
9.00 10.00	01000 DI ETARY	92, 981 103, 752	35, 213 13, 412		777, 711		9.00 10.00
11.00	01100 CAFETERI A	61, 959			0	487, 201	
13.00	01300 NURSI NG ADMI NI STRATI ON	14, 479			0	8, 045	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	49, 307 36, 311	14, 117 0		0	0 12, 156	
16.00	01600 MEDICAL RECORDS & LIBRARY	38, 375	0		0	4, 679	
17.00	01700 SOCIAL SERVICE	0	0	-	0	2, 184	
20. 00 23. 00	02000 NURSI NG SCHOOL 02300 PARAMED ED PRGM	582, 665 4, 880	0	,	0	48, 913 10, 557	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1,000	C	2,207		10,007	20.00
30.00	03000 ADULTS & PEDI ATRI CS	320, 372			382, 070	56, 276	
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	52, 037 0	41, 752 0		96, 703 0	56, 528 0	
41.00	04200 SUBPROVI DER	0	0		0	0	
43.00	04300 NURSERY	0	0	0	0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	213, 631	25, 705		0	25, 440	
56. 00 56. 02	05600 RADI 0I SOTOPE 05602 MRI	42, 159	0		0	2, 640	
56.02	05603 ULTRASOUND	17,822 6,912			0	606 1, 676	
57.00	05700 CT SCAN	19, 800	0		0	5, 455	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 117, 027	4, 629	U U	0	0	59.00 60.00
60.01	06001 BLOOD LABORATORY	0	0		0	0	60.01
65.00	06500 RESPI RATORY THERAPY	32, 667	5, 118		0	14, 803	
66.00 68.00	06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY	121, 435 26, 379			0	72, 567 7, 820	
69.00	06900 ELECTROCARDI OLOGY	49,909		23, 409	0	10, 222	69.00
	07000 ELECTROENCEPHALOGRAPHY	39, 912	0	18, 720	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00	07400 RENAL DIALYSIS	148, 469		69, 638	0		74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76. 98
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 91.01	09100 EMERGENCY 09101 WOUND CARE	191, 896 104, 483			0	35, 324 22, 709	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	104, 403	10, 130	47,007	0	22, 707	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00 97.00	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP SOLD	38, 364			0	61, 932	95.00 97.00
97.00		0			0	0	
	SPECIAL PURPOSE COST CENTERS	-	-	-			
	10900 PANCREAS ACQUISITION	0	0	0	0		109.00
	0 11000 INTESTINAL ACQUISITION 0 11100 ISLET ACQUISITION	0		0	0		110. 00 111. 00
	11300 INTEREST EXPENSE				Ű	0	113.00
	11600 HOSPI CE	50, 468		23, 672	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	2, 740, 260	474, 340	1, 165, 792	478, 773	479, 762	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16, 339	0	7, 664	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
	07950 PATI ENT TRANSPORT 107951 SETON LEASE 1 NORTH	0	0	0	0		194. 00 194. 01
	207951 SETON LEASE T NORTH	89, 885 114, 018		53, 479	0 134, 377		194.01
194.03	307953 HHA (FSEH-E)	20, 037	0	0	0	0	194. 03
194.04	407956PSYCH (FSEH-E)	65, 947	0	30, 932	164, 561	0	194.04

Health Financial Systems	ST. ELIZABE	TH CENTRAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B		
				From 01/01/2014			
				To 09/30/2014			
					2/27/2015 7:0	<u>2 am</u>	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A		
	PLANT	LINEN SERVICE					
	7.00	8.00	9.00	10.00	11.00		
194. 05 07955 VACANT SPACE	0	0		0 0	0	194.05	
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)	3, 046, 486	474, 340	1, 257, 86	57 777, 711	487, 201	202.00	

Heal th	Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150003	Period: From 01/01/2014 To 09/30/2014		
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
	OFNERAL CERVICE COCT CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00550 DATA PROCESSI NG						5.02
5.03	00561 PURCHASING RECEIVING AND STORES						5.03
5.04							5.04
5.05 5.06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00560 ADMI NI STRATI VE AND GENERAL						5.05 5.06
7.00	00700 OPERATI ON OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00		(52,000					11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	652, 098 0	142, 987				13.00
15.00	01500 PHARMACY	0	0	1, 024, 83	5		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 221, 855		16.00
17.00	01700 SOCIAL SERVICE	0	0		0 0	110, 203	17.00
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	
23.00	02300 PARAMED ED PRGM	0	0		0 0	0	23.00
20 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	122 024	0		0 14, 131	7 020	30.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	132, 934 0	0		0 14, 131	7, 020	
41.00	04100 SUBPROVI DER – I RF	0	0		0 0,040	0	1
42.00	04200 SUBPROVI DER	0	0		0 0	0	
43.00	04300 NURSERY	0	0		0 0	0	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	
51.00 54.00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0 0 15,558	0 7, 729	51.00 54.00
56.00	05600 RADI OLOGI - DI AGNOSTI C	6, 474	0		0 15, 558	34	56.00
56.02	05602 MRI	0, 4, 4	0		0 3, 308		
56.03	05603 ULTRASOUND	0	0		0 2, 179		
57.00	05700 CT SCAN	0	0		0 18, 544	9, 212	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	•
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 60. 01		0	0		0 46,250 0 0	22, 967	60.00
65.00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	41, 849	0		0 3,902	0 1, 938	60.01 65.00
66.00	06600 PHYSI CAL THERAPY	130, 732	0		0 15, 596	7, 748	1
68.00	06800 SPEECH PATHOLOGY	19, 180	0		0 1, 963		
69.00	06900 ELECTROCARDI OLOGY	0	0		0 4, 658		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 3, 855		70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	142, 987		0 11, 961		71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	1, 024, 83	0 346 5 16,674		72.00
74.00	07400 RENAL DIALYSIS	0	0	1, 024, 03	0 1, 323		
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 3, 364		
	OUTPATIENT SERVICE COST CENTERS]
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
91.00 91.01	09100 EMERGENCY 09101 WOUND CARE	85, 863 36, 074	0		0 24, 133		•
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART)	30, 074	0		0 7, 569	3, 760	91.01
72.00	OTHER REIMBURSABLE COST CENTERS	II				I	72.00
95.00	09500 AMBULANCE SERVICES	152, 340	0		0 14, 026	6, 968	95.00
97.00	09700 DURABLE MEDICAL EQUIP SOLD	0	0		0 0		97.00
99. 10	09910 CORF	0	0		0 0	0	99.10
100 5	SPECIAL PURPOSE COST CENTERS		_		-	-	100.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	0		0 0		109.00 110.00
	11100 I SLET ACQUI SI TI ON	0	0				111.00
	11300 I NTEREST EXPENSE	0	0		0	0	113.00
	11600 H0SPI CE	46, 652	0		0 5, 800	2, 882	116.00
118.00		652, 098	142, 987	1, 024, 83			
	NONREI MBURSABLE COST CENTERS			1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.00
	07950 PATI ENT TRANSPORT 07951 SETON LEASE 1 NORTH	0	0				194.00 194.01
	07951 SETON LEASE T NORTH		0				194.01
	07953 HHA (FSEH-E)	0	0		0 0		194.02
		-		•	-		

Health Financial Systems		In Lieu of Form CMS-2552-10				
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150003	Peri od:	Worksheet B	
				From 01/01/2014		
				To 09/30/2014		
					2/27/2015 7:0	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	13.00	14.00	15.00	16.00	17.00	
194.04 07956 PSYCH (FSEH-E)	0	0		0 0	0	194.04
194. 05 07955 VACANT SPACE	0	0		0 0	0	194.05
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)	652, 098	142, 987	1, 024, 83	221, 855	110, 203	202.00

	Financial Systems	ST. ELI ZABET				u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 01/01/2014	Worksheet B Part I	
				T	0 09/30/2014	Date/Time Pre 2/27/2015 7:0	
	Cost Center Description	NURSING SCHOOL	PARAMED ED	Subtotal	Intern &	Total	
			PRGM		Residents Cost & Post		
					Stepdown		
		20.00	23.00	24.00	Adjustments 25.00	26.00	
	GENERAL SERVICE COST CENTERS	20.00	20.00	21.00	20.00	20.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.02	00550 DATA PROCESSI NG						5. 02
5.03	00561 PURCHASING RECEIVING AND STORES						5.03
5.04	00570 ADMI TTI NG						5.04
5.05 5.06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00560 ADMI NI STRATI VE AND GENERAL						5.05 5.06
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15.00 16.00
17.00	01700 SOCIAL SERVICE						17.00
	02000 NURSI NG SCHOOL	4, 857, 415					20.00
23.00	02300 PARAMED ED PRGM	0	537, 592				23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	4, 857, 415	0	8, 678, 819	-2, 369, 691	6, 309, 128	30.00
30.00	03100 I NTENSI VE CARE UNI T	4, 057, 415	0	2, 007, 871	-2, 309, 091	2,007,871	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43.00
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	2, 186, 228	0	2, 186, 228	
56.00 56.02	05600 RADI 0I SOTOPE 05602 MRI	0	0	579, 257 88, 232	0	579, 257 88, 232	56.00 56.02
56.03	05603 ULTRASOUND	0	0	178, 638	0	178, 638	1
57.00	05700 CT SCAN	0	0	617, 092	0	617, 092	1
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERIZATION	0	0	0	0	0	58.00 59.00
60.00	06000 LABORATORY	0	0	3, 980, 999	0	3, 980, 999	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPI RATORY THERAPY	0	0	1, 114, 186	0	1, 114, 186	
66. 00 68. 00	06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY	0	0	3, 309, 193	0	3, 309, 193 636, 274	
69.00	06900 ELECTROCARDI OLOGY	0	0	636, 274 1, 003, 121	0	1, 003, 121	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	550, 112	0	550, 112	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	1, 968, 250		1, 968, 250	
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0 311, 803	89, 935 2, 446, 935		89, 935 2, 446, 935	
	07400 RENAL DI ALYSI S	0	0	558, 767	0	558, 767	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	304, 739	0	304, 739	76.98
00.00				~			00.00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
91.00	09100 EMERGENCY	0	225, 789	2, 682, 611	0	2, 682, 611	
	09101 WOUND CARE	0	0	1, 688, 791		1, 688, 791	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	3, 454, 777	0	3, 454, 777	95.00
97.00	09700 DURABLE MEDICAL EQUIP SOLD	0	0	0	0	0	97.00
99. 10	09910 CORF	0	0	0	0	0	99.10
100 00	SPECIAL PURPOSE COST CENTERS		0	0	0	0	109.00
	11000 INTESTINAL ACQUISITION	0	0	0	0		1109.00
111.00	11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
	11300 INTEREST EXPENSE	_	_	4 /07 755	_	4 /07 7/7	113.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0 4, 857, 415	0 537, 592	1, 697, 702 39, 822, 529		1, 697, 702 37, 452, 838	
110.00	NONREI MBURSABLE COST CENTERS	4,007,410	557, 592	57, 022, 529		57, 452, 638	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	34, 358	0	34, 358	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	07950 PATI ENT TRANSPORT 07951 SETON LEASE 1 NORTH	0	0	325, 249 506, 102		325, 249 506, 102	
	10, 20, 10ETON LENGE I NORTH	<u>ו</u> ע	ų	300, 102	U U	500, 102	1, , 1, 01

Health Financial Systems	u of Form CMS-	2552-10				
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part I	
				To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
Cost Center Description	NURSING SCHOOL	PARAMED ED	Subtotal	Intern &	Total	
		PRGM		Residents Cost		
				& Post		
				Stepdown		
				Adjustments		
	20.00	23.00	24.00	25.00	26.00	
194.0207952REHAB (FSEH-E)	0	0	368, 96	B 0	368, 968	194.02
194.0307953HHA (FSEH-E)	0	0	31, 82	7 0	31, 827	194.03
194.0407956PSYCH (FSEH-E)	0	0	300, 24	6 0	300, 246	194.04
194. 05 07955 VACANT SPACE	0	0	(0 0	0	194.05
200.00 Cross Foot Adjustments	0	0	(0 0	0	200.00
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	4, 857, 415	537, 592	41, 389, 27	9 0	39, 019, 588	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS		H CENTRAL Provi der		eriod: com 01/01/2014	ı of Form CMS-2 Worksheet B Part II	2552-10
				To		Date/Time Pre 2/27/2015 7:0	
			CAPI TAL REL	ATED COSTS		2/2//2010 //0	
	Cost Center Description	Di rectl y Assi gned New Capi tal	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 946	629	7, 575	7, 575	4.00
5. 02	00550 DATA PROCESSI NG	0	7, 791	87, 549	95, 340	0	5.02
5.03	00561 PURCHASING RECEIVING AND STORES	0	62, 528	68, 631	131, 159	23	5.03
5.04 5.05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	8, 916 40, 961	1, 687 4, 176	10, 603 45, 137	16 33	5.04 5.05
5.05	00560 ADMINISTRATIVE AND GENERAL	990	224, 364	4, 178 34, 978	260, 332	207	5.05
7.00	00700 OPERATION OF PLANT	0	711, 561	97, 313	808, 874	213	7.00
3.00	00800 LAUNDRY & LINEN SERVICE	0	83, 053	15, 419	98, 472	15	8.00
9.00	00900 HOUSEKEEPING	0	47, 725	6, 846	54, 571	243	9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	0 122	53, 254 31, 802	21, 578 5, 504	74, 832 37, 428	130 127	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	7, 432	28, 285	35, 717	163	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	25, 308	23, 919	49, 227	0	14.00
15.00	01500 PHARMACY	167, 364	18, 638	19, 272	205, 274	204	15.00
	01600 MEDICAL RECORDS & LIBRARY	0	19, 697 0	1, 941 0	21, 638	49	
17.00 20.00	01700 SOCIAL SERVICE 02000 NURSING SCHOOL	0	299, 069	0 36, 779	335, 848	30 912	
	02300 PARAMED ED PRGM	0	2, 505	00,777	2, 505	89	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	164, 440	40, 672	205, 112	218	
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	0	26, 710	53, 418	80, 128 0	890 0	31.00 41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	0	0	0	0	
	ANCI LLARY SERVI CE COST CENTERS						50.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0	0	0	0	50.00 51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	990	109, 652	276, 313	386, 955	344	54.00
56.00	05600 RADI OI SOTOPE	3,000	21, 639	96, 406	121, 045	47	56.00
56. 02	05602 MRI	0	9, 148	1, 826	10, 974	10	56.02
56.03	05603 ULTRASOUND	0	3, 548	17, 410	20, 958	38	56.03
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10, 163	159, 632 0	169, 795 0	88 0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
50.00	06000 LABORATORY	0	60, 068	1, 829	61, 897	7	60.00
	06001 BLOOD LABORATORY	0	0	0	0	0	
55.00 56.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 10, 455	16, 767 62, 330	66, 055 65, 743	82, 822 138, 528	226 760	1
58. 00	06800 SPEECH PATHOLOGY	10, 433	13, 540	17,070	30, 610	148	68.00
59.00	06900 ELECTROCARDI OLOGY	495	25, 617	103, 965	130, 077	193	
	07000 ELECTROENCEPHALOGRAPHY	0	20, 486	41, 682	62, 168	108	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07400 RENAL DIALYSIS	0	76, 206	0	76, 206	4	74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
20 00	OUTPATIENT SERVICE COST CENTERS		~	~			00 00
38.00 39.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
91.00 91.00	09100 EMERGENCY	0	98, 496	53, 482	151, 978	464	91.00
	09101 WOUND CARE	0	53, 629	6, 198	59, 827	361	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	19, 691	50, 453	70, 144	719	95.00
	09300 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP SOLD	0	19,091	50, 453 N	, 0, 144 N	0	95.00
	09910 CORF	0	0	0	0	0	
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0	0	0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	0	0	0		110.00 111.00
	11300 I NTEREST EXPENSE		0	0	0	0	113.00
116.00	11600 HOSPI CE	0	25, 904	0	25, 904		116.00
118.00		183, 416	2, 469, 584	1, 506, 660	4, 159, 660	7,450	118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		8, 386	646	9, 032	0	190.00
100 00				040	9.032	0	1170.00
	19000 CANTEEN 19000 CANTEEN 19000 PHYSI CLANS' PRI VATE OFFICES	0	0, 500	0	0		192.00

Health Financial Systems	ST. ELI ZABET	TH CENTRAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014		
				To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
194.0107951 SETON LEASE 1 NORTH	0	46, 136	3, 04	9 49, 185	96	194.01
194.0207952 REHAB (FSEH-E)	0	58, 523		0 58, 523	0	194. 02
194.0307953 HHA (FSEH-E)	0	10, 284		0 10, 284	0	194.03
194.0407956 PSYCH (FSEH-E)	0	33, 849		0 33, 849	0	194.04
194. 05 07955 VACANT SPACE	0	0		0 0	0	194.05
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	183, 416	2, 626, 762	1, 546, 51	9 4, 356, 697	7, 575	202.00

Heal th	Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part II	
					o 09/30/2014	Date/Time Pre 2/27/2015 7:0	
	Cost Center Description	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND	ADMI TTI NG	CASHI ERI NG/ACC. OUNTS	ADMI NI STRATI VE AND GENERAL	
			STORES		RECEI VABLE		
	GENERAL SERVICE COST CENTERS	5.02	5.03	5.04	5.05	5.06	
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.02	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING	95, 340					4.00 5.02
5.02	00561 PURCHASING RECEIVING AND STORES	638					5.02
	00570 ADMI TTI NG	493		11, 116			5.04
1	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00560 ADMI NI STRATI VE AND GENERAL	1, 062 2, 937				263, 809	5.05 5.06
	00700 OPERATION OF PLANT	2, 204			0	19, 417	7.00
	00800 LAUNDRY & LINEN SERVICE	183			-	1,992	8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY	5, 308 2, 934			-	7, 200 3, 900	9.00 10.00
	01100 CAFETERI A	3, 082	298		0	2, 525	11.00
1	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 263			0	3, 969 360	13.00 14.00
	01500 PHARMACY	1,909	-			6, 114	15.00
1	01600 MEDI CAL RECORDS & LI BRARY	735		C	0 0	1, 025	16.00
	01700 SOCIAL SERVICE 02000 NURSING SCHOOL	343 7,680				688 25, 204	17.00 20.00
	02300 PARAMED ED PRGM	1, 658			-	3, 313	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	8, 836 8, 876				16, 283 11, 004	30. 00 31. 00
	04100 SUBPROVI DER – I RF	0,070	0	1, 042		0	41.00
	04200 SUBPROVI DER	C	0	C		0	42.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	C	0	C	0 0	0	43.00
	05000 OPERATI NG ROOM	C	0	C	0	0	50.00
	05100 RECOVERY ROOM	C	0	C	, si	0	51.00
	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	3, 994 414				11, 459 3, 238	54.00 56.00
	05602 MRI	95		267		360	56.02
	05603 ULTRASOUND	263				1,042	56.03
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	856				3, 536 0	57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	C	0	C	-	0	59.00
		C	7, 715	2, 380	9, 657	23, 807	60.00
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	2, 324	10, 847	547	815	0 6, 365	60. 01 65. 00
66.00	06600 PHYSI CAL THERAPY	11, 397	24, 014	124	3, 258	18, 324	66.00
	06800 SPEECH PATHOLOGY	1,228		114 273		3,618	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 605 C				5, 809 3, 096	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	889		11, 519	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS		0	47 1, 853		570 6, 918	
	07400 RENAL DIALYSIS	33	237			2, 157	74.00
	07698 HYPERBARI C OXYGEN THERAPY	C	0	80	703	1, 910	76. 98
	OUTPATIENT SERVICE COST CENTERS	0	0			0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0	C	0	0	89.00
	09100 EMERGENCY 09101 WOUND CARE	5, 546				12, 335	91.00
	09101 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 566	19, 340	17	1, 581	9, 223	91. 01 92. 00
	OTHER REIMBURSABLE COST CENTERS	1	1	1			,2,00
	09500 AMBULANCE SERVICES	9, 724				20, 161	95.00
	09700 DURABLE MEDICAL EQUIP SOLD 09910 CORF		0			0	97.00 99.10
	SPECIAL PURPOSE COST CENTERS	-	-				
	10900 PANCREAS ACQUISITION	C	0	C	0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION		0				110. 00 111. 00
113.00	11300 INTEREST EXPENSE						113.00
116. 00 118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	2, 986 94, 172			0 1, 212 46, 340	9, 874 258, 315	116.00
+	NONREIMBURSABLE COST CENTERS	74,172	1 131,738	1 11, 11 0	40, 340	200, 315	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	C	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 PATIENT TRANSPORT		0				192. 00 194. 00
194.01	07951 SETON LEASE 1 NORTH	1, 168	82		0	2,605	194.01
	07952 REHAB (FSEH-E)	C	0		0		194.02
194.03	07953 HHA (FSEH-E)	C	0	1 C	ן 0	75	194. 03

Health Financial Systems	ST. ELIZABE	TH CENTRAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
				From 01/01/2014 To 09/30/2014		nared
				10 077 307 2014	2/27/2015 7:0	
Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	ADMI NI STRATI VE	
	PROCESSI NG	RECEIVING AND		OUNTS	AND GENERAL	
		STORES		RECEI VABLE		
	5.02	5.03	5.04	5.05	5.06	
194.0407956 PSYCH (FSEH-E)	0	0		0 0	247	194.04
194. 05 07955 VACANT SPACE	0	0		0 0	0	194.05
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)	95, 340	131, 820	11, 11	6 46, 340	263, 809	202.00

14.00 01400 CENTRAL SERVICES & SUPPLY 13,450 4,311 1,9 15.00 01500 PHARMACY 9,905 0 1,4 16.00 01600 MEDI CAL RECORDS & LI BRARY 10,468 0 1,5 17.00 01700 SOCI AL SERVICE 0	10.00 10.00 16 63 63 118,899 26 67 63 118,899 26 67 63 118,899 26 67 63 118,899 60 0<	$\begin{array}{c} 62, 787\\ 11.0\\ 0\\ 1, 037\\ 13.0\\ 0\\ 0\\ 1, 567\\ 15.0\\ 0\\ 0\\ 0\\ 1, 567\\ 15.0\\ 0\\ 0\\ 0\\ 0\\ 1, 567\\ 15.0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0$
TODO B.00 9.00 I 001 OO100 NEW CAP REL COST CENTERS 0 <th>16 63 118, 899 26 0 67 0 22 00 03 0 0 0 45 58, 412 38 14, 784 0 0</th> <th>$\begin{array}{c ccccccccccccccccccccccccccccccccccc$</th>	16 63 118, 899 26 0 67 0 22 00 03 0 0 0 45 58, 412 38 14, 784 0 0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MUNE E COULP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.02 00550 DATA PROCESSI NG 5.03 00561 PURCHASING RECEIVING AND STORES 5.04 00570 ADMITTING RECEIVABLE 5.06 00580 CASHI ERING/ACCOUNTS RECEIVABLE 5.06 00560 PURCHASING RECEIVING AND STORES 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 44.138 144, 848 9.00 00900 HOUSEKEEPING 1.100 01100 CAFETERIA 1.100 01100 CAFETERIA 1.100 01100 CAFETERIA 1.100 01000 NURSING ADMINISTRATION 3.00 01300 NURSING ADMINISTRATION 3.00 01300 NURSING SCHOOL 1.100 01400 CENTRAL SERVICES & SUPPLY 1.1100 01400 CONTRAL SERVICE 0.1140 1.131 0.124 01400 CONTRAL SERVICE 0.124 01400 CONTRAL SERVICE 0.125 01160 0.1260	63 118, 899 26 0 67 0 22 00 03 0 0 0 45 58, 412 38 14, 784 0 0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$
2.00 002001 NEW CAP REL COSTS-MVBLE EQUIP 4.00 004000 EMPLOYEE BENIFFI TS DEPARTMENT 5.02 005501 DATA PROCESSI NG 5.03 00561 PURCHASI NG RECEI VI NG AND STORES 5.04 00570 ADMI TITI NG CONDREMONDER 5.06 00560 CASHI ERI NG/ACCOUNTS RECEI VABLE 7.00 00700 (PERATI ON OF PLANT 831, 014 8.00 00800 LAUNDRY & LI NEN SERVI CE 44, 138 144, 848 7.00 010000 LAUNDRY & LI NEN SERVI CE 44, 138 144, 946 7.00 010000 LAUNDRY & LI NEN SERVI CE 44, 131 14, 484 7.00 010000 CAFETERI A 16, 901 0 2.4 11.00 01100 CAFETERI A 16, 905 0 1.4 16.00 01600 CENTRAL SERVI CE & S UBPLY 13, 450 4, 311 1.5 11.00 01700 SOCI AL SERVI CE 168, 936 0 2.6 17.00 01700 SOCI AL SERVI CE 188, 936 0 2.6 10.00 00000 ADULTS & PEDI ATRI CS 87, 390	63 118, 899 26 0 67 0 22 00 03 0 0 0 45 58, 412 38 14, 784 0 0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$
23.00 O2300 PARAMED ED PRGM 1, 331 0 1 0.00 O3000 ADULTS & PEDI ATRICS 87, 390 62, 152 12, 5 31.00 O3100 INTENSI VE CARE UNI T 14, 195 12, 750 2, 0 41.00 O4100 SUBPROVI DER - I RF 0 0 0 43.00 O4300 NURSERY 0 0 0 ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 50.00 O5400 RADI OLOGY-DI AGNOSTI C 58, 274 7, 850 8, 3 54.00 O5400 RADI OLOGY-DI AGNOSTI C 58, 274 7, 850 8, 3 55.00 O5602 MRI 4, 862 0 6 2 57.00 O5700 CT SCAN 5, 401 0 7 58.00 OS600 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 60.01 O6000 LABORATORY 31, 922 1, 413 4, 5 60.01 D6000 LABORATORY 0 0 0	91 C 45 58, 412 38 14, 784 0 0 0 0 <t< td=""><td>$\begin{array}{c ccccccccccccccccccccccccccccccccccc$</td></t<>	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 87, 390 62, 152 12, 5 31. 00 03100 INTENSI VE CARE UNI T 14, 195 12, 750 2, 0 41. 00 04100 SUBPROVI DER 0 0 0 42. 00 04200 SUBPROVI DER 0 0 0 ANCI LLARY SERVI CE COST CENTERS 0 0 0 ANCI LLARY SERVI CE COST CENTERS 0 0 0 50. 00 05100 RECOVERY ROOM 0 0 0 54. 00 05400 RADI OLGY-DI AGNOSTI C 58, 274 7, 850 8, 3 56. 00 05602 MRI 4, 862 0 6 56. 02 05602 MRI 4, 862 0 6 57. 00 05700 CT SCAN 5, 401 0 7 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 59. 00 058000 CARDI ACATHETERI ZATI ON 0 0 0 0 59. 00 058000 CARDI ACATHETERI ZATI ON 0<	45 58, 412 38 14, 784 0 0 <tr< td=""><td>$\begin{array}{c ccccccccccccccccccccccccccccccccccc$</td></tr<>	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$
30.00 03000 ADULTS & PEDI ATRI CS 87, 390 62, 152 12, 50 31.00 03100 INTENSI VE CARE UNI T 14, 195 12, 750 2, 0 41.00 04100 SUBPROVI DER - I RF 0 0 0 42.00 04200 SUBPROVI DER 0 0 0 43.00 04300 NURSERY 0 0 0 ANCI LLARY SERVICE COST CENTERS 0 0 0 0 ANCI LLARY SERVICE COST CENTERS 0 0 0 0 50.00 05000 OPERATI NG ROOM 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 58, 274 7, 850 8, 3 56.00 05602 IRI 4, 862 0 6 6 6 6 6 6 6 6 6 6 6 6 7 7 8 0 0 7 58.00 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 6 6 6 6 0 0 0 0<	38 14, 784 0 0 0	4 7,285 31.0 0 0 41.0 0 0 42.0 0 0 42.0 0 0 43.0 0 0 50.0 0 0 51.0 0 3,279 54.0 0 340 56.0 0 703 57.0 0 703 57.0 0 0 58.0 0 0 59.0 0 0 60.0 0 0 60.0
50.00 05000 OPERATING ROOM 0 0 51.00 05100 RECOVERY ROOM 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 58, 274 7, 850 8, 3 56.00 05600 RADI OL SOTOPE 11, 500 0 1, 6 56.02 05602 MRI 4, 862 0 6 56.03 05603 ULTRASOUND 1, 885 0 2 57.00 05700 CT SCAN 5, 401 0 7 58.00 05800 MACNETI C RESONANCE I MAGI NG (MRI) 0 0 0 60.01 06000 LABORATORY 31, 922 1, 413 4, 5 60.01 06000 LABORATORY 0 0 0 65.00 06500 RESPI RATORY THERAPY 8, 911 1, 563 1, 2 66.00 06600 PHYSI CAL THERAPY 33, 125 8, 922 4, 7 68.00 06800 SPEECH PATHOLOGY 7, 196 0	0 0 66 0 51 0 98 0 75 0 0 0 83 0 79 0 55 0 33 0 54 0	0 51.0 3,279 54.0 340 56.0 78 56.0 216 56.0 703 57.0 0 0 0 703 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
54.00 05400 RADI OLOGY-DI AGNOSTI C 58, 274 7, 850 8, 33 56.00 05600 RADI OI SOTOPE 11, 500 0 1, 6 56.02 05602 MRI 4, 862 0 6 56.03 05603 ULTRASOUND 1, 885 0 2 57.00 05700 CT SCAN 5, 401 0 7 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60.01 06000 LABORATORY 31, 922 1, 413 4, 55 60.01 06001 BLOOD LABORATORY 0 0 0 65.00 06500 RESPI RATORY THERAPY 8, 911 1, 563 1, 2 66.00 06600 PHYSI CAL THERAPY 33, 125 8, 922 4, 7 68.00 06800 SPEECH PATHOLOGY 7, 196 0 1, 5 70.00 07000 ELCTROCARDI OLOGY 13, 614 356 1, 5 71.00 <td< td=""><td>66 C 51 C 98 C 71 C 0 C 0 C 83 C 0 C 83 C 79 C 55 C 33 C 55 C 55 C</td><td>3, 279 54. 0 340 56. 0 78 56. 0 216 56. 0 703 57. 0 0 0 58. 0 0 0 59. 0 0 0 59. 0 0 0 60. 0 0 0 60. 0</td></td<>	66 C 51 C 98 C 71 C 0 C 0 C 83 C 0 C 83 C 79 C 55 C 33 C 55 C 55 C	3, 279 54. 0 340 56. 0 78 56. 0 216 56. 0 703 57. 0 0 0 58. 0 0 0 59. 0 0 0 59. 0 0 0 60. 0 0 0 60. 0
56.00 05600 RADI 0I SOTOPE 11, 500 0 1, 6 56.02 05602 MRI 4, 862 0 6 56.03 05603 ULTRASOUND 1, 885 0 2 57.00 05700 CT SCAN 5, 401 0 7 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 60.01 06001 LABORATORY 31, 922 1, 413 4, 5 60.01 06001 BLOOD LABORATORY 0 0 0 65.00 06500 RESPI RATORY THERAPY 8, 911 1, 563 1, 2 66.00 06600 PHYSI CAL THERAPY 33, 125 8, 922 4, 7 68.00 06800 SPEECH PATHOLOGY 7, 196 0 1, 6 69.00 069000 ELCTROCARDI 0LOGY 13, 614 356 1, 5 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI EN	51 C 98 C 71 C 75 C 0 C 83 C 0 C 79 C 55 C 33 C 54 C	340 56.0 78 56.0 78 56.0 216 56.0 703 57.0 0 58.0 0 59.0 0 60.0 0 60.0 0 60.0 0 60.0
56. 02 05602 MRI 4,862 0 6 56. 03 05603 ULTRASOUND 1,885 0 2 57. 00 05700 CT SCAN 5,401 0 7 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 7 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 01 06000 LABORATORY 31,922 1,413 4,5 60. 01 06001 BLOOD LABORATORY 0 0 0 65. 00 06500 RESPI RATORY THERAPY 8,911 1,563 1,2 66. 00 06600 PHYSI CAL THERAPY 33,125 8,922 4,7 68. 00 06800 SPEECH PATHOLOGY 7,196 0 1,0 69. 00 06900 ELECTROCARDI OLOGY 13,614 356 1,5 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 74. 00	98 C 71 C 75 C 0 C 83 C 0 C 79 C 55 C 33 C 54 C	78 56.0 216 56.0 703 57.0 58.0 58.0 0 59.0 0 60.0 0 60.0
57.00 05700 CT SCAN 5,401 0 7 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 60.00 06000 LABORATORY 31,922 1,413 4,5 60.01 06001 BLOOD LABORATORY 0 0 0 65.00 06500 RESPI RATORY THERAPY 8,911 1,563 1,2 66.00 06600 PHYSI CAL THERAPY 8,911 1,563 1,2 66.00 06600 PHYSI CAL THERAPY 33,125 8,922 4,7 68.00 066800 SPEECH PATHOLOGY 7,196 0 1,0 69.00 06900 ELECTROCARDI OLOGY 13,614 356 1,9 70.00 07000 ELECTROENCEPHALOGRAPHY 10,887 0 1,5 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 07200 I IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0	75 C 0 C 83 C 0 C 79 C 55 C 33 C 54 C	703 57.0 0 58.0 0 59.0 0 60.0 0 60.0
58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 60.00 06000 LABORATORY 31,922 1,413 4,5 60.01 06001 BLOOD LABORATORY 0 0 65.00 06500 RESPI RATORY THERAPY 8,911 1,563 1,2 66.00 06600 PHYSI CAL THERAPY 33,125 8,922 4,7 68.00 06600 SPEECH PATHOLOGY 7,196 0 1,0 69.00 66900 ELECTROCARDI OLOGY 13,614 356 1,9 70.00 07000 ELECTROENCEPHALOGRAPHY 10,887 0 1,5 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 07200 I IMPL. DEV. CHARGED TO PATI ENT 0 0 74.00 07400 RNAL DI ALYSI S 40,499 0 5,8 76.98 </td <td>0 0 0 0 83 0 0 0 79 0 55 0 33 0 54 0</td> <td>0 58.0 0 59.0 0 60.0 0 60.0</td>	0 0 0 0 83 0 0 0 79 0 55 0 33 0 54 0	0 58.0 0 59.0 0 60.0 0 60.0
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 60.00 06000 LABORATORY 31,922 1,413 4,5 60.01 06001 BLOOD LABORATORY 0 0 0 65.00 06500 RESPI RATORY THERAPY 8,911 1,563 1,2 66.00 06600 PHYSI CAL THERAPY 33,125 8,922 4,7 68.00 06600 SPECH PATHOLOGY 7,196 0 1,6 69.00 66900 ELECTROCARDI OLOGY 13,614 356 1,9 70.00 07000 ELECTROENCEPHALOGRAPHY 10,887 0 1,5 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 74.00 07400 RENAL DI ALYSI S 40,499 0 5,8 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 <td>0 0 83 0 79 0 55 0 33 0 54 0</td> <td>0 59.0 0 60.0 0 60.0</td>	0 0 83 0 79 0 55 0 33 0 54 0	0 59.0 0 60.0 0 60.0
60.00 06000 LABORATORY 31,922 1,413 4,5 60.01 06001 BLOOD LABORATORY 0 0 65.00 06500 RESPI RATORY THERAPY 8,911 1,563 1,2 66.00 06600 PHYSI CAL THERAPY 33,125 8,922 4,7 68.00 06800 SPEECH PATHOLOGY 7,196 0 1,0 69.00 06900 ELECTROCARDI OLOGY 13,614 356 1,5 70.00 07000 ELECTROENCEPHALOGRAPHY 10,887 0 1,5 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.00 07400 RENAL DI ALYSI S 40,499 0 5,8 0 0 0 0 0 0 0	0 0 79 0 55 0 33 0 54 0	0 60.0 0 0 60.0
65.00 06500 RESPI RATORY THERAPY 8,911 1,563 1,2 66.00 06600 PHYSI CAL THERAPY 33,125 8,922 4,7 68.00 06800 SPECH PATHOLOGY 7,196 0 1,0 69.00 06900 ELECTROCARDI OLOGY 13,614 356 1,9 70.00 O7000 ELECTROENCEPHALOGRAPHY 10,887 0 1,5 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73.00 07400 RENAL DI ALYSI S 40,499 0 5,8 076.98 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINI C 0 0	79 C 55 C 33 C 54 C	
66.00 06600 PHYSI CAL THERAPY 33,125 8,922 4,7 68.00 06800 SPEECH PATHOLOGY 7,196 0 1,0 69.00 06900 ELECTROCARDI OLOGY 13,614 356 1,9 70.00 O7000 ELECTROENCEPHALOGRAPHY 10,887 0 1,5 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.00 07400 RENAL DI ALYSI S 40,499 0 5,8 0 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINI C 0 0	55 C 33 C 54 C) <u>1908</u> 165 0
68.00 06800 SPEECH PATHOLOGY 7, 196 0 1, 0 69.00 06900 ELECTROCARDI OLOGY 13, 614 356 1, 5 70.00 07000 ELECTROENCEPHALOGRAPHY 10, 887 0 1, 5 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.00 07400 RENAL DI ALYSI S 40, 499 0 5, 8 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINI C 0 0	33 C 54 C	9, 351 66. 0
69.00 06900 ELECTROCARDI OLOGY 13,614 356 1,9 70.00 07000 ELECTROENCEPHALOGRAPHY 10,887 0 1,5 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.00 07400 RENAL DI ALYSI S 40,499 0 5,8 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0UTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0	54 C	1,008 68.0
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.00 07400 RENAL DI ALYSI S 40,499 0 5,8 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0UTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0		1, 317 69. 0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 74.00 07400 RENAL DI ALYSI S 40,499 0 5,8 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0	53 C	0 70.0
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 74.00 07400 RENAL DI ALYSI S 40,499 0 5,8 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0	0 0	0 71.0 0 72.0
74. 00 07400 RENAL DI ALYSI S 40, 499 0 5, 8 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0	0 (0 73.0
OUTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0	14 C	27 74.0
88.00 08800 RURAL HEALTH CLINIC 0 0	0 0	0 76.9
	0 (0 88.0
	0 0	0 89.0
91. 00 09100 EMERGENCY 52, 345 25, 137 7, 5		4, 552 91.0
91. 01 09101 WOUND CARE 28, 501 5, 545 4, 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2, 927 91.0
OTHER REIMBURSABLE COST CENTERS		/2.0
95. 00 09500 AMBULANCE SERVICES 10, 465 0 1, 5		
97. 00 09700 DURABLE MEDI CAL EQUI P SOLD 0 0	0 0	
99. 10 09910 CORF 0 0	0 0	0 99.1
109. 00 10900 PANCREAS ACQUI SI TI ON 0 0	0 (0 109. 0
110.00 11000 INTESTINAL ACQUISITION 0 0	0 0	0 110. 0
111.00 11100 I SLET ACQUI SI TI ON 0 0	0 0	0 111.0
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE 13, 767 0 1, 9	76 (2, 451 116. 0
118.00 SUBTOTALS (SUM OF LINES 1-117) 747, 482 144, 848 97, 3		
NONREI MBURSABLE COST CENTERS		
190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 4, 457 0 6 192. 00 19200 PHYSI CI ANS' PRI VATE 0FFI CES 0 0	40 0	0 190.0 0 192.0
192.00 07950 PATIENT TRANSPORT 0 0	0 (0 0 192.0
194.01 07951 SETON LEASE 1 NORTH 24,519 0	0 0	959 194. 0
194. 02 07952 REHAB (FSEH-E) 31, 101 0 4, 4	65 20, 544	4 0 194.0 0 194.0
194. 03 07953 HHA (FSEH-E) 5, 466 0 194. 04 07956 PSYCH (FSEH-E) 17, 989 0 2, 5		1 01404 0

Health Financial Systems	ST. ELIZABET	TH CENTRAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150003	Period:	Worksheet B	
				From 01/01/2014		
				To 09/30/2014		
					2/27/2015 7:0	<u>2 am</u>
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI N	G DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7.00	8.00	9.00	10.00	11.00	
194. 05 07955 VACANT SPACE	0	0		0 0	0	194.05
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)	831, 014	144, 848	105, 0 ⁻	16 118, 899	62, 787	202.00

Heal th	Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	eriod: rom 01/01/2014 o 09/30/2014		
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	RECORDS &	2/27/2015 7:0 SOCIAL SERVICE	<u>2 am</u>
		13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	17.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	10.00	10.00	17.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00550 DATA PROCESSING						5.02
5.03 5.04	00561 PURCHASING RECEIVING AND STORES						5.03
5.04 5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04 5.05
5.06	00560 ADMI NI STRATI VE AND GENERAL						5.06
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00		A((/7					11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	46, 667 0	69, 279				13.00 14.00
15.00	01500 PHARMACY	0	07,277	232, 099			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	36, 024		16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	1, 342	17.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	
23.00	02300 PARAMED ED PRGM	0	0	0	0	0	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0 512	0	0	2, 292	83	30.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	9, 513 0	0		2, 292	39	
41.00	04100 SUBPROVI DER – I RF	0	0	0	1,070	0	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
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0 0		0	0	
51.00 54.00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	0		2, 523	0 92	51.00 54.00
56.00	05600 RADI OI SOTOPE	463	0	0	2, 525	0	56.00
56.02	05602 MRI	0	0	0	537	20	
56.03	05603 ULTRASOUND	0	0	0	353	13	56.03
57.00	05700 CT SCAN	0	0	0	3, 008	110	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	0	0	0 302	59.00 60.00
60.00	06001 BLOOD LABORATORY	0	0		7, 541	0	60.00
65.00	06500 RESPI RATORY THERAPY	2, 995	0	0	633	23	65.00
66.00	06600 PHYSI CAL THERAPY	9, 356	0	0	2, 530	92	66.00
68.00	06800 SPEECH PATHOLOGY	1, 373	0	0	318	12	
	06900 ELECTROCARDI OLOGY	0	0	0	756		69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 69, 279		625 1, 940	23	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	07,277		56	2	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	232, 099		- 99	
74.00	07400 RENAL DIALYSIS	0	0	0	215	8	74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	546	20	76. 98
00.00		0	0	0	0	0	
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
91.00	09100 EMERGENCY	6, 145	0	0	3, 914	143	
91.01	09101 WOUND CARE	2, 582	0	0	1, 228		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	I		1			
95.00	09500 AMBULANCE SERVICES	10, 901	0		2, 275	83	
	09700 DURABLE MEDICAL EQUIP SOLD 09910 CORF	0	0		0	0	97.00 99.10
77. IU	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	0	0	99.10
109.00	10900 PANCREAS ACQUI SI TI ON	0	0	0	0	0	109.00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
	11300 INTEREST EXPENSE	0.05	_	-		- · ·	113.00
116.00 118.00	11600 HOSPICE	3, 339	0	0 222 000	941		116. 00 118. 00
118.UU	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	46, 667	69, 279	232, 099	36, 024	1, 342	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
194.00	07950 PATIENT TRANSPORT	0	0	0	0		194.00
	07951 SETON LEASE 1 NORTH	0	0	0	0		194.01
	07952 REHAB (FSEH-E) 07953 HHA (FSEH-E)	0	0		0		194. 02 194. 03
194.03		<u> </u>	0	I 0	0	0	1174.03

Health Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150003	Peri od:	Worksheet B	
				From 01/01/2014		
				To 09/30/2014		
					2/27/2015 7:0	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	13.00	14.00	15.00	16.00	17.00	
194.04 07956 PSYCH (FSEH-E)	0	0		0 0	0	194.04
194. 05 07955 VACANT SPACE	0	0		0 0	0	194.05
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)	46, 667	69, 279	232, 09	9 36, 024	1, 342	202.00

Heal th	Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	veriod: rom 01/01/2014 o 09/30/2014	Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	NURSI NG SCHOOL	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	<u>2/27/2015</u> 7:0. Total	2 am
		20.00	23.00	24.00	25.00	26.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00561 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHI ERING/ACCOUNTS RECEIVABLE 00560 ADMINI STRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINI STRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02000 NURSING SCHOOL	558, 188					$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 5. \ 05\\ 5. \ 06\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 20. \ 00\\ \end{array}$
23.00	02300 PARAMED ED PRGM		10, 457				23.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY			484, 234 171, 898 C C C	0 0 0	484, 234 171, 898 0 0 0	30. 00 31. 00 41. 00 42. 00 43. 00
45.00	ANCI LLARY SERVICE COST CENTERS				0	0	43.00
$\begin{array}{c} 51.\ 00\\ 54.\ 00\\ 56.\ 02\\ 56.\ 03\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 65.\ 00\\ 66.\ 00\\ 68.\ 00\\ 69.\ 00\\ \end{array}$	05000 OPERATING ROOM 05100 RECOVERY ROOM 05400 RADIOLOGY-DIAGNOSTIC 05600 RADIOISOTOPE 05602 MRI 05603 ULTRASOUND 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06000 LABORATORY 06000 DLOBORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY			C 495, 652 138, 949 18, 596 25, 883 192, 539 C 151, 224 264, 536 47, 116 157, 396 79, 323		$\begin{array}{c} 0\\ 0\\ 495, 652\\ 138, 949\\ 18, 596\\ 25, 883\\ 192, 539\\ 0\\ 0\\ 151, 224\\ 0\\ 151, 224\\ 0\\ 121, 258\\ 264, 536\\ 47, 116\\ 157, 396\\ 79, 323\\ \end{array}$	66. 00 68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			86, 197	1	79, 323 86, 197	
72.00 73.00 74.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07698 HYPERBARIC 0XYGEN THERAPY 0UTPATIENT SERVICE COST CENTERS			747 247, 156 125, 671 3, 259	0 0 0	747 247, 156 125, 671 3, 259	72.00
	08800 RURAL HEALTH CLINIC			C	0	0	88.00
91. 00 91. 01	08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY 09101 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			0 283, 221 138, 834	1 1	0 283, 221 138, 834	89.00 91.00 91.01 92.00
97.00	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP SOLD 09910 CORF SPECIAL PURPOSE COST CENTERS			147, 133 C C	0	147, 133 0 0	95. 00 97. 00 99. 10
110. 00 111. 00 113. 00	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0	0	C C C 65, 443 3, 446, 265		0	
192.00 194.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 PATI ENT TRANSPORT 07951 SETON LEASE 1 NORTH			14, 195 C 38, 266 78, 614	0		192. 00 194. 00

Health Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part II	
				To 09/30/2014	Date/Time Pre	
					2/27/2015 7:0	<u>2 am</u>
Cost Center Description	NURSING SCHOOL	PARAMED ED	Subtotal	Intern &	Total	
		PRGM		Residents Cost		
				& Post		
				Stepdown		
				Adjustments		
	20.00	23.00	24.00	25.00	26.00	
194.0207952 REHAB (FSEH-E)			115, 06	1 0	115, 061	194.02
194.0307953 HHA (FSEH-E)			15, 82	5 0	15, 825	194.03
194.0407956 PSYCH (FSEH-E)			79, 82	6 0	79, 826	194.04
194.0507955 VACANT SPACE			(0 0	0	194.05
200.00 Cross Foot Adjustments	558, 188	10, 457	568, 64	5 0	568, 645	200.00
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	558, 188	10, 457	4, 356, 69	7 0	4, 356, 697	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	ST. ELIZABET			eri od:	u of Form CMS-: Worksheet B-1	2552-10
				Fi To	rom 01/01/2014 0 09/30/2014	Date/Time Pre	
		CAPITAL REL	ATED COSTS			2/27/2015 7:0	2 am
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MANHRS)	PURCHASI NG RECEI VI NG AND STORES (COSTED REQUI STI ON)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5. 02	5.03	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 20.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00561 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHI ERING/ACCOUNTS RECEIVABLE 00560 ADMINISTRATIVE AND GENERAL 005700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02000 NURSING SCHOOL	476, 090 1, 259 1, 412 11, 333 1, 616 7, 424 40, 665 128, 968 15, 053 8, 650 9, 652 5, 764 1, 347 4, 587 3, 378 3, 570 0 54, 205	555, 462 226 31, 445 24, 650 606 1, 500 12, 563 34, 952 5, 538 2, 459 7, 750 1, 977 10, 159 8, 591 6, 922 697 0 13, 210	15, 985, 711 0 48, 585 34, 469 70, 269 436, 025 448, 320 31, 160 511, 646 274, 156 266, 914 343, 040 0 429, 754 102, 807 64, 077 1, 932, 436	727, 809 4, 871 3, 763 8, 108 22, 424 16, 826 1, 400 40, 523 22, 398 23, 528 9, 643 0 14, 571 5, 608 2, 618 58, 628	1, 208, 361 38 990 3, 057 2, 801 444 14, 468 5, 894 2, 731 8 0 52, 289 28 0 4, 455	11.00 13.00 14.00 15.00 16.00 17.00 20.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	454	0	186, 916	12, 654	79	23.00
30.00 31.00 41.00 42.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	29,804 4,841 0 0 0	14, 608 19, 186 0 0 0	460, 270 1, 876, 718 0 0 0	67, 453 67, 756 0 0 0	83, 795 150, 344 0 0 0	41.00 42.00
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 54.\ 00\\ 56.\ 02\\ 56.\ 02\\ 56.\ 03\\ 57.\ 00\\ 59.\ 00\\ 60.\ 01\\ 65.\ 00\\ 60.\ 01\\ 65.\ 00\\ 66.\ 00\\ 68.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ $	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE 05602 MRI 05603 ULTRASOUND 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06000 BLOOD LABORATORY 06000 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07608 HYPERBARI C OXYGEN THERAPY 00TPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09100 EMERGENCY 09101 WOUND CARE 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0 0 19, 874 3, 922 1, 658 643 1, 842 0 0 0 10, 887 0 3, 039 11, 297 2, 454 4, 643 3, 713 0 0 0 13, 812 0 0 17, 852 9, 720	0 99, 243 34, 626 656 6, 253 57, 335 0 0 23, 725 23, 6131 37, 341 14, 971 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 726, 116 99, 436 20, 543 79, 720 185, 562 0 15, 756 0 476, 651 1, 603, 218 312, 901 407, 662 227, 033 0 0 9, 284 0 9 979, 120 761, 594	0 30, 493 3, 164 726 2, 009 6, 538 0 0 0 0 17, 743 86, 981 9, 373 12, 252 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 83, 356 2, 076 39 2, 556 34, 769 0 70, 723 0 99, 436 220, 121 437 4, 039 0 0 0 2, 169 0 71, 516 177, 283	56.00 56.02 56.03 57.00 58.00 59.00 60.01 65.00 66.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 76.98 88.00 89.00 91.00
95. 00 97. 00 99. 10	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP SOLD 09910 CORF	3, 569 0 0	18, 121 0 0	1, 517, 717 0 0	74, 233 0 0	93, 939 0 0	
110.00 111.00 113.00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0 0 4, 695 447, 602	0 0 0 541, 146	0 0 0 782, 239 15, 722, 114	0 0 0 22, 798 718, 893	0	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 520 0	232 0	0 0	0		190. 00 192. 00

Health Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 01/01/2014 To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
	CAPI TAL REL	ATED COSTS				
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	DATA PROCESSING (MANHRS)	PURCHASI NG RECEI VI NG AND STORES (COSTED REQUI STI ON)	
	1.00	2.00	4.00	5. 02	5.03	
194. 00 07950 PATI ENT TRANSPORT	0	12, 989				194.00
194.01 07951 SETON LEASE 1 NORTH	8, 362	1, 095	202, 32	2 8, 916		194.01
194.0207952 REHAB (FSEH-E)	10, 607	0	(0 0		194. 02
194.0307953HHA (FSEH-E)	1, 864	0	(0 0		194.03
194.04 07956 PSYCH (FSEH-E)	6, 135	0	(0 0		194.04
194. 05 07955 VACANT SPACE	0	0	(0 0		194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 626, 762	1, 546, 519	7, 195, 94	B 240, 646	221, 593	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	5. 517364	2. 784203	0. 45014	9 0. 330644	0. 183383	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			7, 57	5 95, 340	131, 820	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 000474	4 0. 130996	0. 109090	205. 00

From DYJUSZUM Starting Program 1 Cost Center Description Availability Starting Program Starting Program 1 Cost Center Description Availability Starting Program Starting Program 1 Cost Center Description Starting Program Starting Program Starting Program 1 Double Starting Program Starting Program Starting Program Starting Program 1 Double Starting Program Starting Program Starting Program Starting Program 1 Double Starting Program Starting Program Starting Program Starting Program 1 Double Starting Program Starting Program Starting Program Starting Program 2 Double Starting Program Starting Program Starting Program Starting Program 2 Double Starting Program Starting Program Starting Program Starting Program 2 Double Starting Program Starting Program Starting Program Starting Program 2 Double Starting Program Starting Program Starting Program	Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	ST. ELIZABET			eri od:	u of Form CMS-: Worksheet B-1	
Cost Center Description Ann Titling (INSYTTED) (INSYTEE) (I							pared:
Image: Problem Image:	Cost Center Description			Reconciliation		OPERATION OF	2 am
Image: status in the							
Final Stand C DOST CONTROL 5.04 5.05 59.06 7.00 7.00 100 00000 NED CAP REL COST SUME F SUMP 100		,	(GROSS		(
1.00 DOTOD RAY CAP HEL COSTS FILEG & H TAY 1.00 2.00 0.00 DOTOD RAY CAP HEL COSTS FUNCT 2.00 0.00 DOTOT AVAILTING ESTIMATION 0 0 2.52 2.67 <t< td=""><td></td><td>5.04</td><td></td><td>5A. 06</td><td>5.06</td><td>7.00</td><td></td></t<>		5.04		5A. 06	5.06	7.00	
2.00 DOUCO LINE CAPTELL COSTS-HOULE. LODIP 2.00 DOUCO LINE PROVINCE SUBJECT SUBJECT 2.00 2.00 DOUCO LINE PROVINCE SUBJECT SUBJECT 2.00 0.00							1 00
b.10 Doese DATA PROMENSING REPTIVE NOR AND STORTS B.01 5.04 DOROMAZIJI TTINE B.0119, R23 B.0119, R2							
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110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 ISLET ACQUISITION 0 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 0 0 0 0 113.00 116.00 11600 HOSPICE 0 3, 115, 158 0 1, 351, 309 4, 695 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 38, 119, 828 119, 176, 231 -5, 287, 159 35, 350, 171 254, 925 118.00 NONREL IMBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 9, 032 1, 520 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 0 192.00 194.00 07950 PATI ENT TRANSPORT 0 0 0 194.00 194.00		0	U	0	<u> </u>	0	99.10
111.00 11100 I SLET ACQUI SI TI ON 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 0 3, 115, 158 0 1, 351, 309 4, 695 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 38, 119, 828 119, 176, 231 -5, 287, 159 35, 350, 171 254, 925 118.00 NONREI MBURSABLE COST CENTERS 190.00 19200 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 9, 032 1, 520 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 194.00 07950 PATI ENT TRANSPORT 0 0 0 194.00 0 194.00		0	0	0	0		
113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 0 3, 115, 158 0 1, 351, 309 4, 695 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 38, 119, 828 119, 176, 231 -5, 287, 159 35, 350, 171 254, 925 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 9, 032 1, 520 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 194.00 07950 PATI ENT TRANSPORT 0 0 0 283, 701 0 194.00		0	0	0	0		
I18.00 SUBTOTALS (SUM OF LINES 1-117) 38, 119, 828 119, 176, 231 -5, 287, 159 35, 350, 171 254, 925 118.00 NONREI MBURSABLE COST CENTERS Image: Cost	113.00 11300 INTEREST EXPENSE		J.	J	J.		113.00
NONRE I MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 9,032 1,520 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 194.00 07950 PATI ENT TRANSPORT 0 0 0 194.00		28 110 020		0 -5 207 150			
190.00 I9000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 9,032 1,520 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 194.00 07950 PATI ENT TRANSPORT 0 0 0 194.00		30, 114, 828	117, 170, 231	-0,207,109	33, 330, 171	204, 925	110.00
194. 00 07950 PATI ENT TRANSPORT 0 0 0 283, 701 0 194. 00	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			
		0	0	0	-		
		0	0	0			

Health Financial Systems	ST. ELIZABE	TH CENTRAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150003	Peri od:	Worksheet B-1	
				From 01/01/2014 To 09/30/2014	Date/Time Pre	
Cost Center Description	ADMI TTI NG	CASHI EDI NG (ACC	Poconciliati	on ADMI NI STRATI VE	2/27/2015 7:0 OPERATION OF	2 am
cost center bescription	(INPATIENT	OUNTS	Reconciliation	AND GENERAL	PLANT	
	REVENUE)	RECEIVABLE		(ACCUM. COST)	(SQUARE	
	nevenoe)	(GROSS		(//000///	FEET)	
		CHARGES)			,	
	5.04	5.05	5A. 06	5.06	7.00	
194.0207952 REHAB (FSEH-E)	0	0		0 58, 523	10, 607	194.02
194.0307953 HHA (FSEH-E)	0	0		0 10, 284	1, 864	194.03
194.0407956 PSYCH (FSEH-E)	0	0		0 33, 849	6, 135	194.04
194. 05 07955 VACANT SPACE	0	0		0 0	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	62,064	278, 437		5, 287, 159	3, 046, 486	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 001628	0. 002336		0. 146450	10. 749281	203.00
204.00 Cost to be allocated (per Wkst. B,	11, 116	46, 340		263, 809	831, 014	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000292	0. 000389		0.007307	2. 932166	205.00
1)						

	Financial Systems LLOCATION - STATISTICAL BASIS	ST. ELIZABET		CCN: 150003 Pe	In Lie eriod:	u of Form CMS-2 Worksheet B-1	2552-10
					om 01/01/2014	Date/Time Pre 2/27/2015 7:03	
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (MANHRS)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	2 011
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS						
11.00 13.00 14.00 15.00 16.00 17.00 20.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00561 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00560 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02000 NURSING SCHOOL 02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	217, 968 16, 181 6, 163 0 6, 487 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	249, 484 9, 652 5, 764 1, 347 4, 587 3, 378 3, 570 0 54, 205 454	55, 757 0 0 0 0 0 0 0 0 0 0 0	583, 968 9, 643 0 14, 571 5, 608 2, 618 58, 628 12, 654	318, 672 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 5. \ 05\\ 5. \ 06\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 20. \ 00\\ 23. \ 00\\ \end{array}$
31.00 41.00 42.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	93, 528 19, 186 0 0 0	29, 804 4, 841 0 0 0	27, 392 6, 933 0 0 0	67, 453 67, 756 0 0 0	64, 963 0 0 0 0	30. 00 31. 00 41. 00 42. 00 43. 00
	ANCILLARY SERVICE COST CENTERS						
51.00 54.00 56.00 56.02 56.03 57.00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05400 RADIOLOGY-DIAGNOSTIC 05600 RADIOISOTOPE 05602 MRI 05603 ULTRASOUND 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0 0 11, 812 0 0 0 0 0 0 0	0 0 19, 874 3, 922 1, 658 643 1, 842 0	0 0 0 0 0 0 0 0 0	0 0 30, 493 3, 164 726 2, 009 6, 538 0	0 0 3, 164 0 0 0 0 0	50. 00 51. 00 54. 00 56. 00 56. 02 56. 03 57. 00 58. 00
60.00 60.01 65.00 66.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07400 RENAL DI ALYSI S	0 2, 127 0 2, 352 13, 426 0 536 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 10, 887 0 3, 039 11, 297 2, 454 4, 643 3, 713 0 0 0 13, 812		0 0 17, 743 86, 981 9, 373 12, 252 0 0 0 0 252	0 0 0 0 0	66.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00
76. 98	07698 HYPERBARIC OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 98
89.00 91.00 91.01	0019ATTENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY 09101 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS	0 0 37, 826 8, 344	0 0 17, 852 9, 720	0 0 0 0	0 0 42, 340 27, 219	0 0 41, 960 17, 629	89.00 91.00
97.00	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP SOLD 09910 CORF	0 0 0	3, 569 0 0	0 0 0	74, 233 0 0		95. 00 97. 00 99. 10
110. 00 111. 00 113. 00		0 0 0 217, 968	0 0 4, 695 231, 222	0 0 0 34, 325	0 0 0 22, 798 575, 052	0 0	
192.00 194.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES 07950 PATI ENT TRANSPORT 07951 SETON LEASE 1 NORTH	0 0 0	1, 520 0 0 0	0 0 0 0	0 0 0 8, 916	0 0	190. 00 192. 00 194. 00 194. 01

Health Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 01/01/2014 To 09/30/2014	Date/Time Pre	
				_	2/27/2015 7:0	<u>2 am</u>
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE	(SQUARE	(MEALS	(MANHRS)	ADMI NI STRATI ON	
	(POUNDS OF	FEET)	SERVED)			
	LAUNDRY)				(DI RECT	
					NRSING HRS)	
	8.00	9.00	10.00	11.00	13.00	
194.0207952REHAB (FSEH-E)	0	10, 607	9, 63	4 0	0	194.02
194.0307953HHA (FSEH-E)	0	0		0 0	0	194. 03
194.0407956 PSYCH (FSEH-E)	0	6, 135	11, 79	в О	0	194.04
194.0507955 VACANT SPACE	0	0		0 0	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	474, 340	1, 257, 867	777, 71	1 487, 201	652, 098	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	2. 176191	5. 041874	13. 94822	0. 834294	2.046298	203.00
204.00 Cost to be allocated (per Wkst. B,	144, 848	105, 016	118, 89	9 62, 787	46, 667	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 664538	0. 420933	2. 13245	0. 107518	0. 146442	205.00
		•	•		•	

	Financial Systems LLOCATION - STATISTICAL BASIS	ST. ELIZABET		CCN: 150003	In Lie Period:	u of Form CMS-2 Worksheet B-1	2552-10
5001 F					From 01/01/2014 To 09/30/2014	Date/Time Pre	oared.
						2/27/2015 7:0	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE (GROSS	(ASSI GNED	
		(COSTED REQUIS.)		(GROSS CHARGES)	CHARGES)	TIME)	
		14.00	15.00	16.00	17.00	20.00	
1 00	GENERAL SERVICE COST CENTERS			[4 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00550 DATA PROCESSI NG						5.02
5.03 5.04	00561 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5.03 5.04
5.04 5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5.06	00560 ADMINI STRATI VE AND GENERAL						5.06
7.00	00700 OPERATION OF PLANT						7.00
3.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	100	100				14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	100 0	119, 176, 23	1		15.00 16.00
	01700 SOCIAL SERVICE	0	0	117, 170, 23	0 119, 176, 231		17.00
	02000 NURSI NG SCHOOL	0	0		0 0	100	20.00
23.00	02300 PARAMED ED PRGM	0	0		0 0		23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	0	7, 589, 38	7, 589, 380	100	30.00
30.00	03100 I NTENSI VE CARE UNI T	0	0	3, 569, 07		0	31.00
41.00	04100 SUBPROVI DER – I RF	0	0	-,,	0 0	0	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
50.00	ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	50.00
	05100 RECOVERY ROOM	0	0		0 0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	8, 355, 47		0	54.00
56.00	05600 RADI OI SOTOPE	0	0	37,03		0	56.00
56.02 56.03	05602 MRI 05603 ULTRASOUND	0	0	1, 776, 50 1, 170, 31		0	56. 02 56. 03
57.00	05700 CT SCAN	0	0	9, 959, 17		0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (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 60. 01		0	0	24, 866, 66	24, 866, 667	0	60.00
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	0	2, 095, 37	0 2,095,378	0	60. 01 65. 00
		0	0	8, 375, 84		0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	1, 054, 42		0	68.00
	06900 ELECTROCARDI OLOGY	0	0	2, 501, 87		0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	2, 070, 11 6, 423, 73		0	70.00 71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	185, 67		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	100	8, 954, 77		0	73.00
	07400 RENAL DI ALYSI S	0	0	710, 28		0	74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0	0	1, 806, 74	6 1, 806, 746	0	76. 98
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
	09100 EMERGENCY	0	0	12, 961, 04		0	91.00
	09101 WOUND CARE	0	0	4, 064, 95	4, 064, 958	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	0	7, 532, 59	7, 532, 599	0	95.00
	09700 DURABLE MEDICAL EQUIP SOLD	0	0		0 0	0	97.00
00 10	09910 CORF	0	0		0 0	0	99. 10
77.10	SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	109. 00
		0	0		0 0		109.00
109. 00		1 1	0		0 0		111.00
109. 00 110. 00	110900 PARCREAS ACCOTSTITUN 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	0				
109.00 110.00 111.00 113.00	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE	0	0				
109.00 110.00 111.00 113.00 116.00	11000 I NTESTI NAL ACQUI SI TI ON 11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE 11600 HOSPI CE	0	0	3, 115, 15		0	116. 00
109.00 110.00 111.00 113.00 116.00	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0 0 100	0 0 100	3, 115, 15 119, 176, 23		0	113. 00 116. 00 118. 00
109.00 110.00 111.00 113.00 116.00 118.00	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0	0 0 100			0 100	116. 00 118. 00
109. 00 110. 00 111. 00 113. 00 116. 00 118. 00 190. 00	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)		0 0 100 0 0 0			0 100 0	116. 00
109.00 110.00 111.00 113.00 116.00 118.00 190.00 192.00 194.00	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11100 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0 0 100 0 0 0 0			0 100 0 0 0 0	116. 00 118. 00 190. 00

Health Financia	al Systems	ST. ELI ZABET	H CENTRAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATIO	DN – STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					To 09/30/2014		
Co	ost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	NURSING SCHOOL	
		SERVICES &	(COSTED	RECORDS &	(05000	(10010155	
		SUPPLY	REQUIS.)	LIBRARY	(GROSS	(ASSI GNED	
		(COSTED		(GROSS	CHARGES)	TI ME)	
		REQUIS.)	15.00	CHARGES)	47.00	00.00	
		14.00	15.00	16.00	17.00	20.00	
194.0207952 RE		0	0		0 0		194. 02
194.0307953 HH	. ,	0	0		0 0		194.03
194.04 07956 PS		0	0		0 0		194.04
194.0507955 VA	ACANT SPACE	0	0		0 0	0	194.05
	ross Foot Adjustments						200.00
201.00 Ne	egative Cost Centers						201.00
	ost to be allocated (per Wkst. B, art I)	142, 987	1, 024, 835	221, 85	5 110, 203	4, 857, 415	202.00
203.00 Un	nit cost multiplier (Wkst. B, Part I)	1, 429. 870000	10, 248. 350000	0. 00186	0. 000925	48, 574. 150000	203.00
	ost to be allocated (per Wkst. B, art II)	69, 279	232, 099	36, 02	4 1, 342	558, 188	204.00
	nit cost multiplier (Wkst. B, Part	692. 790000	2, 320. 990000	0.00030	0. 000011	5, 581. 880000	205.00

Heal th Financial	Systems - STATISTICAL BASIS	ST. ELIZABETH (ENTRAL Provi der CCN: 150003	In Lie	u of Form CMS-2552-10 Worksheet B-1
COST ALLOCATION	- STATISTICAL DASIS		Provider CCN. 150005	From 01/01/2014	Date/Time Prepared:
	t Castos Description			10 07/00/2011	2/27/2015 7:02 am
COS	t Center Description	PARAMED ED PRGM (ASSI GNED TI ME)			
GENERAL S	SERVICE COST CENTERS	23.00			
	CAP REL COSTS-BLDG & FIXT				1.00
	CAP REL COSTS-MVBLE EQUIP				2.00
	LOYEE BENEFITS DEPARTMENT				4.00
	A PROCESSING CHASING RECEIVING AND STORES				5. 02 5. 03
5.04 00570 ADM					5. 04
	HI ERI NG/ACCOUNTS RECEI VABLE				5.05
5.06 00560 ADM	INISTRATIVE AND GENERAL				5.06
	RATION OF PLANT				7.00
	NDRY & LINEN SERVICE				8.00
9.00 00900 HOU 10.00 01000 DI E	SEKEEPING				9. 00 10. 00
11.00 01100 CAF					11.00
	SING ADMINISTRATION				13.00
	TRAL SERVICES & SUPPLY				14.00
15.00 01500 PHA					15.00
16.00 01600 MED 17.00 01700 SOC	ICAL RECORDS & LIBRARY				16. 00 17. 00
	SING SCHOOL				20.00
	AMED ED PRGM	100			23.00
I NPATI ENT	ROUTINE SERVICE COST CENTERS				
	LTS & PEDIATRICS	0			30.00
	ENSIVE CARE UNIT	0			31.00
41.00 04100 SUB 42.00 04200 SUB	PROVIDER - IRF	0			41. 00 42. 00
43.00 04300 NUR		0			43.00
	SERVICE COST CENTERS				
	RATING ROOM	0			50.00
	OVERY ROOM	0			51.00
	I OLOGY-DI AGNOSTI C	0			54.00
56.00 05600 RAD 56.02 05602 MRI	I OI SOTOPE	0			56. 00 56. 02
56.03 05603 ULT	RASOUND	0			56.03
57.00 05700 CT	SCAN	0			57.00
	NETIC RESONANCE IMAGING (MRI)	0			58.00
	DIAC CATHETERIZATION	0			59.00
60.00 06000 LAB 60.01 06001 BL0	OD LABORATORY	0			60. 00 60. 01
	PI RATORY THERAPY	0			65.00
66.00 06600 PHY	SI CAL THERAPY	0			66.00
68.00 06800 SPE		0			68.00
69.00 06900 ELE		0			69.00
	CTROENCEPHALOGRAPHY	0			70. 00 71. 00
	L. DEV. CHARGED TO PATIENT	0			71.00
	GS CHARGED TO PATIENTS	58			73.00
74.00 07400 REN		0			74.00
	ERBARI C OXYGEN THERAPY	0			76. 98
	IT SERVICE COST CENTERS	0			88. 00
	ERALLY QUALIFIED HEALTH CENTER	0			88.00
91.00 09100 EME		42			91.00
91.01 09101 WOU	ND CARE	0			91.01
	ERVATION BEDS (NON-DISTINCT PART)				92.00
	MBURSABLE COST CENTERS				05.00
95.00 09500 AMB	ABLE MEDICAL EQUIP SOLD	0			95. 00 97. 00
99.10 09910 COR		0			99.10
SPECIAL F	PURPOSE COST CENTERS	1			
	CREAS ACQUISITION	0			109.00
	ESTINAL ACQUISITION	0			110.00
111.0011100 I SL 113.0011300 I NT		U			111. OC 113. OC
116. 00 11600 HOS		0			116.00
	TOTALS (SUM OF LINES 1-117)	100			118.00
NONREI MBU	IRSABLE COST CENTERS	,			
	T, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
192.00 19200 PHY 194.00 07950 PAT	SICIANS' PRIVATE OFFICES	0			192. 00 194. 00
	ON LEASE 1 NORTH	0			194.00
194. 02 07952 REH		0			194.02
· · · · ·					I

Health Financial Systems	ST. ELIZABETH C	ENTRAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150003	Period:	Worksheet B-1
			From 01/01/2014 To 09/30/2014	Date/Time Prepared: 2/27/2015 7:02 am
Cost Center Description	PARAMED ED			
	PRGM			
	(ASSI GNED			
	TIME)			
	23.00			
194.0307953HHA (FSEH-E)	0			194. 03
194.0407956 PSYCH (FSEH-E)	0			194.04
194. 05 07955 VACANT SPACE	0			194. 05
200.00 Cross Foot Adjustments				200.00
201.00 Negative Cost Centers				201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	537, 592			202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	5, 375. 920000			203.00
204.00 Cost to be allocated (per Wkst. B,	10, 457			204.00
Part II)				
205.00 Unit cost multiplier (Wkst. B, Part	104. 570000			205.00
11)				

Health Financial Systems	ST. ELIZABETH CENTRAL		In Lie	u of Form CMS-2	2552-10
POST STEPDOWN ADJUSTMENTS	Provi der	CCN: 150003	Period:	Worksheet B-2	
			From 01/01/2014 To 09/30/2014	Date/Time Prep 2/27/2015 7:02	pared: 2 am
		Wor	rksheet		
	Description	Part	Line No.	Amount	
	1.00	2.00	3.00	4.00	
1.00	ADJ FOR EPO COSTS IN RENAL		1 74.00	0	1.00
	DIALYSIS				
2.00	ADJ FOR EPO COSTS IN HOME		1 94.00	0	2.00
	PROGRAM			_	
3.00	ADJ FOR ARANESP COSTS IN		1 74.00	0	3.00
4.00	RENAL DIALYSIS		1 04.00		4 00
4.00	ADJ FOR ARANESP COSTS IN		1 94.00	0	4.00
5.00	HOME PROGRAM ADJ FOR ESA COSTS IN RENAL		1 74.00	0	5.00
5.00	DIALYSIS		1 74.00	U	5.00
6.00	ADJ FOR ESA COSTS IN HOME		1 94.00	0	6.00
0.00	PROGRAM		74.00	U	0.00
7.00	NURSING SCHOOL		1 30.00	-2, 369, 691	7.00

	al Systems F RATIO OF COSTS TO CHARGES	ST. ELIZABE		CCN: 150003	Period:	u of Form CMS- Worksheet C	2552-10
COMPUTATION OF	F RATIO OF COSTS TO CHARGES		Provi der	CCN: 150003	From 01/01/2014		
					To 09/30/2014	Date/Time Pre	pared:
			T; +1	e XVIII	Hospi tal	2/27/2015 7:0 PPS	2 am
			1111		Costs	PP3	
C	ost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
0		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2.00	3.00	4.00	5.00	
	NT ROUTINE SERVICE COST CENTERS						
	DULTS & PEDIATRICS	6, 309, 128		6, 309, 1			
	NTENSIVE CARE UNIT	2,007,871		2, 007, 8			
	UBPROVI DER – I RF UBPROVI DER	0			0 0		
43.00 04300 N		0					
	RY SERVICE COST CENTERS	0			0 0	0	43.00
	PERATING ROOM	0			0 0	0	50.00
	ECOVERY ROOM	0			0 0	-	
	ADI OLOGY-DI AGNOSTI C	2, 186, 228		2, 186, 2	-		
	ADI OI SOTOPE	579, 257		579, 2			
56.02 05602 M		88, 232		88, 2			
56.03 05603 U	LTRASOUND	178, 638		178, 6	38 0	178, 638	56.03
57.00 05700 C		617, 092		617, 0	92 0	617, 092	57.00
	AGNETIC RESONANCE IMAGING (MRI)	0			0 0	-	
	ARDI AC CATHETERI ZATI ON	0			0 0	-	
	ABORATORY	3, 980, 999		3, 980, 9		-, ,	
	LOOD LABORATORY	0			0 0	°	
		1, 114, 186	0	.,,.		1, 114, 186	
	HYSI CAL THERAPY	3, 309, 193	0	0,007,1		3, 309, 193	
	PEECH PATHOLOGY LECTROCARDI OLOGY	636, 274 1, 003, 121	0	636, 2 1, 003, 1		636, 274 1, 006, 048	
	LECTROEARDTOLOGT	550, 112		550, 1		550, 112	
	EDICAL SUPPLIES CHARGED TO PATIENTS	1, 968, 250		1, 968, 2			
	MPL. DEV. CHARGED TO PATIENT	89, 935		89, 9		89, 935	
	RUGS CHARGED TO PATIENTS	2, 446, 935		2, 446, 9			
	ENAL DIALYSIS	558, 767		558, 7			
	YPERBARI C OXYGEN THERAPY	304, 739		304, 7			
	ENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				· · · · ·	
88.00 08800 R	URAL HEALTH CLINIC	0			0 0	0	88.00
	EDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
	MERGENCY	2, 682, 611		2, 682, 6		2/002/011	
	OUND CARE	1, 688, 791		1, 688, 7		.,	
	BSERVATION BEDS (NON-DISTINCT PART)	557, 793		557, 7	93	557, 793	92.00
	EI MBURSABLE COST CENTERS	2 454 777		2 45 4 7	10 205	2 4/5 172	
	MBULANCE SERVICES URABLE MEDICAL EQUIP SOLD	3, 454, 777		3, 454, 7			
99.10 09910 C		0			0 0	0	
	PURPOSE COST CENTERS	0			0	0	99.10
	ANCREAS ACQUISITION	0			0	0	109.00
	NTESTINAL ACQUISITION	0			0		110.00
	SLET ACQUI SI TI ON	0			0		111.00
	NTEREST EXPENSE						113.00
116.00 11600 H		1, 697, 702		1, 697, 7	02	1, 697, 702	
200.00 S	ubtotal (see instructions)	38, 010, 631	0	38, 010, 6	31 13, 322	38, 023, 953	200.00
201.00	ess Observation Beds	557, 793		557, 7	93	557, 793	201.00
202.00 T	otal (see instructions)	37, 452, 838	0	37, 452, 8	38 13, 322	37, 466, 160	202 00

					From 01/01/2014	Part I	
					To 09/30/2014	Date/Time Pre 2/27/2015 7:0	pared: 2 am
			Ti tl	e XVIII	Hospi tal	PPS	2 411
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col.		TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		6.00	7.00	8.00	9.00	Rati o 10. 00	
INP	ATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
	00 ADULTS & PEDIATRICS	7, 030, 682		7, 030, 68	32		30.00
	00 INTENSIVE CARE UNIT	3, 569, 070		3, 569, 07			31.00
41.00 041	00 SUBPROVIDER - IRF	0			0		41.00
42.00 042	OO SUBPROVI DER	0			0		42.00
43.00 043	00 NURSERY	0			0		43.00
	I LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0	0		0 0.000000	0. 000000	
	00 RECOVERY ROOM	0	0		0 0.000000	0.00000	
	00 RADI OLOGY-DI AGNOSTI C	591, 122	7, 764, 357	8, 355, 47		0.00000	
	00 RADI OI SOTOPE	0	37, 038	37, 03		0.00000	
	02 MRI	915, 872	860, 628	1, 776, 50		0.00000	
	03 ULTRASOUND	377, 669	792, 642	1, 170, 31		0.00000	
	OO CT SCAN	2, 053, 879	7, 905, 291	9, 959, 17		0. 000000	
	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000	0.00000	
	00 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.00000	
		8, 203, 775	16, 662, 892	24, 866, 66		0.00000	
	01 BLOOD LABORATORY	0	0		0 0.000000	0.000000	
		1, 871, 839	223, 539			0.000000	
	00 PHYSI CAL THERAPY	426, 095	7, 949, 745	8, 375, 84		0.000000	
	00 SPEECH PATHOLOGY 00 ELECTROCARDI OLOGY	390, 034	664, 395	1, 054, 42		0. 000000 0. 000000	
	00 ELECTROENCEPHALOGRAPHY	936, 410 163, 041	1, 565, 462 1, 907, 078	2, 501, 87 2, 070, 11		0.000000	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 043, 337	3, 380, 400	6, 423, 73		0.000000	
	00 IMPL. DEV. CHARGED TO PATIENT	161, 428	24, 244	185, 67		0.000000	
	00 DRUGS CHARGED TO PATIENTS	6, 345, 160	2, 609, 615	8, 954, 77		0.000000	
	00 RENAL DI ALYSI S	669,001	41, 283	710, 28		0.000000	
	98 HYPERBARI C OXYGEN THERAPY	273, 166	1, 533, 580	1, 806, 74		0.000000	
	PATIENT SERVICE COST CENTERS	270,100	1,000,000	1,000,7	0.100007	0.000000	1 / 0. /
	OO RURAL HEALTH CLINIC	0	0		0		88. 00
	00 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
91.00 091	00 EMERGENCY	1, 041, 154	11, 919, 895	12, 961, 04	0. 206975	0.000000	91.00
91.01 091	01 WOUND CARE	57, 094	4,007,864	4, 064, 95	58 0. 415451	0. 000000	91.0
92.00 092	OO OBSERVATION BEDS (NON-DISTINCT PART)	0	558, 698	558, 69	0. 998380	0.00000	92.00
	ER REIMBURSABLE COST CENTERS						
	00 AMBULANCE SERVI CES	0	7, 532, 599	7, 532, 59		0. 000000	
	OO DURABLE MEDICAL EQUIP SOLD	0	0		0 0.000000	0.00000	
	10 CORF	0	0		0		99.10
	CIAL PURPOSE COST CENTERS						
	OO PANCREAS ACQUI SI TI ON	0	0		0		109.00
	00 INTESTINAL ACQUISITION	0	0		0		110.00
	00 I SLET ACQUI SI TI ON	0	0		0		111.00
			3 115 150	2 115 15	- 0		113.00
	00 HOSPI CE	0	3, 115, 158				116.00
	Subtatal (and instructions)	20 110 000					
200. 00 201. 00	Subtotal (see instructions) Less Observation Beds	38, 119, 828	81, 056, 403	119, 176, 23	31		200.00

	Financial Systems	ST. ELI ZABETH			u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150003	Period: From 01/01/2014 To 09/30/2014	Worksheet C Part I Date/Time Prep 2/27/2015 7:02	
			Title XVIII	Hospi tal	PPS	2 0111
	Cost Center Description	PPS Inpatient				
	·	Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
41.00	04100 SUBPROVI DER – I RF					41.00
42.00	04200 SUBPROVI DER					42.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 261652				54.00
56.00	05600 RADI OI SOTOPE	15. 639532				56.00
56.02	05602 MRI	0. 049666				56.02
56.03	05603 ULTRASOUND	0. 152641				56.03
57.00	05700 CT SCAN	0. 061962				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	06000 LABORATORY	0. 160094				60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60.01
65.00	06500 RESPI RATORY THERAPY	0. 531735				65.00
66.00	06600 PHYSI CAL THERAPY	0. 395088				66.00
68.00	06800 SPEECH PATHOLOGY	0. 603430				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 402118				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 265739				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 306403				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 484376				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 273255				73.00
	07400 RENAL DIALYSIS	0. 786681				74.00
	07698 HYPERBARI C OXYGEN THERAPY	0. 168667				76.98
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC					88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
91.00	09100 EMERGENCY	0. 206975				91.00
91.01	09101 WOUND CARE	0. 415451				91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 998380				92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	0. 460023				95.00
	09700 DURABLE MEDICAL EQUIP SOLD	0. 000000				97.00
	09910 CORF					99.10
	SPECIAL PURPOSE COST CENTERS					1
109.00	10900 PANCREAS ACQUISITION					109.00
	11000 INTESTINAL ACQUISITION					110.00
	11100 I SLET ACQUI SI TI ON					111.00
	11300 INTEREST EXPENSE					113.00
	11600 HOSPI CE					116.00
200.00						200.00
200.00						
200.00	Less Observation Beds					201.00

Health Financial Systems	ST. ELIZABE				u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150003	Period: From 01/01/2014 To 09/30/2014	Date/Time Pre	pared:
					2/27/2015 7:0	2 am
		111	le XIX	<u>Hospital</u> Costs	Cost	
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	1.00	2.00	5.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	6, 309, 128		6, 309, 12	.8 0	6, 309, 128	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2,007,871		2,007,87		2,007,871	31.00
41. 00 04100 SUBPROVI DER – I RF	2,007,071		2,00,10,	0 0	0	
42. 00 04200 SUBPROVI DER	0			0 0	0	•
43. 00 04300 NURSERY	0			0 0	0	•
ANCI LLARY SERVICE COST CENTERS	~			<u> </u>		
50. 00 05000 OPERATI NG ROOM	0)		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0			0 0	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 186, 228		2, 186, 22		2, 186, 228	54.00
56. 00 05600 RADI OI SOTOPE	579, 257		579, 25		579, 257	56.00
56. 02 05602 MRI	88, 232		88, 23		88, 232	56.02
56. 03 05603 ULTRASOUND	178, 638		178, 63		178, 638	
57.00 05700 CT SCAN	617, 092		617, 09		617, 092	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	3, 980, 999		3, 980, 99	9 0	3, 980, 999	60.00
60. 01 06001 BLOOD LABORATORY	0			0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	1, 114, 186	0	1, 114, 18	6 0	1, 114, 186	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 309, 193	0	3, 309, 19	03 0	3, 309, 193	66.00
68.00 06800 SPEECH PATHOLOGY	636, 274	0	636, 27	4 0	636, 274	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 003, 121		1, 003, 12	2, 927	1, 006, 048	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	550, 112		550, 11	2 0	550, 112	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 968, 250		1, 968, 25	0 0	1, 968, 250	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	89, 935		89, 93	5 0	89, 935	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 446, 935		2, 446, 93	5 0	2, 446, 935	73.00
74.00 07400 RENAL DIALYSIS	558, 767		558, 76	07 0	558, 767	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	304, 739		304, 73	9 0	304, 739	76.98
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	89.00
91. 00 09100 EMERGENCY	2, 682, 611		2, 682, 61		2, 682, 611	•
91.01 09101 WOUND CARE	1, 688, 791		1, 688, 79		1, 688, 791	91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	557, 793		557, 79	3	557, 793	92.00
OTHER REIMBURSABLE COST CENTERS	0 454 777		0.454.75	10.005	0.4/5.470	1 05 00
95. 00 09500 AMBULANCE SERVICES	3, 454, 777		3, 454, 77		3, 465, 172	
97. 00 09700 DURABLE MEDICAL EQUIP SOLD 99. 10 09910 CORF	0			0 0	0	97.00
	0	/		0	0	99.10
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION	0		1	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		111.00
113. 00 11300 I NTEREST EXPENSE				0	0	113.00
116. 00 11600 HOSPI CE	1, 697, 702	,	1, 697, 70	12	1, 697, 702	
200.00 Subtotal (see instructions)	38, 010, 631					
201.00 Less Observation Beds	557, 793		557, 79		557, 793	
202.00 Total (see instructions)	37, 452, 838					
	1 57,452,030	'I U	1 37,432,03	13, 322	J 57,400,100	1202. UU

COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150003	Period:	Worksheet C	
					From 01/01/2014 To 09/30/2014	Part I Date/Time Pre 2/27/2015 7:0	epared:
			Tit	le XIX	Hospi tal	Cost	72 ani
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col.		TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		(00	7.00	0.00	0.00	Ratio	
1	NPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
	03000 ADULTS & PEDIATRICS	7, 030, 682		7, 030, 6	32		30.00
	03100 I NTENSI VE CARE UNI T	3, 569, 070		3, 569, 0			31.00
	04100 SUBPROVI DER – I RF	0,007,070		0,007,0	0		41.00
	04200 SUBPROVI DER	0			0		42.00
	04300 NURSERY	0			0		43.00
	ANCI LLARY SERVICE COST CENTERS			1	-		
	D5000 OPERATI NG ROOM	0	0		0 0.000000	0.000000	50.00
	D5100 RECOVERY ROOM	0	0		0 0.000000	0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	591, 122	7, 764, 357	8, 355, 4		0.000000	
	D5600 RADI OI SOTOPE	0	37, 038			0.000000	
56. 02 C	05602 MRI	915, 872	860, 628	1, 776, 5	0. 049666	0.000000	56.02
56. 03 C	05603 ULTRASOUND	377, 669	792, 642	1, 170, 3	0. 152641	0.000000	56.0
57.00 C	D5700 CT SCAN	2, 053, 879	7, 905, 291	9, 959, 1	70 0. 061962	0.000000	57.00
58.00 0	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000	0.000000	58.00
59.00 C	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.000000	59.00
	06000 LABORATORY	8, 203, 775	16, 662, 892	24, 866, 6		0.000000	
	06001 BLOOD LABORATORY	0	0		0 0.000000	0.000000	
	06500 RESPI RATORY THERAPY	1, 871, 839	223, 539			0.000000	
	06600 PHYSI CAL THERAPY	426, 095	7, 949, 745			0.000000	
	06800 SPEECH PATHOLOGY	390, 034	664, 395			0.000000	
	06900 ELECTROCARDI OLOGY	936, 410	1, 565, 462			0.000000	
	D7000 ELECTROENCEPHALOGRAPHY	163, 041	1, 907, 078			0.000000	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	3, 043, 337	3, 380, 400			0.00000	
	07200 IMPL. DEV. CHARGED TO PATIENT	161, 428	24, 244			0.00000	
	D7300 DRUGS CHARGED TO PATIENTS	6, 345, 160	2, 609, 615			0.00000	
	07400 RENAL DI ALYSI S	669,001	41, 283			0.00000	
	07698 HYPERBARI C OXYGEN THERAPY	273, 166	1, 533, 580	1, 806, 7	46 0. 168667	0.00000	76.9
	DUTPATIENT SERVICE COST CENTERS	0	0		0 0.000000	0. 000000	88. 0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0. 000000	
	09100 EMERGENCY	1, 041, 154	11, 919, 895			0. 000000	
	09101 WOUND CARE	57, 094	4, 007, 864			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,094	558, 698			0. 000000	
	THER REIMBURSABLE COST CENTERS	0	330, 070	330,0	0. 770300	0.00000	/ /2.00
	09500 AMBULANCE SERVICES	0	7, 532, 599	7, 532, 5	0. 458643	0.00000	95.00
	09700 DURABLE MEDICAL EQUIP SOLD	0	0		0 0.000000	0. 000000	
	09910 CORF	0	0		0	0.000000	99.10
	SPECIAL PURPOSE COST CENTERS			1	- <u>,</u> _		
	10900 PANCREAS ACQUISITION	0	0		0		109.00
	11000 INTESTINAL ACQUISITION	0	0		0		110.00
	11100 I SLET ACQUI SI TI ON	0	0		0		111.00
	11300 INTEREST EXPENSE						113.0
	11600 HOSPI CE	0	3, 115, 158	3, 115, 1	58		116.0
200.00	Subtotal (see instructions)	38, 119, 828	81, 056, 403				200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	38, 119, 828	81, 056, 403	119, 176, 2	21		202.0

	Financial Systems	ST. ELIZABETH	CENTRAL	In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150003	Period: From 01/01/2014 To 09/30/2014	Worksheet C Part I Date/Time Pre 2/27/2015 7:0	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient		noopritai	0001	
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	· ·				
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
41.00	04100 SUBPROVIDER - IRF					41.00
42.00	04200 SUBPROVI DER					42.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					1
50.00	05000 OPERATING ROOM	0. 000000				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
56.00	05600 RADI OI SOTOPE	0. 000000				56.00
56.02	05602 MRI	0. 000000				56.02
56.03	05603 ULTRASOUND	0. 000000				56.03
57.00	05700 CT SCAN	0. 000000				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60.00	06000 LABORATORY	0. 000000				60.00
60.01	06001 BLOOD LABORATORY	0. 000000				60.01
65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
68.00	06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	07400 RENAL DIALYSIS	0. 000000				74.00
	07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76.98
	OUTPATIENT SERVICE COST CENTERS					1
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0. 000000				89.00
91.00	09100 EMERGENCY	0. 000000				91.00
91.01	09101 WOUND CARE	0. 000000				91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS	· ·				
95.00	09500 AMBULANCE SERVI CES	0.000000				95.00
97.00	09700 DURABLE MEDICAL EQUIP SOLD	0. 000000				97.00
99.10	09910 CORF					99.10
	SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION					109.00
110.00	11000 INTESTINAL ACQUISITION					110.00
111.00	11100 I SLET ACQUI SI TI ON					111.00
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPI CE					116.00
200.00	Subtotal (see instructions)					200.00
						201.00
201.00	Less Observation Beds					201.00

Health Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS		-	Period: From 01/01/2014 To 09/30/2014	Date/Time Pre 2/27/2015 7:0	pared: 2 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col . 1 - col 2)			
	1.00	2.00	3.00	4,00	5,00	
INPATIENT ROUTINE SERVICE COST CENTERS		2100	0.00		0,00	
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT	484, 234 171, 898		484, 23 171, 89			
41. 00 SUBPROVI DER – I RF	0	0)	0 0	0.00	41.00
42. 00 SUBPROVI DER	0	0)	0 0	0.00	42.00
43.00 NURSERY	0			0 0	0.00	43.00
200.00 Total (lines 30-199)	656, 132		656, 13	2 5, 777		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 41. 00 SUBPROVIDER - IRF 42. 00 SUBPROVIDER 43. 00 NURSERY	2, 468 565 0 0 0					30.00 31.00 41.00 42.00 43.00
200.00 Total (lines 30-199)	3, 033	344, 276				200.00

Health Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150003	Period:	Worksheet D	
				From 01/01/2014 To 09/30/2014		nared
					2/27/2015 7:0	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	-
50. 00 05000 OPERATI NG ROOM	0	0	0.0000	00 00	0	50.00
51. 00 05100 RECOVERY ROOM	0				-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	495, 652					
56. 00 05600 RADI OI SOTOPE	138, 949				0	56.00
56. 02 05602 MRI	18, 596				-	56.02
56. 03 05603 ULTRASOUND	25, 883					•
57. 00 05700 CT SCAN	192, 539					57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 0000	0 00	0	59.00
60. 00 06000 LABORATORY	151, 224	24, 866, 667	0. 0060	3, 654, 472	22, 223	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 0000	0 00	0	60.01
65. 00 06500 RESPI RATORY THERAPY	121, 258	2, 095, 378	0. 0578	1, 009, 433	58, 415	65.00
66. 00 06600 PHYSI CAL THERAPY	264, 536	8, 375, 840	0. 0315	33 337, 065	10, 646	66.00
68.00 06800 SPEECH PATHOLOGY	47, 116	1, 054, 429	0. 0446	34 32, 998	1, 474	68.00
69. 00 06900 ELECTROCARDI OLOGY	157, 396	2, 501, 872	0. 0629	11 526, 623	33, 130	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	79, 323	2, 070, 119	0. 0383	18 89, 349	3, 424	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	86, 197					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	747					
73.00 07300 DRUGS CHARGED TO PATIENTS	247, 156					
74.00 07400 RENAL DI ALYSI S	125, 671					74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	3, 259	1, 806, 746	0.0018	04 0	0	76.98
OUTPATIENT SERVICE COST CENTERS	-	-			-	
88.00 08800 RURAL HEALTH CLINIC	0					
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0					
91.00 09100 EMERGENCY	283, 221					•
91.01 09101 WOUND CARE	138, 834				-	91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	42, 811	558, 698	0. 0766	26 0	0	92.00
95. 00 09500 AMBULANCE SERVICES		1	T			95.00
97. 00 09700 DURABLE MEDICAL EQUIP SOLD		, c	0.0000	00 0	0	
200.00 Total (lines 50-199)	2, 620, 368			13, 096, 915		
	2,020,300	71,720,722	-1	13, 070, 713	577,157	I≥00.00

Health Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 01/01/2014 To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cos	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4, 00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1100	2100	0.00		0100	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSI VE CARE UNIT 41. 00 04100 SUBPROVI DER - IRF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY 200. 00 Total (lines 30-199) Cost Center Description	2,487,724 0 0 0 2,487,724 Total Patient Days		Inpatient Program Days	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 487, 724 0 0 0 2, 487, 724	41.00 42.00 43.00
	6. 00	7.00	8. 00	Pass-Through Cost (col. 7 x col. 8) 9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	1	1	1			
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	4, 694 1, 083		56			30.00 31.00 41.00
42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY	0	0.00				41.00 42.00 43.00
200.00 Total (lines 30-199)	5, 777		3, 03	1, 307, 991		200. 00

Health Financial Systems	ST. ELI ZABET	TH CENTRAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	6 Provi der	CCN: 150003	Period: From 01/01/2014 To 09/30/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st	-		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C		0 0	0	
51.00 05100 RECOVERY ROOM	0	C		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	
56. 00 05600 RADI OI SOTOPE	0	C		0 0	0	00.00
56. 02 05602 MRI	0	C		0 0	0	00.02
56. 03 05603 ULTRASOUND	0	C		0 0	0	00.00
57.00 05700 CT SCAN	0	C		0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	00.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	
60. 01 06001 BLOOD LABORATORY	0	C		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	311, 80	03 0	311, 803	
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0)	0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS			1	- (
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0	
91.00 09100 EMERGENCY	0	C	225, 78	39 0	225, 789	1
91.01 09101 WOUND CARE	0	C		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	219, 941		0 0	219, 941	92.00
OTHER REIMBURSABLE COST CENTERS	,		1	-		
95. 00 09500 AMBULANCE SERVICES						95.00
97.00 09700 DURABLE MEDICAL EQUIP SOLD	0	C	D	0 0	0	
200.00 Total (lines 50-199)	0	219, 941	537, 59	02 0	757, 533	200. 00

ealth Financial Systems	ST. ELIZABE				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der	CCN: 150003	Peri od:	Worksheet D	
HROUGH COSTS				From 01/01/2014 To 09/30/2014	Part IV Date/Time Pre	narad
				10 09/30/2014	2/27/2015 7:0	
		Ti tl	e XVIII	Hospi tal	PPS	2 0111
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	5	
	4)	,	, i	7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS			•			
0. 00 05000 OPERATING ROOM	0	0	0.0000	0. 000000	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0.0000	0. 000000	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	8, 355, 479	0.0000	0. 000000	381, 823	54.00
56. 00 05600 RADI 0I SOTOPE	0	37, 038	0.0000	0. 000000	0	56.00
56. 02 05602 MRI	0	1, 776, 500	0.0000	0. 000000	504, 817	56.02
56. 03 05603 ULTRASOUND	0				240, 554	56.03
57.00 05700 CT SCAN	0	9, 959, 170	0.0000	0. 000000	1, 112, 305	57.00
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000	0. 000000	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000	0. 000000	0	59.00
0. 00 06000 LABORATORY	0	24, 866, 667			3, 654, 472	60.00
0. 01 06001 BLOOD LABORATORY	0	0	0.0000		0	1
5. 00 06500 RESPIRATORY THERAPY	0	2,095,378			1, 009, 433	
6. 00 06600 PHYSI CAL THERAPY	0	8, 375, 840			337, 065	
8. 00 06800 SPEECH PATHOLOGY	0	1,054,429			32, 998	1
9.00 06900 ELECTROCARDI OLOGY	0	2, 501, 872			526, 623	
0.00 07000 ELECTROENCEPHALOGRAPHY	0	2,070,119			89, 349	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				896, 284	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0				85, 925	
3.00 07300 DRUGS CHARGED TO PATIENTS	311, 803				3, 231, 236	
4.00 07400 RENAL DIALYSIS	0		1		450, 030	
6. 98 07698 HYPERBARI C OXYGEN THERAPY	0				0	1
OUTPATIENT SERVICE COST CENTERS	- I	,				
38. 00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0.00000	0	88.00
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			0	
21. 00 09100 EMERGENCY	225, 789	12, 961, 049			544,001	91.00
21. 01 09101 WOUND CARE	0				0	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	219, 941				0	
OTHER REI MBURSABLE COST CENTERS						1
25. 00 09500 AMBULANCE SERVICES						95.00
	0	0	0.0000	0. 000000	0	1
97.00 09700 DURABLE MEDICAL EQUIP SOLD	0	0	0.00000	0.00000	0	1 77.00

lealth Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ST. ELIZABET		CCN: 150003	Period:	eu of Form CMS-2552 Worksheet D
THROUGH COSTS	KVICE UINEK PASS	Provider	CCN. 150005	From 01/01/2014	
				To 09/30/2014	4 Date/Time Prepare
					2/27/2015 7:02 an
			e XVIII	Hospi tal	PPS
Cost Center Description	Inpati ent	Outpati ent	Outpatient		
	Program Pass-Through	Program	Program Pass-Throug	h	
	Costs (col. 8	Charges	Costs (col.		
	x col. 10)		x col. 12)	9	
	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00		
0. 00 05000 OPERATING ROOM	0	0	1	0	50
1.00 05100 RECOVERY ROOM	0	0		0	51
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	428, 428		0	54
6. 00 05600 RADI OI SOTOPE	0	13, 354		0	56
6. 02 05602 MRI	0	230, 076		0	56
6. 03 05603 ULTRASOUND	0	117, 084		0	56
7. 00 05700 CT SCAN	0	1, 616, 942		0	57
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C)	0	58
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	C)	0	59
D. 00 06000 LABORATORY	0	2, 402, 308		0	60
D. 01 06001 BLOOD LABORATORY	0	C)	0	60
5. 00 06500 RESPI RATORY THERAPY	0	52, 443		0	65
6. 00 06600 PHYSI CAL THERAPY	0	86, 044		0	66
B. 00 06800 SPEECH PATHOLOGY	0	30, 350)	0	68
9. 00 06900 ELECTROCARDI OLOGY	0	685, 766		0	69
D. 00 07000 ELECTROENCEPHALOGRAPHY	0	745, 113		0	70
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	500, 012		0	71
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C)	0	72
3.00 07300 DRUGS CHARGED TO PATIENTS	112, 512	359, 785	12, 5	28	73
4. 00 07400 RENAL DIALYSIS	0	C		0	74
6. 98 07698 HYPERBARI C OXYGEN THERAPY	0	866, 620		0	76
OUTPATIENT SERVICE COST CENTERS			1		
3. 00 08800 RURAL HEALTH CLINIC	0	C	1	0	88
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	1	0	89
1. 00 09100 EMERGENCY	9, 477	1, 566, 580			91
1. 01 09101 WOUND CARE	0	3, 303, 490	1	0	91
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0	1	0	92
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES		~		0	95
7.00 09700 DURABLE MEDICAL EQUIP SOLD	101 000	12 004 205	20.0	10	97
00.00 Total (lines 50-199)	121, 989	13, 004, 395	39, 8	14	200

	ncial Systems	ST. ELI ZABE				u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provi der		Period: From 01/01/2014	Worksheet D Part V	
					To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
			Titl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS				<u></u>		1
	O OPERATING ROOM	0. 000000			0 0	0	
	O RECOVERY ROOM	0.00000			0 0	0	
	0 RADI OLOGY-DI AGNOSTI C	0. 261652			0 0	112, 099	
	0 RADI OI SOTOPE	15. 639532			0 0	208, 850	1
	2 MRI	0. 049666			0 0	11, 427	
	3 ULTRASOUND	0. 152641			0 0	17, 872	
	O CT SCAN	0. 061962			0 0	100, 189	
	O MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0 0	0	
	O CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	
	O LABORATORY	0. 160094			0 0	384, 595	
	1 BLOOD LABORATORY	0. 000000			0 0	0	60. 01
	0 RESPI RATORY THERAPY	0. 531735			0 0	27, 886	
	O PHYSI CAL THERAPY	0. 395088			0 0	33, 995	
	O SPEECH PATHOLOGY	0. 603430			0 0	18, 314	
	0 ELECTROCARDI OLOGY	0. 400948			0 0	274, 957	1
1	0 ELECTROENCEPHALOGRAPHY	0. 265739			0 0	198, 006	1
1	0 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 306403			0 0	153, 205	
1	O I MPL. DEV. CHARGED TO PATI ENT	0. 484376			0 0	0	
1	O DRUGS CHARGED TO PATIENTS	0. 273255			0 12, 906		
	O RENAL DI ALYSI S	0. 786681			0 0	0	
	8 HYPERBARI C OXYGEN THERAPY	0. 168667	866, 620		0 0	146, 170	76. 98
	ATIENT SERVICE COST CENTERS					-	
	O RURAL HEALTH CLINIC	0. 000000				0	
	0 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			_	0	
	O EMERGENCY	0. 206975			0 0	324, 243	
	1 WOUND CARE	0. 415451			0 0	1, 372, 438	
	0 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 998380	0		0 0	0	92.00
	R REIMBURSABLE COST CENTERS	0.450/10					05 63
	O AMBULANCE SERVICES	0. 458643			0	_	95.00
	O DURABLE MEDI CAL EQUI P SOLD	0. 000000			0 0	0	
200.00	Subtotal (see instructions)		13, 004, 395		0 12, 906	3, 482, 559	
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges Net Charges (line 200 +/- line 201)		13, 004, 395		0 12,906	3, 482, 559	
202.00							

Reimb Serv Subje Ded. & (see i	Cost bursed vices ect To Coins. I 00	Title	CCN: 150003	Peri od: From 01/01/2014 To 09/30/2014 Hospi tal	Worksheet D Part V Date/Time Pre 2/27/2015 7:0 PPS	pared:)2 am
ANCI LLARY SERVICE COST CENTERS Reimb 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 56.02 05600 RADI OLOGY-DI AGNOSTI C 56.02 05600 RADI OLOGY-DI AGNOSTI C 56.03 05603 ULTRASOUND 57.00 05700 CT SCAN	ost oursed vices ect To Coins. I inst.) 00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	e XVIII	Hospi tal	PPS	
ANCI LLARY SERVICE COST CENTERS Reimb 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 56.02 05600 RADI OLOGY-DI AGNOSTI C 56.02 05600 RADI OLOGY-DI AGNOSTI C 56.03 05603 ULTRASOUND 57.00 05700 CT SCAN	ost oursed vices ect To Coins. I inst.) 00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
ANCI LLARY SERVICE COST CENTERS Reimb 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 56.02 05600 RADI OLOGY-DI AGNOSTI C 56.02 05600 RADI OLOGY-DI AGNOSTI C 56.03 05603 ULTRASOUND 57.00 05700 CT SCAN	oursed /i ces ect To Coi ns. I i nst.) 00	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 56.00 05600 RADI OI SOTOPE 56.02 05602 MRI 56.03 05603 ULTRASOUND 57.00 05700 CT						
51.00 05100 RECOVERY ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 56.00 05600 RADI OI SOTOPE 56.02 05602 MRI 56.03 05603 ULTRASOUND 57.00 05700 CT						
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY		0 0 0 0 0 0 0 0 0 0 0 0 0 0				50.00 51.00 54.00 56.02 56.03 57.00 58.00 59.00 60.00 60.01 65.00
66. 00 06600 PHYSI CAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0UTPATI ENT SERVICE COST CENTERS 000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0	0 0 0 0 3, 527 0 0				66. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 98
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 91. 00 09100 EMERGENCY 91. 01 09101 WOUND CARE 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS	0 0 0 0	0 0 0 0				88.00 89.00 91.00 91.01 92.00
95.00 09500 AMBULANCE SERVICES 97.00 09700 DURABLE MEDICAL EQUIP SOLD 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program 0nl y Charges 00 ket Charges (line 200 +/- line 201)	0 0 0 0	0 3, 527				95.00 97.00 200.00

OMPUT	PATION OF INPATIENT OPERATING COST	Title XVIII	Period: From 01/01/2014 To 09/30/2014 Hospital	Worksheet D-1 Date/Time Prep 2/27/2015 7:02 PPS	parec
	Cost Center Description	II the Aviii			
	PART I - ALL PROVIDER COMPONENTS			1.00	
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, ex	aluding nowharn)		4, 694	1 1.(
. 00	Inpatient days (including private room days and swing-bed days, excluding swing-bed a Private room days (excluding swing-bed and observation bed days).	nd newborn days)	ivate room davs	4, 694 4, 694 0	2. (
	do not complete this line.	5 5 1	rvate room days,		
. 00 . 00	Semi-private room days (excluding swing-bed and observation bed da Total swing-bed SNF type inpatient days (including private room da		r 31 of the cost	4, 279 0	
. 00	reporting period Total swing-bed SNF type inpatient days (including private room da reporting period (if calendar year, enter 0 on this line)	ys) after December	31 of the cost	0	6.
. 00	Total swing-bed NF type inpatient days (including private room day reporting period	s) through December	31 of the cost	0	7.
. 00	Total swing-bed NF type inpatient days (including private room day reporting period (if calendar year, enter 0 on this line)	s) after December 3	1 of the cost	0	8.
. 00	Total inpatient days including private room days applicable to the newborn days)	Program (excluding	swing-bed and	2, 468	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (through December 31 of the cost reporting period (see instructions		oom days)	0	10.
1.00	Swing-bed SNF type inpatient days applicable to title XVIII only (December 31 of the cost reporting period (if calendar year, enter	including private r	oom days) after	0	11.
2. 00	Swing-bed NF type inpatient days applicable to titles V or XIX onl through December 31 of the cost reporting period	y (including privat	e room days)	0	12.
3. 00	after December 31 of the cost reporting period (if calendar year,	enter O on this lin	e)	0	13.
4.00 5.00	3 31 3 11 8 1	xcluding swing-bed	days)	0	
6. 00					16.
7.00		rough December 31 o	f the cost	0.00	17.
8. 00	Medicare rate for swing-bed SNF services applicable to services af reporting period	ter December 31 of	the cost	0.00	18.
9. 00		ough December 31 of	the cost	0.00	19.
0. 00	Medicaid rate for swing-bed NF services applicable to services aft reporting period	er December 31 of t	he cost	0.00	20.
1.00 2.00	5 1 ,	of the cost report	ing period (line	6, 309, 128 0	
3.00	5 x line 17)	•		0	
4.00	x line 18)	·			24
5.00	7 x line 19)		0 1 1	0	
6. 00	x line 20) Total swing-bed cost (see instructions)		,	0	
7.00	5	21 minus line 26)		6, 309, 128	
8.00	General inpatient routine service charges (excluding swing-bed and	observation bed ch	arges)		28.
9.00 0.00				0	29.
1.00		e 28)		0. 000000	
2.00	5 .	- /		0.00	
. 00				0.00	
. 00			tions)	0.00	34
5.00)		0.00	
. 00 . 00	General inpatient routine service cost net of swing-bed cost and p	rivate room cost di	fferential (line	0 6, 309, 128	36 37
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTME			1 244 00	1 20
0 00	Adjusted general inpatient routine service cost per diem (see inst	ructions)		1, 344. 08	38.
			I	2 217 100	20
8.00 9.00 0.00		ine 14 v line 25)		3, 317, 189 0	39. 40.

MPUTATION OF INPATIENT OPERATING COST		Provi der	CCN: 150003 P	eriod: rom 01/01/2014	Worksheet D-1	1
				o 09/30/2014		
		Titl	e XVIII	Hospi tal	PPS	JZ all
Cost Center Description	Total Inpatient Costl	Total	Average Per Diem (col. 1 ÷	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	<u>col.2)</u> 3.00	4.00	5.00	
00 NURSERY (title V & XIX only)	0	C) 42
Intensive Care Type Inpatient Hospital Units				1		
00 INTENSIVE CARE UNIT	2,007,871	1, 083	1, 853. 99	565	1, 047, 504	
00 CORONARY CARE UNIT 00 BURN INTENSIVE CARE UNIT						44
00 SURGI CAL I NTENSI VE CARE UNI T						40
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description						
00 Program inpatient ancillary service cost (Wk	et D 2 col 2	Line 200)			1.00	7 40
00 Program inpatient ancillary service cost (Wk 00 Total Program inpatient costs (sum of lines			ins)		3, 406, 837 7, 771, 530	
PASS THROUGH COST ADJUSTMENTS			(13)		1 , , , , , , , , , , , , , , , , , , ,	
00 Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D, sum	of Parts I and	1, 652, 267	7 50
00 Pass through costs applicable to Program inp and IV)	atient ancillary	/ services (fr	om Wkst. D, su	m of Parts II	499, 126	5 51
00 Total Program excludable cost (sum of lines	50 and 51)				2, 151, 393	3 52
00 Total Program inpatient operating cost exclu	ding capital rel	ated, non-phy	sician anesthe	tist, and	5, 620, 137	
medical education costs (line 49 minus line	52)					_
TARGET AMOUNT AND LIMIT COMPUTATION						
00 Program discharges 00 Target amount per discharge					0.00	
00 Target amount (line 54 x line 55)					0.00	
00 Difference between adjusted inpatient operat	ing cost and tar	-get amount (I	ine 56 minus I	ine 53)	C	57
00 Bonus payment (see instructions)					C	
00 Lesser of lines 53/54 or 55 from the cost re	porting period e	ending 1996, ι	pdated and com	pounded by the	0.00	59
market basket 00 Lesser of lines 53/54 or 55 from prior year	cost report upo	ated by the m	arket basket		0.00	0 60
00 If line 53/54 is less than the lower of line				he amount by	C	
which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter zero (see	instructions)					
00 Relief payment (see instructions)00 Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)				
PROGRAM INPATIENT ROUTINE SWING BED COST						
00 Medicare swing-bed SNF inpatient routine cos	ts through Decem	nber 31 of the	cost reportin	g period (See	C	64
instructions)(title XVIII only)		04 6 11				
00 Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts atter Decembe	er 31 of the c	ost reporting	period (See	C) 65
00 Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	54 plus line 6	5)(title XVIII	onlv). For	c c	66
CAH (see instructions)	· · · · · · · · · · · · · · · · · · ·			57		
00 Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost rep	orting period	C	67
(line 12 x line 19) 00 Title V or XIX swing-bed NF inpatient routin	o costs after Do	combor 21 of	the cost repor	ting poriod		
00 Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)		cember 31 01	the cost repor	ting period		68 0
00 Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	68)		C	69 (
PART III - SKILLED NURSING FACILITY, OTHER N					1	
00 Skilled nursing facility/other nursing facil 00 Adjusted general inpatient routine service c						70
00 Program routine service cost (line 9 x line			<i>∠</i>)			71
00 Medically necessary private room cost applic		(line 14 x li	ne 35)			73
00 Total Program general inpatient routine serv	ice costs (line	72 + line 73)				74
00 Capital -related cost allocated to inpatient	routine service	costs (from W	lorksheet B, Pa	rt II, column		75
26, line 45) 00 Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00 Program capital -related costs (line 9 x line	,					77
00 Inpatient routine service cost (line 74 minu						78
00 Aggregate charges to beneficiaries for exces	• •		· · ·			79
00 Total Program routine service costs for comp		ost limitation	ı (line 78 minu	s line 79)		80
00 Inpatient routine service cost per diem limi 00 Inpatient routine service cost limitation (1				81
00 Reasonable inpatient routine service cost frimitation (,					83
00 Program inpatient ancillary services (see in						84
00 Utilization review - physician compensation	(see instruction					85
00 Total Program inpatient operating costs (sum		ough 85)				86
PART IV - COMPUTATION OF OBSERVATION BED PAS 00 Total observation bed days (see instructions					115	5 87
00 Adjusted general inpatient routine cost per		line 2)			1, 344. 08	

Health Financial Systems	ST. ELIZABE	TH CENTRAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				Fo 09/30/2014	Date/Time Prep 2/27/2015 7:02	
		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	484, 234	6, 309, 128	0. 07675 [.]	1 557, 793	42, 811	90.00
91.00 Nursing School cost	2, 487, 724	6, 309, 128	0.394300	5 557, 793	219, 941	91.00
92.00 Allied health cost	0	6, 309, 128	0.00000	557, 793	0	92.00
93.00 All other Medical Education	0	6, 309, 128	0.00000	557, 793	0	93.00

JMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150003	Period: From 01/01/2014	Worksheet D-1	
			To 09/30/2014	Date/Time Prep 2/27/2015 7:02	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	oxcluding nowborn)		4, 694	1.0
	Inpatient days (including private room days and observation bed days, Private room days (excluding swing-bed and observation bed days	d and newborn days)	ivate room days,	4, 694 4, 694 0	2. (
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	dave)	-	4, 279	4. (
00	Total swing-bed SNF type inpatient days (including private room reporting period	5 7	r 31 of the cost	4, 279	
00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	6.
00	Total swing-bed NF type inpatient days (including private room reporting period	3, 0		0	
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	5		0	
00	Total inpatient days including private room days applicable to newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl		Ū į	570	
	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII on	ons)	5 .		11.
	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX	er 0 on this line)			12.
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.
	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	
5. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17.
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost	0.00	18.
9. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19.
0. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20.
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing period (line	6, 309, 128 0	
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23.
4. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25.
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 6, 309, 128	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	28. 29.
	Semi -private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27 \div	line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		+:>	0.00	
	Average per diem private room charge differential (line 32 minu		tions)	0.00	
	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 25)	51)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36)	d private room cost di	fferential (line	0 6, 309, 128	36 37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTO			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see i			1, 344. 08	38
	Program general inpatient routine service cost per drem (see 1	-		766, 126	
	Medically necessary private room cost applicable to the Program	i (line 14 x line 35)		0	40

				CCN: 150003	Period: From 01/01/2014		
					To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
	Cost Center Description	Total	Ti t Total	le XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost				(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.
00	INTENSIVE CARE UNIT	2,007,871	1, 083	1, 853. 9	9 0	0	43
. 00	CORONARY CARE UNIT						44
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						46
. 00	Cost Center Description	1					
00	Program inpatient ancillary service cost (Wks	t D 2 col 2	line 200)			1.00 809,388	8 48
. 00 . 00	Total Program inpatient costs (sum of lines 4			ns)		1, 575, 514	
	PASS THROUGH COST ADJUSTMENTS	A <i>i i</i>		•			
. 00	Pass through costs applicable to Program inpa	tient routine :	services (from	Wkst. D, sum	of Parts I and	0	50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	tient ancillar	v services (fr	om Wkst. D. s	um of Parts II	0	51
	and IV)		, (
. 00	Total Program excludable cost (sum of lines 5		lated are -'		atict and	0	
. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		rated, non-pny	sician anestr	etist, and	0	53
	TARGET AMOUNT AND LIMIT COMPUTATION	_,				1	
. 00	Program discharges					0	
. 00 . 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 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	orting period o	ending 1996, ι	pdated and co	mpounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year of	ost report, up	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines	55, 59 or 60	enter the less	er of 50% of		0	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)	listi ucti olis)				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	s through Decer	mber 31 of the	cost reporti	na period (See	0	64
. 00	instructions) (title XVIII only)	is through beech			ng period (see		/ ⁰
. 00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the c	ost reporting	period (See	0	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	e costs (line)	64 nlus line 6	5)(title XVII	lonly) For	0	66
. 00	CAH (see instructions)				r onry). For		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	f the cost re	porting period	0	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	rtina period	0	68
	(line 13 x line 20)					_	
. 00	Total title V or XIX swing-bed NF inpatient r			,		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70
. 00	Adjusted general inpatient routine service co						71
. 00	Program routine service cost (line 9 x line 7		(line 14 ···	no 25)			72
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73
. 00	Capital -related cost allocated to inpatient r				art II, column		75
00	26, line 45)	2)					_,
. 00 . 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minus						78
. 00	Aggregate charges to beneficiaries for excess			· · · ·			79
. 00 . 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ost limitation	(line 78 min	us line 79)		80
. 00	Inpatient routine service cost per drem find ()				82
. 00	Reasonable inpatient routine service costs (s						83
. 00	Program inpatient ancillary services (see ins						84
. 00 . 00	Utilization review - physician compensation (Total Program inpatient operating costs (sum						85
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1	
. 00	Total observation bed days (see instructions)					415	
. 00	Adjusted general inpatient routine cost per d					1, 344. 08	

Health Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
		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	484, 234	6, 309, 128	0. 07675	1 557, 793	42, 811	90.00
91.00 Nursing School cost	0	6, 309, 128	0.00000	557, 793	0	91.00
92.00 Allied health cost	0	6, 309, 128	0.00000	557, 793	0	92.00
93.00 All other Medical Education	0	6, 309, 128	0.00000	557, 793	0	93.00

Health Financial Systems ST. ELIZABI		CCN: 150003	Peri od:	eu of Form CMS-2 Worksheet D-3	
		0000	From 01/01/2014		
			To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
	Ti tl	e XVIII	Hospi tal	PPS	2 0111
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
			4 050 420		20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T			4, 059, 430		30.00
41. 00 04100 SUBPROVIDER - IRF			1, 803, 272		41.00
42.00 04200 SUBPROVIDER - TRF			0		41.00
43. 00 04300 NURSERY			0		42.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0.0000	00 0	0	50.00
51.00 05100 RECOVERY ROOM		0.0000			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2616		e e e e e e e e e e e e e e e e e e e	
56. 00 05600 RADI OI SOTOPE		15. 6395		0	56.00
56. 02 05602 MRI		0. 0496		25, 072	
56. 03 05603 ULTRASOUND		0. 1526		36, 718	
57. 00 05700 CT SCAN		0.0619			
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
60. 00 06000 LABORATORY		0. 1600			
60. 01 06001 BLOOD LABORATORY		0.0000		0	60.0
65. 00 06500 RESPI RATORY THERAPY		0. 5317	35 1, 009, 433	536, 751	65.0
66. 00 06600 PHYSI CAL THERAPY		0.3950	88 337, 065	133, 170	66.0
58.00 06800 SPEECH PATHOLOGY		0.6034	30 32, 998	19, 912	68.0
59. 00 06900 ELECTROCARDI OLOGY		0. 4021	18 526, 623	211, 765	69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2657	39 89, 349	23, 744	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3064	03 896, 284	274, 624	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 4843		41, 620	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2732	55 3, 231, 236	882, 951	73.0
74.00 07400 RENAL DIALYSIS		0. 7866	81 450, 030	354, 030	74.0
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 1686	67 0	0	76.9
OUTPATIENT SERVICE COST CENTERS			1		
38.00 08800 RURAL HEALTH CLINIC		0.0000		0	
39. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER		0.0000		0	
91. 00 09100 EMERGENCY		0. 2069		112, 595	
91.01 09101 WOUND CARE		0. 4154			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9983	80 0	0	92.0
OTHER REIMBURSABLE COST CENTERS		I			
95. 00 09500 AMBULANCE SERVICES			-	_	95.0
97.00 09700 DURABLE MEDICAL EQUIP SOLD		0.0000			
200.00 Total (sum of lines 50-94 and 96-98)			13, 096, 915	3, 406, 837	
Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		12 00/ 015		201.0
202.00 Net Charges (line 200 minus line 201)		1	13, 096, 915		202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150003	Peri od:	Worksheet D-3	
			From 01/01/2014 To 09/30/2014	Date/Time Pre 2/27/2015 7:0	pared
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 03000 ADULTS & PEDIATRICS			832, 752		30.0
. 00 03100 INTENSIVE CARE UNIT			547, 374		31.0
. 00 04100 SUBPROVI DER – I RF			0		41.0
. 00 04200 SUBPROVI DER			0		42.0
. 00 04300 NURSERY			0		43.0
ANCI LLARY SERVI CE COST CENTERS					
. 00 05000 OPERATING ROOM		0.0000		0	50.0
. 00 05100 RECOVERY ROOM		0.0000	00 0	0	51. (
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2616	52 114, 561	29, 975	54. (
. 00 05600 RADI 0I SOTOPE		15. 6395	32 0	0	56.0
. 02 05602 MRI		0. 0496	66 110, 327	5, 480	56.
. 03 05603 ULTRASOUND		0. 1526	41 44, 552	6, 800	56.
. 00 05700 CT SCAN		0.0619	62 220, 607	13, 669	57.
. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000	00 0	0	58.0
. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000	00 0	0	59.0
. 00 06000 LABORATORY		0. 1600	94 816, 636	130, 739	60.
. 01 06001 BLOOD LABORATORY		0.0000	00 0	0	60.
. 00 06500 RESPI RATORY THERAPY		0. 5317	35 262, 572	139, 619	65.
. 00 06600 PHYSI CAL THERAPY		0. 3950	88 44, 349	17, 522	66.
. 00 06800 SPEECH PATHOLOGY		0.6034		1, 040	
. 00 06900 ELECTROCARDI OLOGY		0. 4009		38, 297	
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2657		5, 753	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3064		73, 402	
. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 4843		6, 905	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2732		257, 610	
. 00 07400 RENAL DIALYSIS		0. 7866		54, 165	
. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 1686		0	
OUTPATIENT SERVICE COST CENTERS				-	
. 00 08800 RURAL HEALTH CLINIC		0.0000	00 0	0	88.
. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER		0.0000		0	
. 00 09100 EMERGENCY		0. 2069		28, 412	
. 01 09101 WOUND CARE		0. 4154		0	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9983		0	
OTHER REIMBURSABLE COST CENTERS					1
. 00 09500 AMBULANCE SERVICES					95.
. 00 09700 DURABLE MEDICAL EQUIP SOLD		0.0000	00 0	0	
0.00 Total (sum of lines 50-94 and 96-98)		0.0000	3, 135, 177	809, 388	
1.00 Less PBP Clinic Laboratory Services-Program only cha	raes (line 61)		0,100,177	007,000	200.
2.00 Net Charges (line 200 minus line 201)	gee (1110 01)		3, 135, 177		202.

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider (CCN: 150003	Period: From 01/01/2014 To 09/30/2014	Worksheet E Part A Date/Time Pi 2/27/2015 7:	repared
		Title	e XVIII	Hospi tal	PPS	
			0	1.00	2.00	
00	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS DRG Amounts Other than Outlier Payments			5, 270, 665		1.
)))1	DRG amounts other than outlier payments for discharges occurring	prior		3, 270, 003		1.
	to October 1, 2013 (see instructions)					
)2	DRG amounts other than outlier payments for discharges occurring	g on or		0		1.
03	after October 1, 2013 (see instructions) DRG for Federal specific operating payment for Model 4 BPCI (see			0		1.
55	instructions)	-		Ŭ		''
00	Outlier payments for discharges. (see instructions)			83, 354		2.
)1))	Outlier reconciliation amount			0		2.
02 00	Outlier payment for discharges for Model 4 BPCI (see instruction Managed Care Simulated Payments	15)		654, 807		2.
00	Bed days available divided by number of days in the cost reporti	na		92.48		4.
	period (see instructions)	3				
~~	Indirect Medical Education Adjustment			0.00		
00	FTE count for allopathic and osteopathic programs for the most in cost reporting period ending on or before 12/31/1996. (see instru			0.00		5.
00	FTE count for allopathic and osteopathic programs which meet the			0.00		6.
	criteria for an add-on to the cap for new programs in accordance	e with 42				
20	CFR 413.79(e)	dam 42		0.00		-
00	MMA Section 422 reduction amount to the IME cap as specified une CFR $\frac{1}{10}$ (1)(iv)(B)(1)	Jer 42		0.00		7.
D1	ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7.
	CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July	1, 2011				
00	then see instructions.	c and		0.00		8.
00	Adjustment (increase or decrease) to the FTE count for allopathi osteopathic programs for affiliated programs in accordance with			0.00		8.
	413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12	2, 1998,				
	page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2					
D1	The amount of increase if the hospital was awarded FTE cap slots			0.00		8.
	section 5503 of the ACA. If the cost report straddles July 1, 20 instructions.	JTI, See				
02	The amount of increase if the hospital was awarded FTE cap slots	s from a		0.00		8.
	closed teaching hospital under section 5506 of ACA. (see instruc					
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	(8, 8,01		0.00		9.
00	FTE count for allopathic and osteopathic programs in the curren	t vear		0.00		10.
	from your records	<i>J</i> = =:				
00	FTE count for residents in dental and podiatric programs.			0.00		11.
00	Current year allowable FTE (see instructions)			0.00 0.00		12.
00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on		0.00		13.
00	or after September 30, 1997, otherwise enter zero.			0.00		
00	Sum of lines 12 through 14 divided by 3.			0.00		15
	Adjustment for residents in initial years of the program			0.00		16
00	Adjusment for residents displaced by program or hospital closure Adjusted rolling average FTE count	9		0.00 0.00		17
00	Current year resident to bed ratio (line 18 divided by line 4).			0.00000		19
00	Prior year resident to bed ratio (see instructions)			0.000000		20.
00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000		21.
00	IME payment adjustment (see instructions)	100 0 11		0		22.
00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen		ne MMA	0.00		23.
00	slots under 42 Sec. 412.105 $(f)(1)(iv)(C)$.	i cap		0.00		23.
00	IME FTE Resident Count Over Cap (see instructions)			0.00		24
00	If the amount on line 24 is greater than -O-, then enter the low	ver of		0.00		25.
00	line 23 or line 24 (see instructions)			0,000000		24
00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0.000000		26.
00	IME add-on adjustment amount (see instructions)			0.000000		27.
00	Total IME payment (sum of lines 22 and 28)			0		29.
_	Disproportionate Share Adjustment					
00	Percentage of SSI recipient patient days to Medicare Part A pati	ent days		5.65		30
00	(see instructions) Percentage of Medicaid patient days (see instructions)			13.52		31
00	Sum of Lines 30 and 31			13. 52		32
00	Allowable disproportionate share percentage (see instructions)			5. 21		33.
00	Disproportionate share adjustment (see instructions)			68, 651		34

.CUL/	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150003	Period: From 01/01/2014	Worksheet E Part A	2552-
			To 09/30/2014	Date/Time Pre	
		Title XVIII	Hospi tal	2/27/2015 7:0 PPS	<u>z alli</u>
			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment		0.046 200 142	0	1 25
00 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		9, 046, 380, 143 0. 000044963	0. 00000000	
	Hospital uncompensated care payment (If line 34 is zero,		406, 752	0	
0.2	enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment		204 220	0	25
03	amount (see instructions)		304, 228	0	35.
00	Total uncompensated care (sum of columns 1 and 2 on line		304, 228		36.
	35.03) Additional payment for high percentage of ESRD beneficiary di	scharges			-
	Total Medicare discharges on Worksheet S-3, Part I		0		40.
	excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				
00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.
01	682, 683, 684 an 685. (see instructions)				4.1
01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.
00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.
00	qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.
	682, 683, 684 an 685. (see instructions)		Ŭ		
00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0. 000000		44.
00	Average weekly cost for dialysis treatments (see		0.00		45.
00	instructions)		0		14
00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.
00	Subtotal (see instructions)		5, 726, 898		47
00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)		0		48
00	Total payment for inpatient operating costs SCH and MDH		5, 726, 898		49
00	only (see instructions)		422 002		E0
00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		433, 002		50
00	Exception payment for inpatient program capital (Worksheet		0		51.
00	L, Part III, see instructions) Direct graduate medical education payment (from Worksheet		0		52
	E-4, line 49 see instructions).				
00 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies		877, 213 0		53 54
00	Net organ acquisition cost (Worksheet D-4 Part III, col.		0		55
00	1, line 69) Cost of physicians' services in a teaching hospital (see		0		56
00	intructions)		0		50
00	Routine service other pass through costs (from Wkst D,		1, 307, 991		57
00	Part III, column 9, lines 30 through 35). Ancillary service other pass through costs from Worksheet		121, 989		58
	D, Part IV, col. 11 line 200)		0.447.000		-
00 00	Total (sum of amounts on lines 49 through 58) Primary payer payments		8, 467, 093 1, 789		59 60
00	Total amount payable for program beneficiaries (line 59		8, 465, 304		61
00	minus line 60) Deductibles billed to program beneficiaries		565, 109		62
00	Coinsurance billed to program beneficiaries		14, 592		63
00	Allowable bad debts (see instructions)		219, 117		64
00 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see		142, 426 78, 157		65 66
55	instructions)		70, 137		
	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8, 028, 029		67
00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68
00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69
00	96). (For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70
50	RURAL DEMONSTRATION PROJECT		0		70
92	Bundled Model 1 discount amount		0		70
93	HVBP incentive payment (see instructions)		0		70
94	Hospital readmissions reduction adjustment (see instructions)		-7,907		70
95	Recovery of accel erated depreciation		0		70
96	Low volume adjustment for federal fiscal year (yyyy)		0 0		70

	Financial Systems ST. ELIZABETH			u of Form CMS-	2002-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150003	Period: From 01/01/2014	Worksheet E Part A	
			To 09/30/2014		pared.
			10 07/00/2011	2/27/2015 7:0	
		Title XVIII	Hospi tal	PPS	
			Prior to	0n/After	
			October 1	October 1	
		0	1.00	2.00	
70.97	Low volume adjustment for federal fiscal year (yyyy)		0 0		70.97
	(Enter in column 0 the corresponding federal year for the				
	period ending on or after 10/1)				
70. 98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus		8, 020, 122		71.00
	lines 69 & 70)				
71.01	Sequestration adjustment (see instructions)		160, 402		71.01
72.00	Interim payments		7, 162, 665		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01,		697, 055		74.00
	72 and 73				
75.00	Protested amounts (nonallowable cost report items) in		0		75.00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2		0		90.00
	(see instructions)				
	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see		0		92.00
	instructions)				
93.00	Capital outlier reconciliation adjustment amount (see		0		93.00
	instructions)				
94.00	The rate used to calculate the time value of money (see		0.00		94.00
05 00	instructions)		~		
95.00	Time value of money for operating expenses (see		0		95.00
0/ 00	instructions)				
96.00	Time value of money for capital related expenses (see		0		96.00
	instructions)				1

			From 01/01/2014 To 09/30/2014	Part B Date/Time Prep 2/27/2015 7:02	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructi	anc)		3, 527	1.00 2.00
3.00	PPS payments	0115)		3, 442, 740 2, 798, 086	3.00
4.00	Outlier payment (see instructions)			42, 686	4.00
5.00	Enter the hospital specific payment to cost ratio (see instruct	tions)		0.000	5.00
6.00 7.00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0.00	6.00 7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Pa	art IV, column 13, lin	e 200	39, 819	9.00
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 3, 527	10.00 11.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			5, 527	11.00
	Reasonabl e charges				
	Ancillary service charges Organ acquisition charges (from Worksheet D-4, Part III, line 6	(0, col , 4)		12, 906 0	12.00 13.00
	Total reasonable charges (sum of lines 12 and 13)	59, COL 4)		12, 906	
	Customary charges				
	Aggregate amount actually collected from patients liable for pa			0	
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR 413.13(e)	payment for services	on a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
	Total customary charges (see instructions)			12, 906	
19.00	Excess of customary charges over reasonable cost (complete only instructions)	/if line 18 exceeds l	ine 11) (see	9, 379	19.00
20.00	Excess of reasonable cost over customary charges (complete only	/ifline 11 exceeds	ine 18) (see	0	20.00
	instructions)				
	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	instructions)		3, 527 0	21.00 22.00
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			2, 880, 591	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)	623, 718	
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus t			2, 260, 400	27.00
28. 00	see instructions) Direct graduate medical education payments (from Worksheet E-4,	ling EQ)		0	28.00
	ESRD direct medical education costs (from Worksheet E-4, line 3	,		0	28.00
	Subtotal (sum of lines 27 through 29)	/		2, 260, 400	
31.00	Primary payer payments			311	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	5)		2, 260, 089	32.00
	Composite rate ESRD (from Worksheet I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			183, 387	1
	Adjusted reimbursable bad debts (see instructions)	(ati ana)		119, 202	
	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	ictions)		85, 868 2, 379, 291	36.00 37.00
	MSP-LCC reconciliation amount from PS&R			2, 377, 271	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.98	Partial or full credits received from manufacturers for replace	ed devices (see instru	ctions)	0	39.98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 2, 379, 291	39.99 40.00
	Sequestration adjustment (see instructions)			47, 586	
	Interim payments			2, 281, 396	1
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00 44.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	chapter 1	50, 309 0	43.00 44.00
17.00	§115. 2				00
00.00	TO BE COMPLETED BY CONTRACTOR				00.07
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
× I. UU				-	
	The rate used to calculate the Time Value of Money			0.001	92.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150003	Period: From 01/01/2014 To 09/30/2014		pare
		Titl	e XVIII	Hospi tal	PPS	
		Inpatier	nt Part A	Pa	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		7, 162, 6		2, 281, 396	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	1				
01	ADJUSTMENTS TO PROVIDER			0	0	3
02				0	0	3
03				0	0	3
04				0	0	3
05				0	0	3
	Provider to Program		1			
50	ADJUSTMENTS TO PROGRAM			0	0	3
51 52				0	0	3
52 53				0	0	3
53				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		7, 162, 6	65	2, 281, 396	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
~~	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1)					
	Program to Provider		1			
01	TENTATI VE TO PROVI DER			0	0	5
02				0	0	5
03				0	0	5
- 0	Provider to Program		1			
50 E 1	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
//	5. 50-5. 98)			0	0	"
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		697, 0	55	50, 309	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		7, 859, 7		2, 331, 705	7
				Contractor	NPR Date	
			0	Number	(Mo/Day/Yr)	
			0	1.00	2.00	8

Health Financial Systems ST. ELIZABETH CENTRAL In Lieu of Form CMS-2							
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150003	Peri od:	Worksheet E-1 Part II			
			From 01/01/2014 To 09/30/2014	Date/Time Pre	pared:		
				2/27/2015 7:0	2 am		
		Title XVIII	Hospi tal	PPS			
				1.00			
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS							
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION							
1.00							
2.00							
3.00	0	3.00					
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1,	8-12		0	4.00		
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	22		0	5.00		
6.00	Total hospital charity care charges from Wkst S-10, column 3 li			0	6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of cer Part I line 168	tified Hill technology	worksneet S-2,	0	7.00		
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00		
9,00	Sequestration adjustment amount (see instructions)			0	9.00		
10,00	Calculation of the HIT incentive payment after sequestration (s	ee instructions)		0	10.00		
10.00	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			0	10.00		
30, 00	Initial/interim HIT payment adjustment (see instructions)			0	30.00		
31.00	Other Adjustment (specify)			0	31.00		
	Balance due provider (line 8 (or line 10) minus line 30 and lin	e 31) (see instruction	s)	0	32.00		
		, (2011)		0			

	Financial Systems ST. ELIZABETH CEN			u of Form CMS-2	
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150003	Period: From 01/01/2014 To 09/30/2014	Worksheet E-3 Part VII Date/Time Pre 2/27/2015 7:02	pare
		Title XIX	Hospi tal	Cost	<u> </u>
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	CES FOR TITLES V OR X	IX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		1 575 514		1.
00	Medical and other services		1, 575, 514	0	
00	Organ acquisition (certified transplant centers only)		0	0	3
00	Subtotal (sum of lines 1, 2 and 3)		1, 575, 514	0	
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		1, 575, 514	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges				
	Routine service charges		0		8
	Ancillary service charges		3, 135, 177	0	
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0	0	1
. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		3, 135, 177	0	12
. 00	Amount actually collected from patients liable for payment for s	arvices on a charge	0	0	13
. 00	basis	er vi ces on a charge	Ŭ	0	
. 00	Amounts that would have been realized from patients liable for p	avment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with 42			-	
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15
. 00	Total customary charges (see instructions)		3, 135, 177	0	16
. 00	Excess of customary charges over reasonable cost (complete only	1, 559, 663	0	17	
	line 4) (see instructions)			_	
3. 00	Excess of reasonable cost over customary charges (complete only	If line 4 exceeds lin	e 0	0	18
0 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line 16)		1, 575, 514	0	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con	npleted for PPS provi		0	2
2. 00	Other than outlier payments		0	0	22
	Outlier payments		0	0	23
	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		25
. 00	Routine and Ancillary service other pass through costs		0	0	26
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		1, 575, 514	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1 575 514	0	
	Deductiblies		1, 575, 514 0	0	
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	1, 575, 514	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		
	Subtotal (line 36 ± line 37)	1, 575, 514	0	38	
	Direct graduate medical education payments (from Wkst. E-4)		0		39
0. 00	Total amount payable to the provider (sum of lines 38 and 39)		1, 575, 514	0	40
. 00	Interim payments		1, 575, 514	0	
				0	42
	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance		0	0	

	Financial Systems ST. ELIZABE SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the General Fund column onl			Period: From 01/01/2014	u of Form CMS- Worksheet G	
nu-ty		y)		09/30/2014	Date/Time Pre 2/27/2015 7:0	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
c	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	8, 796, 486	(0	0	1
	Temporary investments	0	C	0	0	
	Notes receivable	0	(0 0	0	
	Accounts receivable	40, 974, 387	(0	0	
	Other receivable Allowances for uncollectible notes and accounts receivable	0		0	0	
	Inventory	4, 871, 536			0	
	Prepaid expenses	4, 071, 330	(0	
	Other current assets	7, 287, 366	(0	0	
00	Due from other funds	0	(0	10
	Total current assets (sum of lines 1-10)	61, 929, 775	(0 0	0	11
	TIXED ASSETS	40 7/0 //5				1 4 6
	Land improvements	12, 769, 465 2, 216, 033	(0	
	Accumul ated depreciation	2,210,033			0	
	Buildings	234, 221, 317			0	
	Accumulated depreciation	0	(0	0	
	Leasehold improvements	2, 064, 766	(0	0	
	Accumulated depreciation	0	(-	0	
	Fixed equipment	79, 003, 546	(0	0	
	Accumulated depreciation Automobiles and trucks				0	20
	Accumulated depreciation				0	
	Major movable equipment	0	(Ó	0	
00	Accumulated depreciation	0	(0 0	0	
	Minor equipment depreciable	0	(0 0	0	25
	Accumulated depreciation	0	(0 0	0	
	HIT designated Assets	0	(-	0	
	Accumul ated depreciation Minor equipment-nondepreciable	-109, 085, 773		, u	0	
	Total fixed assets (sum of lines 12-29)	221, 189, 354			0	
-	DTHER ASSETS			-1 -1		
00	Investments	9, 872, 836	(0 0	0	31
	Deposits on Leases	0	(-	0	
	Due from owners/officers	0	(-	0	
	Other assets Total other assets (sum of lines 31-34)	3, 444, 082 13, 316, 918		-	0	
	Total assets (sum of lines 11, 30, and 35)	296, 436, 047			0	
	CURRENT LI ABI LI TI ES	27071007017	`	<u>, </u>		
	Accounts payable	10, 608, 251	(0 0	0	37
	Salaries, wages, and fees payable	12, 976, 183	(-	0	
	Payroll taxes payable	0	(0	0	
	Notes and Loans payable (short term)				0	
	Deferred income Accelerated payments				0	41
	Due to other funds	0	(0	0	
	Other current liabilities	8, 725, 628	(o o	0	
00	Total current liabilities (sum of lines 37 thru 44)	32, 310, 062		0	0	45
	LONG TERM LIABILITIES					
	Mortgage payable	0			0	
	Notes payable Unsecured Loans				0	
	Other long term liabilities	17, 188, 369			0	
	Total long term liabilities (sum of lines 46 thru 49	17, 188, 369		-	0	
00	Total liabilites (sum of lines 45 and 50)	49, 498, 431	(0 0	0	51
_	CAPI TAL ACCOUNTS					
	General fund balance	246, 937, 616				52
	Specific purpose fund		C			53
	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54
	Governing body created - endowment fund balance					56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
1	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	246, 937, 616	(0	0	
00	Total liabilities and fund balances (sum of lines 51 and	296, 436, 047	() Ol	0	60

Health Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	eu of Form CMS-2	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 150003	Period: From 01/01/2014 To 09/30/2014		
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
					5.00	
1.00 Fund balances at beginning of period	1.00	2.00	3.00	4.00	5.00	1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)		-7, 197, 360				2.00
3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify)	o	264, 656, 640		0	0	3.00 4.00
5.00	0			0	0	4.00 5.00
6.00	0			0	0	6.00
7.00 8.00	0			0	0	7.00 8.00
9.00	0			0	0	9.00
10.00 Total additions (sum of line 4-9)		0		0		10.00
11.00 Subtotal (line 3 plus line 10) 12.00 ADJUST TO INTERNAL FS	17, 719, 024	264, 656, 640		0	0	11. 00 12. 00
13.00	0			0	0	13.00
14.00 15.00	0			0	0	14.00 15.00
16.00	0			0	0	16.00
	0	47 740 004		0	0	17.00
18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance		17, 719, 024 246, 937, 616		0		18.00 19.00
sheet (line 11 minus line 18)						
	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29)	0			0		1.00 2.00
3.00 Total (sum of line 1 and line 2)	0			0		2.00
4.00 Additions (credit adjustments) (specify)		0				4.00
5. 00 6. 00		0				5.00 6.00
7.00		0				7.00
8.00		0				8.00
9.00 10.00 Total additions (sum of line 4-9)	0	0		0		9.00 10.00
11.00 Subtotal (line 3 plus line 10)	0			0		11.00
12.00 ADJUST TO INTERNAL FS 13.00		0				12.00 13.00
14.00		0				14.00
15.00		0				15.00
16. 00 17. 00		0				16. 00 17. 00
18.00 Total deductions (sum of lines 12-17)	0	0		0		18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00
	1 I		I	I	· · · · · ·	

Health Financial Systems

In Lieu of Form CMS-2552-10

	Financial Systems ST. ELIZABE	TH CENTRAL				
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150003	Peri od: From 01/01/2014 To 09/30/2014	Worksheet G-2 Parts I & II Date/Time Pre 2/27/2015 7:0	pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1.00	General Inpatient Routine Services Hospital		62, 269, 50	1	62, 269, 504	1.00
2.00	SUBPROVIDER - IPF		02, 209, 50	54	02, 209, 304	2.00
3.00	SUBPROVIDER - IRF		2, 188, 53	38	2, 188, 538	3.00
4.00	SUBPROVI DER		2,100,00	0	2, 100, 330	4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		64, 458, 04	42	64, 458, 042	10.00
	Intensive Care Type Inpatient Hospital Services		1			
11.00	INTENSIVE CARE UNIT		11, 136, 88	31	11, 136, 881	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	of Linco	11 12/ 00	21	11 12/ 001	15.00
16.00	Total intensive care type inpatient hospital services (sum 11-15)	or times	11, 136, 88	31	11, 136, 881	16.00
17.00	Total inpatient routine care services (sum of lines 10 and	16)	75, 594, 92	22	75, 594, 923	17.00
18.00	Ancillary services	10)	243, 943, 84		545, 035, 250	
19.00	Outpatient services		6, 858, 3		63, 040, 733	
20.00	RURAL HEALTH CLINIC		0,000,0	0 0	00,010,700	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES			0 0	0	23.00
24.00	СМНС					24.00
24. 10	CORF			0 0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE			0 3, 115, 158	3, 115, 158	
	NI CU		8, 409, 80		8, 427, 454	
27.01	NON REIMBURSABLE		-2, 827, 70		-2, 603, 315	
27.02 27.03	HHA PHYSICIAN (CORP 44)			0 5, 484, 997 0 45, 949, 170	5, 484, 997 45, 949, 170	
	Total patient revenues (sum of lines 17-27)(transfer colum	n 2 to Wkst	331, 979, 12		744, 044, 370	
20.00	G-3, line 1)	II J LU WKSL.	331, 7/7, 12	412, 005, 244	744, 044, 370	20.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			35, 455, 949		29.00
30.00	AFFILIATES		175, 617, 8	17		30.00
31.00	PHYSICIAN (CORP 44)		40, 744, 30	08		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
	Total additions (sum of lines 30-35)			216, 362, 125		36.00
	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00 39.00
39.00 40.00				0		40.00
40.00 41.00				0		40.00
41.00 42.00	Total deductions (sum of lines 37-41)			́		41.00
+∠. UU	Total operating expenses (sum of lines 29 and 36 minus lin	a (1) (transfor		251, 818, 074		42.00
43.00						

STATEMENT OF REVENUES AND EXPENSES On the Down of the CCN: 150003 Provider CCN: 150003 Provider CCN: 150003 Worksheet G-3 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, Line 28) 744,044,370 1.00 2.00 Less contractual allowances and discounts on patients' accounts 490,991,581 2.00 3.00 Net patient revenues (line 1 minus line 2) 744,044,370 1.00 3.00 Net patient revenues (from Wkst. G-2, Part II, Line 43) 253,052,789 3.00 5.00 Net income from inservice to patients (line 3 minus line 4) 1.234,715 5.00 0.01 Conne from investments 0 6.00 1.234,715 5.00 0.00 Revenue from telephone and other miscel laneous communication services 0 7.00 8.00 9.00 0 11.00 11.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.01 10.01 1.00 10.01 1.00 10.01 1.00 1.01 1.00 1.00 10.01 1.00 1.00 1.00	Heal th	Financial Systems ST. ELIZ	ABETH CENTRAL	Inlie	u of Form CMS-2	2552-10
To 09/30/214 Date/Time Prepared: 27/2015 7.02 an 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 744,044,370 1.00 2.00 Less contractual allowances and discounts on patients' accounts 490,991,581 2.00 3.00 Net patient revenues (line 1 minus line 2) 253,052,789 3.00 4.00 Less contractual allowances (from Wkst. G-2, Part II, line 43) 251,818,074 4.00 5.00 Net income from service to patients (line 3 minus line 4) 1,234,715 0.01 Revenues from telephone and other miscellaneous communication services 0 0.00 Revenue from telephone and other miscellaneous communication services 0 8.00 0.01 OPEncember from telephone and other miscellaneous communication services 0 9.00 0.00 Parchase discounts 0 10.00 10.00 0.00 Parchase discounts 0 11.00 12.00 0.01 Revenue from neals sold to employees and guests 0 12.00 0.02 Parking lot receipts 0 13.00 0.03 Revenue from neals of medical and surglical supplies to other than patients <td< td=""><td></td><td></td><td></td><td></td><td>1</td><td>002 10</td></td<>					1	002 10
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, Line 28) 7.44, 044, 370 0.00 Less contractual allowances and discounts on patients' accounts 440, 991, 581 2.00 0.00 Less contractual allowances and discounts on patients' accounts 440, 991, 581 2.00 0.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 251, 818, 074 4.00 0.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) 1, 234, 715 5.00 0.01 Income from investments, bequests, etc 0 6.00 0 0.01 Income from investments 0 7.00 8.00 0.00 Revenue from television and radio service 0 9.00 10.00 9.00 0.01 Revenue from meals sold to employees and guests 0 11.00 12.00 0.02 Revenue from meals sold to tother hap aptients 0 12.00 0.03 Revenue from meals sold to employees and guests 0 14.00 0.04 Revenue from meals sold to employees and abstracts 0 16.00 0.05 Revenue from sale of medical records an						
Image: 100 1.00 1.00 1.00 2.00 Less contractual allowances and discounts on patients' accounts 400.991.581 2.00 2.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 253.052.789 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 251.818.074 4.00 0.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 1.234.715 5.00 0.01 Income from investments 0 1.00 1.234.715 5.00 0.00 Portributions, donations, bequests, etc 0 0 6.00 6.00 0.00 Revenues from television and radio service 0 7.00 8.00 8.00 0.00 Purchase discounts 0 11.00 <td></td> <td></td> <td></td> <td>To 09/30/2014</td> <td></td> <td></td>				To 09/30/2014		
1.00 Total patient revenues (from West. G-2, Part I, column 3, Line 28) 744, 044, 370 1.00 2.00 Less contractual allowances and discounts on patients' accounts 400, 991, 581 2.00 3.00 Net patient revenues (line 1 minus line 2) 253, 052, 789 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 251, 818, 074 4.00 0.01 Less total operating expenses (from Wkst. G-2, Part II, line 43) 1, 234, 715 5.00 0.01 Income from investments 0 1, 234, 715 5.00 0.01 Income from investments 0 6.00 6.00 6.00 0.00 Purchase (discounts) 0 7.00 8.00 8.00 8.00 8.00 9.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00					2/2//2015 7.0.	
1.00 Total patient revenues (from West. G-2, Part I, column 3, Line 28) 744, 044, 370 1.00 2.00 Less contractual allowances and discounts on patients' accounts 400, 991, 581 2.00 3.00 Net patient revenues (line 1 minus line 2) 253, 052, 789 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 251, 818, 074 4.00 0.01 Less total operating expenses (from Wkst. G-2, Part II, line 43) 1, 234, 715 5.00 0.01 Income from investments 0 1, 234, 715 5.00 0.01 Income from investments 0 6.00 6.00 6.00 0.00 Purchase (discounts) 0 7.00 8.00 8.00 8.00 8.00 9.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00					1.00	
3.00 Net patient revenues (line 1 minus line 2) 253,052,789 3.00 4.00 Less total operating expenses (from Wkst, G-2, Part II, line 43) 251,818,074 4.00 0.01 Net income from service to patients (line 3 minus line 4) 1,234,715 5.00 0.01 Income from investments 0 6.00 0.01 0.00 Revenues from telephone and other miscellaneous communication services 0 9.00 0.00 Revenue from telephone and other miscellaneous communication services 0 10.00 0.00 Revenue from telephone and other miscellaneous communication services 0 10.00 0.00 Revenue from telephone and other miscellaneous communication services 0 10.00 0.00 Revenues from telephone and other miscellaneous communication services 0 11.00 0.00 Revenues from telephone and other miscellaneous communication services 0 11.00 0.00 Revenue from andory and linen service 0 11.00 0.01 Revenue from sele of medical and surgical supplies to other than patients 0 15.00 0.00 Revenue from sele of freedical	1.00	Total patient revenues (from Wkst. G-2, Part I, column 3	3, line 28)			1.00
4.00 Less' total operating expenses (from West. G-2, Part II, line 43) 251, 818, 074 4.00 5.00 Met income from service to patients (line 3 minus line 4) 1, 234, 715 5.00 OTHER I NCOME 0 6.00 Contributions, donations, bequests, etc 0 6.00 6.00 7.00 Revenues from telephone and radio service 0 7.00 8.00	2.00					2.00
5.00 Net income from service to patients (line 3 minus line 4) 1,234,715 5.00 OTHER INCOME 0 6.00 Contributions, donations, bequests, etc 0 6.00 6.00 7.00 Income from investments 0 7.00 8.00 8.00 9.00 Revenue from telephone and other miscellaneous communication services 0 0 9.00 0.00 Revenue from telephone and other miscellaneous communication services 0 10.00 0.00 Revenue from telephone and other miscellaneous communication services 0 10.00 0.00 Revenue from telephone and other miscellaneous communication services 0 11.00 0.00 Revenue from laundry and linen service 0 12.00 13.00 11.00 Revenue from sale of medical and surgical supplies to other than patients 0 14.00 0.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 0.00 Revenue from sale of medical records and abstracts 0 18.00 12.00 0.00 Revenue from sale of medical records and abstracts 0	3.00	Net patient revenues (line 1 minus line 2)			253, 052, 789	3.00
OTHER INCOMEContributions, donations, bequests, etc01 ncome from investments08.00Revenues from television and radio service09.00Revenue from television and radio service010.00Purchase discounts010.00Purchase discounts010.00Revenue from laudry and linen service010.00Revenue from laudry and linen service011.00Revenue from rental of to employees and guests013.00Revenue from rental of living quarters014.00Revenue from sale of medical and surgical supplies to other than patients015.00Revenue from sale of drugs to other than patients016.00Revenue from sale of medical records and abstracts017.00Revenue from gifts, flowers, coffee shops, and canteen010.00Revenue from gifts, flowers, coffee shops, and canteen021.00Rental of hospital space023.00Governmental appropriations024.00CHTR UTIONS1,37024.01ELESSE1,37024.02CHTR NERVENUE1,378,15124.03INVESTMENT INCOME024.04GOTHR UTIONS1,37024.05CHTR NERVENUE/EXPENSES025.00Total (there spius files 6-24)1,37026.01Total (there spius files 6-24)1,6,351,326,0027.00EULITY INTERSTING REVENUE/EXPENSES1,6,351,326,0027.01CHTR ASSETS RELEASED <td< td=""><td>4.00</td><td>Less total operating expenses (from Wkst. G-2, Part II,</td><td>line 43)</td><td></td><td>251, 818, 074</td><td>4.00</td></td<>	4.00	Less total operating expenses (from Wkst. G-2, Part II,	line 43)		251, 818, 074	4.00
6.00 Contributions, donations, bequests, etc 0 6.00 7.00 Income from investments 0 7.00 8.00 Revenue from telexision and radio service 0 9.00 9.00 Revenue from telexision and radio service 0 9.00 10.00 Purchase di scounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Revenue from reals sold to employees and guests 0 12.00 13.00 Revenue from sale of medical and surgical supplies to other than patients 0 14.00 15.00 Revenue from sale of medical records and abstracts 0 18.00 10.00 Revenue from gifts, flowers, coffee shops, and canteen 0 21.00 10.00 Revenue from gifts, flowers, coffee shops, and canteen 0 22.00 10.00 Revenue from gifts, flowers, coffee shops, and canteen 0 22.00 10.00 Revenue from gifts, flowers, coffee shops 0 23.00 10.01 Revenue from gifts, flowers, coffee shops 0 24.00	5.00		4)		1, 234, 715	5.00
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22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER OPERATING REVENUE 10,737,477 24.00 24.01 EQUITY IN EARNINGS OF INVESTMENTS 4,378,151 24.01 24.02 NET ASSETS RELEASED 0 24.02 24.03 INVESTMENT INCOME 0 24.03 24.04 CONTRIBUTIONS 1,370 24.04 24.05 OTHER-NON-OPERATING REVENUE/EXPENSES 0 24.05 25.00 Total other income (sum of lines 6-24) 15,116,998 25.00 26.00 Total (line 5 plus line 25) 16,351,713 26.00 27.01 NET ASSETS RELEASED 22,468,139 27.00 27.02 OTHER-NON-OPERATING REVENUE/EXPENSES 3,474 27.01 27.03 MINORITY INTEREST IN CONSOLIDATED AF 1,059,460 27.03 28.00 Total other expenses (sum of line 27 and subscripts) 23,549,073 28.00	20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
23.00 Governmental appropriations 0 23.00 24.00 OTHER OPERATING REVENUE 10,737,477 24.00 24.01 EQUITY IN EARNINGS OF INVESTMENTS 4,378,151 24.01 24.02 NET ASSETS RELEASED 0 24.02 24.03 INVESTMENT INCOME 0 24.03 24.04 CONTRIBUTIONS 1,370 24.04 24.05 OTHER-NON-OPERATING REVENUE/EXPENSES 0 24.05 25.00 Total other income (sum of lines 6-24) 15, 116, 998 25.00 26.00 Total (line 5 plus line 25) 16, 351, 713 26.00 27.00 EQUITY TRANSFERS TO/FROM AFFILIATES 22, 468, 139 27.00 27.01 NET ASSETS RELEASED 3, 74 27.01 27.02 OTHER-NON-OPERATING REVENUE/EXPENSES 18,000 27.02 27.03 MINORITY INTEREST IN CONSOLIDATED AF 1,059,460 27.03 28.00 Total other expenses (sum of line 27 and subscripts) 23,549,073 28.00	21.00	Rental of vending machines			0	21.00
24.00 OTHER OPERATING REVENUE 10,737,477 24.00 24.01 EQUITY IN EARNINGS OF INVESTMENTS 4,378,151 24.01 24.02 NET ASSETS RELEASED 0 24.02 24.03 INVESTMENT INCOME 0 24.02 24.04 CONTRI BUTIONS 1,370 24.04 24.05 OTHER-NON-OPERATING REVENUE/EXPENSES 0 24.05 25.00 Total other income (sum of lines 6-24) 16,351,713 26.00 26.00 Total (line 5 plus line 25) 16,351,713 26.00 27.00 EQUITY TRANSFERS TO/FROM AFFILIATES 22,468,139 27.00 27.01 NET ASSETS RELEASED 3,474 27.01 27.02 OTHER-NON-OPERATING REVENUE/EXPENSES 3,474 27.02 27.03 MINORITY INTEREST IN CONSOLIDATED AF 1,059,460 27.03 28.00 Total other expenses (sum of line 27 and subscripts) 23,549,073 28.00	22.00	Rental of hospital space			0	22.00
24. 01 EQUITY IN EARNINGS OF INVESTMENTS 4, 378, 151 24. 01 24. 02 NET ASSETS RELEASED 0 24. 02 24. 03 INVESTMENT INCOME 0 24. 03 24. 04 CONTRI BUTI ONS 1, 370 24. 04 24. 05 OTHER-NON-OPERATING REVENUE/EXPENSES 0 24. 05 25. 00 Total other income (sum of lines 6-24) 15, 116, 998 25. 00 26. 00 Total (line 5 plus line 25) 16, 351, 713 26. 00 27. 01 NET ASSETS RELEASED 22, 468, 139 27. 00 27. 01 NET ASSETS RELEASED 3, 474 27. 01 27. 02 OTHER-NON-OPERATING REVENUE/EXPENSES 18, 000 27. 02 27. 03 MI NORITY INTEREST IN CONSOLIDATED AF 1, 059, 460 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 23, 549, 073 28. 00	23.00	Governmental appropriations			0	23.00
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27. 01 NET ASSETS RELEASED 3, 474 27. 01 27. 02 OTHER-NON-OPERATING REVENUE/EXPENSES 18, 000 27. 02 27. 03 MINORITY INTEREST IN CONSOLIDATED AF 1, 059, 460 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 23, 549, 073 28. 00						
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27. 03 MINORITY INTEREST IN CONSOLIDATED AF 1,059,460 27. 03 28. 00 Total other expenses (sum of line 27 and subscripts) 23,549,073 28. 00						
28.00 Total other expenses (sum of line 27 and subscripts) 23,549,073 28.00						
			28)			

Health Financial Systems	ST. ELI ZABETH			In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE X	VIII – PART B	Provider CCN: 1		Period:	Worksheet I-5	
				From 01/01/2014 To 09/30/2014	Date/Time Pre	nared
					2/27/2015 7:02	
				1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD	DEBTS - TITLE XVIII	- PART B				
1.00 Total expenses related to care of program	n beneficiaries (see	instructions)		0		1.00
2.00 Total payment due (from Wkst. I-4, col. 6	5, line 11) (see ins	tructions)		0	0	2.00
2.01 Total payment due (from Wkst. I-4, col. 6	5.01, line 11) (see	instructions)				2. 01
2.02 Total payment due(from Wkst. I-4, col. 6.	02, line 11) (see i	nstructions)				2. 02
2.03 Total payment due (see instructions)						2.03
2.04 Outlier payments	0		2.04			
3.00 Deductibles billed to Medicare (Part B)	0	0	3.00			
3.01 Deductibles billed to Medicare (Part B)	oatients (see instru	ctions)				3. 01
3.02 Deductibles billed to Medicare (Part B)	oatients (see instru	ctions)				3. 02
3.03 Total deductibles billed to Medicare (Par	Total deductibles billed to Medicare (Part B) patients (see instructions)					
4.00 Coinsurance billed to Medicare (Part B)	Coinsurance billed to Medicare (Part B) patients					
4.01 Coinsurance billed to Medicare (Part B)	oatients (see instru	ctions)				4.01
4.02 Coinsurance billed to Medicare (Part B)	oatients (see instru	ctions)				4.02
4.03 Total coinsurance billed to Medicare (Par	rt B) patients (see	instructions)		0	0	4.03
5.00 Bad debts for deductibles and coinsurance	e, net of bad debt r	ecoveri es		0	0	5.00
5.01 Transition period 1 (75-25%) bad debts for	or deductibles and c	oinsurance net of b	bad debt	0	0	5. 01
recoveries for services rendered on or at	fter 1/1/2011 but be	fore 1/1/2012				
5.02 Transition period 2 (50-50%) bad debts for	or deductibles and c	oinsurance net of b	bad debt	0	0	5.02
recoveries for services rendered on or at						
5.03 Transition period 3 (25-75%) bad debts for	or deductibles and c	oinsurance net of b	oad debt	0	0	5.03
recoveries for services rendered on or at						
5.04 100% PPS bad debts for deductibles and co	pinsurance net of ba	d debt recoveries f	for	0	0	5.04
services rendered on or after 1/1/2014						
5.05 Total bad debts (sum of line 5 through li	ne 5.04)			0	0	5.05
6.00 Allowable bad debts (see instructions)				0		6.00
7.00 Reimbursable bad debts for dual eligible		,		0		7. OC
8.00 Net deductibles and coinsurance billed to	o Medicare (Part B)	patients (see		0	0	8.00
instructions)						
9.00 Program payment (see instructions)		_		0	0	9.00
10.00 Unrecovered from Medicare (Part B) patier	•	· ·				10.00
11.00 Reimbursable bad debts (see instructions)			ne 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFI		RCENTAGE				
12.00 Total allowable expenses (see instruction				0		12.00
13.00 Total composite costs (from Wkst. I-4, co				0		13.00
14.00 Facility specific composite cost percenta	age (line 13 divideo	by line 12)		0. 000000		14.00

Heal th	Financial Systems	ST. ELI ZABETH	I CENTRAL		In Lie	u of Form CMS-2	2552-10
	SIS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 150003	Peri od:	Worksheet K	
					From 01/01/2014		
			Hospi ce C	CCN: 151563	To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
					Hospi ce I	2/2//2013 7.0	2 0111
		Salaries (from	Employee	Transportati		Other	
			enefits (from			othor	
			Wkst. K-2)		Wkst. K-3)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.				0	0	1.00
2.00	Capital Related Costs-Movable Equip.				0	74, 979	2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	341, 589	0		0 3, 904	70, 237	6.00
	I NPATI ENT CARE SERVI CE					-	
7.00	Inpatient - General Care	518	0		0 3, 702	0	7.00
8.00	Inpatient - Respite Care	8, 194	0		0 1, 550	0	8.00
	VI SI TI NG SERVI CES				a		
9.00	Physi ci an Servi ces	0	0		0 16, 406	0	9.00
10.00	Nursing Care	255, 615	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	4, 241	0		0 0	0	11.00
12.00	Physical Therapy	2, 718	0		0 0	0	12.00
13.00 14.00	Occupational Therapy Speech/ Language Pathology	636	0		0 0	0	13.00 14.00
14.00	Medi cal Soci al Servi ces	56, 042	0		0 0	0	14.00
16.00	Spiritual Counseling	72, 774	0		0 0	0	16.00
17.00	Dietary Counseling	12, 114	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	39, 912	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	0	0		0 0	0	21.00
21.00	OTHER HOSPICE SERVICE COSTS	<u> </u>		1	0 0		21.00
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
23.00	Anal gesi cs	0	0		0 0	0	23.00
24.00	Sedatives / Hypnotics	0	0		0 0	0	24.00
25.00	Other - Specify	0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	26.00
27.00	Patient Transportation	0	0		0 0	0	27.00
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 1, 209	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundraising	0	0		0 0	0	37.00
38.00	Other Program Costs	0	0		0 0	0	38.00
39.00	Total (sum of lines 1 thru 38)	782, 239	0	I	0 26, 771	145, 216	39.00

Heal th	Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	u of Form CMS-	2552-10
	IS OF PROVIDER-BASED HOSPICE COSTS			CCN: 150003	Peri od:	Worksheet K	
71101210					From 01/01/2014 To 09/30/2014	Date/Time Pre	
						2/27/2015 7:0	2 am
		T L L L			Hospi ce I	T L L C L O	
			Recl assi fi cati			Total (col. 8	
		<u>1-5)</u> 6.00	on 7.00	6 ± col. 7) 8.00	9.00	<u>± col. 9)</u> 10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
1.00	Capital Related Costs-Bldg and Fixt.	0	0	1	0 0	0	1.00
2.00		74,979			-	74, 979	
2.00	Capital Related Costs-Movable Equip.	74,979			/9 0		
	Plant Operation and Maintenance	0			0 0	0	
4.00	Transportation - Staff	0	0		0 0	0	
5.00	Volunteer Service Coordination	0	C		0 0	0	
6.00	Administrative and General	415, 730	C	415, 7	30 -111	415, 619	6.00
	I NPATI ENT_CARE_SERVI CE	1				(
7.00	Inpatient - General Care	4, 220					
8.00	Inpatient - Respite Care	9, 744	C	9,7	44 0	9, 744	8.00
	VI SI TI NG SERVI CES		1	1			
9.00	Physician Services	16, 406				16, 406	•
10.00	Nursing Care	255, 615				255, 615	
11.00	Nursing Care-Continuous Home Care	4, 241	0	4, 2		4, 241	11.00
12.00	Physical Therapy	2, 718	0	2,7	18 0	2, 718	12.00
13.00	Occupational Therapy	636	0	6	36 0	636	13.00
14.00	Speech/ Language Pathol ogy	0	0)	0 0	0	14.00
15.00	Medical Social Services	56, 042	0	56, 0	42 0	56, 042	15.00
16.00	Spiritual Counseling	72, 774	0	72, 7	74 0	72, 774	16.00
17.00	Dietary Counseling	0	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	39, 912	0	39,9	12 0	39, 912	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						1
22.00	Drugs, Biological and Infusion Therapy	0	0)	0 0	0	22.00
23.00	Anal gesi cs	0	0		0 0	0	23.00
24.00	Sedatives / Hypnotics	0			0 0	0	24.00
25.00	Other - Specify	0			0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0			0 0	0	•
27.00	Patient Transportation	0			0 0	0	
28.00	I maging Services	0			0 0	0	
29.00	Labs and Diagnostics	0			0 0	0	
30.00	Medical Supplies	0			0 0	0	
31.00	Outpatient Services (including E/R Dept.)	1, 209				1, 209	
32.00	Radiation Therapy	0			0 0	0	
33.00	Chemotherapy	0			0 0	0	•
34.00	Other	0			0 0	0	
54.00	HOSPICE NONREIMBURSABLE SERVICE	0		/	0 0	0	54.00
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0			0 0	0	
37.00	Fundrai si ng					0	
37.00	Other Program Costs					0	
	Total (sum of lines 1 thru 38)	954, 226			0	954, 115	
57.00		704,220		'I 754, Z	-111	754, 115	J J 7. UU

Heal th	Financial Systems	ST. ELI ZABETH	I CENTRAL		In Lie	eu of Form CMS-:	2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 150003	Peri od:	Worksheet K-1	
			Hospi ce C		From 01/01/2014 To 09/30/2014		pared:
					Hospi ce I	2/2//2013 1.0	2 011
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1100	2100	0.00		0.00	
1.00	Capital Related Costs-Bldg and Fixt.						1,00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0 0	-	
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	0	0		0 110, 211	0	6.00
0.00	I NPATI ENT CARE SERVI CE				0 110/211	ŭ	0.00
7.00	Inpatient - General Care	0	0		0 0	518	7.00
8.00	Inpatient - Respite Care	0	0	1	46 0		8.00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10.00	Nursing Care	0	0		0 0	255, 615	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0		•
12.00	Physical Therapy	0	0		0 0		
13.00	Occupational Therapy	0	0		0 0	-	
14.00	Speech/ Language Pathol ogy	0	0		0 0	-	14.00
15.00	Medical Social Services	0	0	56, 0		-	
16.00	Spiritual Counseling	0	0	00,0	0 0	-	
17.00	Di etary Counsel i ng	0	0		0 0	-	17.00
18.00	Counseling - Other	0	0		0 0	-	18.00
19.00	Home Health Aide and Homemaker	0	0		0 0	-	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	-	
21.00	Other	0	0		0 0		•
21.00	OTHER HOSPICE SERVICE COSTS					<u> </u>	21.00
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Anal gesi cs						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0		0 0	0	
28.00	I magi ng Servi ces	0	0		0 0		
29.00	Labs and Diagnostics	0	0		0 0	-	29.00
30.00	Medi cal Supplies	0	0		0 0	-	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radi ati on Therapy	0	0		0 0		
33.00	Chemotherapy	0	0		0 0	-	33.00
34.00	Other	0	0		0 0		34.00
54.00	HOSPICE NONREIMBURSABLE SERVICE	<u>Ч</u>	0		0 0	0	54.00
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0		
37.00	Fundrai si ng	0	0		0 0	-	
37.00	Other Program Costs		0		0 0	0	37.00
	Total (sum of lines 1 thru 38)	0	0	56, 1	-		•
57.00		U U	U	50, 1	110, 211	1 200, 422	1 57.00

Heal th	Financial Systems	ST. ELI ZABETH	H CENTRAL		In Lie	u of Form CMS-2	2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES			CCN: 150003	Peri od:	Worksheet K-1	
					From 01/01/2014		
			Hospi ce CO	CN: 151563	To 09/30/2014	Date/Time Prep	
					Hospi ce I	2/27/2015 7:02	
		Total	Aides	All-Other	Total (1)		
		Therapists	Arues	AIT-Other			
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00	7100		
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0		0 0		3.00
4.00	Transportation - Staff		0		0 0		4.00
5.00	Volunteer Service Coordination		0		0 0		5.00
6.00	Administrative and General		0	231, 3	78 341, 589		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0		0 518		7.00
8.00	Inpatient - Respite Care		0		0 8, 194		8.00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces		0		0 0		9.00
10.00	Nursing Care		0		0 255, 615		10.00
11.00	Nursing Care-Continuous Home Care		0		0 4, 241		11.00
12.00	Physical Therapy	2, 718	0		0 2, 718		12.00
13.00	Occupational Therapy	636	0		0 636		13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0		14.00
15.00	Medical Social Services		О		0 56, 042		15.00
16.00	Spiritual Counseling		О	72, 7	74 72, 774		16.00
17.00	Dietary Counseling		О		0 0		17.00
18.00	Counseling - Other		О		0 0		18.00
19.00	Home Health Aide and Homemaker		39, 912		0 39, 912		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0		20.00
21.00	Other		0		0 0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Anal gesi cs						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0		0 0		27.00
28.00	Imaging Services		0		0 0		28.00
29.00	Labs and Diagnostics		0		0 0		29.00
30.00	Medical Supplies		0		0 0		30.00
31.00	Outpatient Services (including E/R Dept.)		0		0 0		31.00
32.00	Radiation Therapy		0		0 0		32.00
33.00	Chemotherapy		0		0 0		33.00
34.00	Other		0		0 0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0		0 0		35.00
36.00	Volunteer Program Costs		0		0 0		36.00
37.00	Fundrai si ng		0		0 0		37.00
38.00	Other Program Costs		0		0 0		38.00
39.00	Total (sum of lines 1 thru 38)	3, 354	39, 912	304, 1	52 782, 239	I	39.00

Heal th	Financial Systems	ST. ELI ZABETH	CENTRAL		In Lie	u of Form CMS-2	2552-10
HOSPI C	E COMPENSATION ANALYSIS CONTRACTED SERVICES/	PURCHASED SERVICES	i Provi der	CCN: 150003	Peri od:	Worksheet K-3	
					From 01/01/2014		
			Hospi ce C	CN: 151563	To 09/30/2014	Date/Time Pre	
						2/27/2015 7:0	2 am
			Discontract	C	Hospi ce I	NI	
		Admi ni strator	Di rector	Soci al	Supervi sors	Nurses	
		1.00	2.00	Services 3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Brug and TrXt.						2.00
2.00	Plant Operation and Maintenance	0	0		0 0	0	2.00
		0	0		0 0	0	
4.00	Transportation - Staff	-	-		-		
5.00	Volunteer Service Coordination	0	0		0 0	0	
6.00	Administrative and General	0	0		0 0	0	6.00
7 00	I NPATI ENT_CARE_SERVI CE		0		0 0	0	7 00
7.00 8.00	Inpatient - General Care	0	0		0 0 0 0	0	
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
0.00	VI SI TI NG SERVI CES	0	0		0 0	0	0.00
9.00	Physician Services	-	-		0 0	0	9.00
10.00	Nursing Care	0	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	
12.00	Physical Therapy	0	0		0 0	0	
13.00	Occupational Therapy	0	0		0 0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	14.00
15.00	Medical Social Services	0	0		0 0	0	
16.00	Spiritual Counseling	0	0		0 0	0	
17.00	Dietary Counseling	0	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	
21.00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Anal gesi cs						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0		0 0	0	27.00
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						1
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundrai si ng	0	0		0 0	0	37.00
38.00	Other Program Costs	0	0		0 0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0		0 0	0	39.00
		-					

Heal th	Financial Systems	ST. ELIZABETH C	ENTRAL		In Lie	u of Form CMS-2552-10
	E COMPENSATION ANALYSIS CONTRACTED SERVICES/F			CCN: 150003	Peri od:	Worksheet K-3
				CN: 151563	From 01/01/2014	Date/Time Prepared:
			100001 00 0	101000	10 07/00/2011	2/27/2015 7:02 am
					Hospi ce I	
		Total	Ai des	All-Other	Total (1)	
		Therapists				
		6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0		0 0	3.00
4.00	Transportation - Staff		0		0 0	4.00
5.00	Volunteer Service Coordination		0		0 0	5.00
6.00	Administrative and General		0	3, 9	04 3, 904	6.00
	I NPATI ENT CARE SERVI CE					
7.00	Inpatient - General Care		0	3, 7	02 3, 702	7.00
8.00	Inpatient - Respite Care		0	1, 5	50 1, 550	8.00
	VISITING SERVICES					
9.00	Physi ci an Servi ces		0	16, 4	06 16, 406	9.00
10.00	Nursing Care		0		0 0	10.00
11.00	Nursing Care-Continuous Home Care		0		0 0	11.00
12.00	Physical Therapy	0	0		0 0	12.00
13.00	Occupational Therapy	0	0		0 0	13.00
14.00	Speech/ Language Pathology	0	0		0 0	14.00
15.00	Medical Social Services		0		0 0	15.00
16.00	Spiritual Counseling		0		0 0	16.00
17.00	Dietary Counseling		0		0 0	17.00
18.00	Counseling - Other		0		0 0	18.00
19.00	Home Health Aide and Homemaker		0		0 0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.00
21.00	Other		0		0 0	21.00
	OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Anal gesi cs					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0		0 0	27.00
28.00	Imaging Services		0		0 0	28.00
29.00	Labs and Diagnostics		0		0 0	29.00
30.00	Medical Supplies		0		0 0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	1, 2	09 1, 209	31.00
32.00	Radiation Therapy		0		0 0	32.00
33.00	Chemotherapy		0		0 0	33.00
34.00	Other		0		0 0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE					
35.00	Bereavement Program Costs		0		0 0	35.00
36.00	Volunteer Program Costs		0		0 0	36.00
37.00	Fundrai si ng		0		0 0	37.00
38.00	Other Program Costs		0		0 0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	26, 7	71 26, 771	39.00
		· ·				•

Heal th	Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	eu of Form CMS-	2552-10
	ALLOCATION - HOSPICE GENERAL SERVICE COST		Provi der	CCN: 150003	Peri od:	Worksheet K-4	
					From 01/01/2014		
			Hospi ce (CCN: 151563	To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
					Hospi ce I	2/2//2015 7.0	Z dili
			CAPITAL RE	LATED COST	nospi ce i		
		NET EXPENSES	BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	
		FOR COST	FIXTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MALNT.		
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS	T		1			
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	74, 979		74, 9	79		2.00
3.00	Plant Operation and Maintenance	0	0		0 0		3.00
4.00	Transportation - Staff	0	0		0 0	0	
5.00	Volunteer Service Coordination	0	0		0 0	0	
6.00	Administrative and General	415, 619	0	74, 9	79 0	0	6.00
	INPATIENT CARE SERVICE	1	-	1	-	-	
7.00	Inpatient - General Care	4, 220			0 0		•
8.00	Inpatient - Respite Care	9, 744	0		0 0	0	8.00
0.00	VI SI TI NG SERVI CES	14.404					0.00
9.00	Physi ci an Servi ces	16, 406			0 0	-	
10.00	Nursing Care	255, 615	0		0 0	Ű Ő	
11.00	Nursing Care-Continuous Home Care	4, 241	0		0 0	0	
12.00	Physical Therapy	2, 718	0		0 0	0	
13.00	Occupational Therapy	636			0 0	0	
14.00 15.00	Speech/ Language Pathology Medical Social Services	56,042			0 0	0	
16.00	Spiritual Counseling	72, 774			0 0		
17.00	Dietary Counseling	12, 114				0	
18.00	Counseling - Other	0				0	
19.00	Home Health Aide and Homemaker	39, 912				0	
20.00	HH Aide & Homemaker - Cont. Home Care	0			0 0	0	
21.00	Other	0			0 0		
21.00	OTHER HOSPICE SERVICE COSTS		<u> </u>	1		<u> </u>	21.00
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
23.00	Anal gesi cs	0	0		0 0		
24.00	Sedatives / Hypnotics	0	0		0 0	0	
25.00	Other - Specify	0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	26.00
27.00	Patient Transportation	0	0		0 0	0	27.00
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	1, 209	0		0 0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE						
35.00	Bereavement Program Costs	0	-		0 0		
36.00	Volunteer Program Costs	0	0		0 0	-	
37.00	Fundraising	0	0		0 0	0	
38.00	Other Program Costs	0	0	74.0	0 0	0	
39.00	Total (sum of lines 1 thru 38)	954, 115	0	74, 9	79 0	0	39.00

	Financial Systems	ST. ELIZABE	TH CEN			-		u of Form CMS-	
COST A	ALLOCATION - HOSPICE GENERAL SERVICE COST			Provi der	CCN: 150003		ri od:	Worksheet K-4	
				Hochi co (CCN: 151563		om 01/01/2014 09/30/2014	Part I Date/Time Pre	narod.
				Hospi ce (JUN. 101003	10	09/ 30/ 2014	2/27/2015 7:0	pareu. 2 am
							Hospi ce I	2/2//2013 7.0	
		VOLUNTEER	SI	BTOTAL	ADMI NI STRATI		OTAL (col. 5A		
		SERVI CES		5.0 - 5)	& GENERAL		± col. 6)		
		COORDI NATOR		,	d OENERVIE		1 001. 0)		
		5.00		5A	6.00		7.00		
	GENERAL SERVICE COST CENTERS	0.00	I	0.11	0.00				
1.00	Capital Related Costs-Bldg and Fixt.								1.00
2.00	Capital Related Costs-Movable Equip.								2.00
3.00	Plant Operation and Maintenance								3.00
4.00	Transportation - Staff								4.00
5.00	Volunteer Service Coordination	0							5.00
6.00	Administrative and General	0		490, 598	490, 5	98			6.00
0.00	I NPATI ENT_CARE_SERVI CE	0	1	470, 370	470, 3	70			0.00
7.00	Inpatient - General Care	0		4, 220	4,4	67	8, 687		7.00
8.00	Inpatient - Respite Care	0		9, 744			20, 057		8.00
0.00	VI SI TI NG SERVI CES	0	·	7, 744	1 10, 3	15	20,037		0.00
9.00	Physician Services	0		16, 406	17, 3	65	33, 771		9.00
7.00 10.00	Nursi ng Care	0	•	255, 615			526, 163		10.00
10.00	Nursing Care-Continuous Home Care	0							11.00
		0		4, 241			8, 730 5, 595		12.00
12.00	Physical Therapy	0		2, 718					
13.00	Occupational Therapy	0		636	1	73	1, 309		13.00
14.00	Speech/ Language Pathology	0		0		0	145 050		14.00
15.00	Medical Social Services	0		56, 042			115, 358		15.00
16.00	Spiritual Counseling	0		72, 774			149, 800		16.00
17.00	Di etary Counsel i ng	0		0		0	0		17.00
18.00	Counseling - Other	0		0		0	0		18.00
19.00	Home Health Aide and Homemaker	0		39, 912			82, 156		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	1	0		0	0		20.00
21.00	Other	0		0		0	0		21.00
	OTHER HOSPICE SERVICE COSTS	-		-	1	-	-		
22.00	Drugs, Biological and Infusion Therapy	0		0		0	0		22.00
23.00	Anal gesi cs	0		0		0	0		23.00
24.00	Sedatives / Hypnotics	0		0		0	0		24.00
25.00	Other - Specify	0		0		0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0		C		0	0		26.00
27.00	Patient Transportation	0		C		0	0		27.00
28.00	Imaging Services	0		0		0	0		28.00
29.00	Labs and Diagnostics	0		0		0	0		29.00
30.00	Medical Supplies	0		0		0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0		1, 209	1, 2	80	2, 489		31.00
32.00	Radiation Therapy	0		0		0	0		32.00
33.00	Chemotherapy	0		0		0	0		33.00
34.00	Other	0		C		0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE								
35.00	Bereavement Program Costs	0		0		0	0		35.00
36.00	Volunteer Program Costs	0		C		0	0		36.00
37.00	Fundrai si ng	0		C		0	0		37.00
38.00	Other Program Costs	0		0		0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0		954, 115			954, 115		39.00

Heal th	Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 150003	Peri od:	Worksheet K-4	
				201 1515/2	From 01/01/2014	Part II	
		Hospi ce CCN:		CCN: 151563	To 09/30/2014	Date/Time Pre 2/27/2015 7:0	
					Hospi ce I	2/2//2010 /:0	2 011
		CAPITAL RE	LATED COST		•		
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON		
		FIXTURES (SQ. FT.)	EQUIPMENT (\$	OPERATION & MAINT. (SQ.		SERVI CES COORDI NATOR	
		FI.)	VALUE)	FT.)		(HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS				<u>.</u>		
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0					2.00
3.00	Plant Operation and Maintenance	0			0		3.00
4.00	Transportation - Staff	0			0 0	_	4.00
5.00	Volunteer Service Coordination	0			0 0	0	
6.00	Administrative and General	0	5, 158	i	0 0	0	6.00
7 00	INPATIENT CARE SERVICE	0	C		0 0	0	7 00
7.00 8.00	Inpatient - General Care	0			0 0		7.00 8.00
0.00	Inpatient - Respite Care VISITING SERVICES	0			0 0	0	0.00
9.00	Physician Services	0	0		0 0	0	9.00
10.00	Nursi ng Care	0			0 0	0	
11.00	Nursing Care-Continuous Home Care	0			0 0	0	
12.00	Physical Therapy	0	c c)	0 0	0	12.00
13.00	Occupational Therapy	0	c)	0 0	0	13.00
14.00	Speech/ Language Pathol ogy	0	C)	0 0	0	14.00
15.00	Medical Social Services	0	-		0 0	0	
16.00	Spiritual Counseling	0	-		0 0	0	
17.00	Di etary Counsel i ng	0			0 0	0	
18.00	Counseling - Other	0			0 0	0	
19.00	Home Health Aide and Homemaker	0	-		0 0	0	
20.00	HH Aide & Homemaker - Cont. Home Care Other	0	-	1	0 0	0	
21.00	OTHER HOSPICE SERVICE COSTS	0	C	1	0 0	0	21.00
22.00	Drugs, Biological and Infusion Therapy	0	C		0 0	0	22.00
23.00	Anal gesi cs	0	-		0 0	0	
24.00	Sedatives / Hypnotics	0	-		0 0	0	
25.00	Other - Specify	0	C)	0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	C)	0 0	0	26.00
27.00	Patient Transportation	0	c		0 0	0	27.00
28.00	I magi ng Servi ces	0	C		0 0	0	28.00
29.00	Labs and Diagnostics	0	C		0 0	0	29.00
30.00	Medical Supplies	0	C		0 0	0	
31.00	Outpatient Services (including E/R Dept.)	0	C		0 0	0	
32.00	Radi ati on Therapy	0	-		0 0	0	
33.00	Chemotherapy	0	-		0 0	0	
34.00		0	C	1	0 0	0	34.00
35.00	HOSPICE NONREIMBURSABLE SERVICE Bereavement Program Costs	0	C		0 0	0	35.00
36.00	Volunteer Program Costs	0			0 0	0	
37.00	Fundrai si ng	0	l c		0 0	0	
38.00	Other Program Costs	0			0 0	0	
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	74, 979		0 0	0	•
40.00	Unit Cost Multiplier	0. 000000	14. 536448	0.0000	0. 000000	0. 000000	40.00

	Financial Systems	ST. ELI ZABETH				u of Form CMS	
COST A	LLOCATION - STATISTICAL BASIS			CCN: 150003 CN: 151563	Period: From 01/01/2014 To 09/30/2014	Worksheet K- Part II Date/Time Pr 2/27/2015 7:	epared:
					Hospi ce I		
		RECONCI LI ATI ON AD					
			& GENERAL				
			ACC. COST)				
	GENERAL SERVICE COST CENTERS	6A	6.00				
1.00	Capital Related Costs-Bldg and Fixt.	0					1.0
2.00	Capital Related Costs-Movable Equip.	0					2.0
3.00	Plant Operation and Maintenance	0					3.0
4.00	Transportation - Staff	0					4.0
5.00	Volunteer Service Coordination	0					5.0
6.00	Administrative and General	-490, 598	463, 517				6.0
0.00	I NPATI ENT_CARE_SERVI CE	-470, 370	403, 317				- 0.0
7.00	Inpatient - General Care	0	4, 220				7.0
8.00	Inpatient - Respite Care	0	9, 744				8.0
0.00	VI SI TI NG SERVI CES	<u> </u>	7, 744				- 0.0
9.00	Physician Services	0	16, 406				9.0
10.00	Nursi ng Care	0	255, 615				10.0
11.00	Nursing Care-Continuous Home Care	0	4, 241				11.0
12.00	Physical Therapy	0	2, 718				12.0
13.00	Occupational Therapy	0	636				13.0
14.00	Speech/ Language Pathol ogy	0	0				14.0
15.00	Medical Social Services	0	56, 042				15.0
16.00	Spiritual Counseling	0	72, 774				16.0
17.00	Di etary Counsel i ng	0	0				17.0
18.00	Counseling - Other	0	0				18.0
19.00	Home Health Aide and Homemaker	0	39, 912				19.0
20.00	HH Aide & Homemaker - Cont. Home Care	0	0				20.0
21.00	Other	0	o				21.0
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0				22.0
23.00	Anal gesi cs	0	0				23.0
24.00	Sedatives / Hypnotics	0	0				24.0
25.00	Other - Specify	0	0				25.0
26.00	Durable Medical Equipment/Oxygen	0	0				26.0
27.00	Patient Transportation	0	0				27.0
28.00	Imaging Services	0	0				28.0
29.00	Labs and Diagnostics	0	0				29.0
30. 00	Medical Supplies	0	0				30.0
31.00	Outpatient Services (including E/R Dept.)	0	1, 209				31.0
32.00	Radiation Therapy	0	0				32.0
33.00	Chemotherapy	0	0				33.0
34.00	Other	0	0				34.0
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0				35.0
36.00	Volunteer Program Costs	0	0				36.0
37.00	Fundrai si ng	0	0				37.0
38.00	Other Program Costs	0	0				38.0
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		490, 598				39.0
40.00	Unit Cost Multiplier		1.058425				40.0

Health Financial Systems		ST. ELI ZABET	TH CENTRAL			In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS	TO HOSPICE COST	CENTERS		CCN: 150003 CCN: 151563	Fro	iod: m 01/01/2014 09/30/2014	Worksheet K-5 Part I Date/Time Pre 2/27/2015 7:03	
						Hospi ce I		
			CAPI TAL REL	ATED COSTS				
Cost Center Description		Hospice Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUI P		EMPLOYEE BENEFI TS DEPARTMENT	DATA PROCESSI NG	
		0	1.00	2.00		4.00	5.02	
1.00 Administrative and General			25, 904		0	352, 124	7, 538	1.00
2.00 Inpatient - General Care		8, 687	0		0	0	0	2.00
3.00 Inpatient - Respite Care		20, 057	0		0	0	0	3.00
4.00 Physician Services		33, 771	0		0	0	0	4.00
5.00 Nursing Care		526, 163	0		0	0	0	5.00
6.00 Nursing Care-Continuous Home	Care	8, 730	0		0	o	0	6.00
7.00 Physical Therapy		5, 595	0		0	0	0	7.00
8.00 Occupational Therapy		1, 309	0		0	0	0	8,00
9.00 Speech/ Language Pathol ogy		0	0		0	0	0	9.00
10.00 Medical Social Services		115, 358	0		0	0	0	10.00
11.00 Spiritual Counseling		149, 800	0		0	0	0	11.00
12.00 Dietary Counseling		0	0		0	0	0	12.00
13.00 Counseling - Other		0	0		0	0	0	13.00
14.00 Home Health Aide and Homemake	er	82, 156	0		0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. H	lome Care	0	0		0	o	0	15.00
16.00 Other		0	0		0	0	0	16.00
17.00 Drugs, Biological and Infusio	on Therapy	0	0		0	0	0	17.00
18.00 Anal gesi cs	15	0	0		0	0	0	18.00
19.00 Sedatives / Hypnotics		0	0		0	0	0	19.00
20.00 Other - Specify		0	0		0	0	0	20.00
21.00 Durable Medical Equipment/0xy	/gen	0	0		0	0	0	21.00
22.00 Patient Transportation		о	0		0	0	0	22.00
23.00 Imaging Services		о	0		0	0	0	23.00
24.00 Labs and Diagnostics		o	0		0	0	0	24.00
25.00 Medical Supplies		o	0		0	0	0	25.00
26.00 Outpatient Services (includir	ng E/R Dept.)	2, 489	0		0	0	0	26.00
27.00 Radiation Therapy	5	0	0		0	0	0	27.00
28.00 Chemotherapy		0	0		0	0	0	28.00
29.00 Other		0	0		0	0	0	29.00
30.00 Bereavement Program Costs		0	0		0	0	0	30.00
31.00 Volunteer Program Costs		0	0		0	0	0	31,00
32.00 Fundrai si ng		o	0		0	0	0	32.00
33.00 Other Program Costs		o	0		0	0	0	33.00
34.00 Total (sum of lines 1 thru 33	3) (2)	954, 115	25, 904		0	352, 124	7, 538	34.00
35.00 Unit Cost Multiplier (see ins								35.00

From 01/01/2014 Pa	Vorksheet K-5 Part I Date/Time Prep	
	2/27/2015 7:02	ared: am
Hospi ce I		
	MI NI STRATI VE AND GENERAL	
5. 03 5. 04 5. 05 5A. 05	5.06	
1.00 Administrative and General 4,351 0 7,277 397,194	58, 169	1.00
2.00 Inpatient - General Care 0 0 0 8,687	1, 272	2.00
3.00 Inpatient - Respite Care 0 0 0 20,057	2, 937	3.00
4.00 Physician Services 0 0 0 33,771	4, 946	4.00
5. 00 Nursi ng Care 0 0 0 526, 163	77, 056	5.00
6.00 Nursing Care-Continuous Home Care 0 0 0 8,730	1, 279	6.00
7.00 Physical Therapy 0 0 0 5,595	819	7.00
8.00 Occupational Therapy 0 0 0 1,309	192	8.00
9.00 Speech/ Language Pathol ogy 0 0 0 0 0	0	9.00
10.00 Medical Social Services 0 0 0 115, 358	16, 894	10.00
11. 00 Spiritual Counseling 0 0 149, 800	21, 938	11.00
12.00 Dietary Courseling 0 0 0 0	0	12.00
13.00 Counseling - Other 0 0 0 0	o	13.00
14.00 Home Health Aide and Homemaker 0 0 0 82,156	12, 032	14.00
15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0	0	15.00
16.00 Other 0 0 0	o	16.00
17.00 Drugs, Biological and Infusion Therapy 0 0 0 0	0	17.00
18.00 Anal gesi cs 0 0 0 0	o	18.00
19.00 Sedatives / Hypnotics 0 0 0	0	19.00
20.00 Other - Specify 0 0 0 0 0	0	20.00
21.00 Durable Medical Equipment/0xygen 0 0 0 0	0	21.00
22.00 Patient Transportation 0 0 0 0	0	22.00
23.00 Imaging Services 0 0 0 0	Ő	23.00
24.00 Labs and Di agnosti cs 0 0 0 0	Ő	24.00
25.00 Medical Supplies 0 0 0 0	0	25.00
26.00 Outpatient Services (including E/R Dept.) 0 0 0 2,489	365	26.00
27. 00 Radiation Therapy 0 0 0 0	0	27.00
28.00 Chemotherapy 0 0 0 0	0	28.00
29.00 Other 0 0 0	0	29.00
30.00 Bereavement Program Costs 0 0 0 0	0	30.00
31. 00 Volunteer Program Costs 0 0 0 0	0	31.00
32.00 Fundrai si ng	0	32.00
33. 00 Other Program Costs 0 0 0 0	0	32.00
34. 00 Total (sum of lines 1 thru 33) (2) 4, 351 0 7, 277 1, 351, 309	197, 899	34.00
34.00 101ai (Sum of Trifles Filling SS) (2) 4,351 0 7,277 1,351,307 35.00 Unit Cost Multiplier (see instructions) 0.000000 0.000000	177,077	35.00

Heal th	Financial Systems	ST. ELI ZABE	TH CENTRAL			In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150003		ri od:	Worksheet K-5	
			lloopi oo	CCN: 151563		om 01/01/2014	Part I Date/Time Pre	anad.
			Hospi ce	CCN: 151563		09/30/2014	2/27/2015 7:02	2 am
						Hospice I		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI	NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE					
1 00		7.00	8.00	9.00	(70	10.00	11.00	1 00
1.00	Administrative and General	50, 468	(23,		0	19, 020	1.00
2.00 3.00	Inpatient - General Care	0			0	0	0	2.00 3.00
3.00 4.00	Inpatient - Respite Care Physician Services	0			0	0	0	3.00 4.00
4.00 5.00	Nursing Care	0			0	0	0	4.00 5.00
6.00	Nursing Care-Continuous Home Care	0			0	0	0	6.00
7.00	Physical Therapy	0			0	0	0	7.00
8.00	Occupational Therapy	0			0	0	0	8.00
9.00	Speech/ Language Pathol ogy	0	(0	0	0	0	9.00
10,00	Medi cal Soci al Servi ces	0	(0	0	0	0	10.00
11.00	Spiritual Counseling	0	(0	0	0	11.00
12.00	Dietary Counseling	0	(0	0	0	12.00
13.00	Counseling - Other	0	(b	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	(0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	(D	0	0	0	15.00
16.00	Other	0	(D	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	(D	0	0	0	17.00
18.00	Anal gesi cs	0	(D	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	(D	0	0	0	19.00
20.00	Other - Specify	0	(D	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	(D	0	0	0	21.00
22.00	Patient Transportation	0	()	0	0	0	22.00
23.00	Imaging Services	0	()	0	0	0	23.00
24.00	Labs and Diagnostics	0	(0	0	0	24.00
25.00	Medical Supplies	0			0	0	0	25.00
26.00 27.00	Outpatient Services (including E/R Dept.) Radiation Therapy	0			0	0	0	26.00 27.00
27.00	Chemotherapy	0			0	0	0	27.00
28.00	Other	0			0	0	0	29.00
30.00	Bereavement Program Costs	0			0	0	0	30.00
31.00	Volunteer Program Costs	0			0	0	0	31.00
32.00	Fundrai si ng	0			0	0	0	32.00
33.00	Other Program Costs	0			õ	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	50, 468	(23,	672	0	19, 020	34.00
35.00	Unit Cost Multiplier (see instructions)					-	,	35.00
		'		•				

Heal th	Financial Systems	ST. ELI ZABET	TH CENTRAL			In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	T CENTERS		CCN: 150003 CCN: 151563	Fro		Worksheet K-5 Part I Date/Time Prep 2/27/2015 7:02	pared: 2 am
						Hospi ce I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &			RECORDS &		
			SUPPLY			LI BRARY		
		13.00	14.00	15.00		16.00	17.00	
1.00	Administrative and General	46, 652	0		0	5, 800	2, 882	1.00
2.00	Inpatient - General Care	0	0		0	0	0	2.00
3.00	Inpatient - Respite Care	0	0		0	0	0	3.00
4.00	Physician Services	0	0		0	0	0	4.00
5.00	Nursing Care	0	0		0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	Ő	6.00
7.00	Physical Therapy	0	0		0	0	0	7.00
8.00	Occupational Therapy	0	0		0	0	Ő	8.00
9.00	Speech/ Language Pathol ogy	0	0		0	0	0	9.00
10.00	Medi cal Soci al Servi ces	0	0		0	0	0	10.00
11.00	Spiritual Counseling	0	0		0	0	0	11.00
12.00	Dietary Counseling	0	0		0	0	0	12.00
12.00	Counseling - Other	0	0		0	0	0	12.00
		0	0		-	0		
14.00	Home Health Aide and Homemaker	0	0		0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	15.00
16.00	Other	0	0		0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0	0	0	17.00
18.00	Anal gesi cs	0	0		0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0	0	0	19.00
20.00	Other - Specify	0	0		0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	0	21.00
22.00	Patient Transportation	0	0		0	0	0	22.00
23.00	Imaging Services	0	0		0	0	0	23.00
24.00	Labs and Diagnostics	0	0		0	0	0	24.00
25.00	Medical Supplies	0	0		0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	26.00
27.00	Radiation Therapy	0	0		0	0	0	27.00
28.00	Chemotherapy	0	0		0	0	0	28.00
29.00	Other	0	0		0	0	0	29.00
30.00	Bereavement Program Costs	0	0		0	0	0	30.00
31.00	Volunteer Program Costs	0	0		0	0	0	31.00
32.00	Fundrai si ng	0	0		0	0	0	32.00
33.00	Other Program Costs	0	0		Ő	n n	Ő	33.00
34.00	Total (sum of lines 1 thru 33) (2)	46, 652	0		0	5, 800	2, 882	34.00
	Unit Cost Multiplier (see instructions)	.0,002	0		Ŭ	2,000	2,002	35.00
22. 50		1		1	I	I	Į	

Health Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE CO	OST CENTERS		CCN: 150003 CCN: 151563	Period: From 01/01/2014 To 09/30/2014	Worksheet K-5 Part I Date/Time Pre 2/27/2015 7:0	pared:
				Hospi ce I		
Cost Center Description	NURSING SCHOOL	PARAMED ED	Subtotal	Intern &	Subtotal	
		PRGM	(cols. 4A-23) Residents Cost	(cols. 24 ±	
				& Post	25)	
				Stepdown		
				Adjustments		
	20.00	23.00	24.00	25.00	26.00	
1.00 Administrative and General	0	C				1.00
2.00 Inpatient - General Care	0	C				2.00
3.00 Inpatient - Respite Care	0	C	22, 7		22, 994	3.00
4.00 Physician Services	0	C	00, 1		38, 717	4.00
5.00 Nursing Care	0	C	00072		603, 219	5.00
6.00 Nursing Care-Continuous Home Care	0	C	10, 00		10, 009	6.00
7.00 Physical Therapy	0	C	6, 4		6, 414	7.00
8.00 Occupational Therapy	0	C	1, 50		1, 501	8.00
9.00 Speech/ Language Pathol ogy	0	C		0 0	0	9.00
10.00 Medical Social Services	0	C	102,2		132, 252	
11.00 Spiritual Counseling	0	C	171, 7		171, 738	
12.00 Dietary Counseling	0	C		0 0	0	12.00
13.00 Counseling - Other	0	C		0 0	0	13.00
14.00 Home Health Aide and Homemaker	0	C	94, 18	38 0	94, 188	
15.00 HH Aide & Homemaker - Cont. Home Care	0	C		0 0	0	15.00
16.00 Other	0	C		0 0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	C		0 0	0	17.00
18.00 Anal gesi cs	0	C		0 0	0	18.00
19.00 Sedatives / Hypnotics	0	C		0 0	0	19.00
20.00 Other - Specify	0	C		0 0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	C		0 0	0	21.00
22.00 Patient Transportation	0	C		0 0	0	22.00
23.00 Imaging Services	0	C		0 0	0	23.00
24.00 Labs and Diagnostics	0	C)	0 0	0	24.00
25.00 Medical Supplies	0	C		0 0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	C	2, 8		2, 854	26.00
27.00 Radiation Therapy	0	C		0 0	0	27.00
28.00 Chemotherapy	0	C		0 0	0	28.00
29.00 Other	0	C)	0 0	0	29.00
30.00 Bereavement Program Costs	0	C		0 0	0	30.00
31.00 Volunteer Program Costs	0	C)	0 0	0	31.00
32.00 Fundrai si ng	0	C		0 0	0	32.00
33.00 Other Program Costs	0	C		0 0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	C	1, 697, 70	02 0	1, 697, 702	34.00
35.00 Unit Cost Multiplier (see instructions)			1			35.00

ALLOCATI	ON OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	D						
			F	rovi der	CCN: 1	50003	Peri od:	Worksheet K-5	
			н	ospi ce C	CN:	151563	From 01/01/2014 To 09/30/2014	Part I Date/Time Pre	pared:
								2/27/2015 7:0	2 am
							Hospi ce I		
	Cost Center Description	Allocated		Hospi ce					
		Hospi ce A&G		(col s.					
		(See Part II)		± 27) . 00					
1.00 Ad	lministrative and General	27.00	28	. 00					1.00
	npatient - General Care	5, 498		15, 457					2.00
	npatient - Respite Care	12, 694		35, 688					3.00
	nysi ci an Servi ces	21, 374		60, 091					4.00
	irsing Care	333,006		936, 225					5.00
	ursing Care-Continuous Home Care	5, 525	1	15, 534					6.00
	nysical Therapy	3, 523	1	9, 955					7.00
	ccupational Therapy	829		2, 330					8.00
	peech/ Language Pathol ogy	027	1	2, 330					9.00
	edi cal Soci al Servi ces	73,010	1	205, 262					10.00
	biritual Counseling	94, 808		266, 546					11.00
	etary Counseling	0		200, 010					12.00
	bunseling - Other	0	•	0					13.00
	ome Health Aide and Homemaker	51, 996	1	146, 184					14.00
	Aide & Homemaker - Cont. Home Care	0	1	0					15.00
	ther	0		o					16.00
	rugs, Biological and Infusion Therapy	0		0					17.00
	nal gesi cs	0		o					18.00
19.00 Se	edatives / Hypnotics	0		o					19.00
20.00 Ot	ther - Specify	0		o					20.00
21.00 Du	urable Medical Equipment/Oxygen	0		o					21.00
	atient Transportation	0		o					22.00
	nagi ng Servi ces	0		o					23.00
24.00 La	abs and Diagnostics	0		0					24.00
25.00 Me	edical Supplies	0		0					25.00
26.00 Ou	itpatient Services (including E/R Dept.)	1, 576		4, 430					26.00
27.00 Ra	adiation Therapy	0		0					27.00
	nemotherapy	0		0					28.00
29.00 Ot	ther	0		0					29.00
	ereavement Program Costs	0		0					30.00
	olunteer Program Costs	0		0					31.00
	undrai si ng	0		0					32.00
	her Program Costs	0		0					33.00
	otal (sum of lines 1 thru 33) (2)			697, 702					34.00
35.00 Un	nit Cost Multiplier (see instructions)	0. 552050							35.00

Heal th	Financial Systems	ST. ELIZABET	H CENTRAL			In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST TICAL BASIS	CENTERS	Provi der Hospi ce (CCN: 150003 CCN: 151563	Fr	riod: om 01/01/2014	Worksheet K-5 Part II Date/Time Pre 2/27/2015 7:02	pared:
						Hospi ce I		
		CAPITAL REL	ATED COSTS					
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS		DATA PROCESSI NG (MANHRS)	PURCHASI NG RECEI VI NG AND STORES (COSTED	
		1.00	2.00	SALARIES)		F 02	REQUISTION)	
1 00	Administrative and Canaral	1.00	2.00	4.00	20	5. 02 22, 798	5.03	1 00
1.00	Administrative and General	4, 695					23, 728	1.00
2.00	Inpatient - General Care	0	0		0	0	0	2.00
3.00	Inpatient - Respite Care	-	0		-	-	-	3.00
4.00	Physician Services	0	0		0 0	0	0	4.00
5.00 6.00	Nursing Care	0	0		0	0	0	5.00
8.00 7.00	Nursing Care-Continuous Home Care Physical Therapy	0	0	1	0	0	0	6.00 7.00
7.00 8.00	Occupational Therapy	0	0		0	0	0	8.00
8.00 9.00	Speech/ Language Pathol ogy	0	0		0	0	0	8.00 9.00
10.00	Medical Social Services	0	0		0	0	0	10.00
11.00	Spiritual Counseling	0	0		0	0	0	10.00
12.00	Dietary Counseling	0	0		0	0	0	12.00
12.00	Counseling - Other	0	0		0	0	0	12.00
14.00	Home Health Aide and Homemaker	0	0		0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	14.00
16.00	Other	0	0		0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0	0	0	17.00
18.00	Anal gesi cs	0	0		0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0	0	0	19.00
20.00	Other - Specify	0	0		0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	Ő	0	21.00
22.00	Patient Transportation	0	0		0	0	0	22.00
23.00	Imaging Services	0	0)	0	0	0	23.00
24.00	Labs and Diagnostics	0	0		0	0	0	24.00
25.00	Medical Supplies	0	0)	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0)	0	0	0	26.00
27.00	Radiation Therapy	0	0)	0	0	0	27.00
28.00	Chemotherapy	0	0)	0	0	0	28.00
29.00	Other	0	0		0	0	0	29.00
30.00	Bereavement Program Costs	0	0		0	0	0	30.00
31.00	Volunteer Program Costs	0	0)	0	0	0	31.00
32.00	Fundrai si ng	0	0		0	0	0	32.00
33.00	Other Program Costs	0	0		0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	4, 695	0	782, 2	39	22, 798	23, 728	34.00
35.00	Total cost to be allocated	25, 904	0	352, 1	24	7, 538	4, 351	35.00
36.00	Unit Cost Multiplier (see instructions)	5. 517359	0. 000000	0. 4501	49	0. 330643	0. 183370	36.00

Heal th	n Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	eu of Form CMS-	2552-10
ALLOC	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST STICAL BASIS		Provi der	CCN: 150003 CCN: 151563	Period: From 01/01/2014	Worksheet K-5 Part II Date/Time Pre	pared:
					Hospi ce I	2/27/2015 7:0	2 am
	Cost Center Description	ADMI TTI NG (I NPATI ENT REVENUE)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES)	Reconciliati	on ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.04	5.05	5A. 06	5.06	7.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 10.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 33.\ 00\\ \end{array}$	Spiritual Counseling Dietary Counseling Counseling - Other Home Health Aide and Homemaker HH Aide & Homemaker - Cont. Home Care Other Drugs, Biological and Infusion Therapy Analgesics Sedatives / Hypnotics Other - Specify Durable Medical Equipment/Oxygen Patient Transportation Imaging Services Labs and Diagnostics Medical Supplies Outpatient Services (including E/R Dept.) Radiation Therapy Chemotherapy Other Bereavement Program Costs Volunteer Program Costs Fundraising	5.04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 115, 158 3, 115, 158 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 5.06 \\ \hline 0 & 397, 194 \\ 0 & 8, 687 \\ 0 & 20, 057 \\ 0 & 33, 771 \\ 0 & 526, 163 \\ 0 & 8, 730 \\ 0 & 5, 595 \\ 0 & 1, 309 \\ 0 & 0 \\ 0 & 115, 358 \\ 0 & 149, 800 \\ 0 & 0 \\ 0 $		$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$
34.00 35.00	5	0 0 0. 000000	3, 115, 158 7, 277 0. 002336		1, 351, 309 197, 899 0. 146450	4, 695 50, 468	34.00 35.00

Heal th	Financial Systems	ST. ELI ZABE	TH CENTRAL		In Lie	eu of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST			CCN: 150003	Peri od:	Worksheet K-5	
STATI S	STICAL BASIS				From 01/01/2014		
			Hospi ce (CCN: 151563	To 09/30/2014		
					Hospico	2/27/2015 7:0	<u>2 am</u>
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DIETARY	Hospi ce I CAFETERI A	NURSI NG	
	cost center bescription	LINEN SERVICE	(SQUARE	(MEALS		ADMI NI STRATI ON	
		(POUNDS OF	FEET)	SERVED)			
		LAUNDRY)		JERVED)		(DI RECT	
		Enonditity				NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0			0 22, 798		1.00
2.00	Inpatient - General Care	0			0 0		2.00
3.00	Inpatient - Respite Care	0	l d		0 0	0	3.00
4.00	Physician Services	0	l d		0 0	0	4.00
5.00	Nursing Care	0	l d		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	c c		0 0	0	6.00
7.00	Physical Therapy	0	c		0 0	0	7.00
8.00	Occupational Therapy	0	c		0 0	0	8.00
9.00	Speech/ Language Pathology	0	0		0 0	0	9.00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	C)	0 0	0	17.00
18.00	Anal gesi cs	0	0)	0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	-		0 0	-	21.00
22.00	Patient Transportation	0	0		0 0	-	22.00
23.00	Imaging Services	0	0)	0 0		23.00
24.00	Labs and Diagnostics	0	0)	0 0	u u	24.00
25.00	Medical Supplies	0	0)	0 0	-	25.00
26.00	Outpatient Services (including E/R Dept.)	0	C)	0 0		26.00
27.00	Radiation Therapy	0	0	0	0 0	0	27.00
28.00	Chemotherapy	0	0)	0 0	0	28.00
29.00	Other	0	0)	0 0	0	29.00
30.00	Bereavement Program Costs	0	0)	0 0	0	30.00
31.00	Volunteer Program Costs	0	0)	0 0	0	31.00
32.00	Fundrai si ng	0			0 0	0	32.00
33.00	Other Program Costs	0			0 0	Ű	33.00
34.00 35.00	Total (sum of lines 1 thru 33) (2) Total cost to be allocated	0	4, 695 23, 672		0 22, 798 0 19, 020		34.00 35.00
	Unit Cost Multiplier (see instructions)	0. 000000					
30.00		0.00000	5.041900	η 0.0000	0. 034204	2.040320	1 30.00

	Financial Systems	ST. ELI ZABETI	I CENTRAL			eu of Form CMS-2	2552-10
	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150003	Period: From 01/01/2014	Worksheet K-5 Part II	
STATIS	STICAL BASIS		Hospi ce C	CCN: 151563		Date/Time Pre	pared:
					Hospi ce I	2/27/2015 7:02	2 am
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	NURSING SCHOOL	
	· · · · · · · · · · · · · · · · · · ·	SERVICES &	(COSTED	RECORDS &			
		SUPPLY	REQUIS.)	LI BRARY	(GROSS	(ASSI GNED	
		(COSTED		(GROSS	CHARGES)	TIME)	
		REQUIS.)		CHARGES)			
		14.00	15.00	16.00	17.00	20.00	
1.00	Administrative and General	0	0	3, 115, 1	58 3, 115, 158		
2.00	Inpatient - General Care	0	0		0 0	-	2.00
3.00	Inpatient - Respite Care	0	0		0 0	-	3.00
4.00	Physician Services	0	0		0 0	0	4.00
5.00	Nursing Care	0	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	-	9.00
10.00	Medical Social Services	0	0		0 0	-	10.00
11.00	Spiritual Counseling	0	0		0 0	-	11.00
12.00	Dietary Counseling	0	0		0 0	-	12.00
13.00	Counseling - Other	0	0		0 0		13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	-	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0		15.00
16.00	Other	0	0		0 0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	-	17.00
18.00	Anal gesi cs	0	0		0 0	-	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	-	19.00
20.00	Other - Specify	0	0		0 0	-	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	-	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	I magi ng Servi ces	0	0		0 0	-	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	-	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0	0	28.00
29.00	Other	0	0		U 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0			0	31.00
32.00 33.00	Fundrai si ng	0	0			0	32.00 33.00
33.00 34.00	Other Program Costs	0	0	2 11 - 1		-	
34.00	Total (sum of lines 1 thru 33) (2) Total cost to be allocated	0	0	3, 115, 1 5, 8			34.00
35.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000				
30.00		0.000000	0.000000	0.0018	021 0.000923	0.000000	1 30.00

Heal th	Financial Systems	ST. ELIZABETH C	CENTRAL	In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provider CCN: 150003	Peri od:	Worksheet K-5	
STATI S	TICAL BASIS		Hospi ce CCN: 151563	From 01/01/2014 To 09/30/2014	Part II Date/Time Pre	narod
			HOSPICE CCN. 151565	10 09/30/2014	2/27/2015 7:0	pareu. 2 am
				Hospi ce I		
	Cost Center Description	PARAMED ED				
		PRGM				
		(ASSI GNED				
		TI ME) 23.00				
1.00	Administrative and General	23.00		1		1.00
2.00	Inpatient - General Care	0				2.00
3.00	Inpatient - Respite Care	0				3.00
4.00	Physi ci an Servi ces	0				4.00
5.00	Nursing Care	0				5.00
6.00	Nursing Care-Continuous Home Care	0				6.00
7.00	Physical Therapy	0				7.00
8.00	Occupational Therapy	0				8.00
9.00	Speech/ Language Pathol ogy	0				9.00
10.00	Medical Social Services	0				10.00
11.00	Spiritual Counseling	0				11.00
12.00	Dietary Counseling	0				12.00
13.00	Counseling - Other	0				13.00
14.00	Home Health Aide and Homemaker	0				14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0				15.00
16.00	Other	0				16.00
17.00 18.00	Drugs, Biological and Infusion Therapy	0				17.00 18.00
19.00	Anal gesi cs Sedati ves / Hypnoti cs	0				19.00
20.00	Other - Specify	0				20.00
21.00	Durable Medical Equipment/Oxygen	0				21.00
22.00	Pati ent Transportati on	0				22.00
	I maging Services	0				23.00
24.00	Labs and Diagnostics	0				24.00
25.00	Medical Supplies	0				25.00
26.00	Outpatient Services (including E/R Dept.)	0				26.00
27.00	Radiation Therapy	0				27.00
28.00	Chemotherapy	0				28.00
29.00	Other	0				29.00
30.00	Bereavement Program Costs	0				30.00
31.00	Volunteer Program Costs	0				31.00
32.00	Fundrai si ng	0				32.00
33.00 34.00	Other Program Costs	0				33.00 34.00
34.00	Total (sum of lines 1 thru 33) (2) Total cost to be allocated	0				34.00
	Unit Cost Multiplier (see instructions)	0. 000000				36.00
50.00		0.000000				1 30.00

Heal th	Financial Systems	ST. ELI ZABET	H CENTRAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150003	Peri od:	Worksheet K-5	
					From 01/01/2014		
			Hospi ce (CCN: 151563	To 09/30/2014	Date/Time Pre 2/27/2015 7:0	pared:
					Hospi ce I	2/2//2013 7.0.	2 0111
	Cost Center Description		Wkst. C. Part	Cost to Char	ge Total Hospice	Hospi ce Shared	
			I, col. 11	Ratio	Charges	Ancillary	
			line			Costs (cols. 1	
					Records)	x 2)	
			0	1.00	2.00	3.00	
	ANCI LLARY SERVI CE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00	0. 3950	88 0	0	1.00
2.00	OCCUPATIONAL THERAPY		67.00				2.00
3.00	SPEECH PATHOLOGY		68.00	0. 6034	30 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 2732	55 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5.00
6.00	LABORATORY		60.00	0. 1600	94 0	0	6.00
6.01	BLOOD LABORATORY		60.01	0.0000	00 0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0. 3064	03 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8.00
9.00	RADI OLOGY-THERAPEUTI C		55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76.00				10.00
10. 98	HYPERBARI C OXYGEN THERAPY		76.98	0. 1686	67 0	0	10. 98
11.00	Totals (sum of lines 1-10)					0	11.00

Heal th	Financial Systems ST. ELIZABE	TH CENTRAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPICE PER DIEM COST	Provi der	CCN: 150003	Peri od:	Worksheet K-6	
		Hospi ce (CCN: 151563	From 01/01/2014 To 09/30/2014		
				Hospi ce I		
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				1, 697, 702	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				12, 168	2.00
3.00	Average cost per diem (line 1 divided by line 2)				139. 52	3.00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	11, 516				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	1, 606, 712				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		4	07		6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		56, 7	85		7.00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00	Aggregate NF cost (line 3 times line 10)			0		11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			245		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			34, 182		13.00

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 150003	Period: From 01/01/2014 To 09/30/2014	Worksheet L Parts I-III Date/Time Pre 2/27/2015 7:02	
		Title XVIII	Hospi tal	PPS	2 011
		• ·			
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				-
	CAPITAL FEDERAL AMOUNT			400.055	
. 00	Capital DRG other than outlier			420, 855	
. 01 . 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			0 12, 147	
. 00	Model 4 BPCI Capital DRG outlier payments			12, 147	
. 00	Total inpatient days divided by number of days in the cost re	enorting period (see inst	ructions)	19.64	
. 00	Number of interns & residents (see instructions)	cporting period (see that		0.00	
. 00	Indirect medical education percentage (see instructions)			0.00	
. 00		e sum of lines 1 and 1.01)	0.00	
. 00					
. 00	Percentage of Medicaid patient days to total days (see instru	uctions)		0.00	8.
. 00	Sum of lines 7 and 8			0.00	
	Allowable disproportionate share percentage (see instructions			0.00	
	Disproportionate share adjustment (line 10 times the sum of I			0	1
2.00	Total prospective capital payments (sum of lines 1, 1.01, 2,	2.01, 6 and 11)		433, 002	12.
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST				
. 00	Program inpatient routine capital cost (see instructions)			0	1
00	Program inpatient ancillary capital cost (see instructions)			0	
. 00 . 00	Total inpatient program capital cost (line 1 plus line 2)			0	
. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
. 00				0	5.
				1.00	
~~	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 1
. 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstand	oor (coo instructions)		0	
00	Net program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2)	ces (see instructions)		0	
00	Applicable exception percentage (see instructions)			0.00	-
00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
00	Percentage adjustment for extraordinary circumstances (see in	nstructions)		0.00	
00	Adjustment to capital minimum payment level for extraordinary	,	line 6)	0	
00	Capital minimum payment level (line 5 plus line 7)		<i>,</i>	0	8
00	Current year capital payments (from Part I, line 12, as appli	i cabl e)		0	9
0. 00	Current year comparison of capital minimum payment level to a		less line 9)	0	10
I. 00	Carryover of accumulated capital minimum payment level over o Worksheet L, Part III, line 14)		-	0	
	Net comparison of capital minimum payment level to capital pa			0	1
				0	
3.00		capital payment for the f	ollowing period	0	14
3.00	Carryover of accumulated capital minimum payment level over (÷ .		
3.00 4.00	(if line 12 is negative, enter the amount on this line)			0	15
3.00 4.00 5.00	(if line 12 is negative, enter the amount on this line)			0	