Heal th Financia	al Systems	ST. ELIZABETH E	TACT	l n	Lieu of Form	CMC DEED 10
	J					
This report is	required by law (42 USC 1395g	; 42 CFR 413.20(b)). Failu	re to report can r	result in all into	erim FORM APP	ROVED
payments made	since the beginning of the cos	t reporting period being d	eemed overpayments	s (42 USC 1395g).	OMB NO.	0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX CO SUMMARY	ST REPORT CERTIFICATION	Provi der CCN: 150	109 Period: From 01/01/2 To 12/31/2	2014 Date/Tim	
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically filed o	cost report		Date: 5/2	27/2015 Tir	me: 9:45 am
use only	2. [] Manually submitted cos	st report				
	3. [0] If this is an amended 4. [F] Medicare Utilization.			er resubmitted th	is cost repor	t
Contractor use only	(1) As Submitted (2) Settled without Audit		this Provider CCN			

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. ELIZABETH EAST (150109) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
Officer or Ad	dministrator of Provider(s)
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	215, 206	143, 450	94, 319	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	-4, 135	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
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 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	211, 071	143, 450			200. 00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	TDENTIFICATION DA	ATA	Provi der	CCN. 150		Period: From 01/01, To 12/31,	/2014 /2014	Part I Date/Ti	et S-2 me Prep 115 9:45	
	1.00		. 00	3. 00)			4. 00			
1. 00 2. 00	Hospital and Hospital Health Care Co Street: 1701 SOUTH CREASY LANCE City: LAFAYETTE	omplex Address: PO Box: State: I	IN 7i	p Code: 47	005	Count	y: TI PPECAN	INE			1. 00 2. 00
2.00	CITY: LAFATETTE	Component Na	ame (CN CE	BSA Pro	vi der ype	Date Certified	Paymer	nt Syst O, or		2.00
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3. 00 4. 00	Hospi tal Subprovi der - IPF	ST. ELIZABETH EA	.51 15	0109 29	140	1	07/01/1966	N	P	0	3. 00 4. 00
5. 00	Subprovi der - TRF	ST. ELIZABETH RE	HAB 15	T109 29	140	5	01/01/1995	N	Р	0	5. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital -Based SNF Hospital -Based NF Hospital -Based OLTC Hospital -Based HHA Separately Certified ASC Hospital -Based Health Clinic - RHC Hospital -Based Health Clinic - FQHC Hospital -Based (CMHC) Hospital -Based (CORF)	ST. ELIZABETH HH ST. ELIZABETH HO			140		07/06/1966 01/01/1984		Р	N	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
	Renal Dialysis										18. 00
19. 00	Other						From:		To		19. 00
							1.00		To 2. 0		
20. 00	Cost Reporting Period (mm/dd/yyyy)						01/01/2		12/31/		20. 00
21. 00	Type of Control (see instructions)							1			21. 00
22. 00	Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord						Y		N		22. 00
	for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en				(-)(-)(
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r	es or "N" for no October 1. Enter	for the por	tion of t 2, "Y" for	he cost yes or '	"N"	Y		Υ		22. 01
22. 02	(see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for	? (see instruction le cost reporting	ons) Enter i period prio	n column or to Octo	1, "Y" fo ber 1. Ei	or yes nter			Υ		22. 02
22. 03	or after October 1. Did this hospital receive a geograph				5 1				N		22. 03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,	statistical area no for the portic 2, "Y" for yes on ar after October of tot more than 499 b	as adopted bon of the co r "N" for no 1. (see inst peds (as cou	by CMS in ost report o for the cructions)	FY2015? I ing perio portion o Does thi	Enter od of the is	2				
23. 00	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	dicaid days on li f census days, on is cost reportino	ines 24 and/ r 3 if date g period dif	of discha ferent fr	rge. Is on the mo	the ethod		3	N		23. 00
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Medica paid da	id M ays e	State Hedicaid Eligible unpaid	Medicai HMO day	s Med	ther i cai d ays	
24 00	If this provider is an IDDS harmit-	ontor the	1.00	2. 00	3.00		4. 00	5. 00		. 00	24 00
	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in colout-of-state Medicaid paid days in colout-of-state Medicaid eligible unpaid, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter the Medicaid paid days in column 1, the Medicaid eligible unpaid days in colout-of-state Medicaid days in column Medicaid eligible unpaid days in column Medicaid eligible unpaid days in column Medicaid and eligible but unpaid day	nn 1, in-state umn 2, column 3, d days in column it unpaid days in column 6. ie in-state in-state umn 2, i 3, out-of-state		1, 47 ⁻		0	0	4, 9	0	175	24. 00 25. 00

care or general surgery. (see instructions)

Health Financial Systems ST. ELI ZABETH EAST In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150109 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 9:45 am Program Code Unweighted IME Program Name Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in

column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

SPITAL AND HOSPITAL HEALTH CARE COMPLE		ZABETH EAST Provider	CCN: 15010		d:	u of Form CMS Worksheet S-	
					01/01/2014 12/31/2014	Part I Date/Time Pr	enared
					12/31/2014	5/27/2015 9:	
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date in column 1 and termination of			00+1 0p de	.+.			122
12.00 If this is a Medicare certified is in column 1 and termination date,			Cation da	ite			132.
3.00 If this is a Medicare certified of	•		cation da	ate			133.
in column 1 and termination date, 4.00 If this is an organ procurement or			n column	1			134.
and termination date, if applicabl							
All Providers O.00 Are there any related organization	or home office costs a	s defined in CMS	Pub. 15-1	l.	Υ	158014	140.
chapter 10? Enter "Y" for yes or "	N" for no in column 1.	If yes, and home	office co		·		
are claimed, enter in column 2 the		<u>er. (see instruct</u> 2.00	i ons)		3. 00		
If this facility is part of a chai			igh 143 tl	he name ar		of the	
home office and enter the home off I1.00Name: FRANCISCAN ALLIANCE, INC.	<u>Fice contractor name and</u> Contractor's Name:			actor's N	umber: 0810	11	141.
2.00 Street: 1515 DRAGOON TRAIL	PO Box:	1290	Conti	actor 3 N	ullber. Ourc	, ,	142.
3.00 Ci ty: MI SHAWAKA	State:	IN	Zip C	Code:	4654	6-1290	143.
						1.00	+
4.00 Are provider based physicians' cos			_			Y	144.
15.00 If costs for renal services are clonly? Enter "Y" for yes or "N" for		ine 74, are the c	osts for	i npati ent	servi ces	Y	145.
					1. 00	2. 00	
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Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 17.00 Was there a change in the statisti 18.00 Was there a change in the order of 19.00 Was there a change to the simplification. Does this facility contain a provior charges? Enter "Y" for yes or '0.00 Hospital 16.00 Subprovider - IPF 17.00 Subprovider - IRF 18.00 SUBPROVIDER 19.00 SNF 19.00 CMHC 11.00 CMHC 11.10 CORF	column 1. (See CMS Pub column 2. cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method? der that qualifies for "N" for no for each comp	on 15-2, § 4020) I or yes or "N" for for yes or "N" for Y Enter "Y" for ye Part A 1.00 an exemption from N N N N N N N N N N N N N N N N N N N	f yes, er no. r no. s or "N" Part 2.00 n the appl and Part N N N N N N Ses in di	for B Dication (B. (See 4))	N N N N N 3.00 of the lowe 12 CFR §413 N N N N N N N N N N N N N N N N N N N	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplification. Does this facility contain a provior charges? Enter "Y" for yes or '5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF Multicampus 5.00 Is this hospital part of a Multicate Enter "Y" for yes or "N" for no.	Column 1. (See CMS Pub column 2. cal basis? Enter "Y" fo allocation? Enter "Y" ed cost finding method? der that qualifies for N" for no for each comp	pryes or "N" for for yes or "N" for	f yes, er no. r no. s or "N" Part 2.00 n the appl and Part N N N N N N N	B) lication (B. (See 4	N N N N N 3.00 of the lowe 12 CFR §413 N N N N N N N N N N N N N N N N N N N	Title XIX 4.00 er of costs 3.13) N N N N N N N FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplification. Does this facility contain a provious or charges? Enter "Y" for yes or '5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.10 CORF Multicampus 5.00 Is this hospital part of a Multicate Enter "Y" for yes or "N" for no. Multicampus 6.00 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 1. (See CMS Pub column 2. cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method? der that qualifies for "N" for no for each comp	on 15-2, § 4020) I or yes or "N" for for yes or "N" for for yes or "N" for Penter "Y" for ye Part A 1.00 an exemption from N N N N N N One or more campu County	f yes, er no. r no. s or "N" Part 2.00 the appl and Part N N N N N Ses in di	for B D II cation (B. (See 4) Fferent C Zip Code	N N N N N Title V 3.00 of the lowe 12 CFR §413 N N N N N N N N N CBSA	Title XIX 4.00 er of costs 3.13) N N N N N N N FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifino. Does this facility contain a provior charges? Enter "Y" for yes or '5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. Multicampus 6.00 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,	column 1. (See CMS Pub column 2. cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method? der that qualifies for "N" for no for each comp	on 15-2, § 4020) I or yes or "N" for for yes or "N" for for yes or "N" for Penter "Y" for ye Part A 1.00 an exemption from N N N N N N One or more campu County	f yes, er no. r no. s or "N" Part 2.00 the appl and Part N N N N N Ses in di	for B D II cation (B. (See 4) Fferent C Zip Code	N N N N N Title V 3.00 of the lowe 12 CFR §413 N N N N N N N N N CBSA	Title XIX 4.00 er of costs 3.13) N N N N N N N N S T.00 N FTE/Campus 5.00 O.0	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplification. Does this facility contain a provious or charges? Enter "Y" for yes or '5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF Multicampus 5.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no. Multicampus 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	column 1. (See CMS Pub column 2. cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method? der that qualifies for "N" for no for each comp impus hospital that has Name 0	on 15-2, § 4020) I or yes or "N" for for yes or "N" for for yes or "N" for enter "Y" for ye Part A 1.00 an exemption from N N N N N N N N N N N N N N N N N N N	f yes, er no. r no. s or "N" Part 2.00 the appl and Part N N N N N Ses in di State 2.00	for B D D D D D D D D D D D D D D D D D D	N N N N N Title V 3.00 of the lowe 12 CFR §413 N N N N N N N N N CBSA	Title XIX 4.00 er of costs 3.13) N N N N N N N FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in the statistic state of the simplification of the	column 1. (See CMS Pub column 2. cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method? der that qualifies for "N" for no for each comp mapus hospital that has Name 0 O incentive in the Amer under Section §1886(n)	on 15-2, § 4020) I or yes or "N" for for yes or "N" for Part A N N N N N N N N N N N N N N N N N N	f yes, er no. r no. s or "N" Part 2.00 the appl and Part N N N N N Ses in di State 2.00	fferent C Zip Code 3.00	N N N N N Title V 3.00 off the lowe 12 CFR §413 N N N N N S N N N N A N N N N N N N N N	Title XIX 4.00 er of costs 3.13) N N N N N N N N S T.00 N FTE/Campus 5.00 O.0	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplification. Does this facility contain a provious or charges? Enter "Y" for yes or '5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF Multicampus 5.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	Column 1. (See CMS Pub column 2. cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method? der that qualifies for "N" for no for each comp Name O O O O O O O O O O O O O	on 15-2, § 4020) I or yes or "N" for for yes or "N" for for yes or "N" for Part A N"	f yes, er no. r no. s or "N" Part 2.00 the appl and Part N N N N N Ses in di State 2.00	fferent C Zip Code 3.00	N N N N N Title V 3.00 off the lowe 12 CFR §413 N N N N N S S BSAs? CBSA 4.00	Title XIX 4.00 er of costs 3.13) N N N N N N N N N O T.00 N FTE/Campus 5.00 0.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.

Health Financial Systems	· · · · · · · · · · · · · · · · · · ·				In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE								
			From 01/01/2014					
			To 12/31/2014	Date/Time Pre 5/27/2015 9:4				
			Begi nni ng	Endi ng				
			1. 00	2.00				
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)	12/31/2014	170. 00						
				1.00				
171.00 If line 167 is "Y", does this provider Medicare cost plans reported on Wkst. S (see instructions)	N	171. 00						

					10 12/31/2014	5/27/2015 9: 4	
				Pai	rt A	Part B	
		Descr	i pti on	Y/N	Date	Y/N	
			0	1.00	2. 00	3. 00	
1. 00	Was the cost report prepared only using the			N		N	21
ļ	provider's records? If yes, see						
	instructions.						
						1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)			
	Capital Related Cost	,		,			
	Have assets been relifed for Medicare purpose	es? If ves. see	e instructions			N	7 22
	Have changes occurred in the Medicare depreci			als made durin	na the cost	N	23
<i>.</i> . 00	reporting period? If yes, see instructions.	ation expense	ade to applials	ars made adrir	ig the cost		20
4. 00	Were new leases and/or amendments to existing	n Leases entere	ed into durina	this cost rend	orting period?	N	24
1. 00	If yes, see instructions	g reases entere	sa riito aarriig	till 3 cost i cpc	n tring perrous	14	-
5. 00	Have there been new capitalized leases entere	od into durina	the cost roper	ting poriod2 I	f voc coo	l N	25
). OO	instructions.	sa Titto daling	the cost repor	tring period: i	1 yes, see	IN.	23
5. 00	Were assets subject to Sec. 2314 of DEFRA acqu	iirad durina +k	an cost reporti	na noriod2 lf	V0C C00	N	26
J. 00		arred durring ti	ie cost reporti	ng perrous ri	yes, see	IN	20
, ,,,	instructions.			a noriedOlfi	roo oubmi +	N.	1 27
7. 00	Has the provider's capitalization policy char	nged during the	e cost reportin	g period? if s	es, submit	N	27
ļ	copy.					<u> </u>	
	Interest Expense	C 1: 1				N.	١.,
. 00	Were new Loans, mortgage agreements or letter	rs of credit er	ntered into dur	ing the cost r	reporting	N	28
ļ	period? If yes, see instructions.						١
. 00	Did the provider have a funded depreciation a			bt Service Res	serve Fund)	Y	29
ļ	treated as a funded depreciation account? If						
. 00	Has existing debt been replaced prior to its	scheduled matu	urity with new	debt? If yes,	see	N	30
ļ	instructions.						1
. 00	Has debt been recalled before scheduled matur	rity without is	ssuance of new	debt? If yes,	see	N	3
ļ	i nstructi ons.						
ļ	Purchased Services						
. 00	Have changes or new agreements occurred in pa	atient care ser	rvi ces furni she	d through cont	ractual	Y	32
	arrangements with suppliers of services? If y	yes, see instru	uctions.				
. 00	If line 32 is yes, were the requirements of 9	Sec. 2135.2 app	olied pertainin	g to competiti	ve bidding? If	N	33
	no, see instructions.						
ļ	Provi der-Based Physi ci ans						
. 00	Are services furnished at the provider facili	ty under an ar	rangement with	provi der-base	ed physicians?	Y	7 34
ļ	If yes, see instructions.	,	3	•	1 3		
. 00	If line 34 is yes, were there new agreements	or amended exi	sting agreemen	ts with the pr	rovi der-based	N	3!
	physicians during the cost reporting period?						
	<u> </u>	, , , , , , , , , , , , , , , , , , , ,			Y/N	Date	
					1. 00	2. 00	
	Home Office Costs				11.00	2.00	
	Were home office costs claimed on the cost re	enort?			Υ		3
	If line 36 is yes, has a home office cost sta		renared by tho	home office?	Y		3
00	If yes, see instructions.	arement been bi	charea by tile	nome office?	T T		3
00		of the bess of	fine different	from that of	N		1 2
. 00	If line 36 is yes, was the fiscal year end of				N		38
00	the provider? If yes, enter in column 2 the				N.		1
. 00	If line 36 is yes, did the provider render se	ervices to othe	er chain compon	ents? IT yes,	N		3
							1
	see instructions.				1	l	
00	If line 36 is yes, did the provider render se	ervices to the	home office?	lf yes, see	N		4
00		ervices to the	home office?	If yes, see	N		40
. 00	If line 36 is yes, did the provider render se	ervices to the					40
. 00	If line 36 is yes, did the provider render se instructions.	ervices to the		If yes, see		00	40
. 00	If line 36 is yes, did the provider render so instructions. Cost Report Preparer Contact Information		1.		2.	00	40
. 00	If line 36 is yes, did the provider render se instructions.					00	
. 00	If line 36 is yes, did the provider render so instructions. Cost Report Preparer Contact Information	e/posi ti on	1.		2.	00	
. 00	If line 36 is yes, did the provider render seinstructions. Cost Report Preparer Contact Information Enter the first name, last name and the title	e/posi ti on	1.		2.	00	
. 00	If line 36 is yes, did the provider render so instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns.	e/position 1, 2, and 3,	1.		2.	00	4
. 00	If line 36 is yes, did the provider render so instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns respectively.	e/position 1, 2, and 3,	DAVI D		2.	00	42
. 00	If line 36 is yes, did the provider render so instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns respectively. Enter the employer/company name of the cost in	e/position 1, 2, and 3, report	DAVI D		2.		4

Health Financial Systems	ST. ELI ZABE	ETH EAST	In Lie	u of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURS	SEMENT QUESTIONNAIRE	Provider CCN: 150109	From 01/01/2014	Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 9:45 am
	Part B		<u> </u>	
	Date			
	4.00			
PS&R Data	·			

	,	Part B		372172013 7. 4	T dill
			-		
		Date	_		
		4. 00			
	PS&R Data		1		1
16.00	Was the cost report prepared using the PS&R				16. 00
	Report only? If either column 1 or 3 is yes,				
	enter the paid-through date of the PS&R				
	Report used in columns 2 and 4 .(see				
	instructions)				
17.00	Was the cost report prepared using the PS&R	03/16/2015			17. 00
	Report for totals and the provider's records				
	for allocation? If either column 1 or 3 is				
	yes, enter the paid-through date in columns				
	2 and 4. (see instructions)				
18.00	,				18.00
	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					19.00
17.00	made to PS&R Report data for corrections of				17.00
	other PS&R Report information? If yes, see				
	instructions.				
20. 00					20.00
20.00	made to PS&R Report data for Other? Describe				20.00
	the other adjustments:				
21 00	Was the cost report prepared only using the				21.00
21.00	provider's records? If yes, see				21.00
	instructions.				
	THE COUNTY OF STATE O				
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title	e/position	DIRECTOR OF ACCOUNTING		41. 00
	held by the cost report preparer in columns				
	respectively.				
42.00	Enter the employer/company name of the cost i	report			42.00
	preparer.	•			
43.00	Enter the telephone number and email address	of the cost			43. 00
	report preparer in columns 1 and 2, respective				
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	. <i>J</i> .	T.	l	

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | Part | P

					10	0 12/31/2014	5/27/2015 9:4	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		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		138	50, 370	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			138	50, 370	0. 00	0	7. 00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	31. 00		17	4, 021	0. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT	25.00		4.4	F 440	0.00		11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00	1	14	5, 110	0. 00		12.00
13.00	NURSERY	43. 00		4.0	50 504	0.00	0	13.00
14.00	Total (see instructions)			169	59, 501	0. 00		14.00
15.00	CAH visits	40.00					0	15.00
16.00	SUBPROVIDER - I PF	40.00	1	0	0 6, 570			16. 00 17. 00
17. 00	SUBPROVIDER - I RF	41.00	1	18	0, 5/0		0	18.00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY	42. 00		U	U		0	19.00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY	101. 00					0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00					0	23. 00
24. 00	HOSPI CE	116. 00		0	0			24.00
24. 00	HOSPICE (non-distinct part)	30.00		U				24. 10
25. 00	CMHC - CMHC	30.00						25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00					Ö	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	1				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		187				27. 00
28. 00	Observation Bed Days			.07			0	28. 00
29. 00	Ambul ance Tri ps							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			Ĭ				32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
	•	•		'	. '		•	

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared:

					Т	o 12/31/2014	Date/Time Pre 5/27/2015 9:4	
			I/P Days	/ O/P Visits	/ Tri ps	Full Time E	Equi val ents	
		Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
			6. 00	7.00	8. 00	9. 00	10.00	
1	. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11, 844	2, 797	28, 214			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	2. 00	HMO and other (see instructions)	2, 218	4, 920				2. 00
	3. 00	HMO IPF Subprovider	0	0				3. 00
4	1.00	HMO IRF Subprovider	0	0				4. 00
	5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
	o. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7	7. 00	Total Adults and Peds. (exclude observation	11, 844	2, 797	28, 214			7. 00
_		beds) (see instructions)						
	3. 00	INTENSIVE CARE UNIT	1, 852	369	3, 479			8. 00
	9. 00	CORONARY CARE UNIT						9. 00
	0. 00	BURN INTENSIVE CARE UNIT						10.00
	1. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
	2. 00	NEONATAL INTENSIVE CARE UNIT	0	1, 715	2, 756			12.00
	3. 00	NURSERY		0	1, 236			13. 00
	4. 00	Total (see instructions)	13, 696	4, 881	35, 685		1, 107. 42	
	5. 00	CAH visits	0	0	0			15. 00
	6. 00	SUBPROVIDER - I PF	0	0	0	0.00		
	7. 00	SUBPROVIDER - IRF	1, 003	152	2, 017			
	8.00	SUBPROVI DER	O	O	0	0.00	0.00	
	9. 00	SKILLED NURSING FACILITY						19.00
	20.00	NURSING FACILITY						20.00
	21. 00	OTHER LONG TERM CARE	44 747		45 (07	0.00	20.00	21.00
	22. 00	HOME HEALTH AGENCY	11, 747	0	15, 627	0.00	39. 90	
	23. 00	AMBULATORY SURGICAL CENTER (D. P.)			•	0.00	0.00	23. 00
	24. 00	HOSPI CE	0	0	0		2. 93	
	24. 10	HOSPICE (non-distinct part)	0	U	0			24. 10
	25. 00	CMHC - CMHC		0	0	0.00	0.00	25. 00
	25. 10	CMHC - CORF	0	0	0		0.00	
	26. 00	RURAL HEALTH CLINIC	0	0	0	0.00		
	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	U	U	Ü			
	27. 00 28. 00	, ,			0	0.00	1, 162. 06	27. 00 28. 00
	29. 00	Observation Bed Days	0	٩	Ü			28.00
	30.00	Ambulance Trips Employee discount days (see instruction)	٩		0			30.00
					0			
	31.00	Employee discount days - IRF		0	0 505			31.00
	32.00	Labor & delivery days (see instructions)	0	U	2, 535			32. 00
3	32. 01	Total ancillary labor & delivery room			0			32. 01
2	3 00	outpatient days (see instructions) LTCH non-covered days	0					33. 00
J	,J. 00	LION NON COVERED Days	U _I			1		JJ. 00

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | Part | P

				10	12/31/2014	5/27/2015 9:4	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	3, 394	1, 430	8, 582	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)			518	0		2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT						12. 00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	3, 394	1, 430	8, 582	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00	0		0	0	16. 00
17. 00	SUBPROVI DER - I RF	0.00	0		16	182	17. 00
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	0.00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
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						28. 00
29. 00	Ambul ance Tri ps						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						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00

| Period: | Worksheet S-3 | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150109

					To	12/31/2014	Date/Time Pre	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	5/27/2015 9: 4 Average Hourly	
		Line Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	59, 092, 828	3, 513, 834	62, 606, 662	2, 303, 430. 00	27. 18	1.00
	instructions)	200.00	07,072,020	0,0.0,00.	02, 000, 002	2,000,100.00		
2. 00	Non-physician anesthetist Part		C	0	0	0. 00	0.00	2. 00
3. 00	Non-physician anesthetist Part		(0	0	0.00	0.00	3. 00
4. 00	B Physician-Part A -		C		0	0.00	0. 00	4. 00
4.00	Admi ni strati ve			,				
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		(0	0	0. 00 0. 00		
6. 00	Non-physician-Part B		(0	0.00		
7. 00	Interns & residents (in an	21. 00	Ċ	Ö	0	0. 00		
7. 01	approved program) Contracted interns and				0	0. 00	0. 00	7. 01
7.01	residents (in an approved			0		0.00	0.00	7.01
0.00	programs) Home office personnel					0.00	0.00	0.00
8. 00 9. 00	SNF	44. 00	(0. 00 0. 00		
10.00	Excluded area salaries (see		4, 905, 532	161, 483	5, 067, 015	138, 010. 00		
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract labor: Direct Patient		7, 879	0	7, 879	94.00	83. 82	11. 00
12.00	Care Contract Labor: Top Level		(0	0.00	0.00	12.00
12. 00	management and other		(0	U	0. 00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		(0	0	0. 00	0.00	13. 00
	A - Administrative							
14. 00	Home office salaries & wage-related costs		10, 146, 971	0	10, 146, 971	193, 394. 00	52. 47	14. 00
15. 00	Home office: Physician Part A		(0	0	0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		(0	0	0. 00	0. 00	16. 00
	Physicians Part A - Teaching							
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		17, 765, 115	0	17, 765, 115			17. 00
	instructions)							
18. 00	Wage-related costs (other) (see instructions)		(0	0			18. 00
19. 00	Excluded areas		2, 369, 874	0	2, 369, 874			19. 00
20. 00	Non-physician anesthetist Part		(0	0			20. 00
21. 00	Non-physician anesthetist Part		(0	0			21. 00
22. 00	B Physician Part A -		(0	0			22. 00
22.00	Admi ni strati ve)				22.00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		(1	0			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		(1	0			24. 00
25. 00	Interns & residents (in an		C	0	0			25. 00
	approved program) OVERHEAD COSTS - DIRECT SALARIE	S						
26. 00	Employee Benefits Department	4. 00	1, 017, 213	-238, 762	778, 451	25, 610. 00	30. 40	26. 00
27. 00	Administrative & General	5. 00	5, 809, 822	1		292, 243. 00		
28. 00	Administrative & General under contract (see inst.)		364, 934	0	364, 934	5, 614. 00	65. 00	28. 00
29. 00	Maintenance & Repairs	6. 00	(0	0	0.00	0. 00	29. 00
30. 00	Operation of Plant	7. 00	1, 936, 163			110, 572. 00		
31. 00	Laundry & Linen Service	8. 00	36, 914	1		9, 247. 00		
32. 00 33. 00	Housekeeping under contract	9. 00	1, 306, 425 (0	1, 306, 425 0	99, 371. 00 0. 00		1
	(see instructions)	40.00	4 400 700	FE 4 3	(22.27			
34. 00 35. 00	Di etary Di etary under contract (see	10. 00	1, 183, 623 (-554, 746 0	628, 877 0	29, 802. 00 0. 00		
	instructions)							
36. 00 37. 00	Cafeteria Maintenance of Personnel	11. 00 12. 00	370, 007	554, 746	924, 753	75, 696. 00 0. 00		
37. 00 38. 00	Nursing Administration	12.00	2, 742, 15 <i>6</i>	-342, 350	2, 399, 806	63, 182. 00		37.00
39. 00	Central Services and Supply	14. 00	406, 737	0	406, 737	25, 151. 00	16. 17	39. 00
40. 00	Pharmacy	15. 00	2, 140, 549	-21, 253	2, 119, 296	53, 382. 00	39. 70	40. 00

Health Financial Systems ST. ELIZABETH EAST					In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION					Period: From 01/01/2014 To 12/31/2014		pared:
	Worksheet A Line Number	Reported	Reclassificati on of Salaries (from Worksheet A-6)	Salaries (col.2 ± col.	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5. 00	6. 00	
41.00 Medical Records & Medical Records Library	16. 00	1, 305, 651	-100, 056	1, 205, 59	52, 712. 00	22. 87	41. 00
42.00 Social Service	17. 00	492, 947	-64, 077	428, 87	0 17, 201. 00	24. 93	42.00
43.00 Other General Service	18. 00	0	0		0.00	0.00	43. 00

Heal th	Financial Systems	ST. ELIZABETH EAST			In Lieu of Form CMS-2552-10			
HOSPI 1	TAL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014 To 12/31/2014		pared:
		Worksheet A	Amount	Recl assi fi cati	Adj usted		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	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		59, 457, 762	3, 513, 834	62, 971, 59	6 2, 309, 044. 00	27. 27	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 905, 532	161, 483	5, 067, 01	5 138, 010. 00	36. 71	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		54, 552, 230	3, 352, 351	57, 904, 58	1 2, 171, 034. 00	26. 67	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		10, 154, 850	0	10, 154, 85	0 193, 488. 00	52. 48	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		17, 765, 115	0	17, 765, 11	5 0.00	30. 68	5. 00
	(see inst.)							
6 00	Total (sum of lines 3 thru 5)		82 472 195	3 352 351	85 824 54	6 2 364 522 00	d 36 30	6.00

85, 824, 546

20, 503, 119

3, 352, 351 1, 389, 978

2, 364, 522. 00

859, 783. 00

36. 30

23. 85

6.00

7.00

82, 472, 195

19, 113, 141

6. 00

7.00

Total (sum of lines 3 thru 5)
Total overhead cost (see

instructions)

Health Financial Systems	ST. ELIZABETH EAST	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150109	
		From 01/01/2014 Part IV
		To 12/21/2014 Dato/Time Propare

PART IV - WAGE RELATED COSTS 1.00		To 12/31/2014	Date/Time Prep 5/27/2015 9:4	
PART IV - WAGE RELATED COSTS Part A - Core List RETITEMENT COST RETITEMENT COST			Amount	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 20			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2. 00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0.00 0.0	1.00	401K Employer Contributions	0	1.00
Qualified Defined Benefit Plan Cost (see instructions) Qualified Defined Benefit Plan Cost (see instructions) PLAN ADMINISTRATIVE COSTS (Plad to External Organization) S. 00 Control AOTK/TSA Plan Administration fees O. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.	2.00		0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	6, 869, 306	3.00
5.00 401K/TSA Plan Administration fees 0 5.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 Employee Managed Care Program Administration Fees 0 7.00 Employee Managed Care Program Administration Fees 8.00 Health Insurance (Purchased or Self Funded) 8.00 Prescription Drug Plan 0 9.00	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
Legal / Accounting / Management Fees-Pension Plan		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
Toolage Tool	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
Real th Insurance (Purchased or Self Funded) 9.00 9.00 10.00	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental Hearing and Vision Plan 354,894 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 30,516 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 215,343 14.00 15.00 Workers' Compensation Insurance 441,716 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 91,482 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit ion Rei mbursement 47,047 23.00 24.00 Part B - Other than Core Related Cost		HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan 354,894 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 30,516 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 215,343 14.00 15.00 Workers' Compensation Insurance 441,716 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 17.00 Non cumulative portion 16.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 91,482 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 21.00 THER 200 200 200 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 47,047 23.00 24.00 Part B - Other than Core Related Cost 24.00 24.00 Part B - Other than Core Related Cost 200 24.00 24.00 Part B - Other than Core Related Cost 200 200 25.00 25.00 25.00 25.00 26.00 26.00 27.00 27.00 27.00 27.00 27.00 27.00 28.00 28.00 27.00 27.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00	8.00	Heal th Insurance (Purchased or Self Funded)	5, 826, 591	8. 00
11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 21.00 Day Care Cost and Allowances 22.00 Tuition Reimbursement 47,047 23.00 Part B - Other than Core Related Cost	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	354, 894	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 Non cumulative portion) 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Part B - Other than Core Related Cost	11. 00	Life Insurance (If employee is owner or beneficiary)	30, 516	11. 00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 17.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 10.00 Tuit ion Reimbursement 10.00 Total Wage Related cost (Sum of Lines 1 -23) 17.198, 106 Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	215, 343	14.00
Non cumulative portion TAXES To A Employers Portion Only 17.00 18.00 19.00	15.00		441, 716	15. 00
Non cumulative portion TAXES To A Employers Portion Only 17.00 18.00 19.00	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00 FI CA-Employers Portion Only 3, 321, 211 17. 00 18. 00 19. 00 1				
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 91,482 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit ion Reimbursement 47,047 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 17,198,106 24.00		TAXES		
19.00 Unemployment Insurance 91,482 19.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 47,047 23.00 Total Wage Related cost (Sum of Lines 1 -23) 17,198,106 Part B - Other than Core Related Cost	17.00	FICA-Employers Portion Only	3, 321, 211	17.00
20.00 State or Federal Unemployment Taxes 0 DTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 47,047 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 17,198,106 Part B - Other than Core Related Cost	18.00	Medicare Taxes - Employers Portion Only	0	18.00
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 23.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	19.00	Unemployment Insurance	91, 482	19.00
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 21.00 22.00 23.00 24.00 24.00	20.00	State or Federal Unemployment Taxes	0	20.00
instructions)) Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 1 instructions) 22.00 22.00 23.00 24.00 24.00		OTHER		
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 47, 047 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 17, 198, 106 24. 00 Part B - Other than Core Related Cost 24. 00	21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
23.00 Tuition Reimbursement 47,047 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 17,198,106 24.00 Part B - Other than Core Related Cost		instructions))		
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 17, 198, 106 24.00	22.00	Day Care Cost and Allowances	0	22. 00
Part B - Other than Core Related Cost	23.00	Tuition Reimbursement	47, 047	23.00
Part B - Other than Core Related Cost	24.00	Total Wage Related cost (Sum of lines 1 -23)	17, 198, 106	24.00
25. 00 EMPLOYEE ASSISTANCE & TDA 567, 010 25. 00				
	25.00	EMPLOYEE ASSISTANCE & TDA	567, 010	25. 00

Health Financial Systems	ST. ELIZABETH EAST	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150109	From 01/01/2014	Worksheet S-3 Part V Date/Time Pre 5/27/2015 9:4	pared:
Cost Center Description	,	Contract Labor 1.00		
PART V - Contract Labor and Benefit Cost				

			5/27/2015 9:4	5 am
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	C	0	1.00
2.00	Hospi tal	C	0	2.00
3.00	Subprovi der - IPF	C	0	3.00
4.00	Subprovi der - IRF	C	0	4.00
5.00	Subprovi der - (0ther)	C	0	5.00
6.00	Swing Beds - SNF	C	0	6.00
7.00	Swing Beds - NF	C	0	7.00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA	C	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce	C	0	13.00
14.00	Hospital-Based Health Clinic RHC	C	0	14.00
15.00	Hospital-Based Health Clinic FOHC	C	0	15.00
16.00	Hospi tal -Based-CMHC			16.00
16. 10	Hospi tal -Based-CMHC 10	C	0	16. 10
17.00	Renal Dialysis	C	0	17.00
18.00	Other	C	0	18.00

Heal th	Financial Systems	ST. ELI ZAB	FTH FAST		In lie	eu of Form CMS-:	2552-10
	IEALTH AGENCY STATISTICAL DATA	011 2212713			Period: From 01/01/2014	Worksheet S-4	
			Component		To 12/31/2014	Date/Time Pre	
-					Home Health	5/27/2015 9: 4 PPS	<u>3 alli</u>
					Agency I		
						00	
0. 00	County	Title V	Title XVIII	Title XIX	TI PPEECANOE Other	Total	0.00
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	990) 1	8 170	1, 178	1.00
2.00	Unduplicated Census Count (see instructions)	0. 00		13.0	0 325.00	957.00	
				Number of Emp	oloyees (Full Ti	me Equivalent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
)	1.00	2. 00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0. 0 0. 0		l .	
5.00	Other Administrative Personnel			13. 2	0.00	13. 24	5. 00
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			7.8		l .	1
8.00	Physical Therapy Service			1.5	0.00	1.54	8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0.0			1
11. 00	Occupational Therapy Supervisor			0.0	0.00	0.00	11. 00
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 1			1
14.00	Medical Social Service			0. 1	2 0.00	0. 12	14. 00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0.0			1
17. 00	Home Health Aide Supervisor			0.0	0.00	0.00	17. 00
18. 00	INFUSION HOME HEALTH AGENCY CBSA CODES			6.8	0.00	6. 89	18. 00
19. 00	Enter in column 1 the number of CBSAs where				1		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			29140			20. 00
	during this cost reporting period (line 20 contains the first code).						
		Full Ep Without	with Outliers	IIIDA Enisodes	s PEP Only	Total (cols.	
		Outliers		·	Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2.00	3. 00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	5, 246	0	•			1
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	1, 495, 994 3, 504	0		11 18, 762 6 46	l .	
24.00	Physical Therapy Visit Charges	1, 124, 374	0	13, 16	0 14, 476	1, 152, 010	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	1, 164 380, 746	0	•	6 10 4 3, 290		
27. 00	Speech Pathology Visits	64	O		4 0	68	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	20, 980 68	0		6 0	'	1
30.00	Medical Social Service Visit Charges	25, 888	O				30. 00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	1, 295 195, 377	0	l .	3 12 2 1, 848		1
33. 00	Total visits (sum of lines 21, 23, 25, 27,	11, 341	O	27	0 136	11, 747	33. 00
34. 00	29, and 31) Other Charges	0	О		0 0	0	34. 00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	3, 243, 359	a	63, 52	38, 376	3, 345, 260	35. 00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	651		7	3 10	734	36. 00
37. 00	outlier) Total Number of Outlier Episodes		0		1	1	37. 00
38. 00	•	434, 392		•	2, 369		

Health Financial Systems		ST. ELIZAB	ETH E	EAST		In Lie	u of Form CMS-2	2552-10
HOSPITAL IDENTIFICATION DATA					CCN: 150109 CCN: 151563	Peri od: From 01/01/2014 To 12/31/2014		pared:
						Hospi ce I		
	Unduplicated Days							
	Title XVIII	Title XIX	Ti t	le XVIII	Title XIX	All Other	Total (sum of	

						nospi cc i		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		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	2, 499	55	0	0	19	2, 573	2.00
3.00	Inpatient Respite Care	8	0	0	0	0	8	3. 00
4.00	General Inpatient Care	2	0	0	0	0	2	4.00
5.00	Total Hospice Days	2, 509	55	0	0	19	2, 583	5. 00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	59	2	0	0	3	64	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	42. 53	27. 50	0. 00	0.00	6. 33	40. 36	8. 00
	5/line 6)							
9.00	Unduplicated Census Count	62	0	0	0	0	62	9. 00

	∐oal ±h	Financial Systems ST FILTADETH	EAST		In Lie	ou of Form CMS	2552 10				
			_	CCN: 150100	•	_					
	позетт	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider	CCN. 130109			U				
1.00							pared:				
Uncompensated and Indigent care cost computation 1,00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.251556 1,00						5/27/2015 9:4	5 am				
Uncompensated and Indigent care cost computation 1,00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.251556 1,00											
1.00 Cost to charge ratio (Worksheet C, Part line 202 column 3 divided by line 202 column 8) 0.251556 1.00						1.00					
Medical d (see Instructions for each line) 2.00 N 3.00 N	4 00			000 1	0)	0.054557	4 00				
2.00 Net revenue from Medicaid 19,327,111 2.00 3.00 Did you receive DSH or supplemental payments from Medicaid? N 3.00 0.00 If I in a 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? N 4.00 0.50 0.00 If I in a 4 is "no", then enter DSH or supplemental payments from Medicaid? 97,499,370 6.00 0.00 Medicaid cost (line 1 times line 6) 97,499,370 6.00 0.00 Medicaid cost (line 1 times line 6) 24,556,552 7.00 0.00 Medicaid cost (line 1 times line 6) 0.10 0.00	1.00		vraea by ri	ne 202 colum	n 8)	0. 251556	1.00				
3.00 0 1 1 1 1 2 1 2 2 2 1 1	2 00					10 227 111	2 00				
1.1 1.1 1.2							•				
1 1 1 1 1 1 1 1 1 1											
Modical dicharges 97,499,370 6.00		1	1 2	ironi wearcar	u:	0					
Modicaid cost (line 1 times line 6) 24,526,552 7,00 8,00 Note the enter versus and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 5,199,441 8,00 5,199,441 8,00 State Children's Health Insurance Program (SCHIP) (see instructions for each line) 9,00 Note revenue from stand-alone SCHIP charges 0 10,00 10,		, ,	iii wear car a								
8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if 5, 199, 441 8.00 2 coro then enter zero)		1				1					
State Children's Heal th Insurance Program (SCHIP) (see instructions for each line) 9,00			(line 7 mir	nus sum of Li	nes 2 and 5 if	1					
State Chil Idren's Health Insurance Program (SCHIP) (see instructions for each line) 9,00	0.00	1 9	(2 4 0, 1.	0, 1, 7, 111	0.00				
10.00 Stand-al one SCHIP charges 0 10.00 0 11.00 11.00 0 0 11.00 0 0 11.00 0 0 0 11.00 0 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 0 0 0 0 0 12.00 0 0 0 0 0 12.00 0 0 0 0 0 0 0 0 0			tions for e	ach line)							
10.00 Stand-al one SCHIP charges 0 10.00 0 11.00 11.00 0 0 11.00 0 0 11.00 0 0 0 11.00 0 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 0 0 0 0 0 12.00 0 0 0 0 0 12.00 0 0 0 0 0 0 0 0 0	9.00	Net revenue from stand-alone SCHIP				0	9. 00				
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 100 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 100 15.00 State or local indigent care program cost (line 1 times line 14) 0 0 15.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 16) 16.00 17.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 17) 16.00 17.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 17) 16.00 17.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 17) 17.00 17.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 18) 17.00 17.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 2	10.00					0	10.00				
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Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included in lines 2, 5 or 9) 0.00 13.00 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10.00 14.00 15.00 State or local indigent care program cost (line 1 times line 14) 0.00 15.00 0.00	12.00		(line 11 m	ninus line 9;	if < zero then	0	12. 00				
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R, 12 and 16) Uninsured patients Date of the patients Date o		1			ms (sum of lines	5, 199, 441	19. 00				
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times line 20) 22.00 Partial payment by patients approved for charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10.074, 908 20.00 Cost of uncompensated care (line 23 column 3 plus line 29)	21 00			0.707.0	40	0 707 040	21 00				
22.00 Partial payment by patients approved for charity care 0 8,797,849 0 8,797,849 23.00 23.00 Cost of charity care (line 21 minus line 22) 8,797,849 0 8,797,849 23.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 27.00 Medicare bad debt expense for the entire hospital complex (see instructions) 5,597,545 26.00 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 5,076,639 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,277,059 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10,074,908 30.00	21.00		re (iine i	8, 191, 8	49	8, 191, 849	21.00				
23.00 Cost of charity care (line 21 minus line 22) 8,797,849 0 8,797,849 1.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Medicare bad debt expense for the entire hospital complex (see instructions) 7.00 Medicare bad debts for the entire hospital complex (see instructions) 8,797,849 0 8,797,849 1.00 25.00 5,597,845 26.00 5,597,545 26.00 7.00 8,797,849 1.00 1.00 25.00 5,597,545 26.00 5,076,639 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,277,059 10,074,908 30.00	22 00	·			0		22 00				
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29)				Q 707 9							
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 24.00 25.00 5,597,545 60.00 5,076,639 28.00 1,277,059 10,074,908 30.00	23.00	cost of charty care (fine 21 minus fine 22)		0, 171, 0	77	0, 171, 047	23.00				
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 24.00 25.00 5,597,545 60.00 5,076,639 28.00 1,277,059 10,074,908 30.00						1.00					
imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 5,597,545 26.00 5,297,054 50,776,639 10,277,059 29.00 10,074,908 30.00	24. 00	Does the amount in line 20 column 2 include charges for patien	t davs bevo	nd a Length	of stav limit		24. 00				
26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 5,597,545 26.00 520,906 27.00 5,076,639 28.00 1,277,059 29.00 10,074,908 30.00											
27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 520,906 27.00 5,076,639 28.00 1,277,059 29.00 10,074,908 30.00	25.00										
28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 5,076,639 1,277,059 29.00 10,074,908 30.00	26.00	Total bad debt expense for the entire hospital complex (see in	-	5, 597, 545	26. 00						
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,277,059 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10,074,908 30.00											
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10,074,908 30.00		, ,		,		1	1				
			pense (line	e 1 times lin	e 28)	1	1				
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 15,274,349 31.00											
	31. 00	lotal unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			15, 274, 349	31.00				

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	ST. ELIZABET F FXPFNSFS		CCN: 150109 F	In Lie Period:	u of Form CMS-2 Worksheet A	2552-10
1120211		. Lin LineLe	1100146	1	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 9:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +-	J dill
		1.00	2. 00	3.00	4. 00	col . 4) 5.00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT		15, 584, 891	15, 584, 89°	1 4, 084, 516	19, 669, 407	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0		2, 503, 951	2, 503, 951	2. 00
4. 00 5. 01	OO4OO	1, 017, 213 112, 237	26, 775, 236 746, 382			27, 792, 449 858, 619	4. 00 5. 01
5. 02	01140 MGMT INFO SYSTEMS	0	12, 300, 667			12, 300, 667	5. 02
5.03	00550 PURCHASI NG	634, 367	457, 366			1, 091, 733	5. 03
5. 04 5. 05	OO570 ADMITTING OO580 PATIENT ACCOUNTING	123, 837 225, 076	811 937, 643	1		124, 648 1, 162, 719	5. 04 5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	4, 714, 305	30, 296, 851			34, 749, 559	5. 06
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	1, 936, 163 36, 914	6, 927, 444 175, 029			8, 859, 428 211, 943	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	1, 306, 425	600, 208			1, 905, 643	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 183, 623 370, 007	595, 264 444, 811			1, 029, 893 1, 519, 419	
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 742, 156	67, 266			2, 809, 371	
14.00	01400 CENTRAL SERVICES & SUPPLY	406, 737	868, 676			446, 914	
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	2, 140, 549 1, 305, 651	5, 728, 883 1, 084, 694			2, 673, 360 2, 309, 988	
17. 00	01700 SOCIAL SERVICE	492, 947	2, 734	495, 68	0	495, 681	17. 00
20. 00 23. 00	O2000 NURSI NG SCHOOL O2301 PARAMEDI CAL EDUCATI ON PROGRAM	546, 051 26, 287	81, 789 9, 338			823, 378 78, 021	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	20, 207	7, 330	33, 62.	7 42, 370	70,021	23.00
30.00	03000 ADULTS & PEDIATRICS	13, 360, 467	1, 598, 123				1
31. 00 35. 00	03100 INTENSI VE CARE UNIT 02060 NEONATAL INTENSI VE CARE UNIT	1, 013, 800 1, 462, 013	58, 068 364, 838			1, 021, 656 1, 760, 949	1
40.00	04000 SUBPROVI DER - I PF	0	0		0	0	40. 00
41. 00 42. 00	04100 SUBPROVI DER	901, 202	152, 428 0	1, 053, 630	-27, 734	1, 025, 896	41. 00 42. 00
43. 00	04300 NURSERY	0	0	,	534, 436	534, 436	1
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	3, 156, 942	40, 144, 074	43, 301, 010	-20, 422, 983	22, 878, 033	50.00
51. 00	05100 RECOVERY ROOM	634, 447	35, 364			635, 930	1
52. 00 54. 00	O5200 DELIVERY ROOM & LABOR ROOM O5400 RADIOLOGY-DIAGNOSTIC	0 2, 668, 724	0 13, 583, 321	1	-,,	3, 138, 446	1
55. 00	03630 ULTRA SOUND	336, 072	29, 590			13, 534, 739 365, 662	
56.00	05600 RADI OI SOTOPE	30, 127	4, 685			33, 919	1
56. 01 57. 00	03950 CARDI AC CATH LAB 05700 CT SCAN	1, 109, 341 565, 203	3, 952, 222 305, 788			1, 232, 151 870, 991	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	212, 795	213, 040	425, 83	5 0	425, 835	58. 00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	62, 854 1, 403, 558	6, 751, 502 406, 274			6, 705, 628 1, 586, 492	
66.00	06600 PHYSI CAL THERAPY	1, 222, 386	99, 832	1, 322, 218	-60, 397		
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	154, 949 105, 623	32, 905 2, 985			181, 392 108, 465	
69. 00	06900 ELECTROCARDI OLOGY	749, 472	460, 916			1, 186, 248	
70.00	07000 ELECTROENCEPHALOGRAPHY	407, 679	122, 509	1		508, 042	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		14, 600, 009 15, 150, 387	14, 600, 009 15, 150, 387	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(5, 637, 564	5, 637, 564	73. 00
73. 01 74. 00	07301 DI ABETES CENTER 07400 RENAL DI ALYSI S	253, 393 29, 726	20, 220 112, 608			270, 179 138, 960	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	92, 755			92, 246	
88 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	1 (0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89. 00
90.00	09000 CLINIC	259, 650	612, 062			605, 125	
91. 00 91. 01	O9100 EMERGENCY O4950 WOUND CARE	4, 868, 078 286, 777	1, 063, 112 99, 514			5, 051, 511 294, 651	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92. 01	O9201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	1, 085, 013	260, 284	1, 345, 29	7 –255, 006	1, 090, 291	92. 01
	09500 AMBULANCE SERVICES	533, 702	202, 454	736, 156		700, 754	
	09910 CORF 10100 HOME HEALTH AGENCY	0 2, 559, 058	981, 646	3, 540, 704	0 4 0	0 3, 540, 704	
	SPECIAL PURPOSE COST CENTERS	2, 337, 030	701, 040	3, 340, 70	., 0	•	
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	0		0		109. 00 110. 00
	111000 INTESTINAL ACQUISITION 111100 ISLET ACQUISITION		0				111.00
	11300 I NTEREST EXPENSE	240 (70	9, 632, 473			4, 380, 118	
116. 00 118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	248, 678 59, 002, 274	143, 058 185, 224, 633			391, 736 244, 226, 907	
					,		·

Health Financial Systems	ST. ELI ZABI	ETH EAST		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		eri od:	Worksheet A	
				rom 01/01/2014 o 12/31/2014	Date/Time Pre 5/27/2015 9:4	
Cost Center Description	Sal ari es	Other		Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 124	27, 491	34, 615	0	34, 615	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
194. 00 07950 MOB	60, 584	47	60, 631	0	60, 631	194. 00
194. 01 07951 LI FELI NE	11, 881	39, 970	51, 851	0	51, 851	194. 01
194. 02 07952 PATIENT TRANSPORT	2, 433	13, 378	15, 811	0	15, 811	194. 02
194.03 07953 SETON LEASE 1 NORTH	8, 532	3, 339	11, 871	0	11, 871	194. 03
200.00 TOTAL (SUM OF LINES 118-199)	59, 092, 828	185, 308, 858	244, 401, 686	0	244, 401, 686	200. 00

Peri od: From 01/01/2014 To 12/31/2014 Date/Ti me Prepared: 5/27/2015 9:45 am

			5/27/2015 9: 4	5 am
Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS	<u> </u>			
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	-4, 583, 293			1. 00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP	5, 501, 507			2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-6, 787, 251	21, 005, 198		4. 00
5. 01 01160 COMMUNI CATI ONS	309, 954			5. 01
5. 02 01140 MGMT INFO SYSTEMS	-11, 039, 630			5. 02
5. 03 00550 PURCHASI NG	-294, 083			5. 03
5. 04 00570 ADMI TTI NG	300, 618			5. 04
5. 05 00580 PATI ENT ACCOUNTI NG	1, 166, 397			5. 05
5. 06 00560 OTHER ADMINISTRATIVE AND GENERAL	-12, 294, 690			5. 06
7. 00 00700 OPERATION OF PLANT	-123, 585			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	407, 086			8. 00
9. 00 00900 HOUSEKEEPI NG	0			9. 00
10. 00 01000 DI ETARY	-102, 727			10.00
11. 00 01100 CAFETERI A	-829, 190			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-350, 013			13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	-113, 315			14.00
15. 00 01500 PHARMACY	-45, 902	1		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	-199, 524			16. 00 17. 00
17. 00 01700 SOCIAL SERVICE 20. 00 02000 NURSING SCHOOL	-64, 510			
23. 00 02301 PARAMEDI CAL EDUCATI ON PROGRAM	-4, 573 3, 605			20. 00 23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	3,000	01,020		23.00
30. 00 03000 ADULTS & PEDIATRICS	1, 324, 129	11, 193, 279		30. 00
31. 00 03100 NTENSI VE CARE UNI T	1, 324, 127			31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	-207, 255			35. 00
40. 00 04000 SUBPROVI DER - 1 PF	-207, 255	1		40. 00
41. 00 04100 SUBPROVI DER - 1 RF				41. 00
42. 00 04200 SUBPROVI DER				42. 00
43. 00 04300 NURSERY		1		43. 00
ANCI LLARY SERVI CE COST CENTERS		334, 430		43.00
50. 00 05000 OPERATING ROOM	-271, 237	22, 606, 796		50. 00
51. 00 05100 RECOVERY ROOM	0			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-1, 954, 753			54. 00
55. 00 03630 ULTRA SOUND	1,701,700			55. 00
56. 00 05600 RADI OI SOTOPE	-400			56. 00
56. 01 03950 CARDI AC CATH LAB	-118, 340			56. 01
57. 00 05700 CT SCAN	0			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			58. 00
60. 00 06000 LABORATORY	-125, 721			60.00
65. 00 06500 RESPIRATORY THERAPY	-18, 755			65. 00
66. 00 06600 PHYSI CAL THERAPY	850, 776			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1		67. 00
68. 00 06800 SPEECH PATHOLOGY	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	32, 160	1, 218, 408		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	-259, 176			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-516, 056	14, 083, 953		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	-77, 298	15, 073, 089		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5, 637, 564		73.00
73. 01 07301 DI ABETES CENTER	-5, 633	264, 546		73. 01
74. 00 07400 RENAL DI ALYSI S	184, 660	323, 620		74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	92, 246		76. 98
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1		89. 00
90. 00 09000 CLI NI C	0	,		90. 00
91. 00 09100 EMERGENCY	-38, 800			91. 00
91. 01 04950 WOUND CARE	-706	293, 945		91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	1, 090, 291		92. 01
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	-5, 334			95. 00
99. 10 09910 CORF	0	0		99. 10
101.00 10100 HOME HEALTH AGENCY	-13, 083	3, 527, 621		101. 00
SPECIAL PURPOSE COST CENTERS				
109. 00 10900 PANCREAS ACQUISITION	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		110. 00
111. 00 11100 SLET ACQUI SI TI ON	0	0		111. 00
113. 00 11300 INTEREST EXPENSE	-4, 380, 118	1		113.00
116. 00 11600 HOSPI CE	-83			116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	-34, 744, 142	209, 482, 765		118. 00
NONREI MBURSABLE COST CENTERS	T =	6		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34, 615		190. 00

Health Financial Systems

ST. ELIZABETH EAST

In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150109

Period:
From 01/01/2014
To 12/31/2014
Date/Time Prepared:
5/27/2015 9: 45 am

			5/27/2015 9: 45 8	am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7.00		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	19	92.00
194. 00 07950 MOB	0	60, 631	19	94. 00
194. 01 07951 LI FELI NE	0	51, 851	19	94. 01
194.02 07952 PATIENT TRANSPORT	0	15, 811	19	94. 02
194.03 07953 SETON LEASE 1 NORTH	0	11, 871	19	94. 03
200.00 TOTAL (SUM OF LINES 118-199)	-34, 744, 142	209, 657, 544	20	00.00

Provi der CCN: 150109

Peri od: From 01/01/2014 To 12/31/2014

Date/Time Prepared: 5/27/2015 9:45 am

					5/27/2015 9:4	45 am
	Coat Contor	Increases	Calami	Othon		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - BUI LDI NG RENTAL	3.00	4.00	3.00		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	1, 211, 737		1.00
	FIXT			, , ,		
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	0	0		8. 00
0.00	TOTALS — — — — —		— — —	1, 211, 737		0.00
	B - EQUI PMENT RENTAL		<u> </u>	1,211,707		1
1.00	NEW CAP REL COSTS-MVBLE	2. 00	0	112, 125		1.00
	EQUI P			,		
2.00	DI ETARY	10. 00	0	612		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7.00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	ő	0		13. 00
14. 00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16.00
	TOTALS		0	112, 737		
	C - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	14, 600, 009		1.00
2 00	PATI ENTS	72.00	0	15, 150, 387		2 00
2. 00	IMPL. DEV. CHARGED TO PATIENT	72. 00	0	15, 150, 387		2. 00
3.00	PATTENT	0.00	0	0		3. 00
4. 00		0.00	o	0		4. 00
5. 00		0.00	ő	o		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	O	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0. 00	0	0		10.00
11. 00		0. 00	0	0		11. 00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	Ö		18. 00
19. 00		0.00	0	0		19. 00
20. 00		0.00	ő	0		20.00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23.00		0.00	O	0		23. 00
24.00		0.00	0	0		24. 00
25.00		0.00	0	0		25. 00
26.00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
	TOTALS		0	29, 750, 396		1
1 00	D - DRUGS	70.00	٦.	E (07 E(1		1
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5, 637, 564		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4.00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	o	0		7. 00
8. 00		0.00	ő	0		8. 00
9. 00		0.00	Ö	Ö		9. 00
10.00		0.00	O	Ō		10.00
11. 00		0.00	0	0		11. 00
12.00		0. 00	0	0		12. 00

Peri od: From 01/01/2014 To 12/31/2014 Date/Ti me Prepared: 5/27/2015 9:45 am Provi der CCN: 150109

					5/27/2015 9: 45 am
		Increases			
	Cost Center	Li ne #	Salary	0ther	
13. 00	2. 00	3. 00	4. 00	5. 00	13.00
14. 00		0.00	0	0	14.00
15. 00		0.00	0	0	15.00
16. 00		0.00	0	0	16. 00
17. 00		0.00	0	Ö	17. 00
18. 00		0.00	0	0	18. 00
19. 00		0.00	o	0	19.00
20. 00		0.00	ō	0	20.00
	TOTALS	$+$		5, 637, 564	
	E - LDRP				
1.00	NURSERY	43.00	525, 097	9, 339	1.00
2.00	DELI VERY ROOM & LABOR ROOM	52.00	<u>3, 083, 6</u> 02	54, 844	2.00
	TOTALS		3, 608, 699	64, 183	
4 00	F - CAFETERIA	44.00	EE 4 747	101.0(0	1.00
1. 00	CAFETERI A	11.00	554, 746	194, 860	1.00
	TOTALS G - CAPITAL EXP (INT & DEP)		554, 746	194, 860	
1.00	NEW CAP REL COSTS-MVBLE	2.00	O	12, 862	1.00
1.00	EQUI P	2.00	ď	12,002	1.00
	TOTALS			12, 862	
	H - FSEH SHARED SERVICES	· ·	· · · · · · · · · · · · · · · · · · ·	,	
1.00	COMMUNI CATI ONS	5. 01	286, 503	0	1.00
2.00	ADMITTING	5. 04	298, 662	0	2. 00
3.00	PATIENT ACCOUNTING	5. 05	608, 857	0	3.00
4.00	OTHER ADMINISTRATIVE AND	5. 06	784, 730	0	4.00
	GENERAL				
5.00	OPERATION OF PLANT	7. 00	748, 936	0	5. 00
6.00	LAUNDRY & LINEN SERVICE	8.00	79, 497	0	6.00
7. 00 8. 00	MEDI CAL RECORDS & LI BRARY ELECTROCARDI OLOGY	16. 00 69. 00	38, 030 262, 497	0	7. 00 8. 00
9. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	202, 497	238, 762	9.00
10. 00	PURCHASI NG	5. 03	0	48, 585	10.00
11. 00	OTHER ADMINISTRATIVE AND	5. 06	0	339, 860	11.00
	GENERAL	0.00	٩	337, 333	11133
12.00	OPERATION OF PLANT	7. 00	О	251, 861	12.00
13.00	NURSING ADMINISTRATION	13. 00	0	342, 350	13.00
14.00	MEDICAL RECORDS & LIBRARY	16. 00	0	127, 071	14.00
15.00	SOCI AL SERVI CE	17. 00	0	64, 077	15. 00
16.00	RESPI RATORY THERAPY	65. 00	0	2, 438	16. 00
17. 00	PHYSI CAL THERAPY	66.00	0	72, 430	17.00
18. 00	EMERGENCY	<u>91.</u> 00	<u>55, 1</u> 31	0	18. 00
	TOTALS		3, 162, 843	1, 487, 434	
1. 00	I - INTEREST NEW CAP REL COSTS-BLDG &	1. 00	0	2, 872, 779	1.00
1.00	FLXT	1.00	٩	2,012,119	1.00
2.00	NEW CAP REL COSTS-MVBLE	2. 00	o	2, 379, 576	2.00
	EQUI P				
	TOTALS			5, 252, 355	
	J - PURCHASED SERVICES				
1.00	INTENSIVE CARE UNIT	31.00	1, 257, 267	0	1.00
2.00	LABORATORY	60.00	0	15, 756	2.00
3.00	PHYSI CAL THERAPY	66.00	864, 264	0	3.00
4.00	ELECTROCARDI OLOGY	69.00	0	40, 317	4. 00
5. 00	ELECTROENCEPHALOGRAPHY TOTALS		00000000	22 <u>7, 033</u> 283, 106	5.00
	K - NURSING SCHOOL		2, 121, 551	203, 100	
1.00	NURSI NG SCHOOL	20.00	124, 785	70, 753	1.00
2. 00	NORST NO SCHOOL	0.00	124, 705	70, 739	2. 00
3.00		0.00	o	0	3.00
	TOTALS — — — —	— — 	124, 785	70, 753	0.00
	L - PARAMED PROGRAM				
1.00	PARAMEDI CAL EDUCATI ON	23. 00	21, 143	0	1.00
	PROGRAM				
2.00		0.00	O	0	2.00
3.00		0.00	0	0	3.00
4.00	DADAMEDI CAL EDUCAT: C::	0.00	0	0	4. 00
5.00	PARAMEDI CAL EDUCATI ON	23. 00	21, 253	0	5. 00
	TOTALS	+	42, 396		
500 00	Grand Total: Increases		9, 615, 000	44, 077, 987	500.00
500.00	orana rotar. rrici cases	I	7, 013, 000	77,011,701	500.00

Provi der CCN: 150109

Peri od: From 01/01/2014 To 12/31/2014

Date/Time Prepared: 5/27/2015 9:45 am

Cost Center Line # Salary Other Rist, A.7 Ref.			Docroacos				5/27/2015 9:4	+5 aiii
A RILLION DE SPOTATION 1.00 1.0		Cost Center	Decreases	Salary	Other	Wkst A_7 Ref		
A BILLIDING REPREMEN 5.06 0 248,688 10 1.00								
Scheman Sche								
2.00 CARLEBIA A 11.00 0 44,888 10 2.00			5. 06	0	248, 688	10		1. 00
ADDITION PRINTING STATEMENT ADDITION ADDITIO			44.00		44.000	4.0		0.00
A 00 BASI OLDOY-OL MORSTIC 54 00 0 456,275 10 4 0 5 0 6 0		1		· ·	·	l .		1
Description						l 1		1
Description						l .		1
2.00				٦		- 1		6. 00
DARTY DART		1		-				7. 00
TOTALS		,						
B - FOLIPAMENT RENTAL	8.00		<u>95.</u> 00	+				8. 00
1.00 OTHER ADMINISTRATIVE AND 0.00 0.1,075 10 1.00 1.005 1.005 1				0	1, 211, 737			_
ONLINE CONTROL CONTR			5.04	ما	4 005	4.0		1 00
2 00 OPERATION OF PLANT 2 00 0 4.179 10 2.00 3.00 4.00 CAFTERIA 7 11.00 0 0 122 10 4.00 4.00 CAFTERIA SERVICES & SUPPLY 11.00 0 0 1.22 10 4.00 4.00 CAFTERIA SERVICES & SUPPLY 11.00 0 0 1.22 10 4.00 4.00 6.00 ADMINISTRA SERVICES & SUPPLY 11.00 6.0			5.06	U	1, 095	10		1.00
3.00 MOUSEKEEPING 9,00 0 990 10 4.00			7 00	0	A 170	10		2 00
A - 0								3. 00
0.00 HARMIACY 15.00 0 133 10 0 6.00		1						4. 00
7. 00 ADULTS & PEDIATRICS 30. 00 0 19,520 10 8.00 9.00 OPERATING ROOM 50. 00 0 245 10 0 8.00 9.00 OPERATING ROOM 50. 00 0 53. 279 10 9.00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 0 9.90 10 10. 10. 00 11. 00 CARDILOX-51 ARRONSTIC 55. 00 0 9.90 10 10. 10. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 0 9.90 10 10. 10. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 0 9.90 10 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 0 9.90 10 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 0 9.90 10 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 0 9.00 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 0 9.00 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 0 9.00 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 0 9.00 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 9.00 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 9.00 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 9.00 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 9.00 10. 11. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 9.00 10. 00 11. 00 CARDILOX-51 ARRONSTIC 54. 00 9.00 10. 00 12. 00 CARDILOX-51 ARRONSTIC 54. 00 9.	5.00	CENTRAL SERVICES & SUPPLY	14. 00	0	1, 606	10		5. 00
8. 00 SUBPROVIDER - IFF	6.00	PHARMACY	15. 00	0	133	10		6.00
9.00 OPERATI NG ROOM 50.00 0 55.279 10 10.00 10.00 10.00 20.00 10.		1	l l					7. 00
10.00 RADIOLOGY-DIAGNOSTIC 54.00 0 990 10 11.00 11.00 CARDIAL CATH LAB 56.01 0 5.053 10 11.00 12.00 RESPIRATIONY THERAPY 66.00 0 2.1.305 10 11.00 11.00 12.00 RESPIRATIONY THERAPY 66.00 0 2.2.61 10 13.00 14.00 12.00 14.00		1 7 7				l .		8. 00
11.00 CARDI AC CATH LAB		1				l .		1
12.00 RESPIRATORY THERAPY		l I				l .		1
13.00 PHYSICAL THERAPY		1	l l					1
14. 00		1			·	l		
15.00						l .		14. 00
EQUI P		1		0		l .		15. 00
TOTALS	16.00	NEW CAP REL COSTS-MVBLE	2.00	0	612	10		16. 00
C - MEDICAL SUPPLIES 1.00								
1.00				0	112, 737			_
2. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 826, 256 0 0 2. 0	1 00		12.00	٥	F.1			1 00
3. 00 PHARMACY 4. 00 ADULTS & PEDIATRICS 5. 00 INTERSIVE CARE UNIT 5. 00 O BEDIATAL INTERSIVE CARE UNIT 5. 00 O BEDIATAL INTERSIVE CARE UNIT 7. 00 SUBPROVIDER - IRF 41. 00 O 26, 775 O 7. 00 8. 00 OPERATING ROOM 50. 00 O 20, 158, 994 0 0 8. 00 10. 00 RADIOLOGY-DI AGNOSTIC 54. 00 O 2, 20, 98, 629 0 10. 00 11. 00 RADIOLOGY-DI AGNOSTIC 54. 00 O 3, 893 0 0 11. 00 12. 00 CARDIA CATH LAB 56. 01 O 3, 823, 858 0 12. 00 14. 00 RESPIRATORY THERAPY 66. 00 O 10, 20, 110, 110 15. 00 PHYSICAL THERAPY 66. 00 O 20, 110, 110 15. 00 PHYSICAL THERAPY 67. 00 O 20, 824 0 15. 00 17. 00 SPEECH PATHOLOGY 68. 00 O 143 00 CUUPATIONAL THERAPY 67. 00 O 20, 824 0 17. 00 18. 00 ELECTROCARDIOLOGY 68. 00 O 128, 872 0 18. 00 19. 00 19. 00 ELECTROCARDIOLOGY 69. 00 O 20, 964 0 19. 00 21. 00 REPREDIATOR CARE UNIT 70. 00 O 889, 134 0 20. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00						l .		1
4. 00 ADULTS & PEDIATRICS 30. 00 0 999, 544 0 5.00 11 TRISSIVE CARE UNIT 31. 00 0 45, 381 0 0 5.00 10 6. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 0 6. 3884 0 6. 00 7. 00 1999 0 19		l I	l l			l .		3. 00
5.00 INTENSIVE CARE UNIT 31.00 0 45,381 0 6.00 7.00 SUBPROVI DER - I RF 41.00 0 26,775 0 7.00 8.00 OPERATI IN GROOM 50.00 0 20,158,994 0 8.00 9.00 RECOVERY ROOM 51.00 0 33,598 0 9.00 110.00 RADIOLOGY-DI AGNOSTI C 54.00 0 2.098,629 0 10.00 112.00 CARDIOLOGY-DI AGNOSTI C 55.00 0 893 0 11.00 113.00 LABORATORY 66.00 0 106,221 0 13.00 114.00 RESPIRATORY THERAPY 65.00 0 20,1107 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 50,824 0 15.00 16.00 OCCUPATI ONAL THERAPY 67.00 0 50,824 0 15.00 17.00 SPEECH PATHOLOGY 68.00 0 22,872 0 18.00 18.00 SELECTROCARDIOLOGY 69.00 0 22,872 0 18.00 19.00 ELECTROCARDIOLOGY 69.00 0 20,064 0 19.00 19.00 ELECTROCARDIOLOGY 69.00 0 20,064 0 19.00 20.00 DI ABETES CENTER 73.01 0 3,434 0 20.00 21.00 RENAL DI ALYSIS 74.00 0 3,258 0 21.00 22.00 WIPPERBARIC OXYGEN THERAPY 76.98 0 509 0 22.00 23.00 CLINIC SPEECH PATHOLOGY 99.00 0 61,266 0 23.00 24.00 EMERGENCY 91.00 0 61,266 0 23.00 25.00 MOUND CARE 91.01 0 89,134 0 24.00 26.00 DASERVATION BEDS (DISTINCT 92.01 0 50,079 0 26.00 27.00 AMBULANCE SERVICES 95.00 0 4,955,703 0 2.00 27.00 AMBULANCE SERVICES 95.00 0 4,831 0 4.00 28.00 CHINTENSIVE CARE UNIT 31.00 0 4,831 0 4.00 29.00 PARRMACY 15.00 0 20,000 0 4,831 0 4.00 29.00 PARRMACY 15.00 0 4,831 0 4.00 29.00 PARRMACY 15.00 0 10,000 10,000 20.00 DARROWACH 10.000 148,552 0 8.00 20.00 ORDONATAL INTRISIVE CARE UNIT 35.00 0 210,710 0 20.00 CARROWACH 20,000 20,000		1		1		1		4. 00
7. 00 SUBPROVIDER - I RF		l I	31.00	0				5. 00
8. 00 OPERATI INC ROOM SD. 00 O 20,158,994 O 8. 00 9. 00 RECOVERY ROOM SD. 00 O 20,798,629 O 9. 00 10. 00 RADIOLOGY-DIAGNOSTIC S4. 00 O 2,098,629 O 10. 00 11. 00 RADIOLOGY-DIAGNOSTIC S4. 00 O 20,988,629 O 11. 00 12. 00 CARDIAC CATH LAB S6. 01 O 3,823,858 O 11. 00 13. 00 LABORATORY 60. 00 O 106,221 O 13. 00 14. 00 RESPIRATORY THERAPY 65. 00 O 201,107 O 14. 00 15. 00 PHYSICAL THERAPY 66. 00 O 50,824 O 15. 00 17. 00 SPEECH PATHOLOGY 68. 00 O 143 O 17. 00 18. 00 ELECTROCARDIOLOGY 69. 00 O 22,872 O 18. 00 19. 00 ELECTROCARDIOLOGY 69. 00 O 22,872 O 18. 00 19. 00 ELECTROCARDIOLOGY 69. 00 O 20,964 O 19. 00 20. 00 DI ABETES CENTER 73. 01 O 3,434 O 20. 00 21. 00 RENAL DI ALYSIS 74. 00 O 3,258 O 21. 00 22. 00 HYPERBARIC OXYGEN THERAPY 76. 98 O 509 O 22. 00 23. 00 CLINIC 90. 00 O 61,266 O 22. 00 24. 00 EMERGENCY 91. 00 O 61,266 O 22. 00 25. 00 WOUND CARE 91. 01 O 89,134 O 25. 00 26. 00 DI ABETES ERVICES 95. 00 O 48,831 O 25. 00 27. 00 PHARMACY 15. 00 O 4,955,703 O 2. 00 28. 00 PHARMACY 15. 00 O 4,955,703 O 2. 00 38. 00 O O O O O O O O 38. 00 O O O O O O 38. 00 O O O O O O 38. 00 O O		NEONATAL INTENSIVE CARE UNIT	l l	0	63, 884	0		6. 00
9. 00 RECOVERY ROOM 51. 00 0 33, 598 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 2, 098, 629 0 110. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 2, 098, 629 0 110. 00 11		1			·	l		7. 00
10. 00 RADI OLOGY-DI AGNOSTI C 54, 00 0 2, 098, 629 0 10. 00 11. 00 RADI OLOGY-DI AGNOSTI C 56, 00 0 2, 098, 629 0 11. 00 RADI OLOGY-DI AGNOSTI C 56, 00 0 3, 823, 858 0 12. 00 12. 00 13. 00 14. 00 RESPI RATORY 60, 00 0 106, 221 0 0 13. 00 14. 00 RESPI RATORY THERAPY 65, 00 0 201, 107 0 14. 00 15		1		-		l 1		8. 00
11. 00								1
12.00 CARDIAC CATH LAB 56.01 0 3,823,858 0 12.01 13.00 LABORATORY 16.00 0 0 106.221 0 0 13.01 14.00 RESPIRATORY THERAPY 65.00 0 201,107 0 144.01 15.00 PHYSI CAL THERAPY 66.00 0 50,824 0 15.00 16.00 0 0 0 14.00 17.00 17.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 17.00 18.00 18.00 18.00 17.00 18.00 18.00 18.00 18.00 19.00 18.00 18.00 19.00 19.00 18.00 19.00 19.00 18.00 19.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 19.00 18.00 19.00 19.00 18.00 19.00 19.00 18.00 19.00 19.00 18.00 19.0								1
13.00 LABORATORY 60.00 0 106, 221 0 13.00 14.00 RESPI RATORY THERAPY 65.00 0 201, 107 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 50, 824 0 15.00 16.00 OCCUPATI ONAL THERAPY 67.00 0 6, 462 0 16.00 17.00 SPECH PATHOLOGY 68.00 0 143 0 17.00 18.00 ELECTROCARDI OLOGY 69.00 0 22, 872 0 18.00 19.00 ELECTROCARDI OLOGY 69.00 0 20, 964 0 19.00 10.00 DI ABETES CENTER 73.01 0 3, 434 0 20.00 21.00 RENAL DI ALYSIS 74.00 0 3, 258 0 21.00 22.00 HYPERBARI C OXYGEN THERAPY 76.98 0 50.99 0 22.00 23.00 CLINIC 90.00 0 61, 266 0 23.00 24.00 EMERGENCY 91.00 0 819, 134 0 24.00 25.00 WOUND CARE 91.01 0 89, 134 0 25.00 26.00 OBSERVATI ON BEDS (DI STI NCT 92.01 0 50, 079 0 27.00 ABULLANCE SERVI CES 95.00 0 4, 955, 703 0 20.00 PHARMACY 15.00 0 48, 138 0 3.00 3.00 ADULTS & PEDI ATRI CS 30.00 0 48, 138 0 3.00 3.00 ADULTS & PEDI ATRI CS 30.00 0 48, 138 0 3.00 3.00 NEONATAL I INTENSI VE CARE UNIT 31.00 0 4, 831 0 4.00 5.00 NEONATAL I INTENSI VE CARE UNIT 35.00 0 210, 710 0 6.00 OPERATI NG ROOM 51.00 0 283 0 9.00 RADIOLOGY-DI AGNOSTIC 54.00 0 148, 552 0 9.00 9.00 CARDIAC CATH LAB 56.01 0 501 0		I				l .		1
14, 00 RESPIRATORY THERAPY 65. 00 0 201, 107 0 14, 00 15. 00 PHYSI CAL THERAPY 66. 00 0 50, 824 0 15. 00 16. 00 0 0 0 6. 462 0 15. 00 17. 00 0 0 0 0 0 0 0 0 0				-				13. 00
16. 00 OCCUPATIONAL THERAPY 67. 00 0 6, 462 0 16. 00 17. 00 SPEECH PATHOLOGY 68. 00 0 143 0 177. 00 18. 00 ELECTROCARDIOLOGY 69. 00 0 22, 872 0 18. 00 19. 00 ELECTROCARDIOLOGY 70. 00 0 22, 872 0 18. 00 20. 00 DI ABETES CENTER 73. 01 0 3, 434 0 20. 00 21. 00 RADIAL TYSIS 74. 00 0 3, 258 0 21. 00 22. 00 HYPERBARI C OXYGEN THERAPY 76. 98 0 509 0 22. 00 23. 00 CLI NI C 90. 00 0 819, 134 0 23. 00 24. 00 EMERGENCY 91. 00 889, 134 0 23. 00 25. 00 WOUND CARE 91. 01 0 89, 134 0 25. 00 26. 00 OBSERVATI ON BEDS (DI STI NCT 92. 01 9. 00 0 18, 143 0 25. 00 27. 00 AMBULANCE SERVI CES 95. 00 0 18, 143 0 27. 00 27. 00 AMBULANCE SERVI CES 95. 00 0 4, 955, 703 0 2. 00 29. 00 PHARMACY 15. 00 0 4, 955, 703 0 2. 00 30. 00 ADULTS & PEDI ATRI CS 30. 00 0 48, 831 0 3. 00 4. 00 INTENSI VE CARE UNI T 31. 00 0 48, 831 0 3. 00 4. 00 INTENSI VE CARE UNI T 35. 00 0 2, 018 0 5. 00 5. 00 RODATAL INTENSI VE CARE UNI T 35. 00 0 210, 710 0 714 0 6. 00 5. 00 RADIOLOGY FOR THE AUDIT C 54. 00 0 148, 552 0 9. 00 0 CARDIA CATH LAB 56. 01 0 501 0 10. 00 0 CARDIA CATH LAB 56. 01 0 501 0 10. 00 0 CARDIA CATH LAB 56. 01 0 501 0 10. 00 0 CARDIA CATH LAB 56. 01		1		0		0		14. 00
17. 00 SPEECH PATHOLOGY 68. 00 0 143 0 17. 00 18.				0				15. 00
18. 00 ELECTROCARDI OLOGY 69. 00 0 22, 872 0 18. 00 19. 00				٦				16. 00
19. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 20, 964 0 19. 00 20. 0								17. 00
20. 00 DI ABETES CENTER 73. 01 0 3, 434 0 20. 00 21. 00 RENAL DI ALYSIS 74. 00 0 3, 258 0 21. 00 22. 00 HYPERBARIC OXYGEN THERAPY 76. 98 0 509 0 22. 00 23. 00 CLI NI C 90. 00 0 61, 266 0 23. 00 24. 00 EMERGENCY 91. 00 0 819, 134 0 24. 00 25. 00 WOUND CARE 91. 01 0 89, 134 0 25. 00 26. 00 OBSERVATION BEDS (DI STI NCT 92. 01 0 50, 079 0 26. 00 27. 00 AMBULANCE SERVI CES 95. 00 0 18. 143 0 27. 00 27. 00 PART) 27. 00 PARTO 2. 00 PHARMACY 15. 00 0 4, 955, 703 0 1. 00 2. 00 PHARMACY 15. 00 0 48, 138 0 3. 00 2. 00 ADULTS & PEDI ATRI CS 30. 00 0 48, 138 0 3. 00 2. 00 NEONATAL INTENSI VE CARE UNI T 31. 00 0 714 0 6. 00 2. 00 PERATING ROOM 50. 00 0 210, 710 0 6. 00 2. 00 OPERATING ROOM 50. 00 0 220, 710 0 6. 00 2. 00 OPERATING ROOM 50. 00 0 283 0 8. 00 2. 00 ORADI LOGY-DI AGNOSTI C 54. 00 0 148, 552 0 0 9. 00 2. 00 ORADI ACC CATH LAB 56. 01 0 0 148, 552 0 0 9. 00 2. 00 ORADIAC CATH LAB 56. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		-				1
21. 00 RENAL DI ALYSIS 74. 00 0 3, 258 0 22. 00 22. 00 HYPERBARI C OXYGEN THERAPY 76. 98 0 509 0 22. 00 23. 00 CLI NI C 90. 00 0 61, 266 0 23. 00 24. 00 EMERGENCY 91. 00 0 819, 134 0 24. 00 25. 00 WOUND CARE 91. 01 0 89, 134 0 25. 00 26. 00 OBSERVATI ON BEDS (DI STI NCT PART) 22. 01 0 50, 079 0 26. 00 27. 00 AMBULANCE SERVI CES 95. 00 0 18, 143 0 27. 00 27. 00 AMBULANCE SERVI CES 95. 00 0 29, 750, 396 2 1. 00 CENTRAL SERVI CES 8 SUPPLY 14. 00 0 637 0 1. 00 2. 00 PHARMACY 15. 00 0 48, 138 0 3. 00 3. 00 ADULTS & PEDI ATRI CS 30. 00 0 48, 138 0 3. 00 4. 00 I INTENSI VE CARE UNI T 31. 00 0 4, 831 0 4. 00 5. 00 NEONATAL I NTENSI VE CARE UNI T 35. 00 0 2, 018 0 5. 00 6. 00 SUBPROVI DER - I RF 41. 00 0 7. 00 7. 00 OPERATI NG ROOM 50. 00 283 0 8. 00 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 148, 552 0 9. 00 10. 00 CARDI AC CATH LAB 56. 01 0 501 0 0 10. 00				0				
22.00 HYPERBARI C OXYGEN THERAPY 76.98 0 509 0 22.00		1		0				1
23. 00				0		l 1		1
24. 00 EMERGENCY 91. 00 0 819, 134 0 225. 00 25. 00 WOUND CARE 91. 01 0 89, 134 0 25. 00 26. 00 OBSERVATION BEDS (DISTINCT 92. 01 0 50, 079 0 26. 00 27. 00 AMBULANCE SERVICES 95. 00 0 18, 143 0 27. 00 D - DRUGS 1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 637 0 2. 00 2. 00 PHARMACY 15. 00 0 4, 955, 703 0 2. 00 3. 00 ADULTS & PEDIATRICS 30. 00 0 48, 138 0 3. 00 4. 00 INTENSIVE CARE UNIT 31. 00 0 4, 831 0 3. 00 5. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 0 2, 018 0 5. 00 6. 00 SUBPROVIDER - IRF 41. 00 0 714 0 6. 00 7. 00 OPERATING ROOM 50. 00 0 2283 0 9. 00 9. 00 RADIOLOGY-DIAGNOSTIC 54. 00 0 148, 552 0 9. 00 10. 00 CARDIAC CATH LAB 56. 01 0 501 0 10. 00				o		l 1		23. 00
26. 00 OBSERVATION BEDS (DISTINCT PART) 27. 00 AMBULANCE SERVICES 95. 00 0 18, 143 0 27. 00 TOTALS 0 29, 750, 396 D - DRUGS 1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 4, 955, 703 0 2. 00 3. 00 ADULTS & PEDIATRICS 30. 00 0 48, 138 0 3. 00 4. 00 INTENSIVE CARE UNIT 31. 00 0 4, 831 0 3. 00 5. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 0 2, 018 0 5. 00 6. 00 SUBPROVIDER - IRF 41. 00 0 714 0 6. 00 7. 00 OPERATING ROOM 50. 00 220, 710 0 7. 00 8. 00 RECOVERY ROOM 51. 00 0 283 0 0 8. 00 9. 00 RADIOLOGY-DIAGNOSTIC 54. 00 0 148, 552 0 9. 00 10. 00 CARDIAC CATH LAB 56. 01 0 501 0 10. 00		EMERGENCY		0				24. 00
PART AMBULANCE SERVICES	25.00	WOUND CARE	91. 01	0	89, 134	0		25. 00
27. 00 AMBULANCE SERVICES 95. 00 0 18, 143 0			92. 01	0	50, 079	0		26. 00
TOTALS D - DRUGS 1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 637 0 2. 00 PHARMACY 15. 00 0 4, 955, 703 0 3. 00 ADULTS & PEDI ATRICS 30. 00 0 48, 138 0 4. 00 I NTENSI VE CARE UNI T 31. 00 0 4, 831 0 5. 00 NEONATAL I NTENSI VE CARE UNI T 35. 00 0 2, 018 0 6. 00 SUBPROVI DER - I RF 41. 00 0 714 0 5. 00 6. 00 SUBPROVI DER - I RF 41. 00 0 714 0 714 0 714 0 715		· · ·	05.00		40.440			07.00
D - DRUGS 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 637 0 1.00 2.00 PHARMACY 15.00 0 4,955,703 0 2.00 3.00 ADULTS & PEDIATRICS 30.00 0 48,138 0 3.00 4.00 INTENSIVE CARE UNIT 31.00 0 4,831 0 4.00 5.00 NEONATAL INTENSIVE CARE UNIT 35.00 0 2,018 0 5.00 6.00 SUBPROVIDER - IRF 41.00 0 714 0 6.00 7.00 0 0 0 0 0 0 0 0 0	27.00		95.00					27.00
1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 637 0 2. 00 PHARMACY 15. 00 0 4, 955, 703 0 2. 00 3. 00 ADULTS & PEDIATRICS 30. 00 0 48, 138 0 3. 00 4. 00 INTENSIVE CARE UNIT 31. 00 0 4, 831 0 4. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 0 2, 018 0 5. 00 SUBPROVIDER - IRF 41. 00 0 714 0 6. 00 SUBPROVIDER - IRF 41. 00 0 714 0 6. 00 OPERATING ROOM 50. 00 2 20, 710 0 7. 00 RECOVERY ROOM 51. 00 0 283 0 8. 00 9. 00 RADIOLOGY-DIAGNOSTIC 54. 00 0 148, 552 0 9. 00 10. 00 CARDIAC CATH LAB 56. 01 0 501 0 10. 00					29, 730, 390			-
2. 00 PHARMACY 15. 00 0 4, 955, 703 0 3. 00 ADULTS & PEDIATRICS 30. 00 0 48, 138 0 4. 00 INTENSIVE CARE UNIT 31. 00 0 4, 831 0 5. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 0 2, 018 0 6. 00 SUBPROVI DER - IRF 41. 00 0 714 0 6. 00 7. 00 OPERATING ROOM 50. 00 0 210, 710 0 7. 00 8. 00 RECOVERY ROOM 51. 00 0 283 0 8. 00 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 148, 552 0 9. 00 10. 00 CARDI AC CATH LAB 56. 01 0 501 0 10. 00			14 00	0	637	0		1.00
3. 00 ADULTS & PEDIATRICS 30. 00 0 48, 138 0 3. 00 4. 00 INTENSIVE CARE UNIT 31. 00 0 4, 831 0 4. 00 5. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 0 2, 018 0 5. 00 6. 00 SUBPROVI DER - IRF 41. 00 0 714 0 6. 00 7. 00 OPERATING ROOM 50. 00 0 210, 710 0 7. 00 0								2. 00
4. 00 INTENSIVE CARE UNIT 31. 00 0 4, 831 0 5. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 0 2, 018 0 5. 00 6. 00 SUBPROVIDER - IRF 41. 00 0 714 0 6. 00 7. 00 OPERATING ROOM 50. 00 0 210, 710 0 7. 00 8. 00 RECOVERY ROOM 51. 00 0 283 0 8. 00 9. 00 RADIOLOGY-DIAGNOSTIC 54. 00 0 148, 552 0 9. 00 10. 00 CARDIAC CATH LAB 56. 01 0 501 0 10. 00		1		-		l 1		3. 00
6. 00 SUBPROVI DER - I RF 41. 00 0 714 0 6. 00 7. 00 0 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9			31.00	0		l 1		4. 00
7. 00 OPERATI NG ROOM 50. 00 210, 710 0 7. 00 8. 00 RECOVERY ROOM 51. 00 0 283 0 8. 00 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 148, 552 0 9. 00 10. 00 CARDI AC CATH LAB 56. 01 0 501 0 10. 00				0				5. 00
8. 00 RECOVERY ROOM 51. 00 0 283 0 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 148, 552 0 10. 00 CARDI AC CATH LAB 56. 01 0 501 0				0		l .		6. 00
9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 148, 552 0 9. 00 10. 00 CARDI AC CATH LAB 56. 01 0 501 0 10. 00				0		l 1		7. 00
10.00 CARDI AC CATH LAB 56.01 0 501 0 10.00				0		l 1		
				0				1
11. 00 LABORATORY 60. 00 0 1 0 11. 00		l I				l .		11. 00
		1	33. 30	<u> </u>	·	١		

RECLASSI FI CATI ONS

Provider CCN: 150109

Peri od: Worksheet A-6 From 01/01/2014

12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 RESPIRATORY THERAPY 12.00 65.00 928 0 12 00 13.00 PHYSICAL THERAPY 66.00 158 13.00 0 14.00 ELECTROCARDI OLOGY 69.00 0 1, 103 14.00 RENAL DIALYSIS 74.00 0 0 15.00 116 15 00 16.00 CLINIC 90.00 0 205, 321 0 16.00 EMERGENCY 91.00 0 17.00 0 45, 100 17.00 18.00 WOUND CARE 91.01 0 2.506 0 18.00 OBSERVATION BEDS (DISTINCT 19.00 92.01 4, 458 0 19.00 PART) 20.00 AMBULANCE SERVICES 95.00 5, 786 0 20.00 **TOTALS** 5, 637, 564 - I DRP 1.00 ADULTS & PEDIATRICS 30.00 3, 608, 699 64, 183 0 1.00 2.00 0.00 0 2.00 TOTALS 3, 608, 699 64, 183 F - CAFETERIA 1.00 DI ETARY 10.00 554, 746 194, 860 0 1.00 TOTALS 554, 746 194, 860 G - CAPITAL EXP (INT & DEP) 1.00 RADI OLOGY-DI AGNOSTI C 54.00 12, 862 9 1.00 12,862 H - FSEH SHARED SERVICES COMMUNICATIONS 1.00 5.01 286, 503 0 1.00 2.00 ADMITTING 5.04 0 298, 662 0 2.00 3.00 PATIENT ACCOUNTING 5.05 0 608, 857 0 3.00 OTHER ADMINISTRATIVE AND 0 784, 730 0 5.06 4.00 4.00 GENERAL OPERATION OF PLANT 5.00 7.00 0 748, 936 0 5.00 6.00 LAUNDRY & LINEN SERVICE 8.00 o 79, 497 0 6.00 0 7.00 MEDICAL RECORDS & LIBRARY 16.00 0 38, 030 7.00 ELECTROCARDI OLOGY 8 00 69 00 262, 497 0 8 00 9.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 238, 762 0 0 9.00 PURCHASI NG 5.03 48, 585 0 10.00 10.00 0 OTHER ADMINISTRATIVE AND 11.00 5.06 339, 860 0 0 11.00 GENERAL 0 OPERATION OF PLANT 12.00 7 00 251, 861 12.00 13.00 NURSING ADMINISTRATION 13.00 342, 350 0 0 13.00 0 14.00 MEDICAL RECORDS & LIBRARY 16.00 127, 071 0 14.00 SOCIAL SERVICE 15.00 17.00 64,077 0 15.00 0 RESPIRATORY THERAPY 16.00 65.00 2, 438 0 0 16.00 66.00 17.00 PHYSICAL THERAPY 72, 430 0 17.00 18.00 EMERGENCY 91. 00 55, 131 0 18.00 TOTALS 1, 487, 434 3, 162, 843 - INTEREST 1.00 INTEREST EXPENSE 113.00 5, 252, 355 11 1.00 2.00 0.00 0 11 2.00 Ō TOTALS 5, 252, 355 J - PURCHASED SERVICES 1.00 INTENSIVE CARE UNIT 31.00 1, 257, 267 0 1.00 2 00 I ABORATORY 15, 756 60 00 O 2 00 3.00 PHYSICAL THERAPY 66.00 864, 264 0 3.00 4.00 ELECTROCARDI OLOGY 69.00 40, 317 0 4.00 70. 00 5.00 ELECTROENCEPHALOGRAPHY 227, 033 5.00 0 TOTALS 283, 106 2, 121, 531 - NURSING SCHOOL 1.00 OTHER ADMINISTRATIVE AND 5.06 0 10.403 1, 411 1.00 GENERAL MEDICAL RECORDS & LIBRARY 11, 015 2.00 16.00 69, 342 0 2.00 ADULTS & PEDIATRICS 3.00 30.00 103, 367 0 3.00 124, 785 70, 753 TOTALS

1.00

2.00

3.00

4.00

5.00

L - PARAMED PROGRAM

AMBULANCE SERVICES

AMBULANCE SERVICES

500.00 Grand Total: Decreases

EMERGENCY

EMERGENCY

PHARMACY

TOTALS

91.00

95.00

91.00

95.00

15.00

13, 736

3, 989

1,709

1, 709

21, 253

42, 396

6, 101, 166

0

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0

0

47, 591, 821

0

0

0

0

0

1.00

2.00

3.00

4.00

5.00

500.00

Provi der CCN: 150109

Beginning Ball ances 1.00 2.00 3.00 4.00 5.00					T	0 12/31/2014	Date/Time Pre	pared:
Beginning Balances Donation Total Disposals and Retirements Retirements Retirements Retirements Donation Total Disposals and Retirements Donation Retirements Donation Retirements Donation					Acqui si ti ons		5/21/2015 9:4	o alli
PART - ANALYSIS OF CHANGES N CAPITAL ASSET BALANCES 1.00 2.00 3.00 4.00 5.00			Reginning	Durchases		Total	Disposals and	
1.00 2.00 3.00 4.00 5.00				i di chases	Donation	Total		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES				2.00	3.00	4. 00		
1.00 Land Land S, 794, 381 2, 784,000 0 2, 784,000 0 0 0 0 0 0 0 0 0		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
3.00 Buildings and Fixtures 189, 990, 788 474, 628 0 474, 628 0 0 0 0 0 0 0 0 0	1.00	Land	5, 794, 381	2, 784, 000	0	2, 784, 000	0	1.00
A . 00	2.00	Land Improvements	2, 562, 084	0	0	0	0	2.00
Fixed Equipment	3.00	Buildings and Fixtures	189, 990, 788	474, 628	0	474, 628	0	3. 00
6.00 Movable Equipment 60,906,443 2,005,022 0 2,005,022 0 0 7.00 0 7.00 0 0 7.00 0 0 7.00 0 0 7.00 0 0 0 0 0 0 0 0 0	4.00	Building Improvements	0	0	0	0	0	4. 00
6.00 Movable Equipment 60,906,443 2,005,022 0 2,005,022 0 0 7.00 0 7.00 0 0 7.00 0 0 7.00 0 0 7.00 0 0 0 0 0 0 0 0 0	5.00	Fi xed Equipment	0	0	0	0	0	5. 00
8.00 Subtotal (sum of lines 1-7) 259, 253, 696 5, 263, 650 0 5, 263, 650 0 0 0 0 0 0 0 0 0	6.00		60, 906, 443	2, 005, 022	0	2, 005, 022	0	6.00
9.00 Reconciling Items 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00	HIT designated Assets	0	0	0	0	0	7. 00
9.00 Reconciling Items 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00	Subtotal (sum of lines 1-7)	259, 253, 696	5, 263, 650	0	5, 263, 650	0	8. 00
Ending Balance	9.00		0	0	0	0	0	9. 00
Depreciated Assets Section Sec	10.00	Total (line 8 minus line 9)	259, 253, 696	5, 263, 650	0	5, 263, 650	0	10.00
Assets 6.00 7.00			Endi ng Bal ance	Fully				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2.00 Land Improvements 2.562,084 2.562,084 2.562,084 2.00 Land Improvements 1.00 Land Improvements 1.00 2.562,084 2.562,084 2.00 Land Improvements 1.00 Land Improvements 1.00 Land Improvements 1.00 Land Improvements 1.00 1.00 Land Improvements 1.00 1.00 Land Improvements 1.00 1.				Depreci ated				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 8,578,381 8,578,381 2.00 Land Improvements 2,562,084 2,562,084 2.00 3.00 Buildings and Fixtures 190,465,416 190,465,416 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 0 5.00 6.00 Movable Equipment 62,911,465 62,911,465 62,911,465 6.00 Movable Equipment 7.00 8.00 Subtotal (sum of lines 1-7) 264,517,346 264,517,346 8.00 9.00 Reconciling I tems 0 0 9.00 9.00								
1.00 Land 8,578,381 8,578,381 1.00 2.00 Land Improvements 2,562,084 2,562,084 2.00 3.00 Buildings and Fixtures 190,465,416 190,465,416 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 62,911,465 62,911,465 62,911,465 7.00 HIT designated Assets 0 0 0 8.00 Subtotal (sum of lines 1-7) 264,517,346 264,517,346 8.00 9.00 Reconciling Items 0 9.00				7. 00				
2.00 Land Improvements 2,562,084 2,562,084 3.00 Buildings and Fixtures 190,465,416 3.00 4.00 Building Improvements 0 0 5.00 Fixed Equipment 0 0 6.00 Movable Equipment 62,911,465 62,911,465 7.00 HIT designated Assets 0 0 8.00 Subtotal (sum of lines 1-7) 264,517,346 264,517,346 9.00 Reconciling Items 0 9.00								
3.00 Buildings and Fixtures 190,465,416 0 0 0 4.00 5.00 Fixed Equipment 0 0 0 5.00 Movable Equipment 62,911,465 62,911,46								l
4.00 Building Improvements 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· ·						1
5.00 Fi xed Equi pment 0 0 6.00 Movable Equi pment 62, 911, 465 62, 911, 465 7.00 HIT desi gnated Assets 0 0 8.00 Subtotal (sum of lines 1-7) 264, 517, 346 264, 517, 346 9.00 Reconciling I tems 0 9.00			190, 465, 416	190, 465, 416				
6.00 Movable Equipment 62,911,465 62,911,465 62,911,465 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 264,517,346 264,517,346 8.00 9.00 Reconciling I tems 0 9.00			0	0				
7.00 HIT designated Assets 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				
8.00 Subtotal (sum of lines 1-7) 264, 517, 346 264, 517, 346 9.00 Reconciling I tems 9.00 9.00			62, 911, 465	62, 911, 465				
9.00 Reconciling I tems 0 0 9.00			0	0				
			264, 517, 346	264, 517, 346				
10.00 Total (line 8 minus line 9) 264,517,346 264,517,346 10.00			0	0				1
	10. 00	Total (line 8 minus line 9)	264, 517, 346	264, 517, 346				10.00

Heal th	Financial Systems	ST. ELIZAB	ETH EAST		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150109	Peri od:	Worksheet A-7	
					From 01/01/2014 To 12/31/2014		pared.
					12,01,2011	5/27/2015 9:4	5 am
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	15, 584, 891	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)	15, 584, 891	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	15, 584, 891			·	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	15, 584, 891				3. 00

Health Financial Systems	ST. ELIZAE	BETH EAST		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150109	Period: From 01/01/2014 To 12/31/2014		pared:
	COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS C	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 TION OF OTHER O	CAPI TAI	0 1.000000 0 0.000000 0 1.000000 SUMMARY 0		1. 00 2. 00 3. 00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum o cols. 5 through 7)	f Depreciation	Lease	
PART III - RECONCILIATION OF CAPITAL COSTS CE	6.00	7. 00	8. 00	9. 00	10.00	
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	0 0		0 11, 011, 231 0 5, 522, 348 0 16, 533, 579		
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see instructions)	,	Other) Capi tal -Rel ate d Costs (see	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 1. 00 NEW CAP REL COSTS-BLDG & FIXT 2. 00 NEW CAP REL COSTS-MVBLE EQUIP 3. 00 Total (sum of lines 1-2)	2, 863, 146 2, 371, 597 5, 234, 743	0		0 0 0 0 0 0	15, 086, 114 8, 005, 458 23, 091, 572	1

| Peri od: | Worksheet A-8 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150109

				To	12/31/2014	Date/Time Prep 5/27/2015 9:45	pared:
				Expense Classification on		3/2//2015 9.4	3 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1. 00 B	2. 00 -9. 633	3.00 NEW CAP REL COSTS-BLDG &	4. 00 1. 00	5. 00 11	1. 00
	REL COSTS-BLDG & FLXT (chapter		.,	FIXT			
2.00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter	В	-7, 979	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
3. 00	lnvestment income - other		0		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
	expenses (chapter 8)		0				
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
8. 00	21) Tel evi si on and radio servi ce (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -4, 826, 807		0. 00	0 0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0. 00	O	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-24, 923, 763			0	12. 00
13. 00	Laundry and linen service	_	0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-829, 190 0	CAFETERI A	11. 00 0. 00	0	
1/ 00	and others				0.00		1/ 00
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17. 00	Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)	_					
20. 00 21. 00	Vending machines Income from imposition of	В	-7, 177 0	DI ETARY	10. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	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	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - NEW CAP REL		0	FIXT NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist			EQUIP *** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0. 00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
00	limitation (chapter 14)			ADULTO A DESCRIPTION			00.5-
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest	<u> </u>				<u> </u>	

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150109 Peri od: Worksheet A-8 From 01/01/2014
To 12/31/2014
Date/Time Prepared:

Cost Center Description Resis/Code (2) Amount Cost Center Line # Mast A.7 Ref						7 12/31/2014	5/27/2015 9: 4	
Cost Center Description Basis/Code (2) Amount Cost Center Line # Mist A-7 Ref.					Expense Classification on	Worksheet A		
Cost Center Description Basis/Code (2)								
1.00						,		
1.00								
1.00								
1.00								
1.00		Cost Center Description	Basis/Code (2)	Amount	Cost Center	line #	Wkst A_7 Ref	
33.00 RODERTY TAX		oost ochter bescriptron						
SUMBRAL A A A A A A A A A	22 00	DDODEDTY TAY						22 00
33.01 RECRUITMENT A	33.00	TROIERTI TAX		-21, 200		5.00	٥	33.00
33.02 RECRUITMENT	22 01	DECDILI TMENT		150	l e e e e e e e e e e e e e e e e e e e	4 00	_	22 01
SENERAL SENE		1	1					
33. 03 MAP A	33. 02	RECRUITMENT	A	-40, 704		3.00	0	33.02
CRIPERAL	22 02	ПАЕ		1 001 070		E 04		22 02
33.04 ADVERTIS ING EXP	33.03	INAF	A	-1, 991, 0/0		5.00	0	33.03
33.06 ADVERTISHING EXP	22.04	ADVEDTICING EVD		1 000		4.00		22.04
33. 06 ADVERTISING EXP		1	1 . 1		l e			
33. 07 ADVERTISING EXP A -2,750[RADIOLOGY_DIAMONSTIC] 54. 00 0.33, 07 33. 07 33. 08 ADVERTISING EXP A -12,156[LECTROCADIOLOGY_DIAMONSTIC] 54. 00 0.33, 08 ADVERTISING EXP A -12,156[LECTROCADIOLOGY_DIAMONSTIC] 55. 06 0.33, 09 ADVERTISING EXP A -12,156[LECTROCADIOLOGY_DIAMONSTIC] 55. 06 0.33, 09 ADVERTISING EXP A -1,205[DIAMONSTIC] 57. 06 0.33, 10 CENERAL 10. 00 0.33, 11 ADVERTISING EXP A -1,450[DIAMONSTIC] 66. 00 0.33, 11 ADVERTISING EXP A -1,205[PHYSICAL THERAPY_DIAMONSTIC] 66. 00 0.33, 13 33. 13 ADVERTISING EXP A -1,205[PHYSICAL THERAPY_DIAMONSTIC] 66. 00 0.33, 13 33. 14 ADVERTISING EXP A -1,205[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 13 33. 14 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 13 33. 15 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 16 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 16 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 16 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 16 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 16 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 17 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 17 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 17 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 17 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 17 ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 20 ADVERTISING EXP ADVERTISING EXP A -2,200[PHYSICAL THERAPY_DIAMONSTIC] 67. 00 0.33, 20 ADVERTISING EXP		1	1		1			
33. 09 ADVERTISING EXP - PUBLIC A -17. ISB ELECTROCARDIOLOGY 69. 00 0. 33. 09 CRIENTING EXP - PUBLIC A -776. 2170THER ADMIN STRATIVE AND 5. 06 0. 33. 09 CRIENTING EXP A -1.085 THER ADMIN STRATIVE AND 5. 06 0. 33. 09 CRIENTING EXP A -1.085 THER ADMIN STRATIVE AND 5. 06 0. 33. 10 CRIENTING EXP A -1.450 LETARY 10. 00 0. 33. 11 MARKETI NG EXP A -1.450 LETARY 10. 00 0. 33. 13 ADMIN STRATIVE AND 5. 06 0. 00 0. 33. 13 ADMIN STRATIVE EXP A -1.450 LETARY 10. 00 0. 33. 13 ADMIN STRATIVE EXP A -1.420 PHYSICAL THERAPY 66. 00 0. 33. 13 ADMIN STRATIVE EXP A -1.20 PHYSICAL THERAPY 66. 00 0. 33. 13 ADMIN STRATIVE EXP A -1.20 PHYSICAL THERAPY 10. 00 0. 33. 15 ADMIN STRATIVE EXP A -20 MOUND CARE 91. 01 0. 33. 15 ADMIN STRATIVE EXP A -20 MOUND CARE 91. 01 0. 33. 15 ADMIN STRATIVE EXP A -3.00 HOME HEALTH AGENCY 101. 00 0. 33. 16 ADMIN STRATIVE EXP B -772. ADMIN CARP REL COSTS-BLDG & 1.00 0. 33. 16 ADMIN STRATIVE EXP B -772. ADMIN CARP REL COSTS-BLDG & 1.00 0. 33. 16 ADMIN STRATIVE EXP B -772. ADMIN CARP REL COSTS-BLDG & 1.00 0. 33. 16 ADMIN STRATIVE EXP A -8.00 HOME HEALTH AGENCY ADMIN STRATIVE EXP A -9.00 HOME HEALTH AGENCY ADMIN STRATIVE EXP A -8.00 HOME HEALTH AGENCY A -9.00 HOME HEALTH		1	1		1			
33. 09 MARKETING EXP PUBLIC A -276, 2170 THER ADM IN STRATIVE AND CENERAL CENERA		1	1		1			
RELATIONS		1	A					
MARKETI NG EXP	33. 09	II.	A	-276, 217		5. 06	0	33. 09
SENERAL SENE		RELATI ONS						
MARKETING EXP	33. 10	MARKETING EXP	A	-1, 085	OTHER ADMINISTRATIVE AND	5. 06	0	33. 10
MARKETING EXP					GENERAL			
33 13 MARKETI NG EXP	33. 11	MARKETING EXP	A	-145	DI ETARY	10.00	0	33. 11
MARKETING EXP	33. 12	MARKETING EXP	A	-1, 320	PHYSI CAL THERAPY	66.00	0	33. 12
33 15 MARKETI NO EXP	33. 13	MARKETING EXP	A	-1, 627	ELECTROCARDI OLOGY	69.00	0	33. 13
33 16 MARKETI INC EXP A -83 MOSPICE 116.00 0 33.16	33. 14	MARKETING EXP	A	-29	WOUND CARE	91. 01	0	33. 14
33 16 MARKETI INC EXP A -83 MOSPICE 116.00 0 33.16	33. 15	MARKETING EXP	A	-4, 304	HOME HEALTH AGENCY	101.00	0	33. 15
B		MARKETING EXP	1					
STATE STATE STATE STATE STATE STATE STATE		1	1					
33. 18 DISCOUNTS/REBATES B -6.53 MGMT I NFO SYSTEMS 5. 02 0 33. 18 33. 19 DISCOUNTS/REBATES B -8. 492 PURCHASI NG 5. 03 0 33. 19 33. 20 EXP ALLOC SCMC PHYSI CI ANS B -8.61, 000 OTHER ADMINI STRATI VE AND GENERAL 5. 06 0 33. 20 33. 21 MI SC REV B -188, 3485 OTHER ADMINI STRATI VE AND GENERAL 7. 00 0 33. 22 33. 22 MAI NTENANCE/SECURI TY REV B -19, 631 OPERATI ON 0F PLANT 7. 00 0 33. 23 33. 24 MI SC REV/DI SCOUNTS/REBATES B -21, 873 OPERATION 0F PLANT 7. 00 0 33. 23 33. 25 MI SC REV/DI SCOUNTS/REBATES B -95, 376 DI ETARY 10. 00 0 33. 25 33. 26 FOOD SERVICE DAY CARE B -21 DI ETARY 10. 00 0 33. 26 33. 27 DI SCOUNTS/REBATES B -13, 315 CENTRAL SERVICES & SUPPLY 14. 00 0 33. 26 33. 29 MI SC REV/DI SCOUNTS/REBATES B -32, 313 MEDI CAL RECORDS & LI BRARY 16. 00 0 33. 28 33. 29 MI SC REV/DI SCOUNTS/REBATES B -32, 313 MEDI CAL RECORDS & LI BRARY 16. 00 0 33. 29 33. 30 DI SCOUNTS/REBATES B -32, 313 MEDI CAL RECORDS & LI BRARY 16. 00 0 33. 29 33. 31 DI SCOUNTS/REBATES B -32, 313 MEDI CAL RECORDS & LI BRARY 16. 00 0 33. 31 33. 32 MI SC REV/DI SCOUNTS/REBATES B -32, 39 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 33 33. 33 MI SC REV/DI SCOUNTS/REBATES B -20, 68 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 33 33. 33 MI SC REV/DI SCOUNTS/REBATES B -118, 340 CABID IAC CATH LAB 56. 01 0 33. 34 33. 33 MI SC REV/DI SCOUNTS/REBATES B -118, 340 CABID IAC CATH LAB 56. 01 0 33. 34 33. 34 MI SC REV DI SCOUNTS/REBATES B -1, 20 PHASTATI NG ROW 50. 00 0 33. 35 33. 34 MI SC REV DI SCOUNTS/REBATES B -1, 20 PHASTATI NG ROW 50. 00 0 33. 35 33. 34 MI SC REV DI SCOUNTS/REBATES B -1, 20 PHASTATI NG ROW 50. 00 0 33. 34 33. 35 DI SCOUNTS/REBATES B -1, 20 PHASTATI NG ROW 50. 00 0 33. 35 33. 36 DI SCOUNTS/REBATES B -1, 20	00. 17	SESS NEW NEW		1,2,010			ĺ	00,
33.19 DISCOUNTS/REBATES B -8, 49/2 PURCHASING 5.03 0 33.19	33 18	DI SCOUNTS/REBATES	B	-653		5.02	l o	33 18
33. 20 EXP ALLOC SCMC PHYSICIANS B -861, 000 OTHER ADMINISTRATIVE AND 5. 06 GENERAL GENERAL GENERAL GENERAL 5. 06 GENERAL 7. 00 33. 21 6. 00 33. 22 33. 23 MAINTENANCE/SECURITY REV B -79, 651 OPERATION OF PLANT 7. 00 0. 33. 22 33. 23 MAINTENANCE/SECURITY REV B -15, 930 OPERATION OF PLANT 7. 00 0. 33. 23 33. 24 MIS C REV/DISCOUNTS/REBATES B -21, 873 OPERATION OF PLANT 7. 00 0. 33. 24 33. 25 MISC REV/DISCOUNTS/REBATES B -95, 376 DIETARY 10. 00 0. 33. 25 MISC REV/DISCOUNTS/REBATES B -113, 315 CENTRAL SERVICES & SUPPLY 10. 00 0. 33. 27 MISC REV/DISCOUNTS/REBATES B -133, 315 CENTRAL SERVICES & SUPPLY 14. 00 0. 33. 27 MISC REV/DISCOUNTS/REBATES B -23, 334 MISC REV/DISCOUNTS/REBATES B -21, 237 OPERATING ROOM 50. 00 0. 33. 29 MISC REV/DISCOUNTS/REBATES B -21, 237 OPERATING ROOM 50. 00 0. 33. 30 MISC REV/DISCOUNTS/REBATES B -21, 237 OPERATING ROOM 50. 00 0. 33. 30 MISC REV/DISCOUNTS/REBATES B -24, 231 MISC REV/DISCOUNTS/REBATES B -24, 231 MISC REV/DISCOUNTS/REBATES B -24, 430 A01 DISCOUNTS/REBATES B -24, 44, 44 A01		1						
Several Seve		1	1		1			
33. 21 MI SC REV	33. 20	LAF ALLOC SCWC FITTST CTANS	ь	-801,000		5.00	0	33. 20
GENERAL GENE	22 21	MLSC DEV	D	10/ 2/5	1	E 04		22 21
33. 22 MAINTENANCE/SECURITY REV 33. 23 MAINTENANCE/SECURITY REV 33. 24 MISC REV/DISCOUNTS/REBATES 33. 24 MISC REV/DISCOUNTS/REBATES 33. 25 MISC REV/DISCOUNTS/REBATES 33. 26 MISC REV/DISCOUNTS/REBATES 33. 26 MISC REV/DISCOUNTS/REBATES 33. 26 MISC REV/DISCOUNTS/REBATES 33. 27 DISCOUNTS/REBATES 33. 27 DISCOUNTS/REBATES 34 DISCOUNTS/REBATES 35 DISCOUNTS/REBATES 36 DISCOUNTS/REBATES 37 DISCOUNTS/REBATES 38 DISCOUNTS/REBATES 39 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 32 DISCOUNTS/REBATES 33 DISCOUNTS/REBATES 33 DISCOUNTS/REBATES 34 DISCOUNTS/REBATES 35 DISCOUNTS/REBATES 36 DISCOUNTS/REBATES 37 DISCOUNTS/REBATES 38 DISCOUNTS/REBATES 39 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 32 DISCOUNTS/REBATES 33 DISCOUNTS/REBATES 34 DISCOUNTS/REBATES 35 DISCOUNTS/REBATES 36 DISCOUNTS/REBATES 37 DISCOUNTS/REBATES 38 DISCOUNTS/REBATES 39 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 32 DISCOUNTS/REBATES 33 DISCOUNTS/REBATES 34 DISCOUNTS/REBATES 35 DISCOUNTS/REBATES 36 DISCOUNTS/REBATES 37 DISCOUNTS/REBATES 38 DISCOUNTS/REBATES 39 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 31 DISCOUNTS/REBATES 32 DISCOUNTS/REBATES 33 DISCOUNTS/REBATES 34 DISCOUNTS/REBATES 35 DISCOUNTS/REBATES 36 DISCOUNTS/REBATES 37 DISCOUNTS/REBATES 38 DISCOUNTS/REBATES 39 DISCOUNTS/REBATES 39 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 30 DISCOUNTS/REBATES 31 DIS	33. 21	WI 3C REV	D	-104, 343		5.00	0	33. 21
33. 23 MAINTENANCE/SECURITY REV B -15, 930 OPERATION OF PLANT 7. 00 0 33. 23 33. 24 MISC REV/DISCOUNTS/REBATES B -21, 873 OPERATION OF PLANT 7. 00 0 33. 24 10. 00 0 33. 25 10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 22	MALNTENANCE (SECURITY DEV	D	70 451		7 00		22 22
33. 24 MI SC REV/DI SCOUNTS/REBATES B -21,873 OPERATION OF PLANT 7.00 0 33. 24 33. 25 MI SC REV/DI SCOUNTS/REBATES B -95,376 DI ETARY 10.00 0 33. 25 6 03. 27 DI SCOUNTS/REBATES B -7.10 ETARY 10.00 0 33. 26 6 33. 27 DI SCOUNTS/REBATES B -7.10 ETARY 10.00 0 33. 26 6 33. 27 DI SCOUNTS/REBATES B -7.10 ETARY 10.00 0 33. 27 33. 28 MI SC REV/DI SCOUNTS/REBATES B -85,334 PHARMACY 15.00 0 33. 28 MI SC REV/DI SCOUNTS/REBATES B -32,313 MEDI CAL RECORDS & LI BRARY 16.00 0 33. 29 33. 30 DI SCOUNTS/REBATES B -32,313 MEDI CAL RECORDS & LI BRARY 16.00 0 33. 30 DI SCOUNTS/REBATES B -32,313 MEDI CAL RECORDS & LI BRARY 16.00 0 33. 30 33. 31 DI SCOUNTS/REBATES B -211, 237 OPERATING ROOM 50.00 0 33. 31 33. 32 MI SC REV/DI SCOUNTS/REBATES B -2.20,84 RADI OL.0GY-DI AGNOSTI C 54.00 0 33. 31 33. 34 MI SC REV/DI SCOUNTS/REBATES B -4.00 RADI OL.0GY-DI AGNOSTI C 54.00 0 33. 33 33. 34 MI SC REV/DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56.01 0 33. 34 33. 35 DI SCOUNTS/REBATES B -18, 76 (LABORATORY 60.00 0 33. 35 33. 36 DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56.01 0 33. 35 SI SI SCOUNTS/REBATES B -1, 695 RESPI RATORY THERAPY 65.00 0 33. 35 SI SI SU NOCENT PRUDENTI AL B -1, 720 PHYSI CAL THERAPY 66.00 0 33. 38 SI SI VI NOCENT PRUDENTI AL B -1, 720 PHYSI CAL THERAPY 66.00 0 33. 38 SI VI NOCENT PRUDENTI AL B -1, 720 PHYSI CAL THERAPY 91.00 0 33. 38 SI SI VI NOCENT PRUDENTI AL B -1, 720 PHYSI CAL THERAPY 91.00 0 33. 34 DI SCOUNTS/REBATES B -4, 814 EMERGENCY 91.00 0 33. 34 DI SCOUNTS/REBATES B -1, 75, 504 HOME HEALTH AGENCY 101.00 0 33. 40 33. 34 DI SCOUNTS/REBATES B -1, 275 HOME HEALTH AGENCY 101.00 0 33. 41 40 91.23 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0.33. 44 40 91.23 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0.33. 44 40 91.23 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0.33. 44 40 91.23 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0.33. 44 40 91.23 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0.33. 44 40 91.23 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0.33. 44 40 91.23 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0.33. 44 40 91.23 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0.33		1						
33. 25 MI SC REV/DI SCOUNTS/REBATES B -95, 376 DI ETARY 10. 00 0 33. 25 33. 26 FOOD SERVI CE DAY CARE B -21 DI ETARY 10. 00 0 33. 26 33. 27 DI SCOUNTS/REBATES B -113, 315 CENTRAL SERVI CES & SUPPLY 14. 00 0 33. 27 33. 28 MI SC REV/DI SCOUNTS/REBATES B -85, 334 PHARMACY 15. 00 0 33. 28 33. 29 MI SC REV B -32, 313 MEDI CAL RECORDS & LI BRARY 16. 00 0 33. 29 33. 30 DI SCOUNTS/REBATES B -221, 237 DPERATI ING ROOM 50. 00 0 33. 31 0 SCOUNTS/REBATES B -231, 237 DPERATI ING ROOM 50. 00 0 33. 31 33. 31 DI SCOUNTS/REBATES B -35, 939 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 31 33. 32 MI SC REV B -2, 084 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 32 33 33 MI SC REV/DI SCOUNTS/REBATES B -400 RADI OI SOTOPE 56. 00 0 33. 33 33 33 34 MI SC REV/DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56. 01 0 33. 34 33. 35 DI SCOUNTS/REBATES B -18, 876 (LABORATORY 60. 00 0 33. 35 33 35 DI SCOUNTS/REBATES B -1, 695 RESPI RATORY FIREAPY 65. 00 0 33. 36 33. 37 ATHLETIC TRAIN IN GREV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 38 33. 39 MI SC REV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 38 33. 39 MI SC REV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 38 33. 34 DI SCOUNTS/REBATES B -1, 695 RESPI RATORY THERAPY 66. 00 0 33. 38 33. 39 MI SC REV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 38 33. 34 DI SCOUNTS/REBATES B -1, 71, 513 ELECTROCARDI OLOGY 69. 00 0 33. 38 33. 34 DI SCOUNTS/REBATES B -1, 75 04 HOME HEALTH AGENCY 91. 00 0 33. 40 SCOUNTS/REBATES B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 41 33. 42 MI SC REV B -1, 725 HOME HEALTH AGENCY 101. 00 0 33. 42 33. 44 50. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
33. 26 FOOD SERVICE DAY CARE		1						
33. 27 33. 28 MI SC REV/DI SCOUNTS/REBATES B -85, 334 PHARMACY 15. 00 0 33. 27 33. 28 MI SC REV/DI SCOUNTS/REBATES B -85, 334 PHARMACY 15. 00 0 33. 29 33. 30 0 DI SCOUNTS/REBATES B -32, 313 MEDI CAL RECORDS & LI BRARY 16. 00 0 33. 29 33. 30 0 DI SCOUNTS/REBATES B -211, 237 OPERATI NG ROOM 50. 00 0 33. 30 33. 31 0 DI SCOUNTS/REBATES B -211, 237 OPERATI NG ROOM 50. 00 0 33. 31 33. 32 MI SC REV/DI SCOUNTS/REBATES B -20, 084 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 32 33. 34 MI SC REV/DI SCOUNTS/REBATES B -400 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 32 33. 34 MI SC REV/DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56. 01 0 33. 34 33. 35 DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56. 01 0 33. 34 35. 31 0 DI SCOUNTS/REBATES B -1, 695 RESPI RATORY HERAPY 66. 00 0 33. 36 37 38. 38 39. ATHLETI C TRAI NI NG REV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 37 33. 38 33. 34 MI SC REV B -4, 814 LEMERGENCY 91. 00 0 33. 39 33. 40 EDUCATI ON/TEXTBOOK REV B -46, 079 EMERGENCY 91. 00 0 33. 40 0 TOTAL (Sum of Lines 1 thru 49) (Transfer to Worksheet A, column 6, Line 200.)		1	1					
33. 28 MI SC REV/DI SCOUNTS/REBATES B -85, 334 PHARMACY 15. 00 0 33. 28 33. 29 MI SC REV B -32, 313 MEDI CAL RECORDS & LI BRARY 16. 00 0 33. 29 33. 30 DI SCOUNTS/REBATES B -211, 237 OPERATI NG ROOM 50. 00 0 33. 30 DI SCOUNTS/REBATES B -211, 237 OPERATI NG ROOM 50. 00 0 33. 30 DI SCOUNTS/REBATES B -35, 939 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 31 MI SC REV B -2, 084 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 32 33. 33 MI SC REV/DI SCOUNTS/REBATES B -400 RADI OI SOTOPE 56. 00 0 33. 33 DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56. 01 0 33. 34 MI SC REV/DI SCOUNTS/REBATES B -8, 876 LABORATORY 60. 00 0 33. 35 DI SCOUNTS/REBATES B -1, 695 RESPI RATORY THERAPY 65. 00 0 33. 36 MI SC REV/DI SCOUNTS/REBATES B -1, 695 RESPI RATORY THERAPY 66. 00 0 33. 36 MI SC REV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 37 MI SC REV B -4, 814 EMERGENCY 91. 00 0 33. 38 MI SC REV B -46, 079 EMERGENCY 91. 00 0 33. 40 DI SCOUNTS/REBATES B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 40 DI SCOUNTS/REBATES B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 41 MI SC REV B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 43 MI SC REV B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 44 MI SC REV B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 44 MI SC REV B -34, 744, 142 MI SC REV B -34, 744, 144 MI SC REV B -34		1			1			
33. 29 MI SC REV 33. 30 DI SCOUNTS/REBATES B -32, 313 MEDI CAL RECORDS & LI BRARY 16. 00 0 33. 29 33. 31 DI SCOUNTS/REBATES B -211, 237 (DPERATI NG ROOM 50. 00 0 33. 30 33. 31 DI SCOUNTS/REBATES B -35, 939 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 31 33. 32 MI SC REV/DI SCOUNTS/REBATES B -2, 084 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 32 33. 34 MI SC REV/DI SCOUNTS/REBATES B -400 RADI OI SOTOPE 56. 00 0 33. 33 33. 34 MI SC REV/DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56. 01 0 33. 34 33. 35 DI SCOUNTS/REBATES B -8, 876 LABORATORY 60. 00 0 33. 35 33. 36 DI SCOUNTS/REBATES B -1, 695 RESPI RATORY THERAPY 66. 00 0 33. 36 31. 38 ST VI NCENT PRUDENTI AL B -71, 513 ELECTROCARDI OLOGY 69. 00 0 33. 38 33. 39 MI SC REV B -4, 814 EMERGENCY 91. 00 0 33. 40 33. 34 DI SCOUNTS/REBATES B -7, 504 HOME HEALTH AGENCY 101. 00 0 33. 41 33. 42 MI SC REV B -7, 504 HOME HEALTH AGENCY 101. 00 0 33. 42 33. 43 PENSI ON A 409, 123 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 44 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1						
33. 30 DI SCOUNTS/REBATES B -211, 237 OPERATI NG ROOM 50.00 0 33. 30 0 33. 31 DI SCOUNTS/REBATES B -35, 939 RADI OLOGY-DI AGNOSTI C 54.00 0 33. 31 33. 32 MI SC REV B -2, 084 RADI OLOGY-DI AGNOSTI C 54.00 0 33. 31 33. 34 MI SC REV/DI SCOUNTS/REBATES B -400 RADI OI SOTOPE 56.00 0 33. 33 33. 34 MI SC REV/DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56.01 0 33. 34 33. 35 DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56.01 0 33. 35 DI SCOUNTS/REBATES B -8, 876 LABORATORY 60.00 0 33. 35 DI SCOUNTS/REBATES B -1, 695 RESPI RATORY THERAPY 65.00 0 33. 35 DI SCOUNTS/REBATES B -1, 720 PHYSI CAL THERAPY 66.00 0 33. 37 33. 38 ST VI NCENT PRUDENTI AL B -71, 513 ELECTROCARDI OLOGY 69.00 0 33. 38 33. 39 MI SC REV B -44, 814 EMERGENCY 91.00 0 33. 40 EDUCATI ON/TEXTBOOK REV B -46, 079 EMERGENCY 91.00 0 33. 40 33. 41 DI SCOUNTS/REBATES B -1, 275 HOME HEALTH AGENCY 101.00 0 33. 41 33. 43 PENSI ON A 409, 123 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 42 50.00 (Transfer to Worksheet A, col umn 6, 1 i ne 200.)		1						
33. 31 DI SCOUNTS/REBATES B -35, 939 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 31 33. 32 MI SC REV B -2, 084 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 32 33. 33 MI SC REV/DI SCOUNTS/REBATES B -400 RADI OI SOTOPE 56. 00 0 33. 33 33 34 MI SC REV/DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56. 01 0 33. 34 33. 35 DI SCOUNTS/REBATES B -8, 876 LABORATORY 60. 00 0 33. 35 33. 36 DI SCOUNTS/REBATES B -1, 695 RESPI RATORY THERAPY 65. 00 0 33. 36 33. 37 ATHLETI C TRAI NI NG REV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 37 33. 38 ST VI NCENT PRUDENTI AL B -71, 513 ELECTROCARDI OLOGY 69. 00 0 33. 38 33. 39 MI SC REV B -4, 814 EMERGENCY 91. 00 0 33. 39 33. 41 DI SCOUNTS/REBATES B -7, 504 HOME HEALTH AGENCY 101. 00 0 33. 41 33. 42 MI SC REV B -7, 504 HOME HEALTH AGENCY 101. 00 0 33. 42 33. 43 PENSI ON A 409, 123 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 44 50. 00 TOTAL (sum of Lines 1 thru 49) (Transfer to Worksheet A, col umn 6, Line 200.)		4						
33. 32 MI SC REV B -2,084 RADI OLOGY-DI AGNOSTI C 54.00 0 33.32 33. 33 MI SC REV/DI SCOUNTS/REBATES B -400 RADI OI SOTOPE 56.00 0 33.33 33. 34 MI SC REV/DI SCOUNTS/REBATES B -118,340 CARDI AC CATH LAB 56.01 0 33.34 33. 35 DI SCOUNTS/REBATES B -8,876 LABORATORY 60.00 0 33.35 33. 36 DI SCOUNTS/REBATES B -1,695 RESPI RATORY THERAPY 65.00 0 33.36 33. 37 ATHLETIC TRAINING REV B -1,720 PHYSI CAL THERAPY 66.00 0 33.37 33. 38 ST VINCENT PRUDENTIAL B -71,513 ELECTROCARDI OLOGY 69.00 0 33.38 33. 39 MI SC REV B -4,814 EMERGENCY 91.00 0 33.40 33. 40 EDUCATI ON/TEXTBOOK REV B -46,079 EMERGENCY 91.00 0 33.40 33. 41 DI SCOUNTS/REBATES B -7,504 HOME HEALTH AGENCY 101.00 0 33.41 33. 42 MI SC REV B -1,275 HOME HEALTH AGENCY 101.00 0 33.42 33. 43 PENSION A 409,123 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.44 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1				50.00	0	
33. 33 MI SC REV/DI SCOUNTS/REBATES B -400 RADI OI SOTOPE 56. 00 0 33. 33 33 33 34 MI SC REV/DI SCOUNTS/REBATES B -118, 340 CARDI AC CATH LAB 56. 01 0 33. 34 34 35. 35 DI SCOUNTS/REBATES B -8, 876 LABORATORY 60. 00 0 33. 35 0 DI SCOUNTS/REBATES B -1, 695 RESPI RATORY THERAPY 65. 00 0 33. 36 33. 37 ATHLETIC TRAINING REV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 37 33. 38 ST VINCENT PRUDENTI AL B -71, 513 ELECTROCARDI OLOGY 69. 00 0 33. 38 33. 39 MI SC REV B -4, 814 EMERGENCY 91. 00 0 33. 39 33. 40 EDUCATI ON/TEXTBOOK REV B -46, 079 EMERGENCY 91. 00 0 33. 40 DI SCOUNTS/REBATES B -7, 504 HOME HEALTH AGENCY 101. 00 0 33. 41 33. 42 MI SC REV B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 42 33. 43 PENSI ON A 409, 123 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 43 33. 44 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	33. 31	DI SCOUNTS/REBATES	В	-35, 939	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 31
33. 34 MISC REV/DISCOUNTS/REBATES B -118, 340 CARDIAC CATH LAB 56. 01 0 33. 34 33. 35 DI SCOUNTS/REBATES B -8, 876 LABORATORY 60. 00 0 33. 35 DI SCOUNTS/REBATES B -1, 695 RESPIRATORY THERAPY 65. 00 0 33. 36 33. 37 ATHLETIC TRAINING REV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 37 33. 38 ST VINCENT PRUDENTIAL B -71, 513 ELECTROCARDIOLOGY 69. 00 0 33. 38 33. 39 MISC REV B -4, 814 EMERGENCY 91. 00 0 33. 39 33. 40 EDUCATION/TEXTBOOK REV B -46, 079 EMERGENCY 91. 00 0 33. 40 33. 41 DI SCOUNTS/REBATES B -7, 504 HOME HEALTH AGENCY 101. 00 0 33. 41 33. 42 MISC REV B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 42 33. 43 PENSION A 409, 123 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 44 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	33. 32		В	-2, 084	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 32
33. 35 DI SCOUNTS/REBATES B -8,876 LABORATORY 60.00 0 33. 35 33. 36 DI SCOUNTS/REBATES B -1,695 RESPIRATORY THERAPY 65.00 0 33. 36 33. 37 ATHLETIC TRAINING REV B -1,720 PHYSICAL THERAPY 66.00 0 33. 37 33. 38 ST VINCENT PRUDENTIAL B -71,513 ELECTROCARDIOLOGY 69.00 0 33. 38 33. 39 MI SC REV B -4,814 EMERGENCY 91.00 0 33. 39 33. 40 EDUCATION/TEXTBOOK REV B -46,079 EMERGENCY 91.00 0 33. 40 33. 41 DI SCOUNTS/REBATES B -7,504 HOME HEALTH AGENCY 101.00 0 33. 41 33. 42 MI SC REV B -1,275 HOME HEALTH AGENCY 101.00 0 33. 42 33. 43 PENSI ON A 409,123 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 43 33. 44 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	33. 33	MI SC REV/DI SCOUNTS/REBATES	В	-400	RADI OI SOTOPE	56.00	0	33. 33
33. 36 DI SCOUNTS/REBATES B -1, 695 RESPI RATORY THERAPY 65. 00 0 33. 36 33. 37 ATHLETIC TRAINING REV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 37 33. 38 ST VINCENT PRUDENTIAL B -71, 513 ELECTROCARDI OLOGY 69. 00 0 33. 38 33. 39 MI SC REV B -4, 814 EMERGENCY 91. 00 0 33. 39 33. 40 EDUCATION/TEXTBOOK REV B -46, 079 EMERGENCY 91. 00 0 33. 40 33. 41 DI SCOUNTS/REBATES B -7, 504 HOME HEALTH AGENCY 101. 00 0 33. 41 33. 42 MI SC REV B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 42 33. 43 PENSI ON A 409, 123 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 43 33. 44 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	33. 34	MISC REV/DISCOUNTS/REBATES	В	-118, 340	CARDIAC CATH LAB	56. 01	0	33. 34
33. 36 DI SCOUNTS/REBATES B -1, 695 RESPI RATORY THERAPY 65. 00 0 33. 36 33. 37 ATHLETIC TRAINING REV B -1, 720 PHYSI CAL THERAPY 66. 00 0 33. 37 33. 38 ST VINCENT PRUDENTIAL B -71, 513 ELECTROCARDI OLOGY 69. 00 0 33. 38 33. 39 MI SC REV B -4, 814 EMERGENCY 91. 00 0 33. 39 33. 40 EDUCATION/TEXTBOOK REV B -46, 079 EMERGENCY 91. 00 0 33. 40 33. 41 DI SCOUNTS/REBATES B -7, 504 HOME HEALTH AGENCY 101. 00 0 33. 41 33. 42 MI SC REV B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 42 33. 43 PENSI ON A 409, 123 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 43 33. 44 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	33. 35	DI SCOUNTS/REBATES	В	-8, 876	LABORATORY	60.00	0	33. 35
33. 37 ATHLETIC TRAINING REV B -1,720 PHYSICAL THERAPY 66. 00 0 33. 37 33. 38 ST VINCENT PRUDENTIAL B -71,513 ELECTROCARDIOLOGY 69. 00 0 33. 38 33. 39 MI SC REV B -4,814 EMERGENCY 91. 00 0 33. 39 33. 40 EDUCATION/TEXTBOOK REV B -46,079 EMERGENCY 91. 00 0 33. 40 DI SCOUNTS/REBATES B -7,504 HOME HEALTH AGENCY 101. 00 0 33. 41 33. 42 MI SC REV B -1,275 HOME HEALTH AGENCY 101. 00 0 33. 42 33. 43 PENSION A 409,123 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 43 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			В	-1, 695	RESPIRATORY THERAPY	65.00	l 0	
33. 38 ST VINCENT PRUDENTIAL B -71, 513 ELECTROCARDIOLOGY 69. 00 0 33. 38 33. 39 MI SC REV B -44, 814 EMERGENCY 91. 00 0 33. 39 EDUCATION/TEXTBOOK REV B -46, 079 EMERGENCY 91. 00 0 33. 40 DI SCOUNTS/REBATES B -7, 504 HOME HEALTH AGENCY 101. 00 0 33. 41 33. 42 MI SC REV B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 42 33. 43 PENSION A 409, 123 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 43 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)								•
33. 39 MISC REV B -4,814 EMERGENCY 91.00 0 33. 39 33. 40 EDUCATION/TEXTBOOK REV B -46,079 EMERGENCY 91.00 0 33. 40 33. 41 DI SCOUNTS/REBATES B -7,504 HOME HEALTH AGENCY 101.00 0 33. 41 33. 42 MISC REV B -7,504 HOME HEALTH AGENCY 101.00 0 33. 42 33. 43 PENSION A 409,123 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 43 33. 44 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1						
33. 40 EDUCATION/TEXTBOOK REV B -46,079 EMERGENCY 91.00 0 33. 40 33. 41 DI SCOUNTS/REBATES B -7,504 HOME HEALTH AGENCY 101.00 0 33. 41 33. 42 MI SC REV B -1,275 HOME HEALTH AGENCY 101.00 0 33. 42 33. 43 PENSION A 409, 123 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 43 33. 44 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1	1					
33. 41 DI SCOUNTS/REBATES B -7, 504 HOME HEALTH AGENCY 101. 00 0 33. 41 33. 42 MI SC REV B -1, 275 HOME HEALTH AGENCY 101. 00 0 33. 42 33. 43 PENSI ON A 409, 123 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 43 33. 44 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1	1		l .			
33. 42 MISC REV B -1, 275 HOME HEALTH AGENCY 101.00 0 33. 42 33. 43 PENSION A 409, 123 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 43 33. 44 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1	1					
33. 43 PENSION A 409, 123 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 43 0 0 0. 00 0 33. 44 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1	1		l e			•
33. 44 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1	1					
50.00 TOTAL (sum of lines 1 thru 49)		I LIVSTON	A .	407, 123	LIVIT LOTEL DENETTIS DEPARTMENT			•
(Transfer to Worksheet A, column 6, line 200.)		TOTAL (CUM of Lines 1 thro: 40)		24 744 142		0.00		
column 6, line 200.)	SU. UU			-34, /44, 142				30.00
	(1) 5				CMC Duly 1E 1		I	

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 150109 Peri od: Worksheet A-8-1 From 01/01/2014 OFFICE COSTS 12/31/2014 Date/Time Prepared:

					5/27/2015 9: 4	<u>5 am</u>
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	FRANCISCAN DEPRECIATION	1, 929, 374	0	1.00
2.00	2. 00	NEW CAP REL COSTS-MVBLE EQUI	FRANCISCAN DEPRECIATION	1, 533, 821	o	2.00
3.00	113.00	INTEREST EXPENSE	FRANCISCAN INTEREST	5, 252, 355	l ol	3.00
4.00	1	OTHER ADMINISTRATIVE AND GEN		14, 541, 130	0	4. 00
4. 01		PHARMACY	FRANCI SCAN COEP	483, 327	0	4. 01
4. 02		l -	INFORMATION TECHNOLOGY	0	10, 889, 295	4. 02
4. 03	1	PURCHASI NG	PURCHASI NG SERVI CES	0	210, 090	4. 03
4. 04	1	PATIENT ACCOUNTING	PATI ENT ACCT		556, 193	4. 04
4. 05		OTHER ADMINISTRATIVE AND GEN		0	4, 892, 994	4. 05
4. 06		PHARMACY	PHARMACY		366, 820	4. 06
4. 07		RADI OLOGY-DI AGNOSTI C	RADI OLOGY	0	1, 254	4. 00
4. 07		INTEREST EXPENSE	I NTEREST		9, 632, 473	4. 07
4. 09		NEW CAP REL COSTS-BLDG & FIX		_	11, 331, 327	4. 09
4. 10		NEW CAP REL COSTS-BLDG & FIX		5, 000, 936	0	4. 10
4. 11		NEW CAP REL COSTS-MVBLE EQUI		3, 975, 665	0	4. 11
4. 12	I	EMPLOYEE BENEFITS DEPARTMENT		14, 207, 009	21, 401, 250	4. 12
4. 13	1	COMMUNI CATI ONS	FSEH-E SHARED SERVICES	510, 438		4. 13
4. 14		MGMT INFO SYSTEMS	FSEH-E SHARED SERVICES	1, 259, 034	1, 408, 716	4. 14
4. 15		PURCHASI NG	FSEH-E SHARED SERVICES	580, 131	655, 632	4. 15
4. 16		OTHER ADMINISTRATIVE AND GEN		5, 390, 527	23, 214, 038	4. 16
4. 17			FSEH-E SHARED SERVICES	4, 923, 793	6, 260, 209	4. 17
4. 18		NURSING ADMINISTRATION	FSEH-E SHARED SERVICES	1, 694, 644	2, 044, 657	4. 18
4. 19			FSEH-E SHARED SERVICES	1, 134, 543	1, 407, 718	4. 19
4. 20		SOCIAL SERVICE	FSEH-E SHARED SERVICES	312, 335	376, 845	4. 20
4. 21	65. 00	RESPI RATORY THERAPY	FSEH-E SHARED SERVICES	11, 904	14, 363	4. 21
4. 22	66. 00	PHYSI CAL THERAPY	FSEH-E SHARED SERVICES	352, 910	425, 801	4. 22
4. 23	91. 00	EMERGENCY	FSEH-E SHARED SERVICES	-266, 772	-321, 872	4. 23
4. 24	5. 01	COMMUNI CATI ONS	FSEH-C SHARED SERVICES	368, 864	o	4. 24
4. 25	5. 04	ADMITTING	FSEH-C SHARED SERVICES	300, 618	O	4. 25
4. 26	5. 05	PATIENT ACCOUNTING	FSEH-C SHARED SERVICES	1, 722, 590	o	4. 26
4. 27	5. 06	OTHER ADMINISTRATIVE AND GEN	FSEH-C SHARED SERVICES	1, 454, 804	o	4. 27
4. 28	7. 00	OPERATION OF PLANT	FSEH-C SHARED SERVICES	1, 330, 285	o	4. 28
4. 29	8.00	LAUNDRY & LINEN SERVICE	FSEH-C SHARED SERVICES	407, 086	o	4. 29
4.30	16.00	MEDICAL RECORDS & LIBRARY	FSEH-C SHARED SERVICES	136, 150	ol	4. 30
4. 31		ELECTROCARDI OLOGY	FSEH-C SHARED SERVICES	459, 505	0	4. 31
4. 32			FSEH PURCHASED SERVICES	1, 380, 834	0	4. 32
4. 33		LABORATORY	FSEH PURCHASED SERVICES	0	74, 494	4. 33
4. 34		PHYSI CAL THERAPY	FSEH PURCHASED SERVICES	926, 707	0	4. 34
4. 35	I	ELECTROCARDI OLOGY	FSEH PURCHASED SERVICES	720,707	50, 448	4. 35
4. 36			FSEH PURCHASED SERVICES	Ö	254, 196	4. 36
4. 37			FSEH PURCHASED SERVICES	l o	516, 056	4. 37
4. 38		IMPL. DEV. CHARGED TO PATIEN		0	77, 298	4. 38
4. 39		RENAL DIALYSIS	FSEH PURCHASED SERVICES	184, 660	77,270	4. 39
4. 40		PHARMACY	FSEH-PARAMED PROGRAM	184, 660	63, 759	4. 40
4. 40		EMERGENCY	FSEH-PARAMED PROGRAM	0	41, 207	4. 40
4. 41		PHARMACY	FSEH-PHARMACY PROGRAM		11, 966	4. 41
4. 42		PARAMEDICAL EDUCATION PROGRA		_		4. 42
4. 43 5. 00		FARAWEDICAL EDUCATION PROGRA	SEIT-PHAKWACT PRUGKAW	3,605		4. 43 5. 00
ა. 00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to			71, 502, 812	96, 426, 575	5.00
	Worksheet A-8, column 2,					
	line 12.					
				<u> </u>		

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

1103 1101	of been posted to worksheet A, cordinas i and/or 2, the amount arrowable should be mareated in cordinar 4 or this part.					
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2.00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

Health Financial Systems	ST. ELIZABETH E	EAST	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM REL OFFICE COSTS	LATED ORGANIZATIONS AND HOME	Provider CCN: 150109	From 01/01/2014	
			To 12/31/2014	Date/Time Prepared:

					5/27/2015 9: 4	15 am
				Related Organization(s) and		
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2.00	3. 00	4. 00	5. 00	
6.00	G	FSEH	100.00	FSEH - EAST	100.00	6. 00
7. 00	В	FRANCI SCAN ALLI	100.00	FRANCISCAN ALLI	100.00	7. 00
8. 00			0.00		0.00	8. 00
9. 00			0.00		0.00	9. 00
10. 00			0.00		0.00	10.00
100.00	G. Other (financial or	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.
- 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.

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

Provider CCN: 150109 | Period: From 01/01/2014 | To 12/31/2014 | Date/Time Prepare 5/27/2015 9:45 am

OTTICE	. 00313			1	o 12/31/2014	Date/Time Prepared: 5/27/2015 9:45 am
	Net	Wkst. A-7 Ref.				3/2//2013 9. 43 aiii
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
			MENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED OR	GANIZATIONS OR C	LAIMED
	HOME OFFICE CO					
1.00	1, 929, 374					1.00
2.00	1, 533, 821	9				2.00
3. 00 4. 00	5, 252, 355					3.00
4.00	14, 541, 130 483, 327	0				4. 00 4. 01
4.01	-10, 889, 295					4. 01
4. 02	-210, 090					4. 02
4. 04	-556, 193					4. 04
4. 05	-4, 892, 994					4. 05
4. 06	-366, 820					4. 06
4. 07	-1, 254	0				4. 07
4. 08	-9, 632, 473	o o				4. 08
4. 09	-11, 331, 327					4. 09
4. 10	5, 000, 936					4. 10
4. 11	3, 975, 665					4. 11
4. 12	-7, 194, 241	0				4. 12
4.13	-58, 910	0				4. 13
4.14	-149, 682	0				4. 14
4. 15	-75, 501	0				4. 15
4. 16	-17, 823, 511	0				4. 16
4. 17	-1, 336, 416					4. 17
4. 18	-350, 013					4. 18
4. 19	-273, 175					4. 19
4. 20	-64, 510					4. 20
4. 21	-2, 459	0				4. 21
4. 22	-72, 891	_				4. 22 4. 23
4. 23 4. 24	55, 100 368, 864	0				4. 23
4. 24	300, 618					4. 24
4. 26	1, 722, 590					4. 26
4. 27	1, 454, 804					4. 27
4. 28	1, 330, 285					4. 28
4. 29	407, 086					4. 29
4. 30	136, 150					4. 30
4. 31	459, 505					4. 31
4.32	1, 380, 834					4. 32
4.33	-74, 494	0				4. 33
4.34	926, 707	0				4. 34
4. 35	-50, 448					4. 35
4. 36	-254, 196					4. 36
4. 37	-516, 056					4. 37
4. 38	-77, 298					4. 38
4. 39	184, 660					4. 39
4.40	-63, 759					4. 40
4. 41	-41, 207	0				4. 41
4.42	-11, 966					4. 42
4. 43 5. 00	3, 605 -24, 923, 763					4. 43 5. 00
3.00	-24, 723, 703					5.00

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

	Organization(s) Home Office		
Туре	of Business		
	6. 00		
B. INTERREL	ATIONSHIP TO RELATE	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.

	SISTER FACILITY	6. 00
7.00	HOME OFFICE	7. 00
8.00		8. 00

Health Financial Systems	ST. ELI ZABETH I	In Lieu of Form CMS-2552-10			
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 150109	Peri od:	Worksheet A-8-	-1
OFFICE COSTS			From 01/01/2014		
			To 12/31/2014		pared:
				5/27/2015 9: 4	o am
Related Organization(s)					
and/or Home Office					
Type of Business					
6. 00					
9. 00					9. 00
10. 00					10.00
100.00					100.00

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.
 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization. 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

						12/31/2014	5/27/2015 9:4	
	Wkst. A Line #	,	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	Hours 7.00	
1. 00		OTHER ADMINISTRATIVE AND	33, 600	0	33, 600	171, 400	242	1. 00
		GENERAL	•					
2.00	5. 06	OTHER ADMINISTRATIVE AND	75, 833	0	0	171, 400	0	2. 00
2 00	F 0/	GENERAL	117 200		0	171 400		2 00
3. 00	5.06	OTHER ADMINISTRATIVE AND GENERAL	117, 200	0	U	171, 400	0	3. 00
4.00	5. 06	OTHER ADMINISTRATIVE AND	2, 670, 590	1, 703, 702	966, 888	171, 400	16, 309	4. 00
		GENERAL	,	,		,		
5.00	5. 06	OTHER ADMINISTRATIVE AND	281, 217	0	0	171, 400	0	5. 00
	15.00	GENERAL	1 250		0	171 400		/ 00
6. 00 7. 00	•	PHARMACY MEDICAL RECORDS & LIBRARY	1, 350 30, 186		0	171, 400 171, 400	0	6. 00 7. 00
8. 00		ADULTS & PEDIATRICS	42, 900		0	154, 100	0	8. 00
9. 00	•	ADULTS & PEDIATRICS	12, 000		0	154, 100	0	9. 00
10. 00	•	ADULTS & PEDIATRICS	14, 400		14, 400	154, 100	170	10. 00
11. 00		NEONATAL INTENSIVE CARE UNIT	264, 000		108, 000	152, 100	776	
12. 00		SUBPROVI DER - I RF	109, 562	o o	109, 562	171, 400	1, 692	12. 00
13. 00		OPERATING ROOM	60, 000	o o	0	204, 100	0	13. 00
14.00		RADI OLOGY-DI AGNOSTI C	1, 953, 835	0	96, 725	231, 100	370	14. 00
15. 00		LABORATORY	112, 000	0	112, 000	219, 500	660	
16.00	65.00	RESPI RATORY THERAPY	32, 400		32, 400	171, 400	216	16. 00
17.00	69.00	ELECTROCARDI OLOGY	282, 777	0	0	159, 800	0	17. 00
18.00	69. 00	ELECTROCARDI OLOGY	8, 822	0	0	159, 800	0	18. 00
19.00	70.00	ELECTROENCEPHALOGRAPHY	18, 000	0	18, 000	171, 400	158	19.00
20.00		DI ABETES CENTER	12, 225	0	12, 225	171, 400	80	20.00
21.00	91.00	EMERGENCY	1, 800	0	0	171, 400	0	21.00
22.00		WOUND CARE	3, 750	0	3, 750	159, 800	40	22. 00
23.00	95. 00	AMBULANCE SERVICES	11, 250		11, 250		77	23. 00
200.00			6, 149, 697	1, 703, 702			20, 790	200. 00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8. 00	9. 00	Education 12.00	12 13. 00	14. 00	
1. 00		OTHER ADMINISTRATIVE AND	19, 942	997	0		0	1. 00
		GENERAL	,					
2.00	5. 06	OTHER ADMINISTRATIVE AND	0	0	0	0	0	2. 00
		GENERAL						
3. 00	5. 06	OTHER ADMINISTRATIVE AND	0	0	0	0	0	3. 00
4 00	F 0/	GENERAL	1 242 024	/7 10/	0			4 00
4. 00	5.06	OTHER ADMINISTRATIVE AND GENERAL	1, 343, 924	67, 196	0	0	0	4. 00
5.00	5.06	OTHER ADMINISTRATIVE AND	0	0	0	0	0	5. 00
0.00	0.00	GENERAL	Ĭ	Ŭ	Ö		Ĭ	0.00
6.00	15. 00	PHARMACY	0	0	0	0	0	6. 00
7. 00		MEDICAL RECORDS & LIBRARY	0	0	0	0	0	7. 00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	8. 00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	9. 00
10.00	30.00	ADULTS & PEDIATRICS	12, 595	630	0	0	0	10.00
11. 00	35.00	NEONATAL INTENSIVE CARE UNIT	56, 745	2, 837	0	0	0	11. 00
12.00		SUBPROVI DER - I RF	139, 427	6, 971	0	0	0	12.00
13.00		OPERATING ROOM	0	0	0	0	0	13. 00
14. 00		RADI OLOGY-DI AGNOSTI C	41, 109	2, 055	0	0	0	14. 00
15. 00		LABORATORY	69, 649		0	0	0	15. 00
16. 00		RESPI RATORY THERAPY	17, 799		0	0	0	16. 00
17. 00		ELECTROCARDI OLOGY	0	0	0	0	0	17. 00
18. 00		ELECTROCARDI OLOGY	0	0	0	0	0	18. 00
19. 00	1	ELECTROENCEPHALOGRAPHY	13, 020	651	0	0	0	19. 00
20. 00	l .	DI ABETES CENTER	6, 592	330	0	0	0	20.00
21. 00		EMERGENCY	2 072	0	0	0	0	21. 00
22. 00 23. 00		WOUND CARE AMBULANCE SERVICES	3, 073 5, 916	154 296	0	0	0	22. 00 23. 00
200.00	95.00	AWBULANCE SERVICES	1, 729, 791	86, 489	0	0	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	III.St. // Line //	I denti fi er	Component	Li mi t	Di sal I owance	riaj astilierre		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	5. 06	OTHER ADMINISTRATIVE AND	0	19, 942	13, 658	13, 658		1. 00
0.00		GENERAL	_	_	_	75 600		2 22
2.00	5. 06	OTHER ADMINISTRATIVE AND	0	0	0	75, 833		2. 00
3.00		GENERAL				447.000		2 00
	F 04	INTHER ADMINISTRATIVE AND	_ ^	^	/ \	1 1 7 7 7 7 1 1 1		
0.00	5. 06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	117, 200		3. 00

| Peri od: | Worksheet A-8-2 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150109

					רן	To 12/31/2014	Date/Time Pre 5/27/2015 9:4	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	, ., ., ., .,	
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
4.00		OTHER ADMINISTRATIVE AND	0	1, 343, 924	0	1, 703, 702		4. 00
	•	GENERAL				004 047		
5.00		OTHER ADMINISTRATIVE AND	O	0	0	281, 217		5. 00
/ 00	1	GENERAL PHARMACY		0	0	1 250		4 00
6.00		MEDICAL RECORDS & LIBRARY	0	0	0	1, 350		6. 00
7. 00 8. 00		ADULTS & PEDIATRICS	0	0	0	30, 186		7. 00
9. 00		ADULTS & PEDIATRICS	0	0	0	42, 900		8. 00 9. 00
		ADULTS & PEDIATRICS	0	12 505	1 005	12,000		9. 00 10. 00
10. 00 11. 00		NEONATAL INTENSIVE CARE UNIT	0	12, 595				10.00
12.00		SUBPROVIDER - IRF	0	56, 745		207, 255		11.00
12.00		OPERATING ROOM	0	139, 427	0	40.000		12.00
14. 00		RADI OLOGY-DI AGNOSTI C	0	41 100	U FF (1)	60,000		14. 00
15. 00		LABORATORY	0	41, 109	55, 616			15. 00
		RESPI RATORY THERAPY	0	69, 649				16. 00
16. 00 17. 00		ELECTROCARDI OLOGY	0	17, 799	14, 601			17. 00
17.00		ELECTROCARDI OLOGY	0	0	0	282, 777		17. 00
19. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	12 020	4 000	8, 822		19. 00
			0	13, 020				
20. 00 21. 00		DI ABETES CENTER EMERGENCY	0	6, 592	5, 633			20. 00 21. 00
			0	2 072	(77	1, 800		
22. 00		WOUND CARE	0	3, 073		677		22. 00
23. 00		AMBULANCE SERVICES	0	5, 916				23. 00
200.00	1	l	l O	1, 729, 791	195, 910	4, 826, 807		200. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | Part | | Pa Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST. ELIZABETH EAST Provi der CCN: 150109

					To	12/31/2014	Date/Time Prep 5/27/2015 9:4	
				CAPI TAL REL	ATED COSTS		372772013 7.4	Jaiii
			N . E	NEW DIDO 0	NEW MADE	EMBL OVEE	COMMUNICATIONS	
		Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	COMMUNI CATI ONS	
			Allocation	1171	LQUIT	DEPARTMENT		
			(from Wkst A					
			col . 7)	1.00	2.00	4.00	F 01	
	GENER	AL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	5. 01	
1.00		NEW CAP REL COSTS-BLDG & FIXT	15, 086, 114	15, 086, 114				1. 00
2.00		NEW CAP REL COSTS-MVBLE EQUIP	8, 005, 458		8, 005, 458			2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	21, 005, 198	136, 036	72, 347	21, 213, 581	1 222 515	4. 00
5. 01 5. 02	1	COMMUNICATIONS MGMT INFO SYSTEMS	1, 168, 573 1, 261, 037	17, 712 77, 751	9, 420 41, 350	136, 810 0	1, 332, 515 43, 472	5. 01 5. 02
5. 03		PURCHASING	797, 650	222, 756	118, 466	200, 985		5. 03
5.04	1	ADMITTING	425, 266	11, 431	6, 079	144, 962	0	5. 04
5. 05	1	PATIENT ACCOUNTING	2, 329, 116	188, 209	100, 094	286, 127		5. 05
5. 06 7. 00		OTHER ADMINISTRATIVE AND GENERAL OPERATION OF PLANT	22, 454, 869 8, 735, 843	930, 521 2, 491, 793	494, 871 1, 325, 190	1, 770, 139 834, 856		5. 06 7. 00
8. 00		LAUNDRY & LINEN SERVICE	619, 029	106, 469	56, 623	39, 941	1, 890	
9. 00	00900	HOUSEKEEPI NG	1, 905, 643	234, 498	124, 711	448, 241	17, 011	9. 00
10.00		DIETARY	927, 166	425, 933	226, 520	215, 771	56, 703	
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	690, 229 2, 459, 358	309, 250 116, 683	164, 466 62, 055	317, 287 823, 385	0 17, 011	11. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	333, 599		106, 233	139, 553		
15. 00		PHARMACY	2, 627, 458		92, 269	734, 433		
16. 00		MEDICAL RECORDS & LIBRARY	2, 110, 464	89, 464	47, 579	417, 425		
17. 00		SOCIAL SERVICE	431, 171	23, 031	12, 248	147, 147		
20. 00 23. 00		NURSING SCHOOL PARAMEDICAL EDUCATION PROGRAM	818, 805 81, 626		211, 277 1, 715	187, 353 9, 019		20. 00 23. 00
20.00		TENT ROUTINE SERVICE COST CENTERS	01,020	0, 220	1, 710	7,017		20.00
30. 00		ADULTS & PEDIATRICS	11, 193, 279		1, 373, 189	3, 345, 892		
31. 00	1	INTENSIVE CARE UNIT	1, 021, 656		236, 466	779, 214		
35. 00 40. 00	1	NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	1, 553, 694	236, 422 0	125, 734 0	501, 624 0	32, 132	
41. 00		SUBPROVI DER - I RF	1, 025, 896	0	o	309, 207	45, 362	
42.00		SUBPROVI DER	0	0	0	0	0	
43. 00		NURSERY	534, 436	104, 234	55, 434	180, 163	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	22, 606, 796	968, 888	515, 275	1, 083, 163	45, 362	50. 00
51. 00		RECOVERY ROOM	635, 930	91, 445	48, 632	217, 682	15, 121	
52.00		DELIVERY ROOM & LABOR ROOM	3, 138, 446	612, 133	325, 546	1, 057, 999		
54.00		RADI OLOGY-DI AGNOSTI C	11, 579, 986		416, 521	915, 653		
55. 00 56. 00		ULTRA SOUND RADI OI SOTOPE	365, 662 33, 519	25, 238 19, 721	13, 422 10, 488	115, 308 10, 337		55. 00 56. 00
56. 01		CARDI AC CATH LAB	1, 113, 811	310, 551	165, 158	380, 620		56. 01
57. 00	05700	CT SCAN	870, 991	68, 188	36, 264	193, 924		57. 00
58.00	1	MAGNETIC RESONANCE IMAGING (MRI)	425, 835	48, 778	25, 941	73, 011	0	58. 00
60. 00 65. 00	1	LABORATORY RESPI RATORY THERAPY	6, 579, 907 1, 567, 737	295, 329 204, 280	157, 062 108, 641	16, 160 480, 731	83, 164 64, 263	
66. 00		PHYSI CAL THERAPY	2, 112, 597			691, 089		
67. 00	06700	OCCUPATI ONAL THERAPY	181, 392	0	0	53, 164	0	67. 00
68.00	1	SPEECH PATHOLOGY	108, 465	24, 361	12, 956	36, 240		
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	1, 218, 408 248, 866	274, 194 35, 395	145, 822 18, 824	333, 379 61, 981	11, 341	69. 00 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 083, 953	0	0	01, 781	Ö	
72. 00		IMPL. DEV. CHARGED TO PATIENT	15, 073, 089	0	0	0	0	72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	5, 637, 564	0	0	0	0	73. 00
73. 01 74. 00	1	DI ABETES CENTER RENAL DI ALYSI S	264, 546 323, 620	0 110, 770	0 58, 910	86, 940 10, 199		
76. 98	1	HYPERBARI C OXYGEN THERAPY	92, 246	110,770	38, 410	10, 199	0	
		TIENT SERVICE COST CENTERS			-			
88. 00		RURAL HEALTH CLINIC	0	0	0	0	0	
89. 00 90. 00	1	FEDERALLY QUALIFIED HEALTH CENTER	0 605, 125	0	0	0 89, 087	0 60, 483	89. 00 90. 00
90.00		EMERGENCY	5, 012, 711	1, 313, 476	698, 535	1, 689, 178		90.00
91. 01		WOUND CARE	293, 945	68, 754	36, 565	98, 395		91. 01
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92. 01		OBSERVATION BEDS (DISTINCT PART)	1, 090, 291	0	0	372, 273	0	92. 01
95 NN		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	695, 420	25, 238	13, 422	183, 116	0	95. 00
	09910		0	23, 230	0	0		99. 10
101.00		HOME HEALTH AGENCY	3, 527, 621	0	0	878, 026	0	101. 00
100.00		AL PURPOSE COST CENTERS						109. 00
		PANCREAS ACQUISITION INTESTINAL ACQUISITION		0	0	0		1109.00
		I SLET ACQUISITION		Ö	Ö	Ö		111. 00

Health Financial Systems	ST. ELI ZABETI	H EAST	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Peri od: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Pre 5/27/2015 9:4	
·		CAPITAL RELATED COSTS			

			10) 12/31/2014	5/27/2015 9:4	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE		COMMUNI CATI ONS	
	for Cost	FLXT	EQUI P	BENEFI TS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col . 7)					
	0	1. 00	2. 00	4. 00	5. 01	
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	391, 653	33, 217		85, 323	1	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	209, 482, 765	14, 984, 879	7, 951, 619	21, 182, 512	1, 332, 515	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	34, 615	42, 073	22, 375	2, 444	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
194. 00 07950 MOB	60, 631	0	0	20, 787		194. 00
194. 01 07951 LI FELI NE	51, 851	59, 162	31, 464	4, 076		194. 01
194. 02 07952 PATIENT TRANSPORT	15, 811	0	0	835	l e	194. 02
194.03 07953 SETON LEASE 1 NORTH	11, 871	0	0	2, 927	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0	l e	201. 00
202.00 TOTAL (sum lines 118-201)	209, 657, 544	15, 086, 114	8, 005, 458	21, 213, 581	1, 332, 515	202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part
To 12/31/2014	Date/Time Prepared:
5/27/2015 9:45 am	Provi der CCN: 150109

The company of the content of the) 12/31/2014	5/27/2015 9: 4	
STREAM SERVICE COST - PROTECTION S. 0.00		Cost Center Description		PURCHASI NG	ADMITTI NG			
THE PAIR SERVICE COST CENTERS					5.04			
1.00 00100 NEW CAP PICE LOSS SEUDE & H N		CENEDAL CEDALCE COCT CENTEDS	5. 02	5. 03	5. 04	5. 05	5A. 05	
2.00 DOUGOU DEL CONTROL COSTS SAMURE EQUITY 1,423.510 5.00 1.00	1 00							1 00
4.00 0.000 PART OVER PRIFET TS PERATMENT								
11-10 COMMINICATI NOS 1, 423, 616 1, 423, 616 1, 423, 616 1, 425, 616 1,								
1.4274.610 1.400CMSMS INC 1.4274.610		l l						
0.0550 RURCHASH IN 0.01 0.0750 RURCHASH IN 0.01 0.0750 0.0750 0.0750 0.0750 0.0750 0.0750 0.05			1, 423, 610					
0.00 0.00				1, 386, 500				
5.06 0.0560 OTHER ADMINISTRATIVE AND CENERAL 77, 708 1, 147 0 0.0560 CARREST SERVICE 5.974 7.06 0.0 0.0 25, 887, 322 5.06 8.00 0.0500 LAURGEY & LINEN SERVICE 5.974 7.06 0.0 0.0 2.96, 934 8.00 11.00 0.01 0.01 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 0.01 0.01 0.01 0.01 11.00 0.01 0.01 0.01 0.01 0.01 0.01 0.01 0.01 0.01 11.00 0.01	5.04		15, 692					5. 04
2,00 00000 DOPERATION OF PLANT 70, 241 938 0 0 13, 562, 816 7.00	5.05	00580 PATIENT ACCOUNTING	33, 281	280	0	2, 963, 568		5. 05
B.00 0.0800 AJNORY & I.NEN SERVICE 5.874 108 0 0 2.795.29 38 8.00 0.0000 0.0000 1.7147 1.8972 2.999 0 0 1.7257 1.900 1.000 1.0000 1.7147 1.8972 2.999 0 0 1.7257 1.900 1.1000 1.1	5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	97, 708	1, 147	0	0	25, 887, 232	5. 06
9.00 0.9900 MUSERCEPH NO	7.00	00700 OPERATION OF PLANT	70, 241	938	0	0	13, 562, 816	7. 00
10.00 01000 DETARY	8.00	00800 LAUNDRY & LINEN SERVICE	5, 874	108	0	0	829, 934	8. 00
11.00 0 1100 CAFETERIA	9.00	00900 HOUSEKEEPI NG	63, 126	2, 005	0	0	2, 795, 235	9. 00
13.00 01300 MURS NR. AMIN ISTRATION			l			0		
14.00 01400 CENTRAL SERVICES & SUPPLY 15.977 37.065 0 0 839, 740 14.00 15.00			l	522		0		
15.00 01500 PMANMACY 33, 254 9, 991 0 0 3, 174, 274 15, 00 17.00 01700 SCI, ALSENI CE 10, 927 0 0 0 0 2, 730, 253 16, 00 17.00 02, 00 2000 0200 MISSING SCHOLATION PROGRAM 2, 5558 0 0 0 0 1, 25, 199 20, 00 2000 MISSING SCHOLATION PROGRAM 2, 5558 0 0 0 0 1, 25, 199 20, 00 2000 2000 PARAMAEDI CAL EDUCATION PROGRAM 2, 5558 0 0 0 0 0 1, 25, 199 20, 00 20, 20, 20, 20, 20, 20, 20, 20, 20, 20,			1	2		0		
16.00 01-000 MEDI CAL RECORDS & LIBRARY 33, 182			1 · · · · · · · · · · · · · · · · · · ·			0		
17.00 01700 SOCIAL SERVICE 10,927 0 0 0 641,535 17.00 23.00 0200 MIRSI NOS CHORDATION PROGRAM 2,555 0 0 0 0 641,673 17.00 23			1	9, 891	0	0		
20. 00 02000 MURSINS SCHOOL 14, 483 0 0 0 1, 629, 189 20, 20 20,		1	1	7	0	0		
23.00			1	0		-		
INPATI ENT ROUT IN SERVICE COST CENTERS 205,745 28,115 35,353 173,524 19,154,002 30,0 0 31,00 0 3000 (ABUITS & PERINSIVE CARE UNIT 68,263 20 8,438 41,418 2,641,692 31,00 30,0 0 30,0 0 3000 (MONATAL INTENSIVE CARE UNIT 31,246 3,254 8,769 43,040 2,555,915 30,0 0 40,0 0			1	ū		0		
0.00 0.000 0.0000 ADULTS & PEDIATRICS 205, 245 28, 115 35, 353 173, 524 19, 154, 002 30. 00 31. 00 0.0000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000000	23.00		2, 555	U	l o	υĮ	98, 140	23.00
31.00 03100 INTENSIVE CARE UNIT 68, 263 20 8, 438 41, 418 2, 641, 692 31, 00 0300 04000 040000 040000 040000 040000 040000 040000 040000 040000 0400000 0400000000	30 00		205 245	20 11E	25 252	172 524	10 154 002	30 00
15 00 02000 NEOMATAL INTENSIVE CARE UNIT 31,246 3,254 8,769 43,040 2,535,915 35,000 0								
40, 00 04000 04000 04000 0400 0400 0400 0400 0400 0400 041000 041000 04100 04100 04100 04100 04100 04100 04100 04100 04100 04100		i i						
11.00 04100 SUBPROVI DER 1 1 1 1 1 2 1 3 0 0 0 0 0 0 0 0 0		1 1	1	3, 234 N		43, 040		
A2 00 04200 NURSERY 10, 433 2, 427 2, 270 11, 140 90, 537 43.			1 -1	1 201	l ~	10 490		
13. 00 04300 NURSERY 10, 433 2, 427 2, 270 11, 140 900, 537 43. 00			1 ' 1	1, 201		10, 170		
ANCILLARY SERVICE COST CENTERS Service S		1 1	10, 433	2. 427	2, 270	11. 140		
50.00			127.122		_,,	,		
Section Continue	50.00		67, 867	906, 352	110, 232	542, 728	26, 846, 663	50.00
54 00 05400 RADIO LOCY-DI AGNOSTIC 61,423 96,682 52,161 256,026 14,275,054 54,005 50 0 03500 UITAR SOLIND 55,236 997 4,334 21,271 551,438 55,00 056,01 03950 CARDIAC CATH LAB 2,773,977 56,01 13,000 03950 CARDIAC CATH LAB 2,773,977 56,01 13,000 150700 CT SCAN 12,703 151,734 18,719 18,81 2,273,977 56,01 13,000 150700 CT SCAN 13,000	51.00	05100 RECOVERY ROOM	10, 443	1, 507				51.00
55.00 03630 ULTRA SOUND 5, 236 967 4, 334 21, 271 551, 438 55.00 56.00 03600 RADIO ISOTOPE 583 0 0 0 0 0, 74, 648 56.00 56.00 03950 CARDIO ISOTOPE 583 0 0 0 0 0, 74, 648 56.00 56.00 03950 CARDIO IAC CATH LAB 21, 703 171, 534 18, 719 91, 881 2, 273, 977 56.01 57.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	61, 273	14, 254	13, 717	67, 328	5, 339, 838	52. 00
56. 00 05600 RADIO I SOTOPE 583	54.00	05400 RADI OLOGY-DI AGNOSTI C	61, 423	96, 682	52, 161	256, 026	14, 275, 054	54.00
56. 0 03950 CARDIAC CATH LAB	55.00	03630 ULTRA SOUND	5, 236	967	4, 334	21, 271	551, 438	55. 00
57.00 05700 CT SCAN 10,693 5,018 31,939 156,768 1,373,785 57.00	56.00	05600 RADI OI SOTOPE	583	0	0	0	74, 648	56. 00
S80 0 0 0 0 0 0 0 0 0	56. 01	03950 CARDI AC CATH LAB	21, 703	171, 534	18, 719	91, 881	2, 273, 977	56. 01
60.00 06500 CABORATORY 1, 336 40, 556 49, 069 240, 847 7, 463, 430 60, 065 60 06500 RESPIRATORY THERAPY 31, 937 13, 688 5, 103 25, 048 2, 501, 428 65, 00 6600 PHYSI CAL THERAPY 23, 920 20 7, 105 34, 876 3, 109, 354 66, 00 6600 0600 07000 0700 0700 0700 0700 0700 0700 0700 0700 070000 07000 070000 070000 07000 070000 070000 070000	57.00	05700 CT SCAN	10, 693	5, 018	31, 939	156, 768	1, 373, 785	57. 00
65.00 06500 RESPI RATORY THERAPY 31, 937 13, 688 5, 103 25, 048 2, 501, 428 65, 00 66.00 06600 PHYSI CAL THERAPY 23, 920 20 7, 105 34, 876 3, 109, 354 66. 00 67.00 06700 OCCUPATI (MAL THERAPY 3, 634 0 1, 129 5, 540 244, 859 67. 00 68.00 06600 SPEECH PATHOLOGY 1, 680 0 225 1, 104 185, 031 68.00 06600 ELECTROCRORI OLLOGY 21, 434 983 14, 108 69, 249 2, 088, 918 69. 00 70.00 07000 CLECTROCRORI OLLOGY 21, 434 983 14, 108 69, 249 2, 088, 918 69. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 72, 758 357, 123 14, 513, 834 71. 00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 53, 376 261, 988 15, 388, 453 72. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 43, 781 214, 892 5, 896, 237 73. 00 73.01 07300 DRUGS CHARGED TO PATI ENTS 0 0 43, 781 214, 892 5, 896, 237 73. 00 74.00 07400 RENAL DI ALYSIS 692 0 777 3, 812 508, 780 74. 00 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 404 1, 984 94, 634 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 79.00 09000 CLURIC 00, 60 0 0 0 0 79.00 09000 CLURIC 00, 60 0 0 0 79.00 09000 EDERRALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 79.00 09000 EDERRALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 79.00 09000 09000 EDERRALLY OBSERVATION BEDS (DISTINCT PART) 21, 849 2, 237 4, 967 24, 377 1, 515, 994 79.00 09200 DRISERVATION BEDS (DISTINCT PART) 21, 849 2, 237 4, 967 24, 377 1, 515, 994 79.00 09900 OCRF 0 0 0 0 0 0 0 79.00 09000 0100	58. 00		3, 425	793	9, 549		634, 202	58. 00
66.00 06600 PHYSI CAL THERAPY 23, 920 20 7, 105 34, 876 3, 109, 354 66, 00 67. 00 06700 0CCUPATI ONAL THERAPY 3, 634 0 1, 129 5, 540 244, 859 67. 00 68.00 06800 SPECH PATHOLOGY 1, 680 0 225 1, 104 185, 031 68. 00 06800 SPECH PATHOLOGY 21, 434 983 14, 108 69, 249 2, 088, 918 69, 00 0700 CONORO ELECTROCARDI OLOGY 9, 286 940 1, 288 6, 321 382, 901 70. 00 70.00 10700 ELECTROCHORI OLOGY 9, 286 940 1, 288 6, 321 382, 901 70. 00 70.00 10700 ELECTROCHORI OLOGY 72, 758 357, 123 14, 513, 834 71. 00 72. 00 70.00 10700 ELECTROCHORI OLOGY 72. 00 72. 758 357, 123 14, 513, 834 71. 00 73. 00 70.00 10700 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 3, 761 261, 988 15, 388, 453 72. 00 73. 00 70.00 70.00 PHYSI CALL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 4.7 81. 214, 892 5, 896, 237 73. 00 73. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0	60.00	1	1, 336	40, 556	49, 069	240, 847	7, 463, 430	60.00
67.00 06700 05CUPATI ONAL THERAPY 3, 634 0 1, 129 5, 540 244, 859 67, 00 68.00 06800 SPEECH PATHOLOGY 1, 680 0 225 1, 104 185, 031 68.00 070.00 070.00 O70.00 O		i i	1 · · · · · · · · · · · · · · · · · · ·	13, 688				
68.00 06800 SPECH PATHOLOGY 1,680 0 225 1,104 185,031 68.00 70.00 06900 ELECTROCARDIOLOGY 21,434 983 14,108 69,249 2,088,918 69.00 70.00 07000 ELECTROCARDIOLOGY 9,286 940 1,288 6,321 382,901 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 72,758 357,123 14,513,834 71.00 72.00 72.00 IMPL DEV. CHARGED TO PATIENTS 0 0 0 53,376 261,988 15,388,453 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 43,781 214,892 5,896,237 73.00 73.01 07301 DIABETES CENTER 5,609 154 184 902 369,676 73.01 74.00 7400 RENAL DIALYSIS 692 0 777 3,812 508,780 74.00 7400 RENAL DIALYSIS 692 0 777 3,812 508,780 74.00 7400 RENAL DIALYSIS 692 0 777 3,812 508,780 74.00 7400 RENAL DIALYSIS 692 0 777 3,812 508,780 74.00 7400 RENAL DIALYSIS 692 0 777 3,812 508,780 74.00 7400 RENAL DIALYSIS 692 0 777 3,812 508,780 74.00 7400 RENAL DIALYSIS 74.00 74			1					
69.00 06900 ELECTROCARDI OLOGY 21,434 983 14,108 69,249 2,088,918 69,00 70.0		1	1	0				
70. 00 07000 ELECTROENCEPHALOGRAPHY 9, 286 940 1, 288 6, 321 382, 901 70. 00 70. 0			1	0				
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72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0 0 53,376 261,988 15,388,453 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 43,781 214,892 5,896,237 73. 00 73. 01 07301 DIABETES CENTER 5,609 154 184 902 369,676 73. 01 74. 00 07400 RENAL DIALYSIS 692 0 777 3,812 508,780 74. 00 76.98 HYPERBARI C OXYGEN THERAPY 0 0 404 1,984 94. 634 76. 98 76.98 100			1					
73. 01 07301 DRUGS CHARGED TO PATIENTS 0 0 43, 781 214, 892 5, 896, 237 73. 00 73. 01 07301 DI ABETES CENTER 5, 609 154 184 902 369, 676 73. 01 74. 00 07400 RENAL DI ALYSIS 692 0 7777 3, 812 508, 780 74. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 404 1, 984 94, 634 76. 98 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 88. 00 90. 00 09000 CLINIC 0 10, 455 2, 748 585 2, 870 771, 353 90. 00 91. 00 09100 EMERGENCY 107, 673 36, 665 34, 098 167, 365 9, 059, 701 91. 00 91. 01 04950 WOUND CARE 11, 682 0 1, 157 5, 680 516, 178 91. 01 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 21, 849 2, 237 4, 967 24, 377 1, 515, 949 22. 01 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 21, 849 2, 237 4, 967 24, 377 1, 515, 949 22. 01 95. 00 09900 AMBULANCE SERVICES 14, 129 0 2, 237 11, 641 945, 338 95. 00 99. 10 09910 COFF 0 0 0 0 0 0 0 0 0 0 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 52, 717 4, 108 5, 502 27, 005 4, 494, 979 101. 00 109. 00 10900 PANCREAS ACQUI SITION 0 0 0 0 0 0 0 0 1010. 00 110. 00 11000 INTESTI NAL ACQUI SITION 0 0 0 0 0 0 0 0 111. 00 111. 00 11300 INTEREST EXPENSE 118. 00 NONREI MEURSABLE COST CENTERS			0	0	. =,			
73. 01 07301 DI ABETES CENTER 5,609 154 184 902 369,676 73. 01 74. 00 07400 RENAL DI ALYSIS 692 0 777 3,812 508,780 74. 00 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0			0	0				
74. 00 07400 RENAL DIALYSIS 692 0 777 3,812 508,780 74. 00 70698 HYPERBARI C OXYGEN THERAPY 0 0 0 404 1,984 94,634 76. 98			5 600	154				
76. 98			1	154		•		
SERVICE COST CENTERS SERVICE SERVICE COST CENTERS SERVICE SERVICE COST CENTERS SERVICE S				0				
88. 00	, 5. 70		<u> </u>		1 +04	1, 704	74, 034	, 5. 75
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	88. 00		n	n	n	n	n	88. nn
90. 00		l l		0		o o		
91. 00			10, 455	2, 748	-	2, 870		
91. 01 04950 WOUND CARE 91. 01 04950 WOUND CARE 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 09200 OBSERVATI ON BEDS (DISTINCT PART) 21, 849 2, 237 4, 967 24, 377 1, 515, 994 92. 01 07 07 07 07 07 07 07 07 07 07 07 07 07	91.00							
92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 21,849 2,237 4,967 24,377 1,515,994 92. 01	91. 01		11, 682	0			516, 178	91. 01
OTHER REIMBURSABLE COST CENTERS 14, 129 0 2, 372 11, 641 945, 338 95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
95. 00	92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	21, 849	2, 237	4, 967	24, 377	1, 515, 994	92. 01
99. 10		OTHER REIMBURSABLE COST CENTERS						
101. 00		09500 AMBULANCE SERVI CES	14, 129	0	2, 372	11, 641	945, 338	95. 00
SPECIAL PURPOSE COST CENTERS				0	-	0	0	99. 10
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109. 00 110. 00 110. 00 110. 00 110. 00 1110. 00 1110. 01 1100 INTESTINAL ACQUISITION 0 0 0 0 0 0 1110. 00 1110. 01 110	101.00		52, 717	4, 108	5, 502	27, 005	4, 494, 979	101. 00
110. 00								
111. 00		1 1	0	0	0	0		
113. 00		1 1	1	0	0	0		
116. 00 11600 HOSPI CE 3, 878 0 606 2, 975 517, 652 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 1, 418, 982 1, 386, 499 603, 442 2, 963, 568 209, 291, 993 118. 00 NONREI MBURSABLE COST CENTERS			0	0	0	0	0	
118. 00 SUBTOTALS (SUM OF LINES 1-117) 1, 418, 982 1, 386, 499 603, 442 2, 963, 568 209, 291, 993 118. 00 NONREI MBURSABLE COST CENTERS							=1= :::	
NONREI MBURSABLE COST CENTERS				0				
	118.00		1, 418, 982	1, 386, 499	603, 442	2, 963, 568	209, 291, 993	118.00
אסטטטן טורו, רבטייבא, טעררבב אחטר מ טאוובבויין ען ען ען ען ען ען ען די טון אוויבויין אוויבויין ען אוויבויין ען	100.00			^		ol.	101 507	100 00
	190.00	PITTOOO GITT, I LOWER, COFFEE SHOP & CANTEEN	<u>ı</u> 0	0	ı U	υ	101, 507	1170.00

Health Financial Systems

ST. ELIZABETH EAST

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150109
From 01/01/2014
To 12/31/2014
Date/Time Prepared:

					5/27/2015 9:4	5 am
Cost Center Description	MGMT INFO	PURCHASI NG	ADMI TTI NG	PATI ENT	Subtotal	
	SYSTEMS			ACCOUNTI NG		
	5. 02	5. 03	5. 04	5. 05	5A. 05	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
194. 00 07950 MOB	3, 325	1	0	0	84, 744	194. 00
194. 01 07951 LI FELI NE	557	0	0	0	147, 110	194. 01
194. 02 07952 PATI ENT TRANSPORT	144	0	0	0	16, 790	194. 02
194.03 07953 SETON LEASE 1 NORTH	602	0	0	0	15, 400	194. 03
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	1, 423, 610	1, 386, 500	603, 442	2, 963, 568	209, 657, 544	202. 00

					T	o 12/31/2014	Date/Time Pre 5/27/2015 9:4	
		Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	J alli
			ADMI NI STRATI VE AND GENERAL	PLANT	LINEN SERVICE			
			5. 06	7. 00	8. 00	9. 00	10. 00	
4 00		AL SERVICE COST CENTERS		I	ı			4 00
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	1	COMMUNI CATI ONS						5. 01
5.02		MGMT INFO SYSTEMS						5. 02
5.03	1	PURCHASING						5. 03
5. 04 5. 05	1	ADMITTING PATIENT ACCOUNTING						5. 04 5. 05
5.06		OTHER ADMINISTRATIVE AND GENERAL	25, 887, 232					5.06
7. 00		OPERATION OF PLANT	1, 910, 553					7. 00
8.00	1	LAUNDRY & LINEN SERVICE	116, 910			l		8. 00
9.00		HOUSEKEEPI NG	393, 756			3, 543, 912	0.005.047	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	263, 608			141, 482 102, 724	2, 905, 816 0	1
13. 00		NURSING ADMINISTRATION	215, 504 495, 659			38, 759	0	
14. 00		CENTRAL SERVICES & SUPPLY	118, 292			66, 352	0	
15. 00		PHARMACY	523, 219	243, 833	0	57, 631	0	15. 00
16.00	1	MEDICAL RECORDS & LIBRARY	384, 603			29, 718	0	16. 00
17. 00 20. 00		SOCIAL SERVICE NURSING SCHOOL	90, 371 229, 499	32, 368 558, 326		7, 650 131, 962	0	17. 00 20. 00
23. 00	1	PARAMEDICAL EDUCATION PROGRAM	13, 825				0	23. 00
		TENT ROUTINE SERVICE COST CENTERS	,	.,		.,		
30. 00		ADULTS & PEDIATRICS	2, 698, 167				2, 438, 236	1
31. 00		INTENSIVE CARE UNIT	372, 127			147, 695	267, 779	
35. 00 40. 00		NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	357, 227	332, 268 0		78, 532 0	0	35. 00 40. 00
41. 00		SUBPROVIDER - I RF	198, 608	1	_	o	199, 801	41. 00
42. 00		SUBPROVI DER	0	Ö	0	o	0	1
43.00		NURSERY	126, 856	146, 491	40, 393	34, 623	0	43. 00
FO 00		LARY SERVICE COST CENTERS	2 701 0/0	1 2/1 /70	100 201	221 027		F0 00
50. 00 51. 00	1	OPERATING ROOM RECOVERY ROOM	3, 781, 868 149, 809			321, 836 30, 375	0	
52. 00	1	DELIVERY ROOM & LABOR ROOM	752, 207			203, 333	0	52. 00
54.00		RADI OLOGY-DI AGNOSTI C	2, 010, 884	1, 100, 708	67, 476	260, 155	0	54. 00
55. 00	1	ULTRA SOUND	77, 679			8, 383	0	55. 00
56. 00 56. 01	1	RADI OI SOTOPE CARDI AC CATH LAB	10, 515 320, 328			6, 551 103, 156	0	56. 00 56. 01
57. 00	1	CT SCAN	193, 521	95, 831		22, 650	0	57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	89, 338			16, 203	0	•
60.00		LABORATORY	1, 051, 351	415, 057		98, 100	0	60. 00
65. 00	1	RESPI RATORY THERAPY	352, 369				0	65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	438, 005 34, 493		15, 234 0	49, 529	0	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	26, 065	l .		8, 092	0	68. 00
69. 00		ELECTROCARDI OLOGY	294, 260			91, 079	0	69. 00
		ELECTROENCEPHALOGRAPHY	53, 938			11, 757	0	•
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	2, 044, 520			0	0	
73.00		DRUGS CHARGED TO PATIENTS	2, 167, 725 830, 585		0	0	0	72. 00 73. 00
73. 01		DI ABETES CENTER	52, 075		Ö	o	0	1
74. 00		RENAL DIALYSIS	71, 670			36, 794	0	74. 00
76. 98		HYPERBARI C OXYGEN THERAPY	13, 331	0	0	0	0	76. 98
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	1	0	0	O	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	Ö		ő	0	
90.00		CLI NI C	108, 658	0	0	0	0	1
91.00		EMERGENCY	1, 276, 213			436, 299	0	1
91. 01		WOUND CARE	72, 712	96, 627	0	22, 838	0	91. 01
92. 00 92. 01		OBSERVATION BEDS (NON-DISTINCT PART) OBSERVATION BEDS (DISTINCT PART)	213, 554	0	0	o	0	92. 00 92. 01
72.01		REIMBURSABLE COST CENTERS	210,001			<u> </u>		72.01
95.00		AMBULANCE SERVICES	133, 167	35, 469		8, 383	0	1
99. 10	1	l control of the cont	0	0		0	0	
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	633, 194	0	0	0	0	101. 00
109.00		PANCREAS ACQUISITION	0	0	0	O	0	109. 00
110.00	11000	INTESTINAL ACQUISITION	0	o		o	0	110. 00
		I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
		I NTEREST EXPENSE HOSPI CE	72, 920	46, 683	_	11, 034	0	113. 00 116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25, 835, 738					
2.30	1		, , , , , , , , ,	, ., , ,	, , . , . , . ,		,	

Health Financial Systems	ST. ELIZABETH E	EAST	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE	COSTS	Provider CCN: 150109	From 01/01/2014	Worksheet B Part I Date/Time Prepared:

			'		5/27/2015 9:4	
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5. 06	7. 00	8. 00	9. 00	10.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 299	59, 129	0	13, 975	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194. 00 07950 MOB	11, 938	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	20, 723	83, 147	0	19, 652	0	194. 01
194. 02 07952 PATIENT TRANSPORT	2, 365	0	0	0	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	2, 169	0	0	0	0	194. 03
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)	25, 887, 232	15, 473, 369	1, 096, 476	3, 543, 912	2, 905, 816	202.00

			10	12/31/2014	Date/lime Pre 5/27/2015 9:4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11.00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 01160 COMMUNI CATIONS 5. 02 01140 MGMT I NFO SYSTEMS						5. 01 5. 02
5. 03 00550 PURCHASI NG						5. 02
5. 04 00570 ADMI TTI NG						5. 04
5. 05 00580 PATIENT ACCOUNTING		•				5. 05
5.06 00560 OTHER ADMINISTRATIVE 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 10. 00 01000 DI ETARY						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	2, 282, 689					10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	87, 216					13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	34, 718		1, 451, 825			14. 00
15. 00 01500 PHARMACY	72, 261	0	0	4, 611, 218		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	72, 103	0	0	0	3, 342, 411	16. 00
17. 00 01700 SOCIAL SERVICE	23, 744	0	0	0	0	17. 00
20. 00 02000 NURSI NG SCHOOL	31, 472	0	0	0	0	20.00
23. 00 02301 PARAMEDI CAL EDUCATI ON PROGRAM	5, 552	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	445, 991	1, 405, 012	0	0	195, 722	30.00
31. 00 03100 NTENSI VE CARE UNI T	148, 334	359, 742		0	46, 716	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	67, 896	164, 662	Ö	0	48, 546	35. 00
40. 00 04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	33, 904	94, 028	0	0	11, 832	41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NURSERY	22, 670	20, 304	0	0	12, 565	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	147 472	257 001		0	/11 000	FO 00
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM	147, 473 22, 692	357, 981 55, 034	0	0	611, 882 40, 024	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	133, 144	117, 509		0	75, 941	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	133, 470	0	0	0	288, 779	54. 00
55. 00 03630 ULTRA SOUND	11, 377	0	0	0	23, 993	55. 00
56. 00 05600 RADI 0I SOTOPE	1, 267	3, 073		0	0	56. 00
56. 01 03950 CARDI AC CATH LAB	47, 161	114, 376		0	103, 635	56. 01
57. 00 05700 CT SCAN	23, 235	0	0	0	176, 823	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 60.00 06000 LABORATORY	7, 443 2, 903	0	0 0	0	52, 865 271, 658	58. 00 60. 00
65. 00 06500 RESPI RATORY THERAPY	69, 398	168, 304	0	0	28, 252	65.00
66. 00 06600 PHYSI CAL THERAPY	51, 977	120, 408	·	Ö	39, 337	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	7, 896	86, 653		0	6, 249	67. 00
68. 00 06800 SPEECH PATHOLOGY	3, 651	8, 855	0	0	1, 245	68. 00
69. 00 06900 ELECTROCARDI OLOGY	46, 576			0	78, 107	
70. 00 07000 ELECTROENCEPHALOGRAPHY	20, 179			0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	696, 876 754, 949	0	402, 808 295, 503	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	734, 747	4, 611, 218	242, 382	73. 00
73. 01 07301 DI ABETES CENTER	12, 189	29, 561	Ö	0	1, 017	73. 01
74.00 07400 RENAL DIALYSIS	1, 505		0	0	4, 300	74. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	2, 238	76. 98
OUTPATIENT SERVICE COST CENTERS	_					
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 22, 718	0	0	0	0 3, 237	89. 00 90. 00
91. 00 09100 EMERGENCY	233, 972	598, 476	0	0	188, 776	91.00
91. 01 04950 WOUND CARE	25, 385			Ö	6, 407	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	47, 477	0	0	0	27, 496	92. 01
OTHER REIMBURSABLE COST CENTERS		75.053		al	10 100	
95. 00 O9500 AMBULANCE SERVICES	30, 703	75, 257	0	0	13, 130	
99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY	114, 553	277, 816	0	0	0 30, 460	99. 10
SPECIAL PURPOSE COST CENTERS	114, 555	277,010	<u> </u>	0	30, 400	101.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	o	0	110. 00
111.00 11100 I SLET ACQUISITION	0	0	0	O	0	111. 00
113. 00 11300 INTEREST EXPENSE						113.00
116. 00 11600 H0SPI CE	8, 426			4 / 11 210		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 272, 631	4, 304, 251	1, 451, 825	4, 611, 218	3, 342, 411	1110.00

Health Financial Systems ST. ELIZABETH EAST In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150109 | Period: From 01/01/2014 | Part I

			Т	o 12/31/2014	Date/Time Pre 5/27/2015 9:4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194. 00 07950 MOB	7, 225	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	1, 211	0	0	0	0	194. 01
194. 02 07952 PATIENT TRANSPORT	313	0	0	0	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	1, 309	0	0	0	0	194. 03
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)	2, 282, 689	4, 304, 251	1, 451, 825	4, 611, 218	3, 342, 411	202. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part | To | 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150109

					o 12/31/2014	Date/Time Prep 5/27/2015 9:45	
	Cost Center Description	SOCIAL SERVICENU	JRSING SCHOOL		Subtotal	Intern &	J alli
				EDUCATION PROGRAM		Residents Cost & Post	
				1 KOOKAWI		Stepdown	
		17. 00	20.00	23. 00	24.00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	17. 00	20.00	20.00	21.00	20.00	
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
2. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	01140 MGMT INFO SYSTEMS						5. 02
5. 03 5. 04	00550 PURCHASI NG 00570 ADMI TTI NG						5. 03 5. 04
5. 05	00580 PATIENT ACCOUNTING						5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	705 440					16. 00 17. 00
20. 00	02000 NURSI NG SCHOOL	795, 668 0	2, 580, 448				20. 00
23. 00	02301 PARAMEDICAL EDUCATION PROGRAM	0	0				23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	FOF 422	2 500 440		24 207 501	1 204 027	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	595, 432 73, 421	2, 580, 448 0	0			30. 00 31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	58, 163	Ö	C		1	35. 00
40.00	04000 SUBPROVI DER - I PF	0	0	C	_	0	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	42, 567	0	0		0 0	41. 00 42. 00
43. 00	04300 NURSERY	26, 085	0	Ö		Ö	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS		0		22 /24 /02		FO 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0	-		1	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	O		1	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0		0	54.00
55. 00 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	0	0		1	55. 00 56. 00
56. 01	03950 CARDI AC CATH LAB	0	0	O		Ö	56. 01
57. 00	05700 CT SCAN	0	0	C	.,,	1	57. 00
58. 00 60. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	0	0	C		0	58. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	0	O	C			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	O		1	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0			67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	C			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	O		0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		1	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	71, 410			73. 00
73. 01	07301 DI ABETES CENTER	0	0	O			73. 01
74. 00 76. 98	07400 RENAL DI ALYSI S 07698 HYPERBARI C OXYGEN THERAPY	0	0	0		1	74. 00 76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	<u> </u>			110,200		70. 70
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0		0	89. 00 90. 00
91. 00	09100 EMERGENCY	0	Ö	51, 711		Ö	91. 00
91. 01	04950 WOUND CARE	0	0	C	759, 112	1	91. 01
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	C	1, 804, 521	0	92. 00 92. 01
	OTHER REIMBURSABLE COST CENTERS				,		
	09500 AMBULANCE SERVI CES 09910 CORF	0	0			0	95. 00 99. 10
	10100 HOME HEALTH AGENCY	0	0				101.00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	0	0		1	109. 00 110. 00
	11100 I SLET ACQUISITION		o	C	0		111. 00
	11300 INTEREST EXPENSE		5	_	(00.015	1	113.00
116.00) 11600 H0SPI CE	0	0	C	680, 365	<u> </u> 0	116. 00

Heal th Finan	cial Systems	ST. ELIZAB	BETH EAST		In Lie	eu of Form CMS-:	2552-10
COST ALLOCAT	FION - GENERAL SERVICE COSTS		Provi der	CCN: 150109	Peri od: From 01/01/2014	Worksheet B Part I	
					To 12/31/2014		
	Cost Center Description	SOCIAL SERVICE	NURSING SCHOOL	PARAMEDI CAL	Subtotal	Intern &	Jaiii
				EDUCATI ON		Residents Cost	
				PROGRAM		& Post	
						Stepdown	
						Adjustments	
		17. 00	20. 00	23. 00	24. 00	25. 00	
118. 00	SUBTOTALS (SUM OF LINES 1-117)	795, 668	2, 580, 448	123, 12	21 209, 054, 538	0	118. 00
	IMBURSABLE COST CENTERS		,				
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 188, 910	l	190. 00
	PHYSICIANS' PRIVATE OFFICES	0	0		0		192. 00
194. 00 07950		0	0		0 103, 907	l e	194. 00
194. 01 07951		0	0		0 271, 843		194. 01
	PATIENT TRANSPORT	0	0		0 19, 468	0	194. 02
194. 03 07953	SETON LEASE 1 NORTH	0	0		0 18, 878	0	194. 03
200. 00	Cross Foot Adjustments		0		0		200. 00
201. 00	Negative Cost Centers	0	0		0	0	201. 00
202. 00	TOTAL (sum lines 118-201)	795, 668	2, 580, 448	123, 12	209, 657, 544	0	202. 00

			5/27/2015 9: 4	5 am
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01160 COMMUNI CATI ONS			5. 01
5.02	01140 MGMT INFO SYSTEMS			5. 02
5.03	00550 PURCHASI NG	İ		5. 03
5.04	00570 ADMI TTI NG			5. 04
5. 05	00580 PATIENT ACCOUNTING			5. 05
5. 06	00560 OTHER ADMINISTRATIVE AND GENERAL			5. 06
7. 00	00700 OPERATION OF PLANT			7.00
	1			8.00
8.00	00800 LAUNDRY & LINEN SERVICE			1
9.00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
13. 00	01300 NURSING ADMINISTRATION			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15.00	01500 PHARMACY			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17.00	01700 SOCIAL SERVICE			17. 00
20.00	02000 NURSI NG SCHOOL			20.00
23. 00	02301 PARAMEDICAL EDUCATION PROGRAM			23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			20.00
20 00	03000 ADULTS & PEDIATRICS	22 101 764		20 00
30. 00 31. 00		33, 101, 764		30.00
	03100 INTENSIVE CARE UNIT	4, 741, 363		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	3, 667, 786		35. 00
40. 00	04000 SUBPROVI DER - I PF	0		40. 00
41. 00	04100 SUBPROVI DER - I RF	2, 011, 451		41. 00
42.00	04200 SUBPROVI DER	0		42. 00
43.00	04300 NURSERY	1, 330, 524		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATI NG ROOM	33, 621, 683		50.00
51.00	05100 RECOVERY ROOM	1, 525, 288		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 525, 453		52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	18, 136, 526		54.00
55. 00	1			1
	03630 ULTRA SOUND	708, 339		55.00
56. 00	05600 RADI OI SOTOPE	123, 770		56.00
56. 01	03950 CARDI AC CATH LAB	3, 403, 542		56. 01
57. 00	05700 CT SCAN	1, 885, 845		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	868, 604		58. 00
60. 00	06000 LABORATORY	9, 309, 491		60.00
65. 00	06500 RESPI RATORY THERAPY	3, 482, 889		65. 00
66.00	06600 PHYSI CAL THERAPY	4, 033, 400		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	380, 150		67.00
68.00	06800 SPEECH PATHOLOGY	267, 176		68. 00
69.00	06900 ELECTROCARDI OLOGY	3, 061, 658		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	574, 587		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 658, 038		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	18, 606, 630		72. 00
	07300 DRUGS CHARGED TO PATIENTS	11, 651, 832		1
73.00				73.00
73. 01	07301 DI ABETES CENTER	464, 518		73. 01
74. 00	07400 RENAL DIALYSIS	782, 374		74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	110, 203		76. 98
	OUTPATIENT SERVICE COST CENTERS			
88. 00	08800 RURAL HEALTH CLINIC	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		89. 00
90.00	09000 CLI NI C	905, 966		90.00
91.00	09100 EMERGENCY	13, 792, 414		91.00
91. 01	04950 WOUND CARE	759, 112		91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	1, 804, 521		92. 01
01	OTHER REIMBURSABLE COST CENTERS	, .,,,		1 - 7.
95. 00	09500 AMBULANCE SERVICES	1, 241, 447		95. 00
	09910 CORF	1, 241, 447		99. 10
		1		
101.00	10100 HOME HEALTH AGENCY	5, 551, 002		101. 00
460 -	SPECIAL PURPOSE COST CENTERS			400 00
	10900 PANCREAS ACQUISITION	0		109. 00
	11000 INTESTINAL ACQUISITION	0		110. 00
	11100 SLET ACQUISITION	0		111. 00
	11300 I NTEREST EXPENSE			113. 00
116.00	11600 HOSPI CE	680, 365		116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	207, 769, 711		118. 00
,. 50	NONREI MBURSABLE COST CENTERS			1
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	188, 910		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	100, 710		192. 00
172.00	ALIZOO THISTOTANO THEVALL OFFICES	. 0		1,72.00

Health Financial Systems	ST. ELI ZABE	ETH EAST	In Lie	In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150109	Peri od: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepared: 5/27/2015 9:45 am		
Cost Center Description	Total					
	26. 00					
194. 00 07950 MOB	103, 907			194. 00		
194. 01 07951 LI FELI NE	271, 843			194. 01		
194. 02 07952 PATIENT TRANSPORT	19, 468			194. 02		
194.03 07953 SETON LEASE 1 NORTH	18, 878			194. 03		
200.00 Cross Foot Adjustments	O			200. 00		
201.00 Negative Cost Centers	o			201. 00		
202.00 TOTAL (sum lines 118-201)	208, 372, 717			202. 00		

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part II
To 12/31/2014	Date/Time Prepared:
5/27/2015 9:45 am	Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150109

					10	12/31/2014	5/27/2015 9:4	
				CAPI TAL REI	_ATED_COSTS			
		Cook Cooks Doors at the	D:+1	NEW DLDC 0	NEW MADLE	C	EMDL OVEE	
		Cost Center Description	Directly Assigned New	NEW BLDG & FLXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal	1171	EQUIT		DEPARTMENT	
			Related Costs					
			0	1. 00	2.00	2A	4. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1. 00
2. 00		NEW CAP REL COSTS-BLDG & FIXT						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	136, 036	72, 347	208, 383	208, 383	4. 00
5.01		COMMUNI CATI ONS	0	17, 712		27, 132	1, 344	5. 01
5. 02		MGMT INFO SYSTEMS	0	77, 751		119, 101	0	5. 02
5. 03 5. 04		PURCHASI NG	0	222, 756		341, 222	1, 974	5. 03 5. 04
5. 04	1	ADMITTING PATIENT ACCOUNTING	0	11, 431 188, 209		17, 510 288, 303	1, 424 2, 810	5. 04
5. 06		OTHER ADMINISTRATIVE AND GENERAL	249, 783	930, 521		1, 675, 175	17, 386	5. 06
7.00		OPERATION OF PLANT	4, 179	2, 491, 793		3, 821, 162	8, 200	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	106, 469		163, 092	392	8. 00
9.00	1	HOUSEKEEPI NG	990	234, 498		360, 199	4, 403	9.00
10. 00 11. 00		DI ETARY CAFETERI A	5, 190 45, 005	425, 933 309, 250		657, 643 518, 721	2, 119 3, 116	10. 00 11. 00
13. 00	1	NURSING ADMINISTRATION	0	116, 683		178, 738	8, 087	13. 00
14.00		CENTRAL SERVICES & SUPPLY	33, 141	199, 753		339, 127	1, 371	14. 00
15. 00	1	PHARMACY	133	173, 497		265, 899	7, 214	
16.00		MEDICAL RECORDS & LIBRARY	0	89, 464		137, 043	4, 100	16.00
17. 00 20. 00		SOCIAL SERVICE NURSING SCHOOL	0	23, 031 397, 271		35, 279 608, 548	1, 445 1, 840	
23. 00		PARAMEDICAL EDUCATION PROGRAM	O	3, 225		4, 940	89	23. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDI ATRI CS	266, 426	2, 582, 046		4, 221, 661	32, 886	30.00
31. 00 35. 00		INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	917	444, 635		682, 018	7, 653 4, 927	31. 00 35. 00
40. 00		SUBPROVIDER - IPF		236, 422 0		362, 156 0	4, 927	40. 00
41. 00		SUBPROVI DER - I RF	245	0		245	3, 037	41. 00
42.00		SUBPROVI DER	0	0	1	0	0	42.00
43. 00		NURSERY	0	104, 234	55, 434	159, 668	1, 770	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	53, 279	968, 888	515, 275	1, 537, 442	10, 639	50. 00
51.00		RECOVERY ROOM	0	91, 445		140, 077	2, 138	51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	612, 133		937, 679	10, 392	
54.00		RADI OLOGY-DI AGNOSTI C	457, 263	783, 196		1, 656, 980	8, 994	54.00
55. 00		ULTRA SOUND	0	25, 238		38, 660	1, 133	
56. 00 56. 01		RADI OI SOTOPE CARDI AC CATH LAB	5, 053	19, 721 310, 551		30, 209 480, 762	102 3, 738	56. 00 56. 01
57. 00		CT SCAN	0,033	68, 188		104, 452	1, 905	57. 00
58. 00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	48, 778		74, 719	717	58. 00
60.00		LABORATORY	2, 506	295, 329		454, 897	159	60. 00
65.00		RESPIRATORY THERAPY	21, 305	204, 280		334, 226	4, 722	65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	9, 416	149, 107 0		237, 822 0	6, 788 522	
68. 00	1	SPEECH PATHOLOGY	O	24, 361		37, 317		68. 00
69. 00	06900	ELECTROCARDI OLOGY	165	274, 194		420, 181	3, 274	69. 00
70.00		ELECTROENCEPHALOGRAPHY	1, 182	35, 395	18, 824	55, 401	609	70. 00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71. 00 72. 00
73.00		DRUGS CHARGED TO PATTENT		0	0	0	0	72.00
73. 01		DI ABETES CENTER	o	Ö	0	Ö	854	
74.00	07400	RENAL DIALYSIS	0	110, 770	58, 910	169, 680	100	
76. 98		HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	0	0	ol	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89. 00
90.00		CLI NI C	0	0	0	Ö	875	
91. 00	1	EMERGENCY	0	1, 313, 476		2, 012, 011	16, 591	91. 00
91. 01		WOUND CARE	0	68, 754	36, 565	105, 319	966	91. 01
92. 00 92. 01		OBSERVATION BEDS (NON-DISTINCT PART) OBSERVATION BEDS (DISTINCT PART)	200, 469	0	0	200, 469	3, 656	92. 00 92. 01
72.01		REIMBURSABLE COST CENTERS	200, 407	0	<u> </u>	200, 407	3, 030	92.01
95.00		AMBULANCE SERVICES	5, 775	25, 238	13, 422	44, 435	1, 799	95. 00
	09910		0	0		o	0	
101.00		HOME HEALTH AGENCY	0	0	0	0	8, 624	101. 00
109 00		AL PURPOSE COST CENTERS PANCREAS ACQUISITION	n	Λ	0	Λĺ	Ω	109. 00
		INTESTINAL ACQUISITION		o		o		110. 00
111.00	11100	ISLET ACQUISITION	0	0	0	o	0	111. 00
113.00	11300	INTEREST EXPENSE	<u> </u>					113. 00

Health Financial Systems	ST. ELIZABETH EAST			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Pre 5/27/2015 9:4		
Cost Center Description	Directly Assigned New Capital	CAPITAL REI NEW BLDG & FIXT	ATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT		

		CALLIAL KEL	ATED COSTS			
Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2. 00	2A	4. 00	
116. 00 11600 HOSPI CE	0	33, 217	0	33, 217		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 362, 422	14, 984, 879	7, 951, 619	24, 298, 920	208, 078	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42, 073	22, 375	64, 448	24	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
194. 00 07950 MOB	0	0	0	0	204	194. 00
194. 01 07951 LI FELI NE	0	59, 162	31, 464	90, 626	40	194. 01
194. 02 07952 PATI ENT TRANSPORT	0	0	0	0	8	194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0	0	0	29	194. 03
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)	1, 362, 422	15, 086, 114	8, 005, 458	24, 453, 994	208, 383	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150109 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/27/2015 9:45 am Cost Center Description COMMUNICATIONS MGMT INFO PURCHASI NG ADMITTI NG PATI ENT ACCOUNTI NG SYSTEMS 5.01 5.03 5.04 5.02 5.05 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 01160 COMMUNI CATI ONS 5 01 28.476 5 01 5.02 01140 MGMT INFO SYSTEMS 929 120,030 5.02 00550 PURCHASI NG 5.03 565 1, 702 345, 463 5.03 5.04 00570 ADMITTING 1, 323 20, 260 5.04 0 00580 PATIENT ACCOUNTING 70 294, 554 5.05 565 2.806 5.05 5.06 00560 OTHER ADMINISTRATIVE AND GENERAL 2, 949 8, 238 286 0 5.06 7.00 00700 OPERATION OF PLANT 2, 222 5, 922 234 0 0 7 00 00800 LAUNDRY & LINEN SERVICE 0 495 8 00 8 00 40 27 0 0 9.00 00900 HOUSEKEEPI NG 364 5, 322 500 0 9.00 10.00 01000 DI ETARY 1, 212 1, 596 74 0 10.00 01100 CAFETERI A 11.00 4. 054 130 0 11.00 01300 NURSING ADMINISTRATION 13.00 364 3, 384 C 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 162 1, 347 9, 235 0 0 0 0 14.00 01500 PHARMACY 15 00 929 2,804 2, 464 0 15.00 01600 MEDICAL RECORDS & LIBRARY 2, 798 16, 00 16, 00 687 0 01700 SOCIAL SERVICE 0 17.00 364 921 0 17.00 02000 NURSING SCHOOL 0 20.00 1, 221 0 0 20.00 02301 PARAMEDICAL EDUCATION PROGRAM 23.00 215 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4.645 17, 306 7,005 1, 209 17, 265 30.00 31.00 03100 INTENSIVE CARE UNIT 889 5, 756 289 4, 121 31.00 02060 NEONATAL INTENSIVE CARE UNIT 811 35.00 687 2.634 300 4, 282 35.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 0 \cap 0 Ω 40 00 41.00 969 1, 316 299 73 1,044 41.00 04200 SUBPROVI DER 42.00 0 0 42.00 04300 NURSERY 880 605 78 43.00 43.00 1, 108 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 969 5, 722 225, 831 3, 391 53, 687 50.00 05100 RECOVERY ROOM 51.00 323 880 376 247 3, 531 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1 050 5 166 3 552 469 6, 699 52 00 1, 784 05400 RADI OLOGY-DI AGNOSTI C 54.00 2,423 5, 179 24, 089 25, 474 54.00 03630 ULTRA SOUND 441 55.00 55.00 0 241 148 2, 116 56.00 05600 RADI OI SOTOPE 0 0 56.00 49 C 0 03950 CARDIAC CATH LAB 0 9, 142 56.01 1,830 42, 739 640 56.01 05700 CT SCAN 0 902 1, 250 1,092 15, 598 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 289 197 327 4,663 58.00 06000 LABORATORY 1,777 10 105 1, 678 23, 964 60 00 113 06500 RESPIRATORY THERAPY 1,373 2,693 3, 410 175 2, 492 65.00 3, 470 06600 PHYSI CAL THERAPY 242 2, 017 243 66.00 06700 OCCUPATIONAL THERAPY 306 0 39 551 67.00 0 06800 SPEECH PATHOLOGY 0 8 68 00 142 0 110 06900 ELECTROCARDI OLOGY 242 1,807 245 483 6,890 69.00 629 07000 ELECTROENCEPHALOGRAPHY 0 783 234 44 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 35, 533 0 2.488 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENT 0 1, 825 0 C 26, 067 72.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 1, 497 21, 381 73.00 07301 DI ABETES CENTER 242 473 38 90 73.01 07400 RENAL DIALYSIS 379 0 58 0 27 74.00 07698 HYPERBARIC OXYGEN THERAPY 0 Ω 0 14 197 76.98 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 0 0 n 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 C 0 0 0 09000 CLI NI C 1, 293 882 685 20 286 90.00

Heal th Financial Systems

ST. ELIZABETH EAST

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150109
From 01/01/2014
To 12/31/2014
Part II
To 12/31/2014
Prepared:

						5/27/2015 9:4	
	Cost Center Description	COMMUNI CATI ONS	MGMT INFO	PURCHASI NG	ADMITTI NG	PATI ENT	
			SYSTEMS			ACCOUNTI NG	
		5. 01	5. 02	5. 03	5. 04	5. 05	
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194. 00 07950	MOB	0	280	0	0	0	194. 00
194. 01 07951	LIFELINE	0	47	0	0	0	194. 01
194. 02 07952	PATIENT TRANSPORT	0	12	0	0	0	194. 02
194. 03 07953	SETON LEASE 1 NORTH	0	51	0	0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	o	0	201. 00
202.00	TOTAL (sum lines 118-201)	28, 476	120, 030	345, 463	20, 260	294, 554	202. 00

Control Cont					1	0 12/31/2014	Date/lime Pre 5/27/2015 9:4	
DEMANDLE SERVICE ONE TUBILISE		Cost Center Description	ADMI NI STRATI VE			HOUSEKEEPI NG	•	
1.00 00000 MARY CAP MAL COSTS-SHURG & FIXT 2.00				7. 00	8.00	9. 00	10.00	
2.00 00000 INDERIOR PARTICIOSIS—MORLE CODIT P 4.00 00000 INDERIOR SERVICES STATEMENT S								
15.00 0 1500 PHARMACY	2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS 01140 MGMT INFO SYSTEMS 00550 PURCHASING 00570 ADMITTING 00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	125, 768 7, 696 25, 920 17, 353 14, 186 32, 628	38, 328 84, 418 153, 333 111, 328 42, 005	210, 070 4, 858 5, 900 0	485, 984 19, 402 14, 087 5, 315	0	2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00
17.00 0.1700 SOCIAL SERVICE 5, 949 8, 291 0 1, 049 0 17.00 23.00 0.2000 MIRSI NOS SCHOOL 15, 107 143, 015 0 18, 096 0 20, 20 23.00 23.00 MIRSI NOS SCHOOL 15, 107 143, 015 0 147 0 23.00 18, 096 0 20, 20 23.00 18, 096 0 20, 20 23.00 18, 096 0 20, 20 23.00 18, 096 0 20, 20 23.00 19, 20 24.00			1					
20.00	16.00	01600 MEDICAL RECORDS & LIBRARY	25, 318	32, 207	0	4, 075	0	16. 00
23.0 0.3201 PARAMEDICAL EDUCATION PROCRAM 910 1.161 0 147 0 23.0		1 1	1		1			
INPATI ENT ROUTINE SERVICE COST CENTERS 177, 615 929, 524 74, 158 117, 615 720, 488 30, 00 30.00 03000 ADURTS & PEDIA PRICES 177, 615 929, 524 74, 158 117, 615 720, 488 30, 00 31.00 03000 ADURTS & PEDIA PRICES 100, 006 11, 297 20, 254 79, 125 31, 00 40, 00						,		1
30.00 3000 ADULTS & PEDIATRICS 177, 615 929, 524 74, 158 117, 615 720, 468 30, 00 30.00 30.00 0100 01MENSIVE CASE UNIT 24, 496 166, 006 11, 709 10, 769 35, 00 0.00 0	23.00		710	1, 101	0	147	0	23.00
35.00	30.00		177, 615	929, 524	74, 158	117, 615	720, 468	30.00
40.00 04000 SUBPROVIDER - I PF 0 0 0 0 0 0 0 0 0								
11.00 04100 SUBPROVI DER 18		I I		85, 111		10, 769		1
42.00 04200 SUBROVI DER 0 0 0 0 0 0 24.2 00 0 0 0 0 0 24.2 00 043.00 04300 MIRSERY 8.851 3.7, 524 7, 739 4, 748 0.43.00 04300 MIRSERY 6.00 050.00		1 1	-	0	1	0		
ANCILLARY SERVICE COST CENTERS		1 1		0		o		
50.00	43.00		8, 351	37, 524	7, 739	4, 748	0	43. 00
51.00 05100 RECOVERY ROOM			0.40.070	0.40 70.4				
52.00 05200 DELLYERY ROOM & LABOR ROOM		I I						1
55.00 03630 ULTRA SOUND		1 1	1					
56. 00 05600 RADIO I O SOTOPE 6.92 7. 0.99 0 8.98 0 5.6. 00			1		1			1
56 01 03950 CARDI AC CATH LAB 21, 087 111, 797 854 14, 146 0 56, 01 57, 00 5700 CT SCAN 12, 739 24, 547 0 3, 106 0 57, 00 58, 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 5, 881 17, 560 0 2, 222 0 58, 00 60, 00 05000 CABORATORY 69, 208 106, 317 1, 340 13, 453 0 60, 00 60, 00 0500 RESPI RATORY THERAPY 28, 833 53, 678 2, 919 6, 792 0 66, 00		i i	1					1
12, 739			1					
60.00 06000 LABORATORY 69, 208 106, 317 1, 340 13, 453 0 60.00		1 1	1					1
65. 00 06500 06500 06500 06500 06500 06500 06500 066								1
66. 00 06600 06600 06000 0CCUPATI ONAL THERAPY 28,833 53,678 2,919 6,792 0 66,00 67.00 0CCUPATI ONAL THERAPY 2,271 0 0 0 0 0 0 0 67.00 0CCUPATI ONAL THERAPY 2,271 0 0 0 0 0 0 0 0 0		i i	1					1
67. 00 06700 05CUPATIONAL THERAPY 2,271 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 1,716 8,770 0 1,110 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 19,371 98,708 1,190 12,490 069,00 70. 00 07000 ELECTROENCEPHALOGRAPHY 3,551 12,742 0 1,612 0 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 134,587 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 142,697 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 54,676 0 0 0 0 0 0 73. 00 74. 00 07300 DRUGS CHARGED TO PATIENTS 54,676 0 0 0 0 0 0 0 75. 01 07301 DI ABÈTES CENTER 3,428 0 0 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 878 0 0 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 878 0 0 0 0 0 0 76. 98 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 79. 00 09000 CLINIC TESTIVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 79. 00 09000 CLINIC TESTIVICE COST CENTERS 89. 00 09000 05000 05000 05000 05000 79. 00 09000 05000 05000 05000 79. 00 09000 05000 05000 05000 79. 00 09000 05000 05000 05000 79. 00 09200 050500 05000 05000 05000 79. 00 09200 050500 05000 05000 05000 79. 00 09500 05000 05000 05000 05000 79. 00 09500 05000 05000 05000 05000 79. 00 09500 05000 05000 05000 05000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 70.			1					
69.00 06900 ELECTROCARDIOLOGY 19, 371 98, 708 1, 190 12, 490 0 69, 00 70. 00 07000 ELECTROCARDIOLOGY 3, 551 12, 742 0 1, 612 0 70. 00 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 01 73.			1	00,070		0, 7,2		1
70. 00 07000 ELECTROENCEPHALOGRAPHY 3,551 12,742 0 1,612 0 70. 00 71. 00 0710.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 134,587 0 0 0 0 0 0 0 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 070.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 142,697 0 0 0 0 0 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 01 73. 01 73.01 07301 DIABETES CENTER 3,428 0 0 0 0 0 73. 01 74. 00			1					
71. 00								
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 142,697 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 54,676 0 0 0 0 0 0 73. 00 73. 00 73. 01 07301 DIABETES CENTER 3,428 0 0 0 0 0 0 73. 01 74. 00 07400 RENAL DIALYSIS 4,718 39,876 0 5,046 0 74. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 878 0 0 0 0 0 0 0 0 0					0	1, 612	-	
73. 01 07301 DI ABETES CENTER 3, 428 0 0 0 0 73. 01 74. 00 07400 RENAL DI ALYSI S 4, 718 39, 876 0 5, 046 0 74. 00 76. 98 07400 RENAL DI ALYSI S 4, 718 39, 876 0 5, 046 0 74. 00 00 076. 98 MERCEN CENTER				0	Ö	o		1
74. 00 07400 RENAL DIALYSIS 4,718 39,876 0 5,046 0 74. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 878 0 0 0 0 0 0 76. 98 00 0 0 0 0 0 0 0 0				0	0	0		
76. 98				20 976	0	5 046		
B8. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 89.00				34, 870				
89. 00		OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINI C 7, 153 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 84, 011 472, 844 19, 408 59, 831 0 91. 00 91. 01 04950 WOUND CARE 4, 787 24, 751 0 3, 132 0 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92. 00 92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) 14, 058 0 0 0 0 0 OTHER REI MBURSABLE COST CENTERS 8, 766 9, 086 0 1, 150 0 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 41, 682 0 0 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 111. 00 11100 ISLET ACQUI SI TI ON 0 0 0 0 0 113. 00 113.00 INTEREST EXPENSE 113. 00 116. 00 116.00 HOSPI CE 4, 800 11, 958 0 1, 513 0 116. 00				0	0	0		
91. 00			-	0	0	0		
91. 01				472. 844	19. 408	59, 831		
92. 01	91. 01	04950 WOUND CARE	1					91. 01
OTHER REIMBURSABLE COST CENTERS				_	_	_	_	
95. 00 09500 AMBULANCE SERVICES 8, 766 9, 086 0 1, 150 0 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 41, 682 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 110. 00 110. 00 1000 INTESTI NAL ACQUISITION 0 0 0 0 0 110. 00 111. 00 1100 ISLET ACQUISITION 0 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPICE 4, 800 11, 958 0 1, 513 0 116. 00	92. 01		14, 058	0	0	0	0	92.01
99. 10 09910 CORF 0 0 0 0 0 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 41, 682 0 0 0 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 109. 00 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 110. 00 111. 00 1100 ISLET ACQUI SI TI ON 0 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 4, 800 11, 958 0 1, 513 0 116. 00	95. 00		8, 766	9. 086	0	1, 150	0	95. 00
SPECIAL PURPOSE COST CENTERS 109, 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109, 00 110, 00 11000 INTESTI NAL ACQUISITION 0 0 0 0 0 0 110, 00 111, 00 11100 ISLET ACQUISITION 0 0 0 0 0 0 111, 00 113, 00 11300 INTEREST EXPENSE 113, 00 116			1	0	0			
109. 00 10900 PANCREAS ACQUISITION	101.00		41, 682	0	0	0	0	101. 00
110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110. 00 111. 00 111. 00 111. 00 113. 00 INTEREST EXPENSE 113. 00 116. 0	100.00			^		ما	0	100.00
111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 111. 00 113. 00 113.00 I NTEREST EXPENSE 116. 00 116.00 1				0) O			
113. 00 11300 INTEREST EXPENSE 113. 00 116. 00				0	Ö	o		
	113.00	11300 INTEREST EXPENSE						
110.00								
	110.00	13001017LS (30W OF LINES 1-117)	1, 700, 044	5, 921, 004	1 210,070	1 401, 3/3	030, 032	1110.00

Health Financial Systems	ST. ELIZAE	BETH EAST		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150109	Peri od: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Pre 5/27/2015 9:4	
0 1 0 1 5 11	OTHER	ODEDATION OF	L ALINIDDV .	HOUGEKEEDING	DI 5740V	T

					5/27/2015 9: 4	5 am
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5. 06	7. 00	8. 00	9. 00	10.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	941	15, 146	0	1, 916	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194. 00 07950 MOB	786	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	1, 364	21, 298	0	2, 695	0	194. 01
194. 02 07952 PATIENT TRANSPORT	156	0	0	0	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	143	0	0	0	0	194. 03
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)	1, 704, 034	3, 963, 508	210, 070	485, 984	858, 632	202.00

					10	12/31/2014	Date/lime Pre 5/27/2015 9:4	
	Cost Ce	enter Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
				ADMI NI STRATI ON			RECORDS &	
			11.00	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
	GENERAL SERVI	CE COST CENTERS						
1.00		REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00	1	REL COSTS-MVBLE EQUIP						2. 00 4. 00
5. 01	01160 COMMUNI	E BENEFITS DEPARTMENT						5. 01
5. 02	01140 MGMT IN							5. 02
5.03	00550 PURCHAS							5. 03
5.04	00570 ADMITTI							5. 04
5. 05	00580 PATI ENT							5. 05
5. 06 7. 00	00560 OTHER A	ON OF PLANT						5. 06 7. 00
8. 00	1	' & LINEN SERVICE						8. 00
9.00	00900 HOUSEKE	EPI NG						9. 00
10.00	01000 DI ETARY							10.00
11. 00 13. 00	01100 CAFETER	II A 5 ADMINISTRATION	665, 622 25, 432					11. 00 13. 00
14. 00	1 1	. SERVICES & SUPPLY	10, 124					14. 00
15. 00	01500 PHARMAC		21, 071	0,737	_	405, 184		15. 00
16. 00		. RECORDS & LI BRARY	21, 025	0	0	o	227, 255	
17. 00	01700 SOCI AL		6, 924	l .	-	0	0	
20. 00 23. 00	02000 NURSI NG	SCHOOL ICAL EDUCATION PROGRAM	9, 177 1, 619	0		0	0	
23.00		JTINE SERVICE COST CENTERS	1,017		<u> </u>	<u> </u>		23.00
30.00	03000 ADULTS		130, 049	96, 607	0	0	13, 300	30. 00
31. 00	03100 I NTENSI		43, 254			0	3, 174	
35. 00	1	L INTENSIVE CARE UNIT	19, 798			0	3, 299	
40. 00 41. 00	04000 SUBPROV 04100 SUBPROV		9, 886	0 6, 465	-	ol Ol	0 804	
42. 00	04200 SUBPROV		0	0, 403		o	0	1
43.00	04300 NURSERY		6, 611	1, 396	0	О	854	43. 00
		RVI CE COST CENTERS						
50. 00 51. 00	05000 OPERATI 05100 RECOVER		43, 002 6, 617	24, 614 3, 784		0	41, 712 2, 720	
51.00		Y ROOM & LABOR ROOM	38, 824			0	5, 160	
54. 00		GY-DI AGNOSTI C	38, 919			Ö	19, 623	
55. 00	03630 ULTRA S		3, 318			o	1, 630	1
56. 00	05600 RADI 01 S		370			0	0	56.00
56. 01 57. 00	03950 CARDI AC 05700 CT SCAN		13, 752 6, 775	7, 864 0		O O	7, 042 12, 015	1
58. 00	1 1	C RESONANCE IMAGING (MRI)	2, 170			o	3, 592	
60.00	06000 LABORAT		846		0	o	18, 460	1
65. 00	06500 RESPI RA		20, 236			0	1, 920	
66.00	06600 PHYSI CA		15, 156			0	2, 673	
67. 00 68. 00	06800 SPEECH	I ONAL THERAPY PATHOLOGY	2, 302 1, 065			0	425 85	1
69. 00	06900 ELECTRO		13, 581	4, 893		o		69.00
		ENCEPHALOGRAPHY	5, 884	3, 365	0	o	484	70. 00
		SUPPLIES CHARGED TO PATIENTS	0	0		0	27, 371	
72. 00 73. 00		EV. CHARGED TO PATIENT CHARGED TO PATIENTS	0	0	239, 863 0	405, 184	20, 080 16, 470	
73. 01	07301 DI ABETE		3, 554	2, 033	_	403, 104	69	1
74. 00	07400 RENAL D		439			О	292	
76. 98		RIC OXYGEN THERAPY	0	0	0	0	152	76. 98
88. 00	08800 RURAL H	ERVICE COST CENTERS		0	0	ol	0	88. 00
89. 00		LY QUALIFIED HEALTH CENTER	0			0	0	
90. 00	09000 CLI NI C		6, 625	Ö	Ō	ō	220	
91. 00	09100 EMERGEN		68, 225			0	12, 828	
91. 01	04950 WOUND C	ARE TION BEDS (NON-DISTINCT PART)	7, 402	1, 304	0	0	435	
92. 00 92. 01		TION BEDS (NON-DISTINCT PART) TION BEDS (DISTINCT PART)	13, 844	0	0	o	1, 868	92. 00 92. 01
72.01		RSABLE COST CENTERS	10,011		<u> </u>	<u>o</u> լ	1,000	72.01
	09500 AMBULAN	ICE SERVI CES	8, 953	5, 175		0	892	
	09910 CORF	ALTH ACENCY	0	0		0	0	
101.00	10100 HOME HE	ALTH AGENCY DSE COST CENTERS	33, 403	19, 102	0	0	2, 070	101. 00
109.00		S ACQUISITION	0	0	0	0	0	109. 00
110.00	11000 I NTESTI	NAL ACQUISITION	0	0	0	o	0	110. 00
	11100 SLET A		0	0	0	0	0	111.00
	11300 I NTERES 11600 HOSPI CE		2, 457	1, 395	0	0	228	113. 00 116. 00
118.00		LS (SUM OF LINES 1-117)	662, 689			405, 184	227, 255	
	· · · · · · · · · · · · · · · · · · ·	•	•	•	. '			

Heal th Financial Systems ST. ELIZABETH EAST In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150109 | Period: From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared:

				0 12/31/2014		
					5/27/2015 9:4	5 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13.00	14. 00	15. 00	16.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194. 00 07950 MOB	2, 107	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	353	0	0	0	0	194. 01
194.02 07952 PATIENT TRANSPORT	91	0	0	0	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	382	0	0	0	0	194. 03
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)	665, 622	295, 953	461, 275	405, 184	227, 255	202. 00

Heal th Financial Systems

ST. ELIZABETH EAST

In Lieu of Form CMS-2552-10

Provider CCN: 150109 | Period: From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/27/2015 9: 45 am

Cost Center Description | SOCIAL SERVICE NURSING SCHOOL PARAMEDICAL EDUCATION PROGRAM | EDUCATION PROGRAM | Residents Cost & Post Stepdown Adjustments | Adjustments | Adjustments | Adjustments | EDUCATION PROGRAM | EDUCATION PROGRAM | EDUCATION PROGRAM | Adjustments | EDUCATION PROGRAM |

	Cost Center Description	SOCIAL SERVICE	NURSING SCHOOL	PARAMEDI CAL EDUCATI ON PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown	
						Adjustments	
	GENERAL SERVICE COST CENTERS	17. 00	20. 00	23. 00	24. 00	25. 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. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	01140 MGMT INFO SYSTEMS						5. 02
5. 03 5. 04	00550 PURCHASI NG						5. 03 5. 04
5.04	OO570 ADMITTING OO580 PATIENT ACCOUNTING						5. 04
5. 06	00560 OTHER ADMINISTRATIVE 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	01100 CAFETERI A						11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY			•			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY						16. 00
17. 00	01700 SOCIAL SERVICE	60, 222	•			•	17. 00
20.00	02000 NURSI NG SCHOOL	0	797, 004				20. 00
23. 00	02301 PARAMEDICAL EDUCATION PROGRAM	0		9, 081			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			ı			
30.00	03000 ADULTS & PEDIATRICS	45, 067			6, 606, 380	0	30.00
31. 00 35. 00	03100 NTENSI VE CARE UNIT 02060 NEONATAL INTENSI VE CARE UNIT	5, 557 4, 402			1, 072, 689	0	31. 00 35. 00
40. 00	04000 SUBPROVI DER – I PF	4, 402			538, 723	0	40.00
41. 00	04100 SUBPROVI DER - I RF	3, 222			103, 461	0	41. 00
42. 00	04200 SUBPROVI DER	0			0	Ö	42. 00
43.00	04300 NURSERY	1, 974			233, 306	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0			2, 625, 657	0	50.00
51.00	05100 RECOVERY ROOM	0			214, 415	0	51.00
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0			1, 323, 109 2, 246, 388	0	52. 00 54. 00
55. 00	03630 ULTRA SOUND	0			63, 036	0	55. 00
56. 00	05600 RADI OI SOTOPE	0			39, 630	ő	56. 00
56. 01	03950 CARDI AC CATH LAB	0	•		715, 393	0	56. 01
57.00	05700 CT SCAN	0			184, 381	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			112, 337	0	58. 00
60.00	06000 LABORATORY	0			702, 317	0	60. 00
65. 00	06500 RESPI RATORY THERAPY	0			490, 428	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0			368, 917	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0			12, 374 51, 288	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		•	588, 663		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0			85, 338		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			421, 391	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0			430, 532	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0			499, 208		73. 00
73. 01	07301 DI ABETES CENTER	0			10, 787	0	73. 01
74. 00 76. 98	07400 RENAL DI ALYSI S 07698 HYPERBARI C OXYGEN THERAPY	0			220, 866 1, 241	0	74. 00 76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	0			1, 241	0	70. 70
88. 00	08800 RURAL HEALTH CLINIC	0			0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90.00	09000 CLI NI C	0			18, 039	0	90. 00
91. 00	09100 EMERGENCY	0			2, 822, 931	0	91. 00
91. 01 92. 00	04950 WOUND CARE	0			149, 686		91. 01
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0			238, 890	0	92. 00 92. 01
7Z. UI	OTHER REIMBURSABLE COST CENTERS				230, 090		72.01
95.00	09500 AMBULANCE SERVI CES	0			82, 686	0	95. 00
99. 10	09910 CORF	0			0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	0			113, 225	0	101. 00
460 -	SPECIAL PURPOSE COST CENTERS	-			=1	-	100 00
	10900 PANCREAS ACQUISITION	0			0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0			0		110. 00 111. 00
	111300 INTEREST EXPENSE				U		113. 00
	11600 HOSPI CE	0			57, 050	0	116. 00
	·						

Health Finar	ncial Systems	ST. ELIZABETH EAST			In Lieu of Form CMS-2552-10		
ALLOCATION (OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
					From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	nared:
					10 12/31/2014	5/27/2015 9:4	
	Cost Center Description	SOCIAL SERVICE	NURSING SCHOOL	PARAMEDI CAL	Subtotal	Intern &	
				EDUCATI ON		Residents Cost	
				PROGRAM		& Post	
						Stepdown	
						Adjustments	
		17. 00	20. 00	23. 00	24. 00	25. 00	
118. 00	SUBTOTALS (SUM OF LINES 1-117)	60, 222	0		0 23, 444, 762	0	118. 00
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			82, 475	0	190. 00
	PHYSICIANS' PRIVATE OFFICES	0			0	0	192. 00
194. 00 07950	MOB	0			3, 377	0	194. 00
194. 01 07951	LIFELINE	0			116, 423	0	194. 01
194. 02 07952	PATIENT TRANSPORT	0			267	0	194. 02
194. 03 07953	SETON LEASE 1 NORTH	0			605	0	194. 03
200. 00	Cross Foot Adjustments		797, 004	9, 08	81 806, 085	0	200. 00
201.00	Negative Cost Centers	0	0		0	0	201. 00
202. 00	TOTAL (sum lines 118-201)	60, 222	797, 004	9, 08	24, 453, 994	0	202. 00

			5/27/2015 9: 4	<u>5 am</u>
	Cost Center Description	Total		
	CENEDAL CEDVICE COCT CENTERS	26. 00		
1 00	GENERAL SERVICE COST CENTERS			1 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. 01	01160 COMMUNI CATI ONS			5. 01
5. 02	01140 MGMT INFO SYSTEMS			5. 02
5. 02	00550 PURCHASI NG			5. 03
5. 04	00570 ADMITTING			5. 04
5. 05	00580 PATIENT ACCOUNTING			5. 05
5. 06	00560 OTHER ADMINISTRATIVE 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	01100 CAFETERI A			11.00
13.00	01300 NURSING ADMINISTRATION			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15.00	01500 PHARMACY			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY			16.00
17.00	01700 SOCIAL SERVICE			17. 00
20.00	02000 NURSI NG SCHOOL			20. 00
23. 00	02301 PARAMEDICAL EDUCATION PROGRAM			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00	03000 ADULTS & PEDIATRICS	6, 606, 380		30. 00
31.00	03100 I NTENSI VE CARE UNI T	1, 072, 689		31. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	538, 723		35. 00
40. 00	04000 SUBPROVI DER - I PF	0		40. 00
41. 00	04100 SUBPROVI DER - I RF	103, 461		41. 00
42. 00	04200 SUBPROVI DER	0		42. 00
43. 00	04300 NURSERY	233, 306		43. 00
	ANCI LLARY SERVI CE COST CENTERS			
50. 00	05000 OPERATI NG ROOM	2, 625, 657		50. 00
51. 00	05100 RECOVERY ROOM	214, 415		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 323, 109		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 246, 388		54. 00
55. 00	03630 ULTRA SOUND	63, 036		55. 00
56.00	05600 RADI OI SOTOPE	39, 630		56.00
56. 01	03950 CARDI AC CATH LAB	715, 393		56. 01
57. 00	05700 CT SCAN	184, 381		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	112, 337		58.00
60.00	06000 LABORATORY	702, 317		60.00
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	490, 428		65.00
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	368, 917 12, 374		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	51, 288		68. 00
69. 00	06900 ELECTROCARDI OLOGY	588, 663		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	85, 338		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	421, 391		71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	430, 532		72.00
	07300 DRUGS CHARGED TO PATIENTS	499, 208		73. 00
	07301 DI ABETES CENTER	10, 787		73. 00
	07400 RENAL DIALYSIS	220, 866		74.00
	07698 HYPERBARI C OXYGEN THERAPY	1, 241		76. 98
. 5. 75	OUTPATIENT SERVICE COST CENTERS	1,211		1
88. 00	08800 RURAL HEALTH CLINIC	0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	O		89. 00
90.00	09000 CLINIC	18, 039		90.00
	09100 EMERGENCY	2, 822, 931		91.00
91. 01	04950 WOUND CARE	149, 686		91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	238, 890		92. 01
	OTHER REIMBURSABLE COST CENTERS	· · · · ·		
95.00	09500 AMBULANCE SERVICES	82, 686		95. 00
	09910 CORF	0		99. 10
101.00	10100 HOME HEALTH AGENCY	113, 225		101. 00
	SPECIAL PURPOSE COST CENTERS			
109.00	10900 PANCREAS ACQUISITION	0		109. 00
	11000 INTESTINAL ACQUISITION	0		110. 00
	11100 ISLET ACQUISITION	0		111. 00
	11300 INTEREST EXPENSE			113. 00
	11600 H0SPI CE	57, 050		116. 00
118.00		23, 444, 762		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	82, 475		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0		192. 00

Health Financial Systems	ST. ELI ZABETH	EAST	In Lieu of Form CMS-2552-1		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 150109	Peri od:	Worksheet B	
			From 01/01/2014 To 12/31/2014	Part II Date/Time Prepared:	
			10 12/31/2014	5/27/2015 9:45 am	
Cost Center Description	Total				
	26. 00				
194. 00 07950 MOB	3, 377			194. 00	
194. 01 07951 LI FELI NE	116, 423			194. 01	
194. 02 07952 PATIENT TRANSPORT	267			194. 02	
194.03 07953 SETON LEASE 1 NORTH	605			194. 03	
200.00 Cross Foot Adjustments	806, 085			200. 00	
201.00 Negative Cost Centers	0			201. 00	
202.00 TOTAL (sum lines 118-201)	24, 453, 994			202. 00	

	FINANCIAI SYSTEMS	ST. ELIZABE		CCN, 150100 F		Warksheet D 1	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					o 12/31/2014	Date/Time Pre	
		CAPITAL REL	ATED COSTS			5/27/2015 9: 4	5 am
		CALLIAL KEL	AILD COSIS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	COMMUNI CATI ONS	MGMT INFO	
		FIXT	EQUI P	BENEFITS	ć	SYSTEMS	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS	(PHONE	(MANHOURS)	
		'LL')	ILLI)	SALARI ES)	LI NES)		
		1.00	2.00	4.00	5. 01	5. 02	
	GENERAL SERVICE COST CENTERS			l			
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	533, 198	532, 024				1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 808	4, 808				4.00
5. 01	01160 COMMUNI CATI ONS	626	626	1	1		5. 01
5.02	01140 MGMT INFO SYSTEMS	2, 748	2, 748	C	23	2, 241, 015	
5. 03	00550 PURCHASI NG	7, 873	7, 873	585, 782		31, 770	
5. 04 5. 05	00570 ADMITTING 00580 PATIENT ACCOUNTING	404 6, 652	404 6, 652	422, 499 833, 933	1	24, 702 52, 391	5. 04 5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	32, 888	32, 888		1	153, 810	
7. 00	00700 OPERATION OF PLANT	88, 069	88, 069		1	110, 572	
8.00	00800 LAUNDRY & LINEN SERVICE	3, 763	3, 763	116, 411	1	9, 247	
9.00	00900 HOUSEKEEPI NG	8, 288	8, 288			99, 371	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	15, 054 10, 930	15, 054 10, 930	628, 877 924, 753	1	29, 802 75, 696	
13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 124	4, 124		1	63, 182	
14. 00	01400 CENTRAL SERVICES & SUPPLY	7, 060	7, 060			25, 151	1
15. 00	01500 PHARMACY	6, 132	6, 132	2, 140, 549		52, 348	
16.00	01600 MEDI CAL RECORDS & LI BRARY	3, 162	3, 162			52, 234	
17. 00 20. 00	01700 SOCIAL SERVICE 02000 NURSING SCHOOL	814 14, 041	814 14, 041	428, 870 546, 051		17, 201 22, 799	1
23. 00	02301 PARAMEDI CAL EDUCATI ON PROGRAM	114, 041	14, 041	26, 287		4, 022	
	INPATIENT ROUTINE SERVICE COST CENTERS				-,	., -==	
30. 00	03000 ADULTS & PEDIATRICS	91, 259	91, 259			323, 091	1
31. 00 35. 00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	15, 715 8, 356	15, 715 8, 356			107, 458 49, 186	
40. 00	04000 SUBPROVI DER - I PF	0, 330	0, 330	1, 402, 013		49, 180	1
41. 00	04100 SUBPROVI DER - I RF	0	0	901, 202	1	24, 561	1
42.00	04200 SUBPROVI DER	0	0	C	o	0	
43. 00	04300 NURSERY	3, 684	3, 684	525, 097	0	16, 423	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	34, 244	34, 244	3, 156, 942	24	106, 834	50.00
51. 00	05100 RECOVERY ROOM	3, 232	3, 232			16, 439	
52.00	05200 DELIVERY ROOM & LABOR ROOM	21, 635	21, 635	3, 083, 602		96, 454	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	27, 681	27, 681	2, 668, 724		96, 690	
55. 00 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	892 697	892 697	336, 072 30, 127	1	8, 242 918	
56. 01	03950 CARDI AC CATH LAB	10, 976	10, 976		1	34, 165	
57. 00	05700 CT SCAN	2, 410	2, 410		1	16, 832	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 724	1, 724	1	1	5, 392	1
	06000 LABORATORY	10, 438	10, 438		I I	2, 103	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	7, 220 5, 270	7, 220 5, 270			50, 274 37, 654	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0, 270	154, 949		5, 720	
68. 00	06800 SPEECH PATHOLOGY	861	861	105, 623	o	2, 645	
69. 00	06900 ELECTROCARDI OLOGY	9, 691	9, 691	971, 652		33, 741	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 251	1, 251	180, 646	0	14, 618 0	
71.00	07200 IMPL. DEV. CHARGED TO PATIENT		0			0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	l o	0	d	o o	0	1
73. 01	07301 DI ABETES CENTER	0	0	253, 393	6	8, 830	
74. 00	07400 RENAL DIALYSIS	3, 915	3, 915			1, 090	
76. 98	O7698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0	0		0	0	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0	0		ol	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	o	0	1
90.00	09000 CLI NI C	0	0	259, 650	1	16, 458	
91. 00 91. 01	09100 EMERGENCY 04950 WOUND CARE	46, 423	46, 423		1	169, 497	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 430	2, 430	200,777		18, 390	91. 01
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	1, 085, 013	0	34, 394	
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES 09910 CORF	892 0	892 0	533, 702	0 0	22, 242 0	1
	10100 HOME HEALTH AGENCY	0	0	2, 559, 058	1	82, 986	
	SPECIAL PURPOSE COST CENTERS	-1					
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	0				109.00
		0	0				110. 00 111. 00
	1	- 31		1	<u> </u>		

Health Financial Systems	ST. ELI ZABI	ETH EAST		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/27/2015 9:4	
	CAPITAL REL	ATED COSTS				
Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNI CATI ONS (PHONE LI NES)	MGMT INFO SYSTEMS (MANHOURS)	
	1.00	2. 00	4.00	5. 01	5. 02	
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	1, 174	0	248, 678	0	6, 104	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	529, 620	528, 446	61, 737, 65	7 705	2, 233, 729	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 487	1, 487	7, 12	1 0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0		192. 00
194. 00 07950 MOB	0	0	60, 584			194. 00
194. 01 07951 LI FELI NE	2, 091	2, 091	11, 88			194. 01
194. 02 07952 PATI ENT TRANSPORT	0	0	2, 433			194. 02
194. 03 07953 SETON LEASE 1 NORTH	U	0	8, 532			194. 03
200.00 Cross Foot Adjustments						200. 00 201. 00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B.	15 00/ 11/	0 005 450	21 212 50	1 222 515		
202.00 Cost to be allocated (per Wkst. B, Part I)	15, 086, 114	8, 005, 458	21, 213, 58	1, 332, 515	1, 423, 610	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	28. 293643	15. 047175	0. 34310!	1, 890. 092199	0. 635252	203. 00
204.00 Cost to be allocated (per Wkst. B,			208, 383		120, 030	
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0. 003370	40. 391489	0. 053561	205.00
11)						1

| Peri od: | Worksheet B-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150109

				T T	o 12/31/2014	Date/Time Prep 5/27/2015 9:49	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT	Reconciliation		o alli
		(COSTED REQUISITIO)	(GROSS CHARGES)	ACCOUNTI NG (GROSS		ADMI NI STRATI VE AND GENERAL	
		REQUISITIO)	CHARGES)	CHARGES)		(ACCUM. COST)	
	T	5. 03	5. 04	5. 05	5A. 06	5. 06	
1. 00	GENERAL SERVICE COST CENTERS OO100 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. 01	01160 COMMUNI CATI ONS						5. 01
5. 02 5. 03	01140 MGMT INFO SYSTEMS 00550 PURCHASING	30, 908, 008					5. 02 5. 03
5. 04	00570 ADMI TTI NG	257	825, 937, 392				5. 04
5.05	00580 PATIENT ACCOUNTING	6, 249	O	825, 937, 392			5. 05
5. 06 7. 00	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	25, 580	0	0	-25, 887, 232 0		5. 06
8. 00	00800 LAUNDRY & LINEN SERVICE	20, 901 2, 416	0	0	0	13, 562, 816 829, 934	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	44, 692	Ō	0	0	2, 795, 235	9. 00
10.00	01000 DI ETARY	6, 664	0	0	0	1, 871, 324	
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	11, 636 43	0	0	0	1, 529, 840 3, 518, 630	
14. 00	01400 CENTRAL SERVICES & SUPPLY	826, 256	o	0	o o	839, 740	
15.00	01500 PHARMACY	220, 497	0	0	0	-,,	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	163	0	0	0	2, 730, 253	
17. 00 20. 00	02000 NURSI NG SCHOOL	0	0	0	0		17. 00 20. 00
23. 00	02301 PARAMEDICAL EDUCATION PROGRAM	Ö	Ö	0	_		
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 INTENSI VE CARE UNIT	626, 738 448	48, 362, 346 11, 543, 388	48, 362, 346 11, 543, 388			30. 00 31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	72, 542	11, 995, 576	11, 995, 576		2, 535, 915	
40.00	04000 SUBPROVI DER - I PF	0	0	0	0		40. 00
41.00	04100 SUBPROVI DER - I RF	26, 775	2, 923, 658	2, 923, 658		.,,	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	54, 105	3, 104, 845	3, 104, 845	0		42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	34, 103	3, 104, 043	3, 104, 043		700, 337	43.00
50.00	05000 OPERATING ROOM	20, 204, 431	151, 232, 785	151, 232, 785	0		
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	33, 598 317, 758	9, 889, 908 18, 764, 695	9, 889, 908 18, 764, 695		.,,	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 155, 240	71, 356, 238	71, 356, 238			
55. 00	03630 ULTRA SOUND	21, 564	5, 928, 503	5, 928, 503			
56.00	05600 RADI OI SOTOPE	0	0 05 (07 750	05 (07 75)	0	74, 648	
56. 01 57. 00	03950 CARDI AC CATH LAB 05700 CT SCAN	3, 823, 858 111, 865	25, 607, 753 43, 692, 302	25, 607, 753 43, 692, 302	0	2, 273, 977 1, 373, 785	56. 01 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	17, 667	13, 062, 859	13, 062, 859	_	634, 202	
60.00	06000 LABORATORY	904, 086	67, 125, 786	67, 125, 786	0	7, 463, 430	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	305, 132 447	6, 981, 084 9, 720, 115	6, 981, 084 9, 720, 115	0	2, 501, 428 3, 109, 354	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	447	1, 544, 022	1, 544, 022	_		67. 00
68. 00	06800 SPEECH PATHOLOGY	O	307, 665	307, 665	0	185, 031	68. 00
	06900 ELECTROCARDI OLOGY	21, 922	19, 300, 058	19, 300, 058			
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	20, 964	1, 761, 693 99, 532, 518	1, 761, 693 99, 532, 518			70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	o	73, 017, 897	73, 017, 897	o	15, 388, 453	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	59, 891, 763	59, 891, 763		5, 896, 237	
73. 01 74. 00	O7301 DI ABETES CENTER O7400 RENAL DI ALYSI S	3, 434	251, 350 1, 062, 449	251, 350 1, 062, 449		369, 676 508, 780	
76. 98	07400 REINAL DIALISIS 07698 HYPERBARI C OXYGEN THERAPY		553, 072	553, 072			74. 00 76. 98
	OUTPATIENT SERVICE COST CENTERS			·			
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0		88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 61, 266	799, 831	799, 831	0	771, 353	89. 00 90. 00
91. 00	09100 EMERGENCY	817, 340	46, 645, 857	46, 645, 857	Ö	9, 059, 701	91. 00
91. 01	04950 WOUND CARE	0	1, 583, 070	1, 583, 070	0	516, 178	91. 01
92. 00 92. 01	O9200 OBSERVATION BEDS (NON-DISTINCT PART) O9201 OBSERVATION BEDS (DISTINCT PART)	49, 872	4 704 140	6, 794, 169	0	1, 515, 994	92. 00 92. 01
92.01	OTHER REIMBURSABLE COST CENTERS	49,072	6, 794, 169	0, 794, 109	0	1, 515, 994	92.01
	09500 AMBULANCE SERVICES	0	3, 244, 495	3, 244, 495	0	945, 338	
	09910 CORF	0	0	0	0		99. 10
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	91, 586	7, 526, 504	7, 526, 504	0	4, 494, 979	101.00
109.00	10900 PANCREAS ACQUISITION	O	ol	0	0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	O	O	0	0	0	110. 00
	11100 SLET ACQUISITION	0	0	0	0	0	111. 00 113. 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	n	829, 138	829, 138	n	517, 652	
118. 00		30, 907, 992	825, 937, 392	825, 937, 392			

In Lieu of Form CMS-2552-10 Health Financial Systems ST. ELIZABETH EAST COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150109 Peri od: Worksheet B-1

From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am Cost Center Description PURCHASI NG ADMI TTI NG PATI ENT Reconciliation OTHER (COSTED (GROSS ACCOUNTI NG ADMI NI STRATI VE REQUISITIO) CHARGES) (GROSS AND GENERAL CHARGES) (ACCUM. COST) 5.03 5.04 5A. 06 5.05 5.06 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 101, 507 190. 00 0 0 0 0 0 192. 00 84, 744 194. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 194. 00 07950 MOB 16 0 194. 01 07951 LI FELI NE 0 147, 110 194. 01 0 194. 02 07952 PATIENT TRANSPORT 0 0 16, 790 194. 02

1, 386, 500

0. 044859

0.011177

345, 463

15, 400 194. 03

25, 887, 232 202. 00

0. 140867 203. 00

1, 704, 034 204. 00

0.009273 205.00

200.00

201. 00

0

2, 963, 568

0.003588

0.000357

294, 554

C

603, 442

0.000731

0.000025

20, 260

194.03 07953 SETON LEASE 1 NORTH

Part I)

Part II)

11)

Cross Foot Adjustments

Negative Cost Centers

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)

200.00

201.00

202.00

203.00

204.00

205.00

	ALLOCATION - STATISTICAL BASIS	SI. ELIZAL			eri od:	Worksheet B-1	
				Fi	rom 01/01/2014 o 12/31/2014	Date/Time Pre 5/27/2015 9:4	pared: 5 am
	Cost Center Description	OPERATION OF PLANT (SQUARE	LAUNDRY & LI NEN SERVI CE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERI A (MANHOURS)	
		7. 00	LAUNDRY) 8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS 01140 MGMT INFO SYSTEMS 00550 PURCHASING 00570 ADMITTING 00580 PATIENT ACCOUNTING						1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05
5. 06 7. 00 8. 00	OO560 OTHER ADMINISTRATIVE AND GENERAL OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE	389, 130 3, 763					5. 06 7. 00 8. 00
9.00	00900 HOUSEKEEPI NG	8, 288	18, 895	377, 079			9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	15, 054 10, 930			174, 406 0	1, 653, 654	10. 00 11. 00
	01300 NURSI NG ADMI NI STRATI ON	4, 124	l .		0		13. 00
14.00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	7, 060			0		14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	6, 132 3, 162		6, 132 3, 162	0	52, 348 52, 234	
17. 00	01700 SOCI AL SERVI CE	814		814	0	17, 201	17. 00
20.00	O2000 NURSING SCHOOL O2301 PARAMEDICAL EDUCATION PROGRAM	14, 041 114		14, 041 114	0	22, 799 4, 022	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	91, 259 15, 715		· ·		323, 091 107, 458	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	8, 356			0	49, 186	1
40. 00 41. 00	04000 SUBPROVI DER	0	_	-	0 11, 992	0 24, 561	
42. 00	04200 SUBPROVI DER	0		0	0	24, 301	1
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 684	30, 099	3, 684	0	16, 423	43. 00
50. 00		34, 244	143, 294	34, 244	0	106, 834	50.00
51.00	05100 RECOVERY ROOM	3, 232			0	16, 439	
54.00	O5200 DELI VERY ROOM & LABOR ROOM O5400 RADI OLOGY-DI AGNOSTI C	21, 635 27, 681			0	96, 454 96, 690	
55. 00	03630 ULTRA SOUND	892	0	892	0	8, 242	1
56. 00 56. 01	05600 RADI OI SOTOPE 03950 CARDI AC CATH LAB	697 10, 976	l .		0	918 34, 165	
57.00	05700 CT SCAN	2, 410	0	2, 410	0	16, 832	57. 00
58. 00 60. 00	05800 MAGNETIC RESONANCE MAGING (MRI) 06000 LABORATORY	1, 724 10, 438	l .		0	5, 392 2, 103	1
65.00	06500 RESPI RATORY THERAPY	7, 220	6, 100	7, 220	0	50, 274	65. 00
	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	5, 270	11, 352	5, 270	0		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	861	Ö		ō	2, 645	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	9, 691 1, 251		9, 691 1, 251	0	33, 741 14, 618	1
71. 00		0		0	o	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
73. 00	07301 DI ABETES CENTER	0	Ö	0	0	8, 830	73. 01
74.00	07400 RENAL DI ALYSI S	3, 915	0	3, 915 0	0	1, 090	
76. 98	O7698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0	0 16, 458	89. 00 90. 00
91. 00	09100 EMERGENCY	46, 423			O	169, 497	91.00
91. 01 92. 00	04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 430	0	2, 430	0	18, 390	91. 01 92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	34, 394	
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES	892		892	ol	22, 242	95. 00
99. 10	09910 CORF	0	0	0	O	0	99. 10
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	82, 986	101. 00
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000 INTESTINAL ACQUISITION 11100 SLET ACQUISITION	0	0	0	0		110. 00 111. 00
113.00	11300 INTEREST EXPENSE				o _l	Ü	113. 00
116. 00 118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	1, 174 385, 552		1, 174 373 501	174 404	6, 104 1, 646, 368	116.00
110.00		300, 052	017,044	373, 501	174, 406	1, 040, 308	1110.00

Health Financial Systems	ST. ELIZABETH EAST			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der	CCN: 150109	Peri od: From 01/01/2014	Worksheet B-1	
						Date/Time Pre 5/27/2015 9:4	
Cost Center Description	OPERATIO	N OF LA	IINDRY &	HOUSEKEEPING	DIFTARY	CAFFTERLA	

				T	o 12/31/2014	Date/Time Pre 5/27/2015 9:4	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	·	PLANT	LINEN SERVICE	(SQUARE	(MEALS	(MANHOURS)	
		(SQUARE	(POUNDS OF	FEET)	SERVED)		
		FEET)	LAUNDRY)		·		
		7. 00	8. 00	9. 00	10.00	11. 00	
NONR	REIMBURSABLE COST CENTERS						
190. 00 1900	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 487	0	1, 487	0	0	190. 00
192. 00 1920	00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194. 00 0795	50 MOB	0	0	0	0	5, 234	194. 00
194. 01 0795	51 LI FELI NE	2, 091	0	2, 091	0	877	194. 01
194. 02 0795	52 PATIENT TRANSPORT	0	0	0	0	227	194. 02
194. 03 0795	53 SETON LEASE 1 NORTH	0	0	0	0	948	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	15, 473, 369	1, 096, 476	3, 543, 912	2, 905, 816	2, 282, 689	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	39. 764009	1. 342004	9. 398328	16. 661216	1. 380391	203. 00
204.00	Cost to be allocated (per Wkst. B,	3, 963, 508	210, 070	485, 984	858, 632	665, 622	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	10. 185563	0. 257110	1. 288812	4. 923179	0. 402516	205. 00
	11)						

	Financial Systems	ST. ELI ZABE		CON 150100		u of Form CMS-:	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet B-1 Date/Time Pre 5/27/2015 9:4	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	
			SUPPLY	REQUIS.)	LI BRARY	(TIME	
		(DI RECT NRSI NG HRS)	(COSTED REQUIS.)		(GROSS CHARGES)	SPENT)	
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16.00	17. 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. 01	01160 COMMUNI CATI ONS						5. 01
5. 02 5. 03	O1140 MGMT INFO SYSTEMS O0550 PURCHASING						5. 02 5. 03
5. 04 5. 05	00570 ADMITTING 00580 PATIENT ACCOUNTING						5. 04 5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 285, 718 25, 151	100				13. 00 14. 00
15. 00	01500 PHARMACY	25, 151	0	10			15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0		0 825, 937, 392 0 0	37, 702	16. 00 17. 00
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20. 00
23. 00	O2301 PARAMEDICAL EDUCATION PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	0	23. 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	419, 690 107, 458	0		0 48, 362, 346 0 11, 543, 388	28, 214 3, 479	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	49, 186	0		0 11, 995, 576	2, 756	35. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0 28, 087	0		0 0 0 2, 923, 658	0 2, 017	
42.00	04200 SUBPROVI DER	0	0		0 0	0	42. 00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	6, 065	0		0 3, 104, 845	1, 236	43. 00
50. 00 51. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM	106, 932 16, 439	0		0 151, 232, 785 0 9, 889, 908	0	50. 00 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	35, 101	0		0 18, 764, 695	0	52. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0	0		0 71, 356, 238 0 5, 928, 503	0	54. 00 55. 00
56. 00 56. 01	05600 RADI OI SOTOPE 03950 CARDI AC CATH LAB	918 34, 165	0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	56. 00 56. 01
57. 00	05700 CT SCAN	0	0		0 43, 692, 302	0	57. 00
58. 00 60. 00	05800 MAGNETIC RESONANCE MAGING (MRI) 06000 LABORATORY	0	0		0 13, 062, 859 0 67, 125, 786	0	58. 00 60. 00
65. 00	06500 RESPI RATORY THERAPY	50, 274	0		0 6, 981, 084	0	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	35, 967 25, 884	0		0 9, 720, 115 0 1, 544, 022	0	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2, 645 21, 255	0		0 307, 665 0 19, 300, 058	0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	14, 618	0		0 1, 761, 693	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	48 52		0 99, 532, 518 0 73, 017, 897	0	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	10	59, 891, 763	0	73. 00
73. 01 74. 00	07301 DI ABETES CENTER 07400 RENAL DI ALYSI S	8, 830 1, 090	0		0 251, 350 0 1, 062, 449	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0	0		0 553, 072	0	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0		0 799, 831	0	
91. 00 91. 01	09100 EMERGENCY 04950 WOUND CARE	178, 770 5, 665	0		0 46, 645, 857 0 1, 583, 070	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 665	O				92. 00
92. 01	O9201 OBSERVATI ON BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0		0 6, 794, 169	0	92. 01
95. 00	09500 AMBULANCE SERVICES	22, 480	0		0 3, 244, 495	0	
	09910 CORF 10100 HOME HEALTH AGENCY	82, 986	0 0		0 0 7, 526, 504	0	99. 10 101. 00
109 00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	0	0		0 0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0		0 0	0	110. 00
113.00	11100 ISLET ACQUISITION 11300 INTEREST EXPENSE		0		0 0	0	111. 00 113. 00
116.00	11600 H0SPI CE	6, 062	0		0 829, 138	0	116. 00

Health Financial Systems	ST. ELIZABE	ETH EAST		In Lieu of Form CMS-2552		
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					Date/Time Prep 5/27/2015 9:4	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(TIME	
	(DLRECT	(COSTED		(GROSS	SDENT)	

				10) 12/31/2014	5/27/2015 9:4	
C	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	·	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUI S.)	LI BRARY	(TIME	
		(DI RECT	(COSTED		(GROSS	SPENT)	
		NRSING HRS)	REQUI S.)		CHARGES)		
		13. 00	14. 00	15. 00	16. 00	17. 00	
	SUBTOTALS (SUM OF LINES 1-117)	1, 285, 718	100	100	825, 937, 392	37, 702	118. 00
	MBURSABLE COST CENTERS						
1 1	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	-	190. 00
1 1	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
194.00 07950 M		0	0	0	0	-	194. 00
194. 01 07951 L		0	0	0	0	-	194. 01
	PATIENT TRANSPORT	0	0	0	0	-	194. 02
1 1	SETON LEASE 1 NORTH	0	0	0	0	-	194. 03
200.00 C	Cross Foot Adjustments						200. 00
	legative Cost Centers						201. 00
	Cost to be allocated (per Wkst. B,	4, 304, 251	1, 451, 825	4, 611, 218	3, 342, 411	795, 668	202. 00
	Part I)						
203. 00 U	Unit cost multiplier (Wkst. B, Part I)	3. 347741	14, 518. 250000	46, 112. 180000	0. 004047	21. 104132	203. 00
	Cost to be allocated (per Wkst. B,	295, 953	461, 275	405, 184	227, 255	60, 222	204. 00
	Part II)						
	Jnit cost multiplier (Wkst. B, Part	0. 230185	4, 612. 750000	4, 051. 840000	0. 000275	1. 597316	205. 00
1	1)						

ST. ELIZABETH EAST In Lieu of Form CMS-2552-10 Health Financial Systems

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150109 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am Cost Center Description NURSING SCHOOL PARAMEDI CAL **EDUCATION** (ASSI GNED **PROGRAM** TIME) (ASSLGNED TIME) 20.00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 01160 COMMUNI CATI ONS 5.01 5.01 01140 MGMT INFO SYSTEMS 5.02 5.02 00550 PURCHASING 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 PATIENT ACCOUNTING 5.05 00560 OTHER ADMINISTRATIVE AND GENERAL 5 06 5 06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 02000 NURSING SCHOOL 100 20 00 20.00 02301 PARAMEDICAL EDUCATION PROGRAM 23.00 100 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 100 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 0 35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 35.00 04000 SUBPROVIDER - IPF 0 0 40.00 40.00 0 04100 SUBPROVI DER - I RF 41.00 0 41.00 04200 SUBPROVI DER 42.00 0 42.00 43.00 04300 NURSERY 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05100 RECOVERY ROOM 51.00 0 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000000 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 03630 ULTRA SOUND 55.00 0 55.00 0 56.00 05600 RADI OI SOTOPE 56.00 56.01 03950 CARDIAC CATH LAB 0 56, 01 05700 CT SCAN 0 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 58.00 60.00 06000 LABORATORY 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 58 73.00 07301 DI ABETES CENTER 73.01 0 73.01 0 74.00 07400 RENAL DIALYSIS 0 74 00 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLI NI C 0 0 0 90.00 09100 EMERGENCY 91 00 91 00 42 91.01 04950 WOUND CARE 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 95.00 99. 10 09910 CORF 0 0 99.10 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 109.00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 | SLET ACQUISITION 111. 00 0 113.00 11300 I NTEREST EXPENSE 113.00

116.00

116.00 11600 HOSPI CE

Health Financial Systems

ST. ELIZABETH EAST

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150109 | Period: From 01/01/2014 | From 01/01/20

				To 12/31/2014 Date/Time F 5/27/2015 9	
	Cost Center Description	NURSING SCHOOL	PARAMEDI CAL		
			EDUCATI ON		
		(ASSI GNED	PROGRAM		
		TIME)	(ASSI GNED		
			TIME)		
		20.00	23. 00		
118. 00	SUBTOTALS (SUM OF LINES 1-117)	100	100		118. 00
NO	NREIMBURSABLE COST CENTERS				
190. 00 19	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192. 00 19	200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
194. 00 07	950 MOB	0	0		194. 00
194. 01 07	951 LI FELI NE	0	0		194. 01
194. 02 07	952 PATI ENT TRANSPORT	0	0		194. 02
194. 03 07	953 SETON LEASE 1 NORTH	0	0		194. 03
200.00	Cross Foot Adjustments				200. 00
201.00	Negative Cost Centers				201. 00
202.00	Cost to be allocated (per Wkst. B,	2, 580, 448	123, 121		202. 00
	Part I)				
203.00	Unit cost multiplier (Wkst. B, Part I)	25, 804. 480000	1, 231. 210000		203. 00
204.00	Cost to be allocated (per Wkst. B,	797, 004	9, 081		204.00
	Part II)				
205.00	Unit cost multiplier (Wkst. B, Part	7, 970. 040000	90. 810000		205. 00
	11)				

Health Financial Systems
POST STEPDOWN ADJUSTMENTS In Lieu of Form CMS-2552-10
Worksheet B-2 ST. ELIZABETH EAST Period: Worksheet B-2 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am Provi der CCN: 150109

					5/2//2015 9:4	o am
			Works	sheet		
	Description		Part	Li ne No.	Amount	
	1.00		2. 00	3. 00	4. 00	
1.00	ADJ FOR EPO COSTS IN	RENAL	1	74. 00	0	1. 00
	DI ALYSI S					
2. 00	ADJ FOR EPO COSTS IN	HOME	1	94.00	0	2.00
	PROGRAM					
3. 00	ADJ FOR ARANESP COST	SIN	1	74.00	0	3.00
	RENAL DIALYSIS					
4. 00	ADJ FOR ARANESP COST	SIN	1	94.00	0	4.00
	HOME PROGRAM					
5. 00	ADJ FOR ESA COSTS IN	RENAL	1	74.00	0	5.00
	DI ALYSI S					
6. 00	ADJ FOR ESA COSTS IN	HOME	1	94.00	0	6.00
	PROGRAM					
7. 00	NURSING SCHOOL		1	30.00	-1, 284, 827	7. 00

| Peri od: | Worksheet C | From 01/01/2014 | Part | To | 12/31/2014 | Date/Time Prepared: 5/27/2015 9:45 am

						5/27/2015 9:4	5 am
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	•	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS	33, 101, 764		33, 101, 76	1, 805	33, 103, 569	30.00
							1
31.00	03100 NTENSI VE CARE UNI T	4, 741, 363		4, 741, 36			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	3, 667, 786		3, 667, 78			35. 00
40.00	04000 SUBPROVI DER - I PF	0			0	_	40. 00
41. 00	04100 SUBPROVI DER - I RF	2, 011, 451		2, 011, 45			41. 00
42.00	04200 SUBPROVI DER	0			0		42. 00
43.00	04300 NURSERY	1, 330, 524		1, 330, 52	4 0	1, 330, 524	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	33, 621, 683		33, 621, 68	3 0	33, 621, 683	50.00
51.00	05100 RECOVERY ROOM	1, 525, 288		1, 525, 28	8 0	1, 525, 288	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 525, 453		7, 525, 45			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 136, 526		18, 136, 52			54.00
55. 00	03630 ULTRA SOUND	708, 339		708, 33			55. 00
56. 00	05600 RADI OI SOTOPE	123, 770		123, 77			1
56. 01	03950 CARDI AC CATH LAB	3, 403, 542		3, 403, 54			56. 01
57. 00							57. 00
	05700 CT SCAN	1, 885, 845		1, 885, 84			
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	868, 604		868, 60		,	58.00
60.00	06000 LABORATORY	9, 309, 491		9, 309, 49			60.00
65.00	06500 RESPI RATORY THERAPY	3, 482, 889					
66. 00	06600 PHYSI CAL THERAPY	4, 033, 400		.,			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	380, 150	0	380, 15	0	380, 150	67. 00
68.00	06800 SPEECH PATHOLOGY	267, 176	0	267, 17	6 0	267, 176	68. 00
69.00	06900 ELECTROCARDI OLOGY	3, 061, 658		3, 061, 65	8 0	3, 061, 658	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	574, 587		574, 58	4, 980	579, 567	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 658, 038		17, 658, 03			
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	18, 606, 630		18, 606, 63			
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 651, 832		11, 651, 83			
73. 01	07301 DI ABETES CENTER	464, 518		464, 5			73. 01
74. 00	07400 RENAL DI ALYSI S	782, 374		782, 37			74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	110, 203		110, 20			76. 98
70. 90	OUTPATIENT SERVICE COST CENTERS	110, 203		110, 20	13 0	110, 203	70.90
00 00			I	I	0 0	1 0	00.00
88. 00	08800 RURAL HEALTH CLINIC	0			0 0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l		0 0		89. 00
90.00	09000 CLI NI C	905, 966		905, 96			90.00
91. 00	09100 EMERGENCY	13, 792, 414		13, 792, 41			91.00
91. 01	04950 WOUND CARE	759, 112		759, 1 ⁻	2 677	759, 789	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	1, 804, 521		1, 804, 52	1 0	1, 804, 521	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 241, 447		1, 241, 44	7 5, 334	1, 246, 781	95. 00
99, 10	09910 CORF	0			0	0	99. 10
	10100 HOME HEALTH AGENCY	5, 551, 002		5, 551, 00	12	5, 551, 002	101 00
	SPECIAL PURPOSE COST CENTERS	0,00.,002		0,00.,00		0,001,002	
100 00	10900 PANCREAS ACQUISITION	0			0	0	109. 00
	11000 INTESTINAL ACQUISITION	0			0		110.00
	11100 SLET ACQUI SI TI ON	0			0	1	111.00
	11300 NTEREST EXPENSE			405 -	_[113.00
	11600 H0SPI CE	680, 365	l e	680, 36		680, 365	
200.00		207, 769, 711	0	207, 769, 7			
201.00		0			0		201. 00
202.00	Total (see instructions)	207, 769, 711	0	207, 769, 7	1 182, 252	207, 951, 963	202. 00

Provi der CCN: 150109

						5/27/2015 9:4	5 am
			Ti tl	e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpatient	Total (col 6	Cost or Other	TEFRA	
	oost ochter beschiptron	1 inpati ont	outputiont	+ col . 7)	Ratio	Inpati ent	
				+ (01. 7)	Katio	Ratio	
		/ 00	7. 00	8. 00	9. 00		
	IDATI ENT DOUTING CEDVICE COCT CENTEDO	6.00	7.00	8.00	9.00	10. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	48, 362, 346		48, 362, 34			30. 00
	3100 INTENSIVE CARE UNIT	11, 543, 388		11, 543, 38	8		31.00
35. 00 02	2060 NEONATAL INTENSIVE CARE UNIT	11, 995, 576		11, 995, 57	6		35. 00
40.00 04	4000 SUBPROVI DER - I PF	l ol			ol		40.00
	4100 SUBPROVI DER - I RF	2, 923, 658		2, 923, 65	R		41.00
	4200 SUBPROVI DER	_,,			0		42.00
	4300 NURSERY	3, 104, 845		3, 104, 84	~		43. 00
	HOULIARY CERVICE COCT CENTERS	3, 104, 643		3, 104, 64	3		43.00
Ar	NCILLARY SERVICE COST CENTERS		04 000 444	154 000 70		0.00000	
	OPERATING ROOM	54, 939, 321	96, 293, 464			0. 000000	50. 00
	5100 RECOVERY ROOM	4, 484, 949	5, 404, 959			0. 000000	51.00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	18, 233, 023	531, 672	18, 764, 69	0. 401043	0.000000	52.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	11, 572, 613	59, 783, 625	71, 356, 23	0. 254169	0.000000	54.00
55.00 03	3630 ULTRA SOUND	1, 362, 460	4, 566, 043	5, 928, 50	0. 119480	0. 000000	55. 00
	5600 RADI OI SOTOPE	0	0		0.000000	0. 000000	
	3950 CARDI AC CATH LAB	12, 872, 876	12, 734, 877	1		0. 000000	
	5700 CT SCAN	11, 708, 478	31, 983, 824			0. 000000	
	MAGNETIC RESONANCE IMAGING (MRI)	4, 874, 189	8, 188, 670			0. 000000	
	6000 LABORATORY	31, 522, 892	35, 602, 894			0. 000000	
	5500 RESPIRATORY THERAPY	5, 931, 389	1, 049, 695			0. 000000	
66.00 06	6600 PHYSI CAL THERAPY	7, 705, 735	2, 014, 380	9, 720, 11	0. 414954	0.000000	66. 00
67.00 06	5700 OCCUPATIONAL THERAPY	1, 221, 718	322, 304	1, 544, 02	0. 246208	0.000000	67. 00
68.00 06	5800 SPEECH PATHOLOGY	115, 038	192, 627	307, 66	0. 868399	0. 000000	68. 00
	5900 ELECTROCARDI OLOGY	6, 272, 297	13, 027, 761			0. 000000	
	7000 ELECTROENCEPHALOGRAPHY	518, 951	1, 242, 742			0. 000000	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	53, 643, 880	45, 888, 638			0. 000000	
	7200 I MPL. DEV. CHARGED TO PATIENT	56, 803, 552	16, 214, 345			0. 000000	l
	7300 DRUGS CHARGED TO PATIENTS	39, 309, 856	20, 581, 907			0. 000000	
	7301 DI ABETES CENTER	1, 259	250, 091			0. 000000	
74.00 07	7400 RENAL DIALYSIS	1, 024, 640	37, 809	1, 062, 44	9 0. 736387	0.000000	74.00
76. 98 07	7698 HYPERBARIC OXYGEN THERAPY	23, 750	529, 322	553, 07	0. 199256	0.000000	76. 98
OL	JTPATIENT SERVICE COST CENTERS						
	B800 RURAL HEALTH CLINIC	0	C		O		88. 00
	B900 FEDERALLY QUALIFIED HEALTH CENTER	o	0				89. 00
	9000 CLINIC		799, 831		-	0. 000000	90.00
	9100 EMERGENCY	7, 561, 080	39, 084, 777	·		0. 000000	91.00
							1
	4950 WOUND CARE	13, 894	1, 569, 176			0. 000000	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	0. 000000	0. 000000	
	9201 OBSERVATION BEDS (DISTINCT PART)	668, 999	6, 125, 170	6, 794, 16	9 0. 265598	0. 000000	92. 01
07	THER REIMBURSABLE COST CENTERS						
95. 00 09	9500 AMBULANCE SERVICES	0	3, 244, 495	3, 244, 49	0. 382632	0. 000000	95. 00
	9910 CORF	l ol	0		ol		99. 10
	D100 HOME HEALTH AGENCY	0	7, 526, 504	7, 526, 50	4		101.00
	PECIAL PURPOSE COST CENTERS	<u> </u>	7,020,001	7,020,00	'		101.00
	0900 PANCREAS ACQUISITION	l ol	0		O		109. 00
		_					
	1000 INTESTINAL ACQUISITION	0	0		O		110.00
	1100 ISLET ACQUISITION	0	0	1	O		111. 00
	1300 INTEREST EXPENSE						113. 00
116. 00 1	1600 HOSPI CE	0	829, 138	829, 13	В		116. 00
200.00	Subtotal (see instructions)	410, 316, 652	415, 620, 740	825, 937, 39	2		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	410, 316, 652	415, 620, 740	825, 937, 39	2		202. 00
202.00	1.525. (500 111511 4011 0115)	1 110, 010, 002	110,020,740	020, 707, 07	-1	l	1-32.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES ST. ELIZABETH EAST Provi der CCN: 150109

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 9: 45 am | Page 148 | Pa

		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				35.00
40. 00 04000 SUBPROVI DER - I PF				40.00
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	0.000017			F0.00
50. 00 05000 OPERATI NG ROOM	0. 222317			50.00
51. 00 05100 RECOVERY ROOM	0. 154227			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 401043 0. 254948			52. 00 54. 00
55. 00 03630 ULTRA SOUND	0. 254948			55. 00
56. 00 05600 RADI 01 SOTOPE	0. 000000			56. 00
56. 01 03950 CARDI AC CATH LAB	0. 132911			56. 01
57. 00 05700 CT SCAN	0. 043162			57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 066494			58.00
60. 00 06000 LABORATORY	0. 139318			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 500995			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 414954			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 246208			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 868399			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 158635			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 328983			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 177410			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 254823			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 194548			73. 00
73. 01 07301 DI ABETES CENTER	1. 870503			73. 01
74. 00 07400 RENAL DIALYSIS	0. 736387			74. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 199256			76. 98
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00 09000 CLI NI C	1. 132697			90.00
91. 00 09100 EMERGENCY	0. 295684			91.00
91. 01 04950 WOUND CARE	0. 479947			91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 265598			92. 01
OTHER REIMBURSABLE COST CENTERS	0.00407/			05.00
95. 00 09500 AMBULANCE SERVICES	0. 384276			95. 00
99. 10 09910 CORF				99. 10
101. 00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				109.00
109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION				110.00
111. 00 11100 INTESTINAL ACQUISITION				111.00
113. 00 11300 I NTEREST EXPENSE				113.00
116. 00 11600 H0SPI CE				116. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202. 00 Total (see instructions)				202.00
	1			1=02.00

					10 12/31/2014	5/27/2015 9:4	5 am
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	7.09		Di Gai i Gilanoo		
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00	03000 ADULTS & PEDIATRICS	33, 101, 764		33, 101, 76	4 1, 805	33, 103, 569	30.00
31. 00	03100 I NTENSI VE CARE UNI T	4, 741, 363		4, 741, 36	· ·	4, 741, 363	31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	3, 667, 786		3, 667, 78			35.00
40. 00	04000 SUBPROVI DER - I PF	3,007,700		3,007,70	0 31, 233	3, 719, 041	40.00
41. 00	04100 SUBPROVIDER - I RF	2 011 451		2 011 45	-	_	41.00
		2, 011, 451		2, 011, 45			
42.00	04200 SUBPROVI DER	1 220 524			-		42.00
43. 00	04300 NURSERY	1, 330, 524		1, 330, 52	4 0	1, 330, 524	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	00 (04 (00		00 (04 (6		00 (04 (00	F0 00
50.00	05000 OPERATI NG ROOM	33, 621, 683		33, 621, 68		,,	
51.00	05100 RECOVERY ROOM	1, 525, 288		1, 525, 28			
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 525, 453		7, 525, 45		.,,	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	18, 136, 526		18, 136, 52			54. 00
55.00	03630 ULTRA SOUND	708, 339		708, 33			
56.00	05600 RADI 0I SOTOPE	123, 770		123, 77			1
56. 01	03950 CARDI AC CATH LAB	3, 403, 542		3, 403, 54			56. 01
57.00	05700 CT SCAN	1, 885, 845		1, 885, 84	5 0	1, 885, 845	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	868, 604		868, 60	4 0	868, 604	58. 00
60.00	06000 LABORATORY	9, 309, 491		9, 309, 49	1 42, 351	9, 351, 842	60.00
65.00	06500 RESPI RATORY THERAPY	3, 482, 889	0	3, 482, 88	9 14, 601	3, 497, 490	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 033, 400	Ō	4, 033, 40	0 0	4, 033, 400	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	380, 150	0	380, 15	0 0	380, 150	67. 00
68. 00	06800 SPEECH PATHOLOGY	267, 176	0	267, 17		267, 176	
69. 00	06900 ELECTROCARDI OLOGY	3, 061, 658		3, 061, 65			1
70. 00	07000 ELECTROENCEPHALOGRAPHY	574, 587		574, 58			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 658, 038		17, 658, 03	· ·		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	18, 606, 630		18, 606, 63			
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 651, 832		11, 651, 83			
73. 01	07301 DI ABETES CENTER	464, 518		464, 51		470, 151	73. 01
74. 00	07400 RENAL DIALYSIS	782, 374		782, 37			
76. 98	07498 HYPERBARI C OXYGEN THERAPY	110, 203		110, 20			
70. 70	OUTPATIENT SERVICE COST CENTERS	110, 203		110, 20	5	110, 203	70.70
88. 00	08800 RURAL HEALTH CLINIC	0		I	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				0 0		89.00
90.00	09000 CLINIC	905, 966		905, 96			90.00
91. 00	09100 EMERGENCY	13, 792, 414		13, 792, 41			91.00
91.00							
	04950 WOUND CARE	759, 112		759, 11		759, 789	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 004 531			0	1 004 531	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	1, 804, 521		1, 804, 52	1 0	1, 804, 521	92. 01
	OTHER REIMBURSABLE COST CENTERS				= = = = = = = = = = = = = = = = = = = =	4 044 704	
95. 00	09500 AMBULANCE SERVICES	1, 241, 447		1, 241, 44		1, 246, 781	
	09910 CORF	0			0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	5, 551, 002		5, 551, 00	2	5, 551, 002	101. 00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0			0		109. 00
	11000 NTESTINAL ACQUISITION	0			0		110. 00
111.00	11100 ISLET ACQUISITION	0			0	0	111. 00
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	680, 365		680, 36	5	680, 365	116. 00
200.00	Subtotal (see instructions)	207, 769, 711	0	207, 769, 71	1 182, 252	207, 951, 963	200.00
201.00	Less Observation Beds	o			0	0	201. 00
202.00	Total (see instructions)	207, 769, 711	0	207, 769, 71	1 182, 252	207, 951, 963	202. 00

Provi der CCN: 150109

							5/27/2015 9:4	5 am
				Ti t	le XIX	Hospi tal	Cost	
				Charges				
		Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			•		+ col. 7)	Ratio	Inpati ent	
							Ratio	
			6.00	7. 00	8. 00	9. 00	10.00	
	INPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48, 362, 346		48, 362, 346			30.00
31.00	03100	INTENSIVE CARE UNIT	11, 543, 388		11, 543, 388			31.00
35. 00		NEONATAL INTENSIVE CARE UNIT	11, 995, 576		11, 995, 576			35. 00
40. 00		SUBPROVIDER - I PF	0		1			40. 00
41. 00		SUBPROVIDER - IRF	2, 923, 658		2, 923, 658			41. 00
42. 00		SUBPROVI DER	2, 720, 000		2, 720, 000			42. 00
43. 00		NURSERY	3, 104, 845		3, 104, 845			43. 00
43.00		LARY SERVICE COST CENTERS	3, 104, 043		3, 104, 043			45.00
50.00		OPERATING ROOM	54, 939, 321	96, 293, 464	151, 232, 785	0. 222317	0. 000000	50.00
51. 00		RECOVERY ROOM						
			4, 484, 949	5, 404, 959			0.000000	
52. 00		DELIVERY ROOM & LABOR ROOM	18, 233, 023	531, 672			0.000000	
54.00		RADI OLOGY-DI AGNOSTI C	11, 572, 613	59, 783, 625			0. 000000	
55. 00		ULTRA SOUND	1, 362, 460	4, 566, 043			0. 000000	
56. 00		RADI OI SOTOPE	0	0		0. 000000	0. 000000	
56. 01		CARDI AC CATH LAB	12, 872, 876	12, 734, 877			0. 000000	
57. 00		CT SCAN	11, 708, 478	31, 983, 824			0. 000000	
58.00		MAGNETIC RESONANCE IMAGING (MRI)	4, 874, 189	8, 188, 670			0. 000000	58. 00
60.00		LABORATORY	31, 522, 892	35, 602, 894	67, 125, 786		0.000000	60.00
65.00		RESPI RATORY THERAPY	5, 931, 389	1, 049, 695	6, 981, 084	0. 498904	0. 000000	65. 00
66.00	06600	PHYSI CAL THERAPY	7, 705, 735	2, 014, 380	9, 720, 115	0. 414954	0.000000	66. 00
67.00	06700	OCCUPATI ONAL THERAPY	1, 221, 718	322, 304	1, 544, 022	0. 246208	0.000000	67. 00
68.00		SPEECH PATHOLOGY	115, 038	192, 627	307, 665	0. 868399	0.000000	68. 00
69.00	06900	ELECTROCARDI OLOGY	6, 272, 297	13, 027, 761	19, 300, 058		0. 000000	
70.00	07000	ELECTROENCEPHALOGRAPHY	518, 951	1, 242, 742			0. 000000	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	53, 643, 880	45, 888, 638			0.000000	
72. 00		IMPL. DEV. CHARGED TO PATIENT	56, 803, 552	16, 214, 345			0. 000000	
73. 00		DRUGS CHARGED TO PATIENTS	39, 309, 856	20, 581, 907			0. 000000	
73. 01		DI ABETES CENTER	1, 259	250, 091			0. 000000	
74. 00		RENAL DIALYSIS	1, 024, 640	37, 809			0. 000000	
76. 98		HYPERBARI C OXYGEN THERAPY	23, 750	529, 322			0. 000000	
70. 90		TIENT SERVICE COST CENTERS	23, 730	329, 322	555, 072	0. 199230	0.000000	70.90
88. 00	00174	RURAL HEALTH CLINIC	ol	0	0	0. 000000	0. 000000	88. 00
			- 1					
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	700 001			0.000000	
90.00		CLI NI C	0	799, 831			0.000000	
91.00		EMERGENCY	7, 561, 080	39, 084, 777			0.000000	
91. 01		WOUND CARE	13, 894	1, 569, 176	1, 583, 070		0. 000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C	0. 000000	0. 000000	
92. 01		OBSERVATION BEDS (DISTINCT PART)	668, 999	6, 125, 170	6, 794, 169	0. 265598	0. 000000	92. 01
		REIMBURSABLE COST CENTERS						
95.00		AMBULANCE SERVICES	0	3, 244, 495	3, 244, 495	0. 382632	0.000000	
99. 10	09910		0	0	C			99. 10
101.00		HOME HEALTH AGENCY	0	7, 526, 504	7, 526, 504			101. 00
	SPECIA	AL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	C			109. 00
110.00	11000	INTESTINAL ACQUISITION	О	0	C			110. 00
		ISLET ACQUISITION	0	0	C			111. 00
		INTEREST EXPENSE						113. 00
		HOSPI CE	o	829, 138	829, 138			116. 00
200.00		Subtotal (see instructions)	410, 316, 652	415, 620, 740				200.00
201.00	1	Less Observation Beds	, ,					201. 00
202.00		Total (see instructions)	410, 316, 652	415, 620, 740	825, 937, 392			202. 00
00	1	(, 5 . 5 , 5 0 2	, 020, 710	1, , 5., 5,2	1	1	,

Heal th Financial Systems ST. ELIZABETH EAST In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150109 | Period: From 01/01/2014 | Part I To 12/31/2014 | Date/Time Prepared:

5/27/2015 9:45 am Title XIX Hospi tal Cost Cost Center Description PPS Inpatient Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 40.00 04000 SUBPROVI DER - I PF 40.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 42.00 04200 SUBPROVI DER 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 51. 00 05100 RECOVERY ROOM 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 03630 ULTRA SOUND 0.000000 55.00 55.00 56. 00 05600 RADI OI SOTOPE 0.000000 56.00 56.01 03950 CARDIAC CATH LAB 0.000000 56.01 05700 CT SCAN 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 58.00 06000 LABORATORY 0.000000 60.00 60 00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 66.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 73. 01 07301 DI ABETES CENTER 0.000000 73.01 07400 RENAL DIALYSIS 74.00 0.000000 74.00 76.98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 89.00 90.00 09000 CLI NI C 0.000000 90.00 09100 EMERGENCY 91.00 0.000000 91.00 04950 WOUND CARE 0.000000 91.01 91.01 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0.000000 95.00 99. 10 09910 CORF 99. 10 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 | SLET ACQUISITION 111. 00 113.00 11300 INTEREST EXPENSE 113.00

116. 00

200.00

201.00

202.00

116. 00 11600 HOSPI CE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

Health Financial Systems	ST. ELIZAB	RETH FAST		In lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL				Period: From 01/01/2014 To 12/31/2014	Worksheet D Part I	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26) 1. 00	2.00	2)	4.00	Г 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
30.00 ADULTS & PEDIATRICS	6, 606, 380	0	6, 606, 38	0 28, 214	234. 15	30.00
31. 00 INTENSIVE CARE UNIT	1, 072, 689	l .	1, 072, 68		l	
35. 00 NEONATAL INTENSIVE CARE UNIT	538, 723		538, 72			35.00
40. 00 SUBPROVI DER - I PF	030,729		330, 72	0 2,730	0.00	
41. 00 SUBPROVI DER - I RF	103, 461		103, 46	٥	51, 29	
42. 00 SUBPROVI DER	0		1	0 0	0.00	
43. 00 NURSERY	233, 306		233, 30	-	•	
200.00 Total (lines 30-199)	8, 554, 559	l .	8, 554, 55			200. 00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 ADULTS & PEDIATRICS	11, 844					30.00
31. 00 INTENSIVE CARE UNIT	1, 852	571, 027				31.00
35. 00 NEONATAL INTENSIVE CARE UNIT	0		1			35. 00
40. 00 SUBPROVIDER - I PF	1 000	54.44	1			40.00
41. 00 SUBPROVI DER - I RF 42. 00 SUBPROVI DER	1,003	51, 444				41.00
42. 00 SUBPROVI DER 43. 00 NURSERY						42. 00 43. 00
43.00 NURSERY 200.00 Total (lines 30-199)	14, 699	3, 395, 744	1			200. 00
200.00 10tal (111185 30-199)	14, 099	J 3, 393, 744	1			1200.00

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	F	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/27/2015 9:4	pare 5 ai
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal			Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost			to Charges	Program	(column 3 x	
	(from Wkst. B,			(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.		8)	2)			
	26)						
	1.00	2	. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS							4
.00 05000 OPERATING ROOM	2, 625, 657		, 232, 785			463, 388	
. 00 05100 RECOVERY ROOM	214, 415	1	, 889, 908	0. 02168		48, 384	
.00 05200 DELIVERY ROOM & LABOR ROOM	1, 323, 109	1	, 764, 695	0. 07051		2, 127	52
. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 246, 388		, 356, 238		.,	206, 409	
. 00 03630 ULTRA SOUND	63, 036		, 928, 503	0. 01063		7, 181	55
. 00 05600 RADI 0I SOTOPE	39, 630		0	0.00000		0	
. 01 03950 CARDI AC CATH LAB	715, 393		, 607, 753	0. 02793		180, 327	56
. 00 05700 CT SCAN	184, 381		, 692, 302	0. 00422		24, 586	
.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	112, 337	13	, 062, 859	0. 00860		21, 659	58
. 00 06000 LABORATORY	702, 317		, 125, 786	0. 01046	16, 500, 731	172, 647	60
. 00 06500 RESPIRATORY THERAPY	490, 428	6	, 981, 084	0. 07025		214, 987	65
. 00 06600 PHYSI CAL THERAPY	368, 917		, 720, 115	0. 03795	4 3, 186, 290	120, 932	66
. 00 06700 OCCUPATI ONAL THERAPY	12, 374	1	, 544, 022	0. 00801	4 116, 141	931	67
. 00 06800 SPEECH PATHOLOGY	51, 288		307, 665	0. 16670	1 22, 072	3, 679	68
. 00 06900 ELECTROCARDI OLOGY	588, 663	19	, 300, 058	0. 03050	3, 592, 046	109, 561	69
. 00 07000 ELECTROENCEPHALOGRAPHY	85, 338	1	, 761, 693	0. 04844	1 263, 117	12, 746	70
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	421, 391	99	, 532, 518	0. 00423	4 21, 370, 971	90, 485	71
.00 07200 IMPL. DEV. CHARGED TO PATIENT	430, 532	73	, 017, 897	0. 00589		179, 592	72
.00 07300 DRUGS CHARGED TO PATIENTS	499, 208	59	, 891, 763	0. 00833	5 18, 755, 719	156, 329	73
. 01 07301 DI ABETES CENTER	10, 787	·	251, 350	0. 04291		52	73
. 00 07400 RENAL DIALYSIS	220, 866	1	, 062, 449	0. 20788	678, 329	141, 014	74
. 98 07698 HYPERBARIC OXYGEN THERAPY	1, 241		553, 072	0. 00224	4 363	1	76
OUTPATIENT SERVICE COST CENTERS	<u>.</u>						ĺ
. 00 08800 RURAL HEALTH CLINIC	0		0	0.00000	0 0	0	88
.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0.00000	0	0	89
. 00 09000 CLI NI C	18, 039		799, 831	0. 02255	0	0	90
. 00 09100 EMERGENCY	2, 822, 931	46	, 645, 857	0. 06051		226, 095	91
. 01 04950 WOUND CARE	149, 686	1	, 583, 070	0. 09455	0	0	91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0. 00000		0	92
. 01 09201 OBSERVATION BEDS (DISTINCT PART)	238, 890	6	, 794, 169	0. 03516	1 416, 706	14, 652	92
OTHER REIMBURSABLE COST CENTERS							
. 00 09500 AMBULANCE SERVI CES							95
0.00 Total (lines 50-199)	14, 637, 242	736	, 407, 442		153, 142, 979	2, 397, 764	1200

Health Financial Systems							
Title XVIII Hospital Prepared: 5/27/2015 9:45 am Prepared: 5/27/2015 am Prepared: 5/27/2015 am Prepared: 5/27/2015 am Prepared: 5/27/2015 am	Health Financial Systems						2552-10
To 12/31/2014 Date/Time Prepared: 5/27/2015 9: 45 am PPS	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	TS Provi der				
Title XVIII							narod:
Nursing School Allied Health Cost Medical Education Cost Allied Health All Other Medical Education Cost Amount (see Instructions) Instructions In					10 12/31/2014	5/27/2015 9:4	pareu. 5 am
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1, 295, 621 0 0 0 0 0 0 0 0 0			Ti tl	e XVIII	Hospi tal		<u> </u>
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00	Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
INPATI ENT ROUTINE SERVICE COST CENTERS 1,295,621 0 0 0 0 0 0 35.00			Cost	Medi cal	Adjustment	(sum of cols.	
1.00 2.00 3.00 4.00 5.00				Education Cos	t Amount (see	1 through 3,	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1,295,621 0					instructions)	minus col. 4)	
30.00 30.00 ADULTS & PEDIATRICS 1, 295, 621 0 0 0 1, 295, 621 30.00 31.00		1.00	2. 00	3.00	4. 00	5. 00	
31. 00							
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 0 0 0 0 0 35. 00 04000 SUBPROVI DER - I PF 0 0 0 0 0 0 0 0 0		1, 295, 621	0	1	0	1, 295, 621	
A0.00		0	0	1	0	0	
A1. 00		0	0	1	0	0	
A2. 00		0	0	1	0	0	40. 00
A3.00		0	0	1	0	0	
Total (lines 30-199)		0	0	1	0	0	
Total Patient Days	43. 00 04300 NURSERY	0	0	1	0	0	43.00
Days 5 ÷ col . 6 Program Days Program Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 7 x col . 8 Pass-Through Cost (col . 8 Pass-Through		1, 295, 621	0		0	1, 295, 621	200. 00
Pass-Through Cost (col. 7 x col. 8) 6.00 7.00 8.00 9.00	Cost Center Description	Total Patient	Per Diem (col.				
Cost (col. 7 x col. 8) 6.00 7.00 8.00 9.00		Days	5 ÷ col. 6)	Program Days			
NPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 28,214 45.92 11,844 543,876 30.00 3100 INTENSI VE CARE UNIT 3,479 0.00 1,852 0 31.00 35.00 02060 NEONATAL INTENSI VE CARE UNIT 2,756 0.00 0 0 0 35.00 40.00 04000 SUBPROVI DER - I PF 0 0.00 0 0 0 40.00 41.00 04100 SUBPROVI DER - I RF 2,017 0.00 1,003 0 41.00 42.00 04200 SUBPROVI DER 0 0.00 0 0 0 0 0 0 0							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 3000 ADULTS & PEDI ATRI CS 28,214 45.92 11,844 543,876 30.00 31.00 31.00 31.00 INTENSI VE CARE UNI T 3,479 0.00 1,852 0 31.00 35.00 02060 NEONATAL INTENSI VE CARE UNI T 2,756 0.00 0 0 0 35.00 40.00 04000 SUBPROVI DER - I PF 0 0.00 0 0 0 40.00 41.00 04100 SUBPROVI DER - I RF 2,017 0.00 1,003 0 41.00 42.00 04200 SUBPROVI DER 0 0.00 0 0 0 0 0 0 0							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 3000 ADULTS & PEDI ATRI CS 28, 214 45.92 11, 844 543, 876 30.00 31.00 31.00 INTENSI VE CARE UNI T 3, 479 0.00 1, 852 0 31.00 35.00 02060 NEONATAL INTENSI VE CARE UNI T 2, 756 0.00 0 0 0 35.00 40.00 SUBPROVI DER - I PF 0 0.00 0 0 40.00 41.00 04100 SUBPROVI DER - I RF 2, 017 0.00 1, 003 0 41.00 42.00 04200 SUBPROVI DER 0 0.00 0 0 0 0 0 0 0							
30. 00		6. 00	7. 00	8.00	9. 00		
31. 00		1					
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 2,756 0.00 0 0 35. 00 0.00 0 0 0 0 0 0 0			l .				
40. 00 04000 SUBPROVI DER - I PF 0 0.00 0 0 40. 00 41. 00 04100 SUBPROVI DER - I RF 2, 017 0. 00 1, 003 0 41. 00 42. 00 04200 SUBPROVI DER 0 0 0 0 0 42. 00							
41. 00 04100 SUBPROVI DER - I RF 2, 017 0. 00 1, 003 0 41. 00 42. 00 04200 SUBPROVI DER 0 0 0 0 0 0 0 0 0		2, 756			0		
42. 00 04200 SUBPROVI DER 0 0. 00 0 42. 00		0			0		
		1					
43. 00 04300 NURSERY 1 1. 236 0. 00 0 0 43. 00		1	l e		0		
			l e	1	0		
200.00 Total (lines 30-199) 37,702 14,699 543,876 200.00	200.00 lotal (lines 30-199)	37, 702		14, 69	543, 876		J200. 00

Health Financial Systems	ST. ELI ZABETH	EAST		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN:		Period: From 01/01/2014	Worksheet D Part IV	
Inkough Costs				To 12/31/2014		oared: 5 am
		Title XV	111	Hospi tal	PPS	
Cost Center Description	Non Physician Nurs	ing School Alli	ed Health	All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	

			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health	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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	(0	0	0	50.00
	05100 RECOVERY ROOM	0	(0	0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0	0	0	54. 00
	03630 ULTRA SOUND	0	(0	0	0	55. 00
	05600 RADI 0I SOTOPE	0	() C	0	0	56. 00
	03950 CARDI AC CATH LAB	0	() C	0	0	56. 01
57.00	05700 CT SCAN	0	() C	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0	0	0	58. 00
60.00	06000 LABORATORY	0	(0	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	(0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	(0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	(0	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	(0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	() c	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	() c	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	() c	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	() c	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(71, 410	0	71, 410	73.00
73. 01	07301 DI ABETES CENTER	0	() c	0	0	73. 01
74.00	07400 RENAL DI ALYSI S	0	(0	0	74. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0) c	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	(0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0	0	0	89. 00
90.00	09000 CLI NI C	0	(0	0	0	90. 00
91.00	09100 EMERGENCY	0	(51, 711	0	51, 711	91. 00
91. 01	04950 WOUND CARE	0	(0	0	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	() c	0	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	(0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50-199)	0	(123, 121	0	123, 121	200. 00

APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	ST. ELIZAE RVICE OTHER PAS			Period: From 01/01/2014 To 12/31/2014		pared:
		_		e XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cost		I npati 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 .		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	_	1				
50.00	05000 OPERATI NG ROOM	0					
51.00	05100 RECOVERY ROOM	0					1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0. 000000			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	,				
55.00	03630 ULTRA SOUND	0	-, ,				
56.00	05600 RADI OI SOTOPE	0	_	0. 000000			
56. 01	03950 CARDI AC CATH LAB	0		0. 000000			
57. 00	05700 CT SCAN	0		0. 000000			
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0. 000000			
60.00	06000 LABORATORY	0					
65.00	06500 RESPI RATORY THERAPY	0	0,70.,00.	0. 000000		3, 060, 264	
66. 00	06600 PHYSI CAL THERAPY	0	.,.==,				
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 544, 022	0. 000000			1
68. 00	06800 SPEECH PATHOLOGY	0		0. 000000			
69. 00	06900 ELECTROCARDI OLOGY	0					
70.00	07000 ELECTROENCEPHALOGRAPHY	0	.,,				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0		0. 000000			
73.00	07300 DRUGS CHARGED TO PATIENTS	71, 410					
73. 01	07301 DI ABETES CENTER	0					
74.00	07400 RENAL DIALYSIS	0					
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	553, 072	0. 00000	0. 000000	363	76. 98
	OUTPATIENT SERVICE COST CENTERS	_		-			1
88. 00	08800 RURAL HEALTH CLINIC	0					
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0. 000000			
90.00	09000 CLI NI C	0	,	0. 000000			
91.00	09100 EMERGENCY	51, 711		0. 00110			
91. 01	04950 WOUND CARE	0	,	0. 000000			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0. 000000			92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	6, 794, 169	0. 000000	0.000000	416, 706	92. 01
	OTHER REIMBURSABLE COST CENTERS	_					1
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	123, 121	736, 407, 442			153, 142, 979	

Health Financial Systems	ST. ELI ZABETH EAST	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Prov	From 01/01/2014	Worksheet D Part IV Date/Time Prepared:

						5/27/2015 9:45 a	am
				e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col. 4	9		
		x col. 10)		x col. 12)			
		11.00	12. 00	13. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	10, 874, 446		0		0. 00
51.00	05100 RECOVERY ROOM	0	1, 046, 046		0	51	1. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	364		0	52	2. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	10, 094, 171		0	54	4. 00
55.00	03630 ULTRA SOUND	0	1, 017, 206		0	55	5. 00
56.00	05600 RADI OI SOTOPE	0	0		0	56	6. 00
56. 01	03950 CARDI AC CATH LAB	0	6, 129, 803		0	56	6. 01
57.00	05700 CT SCAN	o	9, 162, 243		0	57	7. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	2, 525, 005		0	58	8. 00
60.00	06000 LABORATORY	0	7, 846, 883		0	60	0. 00
65.00	06500 RESPIRATORY THERAPY	0	333, 144		0	65	5. 00
66.00	06600 PHYSI CAL THERAPY	0	1, 166, 233		0	66	6. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		o	67	7. 00
68. 00	06800 SPEECH PATHOLOGY	0	6, 674		0	68	8. 00
69. 00	06900 ELECTROCARDI OLOGY	0	5, 008, 578		0		9. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	266, 665		o		0. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10, 483, 489		o		1. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	9, 981, 968		o		2. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	22, 357	8, 141, 069		04		3. 00
73. 01	07301 DI ABETES CENTER	0	368	· ·	0		3. 01
74. 00	07400 RENAL DI ALYSI S	0	33, 777		Ö		4. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	303, 528		0		6. 98
70.70	OUTPATIENT SERVICE COST CENTERS	9	000,020		<u> </u>	, ,	3. 70
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	88	8. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0		9. 00
90. 00	09000 CLINIC		0				0. 00
91. 00	09100 EMERGENCY	4, 143	7, 824, 040	8, 67	7		1. 00
91. 01	04950 WOUND CARE	0	7,024,040		0		1. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0		2. 00
92. 00	09201 OBSERVATION BEDS (NON-DISTINCT PART)		1, 266, 250		0		2. 00
7Z. UI	OTHER REIMBURSABLE COST CENTERS	ı o	1, 200, 200		<u> </u>	72	<u>.</u> . U I
95. 00						OF	5. 00
200.00		26, 500	93, 511, 950	18, 38	21		0. 00
200.00	10tai (111163 30-177)	20, 300	73, 311, 730	10,30	'''	1200	5. 00

Health Financial Systems	ST.	ELIZABETH EAST		In Lie	ı of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE	COST Provi der (CCN: 150109	Peri od:	Worksheet D

From 01/01/2014 Part V To 12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am Title XVIII Hospi tal PPS Costs Charges Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 222317 10, 874, 446 2, 417, 574 50.00 51.00 05100 RECOVERY ROOM 0. 154227 1, 046, 046 0 0 161, 329 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 401043 364 146 52 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 254169 10, 094, 171 2, 565, 625 54.00 55.00 03630 ULTRA SOUND 0.119480 1, 017, 206 0 121, 536 55.00 05600 RADI OI SOTOPE 0.000000 0 0 56 00 Ω 56 00 0 56.01 03950 CARDI AC CATH LAB 0.132911 6, 129, 803 814, 718 56.01 57.00 05700 CT SCAN 0.043162 9, 162, 243 0 395, 461 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.066494 2, 525, 005 0 167, 898 58.00 06000 LABORATORY 0 138687 180 1, 088, 261 60 00 7, 846, 883 60 00 65.00 06500 RESPIRATORY THERAPY 0.498904 333, 144 0 166, 207 65.00 06600 PHYSI CAL THERAPY 0.414954 1, 166, 233 0 483, 933 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 0. 246208 0 67.00 67.00 0 5, 796 68 00 06800 SPEECH PATHOLOGY 0.868399 6,674 68 00 69.00 06900 ELECTROCARDI OLOGY 0. 158635 5, 008, 578 0 0 794, 536 69.00 07000 ELECTROENCEPHALOGRAPHY 0 86, 974 70.00 0. 326156 266, 665 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 177410 10, 483, 489 0 0 1, 859, 876 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72 00 0.254823 9, 981, 968 2, 543, 635 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 194548 8, 141, 069 0 158, 453 1, 583, 829 73.00 07301 DIABETES CENTER 0 73.01 1.848092 368 0 680 73.01 07400 RENAL DIALYSIS 0 74.00 0.736387 33.777 0 24.873 74.00 07698 HYPERBARI C OXYGEN THERAPY 0. 199256 0 76.98 303, 528 60, 480 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0. 000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 0 90.00 09000 CLI NI C 1.132697 0 Λ 90.00 09100 EMERGENCY 0. 295684 7, 824, 040 0 0 91.00 2, 313, 443 91.00 0 0 91.01 04950 WOUND CARE 0.479519 Ω 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92 00 0.000000 Λ 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0. 265598 1, 266, 250 0 336, 313 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.382632 95.00 0 200.00 Subtotal (see instructions) 93, 511, 950 180 158, 453 17, 993, 123 200. 00 201.00 Less PBP Clinic Lab. Services-Program C 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 93, 511, 950 180 158, 453 17, 993, 123 202. 00

Health Financial Systems

ST. ELIZABETH EAST

In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150109

Period: Worksheet D

From 01/01/2014 | Part V

				To 12/31/2014	Date/Time Pre 5/27/2015 9:4	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCI LLARY SERVI CE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM		0				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0				54.00
55. 00 03630 ULTRA SOUND		0				55. 00
56. 00 05600 RADI OI SOTOPE		0				56. 00
56. 01 03950 CARDI AC CATH LAB		0				56. 01
57. 00 05700 CT SCAN		0				57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0				58.00
60. 00 06000 LABORATORY	25	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	30, 827				73.00
73. 01 07301 DI ABETES CENTER	O	0				73. 01
74.00 07400 RENAL DIALYSIS	O	0				74.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	O	0				76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	0	0				91. 00
91. 01 04950 WOUND CARE	0	0				91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1			92. 00
92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART)	0	0				92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	00.007				95. 00
200.00 Subtotal (see instructions)	25	30, 827	l			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges Not Charges (Line 200 / Line 201)	35	20 027				202 00
202.00 Net Charges (line 200 +/- line 201)	25	30, 827	I			202. 00

Heal th	Financial Systems	ST. ELIZAE	BETH EAST		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		CCN: 150109 t CCN: 15T109	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre	
			Ti tl	e XVIII	Subprovi der -	5/27/2015 9: 4 PPS	<u>5 am</u>
	Cost Center Description	Capi tal	Total Charges	Patio of Cos	I RF t I npati ent	Capital Costs	
	oust defiter beschiptron		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B.				column 4)	
		Part II, col.	8)	2)			
		26)	,	<u> </u>			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATING ROOM	2, 625, 657	151, 232, 785	0. 01736	0	0	50. 00
51.00	05100 RECOVERY ROOM	214, 415	9, 889, 908	0. 02168	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 323, 109	18, 764, 695	0. 07051	1 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 246, 388	71, 356, 238	0. 03148	29, 839	939	54.00
55.00	03630 ULTRA SOUND	63, 036		0. 01063	3, 503	37	55. 00
56.00	05600 RADI 0I SOTOPE	39, 630	C	0. 00000	0 0	0	56.00
56. 01	03950 CARDI AC CATH LAB	715, 393	25, 607, 753	0. 02793	0	0	56. 01
57.00	05700 CT SCAN	184, 381	43, 692, 302	0. 00422	20 37, 353	158	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	112, 337	13, 062, 859	0. 00860	0 0	0	58. 00
60.00	06000 LABORATORY	702, 317	67, 125, 786	0. 01046	339, 948	3, 557	60.00
65.00	06500 RESPI RATORY THERAPY	490, 428	6, 981, 084	0. 07025	140, 546	9, 873	65. 00
66.00	06600 PHYSI CAL THERAPY	368, 917	9, 720, 115	0. 03795	1, 314, 251	49, 881	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	12, 374	1, 544, 022	0. 00801	4 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	51, 288	307, 665	0. 16670	28, 692	4, 783	68. 00
69.00	06900 ELECTROCARDI OLOGY	588, 663	19, 300, 058	0. 03050	1, 841	56	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	85, 338	1, 761, 693	0. 04844	11 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	421, 391	99, 532, 518	0.00423	55, 073	233	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	430, 532	73, 017, 897	0.00589	96 820	5	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	499, 208				2, 751	73. 00
73. 01	07301 DI ABETES CENTER	10, 787	251, 350	0. 04291	6 0	0	73. 01
74.00	07400 RENAL DIALYSIS	220, 866	1, 062, 449			8, 062	74. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 241	553, 072	0. 00224	14 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	C			0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89. 00
90.00	09000 CLI NI C	18, 039	799, 831			0	1
91.00	09100 EMERGENCY	2, 822, 931	46, 645, 857			2	91. 00
91. 01	04950 WOUND CARE	149, 686	1, 583, 070			0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0.0000		0	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	238, 890	6, 794, 169	0. 03516	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES			[95. 00
200. 00	Total (lines 50-199)	14, 637, 242	736, 407, 442	1	2, 320, 699	80, 337	200. 00

	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	ST. ELIZABETI RVICE OTHER PASS	Provi der	CCN: 150109 CCN: 15T109	Peri od: From 01/01/2014 To 12/31/2014		pared:
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician Nu Anesthetist Cost	rsing School	Allied Healt	h All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	LANGULLA DV. OFD. 4 OF COOT OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	T al		T			
50.00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0	0		0 0	0	
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0			0	
55. 00	03630 ULTRA SOUND	0	0			0	
56. 00	05600 RADI OI SOTOPE	o	0		0 0	Ö	
56. 01	03950 CARDI AC CATH LAB	0	0		0 0	0	56. 01
57.00	05700 CT SCAN	0	0		0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS		0	71, 41	-	71, 410	
73. 00	07301 DI ABETES CENTER	0	0	, , , , ,	0	71,410	
74. 00	07400 RENAL DI ALYSI S	o	0		0 0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	O	0		0 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
90.00	09000 CLI NI C	0	0		0	0	
91.00	09100 EMERGENCY	0	0	51, 71		51, 711	
91. 01 92. 00	04950 WOUND CARE	0	0		0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)		0		0 0	0	
7Z. UI	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0		0		72.01
95. 00	09500 AMBULANCE SERVICES						95. 00
		1		ı		l	1 ,0,00

	Financial Systems	ST. ELIZAE			In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der	CCN: 150109	Peri od:	Worksheet D	
THROUG	H COSTS		Componen	t CCN: 15T109	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/27/2015 9:4	pared:
			Ti tl	e XVIII	Subprovider - IRF	PPS	<u> </u>
	Cost Center Description	Total	Total Charges			I npati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	151, 232, 785			0	50.00
51.00	05100 RECOVERY ROOM	0				0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	18, 764, 695	0.00000	0. 000000	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	71, 356, 238	0.00000	0. 000000	29, 839	54.00
55.00	03630 ULTRA SOUND	0	5, 928, 503	0.00000	0. 000000	3, 503	55. 00
56.00	05600 RADI 0I SOTOPE	0	(0.00000	0. 000000	0	56.00
56. 01	03950 CARDI AC CATH LAB	0	25, 607, 753	0.00000	0. 000000	0	56. 01
57.00	05700 CT SCAN	0	43, 692, 302	0.00000	0. 000000	37, 353	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	13, 062, 859	0.00000	0. 000000	0	58. 00
60.00	06000 LABORATORY	0	67, 125, 786	0. 00000	0. 000000	339, 948	60.00
65.00	06500 RESPI RATORY THERAPY	0			0. 000000	140, 546	65.00
66.00	06600 PHYSI CAL THERAPY	0	9, 720, 115		0. 000000	1, 314, 251	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0			0. 000000	0	1
68.00	06800 SPEECH PATHOLOGY	0		1	0. 000000	28, 692	68.00
69. 00	06900 ELECTROCARDI OLOGY	0				1, 841	1
	07000 ELECTROENCEPHALOGRAPHY	0		1		0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	,	•		55, 073	
	07200 IMPL. DEV. CHARGED TO PATIENT	0				820	
	07300 DRUGS CHARGED TO PATIENTS	71, 410				330, 021	73. 00
	07301 DI ABETES CENTER	0				0	
74. 00	07400 RENAL DIALYSIS	0				38, 781	
	07698 HYPERBARI C OXYGEN THERAPY	0				0	
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0		0.00000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		•		Ō	
90.00	09000 CLINIC	0				0	
91.00	09100 EMERGENCY	51, 711	,	l		31	91.00
91. 01	04950 WOUND CARE	0,711		•		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			1		Ö	1
	09201 OBSERVATION BEDS (DISTINCT PART)			•		Ö	
	OTHER REIMBURSABLE COST CENTERS		5,,,,,	3. 23000	2. 223000		1 /2.01
95. 00	09500 AMBULANCE SERVICES						95. 00
200. 00	l	123, 121	736, 407, 442			2, 320, 699	

Heal th	Financial Systems	ST. ELIZAB	ETH EAST		In Lie	u of Form CMS-	2552-10
APPOR	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER GH COSTS	VICE OTHER PASS	Componen	CCN: 150109 t CCN: 15T109	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/27/2015 9:4	
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. x col. 12) 13.00	h		
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00			
50. 00 51. 00 52. 00 54. 00 55. 00 56. 01 57. 00 58. 00 60. 00 65. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 03630 ULTRA SOUND 05600 RADIOISOTOPE 03950 CARDIAC CATH LAB 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY 06500 RESPIRATORY THERAPY	0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0		50. 00 51. 00 52. 00 54. 00 55. 00 56. 00 56. 01 57. 00 58. 00 60. 00 65. 00
66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 01 74. 00 76. 98	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0 0 0 0 0 0 393 0 0			0 0 0 0 0 0 0 0		66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 73. 01 74. 00 76. 98

393

0

0

0

0

0

0

88.00

89.00

90.00

91.00

91.01

92. 00 92. 01 95. 00

200.00

OUTPATIENT SERVICE COST CENTERS
08800 RURAL HEALTH CLINIC

08900 FEDERALLY QUALIFIED HEALTH CENTER

92. 00 | 09200| 0BSERVATI ON BEDS (NON-DISTINCT PART)
92. 01 | 09201| 0BSERVATI ON BEDS (DISTINCT PART)
0THER REIMBURSABLE COST CENTERS
95. 00 | 09500| AMBULANCE SERVICES

Total (lines 50-199)

88.00

89. 00

91.01

200.00

90. 00 09000 CLINIC

91.00 09100 EMERGENCY

04950 WOUND CARE

Health Financial Systems	ST. EL	ST. ELIZABETH EAST In Li				2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der CCN: 150109	Peri od: From 01/01/2014	Worksheet D-1	
					Date/Time Pre 5/27/2015 9:4	
			Title XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	

		Title XVIII	Hospi tal	5/27/2015 9: 4 PPS	<u>5 am</u>
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	oveluding nowborn)		28, 214	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days	28, 214 28, 214 0	2. 00		
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	28, 214 0	4. 00 5. 00
6.00	reporting period Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8.00	reporting period Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	11, 844	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent	er O on this line)	,	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period			0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year	r, enter O on this lin	e)	0	13.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	33, 103, 569 0	21. 00 22. 00
23. 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. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 33, 103, 569	
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed		argos)	0	
29. 00	Private room charges (excluding swing-bed charges)	and observation bed cir	ai ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	s line 33)(see instrue	tions)	0.00	1
34. 00 35. 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		11 0115)	0. 00 0. 00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	31)		0. 00 0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	33, 103, 569	•
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3	,		1, 173. 30 13, 896, 565	1
40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 +	iine 40)		13, 896, 565	41.00

	Financial Systems	ST. ELIZAB			In Li∈	eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (F	Period: From 01/01/2014 Fo 12/31/2014	Worksheet D-1 Date/Time Pre 5/27/2015 9:4	pared:
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days[Average Per Diem (col. 1 - col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42. 00
43. 00	INTENSIVE CARE UNIT	4, 741, 363	3, 479	1, 362. 85	1, 852	2, 523, 998	43.00
44. 00	CORONARY CARE UNIT	1,711,000	0,,	1,002.00	1,002	2,020,770	44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	3, 719, 041	2, 756	1, 349. 43	3 0	0	47. 00
	oost denter bescription					1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ns)		32, 096, 758 48, 517, 321	•
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input	atient routine	services (from	Wkst. D, sum	of Parts I and	3, 888, 176	50.00
51. 00	III) Pass through costs applicable to Program inp	ationt ancillar	v sarvicas (fra	om Wket D ei	ım of Darte II	2, 424, 264	51. 00
	and IV)		y services (iii	JIII WK3t. D, 3t	am or rarts ir		
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu	,	elated, non-phys	sician anesthe	etist, and	6, 312, 440 42, 204, 881	
	medical education costs (line 49 minus line					. , . , , . ,	
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	•
56. 00	Target amount (line 54 x line 55)				>	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (li	ne 56 minus I	ine 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996. ur	odated and con	mounded by the		•
	market basket	0 .			,		
60.00	Lesser of lines 53/54 or 55 from prior year				the emount by	0.00	•
61. 00	If line 53/54 is less than the lower of line: which operating costs (line 53) are less than					0	61. 00
	amount (line 56), otherwise enter zero (see instructions)						
62.00						0	
63.00	00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST					0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 of the	cost reportir	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the co	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 65	5)(title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 of	the cost rer	porting period	0	67. 00
	(line 12 x line 19)	· ·		•	0 .		
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)			·	rting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facil	ty/ICF/MR rout	ine service cos	st (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line 2	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applications		n (line 14 x lir	ne 35)			73.00
74.00	Total Program general inpatient routine serv			•			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from Wo	orksheet B, Pa	art II, column		75. 00
76.00	Per diem capital related costs (line 75 ÷ line						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (* .				83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85.00	Utilization review - physician compensation						85.00
80. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ii ougri 85)				86. 00
87. 00	Total observation bed days (see instructions))				0	
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•					88. 00 89. 00
57.00	(36)					١	1 57.00

Health Financial Systems	ST. ELI ZAE	BETH EAST		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 606, 380	33, 103, 569	0. 19956	7 0	0	90.00
91.00 Nursing School cost	1, 295, 621	33, 103, 569	0. 03913	8 0	0	91.00
92.00 Allied health cost	0	33, 103, 569	0.00000	o o	0	92. 00
93.00 All other Medical Education	0	33, 103, 569	0. 00000	o o	0	93. 00

Health Financial Systems	ST. ELI ZABETH EAST	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150109		Worksheet D-1
		From 01/01/2014	
	Component CCN: 15T109	To 12/31/2014	Date/Time Prepared:
	'		5/27/2015 9:45 am
	Title XVIII	Subprovi der -	PPS
		IRF	
0 1 0 1 D 1 11			

			I RF		
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			2, 017 2, 017	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed days)		oom days	2,017	3. 00
0.00	do not complete this line.	you have omly private	Join days,		0.00
4.00	Semi-private room days (excluding swing-bed and observation bed			2, 017	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through December 31 of	the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December 31 of t	ne cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room of	days) through December 31 of	the cost	o	7. 00
	reporting period	3 ,			
8. 00	Total swing-bed NF type inpatient days (including private room (reporting period (if calendar year, enter 0 on this line)	days) after December 31 of the	e cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding swing-	ped and	1, 003	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		s)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only December 31 of the cost reporting period (if calendar year, enti-	/ (including private room day:	s) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX (days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX of		days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program	r, enter 0 on this line) (excluding swing-bed days)		0	14. 00
15. 00	Total nursery days (title V or XIX only)	(exertaining swring bed days)		0	15. 00
16.00	Nursery days (title V or XIX only)			0	16.00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through Docombor 21 of the co	nct	0.00	17. 00
	reporting period	9			
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period				18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	G	st		19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services a reporting period	after December 31 of the cost			20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporting per	ind (line	2, 011, 451 0	
22.00	5 x line 17)	31 of the cost reporting per	rod (Trile	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	of the cost reporting perior	d (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	31 of the cost reporting peri	od (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting period	(line 8	0	25. 00
26.00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus line 26)		2, 011, 451	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed charges)		0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	-		0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)		ŀ	0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minus	S line 33)(see instructions)		0.00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	1	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost different	ial (line	2, 011, 451	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			997. 25	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	3)		1, 000, 242	39. 00
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		0 1, 000, 242	40. 00 41. 00
- 1. 00	Trotal Trogram general impatrent routine service cost (IIIIe 37 +	11110 40)	1	1, 000, 242	Ŧ1. UU

	Financial Systems ATION OF INPATIENT OPERATING COST	ST. ELI ZABETH		CCN: 150109	Peri od:	worksheet D-1	
			Component	CCN: 15T109	From 01/01/2014 To 12/31/2014		
			Ti tl e	e XVIII	Subprovi der -	PPS	. J Gill
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost Inp	atient Daysl	col . 2)		(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3. 00	4. 00 00 0	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units		<u> </u>	0.	00 0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.	00 0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00			0	0	00		46. 00
47.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	0	Ŋ	0.	00 0	0	47.00
40.00	Donas i anati ant anni llama anni anat (MI	-+ 0.21 2 1	i == 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ns)		800, 726 1, 800, 968	
	PASS THROUGH COST ADJUSTMENTS	¥ , ,					
50. 00	Pass through costs applicable to Program inp	atient routine sem	rvices (from	Wkst. D, su	m of Parts I and	51, 444	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary s	services (fro	om Wkst. D,	sum of Parts II	80, 730	51.00
52.00	Total Program excludable cost (sum of lines		rad nan nhus	delen enset	hatiat and	132, 174	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		.eu, non-pnys	siciali anest	пензі, апа	1, 668, 794	53.00
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00							55.00
56. 00	Target amount (line 54 x line 55)			E	50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targe	et amount (II	ne 56 minus	line 53)	0 0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period end	ding 1996, up	odated and c	ompounded by the		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report undat	ed by the ma	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60 ent	er the Lesse	er of 50% of	the amount by	0.00	•
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(lines 54 x 6	60), or 1% o	f the target		
62. 00		rnstructrons,				0	62.00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instructi	ons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decembe	er 31 of the	cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the co	ost reportin	a period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	plus line 65	5)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through De	ecember 31 of	the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dece	ember 31 of t	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c	ost per diem (line					71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	ine 14 v lir	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	,		ic 30)			74. 00
75. 00	Capital -related cost allocated to inpatient	routine service co	osts (from Wo	orksheet B,	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00			vider records	s)			79.00
80. 00	Total Program routine service costs for comp	arison to the cost			nus line 79)		80.00
31. 00 32. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions)					83.00
34. 00 35. 00	Program inpatient ancillary services (see in Utilization review - physician compensation						84. 00 85. 00
	Total Program inpatient operating costs (sum						86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS						07.00
37. 00 38. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ne 2)			0.00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se		,				89.00

Health Financial Systems	ST. ELI ZAE	BETH EAST		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
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	103, 461	2, 011, 451	0. 05143	6 0	0	90.00
91.00 Nursing School cost	0	2, 011, 451	0.00000	0	0	91.00
92.00 Allied health cost	0	2, 011, 451	0.00000	0	0	92.00
93.00 All other Medical Education	0	2, 011, 451	0.00000	0 0	0	93. 00
90.00 Capital-related cost 91.00 Nursing School cost 92.00 Allied health cost	1.00 COST	2. 00 2, 011, 451 2, 011, 451 2, 011, 451	3. 00 0. 05143 0. 00000 0. 00000	Bed Cost (from line 89) 4.00 6 0 0 0 0 0	Through Cost (col. 3 x col. 4) (see instructions) 5.00	91. 00 92. 00

Health Financial Systems	ST. ELI ZABETH	EAST	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150109	Peri od: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Pre 5/27/2015 9:4	
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room days and	swing-bed days,	excluding newborn)		28, 214	1. 00

	litie XIX Hospital	LOST	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	28, 214	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	28, 214 0	2. 00 3. 00
3.00	do not complete this line.	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	28, 214	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period	_	
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	2, 797	9. 00
	newborn days)	•	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15.00	Total nursery days (title V or XIX only)	1, 236	
16. 00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
17. 00	reporting period	0. 00	17. 00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	33, 101, 764	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	33, 101, 764	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	1
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	ı
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	33, 101, 764	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 173. 24	1
39. 00	Program general inpatient routine service cost (line 9 x line 38)	3, 281, 552	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 3, 281, 552	40.00
	1.112 2 3.10. d	5, 201, 002	,

Heal th	Financial Systems	ST. ELIZAB	ETH EAST		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				eriod: rom 01/01/2014	Worksheet D-1	
				To		Date/Time Pre	
			Ti tl	e XIX	Hospi tal	5/27/2015 9: 4! Cost	5 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	1, 330, 524	1, 236	1, 076. 48	0	0	42. 00
43. 00	INTENSIVE CARE UNIT	4, 741, 363	3, 479	1, 362. 85	369	502, 892	43. 00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	NEONATAL INTENSIVE CARE UNIT	3, 667, 786	2, 756	1, 330. 84	1, 715	2, 282, 391	47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					5, 454, 607	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	ns)		11, 521, 442	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum o	of Parts I and	0	50. 00
51. 00		ationt oncillor		am Wko+ D. o.u	n of Donto II	0	51. 00
51.00	Pass through costs applicable to Program inpand IV)	atrent anciliar	y services (iid	DIII WKSt. D, SUI	II OI PAILS II	U	51.00
52. 00	Total Program excludable cost (sum of lines					0	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-pnys	sician anestne	tist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,				_	
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
56.00	Target amount (line 54 x line 55)					0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (li	ne 56 minus li	ne 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, up	odated and comp	oounded by the	0. 00	
40.00	market basket	cost report ur	dated by the me	erkot backot	-	0. 00	60. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				ne amount by	0.00	61. 00
	which operating costs (line 53) are less tha		s (lines 54 x 6	50), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reporting	period (See	0	64. 00
/F 00	instructions)(title XVIII only)	+ 	21 -6 +6				/F 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 or the co	ost reporting p	berroa (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 65	5)(title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 of	f the cost repo	orting period	0	67. 00
40.00	(line 12 x line 19)	o ocato often [)	the east manage	ting popied		40.00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs arter t	ecember 31 01 t	the cost repor	ing period	U	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil		•				70. 00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line 2	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		n (line 14 x lir	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73)				74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from Wo	orksheet B, Pai	t II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der records	s)			79. 00
80. 00 81. 00	Total Program routine service costs for comp.		cost limitation	(line 78 minus	s line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				82. 00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				0. 00	88. 00
89. UU	Observation bed cost (line 87 x line 88) (se	e instructions)			ļ	ا	89. 00

Health Financial Systems	ST. ELI ZAE	BETH EAST		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 606, 380	33, 101, 764	0. 19957	8 0	0	90.00
91.00 Nursing School cost	0	33, 101, 764	0.00000	o o	0	91.00
92.00 Allied health cost	0	33, 101, 764	0.00000	o o	0	92. 00
93.00 All other Medical Education	0	33, 101, 764	0. 00000	o o	0	93. 00

Health Financial Systems	ST. ELIZABETH EAST	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150109	Peri od: From 01/01/2014	Worksheet D-1	
	Component CCN: 15T109			
	Title XIX	Subprovi der -	Cost	J alli
0 1 0 1 0 1 1		INI		

			IRF		
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			2, 017 2, 017	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed days)		oom days	2,017	3. 00
0.00	do not complete this line.		oo dayo,		0.00
4.00	Semi-private room days (excluding swing-bed and observation bed			2, 017	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through December 31 of	the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December 31 of t	he cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room of	days) through December 31 of	the cost	0	7. 00
8.00	reporting period Total swing-bed NF type inpatient days (including private room of	days) after December 31 of th	e cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding swing-	bed and	152	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only		s)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only	/ (including private room day	s) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ento Swing-bed NF type inpatient days applicable to titles V or XIX of		days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX of			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program	enter 0 on this line)	,	0	14. 00
15. 00	Total nursery days (title V or XIX only)	(exertialing swring bed days)			15. 00
16. 00	Nursery days (title V or XIX only)			0	
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 of the c	ost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of the cos	t	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of the co	st	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of the cost		0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			2, 011, 451	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	31 of the cost reporting per	iod (line	0	
23. 00	Swing-bed cost applicable to SNF type services after December 3' x line 18)	of the cost reporting perio	d (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December : 17 x line 19)	31 of the cost reporting peri	od (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting period	(line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (I) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus line 26)		2, 011, 451	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed charges)		0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -private room charges (excluding swing-bed charges)	: 20)		0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	The 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instructions)		0.00	
35. 00	Average per diem private room cost differential (line 34 x line			0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost different	ial (line	2, 011, 451	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			997. 25	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3)			151, 582	
40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		151, 582	41. 00

	Financial Systems	ST. ELI ZABET		N 150100 D		eu of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CO	Fi	eriod: rom 01/01/2014	Worksheet D-1		
			Component (5/27/2015 9:4		
			Title	XIX	Subprovider - IRF	Cost		
	Cost Center Description	Total Inpatient CostIn		Average Per em (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2. 00	3.00	4. 00	5. 00		
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42. 0	
43. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
44. 00	CORONARY CARE UNIT						44. 0	
15. 00 16. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 0 46. 0	
17. 00	1	O	0	0. 00	0	0	47. 0	
	Cost Center Description					1. 00		
18. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			171, 701	48. 0	
19. 00	Total Program inpatient costs (sum of lines	41 through 48)(se	e instructions)		323, 283	49. 0	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine se	rvices (from W	kst. D. sum o	of Parts I and	0	50. O	
			•					
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (from	Wkst. D, sur	n of Parts II	0	51.0	
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52. 0	
3. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		ted, non-physi	cian anesthet	ist, and	0	53.0	
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					1	
	Program di scharges					0		
5. 00 6. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00		
7. 00	Difference between adjusted inpatient operat	ing cost and targ	et amount (lin	e 56 minus li	ne 53)	0	1	
8. 00 9. 00	0 Bonus payment (see instructions)							
9.00	0 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							
0.00	DO Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							
51. 00	which operating costs (line 53) are less that					0	61.0	
	amount (line 56), otherwise enter zero (see instructions)							
52. 00 53. 00	00 Allowable Inpatient cost plus incentive payment (see instructions)							
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00	<pre>instructions)(title XVIII only)</pre>	ts through Decemb	er 31 of the c	ost reportino	g period (See	0	64. 0	
5.00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cos	t reporting p	period (See	0	65. 0	
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	nlus line 65)	(title XVIII	only) For	0	66.0	
	CAH (see instructions)							
57.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through D	ecember 31 of	the cost repo	orting period	0	67.0	
8. 00	Title V or XIX swing-bed NF inpatient routin	e costs after Dec	ember 31 of th	e cost report	ing period	0	68. 0	
59. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.0	
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/MR ONL	Y		0		
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	-		(line 37)			70.00	
2. 00	Program routine service cost (line 9 x line		ic 70 . Triic 2)				72. 0	
3.00	Medically necessary private room cost applic	,		35)			73.0	
4. 00 5. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		ksheet B, Par	t II, column		74. 0 75. 0	
	26, line 45)		-	•				
76.00 77.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 0 77. 0	
8. 00	Inpatient routine service cost (line 74 minus line 77)						78.0	
9.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				s line 79)		79. 0 80. 0	
31. 00	Inpatient routine service cost per diem limi	tati on					81.0	
32. 00 33. 00	Inpatient routine service cost limitation (I						82. 0 83. 0	
33. 00 34. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in						83.0	
85. 00	Utilization review - physician compensation	(see instructions					85. 0	
36. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		ugh 85)				86.0	
							4	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per					0	87. 0	

Health Financial Systems	ST. ELIZAE	BETH EAST		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15T109	From 01/01/2014 To 12/31/2014		
		Tit	le XIX	Subprovi der - I RF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	103, 461	2, 011, 451	0. 05143	36 0	0	90.00
91.00 Nursing School cost	C	2, 011, 451	0. 00000	00	0	91.00
92.00 Allied health cost	C	2, 011, 451	0. 00000	00	0	92. 00
93.00 All other Medical Education	c	2, 011, 451	0.00000	00 0	0	93. 00

Health Financial Systems	ST. ELIZABETH EAST	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 150109	Period: Worksheet D-3 From 01/01/2014
		To 12/31/2014 Date/Time Prepared:

INFAII	LIVE ANGILLARE SERVICE COST AFFORTIONWENT	FIOVIDE	CCN. 130109	From 01/01/2014	WOLKSHEET D-3	
				To 12/31/2014	Date/Time Pre	pared:
					5/27/2015 9:4	5 am
		li tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30.00	03000 ADULTS & PEDI ATRI CS			21, 952, 493		30. 00
31. 00	03100 NTENSI VE CARE UNI T			5, 946, 348		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT			0	l	35. 00
40. 00	04000 SUBPROVI DER - I PF			0		40.00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
42.00	04200 SUBPROVI DER			0		42.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS		•			1
50.00	05000 OPERATING ROOM		0. 2223	17 26, 689, 777	5, 933, 591	50.00
51.00	05100 RECOVERY ROOM		0. 1542	27 2, 231, 716	344, 191	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 4010	43 30, 163	12, 097	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 2549	48 6, 556, 616	1, 671, 596	54.00
55.00	03630 ULTRA SOUND		0. 1194	30 675, 355	80, 691	55. 00
56.00	05600 RADI 0I SOTOPE		0.0000	00	0	56. 00
56. 01	03950 CARDI AC CATH LAB		0. 1329	11 6, 454, 764	857, 909	56. 01
57.00	05700 CT SCAN		0. 0431	52 5, 826, 131	251, 467	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 0664	94 2, 518, 517	167, 466	
60.00	06000 LABORATORY		0. 1393		2, 298, 849	60.00
65.00	06500 RESPI RATORY THERAPY		0. 5009			1
66. 00	06600 PHYSI CAL THERAPY		0. 4149			
67. 00	06700 OCCUPATI ONAL THERAPY		0. 2462			1
68. 00	06800 SPEECH PATHOLOGY		0. 8683			1
69. 00	06900 ELECTROCARDI OLOGY		0. 1586			1
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 3289			1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1774			1
72.00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 2548			
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1945			1
73. 01	07301 DI ABETES CENTER		1. 8705			1
74.00	07400 RENAL DIALYSIS		0. 7363			
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0. 1992	56 363	72	76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0.0000	20	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90.00	09000 CLINIC		1. 1326			
91. 00	09100 EMERGENCY		0. 2956			
91. 00	04950 WOUND CARE		0. 4799			1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.0000			1
92. 01	09201 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2655		_	
/Z. U I	OTHER REIMBURSABLE COST CENTERS		0. 2000	75, 410, 700	110,070	1 /2.01
95. 00	09500 AMBULANCE SERVI CES		1			95. 00
200.00				153, 142, 979	32, 096, 758	
201.00		(line 61)		0	, 0,0,,00	201. 00
202.00			[153, 142, 979		202. 00
			•		1	

Health Financial Systems ST. INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150109	Peri od:	worksheet D-3	
	Componen	t CCN: 15T109	From 01/01/2014 To 12/31/2014		pared:
	Ti tl	e XVIII	Subprovi der - I RF	PPS	<u> </u>
Cost Center Description	· · · · · · · · · · · · · · · · · · ·	Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				I	
30. 00 03000 ADULTS & PEDI ATRI CS			0	l	30.00
31. 00 03100 INTENSIVE CARE UNIT			0	l	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			0		35.0
40. 00 04000 SUBPROVI DER - 1 PF			1 450 024		40.0
41. 00 04100 SUBPROVI DER - 1 RF			1, 459, 824		41.0
42. 00 04200 SUBPROVI DER			0		42.0
43. 00 O4300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		0 22221	17	0	F0 0
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM		0. 22231		1	
51.00 OSTOO RECOVERY ROOM 52.00 OS200 DELIVERY ROOM & LABOR ROOM		0. 15422 0. 40104		0	
54. 00 05200 DELI VERT ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 25494		-	
55. 00 03630 ULTRA SOUND		0. 23492			•
56. 00 05600 RADI 0I SOTOPE		0. 00000		0	1
56. 01 03950 CARDI AC CATH LAB		0. 13291		0	56.0
57. 00 05700 CT SCAN		0. 04316		1	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 06649		0	
60. 00 06000 LABORATORY		0. 13931		1	
65. 00 06500 RESPIRATORY THERAPY		0. 50099			1
66. 00 06600 PHYSI CAL THERAPY		0. 41495		545, 354	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 24620		0	67.0
68. 00 06800 SPEECH PATHOLOGY		0. 86839		24, 916	68.0
69. 00 06900 ELECTROCARDI OLOGY		0. 15863	1, 841	292	69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 32898	33 0	0	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 17741	55, 073	9, 771	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 25482	23 820	209	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 19454	18 330, 021	64, 205	73.0
73. 01 07301 DI ABETES CENTER		1.87050	0	0	73. 0
74. 00 07400 RENAL DI ALYSI S		0. 73638	38, 781	28, 558	74.0
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 19925	56 0	0	76. 9
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLI NI C		1. 13269			1
91. 00 09100 EMERGENCY		0. 29568		9	1
91. 01 04950 WOUND CARE		0. 47994		-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.00000		-	
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)		0. 26559	98 0	0	92. 0°
OTHER REIMBURSABLE COST CENTERS					ļ
DE ON MOSON AMBILIANCE SERVICES		1	i contract of the contract of	1	05 (

2, 320, 699

2, 320, 699

202. 00

800, 726 200. 00 201. 00

95. 00 09500 AMBULANCE SERVICES

200.00

201.00 202.00 Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

Health Financial Systems	ST. ELIZABETH EAST		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od: From 01/01/2014	Worksheet D-3	
			To 12/31/2014	Date/Time Prep 5/27/2015 9:4	
	Ti	tle XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges		Program Costs (col. 1 x col.	

		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cost	Inpati ent	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS					
	DOO ADULTS & PEDIATRICS			15, 849, 831		30.00
31. 00 031	100 INTENSIVE CARE UNIT			1, 171, 157		31. 00
35.00 020	D60 NEONATAL INTENSIVE CARE UNIT			7, 381, 774		35. 00
	000 SUBPROVI DER - I PF			0		40. 00
41.00 041	100 SUBPROVI DER – I RF			0		41. 00
42.00 042	200 SUBPROVI DER			0		42.00
43.00 043	300 NURSERY			0		43.00
ANC	CILLARY SERVICE COST CENTERS					
50.00 050	OOO OPERATING ROOM		0. 222317	3, 200, 678	711, 565	50.00
51.00 051	100 RECOVERY ROOM		0. 154227	228, 552	35, 249	51.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM		0. 401043	0	0	52. 00
54.00 054	400 RADI OLOGY-DI AGNOSTI C		0. 254169	873, 373	221, 984	54.00
55.00 036	630 ULTRA SOUND		0. 119480	220, 468	26, 342	55. 00
56.00 056	600 RADI OI SOTOPE		0.000000	0	0	56. 00
	950 CARDI AC CATH LAB		0. 132911	707, 021	93, 971	56. 01
57. 00 057	700 CT SCAN		0. 043162	1, 111, 980	47, 995	57.00
	BOO MAGNETIC RESONANCE IMAGING (MRI)		0. 066494	566, 671	37, 680	•
	DOO LABORATORY		0. 138687	4, 698, 640		60.00
	500 RESPIRATORY THERAPY		0. 498904	853, 465		65. 00
	600 PHYSI CAL THERAPY		0. 414954	451, 906		66. 00
	700 OCCUPATI ONAL THERAPY		0. 246208	675, 542		67. 00
	BOO SPEECH PATHOLOGY		0. 868399	9, 351	8, 120	68. 00
	900 ELECTROCARDI OLOGY		0. 158635	569, 278		69.00
	OOO ELECTROENCEPHALOGRAPHY		0. 326156	54, 956		70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 177410	3, 512, 003		71.00
	200 IMPL. DEV. CHARGED TO PATIENT		0. 254823	2, 546, 830		72.00
	300 DRUGS CHARGED TO PATIENTS		0. 194548	6, 104, 644		73. 00
	301 DI ABETES CENTER		1. 848092	0, 104, 044	1, 187, 040	73. 00
	400 RENAL DIALYSIS		0. 736387	102, 582	1	1
	698 HYPERBARI C OXYGEN THERAPY		0. 730367	102, 362		76. 98
	TPATIENT SERVICE COST CENTERS		0. 199256	0	0	76.98
			0.000000	0	0	00 00
	BOO RURAL HEALTH CLINIC		0.000000	-	1	88. 00
	900 FEDERALLY QUALIFIED HEALTH CENTER		0.000000	0	0	89. 00
	OOO CLINIC		1. 132697	(25.5(0	0	90.00
	100 EMERGENCY		0. 295684	635, 568		91.00
	950 WOUND CARE		0. 479519	0	0	91. 01
	200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 000000	0	0	92. 00
	201 OBSERVATION BEDS (DISTINCT PART)		0. 265598	33, 965	9, 021	92. 01
	HER REIMBURSABLE COST CENTERS				T	
	AMBULANCE SERVICES					95. 00
200.00	Total (sum of lines 50-94 and 96-98)			27, 157, 473	5, 454, 607	
201. 00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201. 00
202. 00	Net Charges (line 200 minus line 201)			27, 157, 473		202. 00

Health Financial Systems ST INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	. ELI ZABETH EAST Provi der	CCN: 150109	Peri od:	worksheet D-3	
	Component	t CCN: 15T109	From 01/01/2014 To 12/31/2014		
	Ti t	le XIX	Subprovi der -	Cost	o um
Cost Center Description	,	Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	T	
30. 00 03000 ADULTS & PEDI ATRI CS			0	•	30.00
31. 00 03100 INTENSI VE CARE UNI T			0		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			0		35. 0
40. 00 04000 SUBPROVI DER - 1 PF 41. 00 04100 SUBPROVI DER - 1 RF			204 204		40.0
41. 00 04100 SUBPROVI DER - 1 RF			304, 386		42.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS			0		43.0
50. 00 05000 OPERATING ROOM		0. 22231	17 0	0	50.00
51. 00 05100 RECOVERY ROOM		0. 2223		1	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 40104		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 25416		_	
55. 00 03630 ULTRA SOUND		0. 11948		0	•
56. 00 05600 RADI OI SOTOPE		0.00000			
56. 01 03950 CARDI AC CATH LAB		0. 13291		0	
57. 00 05700 CT SCAN		0. 04316		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.06649		0	58. 0
60. 00 06000 LABORATORY		0. 13868	61, 591	8, 542	60.0
65. 00 06500 RESPIRATORY THERAPY		0. 49890	35, 752	17, 837	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 41495	243, 834	101, 180	66.0
67. 00 06700 OCCUPATI ONAL THERAPY		0. 24620	0 8	0	67.0
68. 00 06800 SPEECH PATHOLOGY		0. 86839	30, 600	26, 573	68. 0
69. 00 06900 ELECTROCARDI OLOGY		0. 15863	2, 593	411	69. 0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 32615	56 0	0	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 17741	· ·	1, 535	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENT		0. 25482		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 19454			
73. 01 07301 DI ABETES CENTER		1. 84809		0	
74. 00 07400 RENAL DI ALYSI S		0. 73638		1	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 19925	56 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS		0.0000	20		
88. 00 08800 RURAL HEALTH CLINIC		0.00000			
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		-	
90. 00 09000 CLI NI C		1. 13269		1	
91. 00 09100 EMERGENCY		0. 29568		0	1
91.01 04950 WOUND CARE 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 47951 0. 00000		1	
92.00 09200 085ERVATION BEDS (NON-DISTINCT PART)		0.00000		1	
OTHER REIMBURSABLE COST CENTERS		0. 20059	0	1 0	72.0
OF OO OOSOO AMBIII ANCE SERVI CES					05 0

201. 00 202. 00

171, 701 200. 00

459, 186

459, 186

95. 00 09500 AMBULANCE SERVICES

200.00

201.00 202.00 Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150109	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre	pared:
		Ti tl	e XVIII	Hospi tal	5/27/2015 9: 4 PPS	5 am
			0	1. 00	2. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	g prior		0 23, 794, 634		1. 00 1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	a on or		9, 154, 405		1. 02
	after October 1 (see instructions)	_		77 10 17 100		
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0		1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1. 04
2.00	Outlier payments for discharges. (see instructions)			1, 893, 803		2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0		2. 01 2. 02
3.00	Managed Care Simulated Payments	,		5, 324, 008		3. 00
4. 00	Bed days available divided by number of days in the cost report period (see instructions)	i ng		163. 02		4. 00
	Indirect Medical Education Adjustment		1			
5. 00	FTE count for allopathic and osteopathic programs for the most cost reporting period ending on or before 12/31/1996. (see instr			0.00		5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the			0.00		6. 00
	criteria for an add-on to the cap for new programs in accordanc CFR 413.79(e)					
7. 00	MMA Section 422 reduction amount to the IME cap as specified un $CFR \S 412.105(f)(1)(iv)(B)(1)$	der 42		0.00		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u			0.00		7. 01
	CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July then see instructions.	1, 2011				
8. 00	Adjustment (increase or decrease) to the FTE count for allopath			0.00		8. 00
	osteopathic programs for affiliated programs in accordance with 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8. 01
0.01	section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		0.01
8. 02	instructions. The amount of increase if the hospital was awarded FTE cap slot	s from a		0.00		8. 02
9. 00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
	and 8,02) (see instructions)					
10. 00	FTE count for allopathic and osteopathic programs in the curren from your records	t year		0.00		10.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs.			0. 00 0. 00		11. 00 12. 00
13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14. 00
15. 00	or after September 30, 1997, otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00		15. 00
16.00				0.00		16.00
17. 00 18. 00	Adjusted rolling average FTE count	е		0. 00 0. 00		17. 00 18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000		19. 00
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000		20.00
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000		21. 00 22. 00
22. 00	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0		22. 00
	Indirect Medical Education Adjustment for the Add-on for Section		he MMA			1
23. 00	Number of additional allopathic and osteopathic IME FTE residen slots under 42 Sec. 412.105 (f)(1)(iv)(C).	т сар		0.00		23. 00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions)	wor of		0.00		24. 00
25.00	If the amount on line 24 is greater than -0-, then enter the lo line 23 or line 24 (see instructions)	wei oi		0.00		25. 00
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26. 00 27. 00
28. 00	IME add-on adjustment amount (see instructions)			0.00000		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0		28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0		29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days		3. 01		30. 00
31. 00	(see instructions) Percentage of Medicaid patient days (see instructions)			25. 64		31.00
32.00	Sum of lines 30 and 31			28. 65		32.00
33. 00 34. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			12. 85 1, 058, 488		33. 00 34. 00
	, , , , , , , , , , , , , , , , , , , ,		1	, 1, 100, 100	ı	,

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2014	Worksheet E Part A	
		-	To 12/31/2014	Date/Time Pre 5/27/2015 9:4	
		Title XVIII	Hospi tal	PPS	
			Prior to October 1	On/After October 1	
		0	1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)			7, 647, 644, 885	35. OC
35. 00	Factor 3 (see instructions)		0. 000000000	0. 000290510	
35. 02	Hospital uncompensated care payment (If line 34 is zero,		2, 399, 806	2, 221, 686	
35. 03	enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment		1, 794, 923	559, 987	35. 03
33. 03	amount (see instructions)		1, 794, 923	337, 707	35.03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line		2, 354, 910		36. 00
	35.03) Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 through	1 46)		
40. 00	Total Medicare discharges on Worksheet S-3, Part I		0		40. 00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
41 01	682, 683, 684 an 685. (see instructions)				41 01
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		U		41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
43. 00	qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
10.00	682, 683, 684 an 685. (see instructions)				101.00
44. 00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0. 000000		44.00
45. 00	Average weekly cost for dialysis treatments (see		0.00		45. 00
47 00	instructions)				47.00
46. 00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47. 00	Subtotal (see instructions)		38, 256, 240		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48. 00
49. 00	Total payment for inpatient operating costs (see		38, 256, 240		49. 00
50. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I		2 142 EO1		50.00
30.00	and Pt. II, as applicable)		3, 142, 501		30.00
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4,		0		52.00
53. 00	line 49 see instructions). Nursing and Allied Health Managed Care payment				53.00
54. 00	Special add-on payments for new technologies		0		54.00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55. 00
56. 00	line 69) Cost of physicians' services in a teaching hospital (see		0		56. 00
	intructions)				
57. 00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		543, 876		57.00
58. 00	Ancillary service other pass through costs from Wkst. D,		26, 500		58. 00
59. 00	Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58)		41, 969, 117		59.00
60.00	Primary payer payments		0		60.00
61. 00	Total amount payable for program beneficiaries (line 59		41, 969, 117		61. 00
62. 00	minus line 60) Deductibles billed to program beneficiaries		3, 135, 232		62.00
63. 00	Coinsurance billed to program beneficiaries		33, 136		63.00
64. 00	Allowable bad debts (see instructions)		285, 512		64.00
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see		185, 583 112, 506		65. 00 66. 00
	instructions)		1.12, 555		
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices		38, 986, 332		67. 00 68. 00
00.00	for applicable to MS-DRGs (see instructions)				00.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69. 00
70. 00	96).(For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70. 50	RURAL DEMONSTRATION PROJECT		Ö		70. 50
70. 89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 90
70 01	instructions)				70.0
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)				70. 9° 70. 9°
70. 93	HVBP payment adjustment amount (see instructions)		-66, 613		70. 93
70. 94	HRR adjustment amount (see instructions)		0		70. 94
70. 95	Recovery of accelerated depreciation		0		70. 95

AITH FINANCIAL SYSTEMS ST. ELIZABET NLCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150109	Peri od: From 01/01/2014 To 12/31/2014	u of Form CMS- Worksheet E Part A Date/Time Pre 5/27/2015 9:4	pared:
	Title XVIII	Hospi tal	PPS	
		Prior to October 1	On/After October 1	
	0	1. 00	2. 00	
0.96 Low volume adjustment for federal fiscal year (yyyy)	·	0 0		70. 96
(Enter in column 0 the corresponding federal year for the				
period prior to 10/1)				
0.97 Low volume adjustment for federal fiscal year (yyyy)		0 0		70. 9
(Enter in column 0 the corresponding federal year for the				
period ending on or after 10/1)				
0.98 Low Volume Payment-3		0		70. 9
0.99 HAC adjustment amount (see instructions)		0		70. 9
.00 Amount due provider (line 67 minus lines 68 plus/minus		38, 919, 719		71.00
lines 69 & 70)				l
.01 Sequestration adjustment (see instructions)		778, 394		71. 0
2.00 Interim payments		37, 926, 119		72. 0
3.00 Tentative settlement (for contractor use only)		0		73. 0
1.00 Balance due provider (Program) (line 71 minus lines 71.01,		215, 206		74. 0
72, and 73)		1 117 050		75. 0
5.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1, 117, 959		/5.0
TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)				
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90.0
instructions)		U		90.0
1.00 Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
2.00 Operating outlier reconciliation adjustment amount (see		0		92. 00
instructions)		0		/2.0
3.00 Capital outlier reconciliation adjustment amount (see		0		93. 0
instructions)		J		70.0
1.00 The rate used to calculate the time value of money (see		0.00		94.0
instructions)				
5.00 Time value of money for operating expenses (see		0		95. 0
instructions)				
5.00 Time value of money for capital related expenses (see		0		96. 0
instructions)				
		Prior to 10/1	On/After 10/1	
		1. 00	2. 00	
HSP Bonus Payment Amount				
00.00 HSP bonus amount (see instructions)		0	0	100. 00
HVBP Adjustment for HSP Bonus Payment				
01.00 HVBP adjustment factor (see instructions)		0	-	101. 0
02.00 HVBP adjustment amount for HSP bonus payment (see instruction	s)	0	0	102. 0
HRR Adjustment for HSP Bonus Payment				
03.00 HRR adjustment factor (see instructions)		0. 0000	0.0000	
04.00 HRR adjustment amount for HSP bonus payment (see instructions		0	0	104.

Health Financial Systems	ST. ELIZABETH EAST		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150109		Worksheet E Part B Date/Time Prepared: 5/27/2015 9:45 am

			To 12/31/2014	Date/Time Prep 5/27/2015 9:4	
		Title XVIII	Hospi tal	PPS	<u> </u>
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			30, 852	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		17, 974, 742	2.00
3.00	PPS payments	ŕ		15, 336, 498	3. 00
4.00	Outlier payment (see instructions)			437, 857	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7.00
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	col 12 line 200		0 18, 381	8. 00 9. 00
10. 00	Organ acquisitions	, cor. 13, 1111e 200		10, 301	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			30, 852	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			,	
	Reasonabl e charges				
12.00	Ancillary service charges			158, 633	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1. 4)		150 (22	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			158, 633	14. 00
15. 00	Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)			 -	
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			158, 633	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	127, 781	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only</pre>	if line 11 exceeds li	ne 18) (see	0	20. 00
20.00	instructions)	TT TITLE TT CXCCCUS TT	110 10) (300	١	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		30, 852	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			15, 792, 736	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)		2, 961, 102	26.00
27. 00	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) pl			12, 862, 486	•
	CAH, see instructions)		, ,	· · · ·	
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			12, 862, 486	1
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			2, 171 12, 860, 315	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	5)		12, 000, 313	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	<u> </u>		0	33. 00
34.00	Allowable bad debts (see instructions)			515, 882	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			335, 323	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		322, 670	ł
37. 00	Subtotal (see instructions)			13, 195, 638	
38. 00	MSP-LCC reconciliation amount from PS&R			0	1
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 00 39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			13, 195, 638	40. 00
40. 01	Sequestration adjustment (see instructions)			263, 913	40. 01
41. 00	Interim payments			12, 788, 275 0	•
42.00					42.00
43.00	Balance due provider/program (see instructions)	a with CMC Dub 1E 2	obonton 1	143, 450	•
44. 00	00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 52,703 §115.2				44. 00
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)		l	0	94. 00

Peri od: Worksheet E-1
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am Provi der CCN: 150109

Impatient Part A						5/27/2015 9: 45	5 am
Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00					Hospi tal	PPS	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.2,752,675 1.2, 1.2, 1.2, 1.2, 1.2, 1.2, 1.2, 1.2,			Inpatien	t Part A	Par	-t B	
Total interim payments paid to provider 37,884,719 12,752,675 1.1							
Interim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1. 00				
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 07/26/2014 41,400 07/26/2014 35,600 3.00							1. 00
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero	2.00			0		0	2. 00
write "NONE" or enter a zero 1.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 3.02 3.03 3.04 3.05 0 0 0 3.3 3.05 9 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 3.50 Provider to Program 3.51 0 0 0 0 3.3 3.53 0 0 0 0 0 3.3 3.53 0 0 0 0 0 3.3 3.53 0 0 0 0 0 3.3 3.54 0 0 0 0 0 3.3 3.55 0 0 0 0 0 3.3 3.55 0 0 0 0 0 3.3 3.50 0 0 0 0 0 3.3 3.50 0 0 0 0 0 3.3 3.50 0 0 0 0 0 3.3 3.50 0 0 0 0 0 3.3 3.50 0 0 0 0 0 0 0 3.3 3.50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3. 00
payment. If none, write "NONE" or enter a zero. (1)		amount based on subsequent revision of the interim rate					
Program to Provider ADJUSTMENTS TO PROVIDER							
3.01 ADJUSTMENTS TO PROVIDER							
3.03 3.04 3.05 3.06 3.06 3.07 3.07 3.08 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.00	2 01		07/2//2014	41 400	07/2//2014	25 (00	2 01
3.03 3.04 0 0 0 3.4 3.05 Provider to Program		ADJUSTMENTS TO PROVIDER	0772672014				
3.04 0						- 1	
3.50 Provider to Program						1	
Provider to Program						1	
3.50 ADJUSTMENTS TO PROGRAM	3.05	Dravi dan ta Dragnam		0		0	3. 05
3.51 3.52 3.53 0 0 0 3.5 3.53 3.54 0 0 0 3.5 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 41,400 35,600 3.5 3.50-3.98 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR	2 50			0			3. 50
3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.55 3.50 3.50-3.98) 3.50-3.98) 3.50-3.98) 37,926,119 12,788,275 4.6 3.50 3.50-3.98) 37,926,119 12,788,275 4.6 3.50		ADJUSTIVIENTS TO FROGRAW					3. 51
3.53 3.54 0 0 0 3.1				-		1	3. 52
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.98) 41,400 35,600 3.50-3.99 37,926,119 12,788,275 4.60 4						1 - 1	3. 53
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.5600 3.560							3. 54
3. 50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3 01-3 40 minus sum of lines					3. 99
12, 788, 275 4.0 12, 788, 275 4.0 12, 788, 275 4.0 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 10 BE COMPLETED BY CONTRACTOR	3. 77			41, 400		35, 600	3. 77
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 5.0 Frogram to Provider 0 0 5.0 5.01 TENTATIVE TO PROVIDER 0 0 5.0 5.03 0 0 5.0 5.00 0 0 5.0 5.01 TENTATIVE TO PROGRAM 0 0 5.0 5.50 TENTATIVE TO PROGRAM 0 0 5.5 5.51 0 0 0 5.5 5.52 0 0 0 5.5 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 5.5 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.0 143,450 6.0 6.02 SETTLEMENT TO PROGRAM 0 12,931,725 7.0 7.00 Total Medicare program liability (see instructions) 38,141,325 12,931,725 7.0 Number (Mo/Day/Yr) 0 1.00 2.00	4 00			37 926 119		12 788 275	4. 00
appropriate TO BE COMPLETED BY CONTRACTOR				0.7.227		, ,	
TO BE COMPLETED BY CONTRACTOR							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					<u>'</u>	•	
Write "NONE" or enter a zero. (1) Program to Provider	5.00	List separately each tentative settlement payment after					5.00
Program to Provider							
TENTATI VE TO PROVI DER							
5.02 0					т.		
Solution	TENTATI VE TO PROVI DER					5. 01	
Provider to Program							5. 02
TENTATI VE TO PROGRAM 0	5. 03			0		0	5. 03
5.51 0					T		
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 215,206 143,450 6.00 Contractor Number 12,931,725 7.00 Total Medicare program liability (see instructions) 38,141,325 Contractor Number (Mo/Day/Yr) 0 1.00 2.00 1.00 2.00 1.00 1.00 2.00 1.00		TENTATIVE TO PROGRAM		_			5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 215, 206 143, 450 6. 0 6. 02 SETTLEMENT TO PROGRAM 0 0 0 6. 0 7. 00 Total Medicare program liability (see instructions) 38, 141, 325 12, 931, 725 7. 0 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 215,206 143,450 6.6 0 6.0 38,141,325 Contractor Number (Mo/Day/Yr) 0 1.00 2.00							5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99			0		0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 215, 206 0 6.0 38, 141, 325 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	/ 00	1 2 2 2 2 2 2					/ 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 215, 206 0 0 6.0 38, 141, 325 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	0.00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 38,141,325 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01			215 204		1/13 /50	6. 01
7.00 Total Medicare program liability (see instructions) 38,141,325 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00						143, 430	6. 02
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00						12 021 725	7. 00
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Tiotal medicale program trabitity (see thistructions)		30, 141, 323			7.00
0 1.00 2.00							
			()			
	8. 00	Name of Contractor					8. 00

		Ti tl	e XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		1, 628, 912 C		0	1. 00 2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER		0			3. 01
3. 02			0			3. 02
3. 04			O		l ől	3. 04
3. 05			O		0	3. 05
	Provider to Program				_	
3.50	ADJUSTMENTS TO PROGRAM		C)	0	3.50
3.51			C)	0	3. 51
3. 52			C		0	3. 52
3.53			C		0	3. 53
3.54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
4 00	3. 50-3. 98)		4 (00 040			4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 628, 912		0	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5. 03	Durandi da mata Dura mana		C		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		C		0	5. 50
5. 50	I LIVIATIVE TO FROUKAW		0			5. 50
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
0. , ,	5. 50-5. 98)					0. , ,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		C	1	0	6. 01
6.02	SETTLEMENT TO PROGRAM		4, 135		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 624, 777		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor			I		8. 00

Health Financial Systems ST. ELIZABETH EAST In Lieu of Form CMS-25					
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150109	Peri od:	Worksheet E-1	
			From 01/01/2014 To 12/31/2014		aanad.
			To 12/31/2014	5/27/2015 9:4	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S		14	8, 582	1. 00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2, 218 34, 449	3. 00 4. 00
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			825, 937, 392	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir			34, 973, 718	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			1, 261, 452 25, 229	8. 00 9. 00
9.00	9.00 Sequestration adjustment amount (see instructions)				
10. 00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				
I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH					
30.00	30.00 Initial/interim HIT payment adjustment (see instructions) 1,141,				
	31.00 Other Adjustment (specify)				
32. 00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 94,319				

Health Financial Systems	ST. ELI ZABETH EAST	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150109		Worksheet E-3
	Component CCN: 15T109	From 01/01/2014 To 12/31/2014	
	·		5/27/2015 9:45 am
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	PFS	
	DADT LLL MEDICARE DADT A GERMAND ARE DEC.			1. 00	
1 00	PART III - MEDICARE PART A SERVICES - IRF PPS			1 574 120	1 00
1.00	Net Federal PPS Payment (see instructions)			1, 574, 139	1. 00 2. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0. 0233		
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			47, 696	3.00
4.00	Outlier Payments			54, 341	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost to November 15, 2004 (see instructions)	t reporting period end	aing on or prior	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count	for residents that were	a displaced by	0.00	5. 01
5.01	program or hospital closure, that would not be counted without a			0.00	3.01
	CFR \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	a temporary cap adjusti	ilent under 42		
6. 00	New Teaching program adjustment. (see instructions)			0. 00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the	e new program growth no	eriod of a "new	0.00	7. 00
7.00	teaching program" (see instructions)	o new program grower po	orrow or a new	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the	e new program growth pe	eriod of a "new	0. 00	8. 00
	teaching program" (see instructions)	pg g p.			
9.00	Intern and resident count for IRF PPS medical education adjustme	ent (see instructions)		0. 00	9. 00
10.00	Average Daily Census (see instructions)	,		5. 526027	10.00
11. 00	Teaching Adjustment Factor (see instructions)			0.000000	11. 00
12.00	Teaching Adjustment (see instructions)			0	12. 00
13.00	Total PPS Payment (see instructions)			1, 676, 176	13. 00
14.00	Nursing and Allied Health Managed Care payments (see instruction	n)		0	14. 00
15.00	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	16. 00
17.00	Subtotal (see instructions)			1, 676, 176	17. 00
18.00	Primary payer payments			4, 649	18. 00
19. 00	Subtotal (line 17 less line 18).			1, 671, 527	19. 00
20.00	Deducti bl es			12, 160	20. 00
21. 00	Subtotal (line 19 minus line 20)			1, 659, 367	21. 00
22. 00	Coi nsurance			1, 824	22. 00
23.00	Subtotal (line 21 minus line 22)			1, 657, 543	23. 00
24. 00	Allowable bad debts (exclude bad debts for professional services	s) (see instructions)		0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)			0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)			1, 657, 543	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 49)		0	28. 00
29. 00	Other pass through costs (see instructions)			393	
30. 00	Outlier payments reconciliation			0	30. 00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	31. 50
31. 99	Recovery of Accelerated Depreciation			0	31. 99
32.00	Total amount payable to the provider (see instructions)			1, 657, 936	32.00
32. 01	Sequestration adjustment (see instructions)			33, 159	
33. 00	Interim payments			1, 628, 912	
34. 00	Tentative settlement (for contractor use only)	3.4		0	34.00
35. 00 36. 00	Balance due provider/program line 32 minus lines 32.01, 33 and 3		ahantan 1	-4, 135 0	35. 00 36. 00
36.00	Protested amounts (nonallowable cost report items) in accordance §115.2	e with two Pub. 15-2, (chapter i,	U	36.00
	TO BE COMPLETED BY CONTRACTOR				
50. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			54, 341	50.00
51. 00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52. 00	The rate used to calculate the Time Value of Money			0. 00	
	Time Value of Money (see instructions)				53. 00
55. 55	1 12. 22 0		ı	٥١	. 55. 55

Health Financial Systems	ST. ELI ZABETH EAST	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150109	Peri od: Worksheet E-3
		From 01/01/2014 Part VII
		T- 10/01/0014 D-+-/T: D

			From 01/01/2014 To 12/31/2014		
		Title XIX	Hospi tal	Cost	<u> </u>
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		11, 521, 442		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		o		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		11, 521, 442	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		11, 521, 442	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		27, 157, 473	0	
10. 00	Organ acquisition charges, net of revenue		0		10. 00
	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		27, 157, 473	0	12. 00
40.00	CUSTOMARY CHARGES		1		
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14 00	basis	normant for carriage on	0	0	14. 00
14. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		٩	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
	Total customary charges (see instructions)		27, 157, 473	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	15, 636, 031	0	17. 00
17.00	line 4) (see instructions)	TT TTHE TO EXCECUS	13, 030, 031	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	o	0	18. 00
	16) (see instructions)			_	
19.00	Interns and Residents (see instructions)		o	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	11, 521, 442	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid	ers.		
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0	_	25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		11 521 442	0	
29. 00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		11, 521, 442	0	29. 00
20.00	Excess of reasonable cost (from line 18)			0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		11, 521, 442	0	
32. 00	Deductibles		11, 321, 442	0	
33. 00	Coinsurance		0	0	1
34. 00	Allowable bad debts (see instructions)			0	34. 00
	Utilization review		0	O	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	11, 521, 442	0	1
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	1	
38. 00	Subtotal (line 36 ± line 37)			0	
39. 00	Direct graduate medical education payments (from Wkst. E-4)				39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		11, 521, 442	0	1
41. 00	Interim payments		11, 521, 442	0	1
42.00	Balance due provider/program (line 40 minus line 41)		O	0	1
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	o	0	43. 00
	chapter 1, §115.2				

Health Financial Systems	ST. ELI ZABETH EAST	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150109	Peri od:	Worksheet E-3
	Component CCN: 15T109	From 01/01/2014 To 12/31/2014	
	Title XIX	Subprovi der -	Cost

		litle XIX	Subprovi der -	Cost	
			I RF	Outpati ant	
			I npati ent 1.00	Outpati ent	
	DADT VIII CALCULATION OF DELMDUDGEMENT ALL OTHER HEALTH CERVIC	TO TOD TITLES WAS VIV		2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	ES FOR TITLES V OR ATA	SERVICES		1
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		222 202		1 00
1. 00 2. 00	Inpatient hospital/SNF/NF services		323, 283	0	1.00
	Medical and other services		0	U	
3.00	Organ acquisition (certified transplant centers only)		222 202	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		323, 283	0	
5.00	Inpatient primary payer payments		U	0	5. 00
6. 00 7. 00	Outpatient primary payer payments		222 202	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		323, 283	0	7.00
					1
0 00	Reasonable Charges				0 00
8. 00 9. 00	Routi ne servi ce charges		450 104	0	8. 00 9. 00
10.00	Ancillary service charges		459, 186 0	U	10.00
	Organ acquisition charges, net of revenue		0		11.00
11. 00 12. 00	Incentive from target amount computation		459, 186	0	
12.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		459, 180	0	12.00
13. 00	Amount actually collected from patients liable for payment for se	arvi cos en a chargo	O	0	13. 00
13.00	basis	er vi ces on a charge	٩	U	13.00
14. 00	Amounts that would have been realized from patients liable for pa	nument for services on	o	0	14.00
14.00	a charge basis had such payment been made in accordance with 42 C	9	J	O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	3413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		459, 186	0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	135, 903	0	
17.00	line 4) (see instructions)	Title to execeus	133, 703	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	T TITLE T CACCCUS TITLE	٩	Ü	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	,	323, 283	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provide			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		O	0	
24.00	1 3		0		24. 00
25.00	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		323, 283	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		323, 283	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	3)	323, 283	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		323, 283	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		323, 283	0	40.00
41.00	Interim payments		323, 283	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

ST. ELIZABETH EAST In Lieu of Form CMS-2552-10 Provider CCN: 150109

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

Peri od: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared:

				0 12/31/2014	5/27/2015 9:4	
		General Fund	Speci fi c	Endowment Fund		
		1 00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1. 00	Cash on hand in banks	1, 017, 000		0	0	1.00
2.00	Temporary investments	3, 885, 000	1	0	0	
3.00	Notes recei vabl e	0) (0	0	3. 00
4.00	Accounts receivable	45, 272, 000	1	0	0	
5.00	Other receivable	0		0	0	1
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	6, 956, 000			0	
8.00	Prepaid expenses	0, 930, 000				
9. 00	Other current assets	6, 213, 000		o o	0	
10.00	Due from other funds	O	1	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	63, 343, 000		0	0	11. 00
	FIXED ASSETS					
12.00	Land	0		-	-	
13.00	Land improvements		1	0	0 0	1
14. 00 15. 00	Accumulated depreciation Buildings	219, 809, 000	1	0	0	
16. 00	Accumulated depreciation	217, 007, 000			0	
17. 00	Leasehold improvements				Ö	
18. 00	Accumul ated depreciation	C		0	0	18. 00
19. 00	Fi xed equipment	0) (0	0	19. 00
20. 00	Accumulated depreciation	0		0	0	
21. 00	Automobiles and trucks	0) (0	0	
22. 00	Accumulated depreciation	0	1	0	0	
23. 00 24. 00	Maj or movable equipment		1	0	0	
25. 00	Accumulated depreciation Minor equipment depreciable					
26. 00	Accumulated depreciation				0	
27. 00	HIT designated Assets	Ö		o o	Ō	
28. 00	Accumulated depreciation	0		0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	C) (0	0	
30. 00	Total fixed assets (sum of lines 12-29)	219, 809, 000) (0	0	30.00
21 00	OTHER ASSETS	0 507 000) (0	0	21 00
31. 00 32. 00	Investments Deposits on Leases	9, 587, 000				
33. 00	Due from owners/officers				Ö	
34. 00	Other assets	3, 438, 000		o o	Ö	
35. 00	Total other assets (sum of lines 31-34)	13, 025, 000		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	296, 177, 000) (0	0	36. 00
	CURRENT LIABILITIES	1				
37. 00	Accounts payable	16, 638, 000	1	0		
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	13, 522, 000		0	0 0	
40. 00	Notes and Loans payable (short term)					
41. 00	Deferred income		ól ö		Ö	
42. 00	Accel erated payments	Ö			_	42. 00
43.00	Due to other funds	0		0	0	43. 00
44. 00		3, 702, 000		0	0	
45. 00		33, 862, 000) (0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	1 0	\		0	46. 00
47. 00	Notes payable					
48. 00	Unsecured Loans		1		Ö	1
49. 00	Other long term liabilities	5, 215, 000			Ō	1
50.00	Total long term liabilities (sum of lines 46 thru 49	5, 215, 000		0	0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	39, 077, 000) (0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	257, 100, 000				52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted					53.00
55. 00	Donor created - endowment fund balance - restricted					55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	257, 100, 000	1	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	296, 177, 000	ή (0 ال	0	60.00
	³⁷ /	I	I		I	I

In Lieu of Form CMS-2552-10 Health Financial Systems ST. ELIZABETH EAST STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 150109 Peri od: Worksheet G-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 271, 854, 000 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 25, 034, 462 2.00 3.00 Total (sum of line 1 and line 2) 296, 888, 462 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 5.00 0 0 0 0 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 296, 888, 462 0 11.00 11.00 12.00 ADJUST TO AFS 39, 788, 462 0 12.00 13.00 13.00 14.00 0 14.00 0 0 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 39, 788, 462 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 257, 100, 000 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00

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16.00

17.00

18.00

19.00

Subtotal (line 3 plus line 10)

sheet (line 11 minus line 18)

Total deductions (sum of lines 12-17)

Fund balance at end of period per balance

ADJUST TO AFS

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150109

		Т	o 12/31/2014	Date/Time Prep 5/27/2015 9:4	pared: 5 am
	Cost Center Description	Inpatient	Outpati ent	Total	
	•	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	83, 405, 745		83, 405, 745	1. 00
2.00	SUBPROVI DER - I PF	0		0	2. 00
3.00	SUBPROVI DER - I RF	2, 923, 658		2, 923, 658	3. 00
4.00	SUBPROVI DER	C		0	4. 00
5.00	Swing bed - SNF	C		0	5. 00
6.00	Swing bed - NF	C		0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8. 00 9. 00	NURSING FACILITY OTHER LONG TERM CARE				8. 00 9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	86, 329, 403		86, 329, 403	
10.00	Intensive Care Type Inpatient Hospital Services	00, 324, 403		00, 327, 403	10.00
11. 00	INTENSIVE CARE UNIT	15, 278, 648		15, 278, 648	11. 00
12. 00	CORONARY CARE UNIT	10,2,0,010		10/2/0/010	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15.00	NEONATAL INTENSIVE CARE UNIT	12, 025, 021		12, 025, 021	15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	27, 303, 669		27, 303, 669	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	113, 633, 072		113, 633, 072	17. 00
18. 00	Ancillary services	330, 883, 630		736, 539, 202	
19. 00	Outpati ent servi ces	9, 909, 214		74, 643, 156	
20. 00	RURAL HEALTH CLINIC	C		0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	C		0	21. 00
22. 00	HOME HEALTH AGENCY		7, 526, 504	7, 526, 504	
23. 00	AMBULANCE SERVI CES	C	10, 777, 095	10, 777, 095	
24. 00	CMHC			0	24. 00
24. 10 25. 00	CORF		0	0	24. 10 25. 00
26. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE		3, 944, 296	3, 944, 296	
27. 00	NON-REI MBURSEABLE	-2, 940, 014		-2, 659, 760	
27. 00	DURABLE MEDI CAL EQUI PMENT	-2, 740, 014		-308	
27. 02	NON HOSPITAL - FPN (CORP 44)			62, 568, 491	27. 02
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	451, 485, 902			
	G-3, line 1)	10171007100	,,	.,,	
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		244, 401, 686		29. 00
30.00	AFFLI LI ATES	35, 458, 693			30.00
31. 00	NON HOSPITAL - FPN (CORP 44)	55, 586, 143			31. 00
32. 00		C			32. 00
33. 00		C			33. 00
34. 00		C			34. 00
35. 00	Total additions (our of Lines 20 25)	C			35. 00
36. 00 37. 00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)		91, 044, 836		36. 00 37. 00
38.00	DEDUCT (SPECIFY)				37.00
39.00					39. 00
40.00					40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)		n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	-	335, 446, 522		43. 00
	to Wkst. G-3, line 4)				

	Financial Systems ST. ELIZABE			u of Form CMS-2	
STATEN	ENT OF REVENUES AND EXPENSES	Provi der CCN: 150109	Peri od: From 01/01/2014	Worksheet G-3	
			To 12/31/2014	Date/Time Pre 5/27/2015 9:4	
				1 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		1. 00 1, 006, 971, 748	1. 00
2.00	Less contractual allowances and discounts on patients' accou			665, 146, 764	1
3.00	Net patient revenues (line 1 minus line 2)			341, 824, 984	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		335, 446, 522	1
5. 00	Net income from service to patients (line 3 minus line 4)			6, 378, 462	•
0.00	OTHER I NCOME			0,0,0,102	0.00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			4, 000	7. 00
8.00	Revenues from telephone and other miscellaneous communication	on services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses		0	11. 00	
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING REVENUE			13, 748, 000	24. 00
24. 01	LOSS ON SALE			-433, 000	24. 01
24. 02	EQUITY IN EARNING OF INVESMENTS			5, 373, 000	
24. 03	CONTRI BUTI ONS			3, 000	24. 03
24. 04				-39, 000	1
	Total other income (sum of lines 6-24)			18, 656, 000	1
	Total (line 5 plus line 25)			25, 034, 462	26. 00 27. 00
27 00	O OTHER EXPENSES (SPECIEY)				

0 27.00 0 28.00

0

25, 034, 462 29. 00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 00 OTHER EXPENSES (SPECIFY)

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

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3, 540, 704

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1, 213, 159

3, 527, 621

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21.00

22.00

23.00

24.00

16.00

17.00

18.00

19.00

20.00

21.00

23.00

Respiratory Therapy

Day Care Program

Homemaker Service

All Others (specify)

24.00 | Total (sum of lines 1-23)

Private Duty Nursing

Health Promotion Activities

Home Delivered Meals Program

0

0

0

0

0

0

0

272, 278

0

0

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0

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0

1, 485, 437

3, 527, 621

16.00

17.00

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24.00

16.00

17.00

18.00

19. 00 20. 00

21.00

22.00

23 00

Clinic

Respiratory Therapy

Day Care Program

Homemaker Service

All Others (specify)

24.00 Total (sum of lines 1-23)

Private Duty Nursing

Health Promotion Activities

Home Delivered Meals Program

Health Financial Systems	ST. ELIZABETH EAST	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HHA STATISTICAL BASIS	Provi der CCN: 150109	Peri od:	Worksheet H-1
	HHA CCN: 157124	From 01/01/2014 To 12/31/2014	Part II Date/Time Prepared:
			5/27/2015 9:45 am
		Home Health	PPS

							5/2//2015 9:4:	5 am
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati o	nReconciliation	Admi ni strati ve	
		Fi xtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
				(SQUARE FEET)				
		1.00	2.00	3. 00	4.00	5A. 00	5. 00	
-	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1. 00
	Fixtures							
2.00	Capital Related - Movable		36, 292			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	C	ol	0		3. 00
4.00	Transportation (see	0	0	C)		4. 00
	instructions)							
5.00	Administrative and General	0	36, 292	C		-646, 604	2, 881, 017	5. 00
	HHA REIMBURSABLE SERVICES	•			•			
6.00	Skilled Nursing Care	0	0	C		0	682, 237	6.00
7. 00	Physical Therapy	0	0	Ċ		0	518, 301	7. 00
8.00	Occupational Therapy	0	0	Ċ		0	202, 518	8. 00
9. 00	Speech Pathology	0	0	Ċ		0	11, 925	
10.00	Medical Social Services	0	0	Ċ		0	6, 033	
11. 00	Home Health Aide	0	0	Č		0	67, 837	
12. 00	Supplies (see instructions)	0	0	Č		0	68, 168	
13. 00	Drugs	l o	0	Č		0	110, 839	
14. 00	DME	0	_	`	1	0		
14.00	HHA NONREIMBURSABLE SERVICES				<u>'</u>	5 0	0	14.00
15. 00	Home Dialysis Aide Services	0	0	(0	0	15. 00
16. 00	Respiratory Therapy	0	0		1	0	0	16. 00
17. 00	Private Duty Nursing	0	0			0	0	17. 00
18. 00	Clinic	0	0				0	18. 00
19. 00	Health Promotion Activities		0				0	19. 00
20. 00	Day Care Program	0	0				0	20.00
21. 00	Home Delivered Meals Program	0	0				0	21. 00
		0	0				0	
	Homemaker Service	0	0				1 010 150	22. 00
	All Others (specify)	0	0	(0	1, 213, 159	
24. 00	Total (sum of lines 1-23)	0	36, 292	<u> </u>]	-646, 604		
25. 00	Cost To Be Allocated (per	0	36, 292	(ין	וי	646, 604	25. 00
0, 0-	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	1. 000000	0. 000000	0.00000	ון	0. 224436	26.00

Peri od: Worksheet H-2
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am HHA CCN: 157124 Home Health PPS

						Agency I	PPS	
			CAPITAL REL	ATED COSTS		Agency 1		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	MGMT INFO SYSTEMS	
		0	1. 00	2.00	4.00	5. 01	5. 02	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 17. 00 20. 00 21. 00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0 835, 356 634, 626 247, 970 14, 601 7, 387 83, 062 83, 467 135, 715 0 0 0 0 0 0 0 0 0 0 1, 485, 437 3, 527, 621	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	52, 717 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00
	Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
		5. 03	5. 04	5. 05	5A. 05	5. 06	7. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	4, 108 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 502 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27, 005 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	835, 356 634, 626 247, 970 14, 601 7, 387 83, 062 83, 467 135, 715 0 0 0 0 0 0 0 0 0	117, 674 89, 398 34, 931 2, 057 1, 041 11, 758 19, 118 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Worksheet H-2 Part I Date/Time Prepared: 5/27/2015 9:45 am Provi der CCN: 150109 Peri od: From 01/01/2014 To 12/31/2014 HHA CCN: 157124

						Home Health Agency I	PPS	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
		8. 00	9. 00	10.00	11.00	13.00	14.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	00 00 00 00 00 00 00 00 00 00 00 00 00		114, 55	3 277, 816 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
	column 26, line 1, rounded to 6 decimal places. Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	ENURSING SCHOO	L PARAMEDI CAL EDUCATI ON PROGRAM	Subtotal	
		15. 00	16. 00	17. 00	20.00	23. 00	24. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30, 460 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1, 526, 456 953, 030 724, 024 282, 901 16, 658 8, 428 94, 763 95, 225 154, 833 0 0 0 0 0 0 0 0 0 0 1, 694, 684 5, 551, 002	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Home Health PPS Agency I

						Agency i	
	Cost Center Description	Intern &	Subtotal	Allocated HHA	Total HHA		
		Residents Cost		A&G (see Part	Costs		
		& Post		11)			
		Stepdown					
		Adjustments					4
		25. 00	26. 00	27. 00	28. 00		
1.00	Administrative and General	0	1, 526, 456				1. 00
2.00	Skilled Nursing Care	0	953, 030				2. 00
3.00	Physical Therapy	0	724, 024		· ·		3. 00
4.00	Occupational Therapy	0	282, 901	107, 301	390, 202		4. 00
5.00	Speech Pathology	0	16, 658				5. 00
6.00	Medical Social Services	0	8, 428	3, 197	11, 625		6. 00
7.00	Home Health Aide	0	94, 763	35, 942	130, 705		7. 00
8.00	Supplies (see instructions)	0	95, 225	36, 118	131, 343		8. 00
9.00	Drugs	0	154, 833	58, 726	213, 559		9. 00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11. 00
12.00	Respiratory Therapy	0	0	0	0		12. 00
13.00	Private Duty Nursing	0	0	0	0		13. 00
14.00	Clinic	0	0	0	0		14. 00
15.00	Health Promotion Activities	o	0	0	0		15. 00
16.00	Day Care Program	o	0	0	0		16. 00
17.00	Home Delivered Meals Program	o	0	0	0		17. 00
18.00	Homemaker Service	0	0	0	0		18. 00
19.00	All Others (specify)	0	1, 694, 684	642, 769	2, 337, 453		19. 00
20.00	Total (sum of lines 1-19) (2)	0	5, 551, 002	1, 526, 456	5, 551, 002		20.00
21.00	Unit Cost Multiplier: column			0. 379287			21. 00
	26, line 1 divided by the sum						
	of column 26, line 20 minus						
	column 26, line 1, rounded to						
	6 decimal places.						

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	ST. ELI ZABETH EAST	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HHA BASIS	COST CENTERS STATISTICAL Provider CCN: 150	Period: Worksheet H-2 From 01/01/2014 Part II
5.10.10	HHA CCN: 15	7124 To 12/31/2014 Date/Time Prepared:

5/27/2015 9:45 am

Home Health **PPS** Agency I CAPITAL RELATED COSTS NEW BLDG & NEW MVBLE **EMPLOYEE** COMMUNICATIONS MGMT INFO PURCHASI NG Cost Center Description FLXT **FOULP BENEFITS SYSTEMS** (COSTED (SQUARE (SQUARE **DEPARTMENT** (PHONE (MANHOURS) REQUISITIO) FEET) FEET) (GROSS LI NES) SALARI ES) 1.00 2.00 5.01 5.03 5.02 4.00 0 2, 559, 058 0 1.00 Administrative and General 0 82, 986 91,586 1.00 0 2.00 Skilled Nursing Care 2.00 3.00 Physical Therapy 00000000000 0 0 3.00 0 Occupational Therapy 0 0 4.00 0 0 4.00 0 5.00 Speech Pathology 5.00 6.00 Medical Social Services 0 0 0 6.00 0 0 0 0 0 0 0 7.00 Home Health Aide 0 0 0 7.00 0 Supplies (see instructions) 0 8.00 8.00 9.00 Drugs 0 0 9.00 10.00 DMF 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 11.00 0 0 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing 0 13.00 00000 0 14.00 Clinic 0 0 0 0 0 0 14.00 0 Health Promotion Activities 15.00 0 15.00 16.00 Day Care Program 0 16.00 17.00 Home Delivered Meals Program 0 0 0 17.00 0 0 o Homemaker Service 18.00 18.00 0 All Others (specify) 0 19.00 0 19.00 0 20.00 Total (sum of lines 1-19) 0 2, 559, 058 0 82, 986 91, 586 20.00 878, 026 52, 717 21.00 Total cost to be allocated 4, 108 21.00 22.00 Unit cost multiplier 0.000000 0.000000 0.343105 0.000000 0.635252 0.044854 22.00 ADMI TTI NG OPERATION OF LAUNDRY & Cost Center Description PATI ENT Reconciliation **OTHER** LINEN SERVICE (GROSS ACCOUNTI NG ADMI NI STRATI VE **PLANT** CHARGES) (GROSS AND GENERAL (SQUARE (POUNDS OF CHARGES) (ACCUM. COST) FEET) LAUNDRY) 5.04 5A. 06 8.00 5.06 7.00 5.05 1.00 7, 526, 504 967, 358 Administrative and General 7, 526, 504 0 1.00 2.00 Skilled Nursing Care C 835, 356 2.00 3.00 Physical Therapy 0 000000000000000 0 634, 626 0 0 0 0 0 0 0 0 0 3.00 Occupational Therapy 0 0 247.970 4.00 4.00 0 0 5.00 14, 601 Speech Pathology 5.00 6.00 Medical Social Services 0 7, 387 6.00 0 7.00 Home Health Aide 83, 062 7.00 0 8 00 0 83 467 O 8.00 Supplies (see instructions) 9.00 Drugs 0 135, 715 9.00 10.00 DME 0 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 11.00 0 0 Respiratory Therapy 0 12 00 12 00 0 13.00 Private Duty Nursing 13.00 0 0 0 14.00 Clinic 0 14.00 0 15 00 Health Promotion Activities Ω 0 15 00 0 0 16.00 Day Care Program 16.00 0 17.00 Home Delivered Meals Program 0 0 0 0 17.00 0 0 Homemaker Service 0 0 18.00 18.00 0 19 00 All Others (specify) O 0 1, 485, 437 19 00 20.00 Total (sum of lines 1-19) 7, 526, 504 7, 526, 504 4, 494, 979 0 20.00 5, 502 27, 005 Total cost to be allocated 633, 194 21.00 0.000731 0.003588 0.140867 0.000000 0.000000 22.00 22.00 Unit cost multiplier

Peri od: Worksheet H-2
From 01/01/2014 Part II
To 12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am
Home Health PPS Peri od: BASIS HHA CCN: 157124

						Home Health Agency I	PPS	
	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	, , , , , , , , , , , , , , , , , , ,	(SQUARE	(MEALS	(MANHOURS)	ADMI NI STRATI ON	SERVICES &	(COSTED	
		FEET)	SERVED)			SUPPLY	REQUIS.)	
					(DI RECT	(COSTED		
					NRSING HRS)	REQUIS.)		
1 00	Administrative and Consumb	9. 00	10.00	11.00	13.00	14.00	15. 00	1 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	0	0	82, 98 <i>6</i>		0	0	
3.00	Physical Therapy	0	0	(0	0	
4. 00	Occupational Therapy	0	0	(1	0	0	
5.00	Speech Pathology	0	0	(0	0	
6. 00	Medical Social Services	0	o	(0	0	
7. 00	Home Heal th Aide	o	Ö	(o	0	
8. 00	Supplies (see instructions)	0	0	Ć	o	0	0	8. 00
9.00	Drugs	0	0	(o	0	0	9. 00
10.00	DME	0	0	(0	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0	(0	0	
12. 00	Respiratory Therapy	0	0	(0	0	
13. 00	Private Duty Nursing	0	0	(0	0	
14.00	Clinic	0	0	(1 "	0	0	
15.00	Health Promotion Activities	0	0	(0	0	0	
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	(1 "	O O	0	
18. 00	Homemaker Service	0	0	(0	0	1
19. 00	All Others (specify)	0	0	(0	0	ı
20. 00	Total (sum of lines 1-19)	0	0	82, 986	1	0	0	
21. 00	Total cost to be allocated	o o	0	114, 553	1	o o	0	21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000	1. 380389		0. 000000	0. 000000	
	Cost Center Description		SOCIAL SERVICE	NURSING SCHOOL				
		RECORDS &			EDUCATI ON			
		LI BRARY	(TIME	(ASSI GNED	PROGRAM			
		(GROSS CHARGES)	SPENT)	TI ME)	(ASSIGNED TIME)			
		16. 00	17. 00	20.00	23. 00			-
1. 00	Administrative and General	7, 526, 504	0	(1. 00
2.00	Skilled Nursing Care	0	0	(o			2. 00
3.00	Physi cal Therapy	0	0	(o			3. 00
4.00	Occupational Therapy	0	0	(0			4. 00
5.00	Speech Pathology	0	0	(1			5. 00
6.00	Medical Social Services	0	0	(6. 00
7.00	Home Health Aide	0	0	(1			7. 00
8.00	Supplies (see instructions)	0	0	(1			8. 00
9.00	Drugs DME	0	0 0	(9.00
10. 00 11. 00	Home Dialysis Aide Services	0	0	(10. 00 11. 00
12. 00	Respiratory Therapy	0	0	(12.00
13. 00	Pri vate Duty Nursing	0	0	(1			13. 00
14. 00	Clinic	o o	o	(14. 00
15. 00	Health Promotion Activities	0	ō	Ċ				15. 00
16. 00	Day Care Program	0	О	(0			16. 00
17. 00	Home Delivered Meals Program	0	O	(1			17. 00
18. 00	Homemaker Service	0	0	(ή			18. 00
19. 00	All Others (specify)	_ 0	0	(0			19. 00
20.00	Total (sum of lines 1-19)	7, 526, 504	0	(0			20.00
21. 00	Total cost to be allocated	30, 460	0 000000	0.00000	0			21. 00
22. 00	Unit cost multiplier	0. 004047	0. 000000	0. 000000	0. 000000			22. 00

	n Financial Systems TIONMENT OF PATIENT SERVICE COST	rs .	ST. ELIZAB		CCN: 150109	Peri od:	u of Form CMS-2 Worksheet H-3	
ALT OK	TONNENT OF PATIENT SERVICE COST			HHA CCN:		From 01/01/2014 To 12/31/2014	Part I	pared:
				Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIM	ITATION COST, OF	?	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							1
1. 00	Skilled Nursing Care	2. 00	1, 314, 502		1, 314, 50	2 7, 086	185. 51	1.00
2.00	Physi cal Therapy	3. 00		O		· ·	192. 79	
3.00	Occupational Therapy	4. 00					· ·	
4.00	Speech Pathology	5. 00			22, 97		14. 41	
5.00	Medical Social Services	6. 00			11, 62		121. 09	
6. 00 7. 00	Home Health Aide Total (sum of lines 1-6)	7. 00	130, 705 2, 868, 647	O	130, 70 2, 868, 64		84. 22	6. 00 7. 00
7.00	Total (suil of Titles 1-6)		2,000,047		Program Visit			7.00
						rt B		1
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t	o Subject to		
					Deductibles 8	Deductibles		
		0	1.00	2.00	Coi nsurance 3.00	4. 00	5. 00	
	Limitation Cost Computation	1 0	1.00	2.00	3.00	4.00	5.00	
8. 00	Skilled Nursing Care		29140	C	5, 52	4		8.00
9.00	Physical Therapy		29140	0	3, 59	6		9. 00
10. 00			29140	0	1, 18	0		10.00
11. 00	Speech Pathology		29140	0	1			11. 00
12.00			29140	0	1			12.00
13. 00 14. 00	l .		29140	0				13. 00 14. 00
14.00		From Wkst. H-2	Facility Costs		Total HHA		Ratio (col. 3	14.00
	oost center bescriptron	Part I, col.	(from Wkst.	Ancillary	Costs (cols.	1 (from HHA	÷ col . 4)	
		28, line	H-2, Part I)	Costs (from Part II)	+ 2)	Record)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput							
15. 00		8. 00			1		0. 000000	
16. 00	Cost of Drugs	9. 00				9 0	0. 000000	16. 00
			Program Visits		Cost of Services			
			Par	t B	J Sel VI Ces	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
	·			Deductibles &		Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF LESSER	6. 00	7.00	8. 00	9. 00	10.00	11. 00	
	BENEFICIARY COST LIMITATION	UF AGGREGATE I	RUGRAW CUST, A	GGREGATE OF TH	IE PRUGRAW LIW	TIATION COST, OF	(
	Cost Per Visit Computation							1
1. 00	Skilled Nursing Care	0	5, 524			0 1, 024, 757		1.00
2.00	Physi cal Therapy	0	3, 596		1	0 693, 273		2. 00
3.00	Occupational Therapy	0			1	0 3, 902, 024		3. 00
4.00	Speech Pathology	0				0 980		4.00
5. 00 6. 00	Medical Social Services Home Health Aide	0 0			1	0 8, 355 0 110, 328		5. 00 6. 00
7. 00	Total (sum of lines 1-6)					0 5, 739, 717		7.00
	Cost Center Description		11, 747			5, 737, 717		7.00
	222 22 2000. pti on	6. 00	7. 00	8. 00	9.00	10.00	11. 00	
	Limitation Cost Computation					1		8.00
8. 00	Skilled Nursing Care							1
8. 00 9. 00	Skilled Nursing Care Physical Therapy							9.00
8. 00 9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy							10.00
8. 00 9. 00 10. 00 11. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology							10. 00 11. 00
8. 00 9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services							9. 00 10. 00 11. 00 12. 00 13. 00

Heal th	Financial Systems		ST. ELIZAE	BETH EAST		In Lie	u of Form CMS-:	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		HHA CCN:				pared:
				Ti t	le XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance		Part A	Part B Not Subject to Deductibles & Coinsurance		
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Computa							
	Cost of Medical Supplies Cost of Drugs	0	0		9 0	0	0	15. 00 16. 00
10.00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00			51			10.00
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE I	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, OF	?	
1 00	Cost Per Visit Computation Skilled Nursing Care	1, 024, 757						1 00
1. 00 2. 00	Physical Therapy	693, 273						1.00 2.00
3.00	Occupati onal Therapy	3, 902, 024						3.00
4.00	Speech Pathology	980						4.00
5. 00	Medical Social Services	8, 355						5. 00
6.00	Home Health Aide	110, 328						6.00
7.00	Total (sum of lines 1-6)	5, 739, 717						7. 00
	Cost Center Description							
		12. 00						
	Limitation Cost Computation							
	Skilled Nursing Care							8. 00
9.00	Physical Therapy							9.00
10. 00 11. 00	Occupational Therapy Speech Pathology							10. 00 11. 00
	Medical Social Services							12.00
	Home Health Aide							13.00
	Total (sum of lines 8-13)							14.00
50	(1	1					,

Heal th	Financial Systems		ST. ELI ZAB	BETH E	AST			In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	S			Provi der	CCN: 150109		ri od:	Worksheet H-3	
					HHA CCN:	157124		om 01/01/2014 12/31/2014		
					Ti tl	e XVIII	H	Home Health	PPS	
							Agency I			
	Cost Center Description	From Wkst. C,	Cost to Charge	Tot	al HHA	HHA Shared		Transfer to		
		Part I, col.	Ratio	Char	ge (from	Ancillary		Part I as		
		9, line		pr	ovi der	Costs (col.	1	Indi cated		
				re	cords)	x col. 2)				
		0	1. 00		2. 00	3.00		4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	SHA	RED HOSPI	TAL DEPARTMEN	NTS			
1.00	Physi cal Therapy	66. 00	0. 414954		0		0 c	ol. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67. 00	0. 246208		0		0 c	ol. 2, line 3	. 00	2.00
3.00	Speech Pathology	68. 00	0. 868399		0		0 c	ol. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71. 00	0. 177410		0		0 c	ol. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73. 00	0. 194548		0		0 c	ol. 2, line 1	6. 00	5.00
5.01	Cost of Drugs 1	73. 01	1. 848092		0		0 c	ol. 2, line 1	6. 01	5. 01

	Financial Systems ST. ELIZABETH E ATION OF HHA REIMBURSEMENT SETTLEMENT	+	CCN: 150109		eri od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	157124		rom 01/01/2014 o 12/31/2014	Part I-II Date/Time Prep 5/27/2015 9:4	
		Ti tl	e XVIII		Home Health Agency I	PPS	
					Par	t B	
			Part A		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			1. 00		2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	ARY CHARGE	S				
	Reasonable Cost of Part A & Part B Services				ام	-	,
0 0	Reasonable cost of services (see instructions) Total charges			0	0	0	1 2
,,,	Customary Charges			U	U	U	4
00	Amount actually collected from patients liable for payment for	servi ces		0	0	0	3
	on a charge basis (from your records)						
00	Amount that would have been realized from patients liable for professions for services on a charge basis had such payment been made in act with 42 CFR §413.13(b)			0	0	0	4
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	000	0. 000000	0. 000000	5
00	Total customary charges (see instructions)			0	0	0	6
00	Excess of total customary charges over total reasonable cost (conly if line 6 exceeds line 1)	ompiete		0	0	0	7
0	Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	ifline		0	0	0	8
0	Primary payer amounts			0	0	0	9
					Part A	Part B	
				ŀ	Servi ces 1. 00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				1.00	2.00	
00	Total reasonable cost (see instructions)				0	0	10
	Total PPS Reimbursement - Full Episodes without Outliers				0	1, 916, 308	
00	Total PPS Reimbursement - Full Episodes with Outliers				0	0	12
00	Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				0	27, 761 12, 194	13
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	12, 194	1!
00	Total PPS Outlier Reimbursement - PEP Episodes				Ö	0	10
00	Total Other Payments				0	217	1
00	DME Payments				0	0	18
00	Oxygen Payments				0	0	19
00	Prosthetic and Orthotic Payments	anaa)			0	0	20
00	Part B deductibles billed to Medicare patients (exclude coinsurant Subtotal (sum of lines 10 thru 20 minus line 21)	ance)			0	1, 956, 480	
00	Excess reasonable cost (from line 8)				0	1, 930, 400	23
00	Subtotal (line 22 minus line 23)				Ö	1, 956, 480	
00	Coinsurance billed to program patients (from your records)					0	25
00	Net cost (line 24 minus line 25)				0	1, 956, 480	
	Reimbursable bad debts (from your records)						27
	Reimbursable bad debts for dual eligible beneficiaries (see ins					1 054 400	28
00	Total costs - current cost reporting period (line 26 plus line : OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	21)			0	1, 956, 480 0	30
50	Pioneer ACO demonstration payment adjustment (see instructions)				0	0	30
00	Subtotal (see instructions)				0	1, 956, 480	
01	Sequestration adjustment (see instructions)				0	39, 130	31
00	Interim payments (see instructions)				0	1, 917, 350	
00	Tentative settlement (for contractor use only)				0	0	33
	Balance due provider/program (line 31 minus lines 31.01, 32, and	Y 33)			O	0	34
00	Protested amounts (nonallowable cost report items) in accordance		D. L 45 0		يّ ا	0	35

In Lieu of Form CMS-2552-10

Health Financial Systems ST. ELIZABETH EAST ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO Provide Provided 150109 | Peri od: From 01/01/2014 | Date/Ti me Prepared: 5/27/2015 9:45 am | PPS Provi der CCN: 150109 PROGRAM BENEFICIARIES HHA CCN:

				Home Health Agency I	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	1, 917, 350 0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01				0	0	3. 01
3.02				0	o	3. 02
3.03				O	0	3. 03
3.04				O	0	3. 04
3.05				O	0	3. 05
	Provider to Program	T				
3.50				0	0	3. 50
3.51				0	0	3. 51 3. 52
3. 52 3. 53				0		3. 52 3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			5	0	3. 99
0. 77	3. 50-3. 98)				Ĭ	0. 77
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		1	D	1, 917, 350	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
E 04	Program to Provider					F 04
5. 01 5. 02				0	0	5. 01 5. 02
5. 02				0		5. 02
3.03	Provider to Program		'	<u> </u>	0	3. 03
5. 50	Trovidor to Trogram			O	0	5. 50
5. 51				0	o	5. 51
5.52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(O	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			O	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			O	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	1, 917, 350	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00	Mama of Contractor	()	1. 00	2. 00	0.00
8. 00	Name of Contractor	I		1	l l	8. 00

Health Financial Systems	ST. E	ELI ZABETH EAST	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSABLE BAD DEBTS	- TITLE XVIII - PART B	Provider CCN: 150109	Peri od: From 01/01/2014	Worksheet I-5

CALCUL	ATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B	Provider CCN: 150109	Peri od:	Worksheet I-5	
			From 01/01/2014 To 12/31/2014		narod:
			10 12/31/2014	5/27/2015 9: 4	
			1. 00	2. 00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - I	PART B			
1.00	Total expenses related to care of program beneficiaries (see in		0		1. 00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instru	ctions)	0	0	2. 00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see ins	tructions)			2. 01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see inst	ructions)			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) patients (see instruction	ons)	0	0	3. 00
3.01	Deductibles billed to Medicare (Part B) patients (see instruction	ons)			3. 01
3.02	Deductibles billed to Medicare (Part B) patients (see instruction	ons)			3. 02
3.03	Total deductibles billed to Medicare (Part B) patients (see ins				3. 03
4.00	Coinsurance billed to Medicare (Part B) patients	,	0	l o	4.00
4. 01	Coinsurance billed to Medicare (Part B) patients (see instructions)				
4.02	Coinsurance billed to Medicare (Part B) patients (see instructi	,			4. 02
4.03	Total coinsurance billed to Medicare (Part B) patients (see ins	0	o	1	
5.00	Bad debts for deductibles and coinsurance, net of bad debt reco	,	0	0	1
5. 01	Transition period 1 (75-25%) bad debts for deductibles and coin		t 0	0	5. 01
	recoveries for services rendered on or after 1/1/2011 but before 1/1/2012				
5.02	Transition period 2 (50-50%) bad debts for deductibles and coin		t 0	0	5. 02
	recoveries for services rendered on or after 1/1/2012 but befor				
5.03	Transition period 3 (25-75%) bad debts for deductibles and coin		t 0	0	5. 03
	recoveries for services rendered on or after 1/1/2013 but before				
5.04	100% PPS bad debts for deductibles and coinsurance net of bad d	ebt recoveries for	0	0	5. 04
	services rendered on or after 1/1/2014				
5.05	Total bad debts (sum of line 5 through line 5.04)		0	0	5. 05
6.00	Allowable bad debts (see instructions)		0		6. 00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see ins	tructi ons)	0		7. 00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) pat	ients (see	0	0	8. 00
	instructions)	•			
9.00	Program payment (see instructions)		0	0	9. 00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)				10. 00
11.00	Reimbursable bad debts (see instructions) (transfer to Workshee	t E, Part B, line 33)	0		11. 00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCEI	NTAGE			1
12.00	Total allowable expenses (see instructions)		0		12. 00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)		0		13. 00
14.00	Facility specific composite cost percentage (line 13 divided by	line 12)	0. 000000		14. 00

			Hospi ce (LCN: 151563 1	0 12/31/2014	5/27/2015 9:4	
					Hospi ce I	3/2//2013 7.4	J dili
		Salaries (from	Empl oyee	Transportati or		Other	
			Benefits (from		Services (from		
			Wkst. K-2)	(() () ()	Wkst. K-3)		
		1.00	2.00	3.00	4.00	5. 00	
	GENERAL SERVICE COST CENTERS	<u> </u>			'		
1.00	Capital Related Costs-Bldg and Fixt.			C)	0	1. 00
2.00	Capital Related Costs-Movable Equip.					36, 685	2. 00
3.00	Plant Operation and Maintenance	o	Ō) c	0	0	3. 00
4.00	Transportation - Staff	o	Ō	o c	0	0	4. 00
5.00	Volunteer Service Coordination	o	0) c	0	0	5. 00
6.00	Administrative and General	136, 271	0) c	2, 580	38, 447	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	380	0) C	325	0	7. 00
8.00	Inpatient - Respite Care	1, 147	0	0	250	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0) c	5, 400	0	9. 00
10.00	Nursi ng Care	76, 816	0) c	0	0	10.00
11. 00	Nursing Care-Continuous Home Care	720	0) c	0	0	11. 00
12.00	Physi cal Therapy	0	0) C	0	0	12. 00
13.00	Occupational Therapy	0	0) c	0	0	13. 00
14.00	Speech/ Language Pathology	0	0) C	0	0	14. 00
15. 00	Medical Social Services	9, 238	0) C	0	0	15. 00
16. 00	Spiritual Counseling	14, 997	0) C	0	0	16. 00
17. 00	Di etary Counsel i ng	0	0) C	0	0	17. 00
18. 00	Counseling - Other	0	0) C		0	18. 00
19. 00	Home Health Aide and Homemaker	9, 109	0) C		0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0	1		_	20. 00
21. 00	Other	0	0) <u> </u>	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0				22. 00
23. 00	Anal gesi cs	0	0	1	1	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) C	,	0	26. 00
27. 00	Pati ent Transportation	0	Ü) C	1	0	27. 00
28. 00	I maging Services	0	Ü) C	,	0	28. 00
29. 00	Labs and Diagnostics	0	Ü) C	1	0	29. 00
30.00	Medical Supplies	0	Ü) C	-	7, 364	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	Ü) C	.,		31.00
32. 00	Radi ati on Therapy	0	Ü) C	-	_	32. 00
33.00	Chemotherapy	0	0	1			33. 00
34.00	Other	0	0) C	0	0	34. 00
25 62	HOSPI CE NONREI MBURSABLE SERVI CE	1 2		J		_	25.00
35. 00	Bereavement Program Costs	0	0			_	35. 00
36.00	Volunteer Program Costs	0	0			0	36. 00 37. 00
37. 00 38. 00	Fundrai si ng		0	1	1	0	37.00
	Other Program Costs Total (sum of lines 1 thru 38)	248, 678	0				
39.00	Total (Suii Of Titles I till u 30)	240,078	U	'1	ار, 337	132, /21	39.00

Health Financial Systems	ST. ELIZABETH EAST	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150109	Period: Worksheet K From 01/01/2014

Hospi ce CCN: 151563 To 12/31/2014 Date/Time Prepared:

			nospi ce (JCN. 131303	10 12/31/2014	5/27/2015 9:4	
					Hospi ce I		
		Total (cols.	Reclassi fi cati	Subtotal (col		Total (col. 8	
		1-5)	on	6 ± col. 7)		± col. 9)	
		6.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	1	0	0	1. 00
2.00	Capital Related Costs-Movable Equip.	36, 685	0	36, 68	5 0	36, 685	2. 00
3.00	Plant Operation and Maintenance	0	0		0	0	3. 00
4.00	Transportation - Staff	0	0		0	0	4. 00
5.00	Volunteer Service Coordination	0	0)	0	0	5. 00
6.00	Administrative and General	177, 298	0	177, 29	8 -83	177, 215	6. 00
	I NPATI ENT CARE SERVI CE						
7. 00	Inpatient - General Care	705					7. 00
8.00	Inpatient - Respite Care	1, 397	0	1, 39	7 0	1, 397	8. 00
	VISITING SERVICES				_		
9.00	Physi ci an Servi ces	5, 400					9. 00
10. 00	Nursing Care	76, 816					
11. 00	Nursing Care-Continuous Home Care	720	0	72		720	
12. 00	Physi cal 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	9, 238	0	9, 23		9, 238	
16. 00	Spiritual Counseling	14, 997	0	14, 99	7 0	14, 997	16. 00
17. 00	Dietary Counseling	0	0)	0	0	17. 00
18. 00	Counseling - Other	0	0		0	0	18. 00
19. 00	Home Health Aide and Homemaker	9, 109	0	9, 10		9, 109	
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0	1	0	-	20. 00
21. 00	Other	0	0)	0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS		Г		T		
22. 00	Drugs, Biological and Infusion Therapy	50, 225	0	1,		,	
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		2	0	0	26. 00
27. 00	Pati ent Transportation	0			0	0	27. 00
28. 00	I maging Services	0			0	0	28. 00
29. 00	Labs and Diagnostics	7 2/4		1	0	0	29. 00
30.00	Medical Supplies	7, 364	l .	7, 36		7, 364	30.00
31. 00	Outpatient Services (including E/R Dept.)	1, 782	0	1, 78		1, 782	
32. 00	Radi ati on Therapy	0			0	0	32.00
33.00	Chemotherapy	0	0	1	0	0	33.00
34. 00	Other	0	0)	0 0	0	34. 00
25 00	HOSPI CE NONREI MBURSABLE SERVI CE			\		0	25 00
35. 00 36. 00	Bereavement Program Costs	0	0	1	0 0	0	35. 00 36. 00
36.00	Volunteer Program Costs				0	0	36.00
37.00	Fundraising Other Program Costs				0	0	37.00
	Total (sum of lines 1 thru 38)	391, 736		391, 73	6 -83	-	
37.00	Tiotai (Suii di Titles I tillu 30)	371,/30	1	1, /3	o _l -83	371,033	J 37. UU

Health Financial Systems		ELI ZABETH I	EAST		In Lieu of Form CMS-2552-10		
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES			Provi der CCN: 150109	Peri od:		Worksheet K-1	

Hospice CCN: 150169 | Perfod: From 01/01/2014 | Hospice CCN: 151563 | To 12/31/2014 | Date/Time Prepared:

			Hospi ce (CN: 151563 10	0 12/31/2014	5/27/2015 9:4	
					Hospi ce I	3/21/2013 7. 4	o ani
		Admi ni strator	Di rector	Soci al	Supervi sors	Nurses	
				Servi ces	·		
		1.00	2. 00	3. 00	4. 00	5. 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	0	3. 00
4.00	Transportation - Staff	0	0	0	0	0	4. 00
5.00	Volunteer Service Coordination	0	0	-	0	0	5. 00
6.00	Administrative and General	0	0	0	33, 870	0	6. 00
	INPATIENT CARE SERVICE						
7. 00	Inpatient - General Care	0	0		0	341	7. 00
8.00	Inpatient - Respite Care	0	0	0	0	1, 104	8. 00
	VI SI TI NG SERVI CES						
9. 00	Physi ci an Servi ces	0	0		0	0	9. 00
10. 00	Nursing Care	0	0	1	0	76, 816	•
11. 00	Nursing Care-Continuous Home Care	0	0	· ·	0	720	11. 00
12.00	Physi cal Therapy	0	0	0	0	0	12.00
13. 00	Occupational Therapy	0	0	0	0	0	13. 00
14. 00	Speech/ Language Pathology	0	0	0	0	0	14. 00
15. 00	Medical Social Services	0	0	9, 238	0	0	15. 00
16. 00	Spiritual Counseling	0	0	0	0	0	16. 00
17. 00	Di etary Counsel i ng	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	20. 00
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	27. 00
28. 00	I maging 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	33. 00
34. 00	Other	0	0	0	0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE			1			
35. 00	1	0	0		0	0	35. 00
36.00	Volunteer Program Costs	0	0	-	0	0	36.00
37. 00	Fundrai si ng	0	0	1	이	0	37. 00
38. 00	Other Program Costs	0	0	-	0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	0	0	9, 238	33, 870	78, 981	39.00

Heal th	Financial Systems	ST. ELIZAB	ETH EAST				In Lie	u of Form CMS	-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES		F				Period: From 01/01/2014		Worksheet K-1	
			Hosp	oice CC	CN: 151563		31/2014	Date/Time Pr 5/27/2015 9:	
						Hospi	ce I		
	·	Total	Ai des	5	All-Other	Total	(1)		
		Therapi sts							
		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	o		5. 00

 Heal th Financial
 Systems
 ST.
 ELIZABETH

 HOSPI CE
 COMPENSATI ON ANALYSI S CONTRACTED
 SERVI CES/PURCHASED
 SERVI CES
 Period: Worksheet From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am Provi der CCN: 150109 Hospi ce CCN: 151563

-						5/21/2015 9:4	o alli
					Hospi ce I		
		Admi ni strator	Di rector	Soci al	Supervi sors	Nurses	
				Servi ces			
	T	1.00	2. 00	3. 00	4. 00	5. 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	0	3. 00
4.00	Transportation - Staff	0	0		0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0	0	5. 00
6.00	Administrative and General	0	0		o o	0	6.00
	I NPATI ENT CARE SERVI CE	<u> </u>	•		<u> </u>		1
7.00	Inpatient - General Care	0	0		0 0	0	7.00
8.00	Inpatient - Respite Care	O	0		o o	0	8.00
	VI SI TI NG SERVI CES		-1				
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10. 00	Nursing Care	0	0		0 0		
11. 00	Nursing Care-Continuous Home Care	0	0		o o	_	
12. 00	Physical Therapy		0		o o	Ö	
13. 00	Occupational Therapy		0		0 0	-	
14. 00	Speech/ Language Pathology		0		0 0	Ö	
15. 00	Medical Social Services		0			-	
16. 00	Spiritual Counseling		0			0	1
17. 00	Di etary Counseling	0	0			_	
18. 00	Counseling - Other	0	0			0	
19. 00	Home Health Aide and Homemaker	0	0		0 0		19.00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0			_	
21. 00	Other	0	0				
21.00	OTHER HOSPICE SERVICE COSTS	l U	U _I		<u>U</u>	ı U	21.00
00.00					T	I	
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		1
28. 00	I maging Services	0	0		0	0	
29. 00	Labs and Diagnostics	0	0		0	1	
30. 00	Medical Supplies	0	0		0	0	
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	1
32.00	Radi ati on Therapy	0	0		0	0	32. 00
33.00	Chemotherapy	0	0		0	0	33. 00
34.00	Other	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	o	o		o o	0	36. 00
37.00	Fundrai si ng	o	o		o o	0	37. 00
38.00	Other Program Costs	o	o		0	0	38. 00
39.00	Total (sum of lines 1 thru 38)	l	o		o o	0	39. 00
		. '	'		•	•	

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES Provider CCN: 150109 Peri od: Worksheet K-3 From 01/01/2014 Hospi ce CCN: 151563 12/31/2014 Date/Time Prepared: 5/27/2015 9:45 am Hospi ce I Total Ai des All-Other Total (1) Therapi sts 7.00 8.00 9. 00 6 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 3 00 Plant Operation and Maintenance 0 4.00 Transportation - Staff 0 0 0 4.00 Volunteer Service Coordination 5.00 5.00 6.00 Administrative and General 0 2, 580 2, 580 6.00 INPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 325 325 7.00 8.00 Inpatient - Respite Care 0 250 250 8.00 VISITING SERVICES 9.00 Physician Services 0 5, 400 5, 400 9.00 10.00 Nursing Care 0 10.00 Nursing Care-Continuous Home Care 0 11.00 0 0 11.00 0 12.00 Physical Therapy 0 12.00 13.00 Occupational Therapy 0 0 0 0 13.00 Speech/ Language Pathology 0 14.00 0 0 0 0 0 14.00 Medical Social Services 0 0 15.00 15.00 0 0 16.00 Spiritual Counseling 16.00 17.00 Dietary Counseling 17.00 0 0 18.00 Counseling - Other 18.00 Home Health Aide and Homemaker 0 19.00 19.00 0 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 20.00 21.00 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 Anal gesi cs 23.00 Sedatives / Hypnotics 24.00 24.00 Other - Specify 25.00 25.00 Durable Medical Equipment/Oxygen 26.00 26,00 27.00 Patient Transportation 27.00 0 0 28.00 Imaging Services 28.00 0 29 00 Labs and Diagnostics Ω O 29 00 0 0 30.00 Medical Supplies 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 1, 782 1, 782 31.00 Radiation Therapy 32.00 0 0 0 32.00 0 0 33.00 Chemotherapy 0 33.00 34.00 0ther 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 0 O 35 00 Bereavement Program Costs 0 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 37.00

0

0

0

10, 337

0

10, 337

38.00

39.00

38.00

Other Program Costs

39.00 Total (sum of lines 1 thru 38)

						5/27/2015 9:4	5 am
					Hospi ce I		
	·		CAPI TAL RE	LATED COST	·		
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1.00	2.00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	36, 685		36, 68	5		2.00
3.00	Plant Operation and Maintenance	0	0	1	0 0		3. 00
4. 00	Transportation - Staff	0	0		0 0		4. 00
5. 00	Volunteer Service Coordination	0	0		0 0	_	5. 00
6.00	Administrative and General	177, 215	0		-1		6.00
0.00	I NPATI ENT CARE SERVI CE	177,213		30, 00	.5		0.00
7. 00	Inpatient - General Care	705	0		0 0	0	7.00
8. 00	Inpatient - Respite Care	1, 397	0		0 0		8.00
0.00	VI SI TI NG SERVI CES	1, 377			0	0	0.00
9. 00	Physician Services	5, 400	0		0 0	0	9. 00
10. 00	Nursing Care	76, 816	0		0 0		10.00
11. 00	Nursing Care-Continuous Home Care	70, 810	0		0 0	_	11.00
12. 00	Physical Therapy	720	0		0 0	1	12.00
13. 00	Occupational Therapy	0	0		0 0		13.00
		0	0		0 0	_	14.00
14. 00	Speech/ Language Pathology	0 220	0		0 0	_	15.00
15. 00 16. 00	Medical Social Services	9, 238	0		0 0	1	16.00
	Spiritual Counseling	14, 997	0		0 0	0	17. 00
17. 00	Di etary Counsel i ng	0	0		-	_	
18. 00	Counseling - Other	0 100	0		0	0	18.00
19. 00	Home Health Aide and Homemaker	9, 109	0	1	0	_	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	_	20.00
21. 00	Other	0	0		0 0	0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS	F0 225	0	I	0 0	0	1 22 20
22. 00	Drugs, Biological and Infusion Therapy	50, 225	_		-1	_	22. 00
23. 00	Anal gesi cs	0	0		0	_	23. 00
24. 00	Sedatives / Hypnotics	0	0		0	0	24. 00
25. 00	Other - Specify	0	0		0	_	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		0	_	26.00
27. 00	Pati ent Transportation	0	0		0	_	27. 00
28. 00	I maging Services	0	0		0	1	28. 00
29. 00	Labs and Diagnostics	0	0		0		29. 00
30. 00	Medi cal Supplies	7, 364	0		0	_	30. 00
31. 00	Outpatient Services (including E/R Dept.)	1, 782	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 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	0	37. 00
38. 00	Other Program Costs	0	0		0		38. 00
39. 00	Total (sum of lines 1 thru 38)	391, 653	0	36, 68	5 0	0	39. 00

			nospi ce v	CON. 131303 1	0 12/31/2014	5/27/2015 9:45 am
					Hospi ce I	0, 2,, 2010 ,1 10 dill
		VOLUNTEER	SUBTOTAL	ADMI NI STRATI VE	TOTAL (col. 5A	
		SERVI CES	(col s. 0 - 5)	& GENERAL	± col. 6)	
		COORDI NATOR	(
		5. 00	5A	6. 00	7. 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					3.00
4. 00	Transportation - Staff					4.00
5. 00	Volunteer Service Coordination					5.00
6. 00	Administrative and General	l c		213, 900		6. 00
0.00	I NPATI ENT CARE SERVI CE		210,700	210,700		0.00
7. 00	Inpatient - General Care	C	705	848	1, 553	7. 00
8. 00	Inpatient - Respite Care		l .			8. 00
0.00	VI SI TI NG SERVI CES		1,077	1,001	0,010	0.00
9. 00	Physician Services	C	5, 400	6, 498	11, 898	9. 00
10. 00	Nursing Care			1		10.00
11. 00	Nursing Care-Continuous Home Care		70, 010	1	1 ' 1	11. 00
12. 00	Physical Therapy		720		1, 500	12.00
13. 00	Occupational Therapy					13. 00
14. 00	Speech/ Language Pathology					14.00
15. 00			9, 238	11, 117	20, 355	15.00
			14, 997	1	1 ' 1	16.00
16.00	, ,		14, 997	10,047	33, 044	17. 00
	Di etary Counseling					
18.00	Counseling - Other		0 100	10 0/1	20.070	18.00
19. 00	·		9, 109	10, 961	20, 070	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		_		0	20.00
21. 00	Other		1	ή	ıl U	21. 00
22.00	OTHER HOSPICE SERVICE COSTS		E0 225	1 (0 420	110 ((4	22.00
	Drugs, Biological and Infusion Therapy			1	110, 664	22.00
23. 00	Anal gesi cs	C	C			23.00
24. 00	J				U	24. 00
25. 00	Other - Specify)	0	25. 00
26. 00	Durable Medical Equipment/Oxygen)	0	26.00
27. 00	Pati ent Transportation	C)	0	27. 00
28. 00	I maging Services	C)	0	28. 00
29. 00	Labs and Diagnostics	C	()	0	29. 00
30. 00	Medical Supplies	C	7, 364			30. 00
31. 00	Outpatient Services (including E/R Dept.)	C	1, 782	2, 144	3, 926	31. 00
32.00	Radi ati on Therapy	C	() C	0	32. 00
33. 00	Chemotherapy	C	() C	0	33.00
34.00	Other	C	() <u> </u>	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	T				
35. 00	Bereavement Program Costs	C	C) c	0	35. 00
36. 00	9	0	() C	0	36. 00
37. 00	Fundrai si ng	C	() C	0	37. 00
38. 00		0	() C	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	C	391, 653	3	391, 653	39.00

					10 12/01/2011	5/27/2015 9: 4	5 am
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.	(22,102)	COORDI NATOR	
		''''	VALUE)	FT.)		(HOURS)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	7.00	3.00	
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Blug and Trxt.	0	1, 174				2.00
		0	1, 1/4				
3.00	Plant Operation and Maintenance	0	0		0		3.00
4.00	Transportation - Staff	0	0		0		4. 00
5.00	Volunteer Servi ce Coordination	0	0		0	_	5. 00
6.00	Administrative and General	0	1, 174		0 0	0	6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0			0		7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	0		0		9. 00
10.00	Nursi ng Care	0	0		0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0	0	12. 00
13.00	Occupational Therapy	0	0		o o	0	13.00
14.00	Speech/ Language Pathology	0	0		0 0	0	14.00
15. 00	Medical Social Services	0	0		o o	0	15. 00
16, 00	Spiritual Counseling	0	0		0	0	16. 00
17. 00	Di etary Counsel i ng	0	n		0 0	0	17. 00
18. 00	Counseling - Other	0	0		o o	_	18. 00
19. 00	Home Health Aide and Homemaker	0	0		o o	Ö	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0		20.00
21. 00	Other	0	0		0 0		21.00
21.00	OTHER HOSPICE SERVICE COSTS	<u> </u>	0		0 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		23. 00
24. 00	Sedatives / Hypnotics		0		0 0		24. 00
25. 00	7.	0	0		0 0	_	25. 00
	Other - Specify	0			0 0	_	
26. 00	Durable Medical Equipment/Oxygen	0	0		-	_	26. 00
27. 00	Pati ent Transportation	0	0		0	_	27. 00
28. 00	I maging Services	0	0		0	_	28. 00
29. 00	Labs and Diagnostics	0	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	Radi ati on Therapy	0	0		0	0	32. 00
33.00	Chemotherapy	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	35. 00
36.00	Volunteer Program Costs	0	0		0	0	36. 00
37.00	Fundrai si ng	0	0		0	0	37. 00
38.00	Other Program Costs	0	0		0 0	0	38. 00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	36, 685		0	0	39. 00
40.00	Unit Cost Multiplier	0. 000000	31. 247871	0. 00000	0. 000000	0. 000000	40. 00
	•		•	-	•	-	-

Heal th Financial Systems ST. ELIZABETH EAST In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150109 Period: From 01/01/2014 Part II

To 12/31/2014 Date/Time Prepared:

5/27/2015 9:45 am Hospi ce I RECONCI LI ATI ON ADMI NI STRATI VE & GENERAL (ACC. COST) 6A 6.00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 0 2.00 Capital Related Costs-Movable Equip. 2.00 3.00 Plant Operation and Maintenance 0 3.00 4.00 4.00 Transportation - Staff 0 5.00 Volunteer Service Coordination 5.00 Administrative and General -213, 900 177, 753 6.00 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 705 7.00 8.00 0 1, 397 8.00 VISITING SERVICES 9.00 Physician Services 0 5, 400 9.00 10.00 Nursing Care 00000000000 76, 816 10.00 11.00 Nursing Care-Continuous Home Care 720 11.00 12.00 Physical Therapy 0 12.00 13.00 Occupational Therapy 13.00 0 Speech/ Language Pathology Medical Social Services 14.00 0 14.00 15.00 9. 238 15.00 16.00 Spiritual Counseling 14, 997 16.00 Dietary Counseling 17.00 17.00 0 18.00 Counseling - Other 18.00 Home Health Aide and Homemaker 19.00 9, 109 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 20.00 0 21.00 Other 0 21.00 OTHER HOSPICE SERVICE COSTS Drugs, Biological and Infusion Therapy 0 22.00 50, 225 22.00 23.00 Anal gesi cs 23.00 00000000000 24.00 Sedatives / Hypnotics 0 24.00 25.00 Other - Specify 25.00 0 26.00 Durable Medical Equipment/Oxygen 0 26.00 Patient Transportation 0 27.00 27.00 28 00 Imaging Services 0 28.00 Labs and Diagnostics 29.00 Ω 29.00 30.00 Medical Supplies 7, 364 30.00 Outpatient Services (including E/R Dept.) 31.00 1, 782 31.00 32 00 Radiation Therapy 0 32.00 33.00 Chemotherapy 0 33.00 34.00 34.00 0 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 35.00 0 36.00 Volunteer Program Costs 0 36.00 37.00 Fundrai si ng 0 37.00 38.00 Other Program Costs 0 38.00 0 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 213, 900 39.00

1. 203355

40.00

40.00 Unit Cost Multiplier

Cost Center Description
Cost Center Description
Balance (1) FIXT EQUIP BENEFITS
Balance (1) FIXT EQUIP BENEFITS
1.00
1.00 Administrative and General 33,217 0 85,323 0 1.00
1.00 Administrative and General 33,217 0 85,323 0 1.00 2.00 Inpatient - General Care 1,553 0 0 0 0 2.00 3.00 Inpatient - Respite Care 3,078 0 0 0 0 0 3.00 4.00 Physical Services 11,898 0 0 0 0 4.00 0 0 0 0 4.00 0 0 0 0 4.00 0<
2.00 Inpatient - General Care 1,553 0 0 0 0 2.00 3.00 Inpatient - Respite Care 3,078 0 0 0 0 3.00 4.00 Physician Services 11,898 0 0 0 0 0 4.00 5.00 Nursing Care 169,253 0 0 0 0 5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td
3.00 Inpatient - Respite Care 3,078 0 0 0 0 3.00 4.00 Physician Services 11,898 0 0 0 0 4.00 5.00 Nursing Care 169,253 0 0 0 0 0 6.00 Nursing Care-Continuous Home Care 1,586 0 0 0 0 7.00 Physical Therapy 0 0 0 0 0 8.00 Occupational Therapy 0 0 0 0 9.00 Speech/ Language Pathology 0 0 0 0 10.00 Medical Social Services 20,355 0 0 11.00 Spiritual Counseling 33,044 0 0 0 12.00 Dietary Counseling 33,044 0 0 0 13.00 Counseling - Other 0 0 0 14.00 Home Health Aide and Homemaker 20,070 0 0 15.00 Other 0 0 0 16.00 Other 0 0 0 17.00 Drugs, Biological and Infusion Therapy 110,664 0 0 19.00 Sedatives / Hypnotics 0 0 0 20.00 Other - Specify 0 0 0 21.00 Durable Medical Equipment/Oxygen 0 0 0 21.00 0 0 0 0 21.00 0 0 0 0 21.00 0 0 0 0 21.00 0 0 0 0 21.00 0 0 0 0 21.00 0 0 0 21.00 0 0 0 21.00 0 0 0 21.00 0 0 0 21.00 0 0 0 21.00 0 0 0 21.00 0 0 0 21.00 0 0 0 21.00 0 0 21.00 0 0 0 21.00 0 0 0 21.00 0 0 21.00 0 0 21.00 0 0 0 21.00 0 0 0 21.00 0 0 21.00 0 0 0 21.00 0
4.00 Physician Services 11,898 0 0 0 4.00 5.00 Nursing Care 169,253 0 0 0 0 5.00 6.00 Nursing Care-Continuous Home Care 1,586 0
5. 00 Nursi ng Care 169, 253 0 0 0 0 5.00 6. 00 Nursi ng Care-Conti nuous Home Care 1,586 0 <t< td=""></t<>
6.00 Nursing Care-Continuous Home Care 1,586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
7. 00 Physical Therapy 0 0 0 0 0 7. 00 8. 00 Occupational Therapy 0 0
8.00 Occupational Therapy 0 0 0 0 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 0 0 0 0 0 9.00 10.00 Medical Social Services 20,355 0 0 0 0 0 10.00 11.00 Spiritual Counseling 33,044 0 0 0 0 0 11.00 11.
9.00 Speech Language Pathology 0 0 0 0 0 0 0 0 0
10.00 Medical Social Services 20,355 0 0 0 0 10.00 11.00 Spiritual Counseling 33,044 0 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 20,070 0 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 110,664 0 0 0 0 0 0 0 0 0 17.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 0 0
11. 00 Spiritual Counseling 33,044 0 0 0 0 11. 00 12. 00 Dietary Counseling 0 0 0 0 0 0 0 12. 00 13. 00 Counseling - Other 0 0 0 0 0 0 0 13. 00 14. 00 Home Health Aide and Homemaker 20,070 0 0 0 0 0 14. 00 15. 00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 15. 00 16. 00 Other 0 0 0 0 0 0 0 0 0 16. 00 17. 00 Drugs, Biological and Infusion Therapy 110, 664 0 0 0 0 0 0 17. 00 18. 00 Analgesics 0 0 0 0 0 0 0 0 18. 00 19. 00 Sedatives / Hypnotics 0 0 0 0 0 0 0 0 0 0
12.00 Dietary Counseling 0 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 20,070 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 110,664 0 0 0 0 0 0 18.00 18.00 Analgesics 0 0 0 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0
13.00 Counseling - Other 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 20,070 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 110,664 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 0 17.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 21.00
14.00 Home Health Aide and Homemaker 20,070 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 110,664 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 0 0 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 21.00
15.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 110,664 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 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 0
16. 00 Other 0 0 0 0 0 16. 00 17. 00 Drugs, Bi ol ogi cal and Infusi on Therapy 110, 664 0 0 0 0 0 17. 00 18. 00 Anal gesi cs 0 0 0 0 0 0 18. 00 19. 00 Sedati ves / Hypnoti cs 0 0 0 0 0 19. 00 20. 00 Other - Speci fy 0 0 0 0 0 0 0 20. 00 21. 00 Durabl e Medi cal Equi pment/Oxygen 0 0 0 0 0 0 21. 00
17. 00 Drugs, Biological and Infusion Therapy 110,664 0 0 0 0 17. 00 18. 00 Anal gesics 0 0 0 0 0 18. 00 19. 00 Sedatives / Hypnotics 0 0 0 0 0 0 19. 00 20. 00 Other - Specify 0 0 0 0 0 0 0 20. 00 21. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 21. 00
17. 00 Drugs, Biological and Infusion Therapy 110,664 0 0 0 0 17. 00 18. 00 Anal gesics 0 0 0 0 0 18. 00 19. 00 Sedatives / Hypnotics 0 0 0 0 0 0 19. 00 20. 00 Other - Specify 0 0 0 0 0 0 0 20. 00 21. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 21. 00
18.00 Anal gesics 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 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 21.00
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/Oxygen 0 0 0 0 0 0 21.00
20.00 Other - Specify 0 0 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 21.00
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 16, 226 0 0 0 25. 00
26.00 Outpatient Services (including E/R Dept.) 3,926 0 0 0 26.00
27.00 Radiation Therapy 0 0 0 0 27.00
28.00 Chemotherapy 0 0 0 0 28.00
29. 00 Other 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 Fundraising 0 0 0 0 32.00
33.00 Other Program Costs 0 0 0 0 33.00
34.00 Total (sum of lines 1 thru 33) (2) 391,653 33,217 0 85,323 0 34.00
35.00 Unit Cost Multiplier (see instructions) 35.00

Provi der CCN: 150109 Hospi ce CCN: 151563

					Hospi ce I	3/21/2013 7. 4	o um
	Cost Center Description	MGMT INFO	PURCHASI NG	ADMI TTI NG	PATIENT	Subtotal	
	cost center bescription	SYSTEMS	PURCHASING	ADMITTING	ACCOUNTING	Subtotal	
		5. 02	5. 03	5. 04	5. 05	5A. 05	
1.00	Administrative and General	3, 878	5. US	5. 04	2, 975	125, 999	1. 00
2. 00	Inpatient - General Care	3,070	0	000	2, 7/3	1, 553	2. 00
3.00	Inpatient - Respite Care		0	0	0	3, 078	3. 00
4. 00	Physician Services		0	0	0	11, 898	4. 00
5.00	Nursing Care		0	0	0	169, 253	5. 00
6. 00	Nursing Care-Continuous Home Care		0	0	0	1, 586	6. 00
7. 00	Physical Therapy	0	0	0	0	1, 560	7. 00
8. 00	Occupational Therapy	0	0	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	20, 355	10.00
11. 00	Spiritual Counseling	0	0	0	0		11. 00
		0	0	0	0	33, 044	
12.00	Dietary Counseling Counseling - Other	0	0	0	0	0	12.00
13. 00 14. 00	Home Health Aide and Homemaker	0	0	0	0	-	13. 00 14. 00
15. 00		0	0	0	U O	20, 070	15. 00
	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	
16.00	Other	0	0	0	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	110, 664	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	I maging Services	0	0	0	0	0	23. 00
24. 00	Labs and Diagnostics	0	0	0	0	1/ 22/	24. 00
25. 00	Medical Supplies	0	0	0	0	16, 226	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	3, 926	26. 00
27. 00	Radi ati on 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)	3, 878	0	606	2, 975	517, 652	34.00
35. 00	Unit Cost Multiplier (see instructions)					0. 000000	35. 00

Health Financial Systems ST. I ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

							5/27/2015 9: 4	<u> 5 am </u>
						Hospi ce I		
	Cost Center Description	OTHER	OPERATION O		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE	PLANT	L	LINEN SERVICE			
		AND GENERAL						
		5. 06	7. 00		8. 00	9. 00	10. 00	
1.00	Administrative and General	17, 749		83	0	11, 034	0	1. 00
2.00	Inpatient - General Care	219		0	0	0	0	2. 00
3.00	Inpatient - Respite Care	434		0	0	0	0	3. 00
4.00	Physi ci an Servi ces	1, 676		0	0	0	0	4. 00
5.00	Nursi ng Care	23, 842		0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	223		0	0	0	0	6. 00
7.00	Physi cal Therapy	0		0	0	0	0	7. 00
8.00	Occupational Therapy	0		0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0		0	0	0	0	9. 00
10.00	Medical Social Services	2, 867		0	0	0	0	10.00
11. 00	Spiritual Counseling	4, 655		0	0	0	0	11. 00
12.00	Di etary Counsel i ng	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	2, 827		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	15, 589		o	0	0	0	17. 00
18. 00	Anal gesi cs	0		o	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	I maging Services	0		0	0	0	0	23. 00
24.00	Labs and Diagnostics	0		0	0	0	0	24. 00
25. 00	Medical Supplies	2, 286		0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	553		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		o	0	0	0	29. 00
30.00	Bereavement Program Costs	0		o	0	0	0	30.00
31.00	Volunteer Program Costs	0		o	0	0	0	31.00
32.00	Fundrai si ng	0		ol	0	0	0	32. 00
33. 00	Other Program Costs	0		0	0	o	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	72, 920	46, 6	83	0	11, 034	0	34. 00
	Unit Cost Multiplier (see instructions)	1			_	,		35. 00
		i .	1			1	1	

						5/27/2015 9:4	5 am
					Hospi ce I		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
1.00	Administrative and General	8, 426	20, 294	0	0	3, 356	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	Physi ci an Servi ces	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	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	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	Di etary Counsel i ng	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	0ther	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	Pati ent Transportation	0	0	0	0	0	22. 00
23.00	I maging 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)	8, 426	20, 294	0	0	3, 356	34. 00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

						5/27/2015 9: 4	5 am
					Hospi ce I		
	Cost Center Description	SOCIAL SERVICE	NURSING SCHOOL	PARAMEDI CAL	Subtotal	Intern &	
				EDUCATI ON	(col s. 4A-23)	Residents Cost	
				PROGRAM		& Post	
						Stepdown	
						Adjustments	
		17. 00	20.00	23.00	24.00	25. 00	
1.00	Administrative and General	0	0		0 233, 541		1. 00
2.00	Inpatient - General Care	0	0		0 1, 772	. 0	2. 00
3.00	Inpatient - Respite Care	0	0		0 3, 512	. 0	3. 00
4.00	Physi ci an Servi ces	0	0		0 13, 574	. 0	4. 00
5.00	Nursi ng Care	0	0		0 193, 095	0	5. 00
6.00	Nursing Care-Continuous Home Care	o	0		1, 809	0	6. 00
7.00	Physical Therapy	o	0		0 0	0	7. 00
8.00	Occupational Therapy	o	0		0 0	0	8. 00
9.00	Speech/ Language Pathology	o	0		0 0	0	9. 00
10.00	Medical Social Services	o	0		0 23, 222	0	10. 00
11. 00	Spiritual Counseling	O	0		0 37, 699	0	11. 00
12.00	Di etary Counsel i ng	O	0		0 0	0	12.00
13.00	Counseling - Other	o	0		ol c	0	13. 00
14.00	Home Health Aide and Homemaker	o	0		0 22, 897	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	o	0		o c	0	15. 00
16. 00	Other	o	0		o c	o	16. 00
17. 00	Drugs, Biological and Infusion Therapy	l ol	0		0 126, 253	0	17. 00
18.00	Anal gesi cs	o	0		0	0	18. 00
19.00	Sedatives / Hypnotics	o	0		o c	o	19. 00
20.00	Other - Specify	o	0		o c	o	20. 00
21. 00	Durable Medical Equipment/Oxygen	o	0		o c	o	21. 00
22. 00	Patient Transportation	o	0		o c	o	22. 00
23.00	I maging Services	o	0		o c	o	23. 00
24.00	Labs and Diagnostics	o	0		o c	o	24. 00
25.00	Medical Supplies	o	0		0 18, 512	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0		0 4, 479	o	26. 00
27. 00	Radiation Therapy	o	0		0	o	27. 00
28. 00	Chemotherapy	l ol	0		ol c	ol	28. 00
29. 00	Other	o	0		o c	o	29. 00
30. 00	Bereavement Program Costs		0		ol d	Ö	30. 00
31. 00	Volunteer Program Costs		0		ol d	Ö	31. 00
32. 00	Fundrai si ng		0		ol d	Ö	32. 00
33. 00	Other Program Costs	0	0		ol d	Ö	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)		0		0 680, 365		34. 00
	Unit Cost Multiplier (see instructions)		_				35. 00
		1			1		

Health Financial Systems ST. I ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS ST. ELI ZABETH EAST Provi der CCN: 150109

Hospi ce CCN: 151563

					Hospi ce I	
	Cost Center Description	Subtotal	Allocated	Total Hospice		
		(cols. 24 ±	Hospi ce A&G	Costs (cols.		
		25)	(See Part II)			
		26.00	27.00	28. 00		
1.00	Administrative and General					1. 00
2.00	Inpatient - General Care	1, 772		6 2, 698		2. 00
3.00	Inpatient - Respite Care	3, 512	1, 83	6 5, 348		3. 00
4.00	Physi ci an Servi ces	13, 574	7, 09	5 20, 669		4. 00
5.00	Nursing Care	193, 095	100, 92	3 294, 018		5. 00
6.00	Nursing Care-Continuous Home Care	1, 809	94	6 2, 755		6. 00
7.00	Physi cal Therapy	0		0 0		7. 00
8.00	Occupational Therapy	0		0 0		8. 00
9.00	Speech/ Language Pathology	0		0 0		9. 00
10.00	Medical Social Services	23, 222	12, 13	7 35, 359		10.00
11. 00	Spiritual Counseling	37, 699	19, 70	4 57, 403		11. 00
12.00	Di etary Counsel i ng	0		0 0		12. 00
13.00	Counseling - Other	0		0 0		13. 00
14.00	Home Health Aide and Homemaker	22, 897	11, 96	8 34, 865		14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0		0 0		15. 00
16.00	0ther	0		0 0		16. 00
17. 00	Drugs, Biological and Infusion Therapy	126, 253	65, 98	9 192, 242		17. 00
18.00	Anal gesi cs	0		0 0		18. 00
19. 00	Sedatives / Hypnotics	0		0 0		19. 00
20.00	Other - Specify	0		0 0		20.00
21.00	Durable Medical Equipment/Oxygen	0		0 0		21. 00
22. 00	Pati ent Transportation	0		0 0		22. 00
23.00	I maging Services	0		0 0		23. 00
24.00	Labs and Diagnostics	0		0 0		24. 00
25.00	Medi cal Supplies	18, 512	9, 67			25. 00
26.00	Outpatient Services (including E/R Dept.)	4, 479	2, 34	1 6, 820		26. 00
27. 00	Radi ati on Therapy	0		0 0		27. 00
28. 00	Chemotherapy	0		0 0		28. 00
29.00	Other	0		0 0		29. 00
30.00	Bereavement Program Costs	0		o o		30.00
31.00	Volunteer Program Costs	0		o o		31. 00
32.00	Fundrai si ng	0		o o		32. 00
33.00	Other Program Costs	0		o o		33. 00
34.00	Total (sum of lines 1 thru 33) (2)	680, 365		680, 365		34.00
35.00	Unit Cost Multiplier (see instructions)		0. 52266	9		35. 00

Provi der CCN: 150109 | Peri od: From 01/01/2014 | Part II | Date/Time Prepared: 5/27/2015 9: 45 am STATISTICAL BASIS

Hospi ce I	
Hospice i	
CAPITAL RELATED COSTS	
Cost Center Description NEW BLDG & NEW MVBLE EMPLOYEE COMMUNICATIONS MGMT INFO	
· FIXT EQUIP BENEFITS SYSTEMS	
(SQUARE SQUARE DEPARTMENT (PHONE (MANHOURS)	
FEET) FEET) (GROSS LINES)	
SALARI ES)	
1.00 2.00 4.00 5.01 5.02	
1.00 Administrative and General 1,174 1,174 248,678 0 6,10	1 1.00
2.00 Inpatient - General Care 0 0 0	2.00
3.00 Inpatient - Respite Care 0 0 0	3.00
	4.00
5.00 Nursing Care 0 0 0 0	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
	23.00
	24.00
	25.00
	26.00
	•
	27. 00
	28.00
29. 00 Other 0 0 0 0	29.00
30.00 Bereavement Program Costs 0 0 0 0	30.00
	31.00
32. 00 Fundrai si ng 0 0 0 0	32. 00
	33. 00
34.00 Total (sum of lines 1 thru 33) (2) 1,174 1,174 248,678 0 6,10	
35.00 Total cost to be allocated 33,217 0 85,323 0 3,87	
36.00 Unit Cost Multiplier (see instructions) 28.293867 0.000000 0.343106 0.000000 0.63532	1 36. 00

Health Financial Systems ST. I ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS ST. ELIZABETH EAST

STATISTICAL BASIS

						3/2//2013 9.4	o alli
					Hospi ce I		
	Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT	Reconciliation		
		(COSTED	(GROSS	ACCOUNTI NG		ADMI NI STRATI VE	
		REQUISITIO)	CHARGES)	(GROSS		AND GENERAL	
		F 02	F 04	CHARGES)	5A. 06	(ACCUM. COST)	
1. 00	Administrative and General	5. 03	5. 04 829, 138	5. 05 829, 13		5. 06 125, 999	1. 00
2. 00	Inpatient - General Care	0	029, 130	029, 130	0	1, 553	2.00
3.00	Inpatient - Respite Care		0		0	3, 078	3.00
4. 00	Physician Services		0			11, 898	4. 00
5. 00	Nursing Care		0	ì		169, 253	5.00
6. 00	Nursing Care-Continuous Home Care		0	ì) 0	1, 586	6. 00
7. 00	Physical Therapy		0			1, 300	7. 00
8. 00	Occupational Therapy		0			0	8.00
9. 00	Speech/ Language Pathology	0	0		0	0	9. 00
10. 00	Medical Social Services		o		0	20, 355	10.00
11. 00	Spiritual Counseling	0	o		0	33, 044	11. 00
12. 00	Di etary Counsel i ng	0	o		0	0	12. 00
13. 00	Counseling - Other	o	o		0	o	13. 00
14. 00	Home Health Aide and Homemaker	0	o		0	20, 070	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	o	o		0	0	15. 00
16.00	Other	0	o		0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	o	(0	110, 664	17. 00
18.00	Anal gesi cs	0	o	(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	22. 00
23.00	I maging 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	16, 226	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	(0	3, 926	26. 00
27. 00	Radiation Therapy	0	0	(0	0	27. 00
28. 00	Chemotherapy	0	0	(0	0	28. 00
29. 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	(و اد	0	31.00
32.00	Fundrai si ng	0	0	(0	0	32.00
33.00	Other Program Costs	0	0	000 10	ار 0	0	33.00
34. 00	Total (sum of lines 1 thru 33) (2)	0	829, 138			517, 652	
35. 00	Total cost to be allocated	0 000000	606	2, 97		72, 920	35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000731	0. 00358	5	0. 140867	36.00

STATISTICAL BASIS

Hospi ce I	2015 9: 45	
I DOSPICE I		
	TERI A	
	HOURS)	
(SQUARE (POUNDS OF FEET) SERVED)		
FEET) LAUNDRY)		
7.00 8.00 9.00 10.00 11	1.00	
1.00 Administrative and General 1,174 0 1,174 0	6, 104	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 Physi ci an Servi ces 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	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 Pathology 0 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	0	11.00
12. 00 Di etary Counsel i ng 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	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	22.00
23.00 I maging Services 0 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 Outpatient Services (including E/R Dept.) 0 0 0	0	26.00
27. 00 Radi ati on Therapy 0 0 0 0	0	27.00
28.00 Chemotherapy 0 0 0	0	28.00
29.00 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	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) 1,174 0 1,174 0	6, 104	34.00
35.00 Total cost to be allocated 46,683 0 11,034 0	8, 426	35.00
36.00 Unit Cost Multiplier (see instructions) 39.764055 0.000000 9.398637 0.000000	1. 380406	36. 00

Heal th Financial Systems

ST. ELIZABETH EAST

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

STATISTICAL BASIS

Brown 01/01/2014

Hospice CCN: 15163

Hospice CCN: 15163

In Lieu of Form CMS-2552-10

Worksheet K-5

Part II

Date/Time Prepared: 5/27/2015 9: 45 am

						5/27/2015 9:4	5 am
					Hospi ce I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	·	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TIME	
		(DI RECT	(COSTED		(GROSS	SPENT)	
		NRSING HRS)	REQUIS.)		CHARGES)	,	
		13. 00	14. 00	15. 00	16.00	17. 00	
1.00	Administrative and General	6, 062		0	0 829, 138	0	1. 00
2.00	Inpatient - General Care	o		o	0 0	0	2. 00
3.00	Inpatient - Respite Care	o		o	0 0	0	3. 00
4.00	Physi ci an Servi ces	o		o	0 0	0	4. 00
5.00	Nursing Care	O		o	0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	O		o	o c	0	6. 00
7.00	Physical Therapy	O		o	o c	0	7. 00
8.00	Occupational Therapy	O		o	o c	0	8. 00
9.00	Speech/ Language Pathology	O		o	0 0	0	9. 00
10.00	Medical Social Services	O		o	0 0	0	10.00
11. 00	Spiritual Counseling	O		o	0 0	0	11. 00
12.00	Di etary Counseling	O		o	0 0	0	12. 00
13.00	Counseling - Other	O		o	0 0	0	13. 00
14.00	Home Health Aide and Homemaker	O		o	0 0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	O		o	o c	0	15. 00
16.00	Other	O		o	o c	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	O		o	o c	0	17. 00
18. 00	Anal gesi cs	o		o	o c	0	18. 00
19.00	Sedatives / Hypnotics	o		o	o c	0	19. 00
20.00	Other - Specify	o		o	o c	0	20.00
21.00	Durable Medical Equipment/Oxygen	o		o	o c	0	21. 00
22. 00	Patient Transportation	O		o	o c	0	22. 00
23.00	I maging Services	O		o	o c	0	23. 00
24.00	Labs and Diagnostics	O		o	o c	0	24. 00
25. 00	Medical Supplies	o		o	o c	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	o		o	o c	0	26. 00
27.00	Radi ati on Therapy	O		o	o c	0	27. 00
28. 00	Chemotherapy	o		o	o c	0	28. 00
29. 00	Other	o		o	o c	0	29. 00
30.00	Bereavement Program Costs	o		o	o c	0	30.00
31.00	Volunteer Program Costs	o		o	o c	0	31.00
32.00	Fundrai si ng	o		o	o c	0	32.00
33. 00	Other Program Costs	0		o	o c	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	6, 062		o	0 829, 138	0	34.00
35. 00	Total cost to be allocated	20, 294		o	0 3, 356		35. 00
36.00	Unit Cost Multiplier (see instructions)	3. 347740	0. 00000	0.0000	0. 004048	0. 000000	36. 00

Heal th Financial Systems

ST. ELIZABETH EAST

In Lieu of Form CMS-2552-10

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

STATISTICAL BASIS

Provider CCN: 150109
Hospice CCN: 151563

Peri od:
From 01/01/2014
To 12/31/2014
Date/Time Prepared:
5/27/2015 9: 45 am

					5/2//2015 9: 4	5 am
				Hospi ce I		
	Cost Center Description	NURSING SCHOOL	PARAMEDI CAL			
			EDUCATI ON			
		(ASSI GNED	PROGRAM			
		TIME)	(ASSI GNED			
		,	TIME)			
		20.00	23. 00			
1.00	Administrative and General	0	0			1. 00
2.00	Inpatient - General Care	0	0			2. 00
3.00	Inpatient - Respite Care	0	0			3. 00
4.00	Physician Services	0	0			4.00
5. 00	Nursi ng Care	0	0			5. 00
6. 00	Nursing Care-Continuous Home Care	0	0			6. 00
7. 00	Physical Therapy	0	0			7. 00
8. 00	Occupational Therapy	0	0			8. 00
9. 00	Speech/ Language Pathology	0	o			9. 00
10. 00	Medical Social Services	0	o			10.00
11. 00	Spiritual Counseling	0	0			11.00
12. 00	Di etary Counsel i ng	0	0			12. 00
13. 00	Counseling - Other	0	0			13. 00
14. 00	Home Health Aide and Homemaker	0	0			14. 00
15. 00	HH Ai de & Homemaker - Cont. Home Care	0	0			15. 00
16. 00	Other	0				16. 00
		0				17. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0			
18.00	Anal gesi cs	0	0			18.00
	Sedatives / Hypnotics	0	0			19.00
20.00	Other - Specify	0	0			20.00
21. 00	Durable Medical Equipment/Oxygen	0	0			21. 00
22. 00	Patient Transportation	0	0			22. 00
23. 00	I maging Services	0	0			23. 00
24. 00	Labs and Diagnostics	0	0			24. 00
25. 00	Medical Supplies	0	0			25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0			26. 00
27. 00	Radiation Therapy	0	0			27. 00
28. 00	Chemotherapy	0	0			28. 00
29. 00	Other	0	0			29. 00
30.00	Bereavement Program Costs	0	0			30. 00
31. 00	Volunteer Program Costs	0	0			31. 00
32.00	Fundrai si ng	0	0			32. 00
33.00	Other Program Costs	0	0			33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0			34. 00
35.00	Total cost to be allocated	0	0			35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000			36. 00
		•	'			•

Heal th	Financial Systems ST. ELIZA	BETH EAST		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS	Provi der	CCN: 150109	Peri od:	Worksheet K-5	
		Hospi ce (CCN: 151563	From 01/01/2014 To 12/31/2014	Part III Date/Time Pre	narod:
		nospi ce v	JCIN. 131303	10 12/31/2014	5/27/2015 9:4	
				Hospi ce I		
	Cost Center Description	Wkst. C, Part			Hospi ce Shared	
		I, col. 11	Ratio	Charges	Ancillary	
		line			Costs (cols. 1	
				Records)	x 2)	
		0	1.00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSI CAL THERAPY	66.00	•		0	1
2.00	OCCUPATI ONAL THERAPY	67.00	•		0	2. 00
3.00	SPEECH PATHOLOGY	68.00	•		0	
4.00	DRUGS CHARGED TO PATIENTS	73.00	•		0	
4. 01	DI ABETES CENTER	73. 01	•	03	0	4. 01
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	1			5. 00
6.00	LABORATORY	60.00	1	18 0	0	
6. 01	BLOOD LABORATORY	60. 01	1			6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	•	10 0	0	,
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	1			8. 00
9.00	ULTRA SOUND	55.00	•	30 0	0	,
10. 00	OTHER ANCILLARY SERVICE COST CENTERS	76.00	1			10. 00
10. 98	HYPERBARI C OXYGEN THERAPY	76. 98	0. 1992	56 0	0	
11. 00	Totals (sum of lines 1-10)				0	11. 00

AL CIII	Financial Systems ST. ELIZAB ATION OF HOSPICE PER DIEM COST	Drovi	dor C	CN: 150109	Peri od:	Worksheet K-6	
CALCUL	ATTON OF HOSPICE PER DIEW COST	PIOVI	uei c	CN. 130109	From 01/01/2014		
		Hospi	ce CCI	N: 151563			
					Hospi ce I	3/2//2013 4.4	J alli
		Title XVI	11	Title XIX	Other	Total	
		1. 00		2.00	3. 00	4. 00	
1. 00	Total cost (see instructions)					680, 365	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)					2, 583	2. 00
3.00	Average cost per diem (line 1 divided by line 2)					263. 40	3. 00
4. 00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	2	509				4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)	660	871				5. 00
6. 00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)			į	55		6. 00
7.00	Aggregate Medicaid cost (line 3 time line 60)			14, 48	37		7. 00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)		o				8. 00
9.00	Aggregate SNF cost (line 3 time line 8)		o				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)				19		12.00
13.00	Aggregate cost for other days (line 3 times line 12)				5, 005		13.00

CALCUI	Financial Systems ST. ELI ATION OF CAPITAL PAYMENT	Provider CCN: 150109	Peri od:	u of Form CMS-2 Worksheet L	∠JJZ = I(
0712002	STITUTE OF STATE OF THE STATE O	11001461 001. 100107	From 01/01/2014 To 12/31/2014	Parts I-III Date/Time Pre 5/27/2015 9:4	
		Title XVIII	Hospi tal	PPS	- uiii
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			2, 629, 643	
1.01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2. 00 2. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments			355, 868 0	2. 00 2. 0
3. 00	Total inpatient days divided by number of days in the co	ost reporting period (see inst	ructions)	101. 33	
1.00	Number of interns & residents (see instructions)	d b (0.00	4.00
5. 00	Indirect medical education percentage (see instructions			0.00	
5. 00	Indirect medical education adjustment (multiply line 5			0	6. 00
7.00	Percentage of SSI recipient patient days to Medicare Pa 30) (see instructions)	, part A line	3. 01 25. 64	7.00	
3. 00 9. 00	Percentage of Medicaid patient days to total days (see instructions)				8. 00 9. 00
10.00	Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)				10.00
11.00					11.00
2. 00	Total prospective capital payments (sum of lines 1, 1.0		3, 142, 501	12. 00	
				1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST	6)		0	 1.00
2. 00	Program inpatient ancillary capital cost (see instruction	rogram inpatient routine capital cost (see instructions)			
3. 00	Total inpatient program capital cost (line 1 plus line 2)				2. 00 3. 00
4. 00					4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1 4 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circui	metances (see instructions)		0	1. 00 2. 00
3.00	Net program inpatient capital costs (line 1 minus line			0	3.00
1. 00	Applicable exception percentage (see instructions)	,		0.00	4.00
5. 00	Capital cost for comparison to payments (line 3 x line	•		0	
5. 00	Percentage adjustment for extraordinary circumstances (0.00	
7.00	Adjustment to capital minimum payment level for extraord	dinary circumstances (line 2 x	line 6)	0	7.00
3. 00 9. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as	annlicable)		0	8. 00 9. 00
0.00	Current year comparison of capital minimum payment leve		Less line 9)	0	10.00
1. 00	Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14)			0	11. 00
12.00	Net comparison of capital minimum payment level to capi	1 3 1	,	0	12.00
13.00	Current year exception payment (if line 12 is positive,		<i>'</i>	0	13.00
4. 00	Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line)	over capital payment for the f	following period	0	14.0
	(11 1110 12 13 negative, enter the amount on this fille)				15 0
15. 00	Current year allowable operating and capital payment (s	ee instructions)	l l	0	15.00
16.00				0	16.0