Health Financial Systems HEART HOSPITAL AT DEACONESS GATEWAY In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150175 Worksheet S Period: From 10/01/2013 To 09/30/2014 Parts I-III Date/Time Prepared: 2/27/2015 7:40 am AND SETTLEMENT SUMMARY Τo PART I - COST REPORT STATUS 1.[ X ] Electronically filed cost report Date: 2/27/2015 Time: 7:40 am Provider ]Manually submitted cost report use only 2.[ ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. 3.[ D 4 1 5. [ 1 ]Cost Report Status 6. Date Received: 10.NPR Date: Contractor 11.Contractor's Vendor Code: As Submitted 7. Contractor No. use only (2) Settled without Audit 8. [N] Initial Report for this Provider CCN [12.[0] If line 5, column 1 is 4: Enter (3) Settled with Audit 9.[N] Final Report for this Provider CCN number of times reopened = 0-9. (3) Settled with Audit (4) Reopened (5) Amended

PART II - CERTIFICATION

MISREPRESENTATION OF 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(5)

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 HEART HOSPITAL AT DEACONESS GATEWAY ( 150175 ) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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	PART III - SETTLEMENT SUMMARY					aara targa tarrag	1
1.00	Hospital	0	18,069	84,821	-25,373	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	18,069	84,821	-25,373	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 038-0050. 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.

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	for yes or "N" for no. Is this facil	ity subject to 42	2 CFR Sect	ion §41								
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	Financial Systems HEART HOSPITA AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		EACONESS GATEW, Provider (	CCN: 150175	l Period: From 10/01 To 09/30	/2013	u of For Workshe Part I Date/Ti 2/26/20	eet S-2 me Pre	2 epared:
				I	Begi nni		Endi	ng:	
36.00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	- 1.00	)	2.	00	36.00
37.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.		umber of period	s MDH status		0			37.00
38.00	Enter applicable beginning and ending dates of MDH st of periods in excess of one and enter subsequent date		Subscript line	38 for number					38.00
					Y/N		Y/ 2.0		-
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	)? Ent∈ µiremer	er in column 1 nts in accordan	"Y" for yes ce with 42					39.00
						V 1.00	XVIII 2.00	XI X 3.00	-
	Prospective Payment System (PPS)-Capital					_			
	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for c	li sproporti onat	e share in a	ccordance	N	N	N	45.00
46.00	ls this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Work    .					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47.00 48.00
	Is this a hospital involved in training residents in or "N" for no.	••			5	N			56.00
	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Worksheet D, Part III & IV and D-2, Par If line 56 is yes, did this facility elect cost reimb	yes or h of th ", comp t II, i	"N" for no in his cost report blete Worksheet f applicable.	column 1. I ing period? E-4. If colu	f column 1 Enter "Y" umn 2 is				57.00
	defined in CMS Pub. 15-1, section 2148? If yes, compl Are costs claimed on line 100 of Worksheet A? If yes	ete Wor	ksheet D-5.		40	N			59.00
60.00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"					N			60.00
		Y/N	I ME	Direct GME	IME		Direc	t GME	
		1.00	2.00	3.00	4.00	0	5.	00	-
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in					0. 00		0.00	61.00
61. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0. 00	0.	oo				61.01
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0. 00	0.	oc				61.02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.	oc				61.03
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.	oc				61.04
61. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.	oc				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.	oc				61.06
		Pro	ogram Name	Program Code	e Unweighte FTE Co		Unwei Direct Cou	GME FTE	-
			1.00	2.00	3.00		4.0	00	
	Of the FTEs in line 61.05, specify each new program 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.					0.00		0. 00	0 61.10

leal th Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	HEART HOSPITA			CCN: 150175	Peri od:	Date/Time Prepa 2/26/2015 5:00 Unweighted Direct GME FTE Count 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	
					From 10/01/2013 To 09/30/2014	Date/Time Pre	pared: 0 pm
		Program	n Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE	
		1. (	00	2.00	3.00		
1.20 Of the FTEs in line 61.05, specify program specialty, if any, and the residents for each expanded program instructions) Enter in column 1 the enter in column 2 the program code, 3 the IME FTE unweighted count and direct GME FTE unweighted count.	number of FTE 1. (see program name, enter in column				0. 00	0.00	61.2
						1.00	
ACA Provisions Affecting the Health 2.00 Enter the number of FTE residents t					riod for which	0.00	62 0
your hospital received HRSA PCRE fu			this cost	reporting pe	induitor which	0.00	02.0
2.01 Énter the number of FTE residents t during in this cost reporting perio	hat rotated from a d of HRSA THC progr	Teaching H ram. (see i	nstructior		o your hospital	0.00	62.0
Teaching Hospitals that Claim Resid 3.00 Has your facility trained residents				cost reportin	a period? Enter	N	63.0
"Y" for yes or "N" for no in column				instructions	)		
				Unwei ghted FTEs Nonprovi der Si te	FTES in	(col. 1 + col.	
				1.00	2.00	3.00	1
Section 5504 of the ACA Base Year F				This base yea	ar is your cost n	reporting	
period that begins on or after July 64.00 Enter in column 1, if line 63 is ye in the base year period, the number resident FTEs attributable to rotat settings. Enter in column 2 the nu resident FTEs that trained in your	es, or your facility of unweighted non- ions occurring in a mber of unweighted	y trained r -primary ca all non-pro non-primar	esidents re vider y care	0.	00 0. 00	0. 000000	64.0
of (column 1 divided by (column 1 +							
	Program Name	Prograr	n Code	Unwei ghted FTEs Nonprovi der Si te	FTEsin	(col. 3 + col.	
55.00 Enter in column 1, if line 63 0	1.00	2. (	00	3.00	4.00		
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)					00 0. 00		
Section 5504 of the ACA Current Yez beginning on or after July 1, 2010 56.00 Enter in column 1 the number of unw	eighted non-primary	, care resi	dent	Unweighted FTEs Nonprovider Site 1.00 sEffective 0.	FTES in Hospital 2.00 for cost reporti		
FTEs attributable to rotations occu Enter in column 2 the number of unw FTEs that trained in your hospital. (column 1 divided by (column 1 + co	rring in all non-pr eighted non-primary Enter in column 3	rovider set y care resi the ratio	tings. dent				

	LEX IDENTIFICATION DA	TA Provi der		eriod: rom 10/01/2 p 09/30/2	2013	Workshe Part I Date/Tii 2/26/20	me Prep	pared
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighte FTEs in Hospital	ed R 1 (	atio (c col. 3 4))	ol. 3/ + col.	
	1.00	2.00	3.00	4.00		5.0	0	
00 Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column	U		0. 00		0.00	υ.	000000	07.
4)). (see instructions)								
				-	1.00	2.00	3.00	
Inpatient Psychiatric Facility F 00 Is this facility an Inpatient Ps				rouldor?	NI			70.
00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no	5 5 1	rr), or does it cont	ain an iPF SUDp	ovider?	Ν			70.
00 If line 70 yes: Column 1: Did th recent cost report filed on or b Column 2: Did this facility trai §412.424 (d)(1)(iii)(D)? Enter ' or 3 respectively in column 3. ( beginning of the fourth year, er the new teaching program in exis	before November 15, 20 n residents in a new 'Y" for yes or "N" for (see instructions) If nter 4 in column 3, or stence, enter 5. (see	04? Enter "Y" for y teaching program in no. Column 3: If co this cost reporting if the 5th or subse	es or "N" for r accordance with lumn 2 is Y, er period covers t	o. 42 CFR ter 1, 2 he			0	71.
Inpatient Rehabilitation Facili 00 Is this facility an Inpatient Re		(IRF) or does it c	ontain an IRF		N	T T		75.
subprovider? Enter "Y" for yes 00  f line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR §412.424 (d)(1)(iii)(D)? Ent 1, 2 or 3 respectively in column beginning of the fourth year, end the new teaching program in exist	ne facility have an ap ding on or before Nove train residents in a ter "Y" for yes or "N" a. (see instructions nter 4 in column 3, or	mber 15, 2004? Enter new teaching program for no. Column 3: I ) If this cost repor if the 5th or subse	"Y" for yes or in accordance f column 2 is Y ting period cov	"N" for with 42 , enter ers the			0	76.
								L
						1.0	0	
Long Term Care Hospital PPS		· · · · · · · · · · · · · · · · · · ·				1.0	0	
00 Is this a long term care hospita	al (LTCH)? Enter "Y"	· · · · · · · · · · · · · · · · · · ·	no.			1.0		80.
00 <u>Is this a long term care hospita</u> <u>TEFRA Providers</u> 00 Is this a new hospital under 42 00 Did this facility establish a ne	CFR Section §413.40(f ew Other subprovider (	for yes and "N" for )(1)(i) TEFRA? Ente	r "Y" for yes c		10.			85.
00 <u>Is this a long term care hospita</u> <u>TEFRA Providers</u> 00 Is this a new hospital under 42	CFR Section §413.40(f ew Other subprovider (	for yes and "N" for )(1)(i) TEFRA? Ente	r "Y" for yes c	V	10.	N N XI X	κ.	85.
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00 Is this a long term care hospita TEFRA Providers 00 Is this a new hospital under 42 00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for Title V and XIX Services 00 Does this facility have title V	CFR Section §413.40(f ew Other subprovider ( or yes and "N" for no. and/or XIX inpatient	for yes and "N" for )(1)(i) TEFRA? Ente excluded unit) under	r "Y" for yes c 42 CFR Section	V		N N XI X	K 0	85.
00 Is this a long term care hospita TEFRA Providers 00 Is this a new hospital under 42 00 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo Title V and XIX Services 00 Does this facility have title V yes or "N" for no in the applica	CFR Section §413.40(f ew Other subprovider ( or yes and "N" for no. and/or XIX inpatient able column.	for yes and "N" for )(1)(i) TEFRA? Ente excluded unit) under hospital services? E	r "Y" for yes o 42 CFR Section nter "Y" for	V 1.00 N		N N XI X 2. 0 Y	K 0	85. 86. 90.
<ul> <li>1 s this a long term care hospital TEFRA Providers</li> <li>1 s this a new hospital under 42</li> <li>2 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for</li> <li>Title V and XIX Services</li> <li>2 Does this facility have title V yes or "N" for no in the applica</li> <li>2 Is this hospital reimbursed for full or in part? Enter "Y" for yes or yes the fact of the provided of the provide</li></ul>	CFR Section §413.40(f ew Other subprovider ( or yes and "N" for no. and/or XIX inpatient able column. title V and/or XIX th yes or "N" for no in t	for yes and "N" for )(1)(i) TEFRA? Ente excluded unit) under hospital services? E rough the cost repor he applicable column	r "Y" for yes c 42 CFR Section nter "Y" for t either in	V 1.00	10.	N N XI X 2. 0	K 0	85. 86. 90. 91.
<ul> <li>1s this a long term care hospital TEFRA Providers</li> <li>1s this a new hospital under 42</li> <li>Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for</li> <li>Title V and XIX Services</li> <li>Does this facility have title V yes or "N" for no in the applica</li> <li>1s this hospital reimbursed for full or in part? Enter "Y" for yoo</li> <li>Are title XIX NF patients occupy</li> </ul>	CFR Section §413.40(f ew Other subprovider ( or yes and "N" for no. and/or XIX inpatient able column. title V and/or XIX th yes or "N" for no in t ying title XVIII SNF b	for yes and "N" for )(1)(i) TEFRA? Ente excluded unit) under hospital services? E rough the cost repor he applicable column eds (dual certificat	r "Y" for yes c 42 CFR Section nter "Y" for t either in	V 1.00 N	10.	N N XI X 2. 0 Y	K 0	85. 86. 90. 91.
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<ul> <li>00 Is this a long term care hospital TEFRA Providers</li> <li>00 Is this a new hospital under 42</li> <li>00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for</li> <li>11 EV and XIX Services</li> <li>00 Does this facility have title V yes or "N" for no in the application</li> <li>00 Is this hospital reimbursed for full or in part? Enter "Y" for yes</li> <li>00 Are title XIX NF patients occupy instructions) Enter "Y" for yes</li> <li>00 Does this facility operate an IO "Y" for yes or "N" for no in the</li> </ul>	CFR Section §413.40(f ew Other subprovider ( or yes and "N" for no. and/or XIX inpatient able column. title V and/or XIX th yes or "N" for no in t ying title XVIII SNF b or "N" for no in the CF\MR facility for pure applicable column.	for yes and "N" for )(1)(i) TEFRA? Ente excluded unit) under hospital services? E rough the cost repor he applicable column eds (dual certificat applicable column. poses of title V and	r "Y" for yes o 42 CFR Section nter "Y" for t either in ion)? (see XIX? Enter	V 1.00 N N	ло.	N N XI X 2. 0 Y N N	K 0	85. 86. 90. 91. 92. 93.
<ul> <li>00 Is this a long term care hospital TEFRA Providers</li> <li>00 Is this a new hospital under 42</li> <li>00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for</li> <li>11 EV and XIX Services</li> <li>00 Does this facility have title V yes or "N" for no in the application</li> <li>00 Is this hospital reimbursed for full or in part? Enter "Y" for yes</li> <li>00 Are title XIX NF patients occupy instructions) Enter "Y" for yes</li> <li>00 Does this facility operate an IC "Y" for yes or "N" for no in the poloes title V or XIX reduce capit applicable column.</li> </ul>	CFR Section §413.40(f ew Other subprovider ( or yes and "N" for no. and/or XIX inpatient able column. title V and/or XIX th yes or "N" for no in t ying title XVIII SNF b or "N" for no in the CF\MR facility for pur e applicable column. tal cost? Enter "Y" fo	for yes and "N" for )(1)(i) TEFRA? Ente excluded unit) under hospital services? E rough the cost repor he applicable column eds (dual certificat applicable column. poses of title V and r yes, and "N" for n	r "Y" for yes o 42 CFR Section nter "Y" for t either in ion)? (see XIX? Enter o in the	V 1.00 N N N		N N X1 X 2. 0 Y N N N	K	85. 86. 90. 91. 92. 93. 94.
00 Is this a long term care hospital TEFRA Providers 00 Is this a new hospital under 42 00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for 11 tle V and XIX Services 10 Does this facility have title V yes or "N" for no in the applica 00 Is this hospital reimbursed for full or in part? Enter "Y" for your 10 Are title XIX NF patients occupy 10 instructions) Enter "Y" for your 10 Does this facility operate an IO "Y" for yes or "N" for no in the 10 Does title V or XIX reduce capital	CFR Section §413.40(f ew Other subprovider ( or yes and "N" for no. and/or XIX inpatient able column. title V and/or XIX th yes or "N" for no in t ying title XVIII SNF b or "N" for no in the CF\MR facility for pur e applicable column. tal cost? Enter "Y" fo duction percentage in	for yes and "N" for )(1)(i) TEFRA? Ente excluded unit) under hospital services? E rough the cost repor he applicable column eds (dual certificat applicable column. poses of title V and r yes, and "N" for n	r "Y" for yes o 42 CFR Section nter "Y" for t either in ion)? (see XIX? Enter o in the n.	V 1.00 N N N	0. 00	N N X1 X 2. 0 Y N N N	K 0	85. 86. 90. 91. 92. 93. 94. 95.
<ul> <li>00 Is this a long term care hospital TEFRA Providers</li> <li>00 Is this a new hospital under 42</li> <li>00 Did this facility establish a new factories</li> <li>01 Title V and XIX Services</li> <li>02 Does this facility have title V yes or "N" for no in the applica</li> <li>00 Is this hospital reimbursed for full or in part? Enter "Y" for yes or "N" for no in the applica</li> <li>00 Does this facility operate an IC "Y" for yes or "N" for no in the applicable column.</li> <li>02 If line 94 is "Y", enter the record point of the provide to the provide the p</li></ul>	CFR Section §413.40(f ew Other subprovider ( or yes and "N" for no. and/or XIX inpatient able column. title V and/or XIX th yes or "N" for no in t yes or "N" for no in the CF\MR facility for pur e applicable column. tal cost? Enter "Y" fo duction percentage in ating cost? Enter "Y"	for yes and "N" for )(1)(i) TEFRA? Ente excluded unit) under hospital services? E rough the cost repor he applicable column eds (dual certificat applicable column. poses of title V and r yes, and "N" for n the applicable colum for yes or "N" for n	r "Y" for yes of 42 CFR Section nter "Y" for t either in ion)? (see XIX? Enter o in the n. o in the	V 1.00 N N N N		N N XI > 2. 0 Y N N N N	K	96.
<ul> <li>00 Is this a long term care hospital TEFRA Providers</li> <li>00 Is this a new hospital under 42</li> <li>00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for</li> <li>11 EV and XIX Services</li> <li>00 Does this facility have title V yes or "N" for no in the applica</li> <li>00 Is this hospital reimbursed for full or in part? Enter "Y" for ys</li> <li>00 Are title XIX NF patients occupy instructions) Enter "Y" for yes</li> <li>00 Does this facility operate an IO "Y" for yes or "N" for no in the applicable column.</li> <li>01 If line 94 is "Y", enter the red opplicable column.</li> </ul>	CFR Section §413.40(f ew Other subprovider ( or yes and "N" for no. and/or XIX inpatient able column. title V and/or XIX th yes or "N" for no in t ying title XVIII SNF b or "N" for no in the CF\MR facility for pure e applicable column. tal cost? Enter "Y" fo duction percentage in ating cost? Enter "Y"	for yes and "N" for )(1)(i) TEFRA? Ente excluded unit) under hospital services? E rough the cost repor he applicable column eds (dual certificat applicable column. poses of title V and r yes, and "N" for n the applicable colum for yes or "N" for n	r "Y" for yes of 42 CFR Section nter "Y" for t either in ion)? (see XIX? Enter o in the n. o in the	V 1.00 N N N N	0. 00	N N XI > 2. 0 Y N N N N	K O O. 00 O. 00	85. 86. 90. 91. 92. 93. 94. 95. 96.

Health Financial Systems HEART HOSPITAL AT D	DEACONESS GATE	ΙAΥ	١r	ו Lieu	of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der			2013	Workshee Part I Date/Tii 2/26/20	me Pre 15 5:0	pared:
			V 1.00		2. 0		
107.00 Column 1: If this facility qualifies as a CAH, is it eligil for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on W 25 and the program would be cost reimbursed. If yes complete Column 2: If this facility is a CAH, do I&Rs in an approve train in the CAH's excluded IPF and/or IRF unit? Enter "Y" column 2. (see instructions)	o in column 1. orksheet B, Pa e Worksheet D-: d medical educa	(see rt I, column 2, Part II. ation program	N		2.0	<u>.</u>	107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dule? See 42	N Speec	h	Pospir	tony	108.00
	1.00	2.00	3.00		Respira 4.0		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N		109. 00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of enter the method used (A, B, or E only) in column 2. If colu- either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital providers 15-1, §2208.1.	umn 2 is "E", o for long term	enter in column care (includes	3	N		0	115. 00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu- no.			N" for	N Y			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	f the policy i	s	1			118.00
		Premi ums	Losses		Insura		
118.01 List amounts of malpractice premiums and paid losses:		1.00 38,689	2.00	0	3.0		118.01
			1.00		2.0	0	
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher and amounts contained therein. 119.00 D0 NOT USE THIS LINE			N		2.0		118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment	n column 1 "Y" ualifies for tl	for yes or ne Outpatient	N		N		120.00
Enter in column 2 "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost impla- patients? Enter "Y" for yes or "N" for no.	antable device	s charged to	Y				121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en	-						126.00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, en	ter the certif	cation date					127.00
in column 1 and termination date, if applicable, in column 1 128.00 If this is a Medicare certified liver transplant center, en	ter the certif	cation date					128. 00
in column 1 and termination date, if applicable, in column 1 129.00 If this is a Medicare certified lung transplant center, ent		cation date in					129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center,		ti fi cati on					130. 00
date in column 1 and termination date, if applicable, in col 131.00 If this is a Medicare certified intestinal transplant center	r, enter the c	erti ficati on					131.00
date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, en	ter the certif	cation date					132.00
in column 1 and termination date, if applicable, in column 1 133.00 If this is a Medicare certified other transplant center, en	ter the certif	cation date					133. 00
in column 1 and termination date, if applicable, in column 1 134.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.		n column 1					134.00
All Providers 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number	yes, and home	office costs	Y				140. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider (	CCN: 1501		ri od:		Worksheet S-2	2
				Fro To		/01/2013 /30/2014	Part I Date/Time Pre 2/26/2015 5:0	
1.00		2.00				3.00	272072015 5.0	T pin
If this facility is part of a cha			gh 143 t	he name	e and		of the	
home office and enter the home of								
1.00 Name:	Contractor's Name:	:	Contr	actor'	s Num	ber:		141.
12.00Street:	PO Box:							142.
13. 00 Ci ty:	State:		Zip (	Code:				143.
							1.00	_
14.00 Are provider based physicians' cos	te included in Werkshe	ot 12					1.00 Y	144.
15.00 If costs for renal services are cl			costs foi	r innat	tient		Y	145.
services only? Enter "Y" for yes	or "N" for no.	inte int, are they	00010 10	mpat	er ont			
					1	. 00	2.00	
46.00 Has the cost allocation methodolog						Ν		146. (
Enter "Y" for yes or "N" for no in		b. 15-2, section 4	020) lf	yes,				
enter the approval date (mm/dd/yy 17.00Was there a change in the statisti		or voc or "N" for	00			N		147.0
18.00 Was there a change in the order of						N		147.
49.00Was there a change to the simplifi				for		N		149.0
no.	ou ooot i i iu iig motilou	. Entor 1 101 30						
· · · ·		Part A	Part	В	Ti	tle V	Title XIX	
I.		1.00	2.00			3.00	4.00	
Does this facility contain a prov								
or charges? Enter "Y" for yes or	"N" for no for each com			<u>    B.   (S</u> €	ee 42			1.55
55.00 Hospital 56.00 Subprovider - IPF		N	N N			N N	N N	155.0
57. 00 Subprovider – IRF		N	N			N	N	157. (
58. OO SUBPROVI DER								158.0
59. 00 SNF		N	Ν			Ν	N	159. (
60.00 HOME HEALTH AGENCY		N	Ν			Ν	N	160. (
61.00 CMHC			N			Ν	N	161. (
								4
							1.00	-
Multicampus 65.00Is this hospital part of a Multica	ampus bospital that has	opo or moro campu	coc in di	fforon		1.62	N	165. (
Enter "Y" for yes or "N" for no.	anipus nospi tai that has	one or nore campu		TIELEI	n cbb	K5 !	IN	105.0
	Name	County	State	Zip C	Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.0		4.00	5.00	
66.00 fline 165 is yes, for each							0.00	0 166. (
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								
col umn 5								
	LL							
							1.00	
Health Information Technology (HI								
57.00 is this provider a meaningful user						the	Y	167.0
58.00 If this provider is a CAH (line 10 reasonable cost incurred for the l			10/15	г), е	enter	ine		0168. (
59.00 If this provider is a meaningful	user (line 167 is "Y") a	and is not a CAH (	line 105	is "N"	'), en	ter the	0.2	5169. (
transition factor. (see instruction					,. <u>.</u>			
					Beg	i nni ng	Endi ng	
						. 00	2.00	
70.00 Enter in columns 1 and 2 the EHR I						01/2014	09/30/2014	170. (

		T HOSPITAL AT DEACONESS GATE			eu of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi der	F	Period: From 10/01/2013 Fo 09/30/2014	Date/Time Pre	epared:
	· · · · ·			Y/N	2/26/2015 5:0 Date	00 pm
				1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	oonses. Enter N for all NO re	esponses. Enter	all dates in	the	
	COMPLETED BY ALL HOSPITALS					
1.00	Provider Organization and Operation Has the provider changed ownership immediatel	y prior to the beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of t		instructions)			
			Y/N 1.00	Date 2.00	V/I 3.00	
2.00	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g.		Y			3.00
	or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or 1	, or members of the board				
	relationships? (see instructions)		Y/N	Туре	Date	
	Financial Data and Danasta		1.00	2.00	3.00	
4.00	Financial Data and Reports Column 1: Were the financial statements prep	pared by a Certified Public	Y	A		4.00
	Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for Compiled, enter date available in				
5.00	Are the cost report total expenses and total those on the filed financial statements? If y	revenues different from	Y			5.00
				Y/N 1.00	Legal Oper. 2.00	
6.00	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ool? Colump 2. If ves is th	e provider is	N		6.00
	the legal operator of the program?		io protridor ro			
7.00 8.00	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog	grams approved and/or renewed	l during the	N N		7.00 8.00
9.00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		t report? If	Ν		9.00
10.00	yes, see instructions. Was an Intern-Resident program been initiated	d or renewed in the current c	cost reporting	Ν		10.00
11.00	period? If yes, see instructions. Are GME cost directly assigned to cost center		proved	Ν		11.00
	Teaching Program on Worksheet A? If yes, see	instructions.			Y/N	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy.			t reporting	Y N	12. 00 13. 00
14.00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments waived? If	<sup>°</sup> yes, see inst	ructions.	N	14.00
15.00	Did total beds available change from the pric	or cost reporting period? If	r ·	uctions. Tt A	N Part B	15.00
		Description	Y/N	Date	Y/N	
	PS&R Data	0	1.00	2.00	3.00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R		N		N	16.00
17.00	Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records		Y	01/27/2015	Y	17.00
18. 00	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments		N		N	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	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

Heal th	Financial Systems HEAR	T HOSPITAL AT	DEACONESS GATEW	VAY	In Lie	u of Form CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE:			CCN: 150175 P	eriod: rom 10/01/2013 o 09/30/2014	Worksheet S-2 Part II	pared:
				Par	rt A	Part B	
		Descri	iption	Y/N	Date	Y/N	
		(	0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21.00
						1 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT Capital Related Cost	ALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)		1.00	•
	Have assets been relifed for Medicare purpose Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.			als made durin	g the cost		22.00 23.00
24.00	Were new leases and/or amendments to existing If yes, see instructions	g Leases entere	ed into during	this cost repo	rting period?		24.00
	Have there been new capitalized leases entered instructions.	0		0.1	5		25.00
	Were assets subject to Sec.2314 of DEFRA acqu instructions. Has the provider's capitalization policy char	C C	•	0 1	5		26.00 27.00
	copy. Interest Expense						27100
	Were new loans, mortgage agreements or letter period? If yes, see instructions. Did the provider have a funded depreciation a						28.00
	treated as a funded depreciation account? If Has existing debt been replaced prior to its	yes, see instr	ructions				30.00
	instructions. Has debt been recalled before scheduled matur instructions.		5	5			31.00
	Hurchased Services Have changes or new agreements occurred in pa	atient care ser	rvi ces furni she	d through cont	ractual		32.00
33.00	arrangements with suppliers of services? If y If line 32 is yes, were the requirements of S no, see instructions.			g to competiti	ve bidding? If		33.00
	Provi der-Based Physi ci ans						
	Are services furnished at the provider facili If yes, see instructions.	5	0				34.00
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			its with the pr		Data	35.00
					Y/N 1.00	 2.00	
	Home Office Costs						
	Were home office costs claimed on the cost re If line 36 is yes, has a home office cost sta If yes, see instructions.	•	repared by the	home office?			36.00 37.00
38.00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the f						38.00
	If line 36 is yes, did the provider render se see instructions.	ervices to othe	er chain compon	ents? If yes,			39.00
40.00	If line 36 is yes, did the provider render se instructions.	ervices to the	home office?	lf yes, see			40.00
			1.	00	2.	00	-
	Cost Report Preparer Contact Information						
	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		ERIC		HENDERSON		41.00
42.00	Enter the employer/company name of the cost r preparer.	report	DEACONESS HOSP	ITAL			42.00
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv		(812) 450-6856		ERI C. HENDERSON	DEACONESS. COM	43.00

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provider CCN: 150175	From 10/01/2013	Worksheet S- Part II Date/Time Pr 2/26/2015 5:	epared
		Part B Date				
		4.00				
	PS&R Data	· · · · · · · · · · · · · · · · · · ·				
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)					16.
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns	01/27/2015				17.
	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					18.
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.					19
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:					20
	Was the cost report prepared only using the provider's records? If yes, see instructions.					21.
			3.00			
	Cost Report Preparer Contact Information		5.00			
. 00	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		EIMBURSEMENT ANALYST			41.
	Enter the employer/company name of the cost r	report				42
. 00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					43

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 150175			Worksheet S Part I Date/Time P 2/26/2015 5	Prep 5:00	
	Component	Worksheet A	No.	of Beds	Bed Days			I/P Days / O <u>Visits / Tri</u> Title V		
		Line Number		2.00	Available		4.00	E 00		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	<u> </u>		<u>2.00</u> 24	<u>3. 00</u> 8, 70	60	<u>4.00</u> 0.00	5.00	0	1.
. 00 . 00 . 00 . 00 . 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF								0	2. 3. 4. 5.
7.00 3.00 9.00 10.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT			24	8, 70	60	0.00		0	7. 8. 9. 10. 11.
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER			24	8, 70	60	0. 00		0	12. 13. 14. 15. 16. 17. 18.
9.00 9.00 1.00 2.00 3.00 4.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE									19. 20. 21. 22. 23. 24.
4. 10 5. 00 6. 00 6. 25 7. 00 8. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Red Dave	30. 00		24					0	24. 25. 26. 26. 27. 28.
9.00 0.00 1.00 2.00	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)			0		0			U	29. 30. 31. 32.
32. 01 33. 00	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days									32 33

JSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	1	Period: From 10/01/2013 Fo 09/30/2014	Worksheet S-3 Part I Date/Time Pre 2/26/2015 5:0	pared
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	<u> </u>
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3, 008	147	5, 63		10.00	1.0
00	HMO and other (see instructions)	672	102				2.0
00	HMO IPF Subprovider	0/2	02				3.0
00	HMO I RF Subprovi der	0	0				4.0
00	Hospital Adults & Peds. Swing Bed SNF	0	0	(			5.0
00	Hospital Adults & Peds. Swing Bed SNI Hospital Adults & Peds. Swing Bed NF	U U	0				6.1
00	Total Adults and Peds. (exclude observation beds) (see instructions)	3, 008	147	5, 633	3		7.0
00	INTENSIVE CARE UNIT						8.0
00	CORONARY CARE UNIT						9.
. 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGICAL INTENSIVE CARE UNIT						11.
. 00	OTHER SPECIAL CARE (SPECIFY)						12.
. 00	NURSERY						13.
. 00	Total (see instructions)	3, 008	147	5, 633	3 0.00	129.91	14.
. 00	CAH visits	0	0	(			15.
. 00	SUBPROVIDER – IPF						16.
. 00	SUBPROVIDER – IRF						17.
. 00	SUBPROVI DER						18.
00	SKILLED NURSING FACILITY						19.
00	NURSING FACILITY						20.
00	OTHER LONG TERM CARE						21.
. 00	HOME HEALTH AGENCY						22.
. 00	AMBULATORY SURGICAL CENTER (D. P. )						23.
00	HOSPICE						24.
10	HOSPICE (non-distinct part)	0	0	(	D		24.
00	CMHC - CMHC						25.
. 00	RURAL HEALTH CLINIC						26.
. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.
00	Total (sum of lines 14-26)		- /		0.00	129.91	
00	Observation Bed Days		56	903	3		28.
00	Ambulance Trips	0					29.
00	Employee discount days (see instruction)			93			30.
. 00	Employee discount days - IRF		-	(			31.
. 00	Labor & delivery days (see instructions)	0	0	(			32.
. 01	Total ancillary labor & delivery room			(	ן		32.
	outpatient days (see instructions)						1

HOSPI -	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der		Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part I Date/Time Pre 2/26/2015 5:00	pared:
		Full Time Equivalents		Di so	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	78		1, 499	1. 00
2.00 3.00 4.00 5.00 6.00 7.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)			17	6 24		2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						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	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY	0. 00	0	78	.0 32	1, 499	14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00
23. 00 24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00					22. 00 24. 00 24. 10 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00

PI T/	AL WAGE INDEX INFORMATION			Provi der	F	eriod: rom 10/01/2013 o 09/30/2014	Date/Time Pre	pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Sal ari es (col.2 ± col.	Paid Hours Related to Salaries in col. 4	2/26/2015 5:0 Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II – WAGE DATA SALARIES							1
	Total salaries (see	200. 00	7,945,400	164, 591	8, 109, 991	272, 395.00	29.77	1.0
0	instructions) Non-physician anesthetist Part		C	0	C	0.00	0.00	2.0
	A		C			0.00	0.00	2.0
0	Non-physician anesthetist Part		C	0	C	0.00	0.00	3.0
0	Physician-Part A -		98, 688	0	98, 688	2,080.00	47.45	4.0
	Admi ni strati ve							
	Physicians - Part A - Teaching Physician-Part B		C	0				
	Non-physician-Part B			0	-			
	Interns & residents (in an	21.00	C	0	-			
	approved program)							
	Contracted interns and residents (in an approved programs)		C	0	C	0.00	0.00	7.C
	Home office personnel		C	0	C	0.00	0.00	8.0
	SNF	44.00	C	0	C			
	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		C	0	C	0.00	0.00	) 10. C
	Contract Labor: Direct Patient		407, 273	0	407, 273	2, 737. 47	148. 78	3 11.0
	Care							
	Contract labor: Top level management and other management and administrative		C	0	C	0.00	0.00	) 12. (
	services Contract Labor: Physician-Part		146, 763	0	146, 763	602.00	243.79	13 0
	A - Administrative		,					
00	Home office salaries &		58, 101	0	58, 101	2,057.00	28. 25	5 14.0
00	wage-related costs Home office: Physician Part A		C	0	c	0.00	0.00	15.0
00	- Administrative		C			0.00	0.00	15.0
	Home office and Contract		C	0	C	0.00	0.00	16.0
	Physicians Part A - Teaching   WAGE-RELATED COSTS							-
	Wage-related costs (core) (see		2, 726, 924	0	2, 726, 924			17. (
	instructions)							
00	Wage-related costs (other)		C	0	C			18.0
00	(see instructions) Excluded areas		7, 789	0	7, 789			19.0
	Non-physician anesthetist Part		C					20.0
	Α							
00	Non-physician anesthetist Part		C	0	C			21.0
00	Physician Part A -		C	0	c			22.0
	Administrative		_	_	_			
	Physician Part A - Teaching		C	0				22.0
	Physician Part B Wage-related costs (RHC/FQHC)							23.0
	Interns & residents (in an		C	0				25.
	approved program)							
	OVERHEAD COSTS - DIRECT SALARIE					0.00	0.00	
	Employee Benefits Department Administrative & General	4.00 5.00	C 847, 053					
	Administrative & General under	5.00	110, 205		110, 205			
	contract (see inst.)		,	-	,			
	Maintenance & Repairs	6.00	C		C			
	Operation of Plant	7.00	C	0	C			
	Laundry & Linen Service Housekeeping	8.00 9.00	C	0				
	Housekeeping under contract	9.00	190, 533	-	-			
	(see instructions)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10,122100		
	Dietary	10.00	C	0				
00	Dietary under contract (see		88, 526	0	88, 526	5, 071. 00	17.46	35. (
00	instructions)	11 00	~	0		0.00	0.00	24
	Cafeteria Maintenance of Personnel	11. 00 12. 00		0				) 36. ( ) 37. (
	Nursing Administration	13.00	C					37.
	Central Services and Supply	14.00	C	0	C	0.00		39.
	Pharmacy	15.00	C	0	C	0.00	0.00	

Health Financial Systems	HEAR	T HOSPI TAL AT	DEAC	CONESS GATEW	ΙAΥ	In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION				Provi der	CCN: 150175	Peri od:	Worksheet S-3	
						From 10/01/2013		
						To 09/30/2014		
			_				2/26/2015 5:0	
	Worksheet A	Amount	Rec	l assi fi cati		Paid Hours	Average Hourly	
	Line Number	Reported	on o	of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col	. Salaries in	col. 5)	
			Worl	ksheet A-6)	3)	col. 4		
	1.00	2.00		3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical	16.00		0	0		0 0.00	0.00	41.00
Records Library								
42.00 Social Service	17.00		0	0		0 0.00	0.00	42.00
43.00 Other General Service	18.00		0	0		0 0.00	0.00	43.00

Heal th	Financial Systems	HEAR	T HOSPITAL AT I	DEACONESS GATEW	ΙΑΥ	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 10/01/2013 To 09/30/2014		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)		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		8, 334, 664	164, 591	8, 499, 25	5 290, 999. 81	29. 21	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		0	0		0 0.00	0. 00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		8, 334, 664	164, 591	8, 499, 25	5 290, 999. 81	29. 21	3.00
4.00	Subtotal other wages & related costs (see inst.)		612, 137	0	612, 13	7 5, 396. 47	113. 43	4.00
5.00	Subtotal wage-related costs (see inst.)		2, 726, 924	0	2, 726, 92	4 0.00	32.08	5.00
6.00	Total (sum of lines 3 thru 5)		11, 673, 725	164, 591	11, 838, 31	6 296, 396. 28	39. 94	6.00
7.00	Total overhead cost (see instructions)		1, 236, 317	-47, 639	1, 188, 67	8 32, 731. 81	36. 32	7.00

HOSPI 1	AL WAGE RELATED COSTS	DEACONESS GATEWAY Provider CCN: 1501	75 Period:	Worksheet S-3	
1105111	AL WAGE RELATED COSTS		From 10/01/2013	Part IV	
			To 09/30/2014		pared:
				2/26/2015 5:0 Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST			<b>T</b>	
1.00	401K Employer Contributions			326, 248	-
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	-
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	
4.00	Qualified Defined Benefit Plan Cost (see instructions)			95, 530	4.0
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			1	
5.00	401K/TSA Plan Administration fees			469	
6.00	Legal /Accounting/Management Fees-Pension Plan			1, 989	
7.00	Employee Managed Care Program Administration Fees			0	7.0
	HEALTH AND INSURANCE COST			•	
8.00	Health Insurance (Purchased or Self Funded)			1, 413, 778	
9.00	Prescription Drug Plan			0	
10.00	Dental, Hearing and Vision Plan			38, 004	
11.00	Life Insurance (If employee is owner or beneficiary)			8, 368	
12.00	Accident Insurance (If employee is owner or beneficiary)			0	
13.00	Disability Insurance (If employee is owner or beneficiary)			126, 765	
14.00	Long-Term Care Insurance (If employee is owner or beneficia	ary)		0	
15.00	'Workers' Compensation Insurance			15, 901	
16.00	Retirement Health Care Cost (Only current year, not the ext	traordi nary accrual requ	ired by FASB 106.	0	16.0
	Non cumulative portion)				
17 00	TAXES			594, 063	1 17 0
17.00	FICA-Employers Portion Only				
18.00	Medicare Taxes - Employers Portion Only			0	
19.00	Unemployment Insurance				19.0
20. 00	State or Federal Unemployment Taxes OTHER			35, 495	20.0
21.00	Executive Deferred Compensation (Other Than Retirement Cost	t Reported on lines 1 th	rough 4 above (see	11, 997	21.0
21.00	instructions))				21.0
22.00	Day Care Cost and Allowances			47, 813	22.0
23.00	Tuition Reimbursement			16, 214	
24.00	Total Wage Related cost (Sum of lines 1 -23)			2, 734, 713	
	Part B - Other than Core Related Cost				1
25 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.0

Heal th	Financial Systems	HEART HOSPI TAL	AT DEACO	NESS GATEW	AY	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST			Provi der	CCN: 150175	Peri od:	Worksheet S-3	
						From 10/01/2013		
						To 09/30/2014		
	Cost Center Description					Contract Labor	2/26/2015 5:0 Benefit Cost	
	cost center bescription					1.00	2.00	
	PART V - Contract Labor and Benefit Cos	st				1.00	2.00	
	Hospital and Hospital-Based Component I							
1.00	Total facility's contract labor and ber					0	0	1.00
2.00	Hospi tal					0	0	2.00
3.00	Subprovider - IPF							3.00
4.00	Subprovider - IRF							4.00
5.00	Subprovider - (Other)					0	0	5.00
6.00	Swing Beds - SNF					0	0	6.00
7.00	Swing Beds - NF					0	0	7.00
8.00	Hospital-Based SNF							8.00
9.00	Hospital-Based NF							9.00
10.00	Hospital-Based OLTC							10.00
11.00	Hospital-Based HHA							11.00
12.00	Separately Certified ASC							12.00
13.00	Hospi tal -Based Hospi ce							13.00
14.00	Hospital-Based Health Clinic RHC							14.00
15.00	Hospital-Based Health Clinic FQHC							15.00
16.00	Hospital-Based-CMHC							16.00
17.00	Renal Dialysis					0	0	17.00
18.00	Other					0	0	18.00

Heal th	Financial Systems HEART HOSPITAL AT DEACON	ESS GATEW	AY	In Lie	u of Form CMS-	2552-10
			CCN: 150175	Peri od:	Worksheet S-1	
				From 10/01/2013		
				To 09/30/2014		
					2/26/2015 5:0	0 pm
					1.00	
	Uncompensated and indigent care cost computation				1100	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lir	ne 202 column	8)	0. 248307	1.00
	Medicaid (see instructions for each line)			- /		
2.00	Net revenue from Medicaid				474, 244	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p	pavments f	<sup>-</sup> rom Medicaid	?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from N				0	
6.00	Medicaid charges				7, 212, 718	
7.00	Medicaid cost (line 1 times line 6)				1, 790, 968	
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minu	us sum of lin	es 2 and 5: if	1, 316, 724	
	< zero then enter zero)			,		
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP				C	9.00
10.00	Stand-alone SCHIP charges				0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 mi	nus line 9;	f < zero then	( C	12.00
	enter zero)					
	Other state or local government indigent care program (see instru					
13.00	Net revenue from state or local indigent care program (Not includ	ded on lir	nes 2, 5 or 9	)	C	13.00
14.00	Charges for patients covered under state or local indigent care p	orogram (N	Not included	n lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)				C	
16.00	Difference between net revenue and costs for state or local indig	gent care	program (lin	e 15 minus line	C	16.00
	13; if < zero then enter zero)					-
17 00	Uncompensated care (see instructions for each line)					1 1 7 . 00
	Private grants, donations, or endowment income restricted to fund				0	
18.00	Government grants, appropriations or transfers for support of hos					
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	i nai gent	care program	s (sum or lines	1, 316, 724	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (a		2, 237, 02	6 170, 129	2, 407, 155	20.00
	charges excluding non-reimbursable cost centers) for the entire f					
21.00	Cost of initial obligation of patients approved for charity care	(line 1	555, 46	9 42, 244	597, 713	21.00
	times line 20)					
	Partial payment by patients approved for charity care		5, 96		5, 960	
23.00	Cost of charity care (line 21 minus line 22)		549, 50	9 42, 244	591, 753	23.00
					1.00	
24.00	Deep the encount in Line 20 column 2 include channel for noticet of			C	1.00 N	24.00
24.00	Does the amount in line 20 column 2 include charges for patient of imposed on patients covered by Medicaid or other indigent care pr		id a rength o	r stay iimit	IN	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent		oaram's longt	of ctay limit	0	25.00
	Total bad debt expense for the entire hospital complex (see instr		gram s rengt	i or stay rillit	1, 201, 819	
	Medicare bad debts for the entire hospital complex (see instructi				94, 282	
27.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		line 27)		1, 107, 537	
	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (The			28)	275,009	
	Cost of uncompensated care (line 23 column 3 plus line 29)	SC (TINC		20)	866, 762	
	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			2, 183, 486	
	I service a service ser				, ,	

		T HOSPITAL AT DE				u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	IF EXPENSES	Provi der		Period: From 10/01/2013	Worksheet A	
					To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	
	cost center bescription	Sararres	other	+ col. 2)	ons (See A-6)	Trial Balance	
				,		(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		0	(	0 1, 644, 361	1, 644, 361	1 1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	(	0 1, 914, 665	1, 914, 665	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	2, 529, 858	2, 529, 85	8 43, 787	2, 573, 645	4.00
5.00	00500 ADMINI STRATI VE & GENERAL	847,053	8, 360, 331				
7.00	00700 OPERATION OF PLANT	0	451, 152				
8.00	00800 LAUNDRY & LINEN SERVICE	0	72, 519			72, 519	
9.00	00900 HOUSEKEEPI NG	0	186, 601			186, 601	9.00
10.00	01000 DI ETARY	0	225, 987				
11.00	01100 CAFETERI A	0	223, 707		, 0 0		1
13.00	01300 NURSI NG ADMI NI STRATI ON	0	73, 454		-	-	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	338, 179			235, 204	
15.00		0	2, 461, 583			730, 799	
16.00	01600 MEDICAL RECORDS & LIBRARY	0					
17.00		0	558,011				
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	175, 467	175, 46	/ 0	175, 467	17.00
30.00		2, 892, 956	680, 537	3, 573, 493	3 5, 625	3, 579, 118	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	2, 092, 930	000, 037	5, 575, 49	5 5, 025	3, 379, 110	30.00
50.00		592, 520	5, 194, 124	5, 786, 64	4 -2, 949, 567	2, 837, 077	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	70, 403	555, 039				
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 197, 105	10, 036, 727			3, 190, 965	
60.00							
		0	1, 418, 752				
64.00	06400 I NTRAVENOUS THERAPY	431, 639	253, 227			496, 339	
65.00	06500 RESPI RATORY THERAPY	0	224, 982				
66.00	06600 PHYSI CAL THERAPY	0	143, 690			110/0/0	
69.00	06900 ELECTROCARDI OLOGY	586, 590	477, 385				
69.01	06902 CARDI AC REHAB	312, 282	97, 443				
71.00		0	0		3, 611, 612		
72.00		0	0		0 8, 281, 453		
73.00		0	0		0 1, 751, 185		
74.00		14, 852	24, 478				
76.00		0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS	TT		1			
92.00							92.00
	SPECIAL PURPOSE COST CENTERS	1 1		1		[	
118.00		7, 945, 400	34, 539, 526	42, 484, 92	6 0	42, 484, 926	_118. 00
	NONREI MBURSABLE COST CENTERS	T T		1	- 1		
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.00
	1 07951 VISITOR ASSISTANTS	0	24, 289				
	207952 PUBLIC RELATIONS	0	12, 357				
194.03	3 07953 DEACONESS HOSPI TAL	0	3, 985				194.03
200.00	D TOTAL (SUM OF LINES 118-199)	7,945,400	34, 580, 157	42, 525, 55	7 0	42, 525, 557	1200 00

Heal th	Financial Systems HEAF	T HOSPITAL AT	DEACONESS GAT	EWAY	In Lie	u of Form CMS-	-2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi de	r CCN: 150175	Peri od:	Worksheet A	
					From 10/01/2013 To 09/30/2014	Date/Time Pre	oparad
					10 09/30/2014	2/26/2015 5:0	
	Cost Center Description	Adjustments	Net Expenses	;			
	· ·	(See A-8)	For Allocatio	on			
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	1	1				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	C					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	C	.,,,,,,,,				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 227, 192					4.00
5.00	00500 ADMINI STRATI VE & GENERAL	-989, 166					5.00
7.00	00700 OPERATION OF PLANT	C					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	10, 764					8.00
9.00	00900 HOUSEKEEPI NG	C					9.00
10.00	01000 DI ETARY	24					10.00
11.00	01100 CAFETERIA	78, 939					11.00
13.00	01300 NURSING ADMINISTRATION	C					13.00
	01400 CENTRAL SERVICES & SUPPLY	C					14.00
	01500 PHARMACY	C					15.00
	01600 MEDI CAL RECORDS & LI BRARY	-36, 383					16.00
17.00	01700 SOCIAL SERVICE	-4, 243	3 171, 22	24			17.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-		-			
30.00	03000 ADULTS & PEDIATRICS	C	3, 579, 11	8			30.00
50.00	ANCI LLARY SERVICE COST CENTERS	4 704 776	1 050 00				
	05000 OPERATING ROOM	-1, 786, 772					50.00
	05400 RADI OLOGY-DI AGNOSTI C	-3, 944		1			54.00
	05900 CARDI AC CATHETERI ZATI ON	-94, 252		1			59.00
	06000 LABORATORY	460, 836		1			60.00
	06400 INTRAVENOUS THERAPY	204 007	1,0,00	1			64.00
		284, 907					65.00
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	-86, 113		•			66.00 69.00
	06902 CARDI AC REHAB	-56, 364		1			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	184, 450					71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	164, 450					71.00
	07300 DRUGS CHARGED TO PATIENTS						73.00
	07400 RENAL DI ALYSI S	-173					73.00
76.00	03020 OTHER ANCI LLARY SERVICE COST CENTERS	-1/3		0			76.00
70.00	OUTPATIENT SERVICE COST CENTERS		<u>/</u>	0			/0.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
72.00	SPECIAL PURPOSE COST CENTERS	I	1				72.00
118.00		-3, 276, 311	39, 208, 6	5			118.00
110.00	NONREI MBURSABLE COST CENTERS	5,270,311	57,200,0	ч 			- 10.00
194 00	07950 OTHER NONREIMBURSABLE COST CENTERS	0		0			194.00
	07950 UTIER NORRET MORSABLE COST CENTERS						194.00
	07952 PUBLIC RELATIONS						194.01
	07953 DEACONESS HOSPI TAL						194.02
200.00		-3, 276, 311		1			200.00
200.00	$\frac{1}{1}$	1 5,270,311	1 37, 247, 24				1200.00

Heal th F	i nanci al	Systems
RECLASSI	FICATION	S

|--|

Provi der CCN: 150175 Peri od:

In Lieu of Form CMS-2552-10 Worksheet A-6

					2/26/2015 5:00
Cost Center	l ncreases Li ne #	Salary	Other		
2.00	3.00	4.00	5.00		
A - EQUIPMENT DEPRECIATION	5.00	4.00	5.00	 	
NEW CAP REL COSTS-MVBLE	2.00	0	918, 833		
EQUI P	2.00	0	,10,000		
20011	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
TOTALS			918, 833		
B - LEASES		0	710,000		
NEW CAP REL COSTS-BLDG &	1.00	0	1, 644, 361		
FLXT	1.00	0	1, 044, 301		
NEW CAP REL COSTS-MVBLE	2.00	0	947, 539		
EQUI P	2.00	Ŭ	747, 557		
TOTALS	+		2, 591, 900		
C - INSURANCE		0	2,371,700		
NEW CAP REL COSTS-MVBLE	2.00	0	22, 641		
EQUI P	2.00	Ŭ	22,041		
TOTALS	+		22,641		
D - PROPERTY TAXES	I		22,011		
NEW CAP REL COSTS-MVBLE	2.00	0	25, 652		
EQUI P	2.00	0	20,002		
	+		25, 652		
E - MEDICAL SUPPLIES AND DRUG	S CHARGED	0	20,002		
MEDICAL SUPPLIES CHARGED TO	71.00	0	3, 611, 612		
PATI ENTS	/1.00	0	5,011,012		
IMPL. DEV. CHARGED TO	72.00	0	8, 281, 453		
PATI ENT	72.00	0	0,201,400		
DRUGS CHARGED TO PATIENTS	73.00	0	1, 751, 185		
	0.00	0	1,701,100		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
TOTALS			13, 644, 250		
F - PROFESSIONAL FEES		<u> </u>	13, 044, 230		
CARDIAC CATHETERIZATION	59.00	0	140, 562		
RENAL DI ALYSI S	74.00		338		
TOTALS		0	140,900		
		0	140, 900		
G - INCENTIVE COMPENSATION	E 00	60 214	<u>^</u>		
ADMINI STRATI VE & GENERAL	5.00	68, 316	0		
ADULTS & PEDIATRICS	30.00	122, 541	0		
CARDIAC CATHETERIZATION	59.00	73, 397	0		
INTRAVENOUS THERAPY	64.00	8, 597	0		
	69.00	32, 876	0		
CARDIAC REHAB	<u></u>	<u> </u>	0 0		
TOTALS		321, 844	0		
H – DI SABI LI TY		-			
EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43, 787		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
		0	0		
TOTALS		0	43, 787		
I - SALARIES IN NON-SALARY AC					
ADMI NI STRATI VE & GENERAL	5.00	600	0		
ADULTS & PEDIATRICS	30.00	1, 295	0		
CARDIAC CATHETERIZATION	59.00	437	0		
ELECTROCARDI OLOGY	69.00	120	0		
CARDI AC REHAB	69.01	50	0		
TOTALS	+	2, 502	ō		
		324, 346			50

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

	SIFICATIONS			Provi der	CCN: 150175	Period: Work From 10/01/2013	ksheet A-6
						To 09/30/2014 Date	e/Time Prepare 5/2015 5:00 pm
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00		
0	A - EQUIPMENT DEPRECIATION	F 00	0	E0 7E0		9	1
)0 )0	ADMI NI STRATI VE & GENERAL NURSI NG ADMI NI STRATI ON	5.00 13.00	0	58, 759 285		9	1.
0	ADULTS & PEDIATRICS	30.00	0	93, 872		9	3.
00	OPERATING ROOM	50.00	o	81, 359		9	4.
00	CARDIAC CATHETERIZATION	59.00	0	512, 513		9	5.
00	INTRAVENOUS THERAPY	64.00	0	8, 687		9	6.
00	ELECTROCARDI OLOGY	69.00	0	129, 322		9	7.
00	CARDI AC REHAB	69.01	0	25, 984		9	8.
00	RENAL_DI ALYSI S	74.00	0	<u>8, 0</u> 52		9	9.
	TOTALS		0	918, 833			
0	B - LEASES	F 00	0	2 501 000	1		1
)0 )0	ADMI NI STRATI VE & GENERAL	5.00 0.00	0	2, 591, 900	1		1.
0	TOTALS		— — — <u>0</u>	2, 591, 900			2.
	C - INSURANCE		<u> Ч</u>	2, 371, 700			
00	ADMI NI STRATI VE & GENERAL	5.00	0	22, 641	1	2	1.
	TOTALS		<del>_</del>	22, 641		-	
	D - PROPERTY TAXES	I	i		1		
00	ADMINISTRATIVE & GENERAL	5.00	0	25, 652	1	3	1.
	TOTALS		0	25, 652			
	E - MEDICAL SUPPLIES AND DRUG	S CHARGED			1		
0	CENTRAL SERVICES & SUPPLY	14.00	0	102, 975		0	1.
0	PHARMACY	15.00	0	1, 730, 784		0	2
0	ADULTS & PEDIATRICS	30.00	0	3, 274		0	3
00	OPERATING ROOM	50.00	0	2,868,208		0	4.
)0 )0	CARDIAC CATHETERIZATION	59.00 64.00	0	8, 729, 580 181, 851		0	5.
0	RESPIRATORY THERAPY	65.00	0	27, 578		0	7.
0	TOTALS	05.00	— — — <del>0</del>	13, 644, 250			1.
	F - PROFESSIONAL FEES	I	U	13, 044, 230			
00	ADMI NI STRATI VE & GENERAL	5.00	0	140, 000		0	1.
0	LABORATORY	60.00	0	900		0	2
	TOTALS		0	140, 900		7	
	G - INCENTIVE COMPENSATION					-	
0	ADMI NI STRATI VE & GENERAL	5.00	115, 968	205, 876		0	1.
0		0.00	0	0		0	2
00		0.00	0	0		0	3.
00		0.00	0	0		0	4.
10 10		0. 00 0. 00	0	0		0	5.
0	TOTALS		115, 968				0.
	H - DI SABI LI TY	I	113, 900	203, 070			
0	ADMI NI STRATI VE & GENERAL	5.00	587	0		0	1.
0	ADULTS & PEDIATRICS	30.00	19, 770	0		o	2.
0	CARDI AC CATHETERI ZATI ON	59.00	14, 733	0		0	3.
0	INTRAVENOUS THERAPY	64.00	6, 586	0		o	4
0	ELECTROCARDI OLOGY	69.00	123	0		o	5.
0	CARDIAC REHAB		<u> </u>	0		୦	6
	TOTALS		43, 787	0			
~	I - SALARIES IN NON-SALARY AC				1		
0	ADMI NI STRATI VE & GENERAL	5.00	0	600		0	1
0	ADULTS & PEDIATRICS	30.00	0	1, 295		0	2
0	CARDI AC CATHETERI ZATI ON ELECTROCARDI OLOGY	59.00 69.00	0	437 120		o	3
10	CARDI AC REHAB	69.00		50		0	5
, U	TOTALS	07.01				잌	1 5.

Heal th	Financial Systems HEAR	T HOSPITAL AT D	EACONESS GATEW	ΙAΥ	In Lie	eu of Form CMS-:	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150175	Period: From 10/01/2013 To 09/30/2014		pared:
				Acqui si ti on	5		
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4,00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		2100	0,00		0.00	
1.00	Land	0	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	7, 963, 538	1, 248, 124		0 1, 248, 124	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	7, 963, 538	1, 248, 124		0 1, 248, 124	0	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	7, 963, 538	1, 248, 124		0 1, 248, 124	0	10.00
		Endi ng Bal ance	Fully				
		-	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	9, 211, 662	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	9, 211, 662	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	9, 211, 662	0				10.00

Heal th	Financial Systems HEAR	T HOSPITAL AT I	DEACONESS GATE	VAY	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150175	Period:	Worksheet A-7	
					From 10/01/2013 To 09/30/2014		narad
					10 09/30/2014	2/26/2015 5:00	
			SL	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cont Conton Decemination	Others	T-+-1 (1) (	-			
	Cost Center Description		Total (1) (sum of cols. 9				
		Capital-Relate d Costs (see					
		instructions)	thi ough 14)				
		14.00	15.00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems HEAR	T HOSPITAL AT	DEACONESS GATE	VAY	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	_	Provi der		Period: From 10/01/2013 To 09/30/2014		pared:
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPI TAL	
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 CI	1.00	2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0 9, 211, 662 9, 211, 662	0	9, 211, 66 9, 211, 66	2 1.000000	0 0	1.00 2.00 3.00
	ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
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 0 918, 833 0 918, 833		1.00 2.00 3.00
		SI	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		1				
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	000000000000000000000000000000000000000	22, 641	25, 65		1, 914, 665	1.00 2.00 3.00

h Financial Systems	HEART HOSPITAL AT DEACONESS GATEWAY

	Financial Systems MENTS TO EXPENSES			DEACONESS GATEWAY Provider CCN: 150175	Peri od:	u of Form CMS-2 Worksheet A-8	
					From 10/01/2013 To 09/30/2014	Date/Time Prep 2/26/2015 5:00	
				Expense Classification To/From Which the Amount i		272072013 5.00	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	1.00		NEW CAP REL COSTS-BLDG & FLXT	1.00		1.
00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE	2.00	0	2
00	2) Investment income - other		0		0.00	0	3
00	(chapter 2) Trade, quantity, and time	В	-142	ADMI NI STRATI VE & GENERAL	5.00	0	4
00	discounts (chapter 8) Refunds and rebates of		C		0.00		5
	expenses (chapter 8) Rental of provider space by		0				
00	suppliers (chapter 8)				0.00		
00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7
00	21) Tel evi si on and radi o servi ce		0		0.00	0	8
00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9
00	Provider-based physician adjustment	A-8-2	-157, 130			0	10
00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11
00	Related organization transactions (chapter 10)	A-8-1	-1, 451, 288			0	12
00	Laundry and linen service		0		0.00		
00 00	Cafeteria-employees and guests Rental of quarters to employee		0 0		0.00 0.00		
00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16
00	patients Sale of drugs to other than		0		0.00	0	17
00	patients Sale of medical records and		0		0.00	0	18
00	abstracts Nursing school (tuition, fees,		O		0.00	0	19
00	books, etc.) Vendi ng machi nes		0		0.00		20
00	Income from imposition of interest, finance or penalty charges (chapter 21)	В		ADMI NI STRATI VE & GENERAL	5.00		
00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22
. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23
00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24
00	limitation (chapter 14) Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted **	* 114.00		25
00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26
00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE	2.00	0	27
00	Non-physician Anesthetist		0	*** Cost Center Deleted **			28
00 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	*** Cost Center Deleted **	* 0.00 * 67.00		29 30
99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30
. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	C	*** Cost Center Deleted **	* 68.00		31
. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32

Heal th	Health Financial Systems HEART HOSPITAL AT DEACONESS GATEWAY In Lieu							
ADJUST	MENTS TO EXPENSES			Provider CCN: 150175	Peri od:	Worksheet A-8		
					From 10/01/2013			
					To 09/30/2014	Date/Time Prep 2/26/2015 5:00	pared:	
				Expense Classification o	Worksheet A	272072015 5.0		
				To/From Which the Amount is				
				TOTTOM WITCH THE AMOUNT IS	to be Aujusteu			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.		
		1.00	2.00	3.00	4.00	5.00		
33.00			0		0.00	0	33.00	
34.00	SELF INSURANCE	A	-1, 227, 192	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	34.00	
35.00	RESEARCH	A	-439, 132	ADMINISTRATIVE & GENERAL	5.00	0	35.00	
37.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37.00	
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	38.00	
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00	
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00	
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00	
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00	
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00	
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00	
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00	
50.00	TOTAL (sum of lines 1 thru 49)		-3, 276, 311				50.00	
	(Transfer to Worksheet A,							

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

Heal th	Financial Systems	HEART HOSPI TAL AT	DEACONESS GATEWAY	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 150175	Period: From 10/01/2013 To 09/30/2014		epared:
	Line 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 ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00		NEW CAP REL COSTS-BLDG & FIX		2, 135, 876		1.00
2.00		NEW CAP REL COSTS-MVBLE EQUI		300, 057		2.00
3.00		EMPLOYEE BENEFITS DEPARTMENT		1, 503, 322		3.00
4.00			CONTRACT SERVICES	2, 356, 971		4.00
4.01			CONTRACT SERVICES	172, 368		
4.02		LAUNDRY & LINEN SERVICE	CONTRACT SERVICES	83, 283		
4.03		HOUSEKEEPING	CONTRACT SERVICES	186, 601	186, 601	4.03
4.04		DI ETARY	CONTRACT SERVICES	226, 011	225, 987	4.04
4.05	11.00	CAFETERIA	CONTRACT SERVICES	78, 939	0	4.05
4.06		NURSING ADMINISTRATION	CONTRACT SERVICES	73, 169	73, 169	4.06
4.07	14.00	CENTRAL SERVICES & SUPPLY	CONTRACT SERVICES	187, 662	187, 662	4.07
4.08	15.00	PHARMACY	CONTRACT SERVICES	694, 580	694, 580	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	CONTRACT SERVICES	521, 628	558, 011	4.09
4.10	17.00	SOCIAL SERVICE	CONTRACT SERVICES	138, 862	138, 862	4.10
4.11	30.00	ADULTS & PEDIATRICS	CONTRACT SERVICES	922, 408	922, 408	4.11
4.12	50.00	OPERATING ROOM	CONTRACT SERVICES	643, 167	2, 429, 939	4.12
4.13	54.00	RADI OLOGY-DI AGNOSTI C	CONTRACT SERVICES	391, 461	395, 405	4.13
4.14	59.00	CARDIAC CATHETERIZATION	CONTRACT SERVICES	658, 269	658, 269	4.14
4.15	60.00	LABORATORY	CONTRACT SERVICES	1, 874, 056	1, 411, 491	4.15
4.16	64.00	INTRAVENOUS THERAPY	CONTRACT SERVICES	327,055	327, 055	4.16
4.17	65.00	RESPI RATORY THERAPY	CONTRACT SERVICES	481, 802	196, 895	4.17
4.18	69.00	ELECTROCARDI OLOGY	CONTRACT SERVICES	271, 787	271, 787	4.18
4.19	69.01	CARDI AC REHAB	CONTRACT SERVICES	53, 246	53, 246	4.19
4.20	71.00	MEDICAL SUPPLIES CHARGED TO	CONTRACT SERVICES	184, 450	0	4.20
4.21	74.00	RENAL DIALYSIS	CONTRACT SERVICES	5,007		4.21
4.23			FACILITY RENT	38, 773		4.23
4.24	66.00	PHYSI CAL THERAPY	THERAPY SERVICES	57, 577		4.24
5.00	0		0	14, 568, 387		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.

nus no									
				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1.00	2.00	3.00	4.00	5.00				
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6.00	В	51.00 DEACONESS HOSPI TAL 0.00	6.00
7.00	В	51.00 DEACONESS HOSPI TAL 0.00	7.00
8.00	В	51.00 DEACONESS HOSPI TAL 0.00	8.00
9.00	В	51.00 DEACONESS HOSPI TAL 0.00	9.00
10.00	В	51.00 DEACONESS HOSPI TAL 0.00	10.00
10.01	В	51.00 DEACONESS HOSPI TAL 0.00	10.01
10. 02	В	51.00 DEACONESS HOSPI TAL 0.00	10.02
10. 03	В	51.00 DEACONESS HOSPI TAL 0.00	10.03
10.04	В	51.00 DEACONESS HOSPI TAL 0.00	10.04
10.05	В	51.00 DEACONESS HOSPI TAL 0.00	10.05
10.06	В	51.00 DEACONESS HOSPI TAL 0.00	10.06
10.07	В	51.00 DEACONESS HOSPI TAL 0.00	10.07
10.08	В	51.00 DEACONESS HOSPI TAL 0.00	10.08
10.09	В	51.00 DEACONESS HOSPI TAL 0.00	10.09
10. 10	В	51.00 DEACONESS HOSPI TAL 0.00	10.10
10. 11	В	51.00 DEACONESS HOSPI TAL 0.00	10.11
10. 12	В	51.00 DEACONESS HOSPI TAL 0.00	10.12
10. 13	В	51.00 DEACONESS HOSPI TAL 0.00	10.13
10.14	В	51.00 DEACONESS HOSPI TAL 0.00	10.14
10. 15	В	51.00 DEACONESS HOSPI TAL 0.00	10. 15
10. 16	В	51.00 DEACONESS HOSPI TAL 0.00	10. 16
10. 17	В	51.00 DEACONESS HOSPI TAL 0.00	10.17
10. 18	В	51.00 DEACONESS HOSPI TAL 0.00	10. 18

Heal th	Financial Systems	HEART HOSPI TAL AT	DEACONESS GATE	WAY	In Lie	eu of Form CMS-	2552-10
STATEMI OFFI CE	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provi der	CCN: 150175	Period: From 10/01/2013	Worksheet A-8	3-1
UTTEL	0313					Date/Time Pre	
				Related Orga	nization(s) and/		
	Symbol (1)	Name	Percentage of Ownership	1	Name	Percentage of Ownership	

			Ownership		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
10. 19	В		51.00	DEACONESS HOSPITAL	0.00	10.19
10.20	В		51.00	DEACONESS HOSPI	0.00	10. 20
10. 21	В		51.00	DEACONESS HOSPI	0.00	10. 21
10. 22	В		51.00	DEAC HEALTH SYS	0.00	10. 22
10. 23	А		0.00	PROGRESSI VE HEA	51.00	10. 23
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

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

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

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

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

Health Financial Systems	HEART HOSPITAL AT DEACC	NESS GATEWAY	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RE	LATED ORGANIZATIONS AND HOME	Provider CCN: 150175	Period: From 10/01/2013	Worksheet A-8-1
			To 09/30/2014	Date/Time Prepared:

					2	2/26/2015 5:00 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			ITS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED	ORGANIZATIONS OR CL	AIMED
	HOME OFFICE CO					
1.00	0	10				1.00
2.00	0	10				2.00
3.00	0	0				3.00
4.00	-548, 096	0				4.00
4.01	0	0				4. 01
4.02	10, 764	0				4. 02
4.03	0	0				4.03
4.04	24	0				4.04
4.05	78, 939	0				4.05
4.06	0	0				4.06
4.07	0	0				4.07
4.08	0	0				4.08
4.09	-36, 383	0				4.09
4.10	0	0				4.10
4.11	0	0				4.11
4.12	-1, 786, 772	0				4.12
4.13	-3, 944					4.13
4.14	0	0				4.14
4.15	462, 565	0				4.15
4.16	0	0				4.16
4.17	284, 907	0				4.17
4.18	0	0				4.18
4.19	0	0				4.19
4.20	184, 450	0				4. 20
4.21	0	0				4. 21
4.23	-11, 629	0				4. 23
4.24	-86, 113	0				4.24
5.00	-1, 451, 288					5.00
* The	amounts on lin	es 1-4 (and subsc	ripts as appropriate) are transf	erred in detail to W	orksheet A column 6	lines as

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

nas	1101	been posted to worksheet A,	COLUMNS	T anu/or	Ζ,	the amount	arrowabre	Shourd	bei	nui cateu	1401	this part.	
		Related Organization(s)											
		and/or Home Office											
		Type of Business											
		6.00											
		B. INTERRELATIONSHIP TO RELA	TED ORGA	NI ZATI ON	(S) A	ND/OR HOM	OFFLCE:						

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

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

6.00       HOSPI TAL       6.00         7.00       HOSPI TAL       7.00         8.00       HOSPI TAL       8.00         9.00       HOSPI TAL       9.00         10.01       HOSPI TAL       10.01         10.02       HOSPI TAL       10.01         10.03       HOSPI TAL       10.02         10.04       HOSPI TAL       10.02         10.05       HOSPI TAL       10.03         10.06       HOSPI TAL       10.05         10.07       HOSPI TAL       10.06         10.08       HOSPI TAL       10.06         10.09       HOSPI TAL       10.02         10.09       HOSPI TAL       10.08         10.10       HOSPI TAL       10.10         10.11       HOSPI TAL       10.11         10.12       HOSPI TAL       10.12         10.11       HOSPI TAL <td< th=""><th></th><th></th><th></th></td<>			
8.00       HOSPI TAL       8.00         9.00       HOSPI TAL       9.00         10.00       HOSPI TAL       10.00         10.01       HOSPI TAL       10.01         10.02       HOSPI TAL       10.02         10.03       HOSPI TAL       10.02         10.04       HOSPI TAL       10.03         10.05       HOSPI TAL       10.04         10.05       HOSPI TAL       10.04         10.05       HOSPI TAL       10.05         10.06       HOSPI TAL       10.05         10.06       HOSPI TAL       10.06         10.07       HOSPI TAL       10.06         10.09       HOSPI TAL       10.07         10.08       HOSPI TAL       10.07         10.09       HOSPI TAL       10.09         10.09       HOSPI TAL       10.09         10.10       HOSPI TAL       10.11         10.11       HOSPI TAL       10.13         10.12       HOSPI TAL       10.13         10.13       HOSPI TAL       10.13         10.14       HOSPI TAL       10.14         10.15       HOSPI TAL       10.16         10.16       HOSPI TAL	6.00	HOSPI TAL	6.00
9.00       HOSPI TAL       9.00         10.00       HOSPI TAL       10.00         10.01       HOSPI TAL       10.01         10.02       HOSPI TAL       10.02         10.03       HOSPI TAL       10.03         10.04       HOSPI TAL       10.03         10.05       HOSPI TAL       10.01         10.06       HOSPI TAL       10.03         10.06       HOSPI TAL       10.05         10.06       HOSPI TAL       10.05         10.07       HOSPI TAL       10.05         10.08       HOSPI TAL       10.07         10.08       HOSPI TAL       10.07         10.09       HOSPI TAL       10.07         10.09       HOSPI TAL       10.07         10.10       HOSPI TAL       10.07         10.11       HOSPI TAL       10.10         10.11       HOSPI TAL       10.11         10.12       HOSPI TAL       10.11         10.12       HOSPI TAL       10.12         10.13       HOSPI TAL       10.12         10.14       HOSPI TAL       10.13         10.15       HOSPI TAL       10.16         10.14       HOSPI TAL	7.00	HOSPI TAL	7.00
10.00       HOSPI TAL       10.00         10.01       HOSPI TAL       10.01         10.02       HOSPI TAL       10.03         10.04       HOSPI TAL       10.03         10.05       HOSPI TAL       10.04         10.05       HOSPI TAL       10.05         10.06       HOSPI TAL       10.05         10.06       HOSPI TAL       10.05         10.06       HOSPI TAL       10.05         10.07       HOSPI TAL       10.07         10.08       HOSPI TAL       10.09         10.09       HOSPI TAL       10.09         10.10       HOSPI TAL       10.09         10.11       HOSPI TAL       10.11         10.11       HOSPI TAL       10.12         10.11       HOSPI TAL       10.11         10.12       HOSPI TAL       10.12         10.13       HOSPI TAL       10.12         10.13       HOSPI TAL       10.14         10.14       HOSPI TAL       10.14         10.15       HOSPI TAL       10.16         10.17       HOSPI TAL       10.16	8.00	HOSPI TAL	8.00
10.01       HOSPI TAL       10.01         10.02       HOSPI TAL       10.02         10.03       HOSPI TAL       10.03         10.04       HOSPI TAL       10.03         10.05       HOSPI TAL       10.04         10.06       HOSPI TAL       10.05         10.07       HOSPI TAL       10.07         10.08       HOSPI TAL       10.08         10.09       HOSPI TAL       10.09         10.11       HOSPI TAL       10.09         10.11       HOSPI TAL       10.01         10.11       HOSPI TAL       10.09         10.11       HOSPI TAL       10.11         10.11       HOSPI TAL       10.11         10.12       HOSPI TAL       10.11         10.13       HOSPI TAL       10.11         10.14       HOSPI TAL       10.13         10.14       HOSPI TAL       10.15         10.15       HOSPI TAL       10.16         10.17       HOSPI TAL       10.16	9.00	HOSPI TAL	9.00
10.02       HOSPI TAL       10.02         10.03       HOSPI TAL       10.03         10.04       HOSPI TAL       10.04         10.05       HOSPI TAL       10.04         10.05       HOSPI TAL       10.06         10.07       HOSPI TAL       10.06         10.07       HOSPI TAL       10.07         10.08       HOSPI TAL       10.07         10.09       HOSPI TAL       10.09         10.10       HOSPI TAL       10.09         10.11       HOSPI TAL       10.09         10.12       HOSPI TAL       10.11         10.13       HOSPI TAL       10.11         10.14       HOSPI TAL       10.13         10.14       HOSPI TAL       10.14         10.15       HOSPI TAL       10.14         10.15       HOSPI TAL       10.14         10.15       HOSPI TAL       10.16         10.17       HOSPI TAL       10.16	10.00	HOSPI TAL	10.00
10.03       HOSPI TAL       10.03         10.04       HOSPI TAL       10.04         10.05       HOSPI TAL       10.05         10.06       HOSPI TAL       10.06         10.07       HOSPI TAL       10.06         10.09       HOSPI TAL       10.07         10.09       HOSPI TAL       10.09         10.10       HOSPI TAL       10.09         10.11       HOSPI TAL       10.09         10.12       HOSPI TAL       10.11         10.13       HOSPI TAL       10.11         10.14       HOSPI TAL       10.13         10.15       HOSPI TAL       10.14         10.14       HOSPI TAL       10.15         10.15       HOSPI TAL       10.16         10.17       HOSPI TAL       10.15	10. 01	HOSPI TAL	10. 01
10.04       HOSPI TAL       10.04         10.05       HOSPI TAL       10.05         10.06       HOSPI TAL       10.06         10.07       HOSPI TAL       10.07         10.08       HOSPI TAL       10.09         10.09       HOSPI TAL       10.08         10.09       HOSPI TAL       10.09         10.10       HOSPI TAL       10.09         10.11       HOSPI TAL       10.10         10.12       HOSPI TAL       10.11         10.13       HOSPI TAL       10.12         10.14       HOSPI TAL       10.13         10.15       HOSPI TAL       10.14         10.15       HOSPI TAL       10.16         10.17       HOSPI TAL       10.16	10. 02	HOSPI TAL	10. 02
10.05       HOSPI TAL       10.05         10.06       HOSPI TAL       10.06         10.07       HOSPI TAL       10.07         10.08       HOSPI TAL       10.08         10.09       HOSPI TAL       10.09         10.10       HOSPI TAL       10.09         10.11       HOSPI TAL       10.10         10.11       HOSPI TAL       10.11         10.12       HOSPI TAL       10.12         10.13       HOSPI TAL       10.13         10.14       HOSPI TAL       10.14         10.15       HOSPI TAL       10.15         10.16       HOSPI TAL       10.15         10.17       HOSPI TAL       10.16	10. 03	HOSPI TAL	10. 03
10.06       HOSPI TAL       10.06         10.07       HOSPI TAL       10.07         10.08       HOSPI TAL       10.08         10.09       HOSPI TAL       10.09         10.10       HOSPI TAL       10.09         10.11       HOSPI TAL       10.10         10.11       HOSPI TAL       10.11         10.12       HOSPI TAL       10.12         10.13       HOSPI TAL       10.13         10.14       HOSPI TAL       10.15         10.15       HOSPI TAL       10.15         10.16       HOSPI TAL       10.16	10.04	HOSPI TAL	10.04
10.07       HOSPI TAL       10.07         10.08       HOSPI TAL       10.08         10.09       HOSPI TAL       10.09         10.10       HOSPI TAL       10.10         10.11       HOSPI TAL       10.11         10.12       HOSPI TAL       10.11         10.13       HOSPI TAL       10.12         10.14       HOSPI TAL       10.13         10.15       HOSPI TAL       10.15         10.16       HOSPI TAL       10.16         10.17       HOSPI TAL       10.15	10.05	HOSPI TAL	10.05
10.08       HOSPI TAL       10.08         10.09       HOSPI TAL       10.09         10.10       HOSPI TAL       10.10         10.11       HOSPI TAL       10.11         10.12       HOSPI TAL       10.12         10.13       HOSPI TAL       10.13         10.14       HOSPI TAL       10.14         10.15       HOSPI TAL       10.14         10.16       HOSPI TAL       10.15         10.16       HOSPI TAL       10.16	10.06	HOSPI TAL	10.06
10.09       HOSPI TAL       10.09         10.10       HOSPI TAL       10.10         10.11       HOSPI TAL       10.11         10.12       HOSPI TAL       10.12         10.13       HOSPI TAL       10.13         10.14       HOSPI TAL       10.14         10.15       HOSPI TAL       10.15         10.16       HOSPI TAL       10.16	10.07	HOSPI TAL	10. 07
10. 10       HOSPI TAL       10. 10         10. 11       HOSPI TAL       10. 11         10. 12       HOSPI TAL       10. 12         10. 13       HOSPI TAL       10. 13         10. 14       HOSPI TAL       10. 13         10. 15       HOSPI TAL       10. 14         10. 16       HOSPI TAL       10. 16         10. 17       HOSPI TAL       10. 16	10.08	HOSPI TAL	10. 08
10. 11       HOSPI TAL       10. 11         10. 12       HOSPI TAL       10. 12         10. 13       HOSPI TAL       10. 13         10. 14       HOSPI TAL       10. 14         10. 15       HOSPI TAL       10. 15         10. 16       HOSPI TAL       10. 16         10. 17       HOSPI TAL       10. 17	10.09	HOSPI TAL	10.09
10. 12       HOSPI TAL       10. 12         10. 13       HOSPI TAL       10. 13         10. 14       HOSPI TAL       10. 14         10. 15       HOSPI TAL       10. 15         10. 16       HOSPI TAL       10. 16         10. 17       HOSPI TAL       10. 17	10. 10	HOSPI TAL	10. 10
10. 13       HOSPI TAL       10. 13         10. 14       HOSPI TAL       10. 14         10. 15       HOSPI TAL       10. 15         10. 16       HOSPI TAL       10. 16         10. 17       HOSPI TAL       10. 17	10. 11	HOSPI TAL	10. 11
10. 14       HOSPI TAL       10. 14         10. 15       HOSPI TAL       10. 15         10. 16       HOSPI TAL       10. 16         10. 17       HOSPI TAL       10. 17	10. 12	HOSPI TAL	10. 12
10. 15       HOSPI TAL       10. 15         10. 16       HOSPI TAL       10. 16         10. 17       HOSPI TAL       10. 17	10. 13	HOSPI TAL	10. 13
10. 16         HOSPI TAL         10. 16           10. 17         HOSPI TAL         10. 17	10.14	HOSPI TAL	10. 14
10.17 HOSPITAL 10.17	10. 15	HOSPI TAL	10. 15
	10. 16	HOSPI TAL	10. 16
10. 18 HOSPI TAL 10. 18	10. 17	HOSPI TAL	10. 17
	10. 18	HOSPI TAL	10. 18

Heal th	Financial Systems	HEART HOSPI TAL	AT DEACON	IESS GATEWA	Υ	In Lieu	u of Form CMS-	-2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND	HOME	Provider C	CN: 150175	Period:	Worksheet A-	8-1
OFFICE	COSTS					From 10/01/2013 To 09/30/2014	Date/Time Pro	enared
						10 0// 00/ 2011	2/26/2015 5:	<u>00 pm</u>
	Related Organization(s)							
	and/or Home Office							
	Type of Business	-						
	Type of Business							
	6.00							
10.19	HOSPI TAL							10.19
10. 20	HOSPI TAL							10.20
10. 21	HOSPI TAL							10. 21
10. 22	HEALTH SYSTEM							10. 22
10. 23	THERAPY PROVIDE							10. 23

100.00

10. 23 THERAPY PROVIDE 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 organi zati on.

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

Heal th	Fi nanc	ial Syst	tems	
	DDACE			LUCTN

## HEART HOSPITAL AT DEACONESS GATEWAY In Lieu of Form CMS-2552-10

near th	TTHANCTAL Syste	IIIS IILF	KI HUSFITAL AT			111 LI (		2002-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der		Period: From 10/01/2013 To 09/30/2014		epared:
	Wkct Aline "	Cost Center/Physician	Total	Professi onal	Provi der	DCE Amount		
	Wkst. A Line #		Total			RCE Amount	Physi ci an/Prov	
		Identi fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	863	0	863	171, 400	6	1.00
2.00	17.00	SOCIAL SERVICE	4, 243	4, 243	0	0	0	2.00
3.00	59.00	CARDI AC CATHETERI ZATI ON	140, 563	0	140, 563	171, 400	562	3.00
4.00	60, 00	LABORATORY	5,000	0	5,000		31	4.00
5.00		ELECTROCARDI OLOGY	56, 364	56, 364	0		0	5.00
6.00		RENAL DIALYSIS	338	00, 004	338	, o	-	6.00
		RENAL DIALISIS	330		330	171,400		
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			207, 371	60, 607	146, 764		601	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	494	25			0	1.00
2.00		SOCIAL SERVICE	0	0		0	0	2.00
3.00		CARDI AC CATHETERI ZATI ON	46, 311	2, 316	-	0	0	3.00
4.00		LABORATORY	3, 271	164	0	0	0	4.00
4.00 5.00		ELECTROCARDI OLOGY	3,2/1	104	0	0	0	4.00 5.00
			U U	0	0	0	-	
6.00		RENAL DIALYSIS	165	8	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			50, 241	2, 513	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18,00		
1.00		ADMINISTRATIVE & GENERAL	0					1.00
2.00		SOCIAL SERVICE	0		0			2.00
3.00		CARDIAC CATHETERIZATION	0	46, 311	94, 252			3.00
3.00 4.00		LABORATORY		3, 271	1, 729			3.00 4.00
			0	3, 2/1				
5.00		ELECTROCARDI OLOGY	0	0	0			5.00
6.00		RENAL DIALYSIS	0	165	173	173		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0		96, 523	157, 130		200.00
	I I			/		,	1	

2. 00         00200 NEW CAP REL COSTS - WABLE EQUIP         1, 914, 665         2.0           4. 00         00400 DENPLOYCE BENFTIS DEPARTMENT         1, 344, 453         0         1, 344, 453         4.0           5. 00         00500 ADMI NISTRATIVE & GENERAL         5, 125, 151         18, 412         122, 442         132, 722         5, 989, 727         5.0           0. 00000 OPERATION OF PLANT         451, 152         19, 153         0         0         83, 283         8.0           0. 00000 INUSEXEEPING         188, 601         6, 951         0         0         193, 552, 90         0         0         78, 393         11.0           11.00         1000 OFERATION OF PLANT         73, 169         0         0         226, 011         10.0         10.0         1000 OFERATION OF CENTRAL SERVICE         17, 72, 43         13.0           13.00         01300 NURSING ADMININTRATION         73, 169         0         0         0         235, 204         0         0         171, 224         17.0           14.00         10400 OFERATION ESTRUCES         3, 579, 118         672, 831         195, 610         497, 577         4, 945, 136         30.0           15.00         01700 SOCIAL SERVICE         31, 597, 118         672, 831         195, 536			T HOSPITAL AT D				u of Form CMS-	2552-10
Cost Center Description         Net Expenses for Cost All coation (From West A         Net WUELE FIXT         Net WUELE FOULP         EMPLOYEE BENEFITS DEPARTMENT         Subtotal           100         00100 New CAP REL 000 New CAP REL COSTS-EUDO & FIXT         1.044,301         1.044,301         1.914,665         1.914,665         1.044,433         0         1.044,433         0         1.044,433         0         0.0700 New CAP REL 0.000 COSO DEPAROVE BENEFITS DEPARTMENT         1.346,463         0         0.400         0.400         0.0700 New CAP REL 0.000 COSO DEPAROVE BENEFITS DEPARTMENT         1.346,463         0         0.0700 New CAP REL 0.000 COSO DEPAROVE BENEFITS DEPARTMENT         1.346,463         0         0.400,000 New CAP REL 0.0700 OPERATION 0.0700 NEW CAP REL 0.0000 COMOUNDEVERTIS DEPARTMENT         1.346,463         0         0.0700 New CAP REL 0.0700 OPERATION 0.0700 NEW CAP REL 0.0700 OPERATION 0.0700 NEW CAP NEW CE 0.0000 ODEPAROVE BENEFITS DEPARTMENT         1.346,463         0         0.470,030 F.0           10.00 DIDOC CREATERN NC CABNA AND NE STRATION 10.00 DIDOC DEFARTION 0.0700 NEW CAP NEW CE 0.00 OSCILL SERVICE COST CENTERS 0.00 DISOU DEPARTING NEW CE COST CENTERS 0	COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150175	From 10/01/2013	Part I Date/Time Pre	
For Cost All caching         FIXT For D         EOUI P         BENEFITS DEPARTMENT           ENERAL SERVICE COST CENTERS         0         1.00         2.00         4.00         4A           1.00         OTOD NEW CAP REL COSTS-ELLOG & FIXT         1.644, 361         1.044, 261         1.914, 665         1.914, 665           2.00         00200 NEW CAP REL COSTS-ELLOG & FIXT         1.644, 361         1.944, 453         0         0         1.346, 453         2.0           4.00         00000 DEAMENTER ELEGIT IS DEPARTMENT         1.346, 453         0         0         0         8.83         0         0         0         8.83         8.0           0.00         00000 DEAMENT SERVICE         432, 33         0         0         0         0         8.83         8.0           0.00         00000 DEAMENT SERVICE         352, 601         6.95         0         0         0         7.37, 753         13.0           1.00         01300 DITESIN KA AWINISTRATION         73, 156         0         0         0         2.01         40.0         0         0         0         2.51, 152         10.0         1.014, 201         1.12, 224         10.0         1.02         1.02         1.014, 201         1.02, 773, 773, 130, 99         10.0				CAPI TAL REL	_ATED COSTS			
GENERAL SERVICE COST CENTRES         -           1.00         00100 NEW CAP REL COSTS-BLOG & FLXT         1.644.361         1.014.665         2.00           0.00         00200 NEW CAP REL COSTS-MUBLE EQUIP         1.914.665         1.914.665         2.00           0.00         00000 DEPLOYCEE BATTHENT TO         1.346.453         0         0         4.0           0.00         00050 ADMINI STRATIVE & GENERAL         5.125.151         18.412         122.442         132.722         5.98.727         5.0           0.00         00050 IAUNORY & LINEN SERVICE         183.283         0         0         8.0         0         0.73.346.453         9.0         0         193.552         9.0         0         0         183.283         0         0         0         123.52         9.0         0         0         123.52         9.0         0         0         123.52         9.0         0         0         123.52         9.0         0         0         123.52         11.00         11.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         123.520.41         10.00         123.520.41         10.00         10.00         10.00         10.00         1		Cost Center Description	for Cost Allocation (from Wkst A			BENEFI TS	Subtotal	
1. 00       00100 NEW CAP REL COSTS-BLOG & FLYT       1, 644, 361       1, 644, 361       1, 914, 665       1, 914, 665         2. 00       00200 NEW CAP REL COSTS-BLOG EXENTET       1, 340, 453       0       1, 340, 453       4.0         0. 00200 DEW CAP REL COSTS-WELE FOULP       1, 914, 665       1, 914, 665       1, 914, 665       2.0         0. 00200 OPE DATI ON OF PLANT       5, 125, 151       18, 412       122, 442       132, 722       5, 989, 727       5.0         0. 00200 OLAUNDRY & LINEN SERVICE       83, 283       0       0       0       83, 283       8.0         0. 00200 HLAUNDRY & LINEN SERVICE       83, 283       0       0       0       226, 011       0       0       192, 552       9.0         11. 00       10100 CAFETER       73, 169       0       0       73, 753       13.0       0       0       235, 204       0       0       235, 204       10.0       10.0       10.0       10.00 CHENCA LECONDS & LIBRARY       730, 799       0       0       235, 204       0       0       235, 204       0       0       235, 204       0       0       236, 204       10.0       126, 201       10.0       10.0       10.0       10.0       10.0       10.0       10.0       10.0			0	1.00	2.00	4.00	4A	
2.00         00200 NEW CAP REL COSTS-MVBLE EQUIP         1, 914, 665         2.0           4.00         00400 DENCLOYCE BURFITS DEPARTIMENT         1, 344, 453         0         1, 344, 453         4.0           5.00         00500 ADMIN STRATI VE & GENERAL         5, 125, 151         18, 412         122, 442         132, 722         5, 98, 727         5.0           0.00         00000 DERATION OF PLANT         451, 152         19, 153         0         0         470, 305         7.0           0.00         00000 DENDEYCKE ENENC         184, 601         6, 951         0         0         193, 852         9.0           0.00         01000 PLUSEKEEENK         178, 939         0         0         0         226, 011         10.0           11.00         1000 OLCAFETERIA         78, 939         0         0         737, 763         13.0           11.00         1000 OLCAFETERIA         730, 799         0         0         737, 763         13.0           11.00         1000 SOLAL SERVICE         171, 224         0         0         737, 724         14.0           11.00         1000 SOLAL SERVICE         171, 224         0         0         737, 727         14.945, 737         14.945, 737         14.945, 737         1								
4. 00       00400       EMPLOYEE BENEFITS DEPARTMENT       1. 346, 453       0       0       1. 346, 453       4.0         5.00       00500       ADMIN ISTRATIVE & GENERAL       5.125, 151       18, 412       132, 722       5.308, 727       5.00       8.0         0.00       00000 LAIMDEY & LINEN SERVICE       83, 283       0       0       0       83, 283       0       0       0       83, 283       8.0         0.00       00000 LAIMDEY & LINEN SERVICE       83, 283       0       0       0       83, 283       0       0       0       83, 283       8.0         0.00       00000 LAIMDEY & LINEN SERVICE       186, 601       6, 951       0       0       228, 201       10.0       10.0       10.00       10.00       173, 669       0       0       73, 763       13.0       13.0       13.00       13.00       13.00       13.00       13.00       13.00       13.00       13.00       12.5, 204       14.0       14.0       14.0       14.0       14.0       14.0       14.0       14.0       14.0       14.0       15.00       10.00       10.00       12.5, 204       14.0       14.0       15.0       14.0       15.0       14.0       15.0       15.0       15.				1, 644, 361				1.00
5.00         00500 (ADMIN STRATI VE & GENERAL         5.125, 151         18, 12         122, 442         132, 722         5.398, 727         5.0           7.00         0700 (OPERATI NO F PLANT         451, 152         19, 153         0         0         08, 00         0         83, 283         0         0         0         08, 00         0900 (DUBDEPAT IN STRATI VE & GENERAL         83, 283         0         0         0         08, 00         0         93, 253         8, 00         0         0         193, 552         9, 00         0900 (DUBDEPAT IN STRATI VE & GENERAL         73, 264         0         0         100         1000 (DUBDEPAT IN STRATI IN TATI IN TAT					1, 914, 66			2.00
7. 00         00700         0PERATION OF PLANT         451, 152         10, 153         0				-				4.00
8.00         00800 LAUNRY & LINEN SERVICE         83,283         0         0         0         8.0         9.00         00900 HOUSEKEEN ING         136,601         6,951         0         0.00         0         226,011         10.0           10.00         01000 CAFETERIA         78,939         0         0         73,763         13.0           11.00         01100 CAFETERIA         78,939         0         0         73,763         13.0           14.00         01500 PHARMACY         730,799         0         0         730,791         16.00           15.00         01500 PHARMACY         730,799         0         0         731,62         0         0         731,63         16.0           16.00         01500 PHARMACY         730,799         0         0         731,763         16.0         731,62         0         0         171,224         0         0         071,724         14.00         171,224         0         0         0         731,63         15,53         98,373         1,537,207         50.0         5000         5000 OSO CADULTS S PEDIATRICS         3,579,118         672,831         195,610         497,577         4,945,135         50.0         5000 OSOO CADULTS S PEDIATRICS         3,576					122, 44	132, 722		5.00
9. 00         00000         HOUSEKEEPING         186, 601         6, 951         0         0         193, 552         9, 0           01.00         01000         DITARY         226, 011         0         0         0         226, 011         0         0         0         226, 011         0         0         0         226, 011         0         0         0         226, 011         0         0         0         226, 011         0         0         0         226, 011         0         0         0         226, 011         0         0         0         78, 939         0         0         0         73, 753         13. 0         0         0         0         235, 204         0         0         0         730, 799         0         0         0         730, 799         0         0         0         731, 728         16.0         171, 224         0         0         0         171, 224         0         0         171, 224         0         0         171, 224         0         0         171, 224         0         0         171, 224         0         0         171, 224         0         0         171, 224         0         0         171, 224         0 <t< td=""><td></td><td></td><td></td><td>19, 153</td><td></td><td>-</td><td></td><td>1</td></t<>				19, 153		-		1
10:00       DI TARY       226.011       0       0       0       226.011       10.0         11:00       OITOO CAFETERIA       78.939       0       0       78.939       11.0         11:00       OITOO CAFETERIA       73.169       0       0       235.204       14.00         11:00       OITOO CAFETERIA       SERVICES & SUPPLY       235.204       0       0       235.204       14.00         11:00       OITOO SOCIAL SERVICES & SUPPLY       235.204       0       0       0       235.204       14.00         11:00       OITOO SOCIAL SERVICE       73.779       0       0       0       571.628       16.0         11:00       OITOO SOCIAL SERVICE COST CENTERS       171.224       0       0       171.224       0       0       171.224       0       0       171.224       0       0       171.224       0       0       171.224       0       0       171.224       0       0       171.224       0       0       11.683.31       153.7209       50.0       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.01.689.536       <				Ū		-		
11.00       ORFTERIA       78,939       0       0       78,939       11.00         13.00       01300 NURSI NG ADMINI STRATI ON       73,169       0       594       0       73,763       13.00         14.00       01400 CENTRAL SERVICES & SUPPLY       235,204       0       0       0       235,204       14.0         16.00       01500 PHARMACY       730,799       0       0       0       521,628       0       0       0       521,628       0       0       0       521,628       16.0       0       17.02       0       0       0       17.224       17.02       0       0       0       17.1,224       17.02				6, 951		-		
13:00       D1300       DURSI NG ADMINISTRATI ON       73, 169       0       594       0       73, 763       13.00         14:00       D1400       CENTRAL SERVICES & SUPPLY       235, 204       0       0       0       225, 204       14.00         15:00       D1500       PHARMACY       730, 799       0       0       0       225, 204       14.00         16:00       D1500       PHARMACY       730, 799       0       0       0       225, 204       170         17:00       D1700 SOCIAL SERVICE & SUPPLY       235, 204       0       0       0       171, 224       0       0       171, 224       0       0       171, 224       0       0       171, 224       0       0       171, 224       0       0       171, 224       0       0       171, 224       0       0       0       171, 224       0       0       0       171, 224       0       0       0       171, 224       0       0       0       171, 224       0       0       0       171, 237, 209       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0				-				
14.00       01400       CENTRAL SERVICES & SUPPLY       235, 204       0       0       235, 204       14.0         15.00       01500       PHARMACY       730, 799       0       0       0       730, 799       0       0       0       521, 628       0       0       0       521, 628       0       0       0       521, 628       0       0       0       521, 628       0       0       0       521, 628       0       0       0       521, 628       0       0       0       521, 628       0       0       0       521, 628       0       0       0       521, 628       10       0       521, 628       10       0       0       521, 628       10       0       0       171, 224       17.0       0       0       171, 224       17.0       0       0       171, 224       17.0       0       0       171, 224       17.0       0       0       171, 52, 628       17.0       0       0       171, 52, 628       17.0       0       0       171, 52, 628       17.0       0       0       171, 52, 628       171, 624       171, 520, 500       0       0       0       171, 624       171, 52, 628       171, 620       0       0	11.00		78, 939	0		0 0	78, 939	11.00
15.00       01500       PHARMACY       730,799       0       0       730,799       15.00         16.00       MEDI CAL RECORDS & LI BRARY       521,628       0       0       0       521,628       16.00         17.00       01700_SOCIAL_SERVICE       COST CENTERS	13.00		73, 169	0	59	94 0	73, 763	13.00
16.00       01600       MEDI CAL RECORDS & LIBRARY       521, 628       0       0       0       521, 628       16.0         17.00       001700       SOCI AL SERVICE       171, 224       0       0       0       171, 02       171, 224       0       0       0       171, 02       171, 224       0       0       0       171, 02       171, 02       171, 02       171, 02       170, 0       0       0       171, 02       171, 02       170, 0       0       0       171, 02       171, 02       170, 0       0       0       171, 02       170, 0       0       0       171, 02       170, 0       0       0       171, 02       170, 0       0       0       0       170, 0       0       0       170, 0       0       0       170, 0       0	14.00	01400 CENTRAL SERVICES & SUPPLY	235, 204	0		0 0	235, 204	14.00
17.00       01700       SOCIAL SERVICE       171,224       0       0       171,224       17.0         INPATI ENT ROUTINE SERVICE COST CENTERS       3,579,118       672,831       195,610       497,577       4,945,136       30.0         0.00       03000/ADULTS & PEDIATRICS       3,579,118       672,831       195,610       497,577       4,945,136       30.0         0.00       05000/DERENTING ROOM       1,050,305       218,995       169,536       98,373       1,537,209       50.0       50.00       50.00       50.00       50.00       50.00       11,689       633,187       54.00       54.00       0.00       11,689       633,187       54.00       50.03       58.6437       64.00       1.878,688       0       0       0       18.78,688       60.00       0       18.78,688       60.00       6600       6600       6600       6600       6600       1482,311       65.00       0       0       0       7.577       60.00       0       7.577       66.00       0       0       7.577       66.00       0       0       3.796,662       71.00       0       0       3.796,662       71.00       0       0       3.796,662       71.00       0       0       7.571,85 <td< td=""><td>15.00</td><td></td><td>730, 799</td><td>0</td><td></td><td>0 0</td><td></td><td></td></td<>	15.00		730, 799	0		0 0		
INPATIENT ROUTINE SERVICE COST CENTERS           30. 00         03000 ADULTS & PEDIATRICS         3, 579, 118         672, 831         195, 610         497, 577         4, 945, 136           ANCI LLARY SERVICE COST CENTERS          1, 050, 305         218, 995         169, 536         98, 373         1, 537, 209         50. 00           54. 00         05900         CARDI ALGOST LC         621, 498         0         1, 1067, 976         374, 584         5, 035, 433         59. 00         05900         CARDI AC CATHETERI ZATI ON         3, 096, 713         496, 160         1, 067, 976         374, 584         5, 035, 433         59. 00         0         0         1, 878, 688         60. 0         0         0         1, 878, 688         60. 0         0         0         1, 878, 688         60. 0         0         0         1, 878, 688         60. 0         0         0         1, 878, 688         60. 0         0         0         0         1, 878, 688         60. 0         0         0         0         1, 878, 688         60. 0         0         0         0         0         0         1, 878, 688         60. 0         0         0         0, 57, 577         66. 0         0         0         0         57, 577         66. 0         0	16.00		521, 628	0		0 0	521, 628	16.00
30.00       03000 ADULTS & PEDIATRICS       3, 579, 118       672, 831       195, 610       497, 577       4, 945, 136       30.0         ANCILLARY SERVICE COST CENTERS	17.00		171, 224	0		0 0	171, 224	17.00
ANCILLARY SERVICE COST CENTERS           50. 00         05000         DPERATING ROOM         1,050,305         218,995         169,536         98,373         1,537,209         50. 00           54. 00         05400         RADILLARY SERVICE COST CENTERS         0         11,689         633,187         54. 00           59. 00         05500         CARDIAC CATHETERIZATION         3,096,713         496,160         1,067,976         374,584         5,035,433         59. 00           60. 00         06400         IABRARDAY         1,878,688         0         0         1,878,688         60. 00           0         06400         INTRAVENDUS THERAPY         496,339         0         18,102         71,996         586,437         64. 00           66. 00         06500         RESPI RATORY THERAPY         492,311         0         0         0         57,577         6. 00         0         0         57,577         66. 00         69. 00         06902         CARDIA CREHAB         386,241         0         54,145         54,200         494,586         69. 00           71. 00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         3,796,062         0         0         3,796,062         0         0         71. 00         <			r					
50.00       05000       OPERATI NG ROM       1,050,305       218,995       169,536       98,373       1,537,209       50.0         54.00       05400       RADI OLOGY-DI AGNOSTI C       621,498       0       0       11,689       633,187       54.0         60.00       06000       LABORATORY       3,096,713       496,160       1,067,976       374,584       50,305,433       59.0         60.00       06000       LABORATORY       1,878,688       0       0       0       1,878,688       60.0         64.00       06400       INTRAVENOUS THERAPY       496,339       0       18,102       71,996       586,437       64.0         65.00       06500       RESPI RATORY THERAPY       496,339       0       0       0       57,577       6.0       0       67,577       66.00       0       6902       6902       6902       6902       6902       690       1,495,228       69.0       6902       690       6902       6902       6902       690       0       0       3,796,662       71.0       0       0       3,796,662       71.0       0       0       0       1,751,185       72.00       7300       0       0       1,751,185       0       0	30.00		3, 579, 118	672, 831	195, 61	10 497, 577	4, 945, 136	30.00
54.00       05400       RADI OLOGY-DI AGNOSTI C       621, 498       0       0       11, 689       633, 187       54.0         59.00       05900       CARDI AC CATHETERI ZATI ON       3, 096, 713       496, 160       1, 067, 976       374, 584       50.035, 433       59.0         60.00       06000       LABORATORY       1, 878, 688       0       0       1, 878, 688       0       0       1, 878, 688       60.0         64.00       06500       RESPI RATORY THERAPY       482, 311       0       0       482, 311       65.00         66.00       06500       RESPI RATORY THERAPY       57, 577       0       0       482, 311       65.00         06.00       06900       ELECTROCARDI OLOGY       911, 042       211, 859       269, 481       102, 846       1, 445, 226       69.0         06900       CARDI AC REHAB       366, 241       0       54, 145       54, 200       494, 586       69.0         07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       3, 796, 062       0       0       3, 796, 062       0       0       3, 796, 062       0       0       1, 751, 185       72.0         72.00       07400       RENAL DI ALYSIS       31, 443       0       16, 77			1 050 005	010.005	1 1 1 2 5		4 503 000	
59.00       05900       CARDI AC CATHETERI ZATI ON       3,096,713       496,160       1,067,976       374,584       5,035,433       59.0         60.00       06000       LABORATORY       1,878,688       0       0       0       1,878,688       60.0         64.00       06400       INTRAVENOUS THERAPY       496,339       0       18,102       71,996       586,437       64.0         65.00       06500       RESPI RATORY THERAPY       482,311       0       0       482,311       66.0         66.00       06600       PHYSI CAL THERAPY       57,577       0       0       0       57,577       66.0         69.01       06900       ELECTROCARDI OLOGY       911,042       211,859       269,481       102,846       1,495,228       69.0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       3,766,062       0       0       0       3,796,062       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       1,751,185       0       0       0       1,751,757       6.0       0       0       1,751,757       6.0       0       0       0       0       71.0       72.00       0       0       0       0       7				218, 995	169, 53			
60.00         06000         LABORATORY         1,878,688         0         0         1,878,688         60.0           64.00         06400         INTRAVENOUS THERAPY         496,339         0         18,102         71,996         586,437         64.0           65.00         06500         RESPI RATORY THERAPY         482,311         0         0         482,311         65.00           0         06600         PHYSI CAL THERAPY         57,577         0         0         0         482,311         65.00           69.00         06902         CARDI AC REHAB         386,241         0         54,145         54,200         494,586         69.0           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         3,796,062         0         0         3,796,062         71.0           73.00         07300         DRUSC CHARGED TO PATI ENTS         1,751,185         0				0	1 0/7 0			
64.00       06400       INTRAVENOUS THERAPY       496, 339       0       18, 102       71, 996       586, 437       64, 0         65.00       06500       RESPI RATORY THERAPY       482, 311       0       0       482, 311       65.00         66.00       06600       PHSYI CAL THERAPY       57, 577       0       0       0       57, 577       66.00         69.00       06900       ELECTROCARDI OLOGY       911, 042       211, 859       269, 481       102, 846       1, 495, 228       69.00         69.01       06902       CARDI AC REHAB       386, 241       0       54, 145       54, 200       494, 586       69.00         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       3, 796, 062       0       0       0       8, 281, 453       0       0       0       8, 281, 453       0       0       0       8, 281, 453       72.00       0       0       0       0       0       73.00       03020       DTHER ANCI LARY SERVICE COST CENTERS       31, 443       0       16, 779       2, 466       50, 688       74.00       76.00       0       0       0       0       0       0       0       0       0       0       0       0       0					1,067,9	/6 3/4,584		
65.00       06500       RESPI RATORY THERAPY       482, 311       0       0       0       482, 311       65.00         66.00       06600       PHYSI CAL THERAPY       57, 577       0       0       0       57, 577       66.0         69.01       06900       ELECTROCARDI OLOGY       911, 042       211, 859       269, 481       102, 846       1, 495, 528       69.0         69.01       06902       CARDI AC REHAB       386, 241       0       54, 145       54, 200       494, 586       69.0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       3, 796, 062       0       0       3, 796, 062       71.0         73.00       07300       DRUS CHARGED TO PATI ENTS       1, 751, 185       0       0       1, 751, 185       73.0         74.00       07400       RENAL DI ALYSI S       31, 443       0       16, 779       2, 466       50, 688       74.0         74.00       07900       OBZOO IMBER SUTION BEDS (NON-DI STINCT PART)       0       0       0       0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70				°	10.10	0 71 00		1
66.00         06600         PHYSI CAL THERAPY         57, 577         0         0         0         57, 577         66.0           69.00         06900         ELECTROCARDI OLOGY         911, 042         211, 859         269, 481         102, 846         1, 495, 228         69.0           69.01         06902         CARDI AC REHAB         386, 241         0         54, 145         54, 200         494, 586         69.0           71.00         OT100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         3, 796, 062         0         0         3, 796, 062         71.0           72.00         07200         IMPL.         DEV. CHARGED TO PATIENTS         3, 796, 062         0         0         0         8, 281, 453         72.0           73.00         07300         DRUGS CHARGED TO PATIENTS         1, 751, 185         0         0         0         1, 751, 185         73.0           74.00         07400         RENAL DI ALYSIS         31, 443         0         16, 779         2, 466         50, 688         74.0           70.00         O2020         DESERVATI ON BEDS (NON-DI STINCT PART)				-	18, 10			
69.00         06900         ELECTROCARDIOLOGY         911,042         211,859         269,481         102,846         1,495,228         69.0           69.01         06902         CARDIAC REHAB         386,241         0         54,145         54,200         494,586         69.0           71.00         O7100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         3,796,062         0         0         0         3,796,062         71.0           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         8,281,453         0         0         0         8,281,453         72.0           73.00         07300         RENAL DI ALYSI S         1,751,185         0         0         0         1,751,85         73.0           74.00         07400         RENAL DI ALYSI S         31,443         0         16,779         2,466         50,688         74.0           76.00         09200         DISERVATI ON BEDS (NON-DI STINCT PART)         0         0         0         0         0         0         0         20.0         0         20.0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0				-		-		
69.01       06902       CARDI AC REHAB       386, 241       0       54, 145       54, 200       494, 586       69.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       3, 796, 062       0       0       0       3, 796, 062       71.0         72.00       07200       IMPL.       DEV. CHARGED TO PATIENT       8, 281, 453       0       0       0       8, 281, 453       72.0         73.00       07300       RUGS CHARGED TO PATIENTS       1, 751, 185       0       0       0       1, 751, 185       73.0         74.00       07400       RENAL DI ALYSIS       31, 443       0       16, 779       2, 466       50, 688       74.0         76.00       03020       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0       76.0         92.00       OBSERVATI ON BEDS (NON-DI STINCT PART)        0       0       0       0       76.0         SPECIAL PURPOSE COST CENTERS       0       0       0       0       0       0       18.0         NONREI MBURSABLE COST CENTERS       0       0       0       0       24, 289       194.0       194.0       194.0       194.0       194.0       194.0				0	0/0 //	-		
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       3,796,062       0       0       3,796,062       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       8,281,453       0       0       0       8,281,453       72.0         73.00       07300       DRUGS CHARGED TO PATI ENTS       1,751,185       0       0       0       1,751,185       73.0         74.00       07400       RENAL DI ALYSI S       31,443       0       16,779       2,466       50,688       74.0         03020       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0       0       76.0         09200       DBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       0       0       70.0         92.00       OP500       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       148.0       1, 644, 361       1, 914, 665       1, 346, 453       39, 208, 615       118.0         194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       194.0         194.01       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       24, 289       194.0								
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENT         8, 281, 453         0         0         8, 281, 453         72.0           73.00         07300         DRUGS CHARGED TO PATIENTS         1, 751, 185         0         0         0         1, 751, 185         73.0           74.00         07400         RENAL DI ALYSI S         31, 443         0         16, 779         2, 466         50, 688         74.0           76.00         03020         OTHER ANCILLARY SERVICE COST CENTERS         0         <				-	54, 14			1
73.00       07300       DRUGS CHARGED TO PATIENTS       1,751,185       0       0       1,751,185       73.0         74.00       07400       RENAL DI ALYSI S       31,443       0       16,779       2,466       50,688       74.0         76.00       03020       OTHER ANCI LLARY SERVICE COST CENTERS       0		0/100 MEDICAL SUPPLIES CHARGED TO PATIENTS						1
74.00       07400       RENAL DI ALYSI S       31, 443       0       16, 779       2, 466       50, 688       74.0         76.00       03020       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0       0       76.00         00TPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0       0       76.00         09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       0       92.0         SPECI AL PURPOSE COST CENTERS        92.00       SUBTOTALS (SUM OF LINES 1-117)       39, 208, 615       1, 644, 361       1, 914, 665       1, 346, 453       39, 208, 615       118.00         NONRE I MBURSABLE COST CENTERS       0       0       0       0       194.00         194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       194.00         194.02       07952       PUBLI C RELATI ONS       12, 357       0       0       24, 289       194.00         194.03       07953       DEACONES HOSPI TAL       3, 985       0       0       3, 985       194.00       0       200.00       0       3, 985       0       0       200.00       0       200.00				-		-		
76.00         03020         OTHER ANCILLARY SERVICE COST CENTERS         0         0         0         0         0         0         0         76.0         0           0UTPATI ENT SERVICE COST CENTERS         0         0         0         0         0         0         0         0         92.0         92.0         92.0         92.0         0         92.0         0         92.0				-				
OUTPATI ENT SERVICE COST CENTERS         0         0         92.00         9200 OBSERVATI ON BEDS (NON-DI STINCT PART)         92.00				-				
92.00       09200   OBSERVATI ON BEDS (NON-DI STINCT PART)       0       92.0         SPECI AL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       39,208,615       1,644,361       1,914,665       1,346,453       39,208,615       118.0         NONREI MBURSABLE COST CENTERS         194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       194.0         194.01       07950       VI SI TOR ASSI STANTS       24,289       0       0       0       24,289       194.0         194.02       07952       PUBLIC RELATIONS       12,357       0       0       12,357       194.0         194.03       07953       DEACONESS HOSPI TAL       3,985       0       0       3,985       194.0         200.00       Cross Foot Adj ustments       0       0       0       200.0       0       200.0         201.00       Negative Cost Centers       0       0       0       0       201.0	/6.00		0	0		0 0	0	/6.00
118.00         SUBTOTALS (SUM OF LINES 1-117)         39, 208, 615         1, 644, 361         1, 914, 665         1, 346, 453         39, 208, 615         118.0           NONREI MBURSABLE COST CENTERS         0         0         0         0         0         194.0         0         194.0         0         0         0         0         194.0         0         194.0         0         0         0         0         0         194.0         0         194.0         0         0         0         0         0         194.0         0         194.0         0         0         0         0         0         194.0         0         0         0         0         0         0         0         194.0         0         0         0         0         24, 289         194.0         0         0         0         24, 289         194.0         0         0         0         12, 357         194.0         0         0         12, 357         194.0         0         3, 985         194.0         0         0         3, 985         194.0         0         200.0         0         200.0         0         200.0         0         200.0         0         200.0         0         200.0         <	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
NONREI MBURSABLE         COST         CENTERS           194.00         07950         OTHER         NONREI MBURSABLE         COST         CENTERS         0         0         0         194.0           194.01         07951         VI SI TOR         ASSI STANTS         24, 289         0         0         0         24, 289         194.0           194.02         07952         PUBLI C         RELATI ONS         12, 357         0         0         0         12, 357         194.0           194.03         07953         DEACONESS HOSPI TAL         3, 985         0         0         3, 985         0         0         200.0         201.00         Vegative Cost Centers         0         0         0         201.0	118.00		39, 208, 615	1, 644, 361	1, 914, 66	1, 346, 453	39, 208, 615	118.00
194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       194.0         194.01       07951       VI SI TOR ASSI STANTS       24, 289       0       0       24, 289       194.0         194.02       07952       PUBLI C RELATI ONS       12, 357       0       0       12, 357       194.0         194.03       07953       DEACONESS HOSPI TAL       3, 985       0       0       3, 985       194.0         200.00       Cross Foot Adj ustments       0       0       0       0       200.0         201.00       Negati ve Cost Centers       0       0       0       0       201.0	2. 50		, , , , , , , , , , , , , , , , , , , ,	, ,	,,.	10.01100	, 200, 510	1
194.01       07951       VI SI TOR ASSI STANTS       24, 289       0       0       24, 289       194.0         194.02       07952       PUBLI C RELATI ONS       12, 357       0       0       12, 357       194.0         194.03       07953       DEACONESS HOSPI TAL       3, 985       0       0       3, 985       194.0         200.00       Cross Foot Adj ustments       0       0       0       0       200.0         201.00       Negati ve Cost Centers       0       0       0       0       201.0	194.00		0	0		0 0	0	194.00
194.02       07952       PUBLI C RELATIONS       12, 357       0       0       12, 357       194.0         194.03       07953       DEACONESS HOSPITAL       3, 985       0       0       0       3, 985       194.0         200.00       Cross Foot Adjustments       0       0       0       0       200.0         201.00       Negative Cost Centers       0       0       0       0       0       201.0			24, 289	0		0 0	24, 289	194.01
194.03         07953         DEACONESS HOSPITAL         3,985         0         0         3,985         194.0           200.00         Cross Foot Adjustments         0         0         0         200.0           201.00         Negative Cost Centers         0         0         0         0         0         201.0				0		0 0		
200.00         Cross Foot Adjustments         0         0         0         200.00           201.00         Negative Cost Centers         0         0         0         0         0         0         201.00				0		0 0		
201.00         Negative Cost Centers         0         0         0         0         0         0         201.0								
		5		0		0 0		
	202.00		39, 249, 246	1, 644, 361	1, 914, 66	5 1, 346, 453	39, 249, 246	202.00

Heal th	Financial Systems HEAR	RT HOSPITAL AT I	DEACONESS GATEV	VAY	In Lie	u of Form CMS-	2552-10
	ALLOCATION - GENERAL SERVICE COSTS				Period: From 10/01/2013 To 09/30/2014	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	2/26/2015 5:0 DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1 1.00
2.00	00200 NEW CAP REL COSTS MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL	5, 398, 727					5.00
7.00	00700 OPERATION OF PLANT	75,008					7.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	13, 283			4		8.00
8.00 9.00	00900 HOUSEKEEPING	30, 869		96, 56	0 226, 780		9.00
							1
10.00	01000 DI ETARY	36, 046			0	262, 057	1
11.00		12, 590			0 0	0	
13.00	01300 NURSING ADMINISTRATION	11, 764	0		0 0	0	1
14.00	01400 CENTRAL SERVICES & SUPPLY	37, 512	0		0 0	0	
15.00	01500 PHARMACY	116, 553	0		0 0	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	83, 193	0		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	27, 308	0		0 0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	788, 685	228, 346	62, 09	9 95, 375	255, 509	30.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	245, 165	74, 322	1, 19	9 31, 043	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	100, 985	0		0 0	0	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	803, 086	168, 386	28, 36	8 70, 331	6, 548	59.00
60.00	06000 LABORATORY	299, 626	0		0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	93, 529	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	76, 922	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	9, 183	l o		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	238, 469		4, 90	30, 031	0	1
69.01	06902 CARDI AC REHAB	78, 880	0	.,	0 0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	605, 423	0		0 0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 320, 792	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	279, 291	0		0 0	0	1
74.00	07400 RENAL DI ALYSI S	8,084	0		0 0	0	
76.00	03020 OTHER ANCI LLARY SERVICE COST CENTERS	0,001	0		0 0	0	
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	0 0		/0.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		5, 392, 246	545, 313	96, 56	6 226, 780	262, 057	1118 00
110.00	NONREI MBURSABLE COST CENTERS	5, 372, 240	545, 515	90, 50	220,700	202, 037	1118.00
104 00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
	07950 UTHER NUNRETMBURSABLE CUST CENTERS	-			0 0		
		3,874					194.01
	207952 PUBLIC RELATIONS	1,971	0		0 0		194.02
	07953 DEACONESS HOSPI TAL	636	0		0	0	194.03
200.00	5	-	-			-	200.00
201.00		0	0	a	0		201.00
202.00	)   TOTAL (sum lines 118-201)	5, 398, 727	545, 313	96, 56	6 226, 780	262, 057	J202. 00

Heal th	Financial Systems HEAR	T HOSPITAL AT	DEACONESS GATEW	IAY	In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150175	Peri od:	Worksheet B	
					From 10/01/2013	Part I	
					To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	cost center bescription		ADMI NI STRATI ON	SERVICES &	THANWACT	RECORDS &	
				SUPPLY		LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
1.00	00100 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
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	91, 529					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	91, 329	85, 527				13.00
13.00	01400 CENTRAL SERVICES & SUPPLY		05, 527	272, 71	2		14.00
14.00	01500 PHARMACY	0	0	272,71			14.00
16.00			0	40		604 001	
16.00	01600 MEDICAL RECORDS & LIBRARY		0		0 0	604, 821	
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.00
30, 00	03000 ADULTS & PEDIATRICS	40, 860	20 502	2.15	7 0	47 502	200.00
30.00	ANCI LLARY SERVICE COST CENTERS	40, 800	38, 582	3, 17	7 0	47, 503	30.00
50.00	05000 OPERATI NG ROOM	7, 578	7, 147		0 0	62, 909	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	892	7, 147		0 0	35, 430	
59.00	05900 CARDI AC CATHETERI ZATI ON	24, 740	23, 345	1, 58		176, 337	
60.00	06000 LABORATORY	24,740	23, 345	1, 56	0 0	39, 979	
64.00	06400 I NTRAVENOUS THERAPY	4, 606	4, 335	58		5, 719	
65.00	06500 RESPIRATORY THERAPY	4,000	4, 335	1		8, 458	
66.00	06600 PHYSI CAL THERAPY		0		0 0	3, 809	
69.00	06900 ELECTROCARDI OLOGY	7, 801	-	1 20	-		
69.00	06902 CARDI AC REHAB	4, 903	7, 356 4, 606	1, 30	7 0	66, 121	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,903	4, 000			3, 517	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	80, 63		38, 255 75, 276	
		0	-	184, 90			
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 847, 810	40, 850	
74.00	07400 RENAL DIALYSIS	149	156		0 0	658	
76.00	03020 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	76.00
92.00	OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART)						00.00
92.00							92.00
110 00	SPECIAL PURPOSE COST CENTERS	01 500	05 527	272 71	( 047.010	(04.021	110 00
118.00		91, 529	85, 527	272, 71	6 847, 810	604, 821	118.00
104 00	NONREI MBURSABLE COST CENTERS	0	0		0 0	0	104 00
	07950 OTHER NONREI MBURSABLE COST CENTERS		0				194.00
	07951 VI SI TOR ASSI STANTS 07952 PUBLI C RELATI ONS		0				194.01
		0	0				194.02
	07953 DEACONESS HOSPI TAL	0	0		0	0	194.03
200.00	5					_	200.00
201.00	5			777 74	4 947 910		201.00
202.00	TOTAL (sum lines 118-201)	91, 529	85, 527	272, 71	6 847, 810	604, 821	1202. UU

ST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150175	Period:	Worksheet B	
				From 10/01/2013 To 09/30/2014	Part I Date/Time Pre 2/26/2015 5:0	pare
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments			
	17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS						
00 00100 NEW CAP REL COSTS-BLDG & FLXT 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.
00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.
00 00500 ADMINI STRATI VE & GENERAL						5.
00 00700 OPERATION OF PLANT						7
00 00800 LAUNDRY & LINEN SERVICE						8
00 00900 HOUSEKEEPI NG						9
. 00 01000 DI ETARY						10
. 00 01100 CAFETERI A						11
. 00 01300 NURSING ADMINISTRATION						13
. 00 01400 CENTRAL SERVICES & SUPPLY						14
. 00 01500 PHARMACY						15
. 00 01600 MEDICAL RECORDS & LIBRARY						16
. 00 01700 SOCIAL SERVICE	198, 532					17
INPATIENT ROUTINE SERVICE COST CENTERS						
. 00 03000 ADULTS & PEDIATRICS	193, 573	6, 698, 845		0 6, 698, 845		30
ANCILLARY SERVICE COST CENTERS						
. 00 05000 OPERATI NG ROOM	0	1, 966, 572		0 1, 966, 572		50
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	770, 494		0 770, 494		54
. 00 05900 CARDI AC CATHETERI ZATI ON	4, 959	6, 343, 118		0 6, 343, 118		59
. 00 06000 LABORATORY	0	2, 218, 293		0 2, 218, 293		60
. 00 06400 I NTRAVENOUS THERAPY	0	695, 207		0 695, 207		64
. 00 06500 RESPI RATORY THERAPY	0	567, 702		0 567, 702		65
00 06600 PHYSI CAL THERAPY	0	70, 569		0 70, 569		66
. 00 06900 ELECTROCARDI OLOGY	0	1, 923, 115		0 1, 923, 115		69
01 06902 CARDI AC REHAB	0	586, 549		0 586, 549		69
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	4, 520, 376		0 4, 520, 376		71
. 00 07200 IMPL. DEV. CHARGED TO PATIENT . 00 07300 DRUGS CHARGED TO PATIENTS	0	9, 862, 423 2, 919, 136		0 9, 862, 423 0 2, 919, 136		72
. 00 07300 DRUGS CHARGED TO PATTENTS	0	2, 919, 130		0 2, 919, 130		74
. 00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	59,735 0		0 59,735		76
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0 0		- '0
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92
SPECIAL PURPOSE COST CENTERS			I	0		1 12
8.00 SUBTOTALS (SUM OF LINES 1-117)	198, 532	39, 202, 134		0 39, 202, 134		1118
NONREI MBURSABLE COST CENTERS	170,002	57, 202, 104	1	5,202,104		1.10
4. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194
4. 01 07951 VI SI TOR ASSI STANTS	0	28, 163		0 28, 163		194
4. 02 07952 PUBLIC RELATIONS	0	14, 328		0 14, 328		194
4. 03 07953 DEACONESS HOSPI TAL	0	4, 621		0 4,621		194
0.00 Cross Foot Adjustments		0		0 0		200
1.00 Negative Cost Centers	0	0		0 0		200
2.00 TOTAL (sum Lines 118-201)	198, 532	39, 249, 246		0 39, 249, 246		202

Health Financial Systems		T HOSPITAL AT D				u of Form CMS-	2552-1
ALLOCATION OF CAPITAL RELATED	0515		Provi der	1	Period: From 10/01/2013 Fo 09/30/2014	Worksheet B Part II Date/Time Pre	pared:
						2/26/2015 5:0	0 pm
			CAPI TAL REL	LATED COSTS			
Cost Center Descr	intion	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	i per on	Assigned New	FLXT	EQUI P	50510101	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CE							1
1.00 00100 NEW CAP REL COSTS 2.00 00200 NEW CAP REL COSTS							1.0
4.00 00400 EMPLOYEE BENEFITS		0	0			0	
5.00 00500 ADMINISTRATIVE &		0	18, 412	122, 442	2 140, 854	0	
7.00 00700 OPERATION OF PLAN		0	19, 153		140, 854	0	
B. 00 00800 LAUNDRY & LINEN S		0	17, 155		0 0	0	
9. 00 00900 HOUSEKEEPI NG		0	6, 951		6, 951	0	
10. 00 01000 DI ETARY		0	0,701		0 0	0	
11. 00 01100 CAFETERIA		0	0			0	
13.00 01300 NURSING ADMINISTR	ATLON	0	0		4 594	0	
14.00 01400 CENTRAL SERVICES		0	0		0 0	0	
15.00 01500 PHARMACY		0	0	(	0 0	0	
6.00 01600 MEDICAL RECORDS 8	LI BRARY	0	0	(	0 0	0	
17.00 01700 SOCIAL SERVICE		0	0	(	0 0	0	17.0
INPATIENT ROUTINE SERVI	CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRI		0	672, 831	195, 610	868, 441	0	30.0
ANCI LLARY SERVICE COST	CENTERS	1					-
50.00 05000 OPERATING ROOM		0	218, 995			0	
54.00 05400 RADI OLOGY-DI AGNOS		0	0		0 0	0	
59.00 05900 CARDI AC CATHETERI	ZATION	0	496, 160	1, 067, 970	5 1, 564, 136	0	
50. 00 06000 LABORATORY 54. 00 06400 I NTRAVENOUS THERA	DV	0	0	10 10	0 10 10 10 10 10 10 10 10 10 10 10 10 10	0	
54. 00 06400 I NTRAVENOUS THERA 55. 00 06500 RESPI RATORY THERA		0	0		2 18, 102 0 0	0	
56. 00 06600 PHYSI CAL THERAPY	AF I	0	0			0	
59. 00 06900 ELECTROCARDI OLOGY	,	0	211, 859		5	0	
59. 01 06902 CARDI AC REHAB		0	211,007			0	
1.00 07100 MEDICAL SUPPLIES	CHARGED TO PATIENTS	0	0			0	
2.00 07200 I MPL. DEV. CHARGE		0	0	(	0 0	0	
73.00 07300 DRUGS CHARGED TO		0	0	(	0 0	0	
74.00 07400 RENAL DIALYSIS		0	0	16, 779	9 16, 779	0	74.0
76.00 03020 OTHER ANCILLARY S	ERVICE COST CENTERS	0	0		0 0	0	76. C
OUTPATIENT SERVICE COST							
92.00 09200 OBSERVATION BEDS SPECIAL PURPOSE COST CE					0		92.0
118.00 SUBTOTALS (SUM OF		0	1, 644, 361	1, 914, 66	5 3, 559, 026	0	1118. C
NONREI MBURSABLE COST CE		0	1, 044, 301	1, 714, 003	5, 557, 020	0	110.0
194. 00 07950 OTHER NONREI MBURS		0	0	(	0 0	0	1 194. c
194. 01 07951 VI SI TOR ASSI STANT		0	0		0 0		194.0
194. 02 07952 PUBLIC RELATIONS	-	0	0				194.0
94. 03 07953 DEACONESS HOSPI TA	AL.	0	0		0 0		194. (
200.00 Cross Foot Adjust					0	0	200. 0
201.00 Negative Cost Cer			0		o o	0	201. C
202.00 TOTAL (sum lines		0	1, 644, 361	1, 914, 66	3, 559, 026		202. C

Heal th	Financial Systems HEAF	RT HOSPITAL AT E	DEACONESS GATE	VAY	Inlie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS				Period:	Worksheet B	2002 10
				1	From 10/01/2013		
					To 09/30/2014	Date/Time Pre 2/26/2015 5:0	pared:
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	0 pili
	Cost center bescription	& GENERAL	PLANT	LINEN SERVICE		DILIARI	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
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
5.00	00500 ADMINISTRATIVE & GENERAL	140, 854					5.00
7.00	00700 OPERATION OF PLANT	1, 957	21, 110				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	347	0	34	7		8.00
9.00	00900 HOUSEKEEPI NG	805	91		7, 847		9.00
10.00	01000 DI ETARY	940	0		0 0	940	10.00
11.00	01100 CAFETERI A	328	0		0 0	0	11.00
13.00	01300 NURSING ADMINISTRATION	307	0		0 0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	979	0		0 0	0	14.00
15.00	01500 PHARMACY	3, 041	0		0 0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	2, 170	0		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	712	0		0 0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	·					1
30.00	03000 ADULTS & PEDIATRICS	20, 577	8, 840	22	3 3, 300	917	30.00
	ANCILLARY SERVICE COST CENTERS			•			1
50.00	05000 OPERATI NG ROOM	6, 396	2, 877		4 1, 074	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2,635	0		0 0	0	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	20, 952	6, 519	10	2 2, 434	23	59.00
60.00	06000 LABORATORY	7,817	0		0 0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	2,440	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	2,007	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	240	0		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	6, 222	2, 783	1	3 1, 039	0	69.00
69.01	06902 CARDI AC REHAB	2,058	0		0 0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 795	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	34, 462	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,287	0		0 0	0	73.00
74.00	07400 RENAL DIALYSIS	211	0		0 0	0	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		140, 685	21, 110	34	7 7, 847	940	118.00
	NONREI MBURSABLE COST CENTERS						
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.00
	07951 VI SI TOR ASSI STANTS	101	0		0 0		194.01
	07952 PUBLIC RELATIONS	51	0		0 0		194. 02
	07953 DEACONESS HOSPI TAL	17	0		0 0	0	194. 03
200.00	,						200.00
201.00	5	0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	140, 854	21, 110	34	7 7, 847	940	202.00

Heal th	Financial Systems HEAR	T HOSPITAL AT I	DEACONESS GATEW	ΙAΥ	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS	_	Provi der	CCN: 150175	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part II Date/Time Pre 2/26/2015 5:0	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL 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 & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	328					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	901				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	201	97	0		14.00
15.00	01500 PHARMACY	0	0	77	2 3, 043		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		0		2 3,043	2, 170	
17.00	01700 SOCIAL SERVICE	0	0		0 0		
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	0	17.00
30, 00	03000 ADULTS & PEDIATRICS	145	406		1 0	174	20.00
30.00	ANCI LLARY SERVICE COST CENTERS	145	406		1 0	1/4	30.00
50, 00	05000 OPERATING ROOM	27	75		0 0	230	50.00
50.00 54.00	05000 OPERATING ROOM 05400 RADI OLOGY-DI AGNOSTI C	3	/5		0 0		
		-	-			129	
59.00	05900 CARDI AC CATHETERI ZATI ON	89	246		-	604	
60.00	06000 LABORATORY	0	0		0 0	146	
64.00	06400 I NTRAVENOUS THERAPY	17	46		2 0	21	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	31	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	14	
69.00	06900 ELECTROCARDI OLOGY	28			5 0	242	
69.01	06902 CARDI AC REHAB	18	49		0 0	13	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	28		140	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	66		275	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 043	149	
74.00	07400 RENAL DI ALYSI S	1	2		0 0	2	
76.00	03020 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		328	901	97	9 3, 043	2, 170	118.00
	NONREI MBURSABLE COST CENTERS						
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.00
194.01	07951 VI SI TOR ASSI STANTS	0	0		0 0	0	194.01
194.02	07952 PUBLIC RELATIONS	0	0		0 0	0	194. 02
194.03	07953 DEACONESS HOSPI TAL	0	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)	328	901	97	9 3, 043	2, 170	202.00

	i nanci al Systems HEAI ON OF CAPI TAL RELATED COSTS	RT HOSPITAL AT DE		CCN: 150175		ri od:	u of Form CMS Worksheet B	
					Fro To	om 10/01/2013 09/30/2014	Part II Date/Time Pr	epared:
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &		Total	2/26/2015 5:	00 pm
	Cost center bescription	SOUTHE SERVICE	Subtotal	Residents Co	st	iotai		
				& Post	,31			
				Stepdown				
				Adjustments	s			
		17.00	24.00	25.00	-	26.00		
GE	ENERAL SERVICE COST CENTERS							
1.00 00	D100 NEW CAP REL COSTS-BLDG & FIXT							1.00
2.00 00	D200 NEW CAP REL COSTS-MVBLE EQUIP							2.00
4.00 00	D400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5.00 00	D500 ADMINI STRATI VE & GENERAL							5.00
7.00 00	0700 OPERATION OF PLANT							7.00
8.00 00	D800 LAUNDRY & LINEN SERVICE							8.00
	D900 HOUSEKEEPI NG							9.00
10.00 01	1000 DI ETARY							10.00
11.00 01	1100 CAFETERI A							11.00
13.00 01	1300 NURSING ADMINISTRATION							13.00
14.00 01	1400 CENTRAL SERVICES & SUPPLY							14.00
15.00 01	1500 PHARMACY							15.00
16.00 01	1600 MEDICAL RECORDS & LIBRARY							16.00
17.00 01	1700 SOCIAL SERVICE	712						17.00
LN	NPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03	3000 ADULTS & PEDIATRICS	694	903, 728	8	0	903, 728		30.00
AN	NCILLARY SERVICE COST CENTERS							
	5000 OPERATI NG ROOM	0	399, 214	Ļ	0	399, 214		50.00
	5400 RADI OLOGY-DI AGNOSTI C	0	2, 767	r	0	2, 767		54.00
59.00 05	5900 CARDI AC CATHETERI ZATI ON	18	1, 595, 129		0	1, 595, 129		59.00
60.00 06	5000 LABORATORY	0	7, 963	5	0	7, 963		60.00
	5400 INTRAVENOUS THERAPY	0	20, 628	8	0	20, 628		64.00
	5500 RESPI RATORY THERAPY	0	2, 038		0	2, 038		65.00
	5600 PHYSI CAL THERAPY	0	254		0	254		66.00
	5900 ELECTROCARDI OLOGY	0	491, 754		0	491, 754		69.00
	5902 CARDI AC REHAB	0	56, 283		0	56, 283		69.01
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16, 224		0	16, 224		71.00
	7200 IMPL. DEV. CHARGED TO PATIENT	0	35, 401		0	35, 401		72.00
	7300 DRUGS CHARGED TO PATIENTS	0	10, 479		0	10, 479		73.00
	7400 RENAL DI ALYSI S	0	16, 995		0	16, 995		74.00
	3020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	)	0	0		76.00
	JTPATIENT SERVICE COST CENTERS							
	9200 OBSERVATION BEDS (NON-DISTINCT PART)				0			92.00
	PECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	712	3, 558, 857		0	3, 558, 857		118.00
	ONREI MBURSABLE COST CENTERS			1				
	7950 OTHER NONREI MBURSABLE COST CENTERS	0	C		0	0		194.00
	7951 VI SI TOR ASSI STANTS	0	101		0	101		194.01
	7952 PUBLIC RELATIONS	0	51		0	51		194.02
	7953 DEACONESS HOSPI TAL	0	17		0	17		194.03
200.00	Cross Foot Adjustments		0		0	0		200. 00
201.00	Negative Cost Centers	0	0		0	0		201.00
202.00	TOTAL (sum lines 118-201)	712	3, 559, 026	1	0	3, 559, 026		202.00

## HEART HOSPITAL AT DEACONESS GATEWAY

In Lieu of Form CMS-2552-10

GENERAL         SERVI (1)           1.00         00100         NEW CAP           2.00         00200         NEW CAP           2.00         00200         NEW CAP           4.00         00400         EMPLOYEE           5.00         00500         ADMI NI ST           7.00         00700         OPERATIO           8.00         00300         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         0700         SOCI AL           30.00         03000         ADULTS           30.00         03000         ADULTS           30.00         05000         OPERATI N           54.00         05400         RADI AC           55.00         05000         CARDI AC           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06600         LABORATT <th>- STATISTICAL BASIS Center Description RVICE COST CENTERS CAP REL COSTS-BLDG &amp; FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE &amp; GENERAL ATION OF PLANT DRY &amp; LINEN SERVICE</th> <th>CAPI TAL REL NEW BLDG &amp; FI XT (SQUARE FEET) 1.00 53, 229 0</th> <th>ATED COSTS NEW MVBLE EQUI P (DEPRECI ATI ON COST) 2.00</th> <th>Fi Ta</th> <th>eriod: rom 10/01/2013 o 09/30/2014 Reconciliation</th> <th>Worksheet B-1 Date/Time Prep 2/26/2015 5:00 ADMI NI STRATI VE &amp; GENERAL (ACCUM. COST)</th> <th></th>	- STATISTICAL BASIS Center Description RVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT DRY & LINEN SERVICE	CAPI TAL REL NEW BLDG & FI XT (SQUARE FEET) 1.00 53, 229 0	ATED COSTS NEW MVBLE EQUI P (DEPRECI ATI ON COST) 2.00	Fi Ta	eriod: rom 10/01/2013 o 09/30/2014 Reconciliation	Worksheet B-1 Date/Time Prep 2/26/2015 5:00 ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
GENERAL         SERVI 0           1.00         00100         NEW CAP           2.00         00200         NEW CAP           4.00         00400         EMPLOYEE           5.00         00500         ADMI NI ST           7.00         00700         OPERATIO           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         03000         ADULTS           30.00         03000         ADULTS           30.00         03000         ADULTS           30.00         05000         OPERATIN           54.00         05400         RADI AL           30.00         05000         OPERATIN           54.00         05400         RADI AL           66.00         06400         INTRAVEN           65.00         05900         CARDI AC           71.00         07400         RENAL	RVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	NEW BLDG & FIXT (SQUARE FEET) 1.00 53,229	NEW MVBLE EQUI P (DEPRECI ATI ON COST) 2.00	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	o 09/30/2014 Reconciliation	2/26/2015 5: 00 ADMI NI STRATI VE & GENERAL (ACCUM.	
GENERAL         SERVI 0           1.00         00100         NEW CAP           2.00         00200         NEW CAP           2.00         00400         EMPLOYEE           5.00         00500         ADMI NI ST           7.00         00700         OPERATIO           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         03000         AURSI NG           30.00         03000         ADULTS           30.00         03000         ADULTS           30.00         05000         OPERATIN           54.00         05400         RADI AL           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06600         LECTROC           69.01         06902         CARDI AC           71.00         07400         RENAL	RVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	NEW BLDG & FIXT (SQUARE FEET) 1.00 53,229	NEW MVBLE EQUI P (DEPRECI ATI ON COST) 2.00	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation,	2/26/2015 5: 00 ADMI NI STRATI VE & GENERAL (ACCUM.	
GENERAL         SERVI 0           1. 00         00100         NEW CAP           2. 00         00200         NEW CAP           4. 00         00400         EMPLOYEE           5. 00         00500         ADMI NI ST           7. 00         00700         OPERATIO           8. 00         00800         LAUNDRY           9. 00         00900         HOUSEKEE           10. 00         01000         DI ETARY           11. 00         01400         CAFETERI           13. 00         01300         NURSI NG           14. 00         01400         CENTRAL           15. 00         01500         PHARMACY           16. 00         01600         MURSI NG           17. 00         01700         SOCI AL           17. 00         01700         SOCI AL           30. 00         03000         ADULTS           30. 00         03000         ADULTS           30. 00         05000         OPERATI N           54. 00         05400         RADI AL           65. 00         05500         RESPI RAT           66. 00         06600         LECTROC           69. 01         06902	RVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	NEW BLDG & FIXT (SQUARE FEET) 1.00 53,229	NEW MVBLE EQUI P (DEPRECI ATI ON COST) 2.00	BENEFI TS DEPARTMENT (GROSS SALARI ES)		ADMI NI STRATI VE & GENERAL (ACCUM.	o piii
GENERAL         SERVI 0           1. 00         00100         NEW CAP           2. 00         00200         NEW CAP           4. 00         00400         EMPLOYEE           5. 00         00500         ADMI NI ST           7. 00         00700         OPERATIO           8. 00         00800         LAUNDRY           9. 00         00900         HOUSEKEE           10. 00         01000         DI ETARY           11. 00         01400         CAFETERI           13. 00         01300         NURSI NG           14. 00         01400         CENTRAL           15. 00         01500         PHARMACY           16. 00         01600         MURSI NG           17. 00         01700         SOCI AL           17. 00         01700         SOCI AL           30. 00         03000         ADULTS           30. 00         03000         ADULTS           30. 00         05000         OPERATI N           54. 00         05400         RADI AL           65. 00         05500         RESPI RAT           66. 00         06600         LECTROC           69. 01         06902	RVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	NEW BLDG & FIXT (SQUARE FEET) 1.00 53,229	NEW MVBLE EQUI P (DEPRECI ATI ON COST) 2.00	BENEFI TS DEPARTMENT (GROSS SALARI ES)		& GENERAL (ACCUM.	
GENERAL         SERVI 0           1. 00         00100         NEW CAP           2. 00         00200         NEW CAP           4. 00         00400         EMPLOYEE           5. 00         00500         ADMI NI ST           7. 00         00700         OPERATIO           8. 00         00800         LAUNDRY           9. 00         00900         HOUSEKEE           10. 00         01000         DI ETARY           11. 00         01400         CAFETERI           13. 00         01300         NURSI NG           14. 00         01400         CENTRAL           15. 00         01500         PHARMACY           16. 00         01600         MURSI NG           17. 00         01700         SOCI AL           17. 00         01700         SOCI AL           30. 00         03000         ADULTS           30. 00         03000         ADULTS           30. 00         05000         OPERATI N           54. 00         05400         RADI AL           65. 00         05500         RESPI RAT           66. 00         06600         LECTROC           69. 01         06902	RVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	FI XT (SQUARE FEET) 1.00 53,229	EQUI P (DEPRECI ATI ON COST) 2. 00	BENEFI TS DEPARTMENT (GROSS SALARI ES)		& GENERAL (ACCUM.	
GENERAL         SERVI 0           1. 00         00100         NEW CAP           2. 00         00200         NEW CAP           4. 00         00400         EMPLOYEE           5. 00         00500         ADMI NI ST           7. 00         00700         OPERATIO           8. 00         00800         LAUNDRY           9. 00         00900         HOUSEKEE           10. 00         01000         DI ETARY           11. 00         01400         CAFETERI           13. 00         01300         NURSI NG           14. 00         01400         CENTRAL           15. 00         01500         PHARMACY           16. 00         01600         MURSI NG           17. 00         01700         SOCI AL           17. 00         01700         SOCI AL           30. 00         03000         ADULTS           30. 00         03000         ADULTS           30. 00         05000         OPERATI N           54. 00         05400         RADI AL           65. 00         05500         RESPI RAT           66. 00         06600         LECTROC           69. 01         06902	RVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	FI XT (SQUARE FEET) 1.00 53,229	EQUI P (DEPRECI ATI ON COST) 2. 00	BENEFI TS DEPARTMENT (GROSS SALARI ES)		& GENERAL (ACCUM.	
1.00         00100         NEW CAP           2.00         00200         NEW CAP           4.00         00400         EMPLOYEE           5.00         00500         ADMINIST           7.00         00700         OPERATIO           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01000         DI ETARY           11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         01700         SOCI AL           18.00         03000         ADULTS           30.00         03000         ADULTS           4NCI LLARY SER         SO         00           50.00         05400         RADI OLOC           59.00         05900         CARDI AC           64.00         06400         INTRAVER           65.00         06500         RESPI RAT           66.00         06902         CARDI AC           71.00         07100	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	(SQUARE FEET) 1.00 53,229	(DEPRECIATION COST) 2.00	DEPARTMENT (GROSS SALARI ES)		(ACCUM.	
1.00         00100         NEW CAP           2.00         00200         NEW CAP           4.00         00400         EMPLOYEE           5.00         00500         ADMINIST           7.00         00700         OPERATIO           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01000         DI ETARY           11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         01700         SOCI AL           18.00         03000         ADULTS           30.00         03000         ADULTS           4NCI LLARY SER         SO         00           50.00         05400         RADI OLOC           59.00         05900         CARDI AC           64.00         06400         INTRAVER           65.00         06500         RESPI RAT           66.00         06902         CARDI AC           71.00         07100	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	FEET) 1.00 53,229	COST)	(GROSS SALARI ES)			
1.00         00100         NEW CAP           2.00         00200         NEW CAP           4.00         00400         EMPLOYEE           5.00         00500         ADMINIST           7.00         00700         OPERATIO           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01000         DI ETARY           11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           700         0700         SOCI AL           30.00         03000         ADULTS           4NOLLLARY SER         SOCO         OPERATION           50.00         05400         RADI OLOC           59.00         05900         CARDI AC           60.00         064001         INTRAVER           64.00         064001         INTRAVEN           65.00         065000         RESPI RAT           66.00         06902         CARDI AC           69.00         06	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	1.00 53,229	2.00	SALARI ES)		0001)	
1.00         00100         NEW CAP           2.00         00200         NEW CAP           4.00         00400         EMPLOYEE           5.00         00500         ADMINIST           7.00         00700         OPERATIO           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01000         DI ETARY           11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           700         0700         SOCI AL           30.00         03000         ADULTS           4NOLLLARY SER         SOCO         OPERATION           50.00         05400         RADI OLOC           59.00         05900         CARDI AC           60.00         064001         INTRAVER           64.00         064001         INTRAVEN           65.00         065000         RESPI RAT           66.00         06902         CARDI AC           69.00         06	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	53, 229					
1.00         00100         NEW CAP           2.00         00200         NEW CAP           4.00         00400         EMPLOYEE           5.00         00500         ADMINIST           7.00         00700         OPERATIO           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01000         DI ETARY           11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         01700         SOCI AL           18.00         03000         ADULTS           30.00         03000         ADULTS           4NCI LLARY SER         SO         00           50.00         05400         RADI OLOC           59.00         05900         CARDI AC           64.00         06400         INTRAVER           65.00         06500         RESPI RAT           66.00         06902         CARDI AC           71.00         07100	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	53, 229		1.00	5A	5.00	
1.00         00100         NEW CAP           2.00         00200         NEW CAP           4.00         00400         EMPLOYEE           5.00         00500         ADMINIST           7.00         00700         OPERATIO           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01000         DI ETARY           11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         01700         SOCI AL           18.00         03000         ADULTS           30.00         03000         ADULTS           4NCI LLARY SER         SO         00           50.00         05400         RADI OLOC           59.00         05900         CARDI AC           64.00         06400         INTRAVER           65.00         06500         RESPI RAT           66.00         06902         CARDI AC           71.00         07100	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT				0/1	0.00	
2.00         00200         NEW CAP           4.00         00400         EMPLOYEE           5.00         00500         ADMINIST           7.00         00700         OPERATIC           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01000         DI ETARY           11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         01700         SOCI AL           18.00         03000         ADULTS           19.00         05000         OPERATIN           50.00         05000         OPERATIN           54.00         05400         RADI OLOC           65.00         06500         CARDI AC           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06902         CARDI AC           69.00         06902         CARDI AC           69.00         07300 <td>CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE &amp; GENERAL ATION OF PLANT</td> <td></td> <td>۱ I</td> <td></td> <td></td> <td></td> <td>1.00</td>	CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT		۱ I				1.00
4.00         00400         EMPLOYEE           5.00         00500         ADMINIST           7.00         00700         OPERATIC           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01000         DI ETARY           11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         01700         SOCI AL           17.00         03000         ADULTS           ANCI LLARY SER         SO         00           50.00         05400         RADI OLOC           59.00         05900         CARDI AC           60.00         06400         I NTRAVEN           65.00         06500         RESPI RAT           66.00         06600         PHYSI CAL           69.00         07200         I MPL           71.00         07100         MEDI CAL           72.00         07200         I MPL           73.00         07300	OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT	0	918, 834				2.00
5.00         00500         ADMI NI ST           7.00         00700         OPERATI (0           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         0700 SOCI AL         SI           17.00         03000         ADULTS           16.00         0400         CENTRAL           17.00         0700 SOCI AL         SI           17.00         03000         ADULTS           30.00         03000         ADULTS           4MCI LLARY SER         SO         SO           50.00         05000         OPERATIN           54.00         05400         RADI OLOC           59.00         05900         CARDI AC           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         066000         LECTROC           69.01         0690	NISTRATIVE & GENERAL ATION OF PLANT	0	/10, 034	8, 109, 991			4.00
7.00         00700         OPERATIO           8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01000         DI ETARY           11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         01700         SOCI AL           17.00         03000         ADULTS           30.00         03000         ADULTS           30.00         03000         ADULTS           30.00         05000         OPERATIN           54.00         05400         RADI OLOC           59.00         05900         CARDI AC           60.00         06000         LABORATC           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06600         LBORATC           71.00         07100         MEDI CAL           72.00         07200         IMPL           73.00         07300	ATION OF PLANT	596	58, 759	799, 414		33, 850, 519	5.00
8.00         00800         LAUNDRY           9.00         00900         HOUSEKEE           10.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         01700         SOCI AL           18.00         05000         PHARMACY           16.00         05000         ADULTS           17.00         05000         OPERATIN           30.00         05000         CARDI AC           50.00         05000         CARDI AC           60.00         06000         LABORATC           61.00         064001         INTRAVEN           65.00         06500         RESPI RAT           66.00         064000         PHYSI CAL           69.00         06900         CARDI AC           71.00         07100         MEDI CAL           72.00         07200         IMPL         DI           73.00         07300         DRUSC G         A           74.00         07400         RENAL         DI		620	50,759	/ 77, 414	-5, 570, 727	470, 305	7.00
9.00         00900         HOUSEKEE           10.00         01000         DI ETARY           11.00         01000         DI ETARY           11.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01600         MEDI CAL           17.00         01700         SOCI AL           18.00         05000         OPERATIN           30.00         05400         RADI OLOC           59.00         05900         CARDI AC           60.00         06400         INTRAVEN           61.00         06600         PHYSI CAL           62.00         06902         CARDI AC           64.00         06400         INTRAVEN           65.00         06902         CARDI AC           69.00         06902         CARDI AC           71.00         07100         MEDI CAL           72.00         07200         IMPL           73.00         07300 </td <td>JRY &amp; LINEN SERVICE</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>	JRY & LINEN SERVICE		0	0	0		
10.00         01000         DI ETARY           11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01700         SOCI AL           17.00         01700         SOCI AL           18.00         03000         ADULTS           19.00         03000         ADULTS           10.00         05400         RADI OLOC           50.00         05400         CARDI AC           50.00         05400         CARDI AC           60.00         06400         I NTRAVER           65.00         06500         RESPI RAT           66.00         06400         I NTRAVER           65.00         06900         CARDI AC           69.00         06900         CARDI AC           69.00         06900         CARDI AL           71.00         07100         MEDI CAL           72.00         07200         I MPL.           73.00         07300         DRUSC CA           74.00         07400         RENAL           76.00         03020<		0	0	0	0	83, 283	8.00
11.00         01100         CAFETERI           13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         01700         SOCI AL           17.00         03000         ADULTS           18.00         03000         ADULTS           19.00         03000         ADULTS           10.00         03000         ADULTS           10.00         05000         OPERATIN           50.00         05900         CARDI AC           60.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06600         PHYSI CAL           69.00         06900         ELECTROM           69.00         06900         ELECTROM           69.00         06900         ELECTROM           71.00         07100         MEDI CAL           72.00         07200         IMPL.           73.00         07300         DRUGS CH           74.00         07400         RENAL DI           76.00         03020 <td></td> <td>225</td> <td>0</td> <td>0</td> <td>0</td> <td>193, 552</td> <td>9.00</td>		225	0	0	0	193, 552	9.00
13.00         01300         NURSI NG           14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         0700 SOCI AL S         INPATI ENT ROU           30.00         03000         ADULTS &           ANCI LLARY SER         SO         00           50.00         05000         OPERATIN           54.00         05400         RADI OLOC           59.00         05900         CARDI AC           60.00         06000         LABORATC           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06600         PHYSI CAL           69.01         06900         ELECTROC           69.01         06900         CARDI AC           71.00         07100         MEDI CAL           72.00         07200         IMPL         DE           73.00         07300         DRUGS CH         AN           74.00         07400         RENAL DI         DE           76.00         03020         OTHER AN         DUTPATI ENT SEI           92.00<		0	0	0	0	226, 011	10.00
14.00         01400         CENTRAL           15.00         01500         PHARMACY           16.00         01500         PHARMACY           16.00         01500         PHARMACY           17.00         00701         SOCIALS           INPATI ENT ROUT         30.00         03000         ADULTS           30.00         03000         ADULTS         ANCI LLARY SER           50.00         05000         OPERATIN           54.00         05400         RADI OLOC           59.00         05900         CARDI AC           60.00         06000         LABORATC           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06600         PHYSI CAI           69.01         06902         CARDI AC           71.00         07100         MEDI CAL           72.00         07200         IMPL         DE           73.00         07300         DRUGS         C           74.00         07400         RENAL DI         D           76.00         03020         OTHER AN         D           000         09200         DSERVAL         D<		0	0	0	0	78, 939	11.00
15.00         01500         PHARMACY           16.00         01600         MEDICAL           17.00         01700         SOCIAL           17.00         01700         SOCIAL           17.00         01700         SOCIAL           17.00         0000         ADULTS           ANCILLARY         SER           50.00         05000         OPERATIN           54.00         05400         RADIOLOC           59.00         05900         CARDIAC           60.00         06400         INTRAVEN           65.00         06500         RESPIRAT           66.00         06600         PHYSICAL           69.01         06902         CARDIAC           69.01         06902         CARDIAC           71.00         07100         MEDICAL           72.00         07200         IMPL         DE           73.00         07300         DRUGS CF           74.00         07400         RENAL         DI           76.00         03020         OTHER AN         OUTPATIENT SEI           92.00         OSBERVAT         SPECIAL PURPO         SUBTOTAI           NONREI MBURSABI         194.00		0	285	0	0	73, 763	
16.00         01600         MEDI CAL           17.00         01700         SOCI AL         SOCI AL           17.00         03000         ADULTS         ANCI LLARY SER           50.00         05000         OPERATIN         SOCI AL           54.00         05000         OPERATIN         SOCI AL           54.00         05400         RADI OLOC         SOCI AL           59.00         05900         CARDI AC         SOCI AL           60.00         06400         RATIA         SOCI AL           64.00         06400         RADI OLOC         SOCI AL           65.00         06500         CARDI AC         SOCI AL           66.00         06600         PHYSI CAL         SOCI AL           67.00         06900         CARDI AC         SOCI AL           69.00         06900         CARDI AC         SOCI AL           71.00         07100         MEDI CAL         SOCI AC           71.00         07100         MEDI CAL         SOCI AC           71.00         07200         IMPL         DI           73.00         07300         DRUSC CA         SPECI AL         DI           76.00         03200         OHERAL	RAL SERVICES & SUPPLY	0	0	0	0	235, 204	14.00
17.00         01700         SOCI AL         SO		0	0	0	0	730, 799	15.00
INPATI ENT ROU           30.00         03000 ADULTS &           ANCI LLARY SER           50.00         05000 OPERATIN           54.00         05400 RADI OLOC           59.00         05900 CARDI AC           60.00         06000 LABORATO           64.00         06400 I NTRAVEN           65.00         06500 RESPI RAT           66.00         06600 PHYSI CAI           69.00         06900 ELECTROC           69.00         06900 ELECTROC           69.01         06902 CARDI AC           71.00         07100 MEDI CAL           72.00         07200 I MPL. DE           73.00         07300 DRUGS CH           74.00         07400 RENAL DI           76.00         03020 OTHER AN           00179ATI ENT SEE         92.00           09200 OBSERVAT         SPECI AL PURPO           118.00         SUBTOTAI           NONREI MBURSABI         194.00           194.01         07950 OTHER NO           194.02         07952 PUBLI C F	CAL RECORDS & LIBRARY	0	0	0	0	521, 628	16.00
30. 00         03000 ADULTS         ANCI LLARY         SER           50. 00         05000 OPERATIN         SER         <	AL SERVICE	0	0	0	0	171, 224	17.00
ANCI LLARY SER           50.00         05000         OPERATI I           54.00         05400         RADI OLOC           59.00         05900         CARDI AC           60.00         06000         LABORATI I           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06600         PHYSI CAI           69.01         06900         ELECTROC           69.01         06900         ELECTROC           71.00         07100         MEDI CAL           72.00         07200         IMPL.           73.00         07300         DRUGS CH           74.00         07400         RENAL DI           76.00         03020         OTHER AN           0017PATI ENT SEI         92.00         09200           92.00         09200         DESERVAT           SPECI AL PURPOS         118.00         SUBTOTAL           NONREI MEURSABI         194.00         07950           194.01         07952         PUBLI C F	ROUTINE SERVICE COST CENTERS						1
50.00         05000         OPERATIN           54.00         05400         RADI 0L00           59.00         05900         CARDI AC           60.00         06000         LABORATO           64.00         06400         INTRAVEN           65.00         06500         RESPIRAT           66.00         06600         PHYSI CAL           69.00         06900         ELECTROC           69.01         06902         CARDI AC           71.00         07100         MEDI CAL           72.00         07200         IMPL.DE           73.00         07300         DRUGS CF           74.00         07400         RENAL DI           76.00         03020         OHERAK DI           76.00         03020         OHERAK DI           76.00         03020         OBSERVA           SPECIAL PURPO         118.00         SUBTOTAL           NONREI MBURSABI         194.00         07950           194.01         07951         VI SI TOR           194.02         07952         PUBLI C F	TS & PEDIATRICS	21, 780	93, 872	2, 997, 022	0	4, 945, 136	30.00
54.00         05400         RADI OLOC           59.00         05900         CARDI AC           60.00         06000         LABORATC           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06600         PHYSI CAL           69.01         06900         ELECTROC           69.01         06902         CARDI AC           71.00         07100         MEDI CAL           72.00         07200         IMPL.DE           73.00         07300         DRUGS CF           74.00         07400         RENAL DI           76.00         03020         OTHER AN           0017PATI ENT SEI         92.00         OSECI AL PURPO           118.00         SUBTOTAI         NONREI MBURSABI           194.00         07950         OTHER NO           194.01         07951         VI SI TOR           194.02         07952         PUBLI C	SERVICE COST CENTERS						
59.00         05900         CARDI AC           60.00         06000         LABORATC           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06600         PHYSI CAL           69.00         06900         CARDI AC           69.00         06900         PLECTROC           69.01         06902         CARDI AC           71.00         07100         MEDI CAL           72.00         07200         IMPL.           73.00         07300         DRUGS CF           74.00         07400         RENAL DI           76.00         03020         OTHER AN           0UTPATI ENT SEI         92.00         OBSERVAT           SPECI AL PURPO:         118.00         SUBTOTAI           NONREI MBURSABI         194.00         07950           194.00         07950         THER NO           194.01         07951         VI SI TOR           194.02         07952         PUBLI C	ATING ROOM	7, 089	81, 359	592, 520	0	1, 537, 209	50.00
60.00         06000         LABORATC           64.00         06400         INTRAVEN           65.00         06500         RESPI RAT           66.00         06600         PHYSI CAL           69.00         06900         ELECTROC           69.01         06902         CARDI AC           71.00         07100         MEDI CAL           72.00         07200         IMPL.           73.00         07300         DRUGS CH           74.00         07400         RENAL DI           76.00         03020         OTHER AN           0UTPATI ENT SEI         92.00         09200           92.00         09200         DBSERVAT           SPECI AL PURPOS         118.00         SUBTOTAI           NONREI MBURSABI         194.00         07950         OTHER NO           194.01         07951         VI SI TOR         194.01	OLOGY-DI AGNOSTI C	0	0	70, 403	0	633, 187	54.00
64.00         06400         INTRAVEN           65.00         06500         RESPIRAT           66.00         06600         PHYSICAI           69.00         06900         ELECTROC           69.01         06902         CARDIAC           71.00         07100         MEDICAL           72.00         07200         IMPL.DE           73.00         07300         DRUGS CH           74.00         07400         RENAL DI           76.00         03020         OTHER AN           0UTPATI ENT SEI         92.00         O9200 OBSERVAT           SPECIAL PURPOS         118.00         SUBTOTAI           NONREI MBURSABI         194.00         07950           194.01         07951         VI SI TOR           194.02         07952         PUBLIC F	I AC CATHETERI ZATI ON	16,061	512, 514	2, 256, 206	0	5, 035, 433	59.00
64.00         06400         INTRAVEN           65.00         06500         RESPIRAT           66.00         06600         PHYSICAI           69.00         06900         ELECTROC           69.01         06902         CARDIAC           71.00         07100         MEDICAL           72.00         07200         IMPL.DE           73.00         07300         DRUGS CH           74.00         07400         RENAL DI           76.00         03020         OTHER AN           0UTPATI ENT SEI         92.00         O9200 OBSERVAT           SPECIAL PURPOS         118.00         SUBTOTAI           NONREI MBURSABI         194.00         07950           194.01         07951         VI SI TOR           194.02         07952         PUBLIC F	RATORY	0	0	0	0	1, 878, 688	60.00
65.00         06500         RESPI RAT           66.00         06600         PHYSI CAL           69.01         06900         ELECTROC           69.01         06900         ELECTROC           71.00         07100         MEDI CAL           72.00         07200         IMPL.         DE           73.00         07400         RENAL         DI           76.00         03020         OTHER         AN           0000         09200         OBSERVAT         SPECIAL         PURPO           118.00         SUBTOTAL         NONREI MBURSABI         NORSEI         NU           194.00         07950         OTHER         NO         194.01         07951         VI SI TOR           194.02         07952         PUBLI C         F         194.02         100         SI         100	AVENOUS THERAPY	0	8, 687	433, 650	0	586, 437	64.00
66.00         06600         PHYSI CAL           69.00         06900         ELECTROC           69.01         06902         CARDI AC           71.00         07100         MEDI CAL           72.00         07200         IMPL.           73.00         07300         DRUGS CH           74.00         07400         RENAL           00         03020         OTHER           92.00         09200         OBSERVAT           SPECIAL         PURPO           118.00         SUBTOTAL           NONREI         MBURSABI           194.00         07950           194.01         07951           194.02         07952           PUBLIC F		0	0	0	0	482, 311	65.00
69.00         06900         ELECTROC           69.01         06902         CARDI AC           71.00         07100         MEDI CAL           72.00         07200         I MPL.         DE           73.00         07300         DRUGS CF           74.00         07400         RENAL DI           76.00         03020         OTHER AH           92.00         09200         OBSERVAT           SPECI AL         PURPO:           118.00         SUBTOTAL           NONREI MBURSABI         194.00           194.01         07950           194.02         07952           PUBLI C         F		0	0	0	0	57, 577	66.00
69. 01         06902         CARDI AC           71. 00         07100         MEDI CAL           72. 00         07200         I MPL.         DE           73. 00         07300         DRUGS CF         DRUGS CF           74. 00         07400         RENAL DI         DE           76. 00         03020         OTHER AN         DUTPATI ENT SEI           92. 00         09200         OBSERVAT         SPECI AL PURPOS           118. 00         SUBTOTAL         NONREI MBURSABI           194. 00         07950         OTHER NO           194. 01         07951         VI SI TOR           194. 02         07952         PUBLI C		6, 858	129, 322	619, 463	0	1, 495, 228	69.00
71.00         07100         MEDICAL           72.00         07200         IMPL.DE           73.00         07300         DRUGS CF           74.00         07400         RENAL DF           76.00         03020         OTHER AN           0UTPATIENT SEE         92.00         09200           92.00         09200         0BSERVAT           SPECIAL PURPOS         118.00         SUBTOTAL           NONREI MBURSABI         194.00         07950         OTHER NO           194.01         07952         PUBLIC F         194.02		0,000	25, 984	326, 461	0	494, 586	69.01
72.00         07200         I MPL. DE           73.00         07300         DRUGS CE           74.00         07400         RENAL DI           76.00         03020         OTHER AF           0UTPATI ENT SEE         09200         OBSERVAT           92.00         092ECI AL PURPOS         118.00           SUBTOTAI         NONREI MBURSABI           194.00         07950         OTHER NO           194.01         07952         PUBLI C F	CAL SUPPLIES CHARGED TO PATIENTS	0	20, 701	020, 101	0	3, 796, 062	
73.00         07300         DRUGS         CF           74.00         07400         RENAL         DI           76.00         03020         OTHER         AN           0UTPATI         ENT         SEI           92.00         OBSERVAT         SPECIAL         PURPOS           118.00         SUBTOTAL         NONREI         MBURSABI           194.00         07950         OTHER         NC           194.01         07952         PUBLIC         F	. DEV. CHARGED TO PATIENTS	0	0	0	0	8, 281, 453	
74.00         07400         RENAL         DI           76.00         03020         OTHER         AN           0UTPATI         ENT         SEI           92.00         0BSERVAT         SPECIAL         PURPOS           118.00         SUBTOTAL         NONREI         MBURSABI           194.00         07950         OTHER         NC           194.01         07952         PUBLIC         F		0	0	0	0	1, 751, 185	
76.00         03020         OTHER AN OUTPATI ENT SET           92.00         09200         0BSERVAT           SPECIAL PURPOT         SUBTOTAL           NONREI MBURSABI         07950         OTHER NO           194.00         07950         OTHER NO           194.02         07952         PUBLIC F		0		14 050	0		
0UTPATI ENT SE 92. 00 09200 0BSERVAT SPECIAL PURPO 118. 00 SUBTOTAL NONREI MBURSABI 194. 00 07950 0THER NC 194. 01 07951 VI SI TOR 194. 02 07952 PUBLIC F		0	8, 052	14, 852	0	50, 688	74.00
92. 00 92.00 9	R ANCILLARY SERVICE COST CENTERS	<u> </u>	U U	0	0	0	76.00
SPECIAL PURPOS           118.00         SUBTOTAI           NONREI MBURSABI         194.00           194.01         07950           194.02         07951           194.02         07952		1 1			r r		00.00
118. 00 SUBTOTAL NONREI MBURSABI 194. 00 07950 OTHER NO 194. 01 07951 VI SI TOR 194. 02 07952 PUBLI C F	RVATION BEDS (NON-DISTINCT PART)				<u> </u>		92.00
NONRE I MBURSABI 194. 00 07950 OTHER NO 194. 01 07951 VI SI TOR 194. 02 07952 PUBLI C F		<b>E</b> 2, 220	010 024	0 100 001	F 200 727	22,000,000	110 00
194. 00 07950 OTHER NO 194. 01 07951 VI SI TOR 194. 02 07952 PUBLIC F	OTALS (SUM OF LINES 1-117)	53, 229	918, 834	8, 109, 991	-5, 398, 727	33, 809, 888	118.00
194. 01 07951 VI SI TOR 194. 02 07952 PUBLIC F	SABLE COST CENTERS	-1					
194.0207952 PUBLIC F	<pre>&lt; NUNREIMBURSABLE COST CENTERS</pre>	0	-	0			194.00
		0	-	0		24, 289	
1 1		0	0	0	Ű	12, 357	
194.0307953 DEACONES		0	0	0	0		194.03
							200.00
201.00 Negative	s Foot Adjustments						201.00
202.00 Cost to		1, 644, 361	1, 914, 665	1, 346, 453		5, 398, 727	202.00
Part I)	s Foot Adjustments	1,044,001	, · · · · · · · · · · · · · · · · · · ·				
203.00 Unit cos	s Foot Adjustments tive Cost Centers to be allocated (per Wkst. B, l)	1, 044, 301	l	·			1203 00
	s Foot Adjustments tive Cost Centers to be allocated (per Wkst. B, l)	30. 892202	2. 083799	0. 166024		0. 159487	1∠UJ. UU
Part II)	s Foot Adjustments tive Cost Centers to be allocated (per Wkst. B, I) cost multiplier (Wkst. B, Part I)		2. 083799	0. 166024 0			
	s Foot Adjustments tive Cost Centers to be allocated (per Wkst. B, I) cost multiplier (Wkst. B, Part I) to be allocated (per Wkst. B,		2. 083799	0. 166024 0		0. 159487 140, 854	
	s Foot Adjustments tive Cost Centers to be allocated (per Wkst. B, I) cost multiplier (Wkst. B, Part I) to be allocated (per Wkst. B,		2. 083799	0. 166024 0 0. 000000			204.00

Heal th	Financial Systems HEAR	T HOSPITAL AT I	DEACONESS GATE	WAY	In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 10/01/2013 To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE		(MEALS	(FTES)	
		(SQUARE	(POUNDS OF	FEET)	SERVED)		
		FEET)	LAUNDRY)	0.00	10.00	44.00	
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATI ON OF PLANT	52, 013					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	02,010	130, 433	3			8.00
9,00	00900 HOUSEKEEPI NG	225	00,100		8		9.00
10.00	01000 DI ETARY	0			0 22, 412		10.00
11.00	01100 CAFETERIA	0			0 0	1, 232	1
13.00	01300 NURSING ADMINISTRATION	0			0 0	0	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	l c		0 0	0	1
15.00	01500 PHARMACY	0	C		0 0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	C		0 0	0	1
17.00	01700 SOCIAL SERVICE	0	C	þ	0 0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	21, 780	83, 879	21, 78	0 21, 852	550	30.00
	ANCILLARY SERVICE COST CENTERS		·				
50.00	05000 OPERATING ROOM	7, 089	1, 619	7,08	9 0	102	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C	)	0 0	12	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	16, 061	38, 317	16, 06	1 560	333	59.00
60.00	06000 LABORATORY	0	C		0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	C	)	0 0	62	64.00
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	6, 858	6, 618	6, 85	8 0	105	69.00
69.01	06902 CARDI AC REHAB	0	C		0 0	66	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	
74.00	07400 RENAL DI ALYSI S	0	C		0 0	2	74.00
76.00	03020 OTHER ANCI LLARY SERVICE COST CENTERS	0	C	)	0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS		1	1			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
110.00	SPECIAL PURPOSE COST CENTERS	F2 012	120 422	L F1 70	0 22 412	1 000	110 00
118.00	/	52,013	130, 433	51, 78	8 22, 412	1, 232	118.00
104 00	NONREI MBURSABLE COST CENTERS	0		N.		0	104 00
	07950 OTHER NONREIMBURSABLE COST CENTERS 07951 VISITOR ASSISTANTS	0	-		0 0		194.00
	07951 VISITOR ASSISTANTS 07952 PUBLIC RELATIONS	0			0 0		194. 01 194. 02
	07953 DEACONESS HOSPI TAL	0			0 0		194.02
200.00		0			0 0	0	200.00
200.00							200.00
201.00		545 212	06 566	226 70	0 262 057	01 520	201.00
202.00	Part I)	545, 313	96, 566	226, 78	0 262, 057	91, 329	202.00
203.00		10. 484167	0. 740349	4. 37900	7 11.692709	74. 293019	203 00
203.00		21, 110					203.00
204.00	Part II)	21,110	347	/, 04	, 940	520	204.00
205.00		0. 405860	0. 002660	0. 15152	2 0. 041942	0. 266234	205.00
200.00		000000	0.002000			0.200201	
		1	1		- I		•

DST A	Financial Systems HEAF LLOCATION - STATISTICAL BASIS	RT HOSPITAL AT D		- CCN: 150175	Peri od:	wof Form CMS- Worksheet B-1	
					From 10/01/2013		
					To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TIME	
		(DI RECT	(COSTED		(TIME	SPENT)	
		NRSING HRS)	REQUIS.)		SPENT)		
		13.00	14.00	15.00	16.00	17.00	
0	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1		1		1	
00 00	00200 NEW CAP REL COSTS-BEDG & FIXT						
00	00400 EMPLOYEE BENEFITS DEPARTMENT						
00	00500 ADMINI STRATI VE & GENERAL						
00	00700 OPERATION OF PLANT						
00	00800 LAUNDRY & LINEN SERVICE						8
00	00900 HOUSEKEEPI NG						0
	01000 DI ETARY						1 10
00	01100 CAFETERI A						1
00	01300 NURSI NG ADMI NI STRATI ON	253, 794					1:
00	01400 CENTRAL SERVICES & SUPPLY	0	12, 214, 53	8			14
00	01500 PHARMACY	0	20, 51	9 1, 751, 1	85		1!
00	01600 MEDICAL RECORDS & LIBRARY	0		0	0 157, 877, 860		10
00	01700 SOCIAL SERVICE	0		0	0 0	6, 806	17
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·		-			
00	03000 ADULTS & PEDIATRICS	114, 487	142, 27	8	0 12, 399, 683	6, 636	30
	ANCI LLARY SERVICE COST CENTERS			-1		-	
	05000 OPERATING ROOM	21, 208		0	0 16, 421, 007		
	05400 RADI OLOGY-DI AGNOSTI C	0		0	0 9, 248, 318		
	05900 CARDI AC CATHETERI ZATI ON	69, 275	70, 96	9	0 46, 031, 264		
		12.045	24 02	2	0 10, 435, 718		
00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	12, 865	26, 02		0 11 12 070		
	06600 PHYSI CAL THERAPY	0	50	0	0 2, 207, 688 0 994, 181		
	06900 ELECTROCARDI OLOGY	21, 827	58, 63	-	0 17, 259, 397		
	06902 CARDI AC REHAB	13, 668	2, 54		0 918, 110		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 611, 61		0 9, 985, 708		
	07200 I MPL. DEV. CHARGED TO PATIENT	0	8, 281, 45		0 19, 649, 190		
	07300 DRUGS CHARGED TO PATIENTS	0		0 1, 751, 1			
	07400 RENAL DI ALYSI S	464		0	0 171, 740		
	03020 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0 0	0	76
	OUTPATIENT SERVICE COST CENTERS			•			
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	SPECIAL PURPOSE COST CENTERS			_			
3.00		253, 794	12, 214, 53	8 1, 751, 1	85 157, 877, 860	6, 806	118
	NONREI MBURSABLE COST CENTERS	1					
	07950 OTHER NONREI MBURSABLE COST CENTERS	0		0	0 0		) 194
	07951 VI SI TOR ASSI STANTS	0		0	0 0		194
	07952 PUBLI C RELATI ONS	0			0		194
	07953 DEACONESS HOSPI TAL	0		U	0 0	0	) 194
). 00							200
1.00		05 507	272 74		404 001	100 500	201
2.00	Cost to be allocated (per Wkst. B, Part I)	85, 527	272, 71	6 847,8	604, 821	198, 532	202
3. 00		0. 336994	0. 02232	7 0. 4841	35 0.003831	29. 170144	1203
s. 00 1. 00		0. 336994	0. 02232 97				2 202
r. UU	Part II)	701	97	í  <sup>3,0</sup>	2,170	/12	204
5.00		0. 003550	0. 00008	0 0.0017	0. 000014	0. 104614	1205
	11)	0.000000	0.00008	J 0.001/	0.000014	0.104014	1200

	ART HOSPITAL AT			In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 10/01/2013 To 09/30/2014		pared: 0 pm
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	6, 698, 845		6, 698, 84	5 0	6, 698, 845	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 966, 572		1, 966, 57		1, 966, 572	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	770, 494		770, 49		770, 494	
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 343, 118		6, 343, 11			
60. 00 06000 LABORATORY	2, 218, 293		2, 218, 29			
64.00 06400 INTRAVENOUS THERAPY	695, 207		695, 20		695, 207	
65. 00 06500 RESPI RATORY THERAPY	567, 702		567,70		567, 702	
66. 00 06600 PHYSI CAL THERAPY	70, 569		70, 56		70, 569	
69.00 06900 ELECTROCARDI OLOGY	1, 923, 115		1, 923, 11		1, 923, 115	
69. 01 06902 CARDI AC REHAB	586, 549		586, 54		586, 549	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 520, 376		4, 520, 37		4, 520, 376	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 862, 423		9, 862, 42		9, 862, 423	
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 919, 136		2, 919, 13		2, 919, 136	
74.00 07400 RENAL DIALYSIS	59, 735		59, 73			74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	925, 503		925, 50		925, 503	
200.00 Subtotal (see instructions)	40, 127, 637					
201.00 Less Observation Beds	925, 503		925, 50		925, 503	
202.00  Total (see instructions)	39, 202, 134	0	39, 202, 13	4 96, 154	39, 298, 288	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		F		Period: From 10/01/2013 Fo 09/30/2014	Date/Time Pre 2/26/2015 5:0	pared: )0 pm
			e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	lotal (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	11, 115, 682		11, 115, 682	2		30.00
ANCILLARY SERVICE COST CENTERS						4
50. 00 05000 OPERATI NG ROOM	15, 652, 737	768, 271				
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 072, 283	6, 176, 035			0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	16, 149, 061	29, 882, 203				
60. 00 06000 LABORATORY	8, 617, 906	1, 817, 812			0. 000000	
64.00 06400 INTRAVENOUS THERAPY	1, 446, 870	46, 020				
65. 00 06500 RESPI RATORY THERAPY	2, 172, 559	35, 130				
66. 00 06600 PHYSI CAL THERAPY	966, 131	28, 050				
69. 00 06900 ELECTROCARDI OLOGY	8, 325, 183	8, 934, 214			0. 000000	
69. 01 06902 CARDI AC REHAB	914	917, 196				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 152, 084	2, 833, 624				
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	6, 723, 510	12, 925, 680				
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 158, 966	2, 504, 000	10, 662, 966	6 0. 273764	0. 000000	73.0
74. 00 07400 RENAL DI ALYSI S	160, 487	11, 253	171, 740	0. 347822	0.000000	74.0
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(	0. 000000	0.00000	76.0
OUTPATIENT SERVICE COST CENTERS				1		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	375, 192	908, 809			0. 000000	
200.00 Subtotal (see instructions)	90, 089, 565	67, 788, 297	157, 877, 862	2		200.0
201.00 Less Observation Beds						201.0
202.00 Total (see instructions)	90, 089, 565	67, 788, 297	157, 877, 862	2		202.0

Heal th Financial Systems HEA COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150175	Peri od:	Worksheet C
			From 10/01/2013	Part I
			To 09/30/2014	Date/Time Prepared 2/26/2015 5:00 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 119760			50.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 083312			54.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 139848			59.0
50. 00 06000 LABORATORY	0. 212733			60.0
54.00 06400 INTRAVENOUS THERAPY	0. 465679			64.0
55. 00 06500 RESPI RATORY THERAPY	0. 257148			65.0
56. 00 06600 PHYSI CAL THERAPY	0. 070982			66.0
59. 00 06900 ELECTROCARDI OLOGY	0. 111424			69.0
59. 01 06902 CARDI AC REHAB	0. 638866			69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 452685			71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 501925			72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 273764			73.0
74.00 07400 RENAL DIALYSIS	0. 348830			74.0
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76.
OUTPATIENT SERVICE COST CENTERS	1			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 720796			92.
200.00 Subtotal (see instructions)				200. (
201.00 Less Observation Beds				201. (
202.00 Total (see instructions)				202.

Health Financial Systems HEA	RT HOSPITAL AT I	DEACONESS GATE	WAY	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 10/01/2013 To 09/30/2014		pared: O pm
		Ti t	le XIX	Hospi tal	PPS	_
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		•				
30. 00 03000 ADULTS & PEDI ATRI CS	6, 698, 845		6, 698, 84	5 0	6, 698, 845	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 966, 572		1, 966, 57	2 0	1, 966, 572	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	770, 494		770, 49		770, 494	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 343, 118		6, 343, 11			•
60. 00 06000 LABORATORY	2, 218, 293		2, 218, 29	3 1, 729		
64.00 06400 INTRAVENOUS THERAPY	695, 207		695, 20		695, 207	•
65. 00 06500 RESPI RATORY THERAPY	567, 702		567, 70		567, 702	•
66. 00 06600 PHYSI CAL THERAPY	70, 569		70, 56		70, 569	
69. 00 06900 ELECTROCARDI OLOGY	1, 923, 115		1, 923, 11		1, 923, 115	
69. 01 06902 CARDI AC REHAB	586, 549		586, 54	9 0	586, 549	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 520, 376		4, 520, 37	6 0	4, 520, 376	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 862, 423		9, 862, 42	3 0	9, 862, 423	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 919, 136		2, 919, 13	6 0	2, 919, 136	73.00
74. 00 07400 RENAL DI ALYSI S	59, 735		59, 73	5 173	59, 908	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	925, 503		925, 50		925, 503	
200.00 Subtotal (see instructions)	40, 127, 637		40, 127, 63	7 96, 154		
201.00 Less Observation Beds	925, 503		925, 50		925, 503	
202.00   Total (see instructions)	39, 202, 134	C	39, 202, 13	4 96, 154	39, 298, 288	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			F T	Period: From 10/01/2013 Fo 09/30/2014		
			le XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
	(				Ratio	
	6.00	7.00	8.00	9.00	10.00	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	11 115 (00)					1 00 0
30. 00 03000 ADULTS & PEDI ATRI CS	11, 115, 682		11, 115, 682	2		30.0
ANCI LLARY SERVICE COST CENTERS	45 (50 303	7/0.074	14 101 000		0.000000	1
50. 00 05000 OPERATING ROOM	15, 652, 737	768, 271				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 072, 283	6, 176, 035			0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	16, 149, 061	29, 882, 203				
60. 00 06000 LABORATORY	8, 617, 906	1, 817, 812			0.00000	
64. 00 06400 I NTRAVENOUS THERAPY	1, 446, 870	46, 020				
65. 00 06500 RESPI RATORY THERAPY	2, 172, 559	35, 130				
66. 00 06600 PHYSI CAL THERAPY	966, 131	28, 050				
59. 00 06900 ELECTROCARDI OLOGY	8, 325, 183	8, 934, 214				
69. 01 06902 CARDI AC REHAB	914	917, 196				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 152, 084	2, 833, 624				
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	6, 723, 510	12, 925, 680				
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 158, 966	2, 504, 000			0. 000000	
74.00 07400 RENAL DIALYSIS	160, 487	11, 253	171, 740		0. 000000	
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(	0. 000000	0.00000	76.0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	375, 192				0. 000000	
200.00 Subtotal (see instructions)	90, 089, 565	67, 788, 297	157, 877, 862	2		200.0
201.00 Less Observation Beds						201.0
202.00 Total (see instructions)	90, 089, 565	67, 788, 297	157, 877, 862	2		202.0

Health Financial Systems HEA	RT HOSPITAL AT DE	ACONESS GATEWAY	In Lie	u of Form CMS-2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150175	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 2/26/2015 5:00 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.0
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 119760			50.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 083312			54.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 139848			59.0
60. 00 06000 LABORATORY	0. 212733			60.0
64.00 06400 INTRAVENOUS THERAPY	0. 465679			64.0
65. 00 06500 RESPI RATORY THERAPY	0. 257148			65.0
66. 00 06600 PHYSI CAL THERAPY	0. 070982			66.0
69. 00 06900 ELECTROCARDI OLOGY	0. 111424			69.0
69. 01 06902 CARDI AC REHAB	0. 638866			69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 452685			71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 501925			72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 273764			73.0
74.00 07400 RENAL DIALYSIS	0. 348830			74.0
76.00 03020 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000			76.0
OUTPATIENT SERVICE COST CENTERS	1			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 720796			92.0
200.00 Subtotal (see instructions)				200. 0
201.00 Less Observation Beds				201.0
202.00  Total (see instructions)				202.0

Health Financial Systems HEAR	RT HOSPITAL AT	DEACONESS GATE	WAY	In Lie	eu of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF			Period: From 10/01/2013 To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
			le XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part			Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1			-		
50.00 05000 OPERATI NG ROOM	1, 966, 572			8 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	770, 494			.7 0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 343, 118	1, 595, 129	4, 747, 98	9 0	0	59.00
60. 00 06000 LABORATORY	2, 218, 293	7, 963	2, 210, 33	0 0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	695, 207	20, 628	674, 57	9 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	567, 702	2, 038	565, 66	4 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	70, 569	254	70, 31	5 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY	1, 923, 115	491, 754	1, 431, 36	1 0	0	69.00
69. 01 06902 CARDI AC REHAB	586, 549	56, 283	530, 26	6 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 520, 376	16, 224	4, 504, 15	2 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 862, 423	35, 401	9, 827, 02	2 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 919, 136	10, 479	2, 908, 65	7 0	0	73.00
74.00 07400 RENAL DIALYSIS	59, 735	16, 995	42, 74	0 0	0	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	925, 503	124, 858	800, 64	5 0	0	92.00
200.00 Subtotal (sum of lines 50 thru 199)	33, 428, 792	2, 779, 987	30, 648, 80	5 0	0	200.00
201.00 Less Observation Beds	925, 503	124, 858	800, 64	5 0	0	201.00
202.00 Total (line 200 minus line 201)	32, 503, 289	2, 655, 129	29, 848, 16	0 0	0	202.00

Health Financial Systems H	EART HOSPITAL AT	DEACONESS GATE	VAY	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE	RATIOS NET OF	Provi der	CCN: 150175	Peri od:	Worksheet C
REDUCTIONS FOR MEDICAID ONLY				From 10/01/2013 To 09/30/2014	
				10 09/30/2014	2/26/2015 5:00 pm
		Tit	le XIX	Hospi tal	PPS
Cost Center Description		Total Charges			
		(Worksheet C,			
	Operating Cost			6	
	Reducti on	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS		i			
50.00 05000 OPERATING ROOM	1, 966, 572				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	770, 494				54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 343, 118				59.00
60. 00 06000 LABORATORY	2, 218, 293			-	60.00
64.00 06400 INTRAVENOUS THERAPY	695, 207				64.00
65. 00 06500 RESPI RATORY THERAPY	567, 702				65.00
66. 00 06600 PHYSI CAL THERAPY	70, 569				66.00
69. 00 06900 ELECTROCARDI OLOGY	1, 923, 115				69.00
69. 01 06902 CARDI AC REHAB	586, 549	918, 110			69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 520, 376	9, 985, 708	0. 4526	85	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 862, 423	19, 649, 190	0. 50192	25	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 919, 136	10, 662, 966			73.00
74.00 07400 RENAL DIALYSIS	59, 735	171, 740	0. 3478	22	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.0000	00	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	925, 503	1, 284, 001	0. 7207	96	92.00
200.00 Subtotal (sum of lines 50 thru 199)	33, 428, 792	146, 762, 180			200.00
201.00 Less Observation Beds	925, 503				201.00
202.00   Total (line 200 minus line 201)	32, 503, 289	146, 762, 180			202.00

Health Financial Systems	HEART HOSPITAL AT DEACONESS GATEWAY In Lieu of Form CM					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	PLTAL COSTS	Provi der		Period: From 10/01/2013 To 09/30/2014		pared:
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)	Days	Per Diem (col. 3 / col. 4)	
	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 ADULTS & PEDIATRICS	903, 728	0	903, 72	8 6, 536	138.27	30.00
200.00 Total (lines 30-199)	903, 728		903, 72	8 6, 536		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30-199)	3, 008 3, 008		1			30.00 200.00

Health Financial Systems HEAR	T HOSPITAL AT	DEACONESS GATE	VAY	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		CCN: 150175	Period: From 10/01/2013 To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	I	T	- 1	1	
50.00 05000 OPERATING ROOM	399, 214					
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 767					54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 595, 129					59.00
60. 00 06000 LABORATORY	7,963					
64.00 06400 INTRAVENOUS THERAPY	20, 628					
65. 00 06500 RESPI RATORY THERAPY	2,038				1, 073	65.00
66. 00 06600 PHYSI CAL THERAPY	254					66.00
69. 00 06900 ELECTROCARDI OLOGY	491, 754				31, 745	
69. 01 06902 CARDI AC REHAB	56, 283				0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 224	9, 985, 708			5, 653	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	35, 401					
73.00 07300 DRUGS CHARGED TO PATIENTS	10, 479					73.00
74. 00 07400 RENAL DIALYSIS	16, 995	171, 740	0. 09895	58 116, 718	11, 550	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.0000	0 00	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	124, 858	1, 284, 001	0. 09724	41 256, 937		
200.00 Total (lines 50-199)	2, 779, 987	146, 762, 180		34, 858, 276	522, 332	200.00

Health Financial Systems HEA	RT HOSPITAL AT I	DEACON	IESS GATEV	IAY	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS		CCN: 150175	Period: From 10/01/2013 To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
				e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School		Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00		2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30-199)	0		0		0 0	0	30.00 200.00
Cost Center Description	Total Pati ent Days	5 ÷	iem (col. col. 6) 7.00	Inpatient Program Days 8.00	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		200.00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00			0.00		<u> </u>	
30. 00         03000         ADULTS & PEDIATRICS           200. 00         Total (Lines 30-199)	6, 536 6, 536		0.00	3, 00 3, 00			30. 00 200. 00

Health Financial Systems	EART HOSPI TAL AT	DEACONESS GATE	WAY	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PA	SS Provi der	CCN: 150175	Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2013		
				To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physiciar	Nursing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Educati on Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM		0 0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0 0		0 0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0 0		0 0	0	59.00
60. 00 06000 LABORATORY		0 0		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY		0 0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0 0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY		0 0		0 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY		0 0		0 0	0	69.00
69. 01 06902 CARDI AC REHAB		0 0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5	0 0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0 0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0 0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS		0 0		0 0	0	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	5	0 0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		·				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0 0		0 0	0	92.00
200.00 Total (lines 50-199)		o  (	이	0 0	0	200. 00

Health Financial Systems HEAR	T HOSPITAL AT	DEACONESS GATE	VAY	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 10/01/2013 To 09/30/2014		norod.
				10 09/30/2014	2/26/2015 5:0	pareu: Onm
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	16, 421, 008	0.00000	0 0. 000000	7, 260, 838	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 248, 318	0.00000	0 0. 000000	1, 142, 343	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	46, 031, 264	0.00000	0 0. 000000	7, 372, 844	59.00
60. 00 06000 LABORATORY	0	10, 435, 718	0.00000	0 0. 000000	4, 553, 972	60.00
64.00 06400 INTRAVENOUS THERAPY	0	1, 492, 890	0.00000	0 0. 000000	65, 866	64.00
65. 00 06500 RESPI RATORY THERAPY	0	2, 207, 689	0.00000	0 0. 000000	1, 163, 002	65.00
66. 00 06600 PHYSI CAL THERAPY	0	994, 181	0.00000	0 0. 000000	655, 952	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	17, 259, 397	0.00000	0 0. 000000	1, 114, 181	69.00
69. 01 06902 CARDI AC REHAB	0	918, 110	0.00000	0 0. 000000	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 985, 708	0.00000	0 0. 000000	3, 478, 821	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	19, 649, 190	0.00000	0 0. 000000	3, 512, 898	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 662, 966	0.00000	0 0. 000000	4, 163, 904	73.00
74. 00 07400 RENAL DI ALYSI S	0	171, 740	0.00000	0 0. 000000	116, 718	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.00000	0 0. 000000	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 284, 001	0.00000	0 0. 000000		
200.00 Total (lines 50-199)	0	146, 762, 180			34, 858, 276	200. 00

Health Financial Systems HEAR	RT HOSPITAL AT D	EACONESS GATE	VAY	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der	CCN: 150175	Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2013 To 09/30/2014		nored.
				10 09/30/2014	2/26/2015 5:0	opareu:
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS	r		-	r		
50.00 05000 OPERATING ROOM	0	335, 284		0		50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	888, 560		0		54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	13, 710, 445		0		59.00
60. 00 06000 LABORATORY	0	557, 210		0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	15, 330		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 553, 815		0		69.00
69. 01 06902 CARDI AC REHAB	0	452, 483		0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 322, 473		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	6, 977, 641		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 239, 831		0		73.00
74.00 07400 RENAL DIALYSIS	0	1, 709		0		74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	)	0		76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	275, 806	,	0		92.00
200.00 Total (lines 50-199)	0	27, 330, 587	1	0		200.00

Health Financial Systems HEAR	RT HOSPITAL AT	DEACONESS GATE	VAY	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provi der		Period: From 10/01/2013 To 09/30/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0. 119760			0 0	40, 154	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 083312			0 0	74, 028	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 137800			0 0	1, 889, 299	1
60. 00 06000 LABORATORY	0. 212567			0 0	118, 444	1
64.00 06400 INTRAVENOUS THERAPY	0. 465679			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 257148			0 0	3, 942	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 070982			0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 111424			0 0	173, 132	69.00
69. 01 06902 CARDI AC REHAB	0. 638866			0 0	289, 076	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 452685			0 0	598, 664	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 501925	6, 977, 641		0 0	3, 502, 252	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 273764			0 43, 506	339, 421	73.00
74.00 07400 RENAL DIALYSIS	0. 347822	1, 709		0 0	594	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 720796	275, 806		0 0	198, 800	92.00
200.00 Subtotal (see instructions)		27, 330, 587		0 43, 506	7, 227, 806	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		27, 330, 587		0 43, 506	7, 227, 806	202.00

Heal th	Financial Systems HEAR	T HOSPITAL AT	DEACONESS GATEW	VAY	In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150175	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Pre 2/26/2015 5:0	
				e XVIII	Hospi tal	PPS	
			sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	-			
		6.00	7.00				
50, 00	ANCI LLARY SERVI CE COST CENTERS		0				50.00
50.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				50.00
54.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	0	0				60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00	06500 RESPIRATORY THERAPY	0	0				65.00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
69.00	06900 ELECTROCARDI OLOGY	0	0				69.00
69.00 69.01	06902 CARDI AC REHAB	0	0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
72.00	07300 DRUGS CHARGED TO PATIENTS	0	11, 910				73.00
	07400 RENAL DIALYSIS	0	0	1			74.00
	03020 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	•			76.00
70.00	OUTPATIENT SERVICE COST CENTERS		1 <u></u> 0	1			- /0.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
200.00		0	11, 910				200.00
200.00		0	11, 710				201.00
201.00	Only Charges						201.00
202.00		0	11, 910				202.00

Health Financial Systems HE	ART HOSPITAL AT	DEACONE	SS GATEW	VAY	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	P	rovi der		Period: From 10/01/2013 To 09/30/2014		
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Adj us	g Bed tment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col.			(col. 1 - col	•		
	26)			2)			
	1.00	2.	00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	903, 728	3	0	903, 72	6, 536	138.27	30.00
200.00 Total (lines 30-199)	903, 728	3		903, 72	6, 536		200.00
Cost Center Description	Inpatient Program days	Pro Capita (col.5	/				
	6.00	7.	00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDI ATRI CS	147		20, 326				30.00
200.00 Total (lines 30-199)	147	'	20, 326				200.00

······································	RT HOSPITAL AT I	DEACONESS GATE	VAY		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150175	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part II Date/Time Pre 2/26/2015 5:0	
			le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	r		- 1		
50. 00 05000 OPERATI NG ROOM	399, 214				20, 525	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2,767				26	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 595, 129				23, 699	
60. 00 06000 LABORATORY	7, 963				275	
64.00 06400 INTRAVENOUS THERAPY	20, 628			17 2, 386	33	
65. 00 06500 RESPI RATORY THERAPY	2,038	2, 207, 689	0.00092	23 103, 256	95	65. OC
66. 00 06600 PHYSI CAL THERAPY	254			55 30, 825	8	66. OC
69. 00 06900 ELECTROCARDI OLOGY	491, 754	17, 259, 397	0. 02849	92 88, 404	2, 519	69. OC
69. 01 06902 CARDI AC REHAB	56, 283	918, 110	0.06130	03 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 224	9, 985, 708	0.00162	25 221, 330	360	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	35, 401	19, 649, 190	0.00180	02 227, 745	410	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	10, 479	10, 662, 966	0.00098	33 379, 573	373	73.00
74.00 07400 RENAL DIALYSIS	16, 995	171, 740	0. 09895	58 0	0	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.0000	0 00	0	76.00
OUTPATIENT SERVICE COST CENTERS						]
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	124, 858	1, 284, 001	0. 09724	11 13, 498	1, 313	92.00
200.00 Total (lines 50-199)	2, 779, 987	146, 762, 180		3, 041, 919	49, 636	200 00

Health Financial Systems HEA	RT HOSPITAL AT	DEACO	NESS GATEW	ΙAΥ	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS			Period: From 10/01/2013 To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
				le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Alli	ed Health	All Other	Swi ng-Bed	Total Costs	
			Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	st Amount (see	1 through 3,	
					instructions)	minus col. 4)	
	1.00		2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	0		0		0 0	0	30.00
200.00 Total (lines 30-199)	0		0		0	0	200.00
Cost Center Description	Total Patient	Per D	iem (col.	Inpati ent	I npati ent		
	Days	5 ÷	col. 6)	Program Days	s Program		
			í.	5 5	Pass-Through		
					Cost (col. 7 x		
					col. 8)		
	6.00		7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	·						
30. 00 03000 ADULTS & PEDI ATRI CS	6, 536		0.00	14	17 0		30.00
200.00   Total (lines 30-199)	6, 536			14	17 0	ĺ	200. 00

Health Financial Systems HEAF	T HOSPITAL AT	DEACONESS GATE	WAY	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	SS Provi der	CCN: 150175	Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2013		
				To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Non Physiciar	Nursing School	Allied Healt		Total Cost	
	Anesthetist	Ŭ		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS				-		
50.00 05000 OPERATI NG ROOM		0 0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0 0		0 0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0 0		0 0	0	59.00
60. 00 06000 LABORATORY	(	0 0	)	0 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	(	0 0	)	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0 0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0 0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY		o o		0 0	0	69.00
69. 01 06902 CARDI AC REHAB		0 0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0 0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0 0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		o o		0 0	0	73.00
74.00 07400 RENAL DIALYSIS		o o		0 0	0	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS		o o		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	(	0 0	)	0 0	0	92.00
200.00   Total (lines 50-199)		o  C		0 0	0	200. 00

Health Financial Systems HEAR	Systems HEART HOSPITAL AT DEACONESS GATEWAY In Lieu of Form CMS-255					
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 10/01/2013 To 09/30/2014	Part IV	narad
				10 09/30/2014	Date/Time Pre 2/26/2015 5:0	Dareu: O nm
	Ti t	le XIX	Hospi tal	PPS	<u>o p</u>	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1	1		
50.00 OPERATING ROOM	0	16, 421, 008				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 248, 318				54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	46, 031, 264				59.00
60. 00 06000 LABORATORY	0	10, 435, 718				60.00
64.00 06400 INTRAVENOUS THERAPY	0	1, 492, 890			2, 386	64.00
65. 00 06500 RESPI RATORY THERAPY	0	2, 207, 689				65.00
66. 00 06600 PHYSI CAL THERAPY	0	994, 181	0.00000	0 0. 000000	30, 825	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	17, 259, 397	0.00000	0 0. 000000	88, 404	69.00
69. 01 06902 CARDI AC REHAB	0	918, 110			0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 985, 708	0.00000	0 0. 000000	221, 330	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	19, 649, 190	0.00000	0 0. 000000	227, 745	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 662, 966	0.00000	0 0. 000000	379, 573	73.00
74. 00 07400 RENAL DI ALYSI S	0	171, 740	0.00000	0 0. 000000	0	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.00000	0 0. 000000	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 284, 001	0.00000	0 0.000000		92.00
200.00 Total (lines 50-199)	0	146, 762, 180			3, 041, 919	200.00

Health Financial Systems HEAR	T HOSPITAL AT D	EACONESS GATE	VAY	In Lie	u of Form CMS-255	2-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150175	Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2013 To 09/30/2014		a d.
				To 09/30/2014	Date/Time Prepar 2/26/2015 5:00 p	meu:
		Tit		Hospi tal	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0	C		0		0. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		4.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0	-	9.00
60. 00 06000 LABORATORY	0	C		0		0. 00
64.00 06400 I NTRAVENOUS THERAPY	0	C		0	-	4.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0		5.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		6.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		9.00
69. 01 06902 CARDI AC REHAB	0	C		0		9. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		1. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0		2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		3.00
74. 00 07400 RENAL DIALYSI S	0	C		0		4.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	76	6.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		2.00
200.00   Total (lines 50-199)	0	C		0	200	0.00

Heal th Finar	ncial Systems HEAF	RT HOSPITAL AT I	DEACONESS GATE	VAY	In Lie	u of Form CMS-:	2552-10
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Pre 2/26/2015 5:0	pared: 0 pm
		_	Tit	le XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LARY SERVICE COST CENTERS	1					
	OPERATING ROOM	0. 119760			0 55, 840		
	D RADI OLOGY-DI AGNOSTI C	0. 083312			0 98, 659	0	54.00
	D CARDI AC CATHETERI ZATI ON	0. 137800			0 1, 737, 357	0	59.00
60.00 06000	DLABORATORY	0. 212567	0		0 118, 052	0	60.00
64.00 06400	DINTRAVENOUS THERAPY	0. 465679	0		0 0	0	64.00
65.00 06500	RESPI RATORY THERAPY	0. 257148	0		0 4, 462	0	65.00
66.00 06600	PHYSI CAL THERAPY	0. 070982	0		0 1, 680	0	66.00
69.00 06900	D ELECTROCARDI OLOGY	0. 111424	0		0 350, 686	0	69.00
69.01 06902	2 CARDI AC REHAB	0. 638866	0		0 32, 822	0	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 452685	0		0 195, 123	0	71.00
72.00 07200	DIMPL. DEV. CHARGED TO PATIENT	0. 501925	0		0 848, 602	0	72.00
73.00 07300	D DRUGS CHARGED TO PATIENTS	0. 273764	0		0 168, 980	0	73.00
74.00 07400	RENAL DIALYSIS	0. 347822	0		0 1, 882	0	74.00
76.00 03020	OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.00
OUTPA	ATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0. 720796	0		0 81, 978	0	92.00
200.00	Subtotal (see instructions)		0		0 3, 696, 123	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	1	0 3, 696, 123	0	202.00

Health Financial Systems HEAF	RT HOSPITAL AT	DEACONESS GATE	VAY	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST		CCN: 150175	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Pre 2/26/2015 5:0	
			le XIX	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				-
ANCI LLARY SERVI CE COST CENTERS		6, 687				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		8, 219				50.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		239, 408				59.00
60. 00 06000 LABORATORY		239, 408				60.00
64. 00 06400 INTRAVENOUS THERAPY		25, 094				64.00
65. 00 06500 RESPIRATORY THERAPY						65.00
66. 00 06600 PHYSI CAL THERAPY		1, 147 119				66.00
69. 00 06900 ELECTROCARDI OLOGY		39,075				69.00
69. 01  06900  ELECTROCARDI OLOGY 69. 01  06902  CARDI AC_REHAB		20, 969				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		88, 329				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		425, 935				72.00
73. 00 07300 DRUGS CHARGED TO PATIENT		425, 935				73.00
74. 00 07400 RENAL DIALYSIS		40, 201				74.00
76. 00 03020 OTHER ANCI LLARY SERVICE COST CENTERS						76.00
OUTPATIENT SERVICE COST CENTERS		<u>'i</u> 0	1			- 10.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		59, 089				92.00
200.00 Subtotal (see instructions)		960, 987				200.00
201.00 Less PBP Clinic Lab. Services-Program		700, 707				200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	C	960, 987				202.00

HEART	HOSPI TAL	AT	DEACONESS	GATEWAY	

In Lieu of Form CMS-2552-10

Heal th	Financial Systems HEART HOSPITAL AT DEAC	ONESS GATEWAY	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provider CCN: 150175	Peri od:	Worksheet D-1	
			From 10/01/2013 To 09/30/2014	2/26/2015 5:0	
	Cost Costor Description	Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			6, 536	
2.00 3.00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days do not complete this line.		rivate room days,	6, 536 0	
4.00	Semi-private room days (excluding swing-bed and observation bed	t days)		5, 633	4.00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period		er 31 of the cost	0	
6.00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7.00
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 3	31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	g swing-bed and	3, 008	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		room 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		room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year	ar, enter O on this lir	ne)	0	13.00
14.00	Medically necessary private room days applicable to the Program	n (excluding swing-bed	days)	0	
15.00 16.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT			0	10.00
17.00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 c	of the cost	0.00	17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	0.00	18.00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	19.00		
20.00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	the cost	0.00	20.00
21.00	reporting period Total general inpatient routine service cost (see instructions)			6, 698, 845	21.00
22.00	Swing-bed cost applicable to SNF type services through December		ing period (line	0, 070, 045	1
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3		0.1	0	
24 00	x line 18)	21 of the east report:	ng pariod (line	0	24.00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)				
	Swing-bed cost applicable to NF type services after December 31 x line 20)	or the cost reporting	j period (line 8	0	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 6, 698, 845	26.00 27.00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and abcomunition had a	22222	0	
28.00 29.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cr	arges)	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	
32.00	Average private room per diem charge (line 29 ÷ line 3)			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 minu		ctions)	0.00	
35.00 36.00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	: 31)		0.00	
36.00 37.00	General inpatient routine service cost net of swing-bed cost ar 27 minus line 36)	nd private room cost di	fferential (line	6, 698, 845	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see i	nstructions)		1, 024. 92	
39.00	Program general inpatient routine service cost (line 9 x line 3			3, 082, 959	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 4			0 3, 082, 959	40.00 41.00

		T HOSPITAL AT D				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2013	Worksheet D-1	
					Fo 09/30/2014		
			T: +1	o. XV/111	lloonital	2/26/2015 5:0	0 pm
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
			Inpatient Days			(col. 3 x col.	
				col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00 46.00
	OTHER SPECIAL CARE (SPECIFY)						40.00
	Cost Center Description						
10.00						1.00	40.00
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ne)		8, 168, 892 11, 251, 851	48.00 49.00
47.00	PASS THROUGH COST ADJUSTMENTS			(13)		11,231,031	47.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	415, 916	50.00
51.00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	ry services (fr	rom Wkst. D, su	um of Parts II	522, 332	51.00
E2 00	and IV)	(0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0				938, 248	52.00
	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		lated non-phy	sician anesthe	etist and	10, 313, 603	
00100	medical education costs (line 49 minus line 5		natoa, non phy	or or an anos the	dia dia	10/010/000	00,00
	TARGET AMOUNT AND LIMIT COMPUTATION					-	
	Program discharges Target amount per discharge					0.00	54.00 55.00
	Target amount (line 54 x line 55)					0.00	56.00
	Difference between adjusted inpatient operati	ng cost and ta	arget amount (I	ine 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions)		0	58.00			
59.00	Lesser of lines 53/54 or 55 from the cost rep market basket	pounded by the	0.00	59.00			
60.00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	arket basket		0.00	60.00
61.00							
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)		0	62.00			
	Allowable Inpatient cost plus incentive payme		0	63.00			
( 1 . 0.0	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Dece	emper 31 of the	cost reportir	ig period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65.00
	instructions)(title XVIII only)			-			
	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)				•	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	n December 31 o	of the cost rep	orting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost repor	ting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient r					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00
	Adjusted general inpatient routine service co	2					71.00
72.00	Program routine service cost (line 9 x line 7	71)					72.00
	Medically necessary private room cost applica						73.00
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•			art II column		74.00 75.00
70.00	26, line 45)						70.00
	Per diem capital-related costs (line 75 ÷ lir						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	Aggregate charges to beneficiaries for excess		orovi der record	s)			79.00
80.00	Total Program routine service costs for compa				us line 79)		80.00
81.00	Inpatient routine service cost per diem limit		\ \				81.00
82.00 83.00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82.00 83.00
	Program inpatient ancillary services (see ins		,				84.00
85.00	Utilization review - physician compensation (	(see instructio					85.00
86.00	Total Program inpatient operating costs (sum		nrough 85)				86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					903	87.00
88.00	Adjusted general inpatient routine cost per o		line 2)			1, 024. 92	88.00
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				925, 503	89.00

Health Financial Systems HEAR	T HOSPITAL AT I	DEACONESS GATEW	ΙAΥ	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2013	Worksheet D-1	
				To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	903, 728	6, 698, 845	0. 13490	925, 503	124, 858	90.00
91.00 Nursing School cost	0	6, 698, 845	0.00000	925, 503	0	91.00
92.00 Allied health cost	0	6, 698, 845	0.00000	925, 503	0	92.00
93.00 All other Medical Education	0	6, 698, 845	0.00000	925, 503	0	93.00

Health Financial System

HEART	HOSPI TAL	AT	DEACONESS	GATEWAY	

In Lieu of Form CMS-2552-10

Heal th	Financial Systems HEART HOSPITAL AT DEACO	NESS GATEWAY	In Lie	eu of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST	Provider CCN: 150175	Peri od:	Worksheet D-1		
			From 10/01/2013 To 09/30/2014	Date/Time Pre 2/26/2015 5:0		
		Title XIX	Hospi tal	PPS		
	Cost Center Description					
				1.00		
	PART I - ALL PROVIDER COMPONENTS				-	
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		6, 536	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 do not complete this line.	d and newborn days)	ivate room days,	6, 536 0	2.00 3.00	
4.00 5.00	<ul> <li>8.00 Semi-private room days (excluding swing-bed and observation bed days)</li> <li>5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost</li> </ul>					
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 reporting period	days) through December	31 of the cost	0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	8.00	
9.00	Total inpatient days including private room days applicable to newborn days)	147				
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructi	0				
11.00 12.00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX	er 0 on this line)	5,	0	11.00 12.00	
12.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	J	5	0		
	After December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program	r, enter O on this lin	e)	0	14.00	
15.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0		
	SWING BED ADJUSTMENT					
	Medicare rate for swing-bed SNF services applicable to services reporting period	C		0.00		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period					
	reporting period				19.00	
	Medicaid rate for swing-bed NF services applicable to services reporting period		ne cost	0.00		
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)		ing period (line	6, 698, 845 0	1	
23.00	Swing-bed cost applicable to SNF type services after December 3 x line 18) $$	1 of the cost reportin	g period (line 6	0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19) $$	·		0	24.00	
	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0		
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		0 6, 698, 845		
28.00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28.00	
29.00	Private room charges (excluding swing-bed charges)		-	0	1	
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		
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		
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	s line 33) (see instruc	tions)	0.00	1	
	Average per diem private room cost differential (line 34 x line		(1013)	0.00	1	
36.00	Private room cost differential adjustment (line 3 x line 35)	0.7		0.00	1	
37.00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	d private room cost di	fferential (line		1	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			·	1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS					
	Adjusted general inpatient routine service cost per diem (see i			1, 024. 92		
	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	-		150, 663 0	1	
	Total Program general inpatient routine service cost (line 39 +			150, 663	1	

Heal th	Financial Systems HEAF	RT HOSPITAL AT D	DEACONESS GATEW	VAY	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2013	Worksheet D-1	
					09/30/2014		pared:
			Ti t	le XIX	Hospi tal	2/26/2015 5: 00 PPS	) pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days			(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)		2.00	0100		0100	42.00
42.00	Intensive Care Type Inpatient Hospital Units	1					42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.00 44.00
	BURN I NTENSI VE CARE UNI T						45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			648, 522	48.00
49.00	Total Program inpatient costs (sum of lines	41 through 48)(	see instructio	ns)		799, 185	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	corvicos (from	Wket D cum	of Parts L and	20, 326	50.00
50.00	<pre>[11] [11] [11] [11] [11] [11] [11] [11]</pre>		Services (110m	I WKST. D, SUM		20, 320	50.00
51.00	Pass through costs applicable to Program inp and IV)	m of Parts II	49, 636	51.00			
52.00	Total Program excludable cost (sum of lines					69, 962	52.00
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		elated, non-phy	sician anesthe	tist, and	729, 223	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program discharges					0	54.00
	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	55. 00 56. 00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions)	5	5 .			0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re	pounded by the	0.00	59.00			
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. up	dated by the m	arket basket		0.00	60.00
	If line 53/54 is less than the lower of line				he amount by	0	61.00
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			0	
( 1 . 00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	( 1 00
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through bece	ember 31 01 the	cost reportin	ig period (see	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	61 plus line 6	5)(+i+l_ XVIII	oply) For	0	66.00
	CAH (see instructions)				•		
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 o	of the cost rep	orting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repor	ting 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 N						70.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						71.00
	Program routine service cost (line 9 x line			,			72.00
73.00	Medically necessary private room cost applic	0	•				73.00
74.00 75.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			rt II column		74.00 75.00
	26, line 45)						
	Per diem capital-related costs (line 75 ÷ li	,					76.00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.00 78.00
	Aggregate charges to beneficiaries for exces		orovi der record	ls)			79.00
80.00	Total Program routine service costs for comp		ost limitation	ı (line 78 minu	s line 79)		80.00
81.00	Inpatient routine service cost per diem limi		)				81.00 82.00
82.00 83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		· .				82.00 83.00
	Program inpatient ancillary services (see in		- /				84.00
	Utilization review - physician compensation	•					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)				86.00
87.00	Total observation bed days (see instructions					903	87.00
	Adjusted general inpatient routine cost per	•				1,024.92	
87. UU	Observation bed cost (line 87 x line 88) (se	e instructions)				925, 503	87. UU

Health Financial Systems HEAF	RT HOSPITAL AT	DEACONESS GATEW	ΙAΥ	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 10/01/2013 To 09/30/2014		
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	903, 728	6, 698, 845	0. 13490	B 925, 503	124, 858	90.00
91.00 Nursing School cost	0	6, 698, 845	0.00000	925, 503	0	91.00
92.00 Allied health cost	0	6, 698, 845	0.00000	925, 503	0	92.00
93.00 All other Medical Education	C	6, 698, 845	0.00000	925, 503	0	93.00

Health Financial Systems HEART H	HOSPITAL AT DEACONESS GATEWAY		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 1	F	eriod: rom 10/01/2013 o 09/30/2014	Worksheet D-3 Date/Time Pre	
				2/26/2015 5:0	
	Title XVII		Hospi tal	PPS	
Cost Center Description	Ratio	of Cost	Inpati ent	Inpati ent	
	To C	Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
	1	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			5, 868, 655		30.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATI NG ROOM		0. 119760		869, 558	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.083312		95, 171	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.139848		1, 031, 077	
60. 00 06000 LABORATORY		0.212733		968, 780	
64. 00 06400 I NTRAVENOUS THERAPY		0.465679		30, 672	
65. 00 06500 RESPI RATORY THERAPY		0.257148		299, 064	
66. 00 06600 PHYSI CAL THERAPY		0.070982		46, 561	
69. 00 06900 ELECTROCARDI OLOGY		0. 111424		124, 147	
69. 01 06902 CARDI AC REHAB		0.638866		0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.452685		1, 574, 810	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.501925		1, 763, 211	
73.00 07300 DRUGS CHARGED TO PATIENTS		0.273764		1, 139, 927	
74.00 07400 RENAL DIALYSIS		0.348830	116, 718	40, 715	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS		0.00000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.720796		185, 199	
200.00 Total (sum of lines 50-94 and 96-98)			34, 858, 276	8, 168, 892	200.00
201.00 Less PBP Clinic Laboratory Services-Progra	am only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			34, 858, 276		202.00

Health Financial Systems HEAR	T HOSPITAL AT DEACONESS GATEW	VAY	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Period: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Pre 2/26/2015 5:0	pared:
	Tit	le XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS ANCI LLARY SERVICE COST CENTERS			474, 675		30.00
50. 00 05000 OPERATI NG ROOM		0. 11976	60 844, 257	101, 108	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 08331	2 85, 879	7, 155	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 13984	683, 882	95, 640	59.00
60. 00 06000 LABORATORY		0. 21273	33 360, 884	76, 772	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 46567			
65. 00 06500 RESPI RATORY THERAPY		0. 25714			
66. 00 06600 PHYSI CAL THERAPY		0. 07098			
69. 00 06900 ELECTROCARDI OLOGY		0. 11142	88, 404	9, 850	69.00
69. 01 06902 CARDI AC REHAB		0. 63886		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 45268			
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 50192	25 227, 745	114, 311	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27376	379, 573	103, 913	73.00
74.00 07400 RENAL DIALYSIS		0. 34883	30 O	0	74.00
76.00 03020 OTHER ANCI LLARY SERVICE COST CENTERS		0.0000	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 72079			92.00
200.00 Total (sum of lines 50-94 and 96-98)			3, 041, 919	648, 522	
201.00 Less PBP Clinic Laboratory Services-Pro	gram only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		l	3, 041, 919		202.00

CUL.	ATION OF REIMBURSEMENT SETTLEMENT	Provi dei	r CCN: 150175	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Pi 2/26/2015 5	repared
		Ti t	le XVIII	Hospi tal	PPS	
		0	before 1/1 1.00	on/after 1/1 1.01	2.00	_
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS	0	1.00	1.01	2.00	-
0	DRG Amounts Other than Outlier Payments		9, 368, 3	34		1.0
)1	DRG amounts other than outlier payments for discharges			0		1.0
12	occurring prior to October 1, 2013 (see instructions)			0		1 1 0
)2	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)			0		1.0
)3	DRG for Federal specific operating payment for Model 4			0		1.0
	BPCI (see instructions)					
0	Outlier payments for discharges. (see instructions)		103, 2	50		2.0
)1 )2	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see			0		2.0
12	instructions)			0		2.0
00	Managed Care Simulated Payments			0		3.0
00	Bed days available divided by number of days in the cost		21.	53		4.0
	reporting period (see instructions)					_
0	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the		0.	00		5.0
0	most recent cost reporting period ending on or before		0.	00		5.0
	12/31/1996. (see instructions)					
00	FTE count for allopathic and osteopathic programs which		0.	00		6.0
	meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)					
0	MMA Section 422 reduction amount to the IME cap as		0.	00		7.0
-	specified under 42 CFR §412.105(f)(1)(iv)(B)(1)					
)1	ACA Section 5503 reduction amount to the IME cap as		0.	00		7.0
	specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the					
0	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for		0.	00		8. (
	allopathic and osteopathic programs for affiliated					
	programs in accordance with 42 CFR 413.75(b),					
	413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12,					
	1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.					
)1	The amount of increase if the hospital was awarded FTE cap		0.	00		8. (
	slots under section 5503 of the ACA. If the cost report					
12	straddles July 1, 2011, see instructions.			00		
)2	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506		0.	00		8. (
	of ACA. (see instructions)					
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		0.	00		9. (
00	lines (8, 8,01 and 8,02) (see instructions)		0.	00		10. (
00	FTE count for allopathic and osteopathic programs in the current year from your records		0.	00		10.1
00	FTE count for residents in dental and podiatric programs.		0.	00		11.0
00	Current year allowable FTE (see instructions)		0.			12.
	Total allowable FTE count for the prior year.		0.			13.
00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter		0.	00		14.
	zero.					
00	Sum of lines 12 through 14 divided by 3.		0.			15.0
00	Adjustment for residents in initial years of the program		0.			16.
00	Adjusment for residents displaced by program or hospital closure		0.	00		17.
00	Adjusted rolling average FTE count		0.	00		18.
00	Current year resident to bed ratio (line 18 divided by		0.0000	00		19.
	line 4).					
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)		0.0000			20.
	IME payment adjustment (see instructions)		0.0000	0		21.
	Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of	the MMA			
00	Number of additional allopathic and osteopathic IME FTE		0.	00		23.
00	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0	00		24
00 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter		0. 0.			24. 25.
	the lower of line 23 or line 24 (see instructions)		0.1			20.
00	Resident to bed ratio (divide line 25 by line 4)		0.0000			26.
	IME payments adjustment factor. (see instructions)		0.0000			27.
	IME add-on adjustment amount (see instructions)			0		28.
00	Total IME payment ( sum of lines 22 and 28) Disproportionate Share Adjustment			0		29.
00	Percentage of SSI recipient patient days to Medicare Part		0.	00		30.
	A patient days (see instructions)					
00	Percentage of Medicaid patient days (see instructions)		0.	00		31.

LCULA	TION OF REIMBURSEMENT SETTLEMENT		Provi de	r CCN: 150175	Period: From 10/01/2013 To 09/30/2014	Date/Time Pre	
					11	2/26/2015 5:00	0 pm
	· · · · · · · · · · · · · · · · · · ·			tle XVIII before 1/1	Hospital on/after 1/1	PPS	
			0	1.00	1. 01	2.00	
. 00 /	Allowable disproportionate share percentage (	see		0. (			33.
	instructions)						
. 00	Disproportionate share adjustment (see instru	ctions)			0	0 (1.5)	34.
				Prior to October 1		On/After October 1	
	-	0		1.00	1. 01	2.00	
ι	Incompensated Care Adjustment						
	Total uncompensated care amount (see				0	0	35.
. 01	instructions) Factor 3 (see instructions)			0. 0000000	20	0. 00000000	35.
	Hospital uncompensated care payment (If			0.0000000	0	0.0000000000000000000000000000000000000	35.
	line 34 is zero, enter zero on this line)				-	-	
	(see instructions)						
	Pro rata share of the hospital uncompensated				0	0	35.
	care payment amount (see instructions) Total uncompensated care (sum of columns 1				0		36.
	and 2 on Line 35.03)				0		30.
	Additional payment for high percentage of ESR	) beneficiary di	scharges	1			
. 00	Total Medicare discharges on Worksheet S-3,				0		40.
	Part I excluding discharges for MS-DRGs 652,						
	682, 683, 684 and 685 (see instructions)				0 0		11
	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see				0		41
	instructions)						
	Total ESRD Medicare covered and paid				0 0		41
	discharges excluding MS-DRGs 652, 682, 683,						
	684 an 685. (see instructions)				20		12
	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			0.0	50		42
	Total Medicare ESRD inpatient days excluding				0		43
	MS-DRGs 652, 682, 683, 684 an 685. (see						
	instructions)						
	Ratio of average length of stay to one week			0.0000	00		44
	(line 43 divided by line 41 divided by 7 days)						
	Average weekly cost for dialysis treatments			0.0	0. 00		45
	(see instructions)				0,00		
	Total additional payment (line 45 times line				0		46
	44 times line 41.01)						
	Subtotal (see instructions)			9, 471, 58	84		47
	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals				0		48
	only. (see instructions)						
	Total payment for inpatient operating costs			9, 471, 58	84		49
	SCH and MDH only (see instructions)						
	Payment for inpatient program capital (from			763, 6	78		50
	Norksheet L, Parts I, II, as applicable) Exception payment for inpatient program				0		51
	capital (Worksheet L, Part III, see				0		
	instructions)						
	Direct graduate medical education payment				0		52
	(from Worksheet E-4, line 49 see						
	instructions). Nursing and Allied Health Managed Care				0		53
	payment				Ŭ		33
	Special add-on payments for new technologies				0		54
	Net organ acquisition cost (Worksheet D-4				0		55
	Part III, col. 1, line 69)						-
	Cost of physicians' services in a teaching hospital (see intructions)				0		56
	Routine service other pass through costs				0		57
	(from Wkst D, Part III, column 9, lines 30				-		
	through 35).						_
	Ancillary service other pass through costs				U		58
	from Worksheet D, Part IV, col. 11 line 200) Total (sum of amounts on lines 49 through			10, 235, 20	52		59
	58)			10, 200, 20	-		
	Primary payer payments				0		60
	Total amount payable for program			10, 235, 20	62		61
	beneficiaries (line 59 minus line 60)			100 -	16		
	Deductibles billed to program beneficiaries			680, 5			62
	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			28, 30	08 67		63 64
	Adjusted reimbursable bad debts (see			18, 43			65
	instructions)						1

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT			CCN: 150175	Peri Fror To	iod: m 10/01/2013 09/30/2014	Worksheet E Part A Date/Time Pro 2/26/2015 5:0	epared: 00 pm
	· · · · · · · · · · · · · · · · · · ·		Title	e XVIII		Hospi tal	PPS	_
				Prior to			On/After	
				October 1			October 1	
		0		1.00		1.01	2.00	
66. 00	Allowable bad debts for dual eligible			19, 0	10			66.00
(7.00	beneficiaries (see instructions)			0 570 5	70			1 /7 00
67.00	Subtotal (line 61 plus line 65 minus lines			9, 572, 5	/8			67.00
68.00	62 and 63) Credits received from manufacturers for				0			68.00
06.00	replaced devices applicable to MS-DRG (see				0			00.00
	instructions)							
69.00	Outlier payments reconciliation (sum of				0			69.00
07.00	lines 93, 95 and 96). (For SCH see				Ŭ			07.00
	instructions)							
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)				0			70.00
	(SPECI FY)							
70.50	RURAL DEMONSTRATION PROJECT				0			70.50
70. 92	Bundled Model 1 discount amount				0			70.92
70. 93	HVBP incentive payment (see instructions)			33, 6	17			70.93
70. 94	Hospital readmissions reduction adjustment				0			70.94
	(see instructions)							
70. 95	Recovery of accelerated depreciation				0			70.95
70. 96	Low volume adjustment for federal fiscal		0		0			70.96
	year (yyyy) (Enter in column 0 the							
	corresponding federal year for the period							
	prior to 10/1)							
70. 97	Low volume adjustment for federal fiscal		0		0			70.97
	year (yyyy) (Enter in column O the							
	corresponding federal year for the period							
70 00	ending on or after 10/1)				~			70.00
70.98	Low Volume Payment-3			0 (0( 1)	0			70.98
71.00	Amount due provider (line 67 minus lines 68			9, 606, 1	95			71.00
71.01	plus/minus lines 69 & 70) Sequestration adjustment (see instructions)			192, 1	24			71.01
72.00	Interim payments			9, 396, 0				72.00
73.00	Tentative settlement (for contractor use			7, 370, 0	02			73.00
/ 5. 00	only)				0			/ 5. 00
74.00	Balance due provider (Program) line 71 minus			18, 0	69			74.00
	lines 71.01, 72 and 73							
75.00	Protested amounts (nonallowable cost report			18, 7	37			75.00
	items) in accordance with CMS Pub. 15-2,							
	chapter 1, §115.2							
	TO BE COMPLETED BY CONTRACTOR							
90.00	Operating outlier amount from Worksheet E,				0			90.00
	Part A line 2 (see instructions)							
91.00	Capital outlier from Worksheet L, Part I,				0			91.00
~ ~ ~	line 2				~			
92.00	Operating outlier reconciliation adjustment				0			92.00
93.00	amount (see instructions) Capital outlier reconciliation adjustment				0			93.00
93.00	amount (see instructions)				0			93.00
94.00	The rate used to calculate the time value of		·	0.	00			94.00
, 4. 00	money (see instructions)			0.1				/ . 00
95.00					0			95.00
	(see instructions)				Ŭ			
96.00	Time value of money for capital related				0			96.00
	expenses (see instructions)				- 1			

	DLUME CALCULATION EXHIBIT 4			Provider		Peri od:	Worksheet E	
						From 10/01/2013 To 09/30/2014		epa
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	9, 368, 334	0		0 9, 368, 334	9, 368, 334	I I
01	payments DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	0	0		o o	0	þ
2	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1. 02	0	0		o o	0	)
)3	DRG for Federal specific operating payment for Model 4 BPCI	1. 03	Ο	0		0 0	0	)
00	Outlier payments for discharges (see instructions)	2.00	103, 250	0		0 103, 250	103, 250	)
)1	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	)
00	Operating outlier reconciliation	2. 01	0	0		0 0	0	)
00	Managed care simulated payments	3.00	0	0		0 0	0	'
	Indirect Medical Education Adju					1		4
0	Amount from Worksheet E, Part	21.00	0. 000000	0.00000	0. 00000	0 0. 000000		1
0	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	0	0		o o	0	,
	Indirect Medical Education Adju	istment for the	Add_on for Se	ction 122 of t	ha MMA			
0	Amount from Worksheet E Part	27.00	0. 000000			0 0. 000000		1.
0	A, line 27 (see instructions)	27.00	0.000000	0.000000	0.00000	0 0.000000		
0	IME adjustment (see instructions)	28.00	0	0		0 0	0	)
0	Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	þ
	Disproportionate Share Adjustme	ent						1
00	Allowable disproportionate share percentage (see	33.00	0. 0000	0.0000	0.000	0 0. 0000		1
00	instructions) Disproportionate share adjustment (see instructions)	34.00	0	0		o o	0	) 1
01	Uncompensated care payments	36.00	0	0		0 0	0	1 1
	Additional payment for high per		RD beneficiary	di scharges				1
00	Total ESRD additional payment (see instructions)	46.00	0	0		0 0	0	0 1
00 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, small rural hospitals	47.00 48.00	9, 471, 584 0	0 0		0 9, 471, 584 0 0	9, 471, 584 0	
00	only. (see instructions) Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	9, 471, 584	0		0 9, 471, 584	9, 471, 584	1
00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	763, 678	0		0 763, 678	763, 678	1
00	Special add-on payments for new technologies	54.00	0	0		0 0	0	1
00	Capital outlier reconciliation adjustment amount (see	93.00	0	0		0 0	0	) 1
	instructions)							

_OW VO	Financial Systems LUME CALCULATION EXHIBIT 4				-	Period: From 10/01/2013 To 09/30/2014		pared:
				Title	e XVIII	Hospi tal	PPS	
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	737, 954	0		0 737, 954	737, 954	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	25, 724	0		25, 724	25, 724	21.00
	Model 4 BPCI Capital DRG outlier payments	2.01	0	0		0 0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0.0000		22.00
3. 00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0		0 0	0	23.00
	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0.0000		24.00
	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	I	0 0	0	25.00
6. 00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	763, 678	0		0 763, 678	763, 678	26.00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
7.00	Low volume adjustment factor				0.00000	0. 090357		27.00
	Low volume adjustment (transfer amount to W/S E Part A line)	70.96					0	28.00
9. 00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				924, 828	924, 828	29.00
00.00	Transfer low volume adjustments to W/S E Part A.		Y					100. 00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150175	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Pre 2/26/2015 5:0	
	·	Title XVIII	Hospi tal	PPS	
				1.00	-
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	-
	Medical and other services (see instructions)			11, 910	1 1
00	Medical and other services reimbursed under OPPS (see instruct	i ons)		7, 227, 806	
00	PPS payments			8, 345, 698	
00	Outlier payment (see instructions)			205, 899	4
00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	
00	Line 2 times line 5			0	
00	Sum of line 3 plus line 4 divided by line 6			0.00	
00 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Worksheet D, P.	art IV column 13 lin	a 200	0	
	Organ acquisitions		8 200	0	
	Total cost (sum of lines 1 and 10) (see instructions)			11, 910	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e charges				
	Ancillary service charges			43, 506	
	Organ acquisition charges (from Worksheet D-4, Part III, line	69, col. 4)		0	
	Total reasonable charges (sum of lines 12 and 13)			43, 506	114
	Customary charges Aggregate amount actually collected from patients liable for p	avment for services on	a charge basis	0	1 15
	Amounts that would have been realized from patients liable for	5	0	0	
	had such payment been made in accordance with 42 CFR 413.13(e)		on a onargozaoro	Ū	
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17
. 00	Total customary charges (see instructions)			43, 506	18
. 00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds li	ine 11) (see	31, 596	19
00	instructions)		10) (		
. 00	Excess of reasonable cost over customary charges (complete onl) instructions)	y IT II ne II exceeds II	ine 18) (see	0	20
00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		11, 910	21
	Interns and residents (see instructions)			0	
. 00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			8, 551, 597	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (for CAH, see instructions)		\ \	0	
	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus			1, 010, 561 7, 552, 946	
. 00	see instructions)	the sum of times 22 and	u 23) (TUI CAII,	7, 552, 940	21
00	Direct graduate medical education payments (from Worksheet E-4	, line 50)		0	28
	ESRD direct medical education costs (from Worksheet E-4, line			0	29
	Subtotal (sum of lines 27 through 29)			7, 552, 946	30
	Primary payer payments			4, 055	
	Subtotal (line 30 minus line 31)	50)		7, 548, 891	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Worksheet 1-5, line 11)	ES)		0	33
	Allowable bad debts (see instructions)			116, 682	
	Adjusted reimbursable bad debts (see instructions)			75, 843	
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		98, 304	
. 00	Subtotal (see instructions)			7, 624, 734	37
	MSP-LCC reconciliation amount from PS&R			-57	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Partial or full credits received from manufacturers for replace	ed devices (see instru	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 7, 624, 791	
	Sequestration adjustment (see instructions)			152, 496	
	Interim payments			7, 387, 474	
	Tentative settlement (for contractors use only)			0	
	Balance due provider/program (see instructions)			84, 821	
00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	chapter 1,	0	44
	\$115.2				1
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)				90
	Outlier reconciliation adjustment amount (see instructions)				91
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)				93
	Total (sum of lines 91 and 93)			0	94

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150175	Period: From 10/01/201 To 09/30/201		pare
		Titl	e XVIII	Hospi tal	PPS	
		I npati er	nt Part A	Pa	art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		9, 396, 0	02	7, 387, 474	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			<b>!</b>		
01	ADJUSTMENTS TO PROVIDER			0	0	1 3
02				0	0	3
03				0	0	
04				0	0	
05				0	0	3
- 0	Provider to Program	1		0		
50 51	ADJUSTMENTS TO PROGRAM			0	0	
52				0	0	
52 53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 396, 0	02	7, 387, 474	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
00	desk review. Also show date of each payment. If none,					Ĭ
	write "NONE" or enter a zero. (1)					
	Program to Provider	1	1		- 1	
01	TENTATI VE TO PROVIDER			0	0	
02				0	0	
03	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
50 51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		18, 0		84, 821	6
)2	SETTLEMENT TO PROGRAM		0 414 0	0	0	-
00	Total Medicare program liability (see instructions)		9, 414, 0	Contractor	7,472,295 NPR Date	7
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	
00	Name of Contractor					8

Heal th	Financial Systems HEART HOSPITAL AT DEACO	DNESS GATEWAY	In Lie	u of Form CMS-2	2552-10			
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150175	Peri od:	Worksheet E-1				
			From 10/01/2013					
			To 09/30/2014					
			llooni tol	2/26/2015 5:00	<u>o pm</u>			
		Title XVIII	Hospi tal	PPS				
				1.00				
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS							
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION							
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-	3, Part I column 15 li	ne 14	1, 499	1.00			
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8		3, 008	2.00				
3.00	3.00 Medicare HMO days from Wkst S-3, Part I, column 6. Line 2							
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1,	8-12		5, 633	4.00			
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			157, 877, 862	5.00			
6.00	Total hospital charity care charges from Wkst S-10, column 3 li	ne 20		2, 407, 155	6.00			
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Worksheet S-2,	0	7.00			
	Part I line 168							
8.00	Calculation of the HIT incentive payment (see instructions)			343, 310	8.00			
9.00	Sequestration adjustment amount (see instructions)			6, 866	9.00			
10.00	Calculation of the HIT incentive payment after sequestration (s	ee instructions)		336, 444	10.00			
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH							
30.00	Initial/interim HIT payment adjustment (see instructions)			361, 817	30.00			
31.00	Other Adjustment (specify)			0	31.00			
32.00	Balance due provider (line 8 (or line 10) minus line 30 and lin	e 31) (see instruction	is)	-25, 373	32.00			

ALANC	Financial Systems HEART HOSPITAL AT I E SHEET (If you are nonproprietary and do not maintain	Provi der	CCN: 150175	Period: From 10/01/2013	u of Form CMS- Worksheet G	
una-t	ype accounting records, complete the General Fund column onl	(y)		To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS	I	1			
00	Cash on hand in banks	1, 299, 622		0 0	0	
00 00	Temporary investments Notes receivable				0	
00	Accounts receivable	15, 497, 783		0 0	0	
00	Other receivable	0		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-8, 833, 043		o c	0	6.
00	Inventory	839, 522		0 C	0	
00	Prepai d expenses	172, 091		0 0	0	
00 ). 00	Other current assets Due from other funds	758, 090			0	
1.00	Total current assets (sum of lines 1-10)	9, 734, 065		0 0	0	
1.00	FI XED ASSETS	7,734,003	· · · · · · · · · · · · · · · · · · ·	<u> </u>	0	1
2.00	Land	0		0 0	0	12
8.00	Land improvements	0		0 0	0	13
. 00	Accumulated depreciation	0		0 0	0	
5.00	Buildings	0		0 0	0	
b. 00 7. 00	Accumulated depreciation Leasehold improvements				0	
3.00	Accumulated depreciation				0	
9.00	Fixed equipment	0		0 0	0	
0. 00	Accumulated depreciation	0		0 0	0	
I. 00	Automobiles and trucks	0		o c	0	21
2.00	Accumulated depreciation	0		0 C	0	
3.00	Major movable equipment	9, 211, 662		0 0	0	
1.00	Accumulated depreciation	-4, 310, 232			0	
. 00 . 00	Minor equipment depreciable Accumulated depreciation				0	
. 00 . 00	HIT designated Assets			0 0	0	
3.00	Accumulated depreciation	0		0 0	0	
9.00	Mi nor equi pment-nondepreci abl e	0		o o	0	29
0. 00	Total fixed assets (sum of lines 12-29)	4, 901, 430	(	0 0	0	30
	OTHER ASSETS		1			1
. 00	Investments	0			0	
2.00 3.00	Deposits on leases Due from owners/officers				0	
I. 00	Other assets	6, 658, 814		0 0	0	
5.00	Total other assets (sum of lines 31-34)	6, 658, 814		0 0	0	
5.00	Total assets (sum of lines 11, 30, and 35)	21, 294, 309		0 0	0	
	CURRENT LI ABI LI TI ES					
7.00	Accounts payable	2, 261, 021		0 C	0	
3.00	Salaries, wages, and fees payable	861, 750		0 0	0	
9.00	Payroll taxes payable Notes and loans payable (short term)	0			0	
). 00 . 00	Deferred income	210, 735			0	
2.00	Accel erated payments			0	0	42
3.00	Due to other funds	0		o o	0	
4.00	Other current liabilities	1, 660, 398		o o	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	4, 993, 904		0 0	0	45
	LONG TERM LI ABI LI TI ES	-	1	-		1
5.00	Mortgage payable	0		0 0	0	
7.00 3.00	Notes payable Unsecured Loans	760, 886			0	
9.00 9.00	Other long term liabilities				0	
. 00	Total long term liabilities (sum of lines 46 thru 49	760, 886		0 0	0	
. 00	Total liabilites (sum of lines 45 and 50)	5, 754, 790		0 0	0	
	CAPI TAL ACCOUNTS					
. 00	General fund balance	15, 539, 519				52
. 00	Specific purpose fund			0		53
. 00	Donor created - endowment fund balance - restricted			0		54
5.00 5.00	Donor created - endowment fund balance - unrestricted			0		55
. 00 . 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	
3.00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	
9.00	Total fund balances (sum of lines 52 thru 58)	15, 539, 519		o o	0	
0. 00	Total liabilities and fund balances (sum of lines 51 and	21, 294, 309		n n	0	60

		T HOSPITAL AT D			_		u of Form CMS-	
STATEM	ENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 150175		eriod: com 10/01/2013 o 09/30/2014	Worksheet G- Date/Time Pro 2/26/2015 5:0	epared:
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fund	I
		1.00	2.00	3.00		4.00	5.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) DISTRIBUTIONS TO MEMBERS Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0 0 12, 918, 474 0 0 0 0 0 0 0	14, 578, 775 13, 879, 218 28, 457, 993 0 28, 457, 993 12, 918, 474 15, 539, 519			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
	sheet (line 11 minus line 18)					0		
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) DISTRIBUTIONS TO MEMBERS	0 0	0 0 0 0 0 0 0		0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0 0			18 19

STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150175		i od: m 10/01/2013 09/30/2014	Worksheet G-2 Parts I & II Date/Time Pre	pared:
			1		0	2/26/2015 5:00	0 pm
	Cost Center Description		<u>Inpatient</u> 1.00		Outpatient 2.00	<u>Total</u> 3.00	
	PART I – PATIENT REVENUES		1.00		2.00	3.00	
	General Inpatient Routine Services						
1.00	Hospi tal		11, 728, 8	74		11, 728, 874	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVI DER						4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		11, 728, 8	74		11, 728, 874	10.00
11 00	Intensive Care Type Inpatient Hospital Services				I		111 00
11.00 12.00	I NTENSI VE CARE UNI T						11.00 12.00
12.00	BURN INTENSIVE CARE UNIT						12.00
13.00	SURGI CAL INTENSIVE CARE UNIT						14.00
14.00	OTHER SPECIAL CARE (SPECIFY)						14.00
16.00	Total intensive care type inpatient hospital services (sum of li	nes		0		0	
10.00	11-15)	nes		0		0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		11, 728, 8	74		11, 728, 874	17.00
18.00	Ancillary services		73, 769, 2		59, 647, 582	133, 416, 874	18.00
19.00	Outpatient services		-, - ,	0	920, 883	920, 883	•
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPICE						26.00
27.00	OTHER (SPECIFY)		05 400 4	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	WKST.	85, 498, 1	66	60, 568, 465	146, 066, 631	28.00
	G-3, line 1) PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				42, 525, 557		29.00
30.00	ADD (SPECIFY)			0	42, 525, 557		30.00
31.00				0			31.00
32.00				Ö			32.00
33.00				Ö			33.00
34.00				Ö			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)			-	0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00	GROSS UP CREDITS SVC TO DEACONESS		2, 574, 0	77			38.00
39.00	ROUNDING			6			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				2, 574, 083		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(	transfer			39, 951, 474		43.00
	to Wkst. G-3, line 4)						

Heal th	Health Financial Systems HEART HOSPITAL AT DEACONESS GATEWAY In Lieu						
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 150175	Peri od:	Worksheet G-3			
			From 10/01/2013		l		
			To 09/30/2014	Date/Time Prep 2/26/2015 5:00			
				2/20/2010 0.0			
				1.00			
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		146, 066, 631	1.00		
2.00	Less contractual allowances and discounts on patients' accounts	5		92, 961, 108	2.00		
3.00	Net patient revenues (line 1 minus line 2)			53, 105, 523	3.00		
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		39, 951, 474	4.00		
5.00	Net income from service to patients (line 3 minus line 4)			13, 154, 049	5.00		
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc			0	6.00		
7.00	Income from investments			1, 357	7.00		
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8.00		
9.00	Revenue from television and radio service			0	9.00		
10.00				0	10.00		
11.00				0	11.00		
12.00				0	12.00		
13.00	,			0	13.00		
	Revenue from meals sold to employees and guests			0	14.00		
	Revenue from rental of living quarters			0	15.00		
	Revenue from sale of medical and surgical supplies to other that	an patients		0	16.00		
	Revenue from sale of drugs to other than patients			0	17.00		
	Revenue from sale of medical records and abstracts			0	18.00		
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00		
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00		
21.00				0	21.00		
22.00				0	22.00		
23.00				0	23.00		
24.00				723, 812	24.00		
25.00				725, 169	25.00		
26.00	Total (line 5 plus line 25)			13, 879, 218			
27.00				0	27.00		
	Total other expenses (sum of line 27 and subscripts)			0	28.00		
29.00	Net income (or loss) for the period (line 26 minus line 28)			13, 879, 218	29.00		

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 150175	Period: From 10/01/2013	Worksheet L Parts I-III	
			To 09/30/2014	Date/Time Pre 2/26/2015 5:0	
		Title XVIII	Hospi tal	PPS	
			-	1.00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				-
00	Capital DRG other than outlier			737, 954	1.
00	Model 4 BPCI Capital DRG other than outlier			/3/, /34	
00	Capital DRG outlier payments			25, 724	
01	Model 4 BPCI Capital DRG outlier payments			23, 724	
00	Total inpatient days divided by number of days in the cost report	rting period (see inst	ructions)	15.69	
00	Number of interns & residents (see instructions)			0.00	
00	Indirect medical education percentage (see instructions)			0.00	
00	Indirect medical education adjustment (multiply line 5 by the su	um of lines 1 and 1.01	)	0	6.
00	Percentage of SSI recipient patient days to Medicare Part A pati 30) (see instructions)			0.00	7.
00	Percentage of Medicaid patient days to total days (see instruction	i ons)		0.00	8.
00	Sum of lines 7 and 8			0.00	9
. 00	Allowable disproportionate share percentage (see instructions)			0.00	10
I. 00	Disproportionate share adjustment (line 10 times the sum of line	es 1 and 1.01)		0	11
2.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.0	01, 6 and 11)		763, 678	12
			-	1.00	
	PART II – PAYMENT UNDER REASONABLE COST				
00	Program inpatient routine capital cost (see instructions)			0	
00	Program inpatient ancillary capital cost (see instructions)			0	
00	Total inpatient program capital cost (line 1 plus line 2)			0	
00	Capital cost payment factor (see instructions)			0	4.
00	Total inpatient program capital cost (line 3 x line 4)			0	5
				1.00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 1
00 00	Program inpatient capital costs (see instructions)	(coo instructions)		0	
00	Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2)	(see Thisti uctions)		0	
00	Applicable exception percentage (see instructions)			0.00	-
00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
00	Percentage adjustment for extraordinary circumstances (see insti	ructions)		0.00	
00	Adjustment to capital minimum payment level for extraordinary ci		line 6)	0.00	
00	Capital minimum payment level (line 5 plus line 7)			0	
00	Current year capital payments (from Part I, line 12, as applical	bl e)		0	
0.00	Current year comparison of capital minimum payment level to capi		less line 9)	0	
. 00	Carryover of accumulated capital minimum payment level over capi Worksheet L, Part III, line 14)			0	
2.00	Net comparison of capital minimum payment level to capital payme	ents (line 10 plus lin	e 11)	0	12.
3.00	Current year exception payment (if line 12 is positive, enter th			0	
1 00	Carryover of accumulated capital minimum payment level over capi			0	

0 14.00

0 15.00 0 16.00 0 17.00

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)
15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)