This payme	report is required by law (42 USC 1395g; 42 nts made since the beginning of the cost rep	orting period being	lure to repo deemed over	rt can resul payments (42	t in all intorin	eu of Form CMS FORM APPROVE OMB NO. 0938 EXPIRES 05-3	D -0050
AND S	TAL AND HOSPITAL HEALTH CARE COMPLEX COST RE ETTLEMENT SUMMARY	PORT CERTIFICATION	Provider CC	N: 15-0175	Period: From 10/01/2015 To 09/30/2016		
	I - COST REPORT STATUS						
Provi	- Cost i				Date: 2/27/20	017 Time:	2:45 pm
use o	1ly 2.[] Manually submitted cost rep 3.[0] If this is an amended repor 4.[F] Medicare Utilization. Enter	t enter the number	of times the " for low.	provider re	esubmitted this o	cost report	
Contruse of	nly (1) As Submitted 7. Con (2) Settled without Audit 8. [N	e Received: tractor No.]Initial Report fo]Final Report for	or this Provi this Provide	der CCN 12. [or Code: olumn 1 is 4: mes reopened =	
PART	II - CERTIFICATION						
PROVID	PRESENTATION OR FALSIFICATION OF ANY INFORMAL STRATIVE ACTION, FINE AND/OR IMPRISONMENT UPDED OR PROCURED THROUGH THE PAYMENT DIRECTLY CERTIFICATION BY OFFICER OR ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT IN CERTIFICATION BY OFFICER OR ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT IN EXPENSES PREPARED BY HEART HOSPITAL AT DE 10/01/2015 and ending 09/30/2016 and to the correct, complete and prepared from the binstructions, except as noted. If further provision of health care services, and the compliance with such laws and regulations Encryption Information ECR: Date: 2/27/2017 Time: 2:45 pm T69:TILLTB&KGEAIE4NMCENVRJOEJHO	NDER FEDERAL LAW. OR INDIRECTLY OF A MAY RESULT. WISTRATOR OF PROVIDING to cortification st d cost report and t ACONESS GATEWAY (1) he best of my knowl ooks and records of certify that I am at the services ide	ER(S) atement and the Balance State of	that I have neet and Stathe cost registry in accordant the laws a point cost representation or Adminis	examined the acc tement of Revenu porting period b port and stateme nce with applica nd regulations r ort were provide	ompanying e and eginning nt are true, ble egarding the d in	3.0
	ZZU1E001Jw01kS2wrnCkRxwzabwewB 7QTf0N.81r0Aw8ar PI: Date: 2/27/2017 Time: 2:45 pm ROUh8FKPgZHL4yfR10M13Fp1.CCNx0	4	EXECUT.	WE DI.	RECTOR \$	CNO	
	UPe0b08vg.jAGjcGJP9T3OCF1cg4qq wUtr09zEfr0Kyw65		Date	mary	30,0	011	
		Title V	Part A 2.00	Part B	HIT 4.00	Title XIX	
	PART III - SETTLEMENT SUMMARY	1.00	2.00	3.00	4.00	3.00	-
1.00 2.00 3.00 5.00	Hospital Subprovider - IPF Subprovider - IRF Swing bed - SNF	0 0 0	27,589 0 0		5 0 0 0	0 0 0	2.00 3.00

	TILLE X	VIII			
Title V	Part A	Part B	HIT	Title XIX	
1.00	2.00	3.00	4.00		
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0	27.589	46.265	0	0	1.00
0	0	0		0	2.00
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0	27,589	46,265	0	0	200.00
	1.00 0 0 0 0 0	Title V Part A 1.00 2.00 0 27,589 0 0 0 0 0 0 0 0 0 27,589	Title V Part A Part B 1.00 2.00 3.00 0 27,589 46,265 0	Title V Part A Part B HIT 1.00 2.00 3.00 4.00 0 27,589 46,265 0	1.00 2.00 3.00 4.00 5.00 0 27,589 46,265 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved. 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0175 Peri od: Worksheet S-2 From 10/01/2015 To 09/30/2016 Part I Date/Time Prepared: 2/27/2017 2:04 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 4007 GATEWAY BOULEVARD 1.00 PO Box: 1.00 State: IN 2.00 City: NEWBURGH Zi p Code: 47630-County: WARRICK 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HEART HOSPITAL AT 150175 21780 1 02/23/2009 Ν 3.00 DEACONESS GATEWAY Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2015 09/30/2016 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 | Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 Ν 23 00 3 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days pai d days unpai d el i gi bl e days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2. out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

OSPITAL AND HOSPITAL H	S HEART HOSPITA EALTH CARE COMPLEX IDENTIFICATION DAT		Provi der CC	N: 15-0175	Peri od:		Workshe		
					From 10/01/ Fo 09/30/	/2015 /2016	Part I Date/Ti 2/27/20		
					Urban/Rui 1.00		Date of 2. C		
	ard geographic classification (not wag		is at the beg	inning of the	_	1	2.0		26.
7.00 Enter your standareporting period.	eriod. Enter "1" for urban or "2" for ard geographic classification (not wag Enter in column 1, "1" for urban or	ge) statı "2" for	rural. If ap			1			27.
5.00 If this is a sole	ve date of the geographic reclassific e community hospital (SCH), enter the st reporting period.			H status in		0			35.
					Begi nni 1. 00		Endi i		
	beginning and ending dates of SCH sta		script line	36 for number	_		2.0	10	36.
7.00 If this is a Medi	cess of one and enter subsequent dates care dependent hospital (MDH), enter		er of period	s MDH status		0			37.
7.01 Is this hospital	the cost reporting period. a former MDH that is eligible for the TY 2016 OPPS final rule? Enter "Y" for								37.
instructions)	enter the beginning and ending dates	•							38.
greater than 1, s	subscript this line for the number of								30.
enter subsequent	dates.				Y/N		Y/I	N	
9.00 Does this facilit	ry qualify for the inpatient hospital	pavment	adiustment f	or low volume	1. 00 N		2. C		39.
hospitals in acco	ordance with 42 CFR §412.101(b)(2)(ii) bes the facility meet the mileage requ)? Enter	in column 1	"Y" for yes					
CFR 412.101(b)(2) 0.00 Is this hospital	(ii)? Enter in column 2 "Y" for yes of subject to the HAC program reduction umn 1, for discharges prior to Octobe	or "N" fo adjustme	or no. (see i ent? Enter "Y	nstructions) " for yes or	N		N		40
no in column 2, 1	for discharges on or after October 1.	(see ins	structions)			V	XVIII	XI X	
						1.00		3.00	
	ent System (PPS)-Capital by qualify and receive Capital payment	t for dis	sproporti onat	e share in ac	cordance	N	N	N	45.
5.00 Is this facility pursuant to 42 CF	on §412.320? (see instructions) eligible for additional payment excep R §412.348(f)? If yes, complete Wkst.					N	N	N	46
7.00 Is this a new hos 3.00 Is the facility (Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for r Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N N	N N	47 48
Teaching Hospital 5.00 Is this a hospital	s Il involved in training residents in a	approved	GME programs	? Enter "Y"	for yes	N			56
or "N" for no. 7.00 If line 56 is yes	s, is this the first cost reporting pe	eriod dur	ina which re	sidents in ap	proved				 57
GME programs trai is "Y" did reside for yes or "N" fo	ned at this facility? Enter "Y" for ents start training in the first month or no in column 2. If column 2 is "Y" st. D, Parts III & IV and D-2, Pt. II,	yes or " h of this ", comple	N" for no in s cost report ete Worksheet	column 1. If ing period?	column 1 Enter "Y"				
3.00 If line 56 is yes	s, did this facility elect cost reimbu ub. 15-1, chapter 21, §2148? If yes, c	ursement	for physicia	ns' services	as				58
9.00 Are costs claimed	I on line 100 of Worksheet A? If yes,	, complet	e Wkst. D-2,			N			59
	nursing school and/or allied health of criteria under §413.85? Enter "Y" f					N			60
		Y/N	IME	Direct GME	IME		Di rect	GME	
00 01 1	- FTE - L - L - L - L - L - L - L - L - L -	1. 00	2. 00	3. 00	4.00		5. C		
section 5503? Ent						0.00		0. 00	61
FTEs from the hosending and submit	e number of unweighted primary care spital's 3 most recent cost reports sted before March 23, 2010. (see		0. 00	0.0	OO				61
FTE count (exclud	: year total unweighted primary care ling OB/GYN, general surgery FTEs, FTEs added under section 5503 of		0. 00	0.0	od				61
ACA). (see instru .03 Enter the base li			0. 00	0.0	oo				61
instructions) .04 Enter the number	iance with the 75% test. (see of unweighted primary care/or		0. 00	0.0	00				61
current cost repo	c and/or osteopathic FTEs in the orting period. (see instructions). Ence between the baseline primary		0. 00	0.0	od				61
and/or general su	irgery FTEs and the current year's //or general surgery FTE counts (line		3.39						

Health Financial Systems			EACONESS GATEW			u of Form CMS-2		
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	ATA	Provi der CC	F	Period: From 10/01/2015 To 09/30/2016		pared:	
		Y/N	I ME	Direct GME	IME	Direct GME	- piii	
61.06 Enter the amount of ACA §5503 awa used for cap relief and/or FTEs care or general surgery. (see ins	hat are nonprimary	1. 00	2.00	3.00	4.00	5. 00	61. 06	
jeure or general surgery. (See This	structions)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
			1. 00	2. 00	3.00	4.00		
61.10 Of the FTEs in line 61.05, special special ty, if any, and the number for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count.	of FTE residents uctions) Enter in in column 2, the the IME FTE				0. 00	0.00	61.10	
61.20 Of the FTEs in line 61.05, special program specialty, if any, and the residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program column 2, the IME FTE unweighted count 4, direct GME FTE unweighted count	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0. 00	61. 20	
						1.00		
ACA Provisions Affecting the Heal	th Resources and Se	rvi ces i	Administration	(HRSA)		1.00		
62.00 Enter the number of FTE residents	,		d in this cost	reporting per	iod for which	0.00	62.00	
your hospital received HRSA PCRE 62.01 Enter the number of FTE residents during in this cost reporting per	s that rotated from a riod of HRSA THC pro	a Teachi gram. (s	see instruction		your hospital	0.00	62. 01	
63.00 Has your facility trained resider	Teaching Hospitals that Claim Residents in Nonprovider Settings .00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)							
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
C+: FFOA -6 +b- ACA D V	- FTF D! ! N		C-++:	1.00	2.00	3.00		
Section 5504 of the ACA Base Year period that begins on or after Ju			9	inis base year	is your cost i	eportring		
64.00 Enter in column 1, if line 63 is in the base year period, the number resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column)	yes, or your facili per of unweighted non cations occurring in number of unweighted ur hospital. Enter in	ty trair n-priman all nor d non-pr n columr	ned residents ry care nprovider rimary care n 3 the ratio	0. 00	0.00	0. 000000	64.00	
	Program Name Prog		ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00		2. 00	3. 00	4.00	5.00		
65.00 Enter in column 1, if line 63 (is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column		0		0.00	0.00	0. 000000	. 63. 00	

Health Financial Systems HEART HOSPITAL AT D	DEACONESS GATEW	/AY	In Li	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		eriod: rom 10/01/2015 o 09/30/2016		epared:
	1	1	V	XI X	
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			1. 00 0. 00 N	2. 00 0. 00 N	95. 00 96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the approximate approximately approximately approximately approximately approximately applicable column.	plicable column	า.	0.00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (C/L) 106.00 of this facility qualifies as a CAH, has it elected the all-		nod of payment	N N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, column reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see insti	ructions) If	N		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108. 00
	Physi cal 1.00	0ccupational 2.00	Speech 3.00	Respiratory 4.00	
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
440.00 00 111111111111111111111111111111		(440		1.00	110.00
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)Tor	N	110. 00
Mi good Langevia Cost Deporting Information			1. (00 2.00 3.00	
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes on	r "N" for no in	n column 1. If	column 1 N	0	115. 00
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	. If column 2 i nt for long te	is "E", enter i rm care (includ	n column es		
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur			N" for Y		116. 00 117. 00
118.00 Is the mal practice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	f the policy i	s 1		118. 00
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	+
118.01 List amounts of malpractice premiums and paid losses:		6, 876		0	0118.01
			1. 00	2.00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.	center other dule listing co	than the ost centers	N		118. 02
119.00 DO NOT USE THIS LINE 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 qualified Hold Harmless provision in ACA §3121 and applicable amendments.	n column 1, "Y' ualifies for th	' for yes or ne Outpatient	N	N	119. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Υ		121. 00
122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.			N		122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no lf	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.			IN IN		
126.00 f this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2		fication date			126. 00
127.00 If this is a Medicare certified heart transplant center, en	ter the certifi	cation date			127. 00
in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2	ter the certifi	cation date			128. 00
129.00 If this is a Medicare certified lung transplant center, enter		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 column 131.00 of this is a Medicare certified intestinal transplant center	r, enter the c	erti fi cati 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 in column 1 and termination date, if applicable, in column 2	ter the certifi	cation date			132. 00

Health Financial Systems HEART H HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATI		Provider CC				u of Form CMS Worksheet S- Part I Date/Time Pr 2/27/2017 2:	-2 repared:
					1. 00	2. 00	_
133.00 f this is a Medicare certified other transplant	center ent	er the certifi	cation date		1.00	2.00	133. 00
in column 1 and termination date, if applicable, 134.00 If this is an organ procurement organization (OF	in column 2 PO), enter the						134. 00
and termination date, if applicable, in column 2 All Providers	<u>.</u>						
140.00 Are there any related organization or home offic chapter 10? Enter "Y" for yes or "N" for no in care claimed, enter in column 2 the home office of	column 1. If	yes, and home	office cost	6	Υ	HB0778	140. 00
1.00	2. 00	•	10113)		3. 00		
If this facility is part of a chain organization				name and		of the	
home office and enter the home office contractor							
	or's Name: WPS	;	Contract	or's Nu	mber: 0800	1	141. 00
142.00 Street: 600 MARY STREET PO Box:	LN		7: n Code	· .	4771	0	142. 00
143.00 City: EVANSVILLE State:	IN		Zi p Code	ð: 	4771	U	143. 00
						1. 00	
144.00 Are provider based physicians' costs included in	Worksheet A	?				Y	144. 00
					1. 00	2. 00	
145.00 If costs for renal services are claimed on Wkst.					Υ		145. 00
inpatient services only? Enter "Y" for yes or "N no, does the dialysis facility include Medicare period? Enter "Y" for yes or "N" for no in colu	utilization ³						
146.00 Has the cost allocation methodology changed from Enter "Y" for yes or "N" for no in column 1. (Se	n the previous ee CMS Pub. 19			f	N		146. 00
yes, enter the approval date (mm/dd/yyyy) in col	uiiii Z.						
						1.00	
147.00 Was there a change in the statistical basis? Ent	er "Y" for y	es or "N" for	no.			N	147. 00
148.00 Was there a change in the order of allocation? E	inter "Y" for	yes or "N" fo	r no.			N	148. 00
149.00 Was there a change to the simplified cost findir	ig method? En					N	149. 00
	-	Part A	Part B	T	itle V	Title XIX	
Does this facility contain a provider that quali	fine for an	1.00	2.00	ation of	3.00	4.00	
or charges? Enter "Y" for yes or "N" for no for							
155.00Hospi tal		N	N		N	N	155. 00
156.00 Subprovider - IPF		N	N		N	N	156. 00
157. 00 Subprovi der – I RF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N		N N	N N	160. 00 161. 00
101. 00 CWITC			IV.		IV	IV	101.00
						1. 00	
Multicampus							
165.00 Is this hospital part of a Multicampus hospital	that has one	or more campu	ses in diff	erent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.		County	Ctata 7	n Codo	CDCA	FTF /Compus	
Name		County 1.00	State Zi	p Code 3. 00	4. 00	FTE/Campus 5.00	
				3.00	4.00		00 166. 00
0 166 OOLf Line 165 is yes for each						٠.,	00.00
166.00 If line 165 is yes, for each campus enter the name in column							
166.00 f line 165 is yes, for each							
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,							
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,							
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						1.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	n the America			nt Act		1.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT) incentive in 167.00 Is this provider a meaningful user under §1886(r	n)? Enter "Y	n Recovery and " for yes or "	Reinvestme N" for no.			1.00 Y	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive in 167.00 Is this provider a meaningful user under §1886(r 168.00 If this provider is a CAH (line 105 is "Y") and	n)? Enter "Y is a meaning	n Recovery and " for yes or " ful user (line	Reinvestme N" for no.		the		
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive in 167.00 Is this provider a meaningful user under \$1886(rampus) 168.00 If this provider is a CAH (line 105 is "Y") and reasonable cost incurred for the HIT assets (see	n)? Enter "Y is a meaning e instruction	n Recovery and " for yes or " ful user (line s)	Reinvestme N" for no. 167 is "Y"), enter			167. 00 0168. 00
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive in 167.00 Is this provider a meaningful user under \$1886 (reasonable cost incurred for the HIT assets (see 168.01 If this provider is a CAH and is not a meaningful	n)? Enter "Y is a meaning e instruction ul user, does	n Recovery and " for yes or " ful user (line s) this provider	Reinvestme N" for no. 167 is "Y";), enter a hard			
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive in 167.00 Is this provider a meaningful user under \$1886(rate) 168.00 If this provider is a CAH (line 105 is "Y") and reasonable cost incurred for the HIT assets (see	n)? Enter "Y is a meaning e instruction: ul user, does yes or "N"	n Recovery and " for yes or " ful user (line s) this provider for no. (see i	Reinvestme N" for no. 167 is "Y"; qualify for), enter a hard	shi p	Y	0168.00

Health Financial Systems	ACONESS GATEWAY	In Lie	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Peri od: From 10/01/2015	Worksheet S-2		
				Date/Time Pre 2/27/2017 2:0	
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	10/03/2016	12/31/2016	170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this pro	vider have any days for indi	viduals enrolled in	N	0	171. 00
section 1876 Medicare cost plans	reported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in col	umn 1. If column 1 is yes, e	enter the number of section	n		
1876 Medicare days in column 2. (see instructions)				

lospi t	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0175	Peri od: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Pre 2/27/2017 2:0	epared:
		-		Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	I for all NO re	esponses. Ente	er all dates in t	ine	
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	e beginning of column 2. (see	the cost	N		1.00
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare F)ragram? I.f	1. 00 N	2. 00	3. 00	2.00
00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	Y			2.00
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home commedical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other			3.00		
	relationships? (see instructions)		Y/N	Tymo	Data	
			1.00	7ype 2.00	Date 3.00	
	Financial Data and Reports		1.00	2.00	0.00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	A		4.00		
00	Are the cost report total expenses and total revenues differentiations on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues differentiations.		Y			5. 00
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		ne provider is	S N		6.00
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7. 00 8. 00
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		N		9.00
. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N N		10.00
1. 00	Teaching Program on Worksheet A? If yes, see instructions.	a it iii ali App	71			11.00
					Y/N	
	Bad Debts				1. 00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes	s. see instruct	i ons.		Υ	12.00
3. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	oolicy change o	during this co		N	13. 00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti				N N	14.00
5. 00	plid total beds available change from the pirol cost reporti		t A		t B	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
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	N		N		16. 00
00	date of the PS&R 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 for allocation? If	Y	02/01/2017	Y	02/01/2017	17. 00
. 00	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 made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					1

19.00

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.

Heal th	Financial Systems HEART HOSPITAL AT	DEACONESS GATE	VAY	In Lie	u of Form CMS-:	2552-10				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0175	Peri od: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Pre 2/27/2017 2:0	pared:				
			ipti on	Y/N	Y/N	ļ , , , , , , , , , , , , , , , , , , ,				
20.00	If line 1/ or 17 is yes were adjustments made to DCOD)	1. 00 N	3. 00 N	20.00				
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	IN	20.00				
		Y/N	Date	Y/N	Date					
21 00	Was the east report propored only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21.00				
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	IV		IV.		21.00				
					1. 00					
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			_				
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	e instructions				22. 00				
23. 00	Have changes occurred in the Medicare depreciation expense		23. 00							
	reporting period? If yes, see instructions.					24. 00				
24. 00	If yes, see instructions									
25. 00	Have there been new capitalized leases entered into during instructions.	tne cost repor	Ting period?	'IT yes, see		25. 00				
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? I	f yes, see		26. 00				
27. 00										
28. 00	Interest Expense									
29. 00	period? If yes, see instructions.									
30. 00	treated as a funded depreciation account? If yes, see insti Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see		30.00				
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	, see		31. 00				
	instructions. Purchased Services									
32. 00	Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru		d through co	ntractual		32. 00				
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appling, see instructions.	plied pertainir	g to competi	tive bidding? If		33. 00				
	Provi der-Based Physi ci ans									
34. 00	Are services furnished at the provider facility under an allf yes, see instructions.	rrangement with	provi der-ba	ised physicians?		34. 00				
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		its with the	provi der-based		35. 00				
				Y/N	Date					
	Home Office Costs			1. 00	2. 00					
36. 00				Y		36. 00				
37. 00	If line 36 is yes, has a home office cost statement been pulf yes, see instructions.	repared by the	home office?			37. 00				
38. 00				N		38. 00				
39. 00	If line 36 is yes, did the provider render services to other see instructions.			s, Y		39. 00				
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	Y		40. 00				
		1	00		00					
	Cost Report Preparer Contact Information	1.	00	2.	00					
41. 00		DANI ELLE		METZGER-CUNDI FI		41. 00				
42. 00	respectively. Enter the employer/company name of the cost report	DEACONESS HOSP	I TAL			42. 00				
43 00	preparer. Enter the telephone number and email address of the cost	(812) 450-7423		DANI ELLE. METZGI	ED_CIINDI EE@DEA	43. 00				
43. 00	report preparer in columns 1 and 2, respectively.	(012) 400-7423		CONESS. C	LIV-CONDI EL@DEU	43.00				

Heal th	Financial Systems	HEART HOSPITAL A	T DEA	CONESS GATEW	AY		In Lieu	u of Form CMS-	2552-10
HOSPI 7	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provider CC	N: 15-0175	Peri		Worksheet S-2	2
						To	10/01/2015 09/30/2016	Part II Date/Time Pro 2/27/2017 2:0	epared: 04 pm
				3. (00				
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the t	itle/position	REI	I MBURSEMENT A	NALYST				41. 00
	held by the cost report preparer in colum	ns 1, 2, and 3,							
	respectively.								
42.00	Enter the employer/company name of the co	st report							42.00
	preparer.								
43.00	Enter the telephone number and email addr	ess of the cost							43.00
	report preparer in columns 1 and 2, respe	cti vel y.							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0175 Pe

Peri od: Worksheet S-3 From 10/01/2015 Part I To 09/30/2016 Date/Time Prepared:

2/27/2017 2:04 pm I/P Days / O/P Visits / Trips Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Avai I abl e 5.00 1.00 2.00 3.00 4.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 24 8, 784 0.00 0 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 0 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 24 8,784 0.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 24 8, 784 0.00 0 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 30.00 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26, 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 26.25 27.00 Total (sum of lines 14-26) 24 27.00 28.00 Observation Bed Days 28.00 29.00 Ambul ance Trips 29.00 30 00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 0 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0175

Peri od: Worksheet S-3 From 10/01/2015 Part I To 09/30/2016 Date/Time Prepared:

2/27/2017 2:04 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 10.00 6.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 3, 282 97 6, 208 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 865 191 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 3, 282 97 6, 208 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 3, 282 97 6, 208 0.00 144.50 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 0 24. 10 25.00 CMHC - CMHC 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0 0.00 26. 25 0 Ω 26.25 27.00 Total (sum of lines 14-26) 0.00 144.50 27.00 28.00 Observation Bed Days 77 718 28.00 29.00 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 32.00 32.00 C Total ancillary labor & delivery room 0 32.01 32.01 outpatient days (see instructions)

33.00 LTCH non-covered days

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0175

Peri od: Worksheet S-3 From 10/01/2015 Part I To 09/30/2016 Date/Time Prepared:

2/27/2017 2:04 pm Full Time Di scharges Equi val ents Title V Title XVIII Total All Component Nonpai d Title XIX Workers Pati ents 12.00 13.00 14.00 11.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 849 23 1, 590 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 182 2 00 49 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 1, 590 14.00 Total (see instructions) 0.00 0 849 23 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 00 26.25 27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 29.00 Ambul ance Trips 29.00 30 00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

Provider CCN: 15-0175

					11	0 09/30/2016	Date/lime Pre 2/27/2017 2:0	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							4
1.00	Total salaries (see	200. 00	9, 200, 808	36, 524	9, 237, 332	300, 413. 00	30. 75	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4.00	Physician-Part A - Administrative		105, 385	0	105, 385	2, 080. 00	50. 67	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	•	0	0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FOHC		0	0	0	0. 00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7. 01
8.00	Home office and/or related organization personnel		0	0	0	0. 00	0.00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 749	0		0. 00 25. 00		
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract Labor: Direct Patient Care		984, 003	0	984, 003	11, 590. 00	84. 90	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part		45, 535	0	45, 535	319. 00	142. 74	13. 00
14. 00	A - Administrative Home office and/or related orgainzation salaries and wage-related costs		85, 958	0	85, 958	2, 943. 00	29. 21	14. 00
14. 01	Home office salaries		1, 529, 314	0	1, 529, 314			14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		2, 634, 617	0	2, 634, 617			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		18, 271 0	0	18, 271 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	1	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0	•	0			24. 00 25. 00
25. 50 25. 51	Home office wage-related Related organization		0	0	0			25. 50 25. 51
25. 52	wage-related Home office: Physician Part A		0	0	0			25. 52
25. 53	- Administrative - wage-related Home office & Contract		0	0	0			25. 53
20.00	Physicians Part A - Teaching - wage-related		0					25.55
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	0	0	0	0.00	0.00	26. 00
	Administrative & General	5. 00	756, 959	22, 967	779, 926			27. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0175

Worksheet A Amount Reclassificati Adjusted Paid Hours Average Hourly on of Salaries Salaries Related to Wage (col. 4 ÷ (from (col. 2 ± col. Salaries in col. 5)	
(from (col.2 ± col. Salaries in col. 5)	
(
1.00 2.00 3.00 4.00 5.00 6.00	
28.00 Administrative & General under 159,799 0 159,799 322.35 495.73 28	.8. 00
contract (see inst.)	
29. 00 Maintenance & Repairs 6. 00 0 0 0 0. 00 29	
30.00 Operation of Plant 7.00 0 0 0 0.00 0.00 30	0.00
31.00 Laundry & Li nen Servi ce 8.00 0 0 0 0.00 0.00 31	1. 00
32. 00 Housekeepi ng 9. 00 0 0 0 0 0 0. 00 32	2.00
33.00 Housekeeping under contract 264, 870 0 264, 870 16, 831.00 15.74 33	3.00
(see instructions)	
34. 00 Di etary 10. 00 0 0 0 0. 00 34	4. 00
35.00 Di etary under contract (see 115, 910 0 115, 910 6, 403.00 18.10 35	5. 00
instructions)	
36. 00 Cafeteri a 11. 00 0 0 0 0. 00 0. 00 36	6. 00
37. 00 Maintenance of Personnel 12. 00 0 0 0 0. 00 37	7. 00
38.00 Nursing Administration 13.00 0 0 0 0.00 38	8. 00
39.00 Central Services and Supply 14.00 0 0 0 0.00 39	9.00
40.00 Pharmacy 15.00 0 0 0 0.00 0.00 40	0.00
41.00 Medical Records & Medical 16.00 0 0 0 0 0.00 41	1.00
Records Library	
42.00 Social Service 17.00 0 0 0 0.00 42	2.00
43.00 Other General Service 18.00 0 0 0 0 0.00 0.00 43	3.00

5.00

6.00

7.00

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

(see inst.)

instructions)

26.95

35 49

33.82

5.00

6.00

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0175 Peri od: From 10/01/2015 To 09/30/2016 2/27/2017 2:04 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 9, 741, 387 9, 777, 911 323, 969. 35 30. 18 1.00 36, 524 instructions) 2.00 Excluded area salaries (see 749 749 25.00 29. 96 2.00 instructions) 3.00 Subtotal salaries (line 1 9, 740, 638 36, 524 9, 777, 162 323, 944. 35 30.18 3.00 minus line 2) 4.00 Subtotal other wages & related 2, 644, 810 2, 644, 810 100, 285. 00 26.37 4.00 costs (see inst.)

C

36, 524

22, 967

2, 634, 617

15, 056, 589

1, 320, 505

0.00

424, 229. 35

39, 040. 79

2, 634, 617

15, 020, 065

1, 297, 538

позетт	AL WAGE RELATED COSTS	Provider CCN. 13-0175	From 10/01/2015 To 09/30/2016		pared:			
				Amount				
				Reported				
				1. 00				
	PART IV - WAGE RELATED COSTS							
	Part A - Core List							
	RETI REMENT COST							
1.00	401K Employer Contributions			374, 225	1. 00			
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2. 00			
3.00	Nonqualified Defined Benefit Plan Cost (see instructions) 0							
4.00	Qualified Defined Benefit Plan Cost (see instructions) 26,393 4							
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)							
5.00	401K/TSA Plan Administration fees			77	5. 00			
6.00	Legal/Accounting/Management Fees-Pension Plan			364	6. 00			
7.00	Employee Managed Care Program Administration Fees			0	7. 00			
	HEALTH AND INSURANCE COST							
8.00	Health Insurance (Purchased or Self Funded)			1, 207, 011	8. 00			
8. 01	Health Insurance (Self Funded without a Third Party Administrat	tor)		0	8. 01			
8.02	2 Health Insurance (Self Funded with a Third Party Administrator)							
8.03	Health Insurance (Purchased)			0	8. 03			
9.00	Prescription Drug Plan			0	9. 00			
10.00	Dental, Hearing and Vision Plan			49, 873	10. 00			
11. 00	Life Insurance (If employee is owner or beneficiary)			3, 071	11. 00			
12.00	Accident Insurance (If employee is owner or beneficiary)			8	12. 00			
13.00	Disability Insurance (If employee is owner or beneficiary)			121, 483	13. 00			
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0	14. 00			
15. 00	'Workers' Compensation Insurance			2, 998	15. 00			
16.00	Retirement Health Care Cost (Only current year, not the extraor	rdinary accrual require	d by FASB 106.	0	16. 00			
	Non cumulative portion)							
	TAXES							
17. 00	FICA-Employers Portion Only			697, 900	17. 00			
18.00	Medicare Taxes - Employers Portion Only			0	18. 00			
19.00	Unemployment Insurance			105	19. 00			
20.00	State or Federal Unemployment Taxes			54, 342	20. 00			
	OTHER							
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Replacement Cost Replacement)	ported on lines 1 throu	gh 4 above. (see	0	21. 00			
22.00	instructions))			01 200	22.00			
	DO Day Care Cost and Allowances 91, 299 2							

23, 739 2, 652, 888

39 23.00 38 24.00 0 25.00

23.00 Tuition Reimbursement
24.00 Total Wage Related cost (Sum of lines 1 -23)
Part B - Other than Core Related Cost
25.00 OTHER WAGE RELATED COSTS (SPECIFY)

Health Financial Systems	HEART HOSPITAL AT DEACONESS GATEWAY	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0175	Peri od: Worksheet S-3
		From 10/01/2015 Part V

		10	09/30/2016	Date/lime Pre 2/27/2017 2:0	
	Cost Center Description		Contract Labor		4 pili
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost	·			
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0	1.00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der - IPF				3. 00
4.00	Subprovi der - I RF				4. 00
5.00	Subprovider - (0ther)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF				8. 00
9. 00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based 0LTC				10.00
11. 00	Hospi tal -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	Hospi tal -Based-CMHC				16. 00
17. 00	Renal Dialysis		0	0	17. 00
18.00	Other		0	0	18. 00

		L AT DEACONESS GATEV			u of Form CMS-2	
HOSPI 1	FAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-0175	Peri od: From 10/01/2015	Worksheet S-10	0
				To 09/30/2016	Date/Time Prep 2/27/2017 2:0	
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 col	lumn 3 divided by li	ne 202 colum	n 8)	0. 237631	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				967, 103	
3.00	Did you receive DSH or supplemental payments from Medi			10		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or sup		from Medicai	ď?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental paym	ments from Medicaid			0	
6.00	Medi cai d charges				8, 542, 745	
7.00	Medicaid cost (line 1 times line 6)	/II. 7	6.1.	0 15 16	2, 030, 021	
8.00	Difference between net revenue and costs for Medicaid < zero then enter zero)	program (line / min	us sum of II	nes 2 and 5; IT	1, 062, 918	8. 00
	Children's Health Insurance Program (CHIP) (see instru	ictions for each lin	<u>e)</u>			
9.00	Net revenue from stand-alone CHIP	actrons for each fifth	c)		0	9.00
10.00					0	
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00		one CHIP (line 11 mi	nus line 9	if < zero then	0	
12.00	enter zero)	she shir (rine ri iii	nus iine ,	11 \ 2010 then	Ö	12.00
	Other state or local government indigent care program	(see instructions f	or each line)		İ
13.00	9)	0	13.00			
14.00	in lines 6 or	0	14.00			
	10)					
15.00	State or local indigent care program cost (line 1 time	es line 14)			0	15. 00
16.00	Difference between net revenue and costs for state or	local indigent care	program (li	ne 15 minus line	0	16. 00
	13; if < zero then enter zero)					ļ
	Uncompensated care (see instructions for each line)					
	Private grants, donations, or endowment income restrict	9	,		-	17.00
18.00					0	
19. 00		and Local Indigent	care program	s (sum of lines	1, 062, 918	19.00
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
			1, 00	2. 00	3. 00	
20. 00	Charity care charges for the entire facility (see inst	tructions)	931, 8		1, 217, 147	20.00
21. 00	Cost of patients approved for charity care (line 1 time		221, 4		289, 232	
22. 00		,		05 0	305	
23. 00	1 3 3 1 11		221, 1	28 67, 799	288, 927	
					1. 00	
24.00	Does the amount in line 20 column 2 include charges for	or patient days beyo	nd a Length	of stay limit	N	24. 00
	imposed on patients covered by Medicaid or other indig					
25. 00			ogram's leng	th of stay limit	0	
26. 00	· · · · · · · · · · · · · · · · · · ·				1, 115, 858	
27. 00					68, 788	
28. 00			,		1, 047, 070	
29. 00		1 ,	1 times lin	e 28)	248, 816	•
30.00	Cost of uncompensated care (line 23 column 3 plus line	e 29)			537, 743	30.00
	Total unreimbursed and uncompensated care cost (line 1				1, 600, 661	

ealth Financial Systems	HEART HOSPITAL AT DEACONESS GATEWAY	In Lieu of Form CMS-2552

Heal th	Financial Systems HEAR	T HOSPITAL AT DE	ACONESS GATEW	VAY	In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Peri od:	Worksheet A	
					From 10/01/2015 To 09/30/2016	Doto/Time Dro	nanad.
					To 09/30/2016	Date/Time Pre 2/27/2017 2:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	, p
				+ 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 CAP REL COSTS-BLDG & FIXT		0		1, 724, 416	1, 724, 416	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		2, 611, 065	2, 611, 065	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 054, 011	2, 054, 01	1 0	2, 054, 011	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	756, 959	7, 779, 435	8, 536, 39	4 -2, 772, 751	5, 763, 643	5. 00
7.00	00700 OPERATION OF PLANT	0	430, 803	430, 80	3 0	430, 803	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	108, 259	108, 25	9 0	108, 259	8. 00
9.00	00900 HOUSEKEEPI NG	0	261, 415	261, 41	5 0	261, 415	9. 00
10.00	01000 DI ETARY	o	240, 741	240, 74°	1 0	240, 741	10.00
11.00	01100 CAFETERI A	o	0		0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	o	76, 049	76, 04	9 -285	75, 764	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	o	238, 615	238, 61		224, 659	14. 00
15.00	01500 PHARMACY	o	2, 639, 189			754, 950	15. 00
16, 00	01600 MEDICAL RECORDS & LIBRARY	l ol	592, 609				16.00
17. 00	01700 SOCI AL SERVI CE	o	157, 659				1
	INPATIENT ROUTINE SERVICE COST CENTERS		,				
30.00	03000 ADULTS & PEDI ATRI CS	3, 329, 262	1, 785, 068	5, 114, 330	-400, 675	4, 713, 655	30.00
	ANCILLARY SERVICE COST CENTERS				<u> </u>		1
50.00	05000 OPERATI NG ROOM	646, 217	5, 399, 546	6, 045, 76	3 -1, 559, 074	4, 486, 689	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 076	652, 360	658, 43	6 0	658, 436	54. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 539, 946	11, 047, 573	13, 587, 519	9 -8, 365, 435	5, 222, 084	59. 00
60.00	06000 LABORATORY	0	1, 606, 034			1, 603, 971	
64.00	06400 I NTRAVENOUS THERAPY	586, 521	301, 514	888, 03	5 -175, 547	712, 488	64.00
65. 00	06500 RESPIRATORY THERAPY	0	265, 389				1
66.00	06600 PHYSI CAL THERAPY	o	205, 196			205, 196	
69. 00	06900 ELECTROCARDI OLOGY	818, 505	801, 918				
69. 01	06901 CARDI AC REHAB	485, 817	172, 514	658, 33		642, 559	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		1, 180, 238	•	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				
73. 00	07300 DRUGS CHARGED TO PATIENTS	l ol	0		1, 884, 239		
74. 00	07400 RENAL DIALYSIS	30, 756	34, 326	65, 08:			
	OUTPATIENT SERVICE COST CENTERS		2 ., 5=5				1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	L		I.			
118.00		9, 200, 059	36, 850, 223	46, 050, 28	2 0	46, 050, 282	118.00
	NONREI MBURSABLE COST CENTERS	7,200,007	00/000/220	10/000/20		10, 000, 202	1
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	749	580	1, 32			192.00
	07954 MISC NONREI MBURSABLE	1 , , ,	0	1, 32			194. 00
	07951 VISITOR ASSISTANTS	ام	n		0		194. 01
	2 07952 PUBLIC RELATIONS		24, 929	24, 92	٥		
	3 07953 DEACONESS HOSPI TAL		39, 877	39, 87		39, 877	
200.00		9, 200, 808	36, 915, 609			•	
200.00	1.3.7.2 (3011 01 211123 110 177)	7, 200, 000	30, 710, 007	1 10, 110, 41	. 1	10, 110, 417	1-30.00

 Heal th Financial
 Systems
 HEART
 HOSPITAL
 AT
 DEACONESS GATEWAY

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN:

Provider CCN: 15-0175

Peri od: From 10/01/2015 To 09/30/2016 Date/Time Prepared:

Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS	1. 00 2. 00
GENERAL SERVICE COST CENTERS 6.00 7.00	2. 00
GENERAL SERVICE COST CENTERS	2. 00
	2. 00
	2. 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT -700, 930 1, 023, 486	
2. 00 00200 CAP REL COSTS-MVBLE EQUI P -15 2, 611, 050	
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 768, 615 2, 822, 626	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL -1, 589, 074 4, 174, 569	5.00
7. 00 00700 OPERATION OF PLANT -146, 276 284, 527	7.00
8.00 00800 LAUNDRY & LINEN SERVICE -28,667 79,592	8.00
9. 00 00900 HOUSEKEEPI NG -181, 029 80, 386	9.00
10. 00 01000 DI ETARY -191, 408 49, 333	10. 00
11. 00 01100 CAFETERI A 133, 239 133, 239 1	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 1, 038 76, 802	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY -153, 193 71, 466	14. 00
	15. 00
	16. 00
	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
	30. 00
ANCILLARY SERVICE COST CENTERS	
	50. 00
	54. 00
	59. 00
	60. 00
	64. 00
	65. 00
	66. 00
	59. 00
	59. 01
	71. 00
	72.00
	73. 00
	74. 00
OUTPATIENT SERVICE COST CENTERS	74.00
	92. 00
SPECIAL PURPOSE COST CENTERS	72.00
	18. 00
NONREI MBURSABLE COST CENTERS	16.00
	90. 00
	90.00
	92. 00 94. 00
	94. 00 94. 01
	94. 01 94. 02
	94. 02 94. 03
	94. U3 00. 00
200. 00 TOTAL (SUM OF LINES 118-199) -4, 166, 591 41, 949, 826 20	50.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 HEART HOSPITAL AT DEACONESS GATEWAY Peri od: Worksheet A-6 From 10/01/2015 To 09/30/2016 Date/Time Prepared: Provider CCN: 15-0175

					To 09/30/2016 Date/Time Pro	epared:
		Increases			2/2//2017 2.1	J4 piii
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
1. 00	A - EQUIPMENT DEPRECIATION CAP REL COSTS-MVBLE EQUIP	2.00	O	1, 688, 030		1.00
2.00	CAP REL COSTS-WVBLE EQUIP	0.00	0	1, 000, 030		2.00
3. 00		0.00	0	Ö		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
7. 00	<u> </u>			1, 688, 030		7.00
	B - LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 724, 416		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	821, 848		2.00
3. 00				0 0 2,546, 264		3. 00
	C - INSURANCE		O ₁	2, 540, 204		1
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	26, 477		1.00
2.00	L	0.00	0	0		2. 00
	0		0	26, 477		
1 00	D - PROPERTY TAXES	2 00		15 500		1 00
1. 00 2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	15, 503 0		1. 00 2. 00
2.00				_{15, 503}		2.00
	E - MEDICAL SUPPLIES AND DRUG	GS CHARGED	<u> </u>	107 000		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 180, 238		1. 00
	PATI ENTS	70.00		0.074.0/0		
2. 00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8, 071, 062		2. 00
3. 00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 884, 239		3. 00
4. 00	BROOS STANGED TO TAITENTS	0.00	0	0		4. 00
5.00		0.00	O	0		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00	<u> </u>	0.00	— — 0	00 11, 135, 539		9. 00
	F - PROFESSIONAL FEES		<u> </u>	11, 133, 337		1
1.00	CARDIAC CATHETERIZATION	59.00	0	39, 563		1.00
2. 00	RENAL DIALYSIS	74.00	0	1, 050		2. 00
3. 00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 013		3. 00
4.00		0.00	0	0		4. 00
5. 00			— — 	41, 626		5. 00
	G - INCENTIVE COMPENSATION		<u> </u>	41, 020		
1.00	ADMINISTRATIVE & GENERAL	5. 00	23, 967	13, 533		1.00
2.00	ADULTS & PEDIATRICS	30.00	16, 662	0		2. 00
3.00	CARDIAC CATHETERIZATION	59. 00	12, 366	0		3. 00
4.00	I NTRAVENOUS THERAPY	64.00	2, 019	0		4. 00
5.00	ELECTROCARDI OLOGY	69.00	7, 253	0		5. 00
6. 00 7. 00	CARDI AC REHAB	69. 01 0. 00	5, 986	0		6. 00 7. 00
7.00	0 — — — — —		68, 253	13, 533		7.00
	H - DISABILITY		55, 255			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 250		1. 00
2.00	ADULTS & PEDIATRICS	30.00	0	29, 453		2. 00
3.00	OPERATING ROOM	50.00	0	759		3. 00
4.00	CARDI AC CATHETERI ZATI ON ELECTROCARDI OLOGY	59. 00 69. 00	0	7, 504		4.00
5. 00 6. 00	CARDI AC REHAB	69.00	0	692 4, 846		5. 00 6. 00
0.00	0		— — ў	44, 504		0.00
	I - SALARIES IN NON-SALARY AC		-1			1
1.00	ADMINISTRATIVE & GENERAL	5. 00	250	0		1. 00
2.00	ADULTS & PEDIATRICS	30.00	9, 985	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	1, 055	0		3.00
4.00	I NTRAVENOUS THERAPY	64. 00 69. 00	655 555	0		4.00
5. 00 6. 00	ELECTROCARDI OLOGY CARDI AC REHAB	69. 00	275	0		5. 00 6. 00
7. 00	S. I.S. I TIO RELIED	0.00	2/3	o		7. 00
8. 00		0.00	Ö	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	O	0		10.00
11. 00			0	0		11. 00
	0		12, 775	₀		1

Heal th	Fi nanci al	Systems	HEA	RT HOSPITAL AT	DEACC	ONESS GAT	EWA	Υ		In Lie	u of Form	CMS-	2552-10
RECLA	SSIFICATION	S			ı	Provi der	CCN	: 15-0175	Peri o		Worksheet	A-6	
										10/01/2015 09/30/2016		Pre	nared·
	_						_				2/27/2017		
			Increases										

						2/21/201/ 2:	04 pm		
		Increases							
	Cost Center	Li ne #	Sal ary	Other					
	2. 00	3. 00	4. 00	5. 00					
	J - INTEREST EXPENSE								
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	59, 207			1. 00		
2.00		0.00	0	0			2. 00		
	0		0	59, 207					
500.00	Grand Total: Increases		81, 028	15, 570, 683			500.00		

	Financial Systems	HEAR	T HOSPITAL AT I				u of Form CMS-	
RECLAS:	SIFICATIONS			Provi der C	CCN: 15-0175 F	Period: From 10/01/2015	Worksheet A-	6
						Го 09/30/2016	Date/Time Pro 2/27/2017 2:0	epared: 04 pm
		Decreases					2,2,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	J
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00			
	A - EQUIPMENT DEPRECIATION	7.00	0.00	7. 00	10.00			
1. 00 2. 00	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	0	9	ł .		1. 00 2. 00
3.00	NURSING ADMINISTRATION	13.00	0	42, 464 285	_	•		3. 00
4.00	ADULTS & PEDIATRICS	30.00	O	417, 337				4. 00
5.00	OPERATING ROOM CARDIAC CATHETERIZATION	50. 00 59. 00	0	100, 868				5. 00 6. 00
6. 00 7. 00	INTRAVENOUS THERAPY	64.00	0	821, 787 12, 218				7. 00
8.00	ELECTROCARDI OLOGY	69.00	O	271, 313	0			8. 00
9. 00	CARDI AC REHAB	<u>69.</u> 01	0	2 <u>1, 7</u> 58 1, 688, 030				9. 00
	B - LEASES		U _I	1, 000, 030				
1.00		0.00	0	0				1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	0 2, 546, 264	10 0	l e		2. 00 3. 00
0.00	0 — — — — —			2, 546, 264				0.00
1. 00	C - I NSURANCE	0.00	o	0	12			1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	o_	26, 477				2. 00
	D DDODEDTY TAYES		0	26, 477				
1.00	D - PROPERTY TAXES	0.00	0	0	13			1.00
2.00	ADMINISTRATIVE & GENERAL		0	1 <u>5, 5</u> 03	0			2. 00
	O E - MEDICAL SUPPLIES AND DRUG	S CHARGED	0	15, 503				-
1.00	WEDT ONE SOLT ETES AND BROCK	0.00	0	0	0			1. 00
2.00		0.00	0	0	0	•		2.00
3. 00 4. 00	CENTRAL SERVICES & SUPPLY	0. 00 14. 00	0	0 13, 956	0	•		3. 00 4. 00
5. 00	PHARMACY	15.00	Ö	1, 884, 239				5. 00
6. 00	OPERATING ROOM	50.00	0	1, 458, 206		1		6. 00
7. 00 8. 00	CARDI AC CATHETERI ZATI ON I NTRAVENOUS THERAPY	59. 00 64. 00	0	7, 595, 577 165, 348		1		7. 00 8. 00
9. 00	RESPIRATORY THERAPY	65.00	0	1 <u>8, 2</u> 13		ł		9. 00
	F - PROFESSI ONAL FEES		0	11, 135, 539				-
1.00	THOI ESSI OWIE TEES	0.00	0	0	0			1. 00
2. 00 3. 00		0. 00 0. 00	0	0	0	ł		2. 00 3. 00
4. 00	ADMINISTRATIVE & GENERAL	5.00	o	39, 563	_	•		4. 00
5.00	LABORATORY	60.00	•					5. 00
	G - INCENTIVE COMPENSATION		0	41, 626				1
1.00		0.00	0	0		l e		1. 00
2.00		0.00	0	0	_	•		2.00
3. 00 4. 00		0. 00 0. 00	0	0	0	•		3. 00 4. 00
5.00		0.00	O	0	0			5. 00
6.00	ADMINISTRATIVE & CENEDAL	0.00	0	01 704	_	•		6. 00
7. 00	ADMI NI STRATI VE & GENERAL 0			8 <u>1, 7</u> 8 <u>6</u> 81, 786				7. 00
	H - DI SABI LI TY	5 00				I		1
1. 00 2. 00	ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	5. 00 30. 00	1, 250 29, 453	0	0	•		1. 00 2. 00
3.00	OPERATING ROOM	50.00	759	0	0	ł		3. 00
4.00	CARDI AC CATHETERI ZATI ON	59.00	7, 504	0	0	1		4.00
5. 00 6. 00	ELECTROCARDI OLOGY CARDI AC REHAB	69. 00 69. 01	692 4, 846	0	0	ł		5. 00 6. 00
	0		44, 504	0				1
1. 00	I - SALARIES IN NON-SALARY AC	CCOUNTS 0. 00	0	0	0			1.00
2.00		0.00	0	0	0			2. 00
3.00		0.00	0	0	0	•		3. 00
4. 00 5. 00		0. 00 0. 00	0	0	0			4. 00 5. 00
6.00	ADMINISTRATIVE & GENERAL	5. 00	ő	250	0			6. 00
7.00	ADULTS & PEDIATRICS	30.00	O	9, 985		•		7.00
8. 00 9. 00	CARDI AC CATHETERI ZATI ON INTRAVENOUS THERAPY	59. 00 64. 00	0	1, 055 655				8. 00 9. 00
10. 00	ELECTROCARDI OLOGY	69.00	ő	555	0	•		10.00
11. 00	CARDI AC REHAB	6901	0	<u>2</u> 75 12, 775		-		11. 00
	0	i I	Ч	12, 775	l	I		I

Health Financial Systems HEART HOSPITAL AT DEACONESS GATEWAY In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 15-0175 Period: From 10/01/2015 To 09/30/2016 Date/Time Prepared:

						2/27/2017 2:	04 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	J - INTEREST EXPENSE						
1.00		0.00	0	C	11	1	1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	59, 207	' C		2. 00
	0		0	59, 207			
500.00	Grand Total: Decreases		44, 504	15, 607, 207	1		500.00

7.00

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0175 Peri od: Worksheet A-7 From 10/01/2015 Part I Date/Time Prepared: 09/30/2016 2/27/2017 2:04 pm Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 0 0 2.00 Land Improvements 0 0 0 0 2.00 3.00 3.00 Buildings and Fixtures Ω 0 Building Improvements 0 4.00 C 0 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 12, 598, 785 2, 035, 109 2, 035, 109 0 6.00 0 7.00 HIT designated Assets 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 12, 598, 785 2, 035, 109 2, 035, 109 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 12, 598, 785 2, 035, 109 O 2, 035, 109 10.00 10.00 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 0 1.00 2.00 Land Improvements 0 2.00 0 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 0 5.00 Movable Equipment 0 6.00 14, 633, 894 6.00

14, 633, 894

14, 633, 894

0

0

0

Heal th	Financial Systems HEAR	T HOSPITAL AT D	DEACONESS GATEV	NAY	In Li∈	eu of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0175	Peri od: From 10/01/2015	Worksheet A-7	
					To 09/30/2016		pared:
						2/27/2017 2:0	
			Sl	JMMARY OF CAF	ri 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	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1. 00	CAP REL COSTS-BLDG & FLXT	0	0)	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1	0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0)			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)			2. 00
3.00	Total (sum of lines 1-2)	0	0)			3. 00
		1		'			

Heal th	n Financial Systems HEAR	RT HOSPITAL AT I	DEACONESS GATEV	WAY	In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 10/01/2015 Fo 09/30/2016		pared:
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	T	1.00	2.00	3. 00	4. 00	5. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		ı	0.00000		4 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	14, 633, 894	0	14, 633, 89	0. 000000 1. 00000		1. 00 2. 00
3. 00	Total (sum of lines 1-2)	14, 633, 894		14, 633, 894			3.00
3.00	Total (suil of Titles 1-2)	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		3.00
		/\LLOON	THOM OF OTHER V	5711 T T712	JONINI II C	N ON TIME	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	col s. 5	·		
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		_	1	_1		
1.00	CAP REL COSTS-BLDG & FLXT	0	1		0	1, 023, 486	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			1, 688, 030		2.00
3. 00	Total (sum of lines 1-2)	0	0	JMMARY OF CAPI	1, 688, 030	1, 845, 334	3. 00
			50	JIVIIVIARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		-	1	-	4 000 :::	
1.00	CAP REL COSTS-BLDG & FIXT	0	,	1	0	.,,	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	59, 192				2,0,000	
3. 00	Total (sum of lines 1-2)	59, 192	26, 477	15, 50	3 0	3, 634, 536	3. 00

| Period: | Worksheet A-8 | From 10/01/2015 | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES HEART HOSPITAL AT DEACONESS GATEWAY

Provider CCN: 15-0175

					o 09/30/2016	Date/Time Prep 2/27/2017 2:04	
				Expense Classification on To/From Which the Amount is			+ piii
				10/11 oill will cit the Allount 15	to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	В		CAP REL COSTS-MVBLE EQUIP	2.00		2. 00
	COSTS-MVBLE EQUIP (chapter 2)			CAL REE COSTS-WINDEL EQUIT			
3. 00	Investment income - other (chapter 2)		0		0.00		3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)	В	-1, 118	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	o	6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-102, 920			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-3, 068, 277			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00		13. 00 14. 00
15. 00	Rental of quarters to employee and others	1	0		0.00		15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
00.00	repay Medicare overpayments			DECOL DATODY, THEDADY	45.00		00.00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	Ü	RESPI RATORY THERAPY	65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00		29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
33. 00	RESEARCH	A		ADMINISTRATIVE & GENERAL	5. 00		
34. 00	HOSPITAL ASSESSMENT FEE	A	-573, 590	ADMINISTRATIVE & GENERAL	5. 00	<u> </u> 0	34. 00

Health Financial Systems	HEAR	T HOSPITAL AT	DEACONESS GATEWAY	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0175	Peri od:	Worksheet A-8	
				From 10/01/2015 To 09/30/2016	Date/Time Pre 2/27/2017 2:0	
			Expense Classification	on Worksheet A		
			To/From Which the Amount i	s to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2.00	3. 00	4. 00	5. 00	
50.00 TOTAL (sum of lines 1 thru 49)		-4, 166, 59	1			50.00
(Transfer to Worksheet A,						
column 6. line 200.)						

- A. Costs if cost, including applicable overhead, can be determined.

 B. Amount Received if cost cannot be determined.

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

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

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

Provider CCN: 15-0175 Period: From 10/01/2015 To 09/30/2016 Date/Time Prepared: 2/27/2017 2:04 pm

				10 09/30/2016	2/27/2017 2:0	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			· ·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CONTRACTED SERVICES	1, 023, 486	1, 724, 416	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	CONTRACTED SERVICES	821, 848	821, 848	2.00
3.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	CONTRACTED SERVICES	817, 598	48, 983	3.00
4.00	5. 00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES	1, 805, 022	2, 398, 306	4.00
4.01	7. 00	OPERATION OF PLANT	CONTRACTED SERVICES	46, 959	193, 235	4. 01
4.02	8. 00	LAUNDRY & LINEN SERVICE	CONTRACTED SERVICES	79, 592	108, 259	4. 02
4.03	9. 00	HOUSEKEEPI NG	CONTRACTED SERVICES	80, 386	261, 415	4. 03
4.04	10.00	DI ETARY	CONTRACTED SERVICES	49, 333	240, 741	4.04
4.05	11.00	CAFETERI A	CONTRACTED SERVICES	133, 239	0	4.05
4.06	13. 00	NURSING ADMINISTRATION	CONTRACTED SERVICES	76, 802	75, 764	4.06
4.07	14. 00	CENTRAL SERVICES & SUPPLY	CONTRACTED SERVICES	57, 109	210, 302	4.07
4.08	15. 00	PHARMACY	CONTRACTED SERVICES	12, 346	704, 301	4. 08
4.09	16. 00	MEDICAL RECORDS & LIBRARY	CONTRACTED SERVICES	142, 822	592, 609	4.09
4.10	17. 00	SOCIAL SERVICE	CONTRACTED SERVICES	112, 324	144, 113	4. 10
4. 11	30.00	ADULTS & PEDIATRICS	CONTRACTED SERVICES	168, 007	168, 007	4. 11
4.12	50.00	OPERATING ROOM	CONTRACTED SERVICES	701, 872	2, 372, 178	4. 12
4.13	54.00	RADI OLOGY-DI AGNOSTI C	CONTRACTED SERVICES	394, 223	439, 100	4. 13
4.14	59. 00	CARDIAC CATHETERIZATION	CONTRACTED SERVICES	-216, 696	-216, 696	4. 14
4. 15	60.00	LABORATORY	CONTRACTED SERVICES	1, 918, 182	1, 601, 284	4. 15
4. 16	64.00	INTRAVENOUS THERAPY	CONTRACTED SERVICES	10, 510	10, 510	4. 16
4. 17	65. 00	RESPI RATORY THERAPY	CONTRACTED SERVICES	599, 398	235, 108	4. 17
4. 18	69. 00	ELECTROCARDI OLOGY	CONTRACTED SERVICES	66, 140	66, 140	4. 18
4.19	69. 01	CARDI AC REHAB	CONTRACTED SERVICES	-19, 752	-19, 752	4. 19
4.20	71.00	MEDICAL SUPPLIES CHARGED TO	CONTRACTED SERVICES	307, 025	O	4. 20
4. 21	74. 00	RENAL DIALYSIS	CONTRACTED SERVICES	51	51	4. 21
4.22	66. 00	PHYSI CAL THERAPY	CONTRACTED SERVICES	129, 315	205, 196	4. 22
5.00	TOTALS (sum of lines 1-4).			9, 317, 141	12, 385, 418	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
* The	amounts on lines 1-4 (and sub	ecripte as appropriato) are	transformed in detail to Work	choot 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.

			Related Organization(s) and/	or Home Office		
Symbol (1)	Name	Percentage of	Name	Percentage of		
3 , , ,		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 0. 0	00 6.00
7.00	В	51.00 DEACONESS HOSPI 0.0	7. 00
8.00	В	51.00 DEACONESS HOSPI 0.0	8.00
9.00	В	51.00 DEACONESS HOSPI 0.0	9.00
10.00	В	51.00 DEACONESS HOSPI 0.0	10.00
10. 01	В	51.00 DEACONESS HOSPI 0.0	10. 01
10. 02	В	51.00 DEACONESS HOSPI 0.0	10. 02
10. 03	В	51.00 DEACONESS HOSPI 0.0	10. 03
10.04	В	51.00 DEACONESS HOSPI 0.0	10. 04
10. 05	В	51.00 DEACONESS HOSPI 0.0	10. 05
10.06	В	51.00 DEACONESS HOSPI 0.0	10.06
10. 07	В	51.00 DEACONESS HOSPI 0.0	10. 07
10. 08	В	51.00 DEACONESS HOSPI 0.0	10. 08
10. 09	В	51.00 DEACONESS HOSPI 0.0	10. 09
10. 10	В	51.00 DEACONESS HOSPI 0.0	10. 10
10. 11	В	51.00 DEACONESS HOSPI 0.0	00 10.11
10. 12	В	51.00 DEACONESS HOSPI 0.0	10. 12
10. 13	В	51.00 DEACONESS HOSPI 0.0	10. 13
10. 14	В	51.00 DEACONESS HOSPI 0.0	10. 14
10. 15	В	51.00 DEACONESS HOSPI 0.0	10. 15
10. 16	В	51.00 DEACONESS HOSPI 0.0	10. 16

Health Financial Systems HEART HOSPITAL AT DEACONESS GATEWAY In Lieu of Form CMS-2552-10 STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0175

Peri od: From 10/01/2015 To 09/30/2016 Date/Ti me Prepared: 2/27/2017 2:04 pm OFFICE COSTS

					2/2//2017 2.0	7 1 2111
				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	
10. 17	В		51.00	DEACONESS HOSPI	0. 00	10. 17
10. 18	В		51.00	DEACONESS HOSPI	0.00	10. 18
10. 19	В		51.00	DEACONESS HOSPI	0.00	10. 19
10. 20	В		51.00	DEACONESS HOSPI	0.00	10. 20
10. 22	A		0.00	PROGRESSIVE HEA	51. 00	10. 22
100.00	G. Other (financial or					100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

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

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

Provider CCN: 15-0175 | Period: From 10/01/2015 | To 09/30/2016 | Date/Time Prepared: 2/27/2017 2:04 pm

			2/27/2017 2:0)4 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			ENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	-700, 930			1. 00
2.00	0	10		2. 00
3.00	768, 615			3. 00
4.00	-593, 284	0		4. 00
4. 01	-146, 276			4. 01
4. 02	-28, 667	0		4. 02
4. 03	-181, 029			4. 03
4.04	-191, 408			4. 04
4. 05	133, 239			4. 05
4.06	1, 038			4. 06
4.07	-153, 193			4. 07
4. 08	-691, 955	0		4. 08
4.09	-449, 787	0		4. 09
4. 10	-31, 789			4. 10
4. 11	0	0		4. 11
4. 12	-1, 670, 306			4. 12
4. 13	-44, 877	0		4. 13
4. 14	0	0		4. 14
4. 15	316, 898			4. 15
4. 16	0	0		4. 16
4. 17	364, 290	0		4. 17
4. 18	0	0		4. 18
4. 19	0	0		4. 19
4. 20	307, 025			4. 20
4. 21	0	0		4. 21
4. 22	-75, 881	0		4. 22
5.00	-3, 068, 277			5. 00

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

1103 1101	been posted to worksheet A,	cordining i and/or 2, the amount arrowable should be indicated in cordinin 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
-	B. INTERRELATIONSHIP TO RELAT	TED 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.

i ei iiibu	i Sellietti uttuet ti ti e Aviiti.		
6.00	HOSPI TAL		6. 00
7.00	HOSPI TAL		7.00
8.00	HOSPI TAL		8.00
9.00	HOSPI TAL		9.00
10.00	HOSPI TAL	1	0.00
10. 01	HOSPI TAL	1	10. 01
10. 02	HOSPI TAL	1	10. 02
10. 03	HOSPI TAL		10. 03
10. 04	HOSPI TAL	1	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. 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	HOSPITAL		10. 15
10. 16	HOSPITAL		10. 16
10. 17	HOSPITAL		10. 17
10. 18	HOSPITAL		10. 18
10. 19	HOSPI TAL	1	10. 19

Heal th Financ	ial Systems	HEART HOSPITA	L AT DEA	ACONESS GATE	WAY	In Lieu	u of Form CM	S-2552-10
	COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AN	ID HOME	Provider C	CN: 15-0175	Peri od:	Worksheet A	-8-1
OFFICE COSTS						From 10/01/2015 To 09/30/2016	Date/Time P	repared:
						77, 667, 2616	2/27/2017 2	
Rel	ated Organization(s)							
a	and/or Home Office							
	Type of Business							
	6. 00	_						
10. 20 H0SPI T			-					10, 20
	PY PROVIDE							10. 20
100.00	I INOVIDE							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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

						0 09/30/2016	2/27/2017 2:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	, p
		I denti fi er	Remuneration	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	1, 013	0	1, 013	179, 000	7	1. 00
2.00	59. 00	CARDIAC CATHETERIZATION	39, 563	0	39, 563	179, 000	274	2. 00
3.00	60.00	LABORATORY	400	0	400	260, 300	3	3. 00
4.00	69. 00	ELECTROCARDI OLOGY	86, 053	86, 053	0	0	0	4. 00
5. 00	69. 01	CARDI AC REHAB	3, 510	0	3, 510	271, 900	29	5. 00
6. 00	74. 00	RENAL DIALYSIS	1, 050	0	1, 050	179, 000	7	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			131, 589	86, 053	45, 536		320	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l 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	602	30		0		1. 00
2.00		CARDIAC CATHETERIZATION	23, 580			0		2. 00
3. 00		LABORATORY	375			0	0	3. 00
4. 00		ELECTROCARDI OLOGY	0	0		0	0	4. 00
5. 00		CARDI AC REHAB	3, 791	190		0	0	5. 00
6. 00		RENAL DIALYSIS	602	30		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			28, 950			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1.00		ADMINISTRATIVE & GENERAL	0		411	411		1. 00
2.00		CARDI AC CATHETERI ZATI ON	0			15, 983		2.00
3. 00		LABORATORY	0	375		25	•	3. 00
4. 00		ELECTROCARDI OLOGY	0	0	0	86, 053		4. 00
5. 00		CARDI AC REHAB	0	3, 791	0	00,039		5. 00
6. 00		RENAL DI ALYSI S		602	448	448	1	6. 00
7. 00	0.00		0	002		0	•	7. 00
8. 00	0.00			0	l 0	0		8.00
9. 00	0.00			0	l 0	0		9. 00
10.00	0.00			0	l 0	0	1	10.00
200.00	0.00		0	28, 950	16, 867	_	1	200.00
200.00	l	I	1	20, 730	10,007	102, 720	I	200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0175 Peri od: Worksheet B From 10/01/2015 Part I Date/Time Prepared: 09/30/2016 2/27/2017 2:04 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 1,023,486 1, 023, 486 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2, 611, 050 2, 611, 050 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 822, 626 2, 822, 626 4.00 00500 ADMINISTRATIVE & GENERAL 4, 486, 929 5 00 4, 174, 569 8 357 65, 683 238, 320 5 00 7.00 00700 OPERATION OF PLANT 284, 527 13, 432 0 0 297, 959 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 79, 592 79, 592 8.00 9.00 00900 HOUSEKEEPI NG 80, 386 5, 288 0 0 85, 674 9.00 Ó 01000 DI ETARY 10.00 0 49.333 49.333 10 00 C 11.00 01100 CAFETERI A 133, 239 C 0 0 133, 239 11.00 01300 NURSING ADMINISTRATION 76, 802 0 77, 243 13.00 0 441 13.00 0 01400 CENTRAL SERVICES & SUPPLY 71, 466 71, 466 14.00 14.00 0 0 62, 995 62, 995 15.00 0 15.00 01500 PHARMACY Ω 16.00 01600 MEDICAL RECORDS & LIBRARY 142, 822 0 0 142, 822 16.00 01700 SOCIAL SERVICE 17.00 125,870 125, 870 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 713, 655 420, 341 645, 539 1, 016, 455 6, 795, 990 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 816, 383 136, 794 156, 023 197, 231 3, 306, 431 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 613, 559 1.857 615, 416 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 5, 206, 101 309, 968 1, 271, 143 777, 932 7, 565, 144 59.00 06000 LABORATORY 1, 920, 844 1, 920, 844 60.00 60.00 64.00 06400 I NTRAVENOUS THERAPY 712, 488 18, 899 180, 039 911, 426 64.00 611, 466 65. NN 06500 RESPIRATORY THERAPY 611, 466 65.00 0 0 0 66.00 06600 PHYSI CAL THERAPY 129, 315 0 129, 315 66.00 06900 ELECTROCARDI OLOGY 419, 668 2, 071, 567 69.00 1, 270, 310 129, 306 252, 283 69.00 69.01 06901 CARDI AC REHAB 642, 559 C 33.654 148, 882 825, 095 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 1, 487, 263 C C 0 1, 487, 263 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8,071,062 8, 071, 062 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 884, 239 0 1, 884, 239 73.00 07400 RENAL DIALYSIS 0 9, 398 75, 082 74.00 65,684 74.00 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 41, 883, 691 1, 023, 486 2, 611, 050 2, 822, 397 41, 883, 462 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1.329 0 229 1, 558 192, 00 Ω 194. 00 07954 MISC NONREI MBURSABLE 0 0 0 0 0 194.00 194. 01 07951 VI SI TOR ASSISTANTS 0 0 0 0 194. 01 194. 02 07952 PUBLIC RELATIONS 0 24, 929 0 0 24, 929 194. 02 194. 03 07953 DEACONESS HOSPI TAL 39, 877 194. 03 0 0 39.877 200.00 Cross Foot Adjustments 0 200. 00

41, 949, 826

1, 023, 486

2, 611, 050

2, 822, 626

0 201. 00

41, 949, 826 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

Provider CCN: 15-0175

In Lieu of Form CMS-2552-10

Period:	Worksheet B	
From 10/01/2015	Part	
To 09/30/2016	Date/Time Prepared:	2/27/2017 2:04 pm

				'	0 077 007 2010	2/27/2017 2:0	4 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 486, 929					5. 00
7. 00	00700 OPERATION OF PLANT	35, 687	333, 646				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	9, 533	000, 0.10	89, 125			8. 00
9. 00	00900 HOUSEKEEPI NG	10, 261	1, 761	07, 120	97, 696		9.00
10.00	01000 DI ETARY	5, 909	1, 701		77, 070	55, 242	10.00
11. 00	01100 CAFETERI A	15, 958	0		0	0 0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	9, 251	0		0	0	13. 00
			0		0	0	ł
14. 00	01400 CENTRAL SERVICES & SUPPLY	8, 559	0	0	0	_	14.00
15. 00	01500 PHARMACY	7, 545	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	17, 106	0	0	0	0	16.00
17. 00	01700 SOCI AL SERVI CE	15, 075	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	11		1			
30. 00	03000 ADULTS & PEDIATRICS	813, 956	140, 008	52, 445	41, 214	54, 237	30. 00
	ANCI LLARY SERVI CE COST CENTERS	1		1			
50. 00	05000 OPERATING ROOM	396, 011	45, 564	1, 512	13, 412	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	73, 708	0	0	0	0	54.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	906, 077	103, 244	26, 125	30, 392	1, 005	59. 00
60.00	06000 LABORATORY	230, 059	0	0	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	109, 161	0	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	73, 235	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	15, 488	0	0	0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	248, 112	43, 069	9, 043	12, 678	0	69. 00
69. 01	06901 CARDI AC REHAB	98, 822	0	0	0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	178, 129	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	966, 670	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	225, 675	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	8, 993	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>		•	'		
118.00		4, 478, 980	333, 646	89, 125	97, 696	55, 242	118. 00
	NONREI MBURSABLE COST CENTERS						
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	187	0		-		192. 00
	07954 MISC NONREI MBURSABLE	0	0		0		194. 00
	07754 WISCHONKET MIDDING ABEL	0	0	0	0		194. 01
	207952 PUBLIC RELATIONS	2, 986	0		0		194. 02
	3 07953 DEACONESS HOSPI TAL	4, 776	0				194. 02
200.00		4,770	0			U	200. 00
200.00			<u> </u>	_	0	0	200.00
201.00	1 1 3	4, 486, 929	333, 646	89, 125	97, 696		
202.00	TOTAL (Suil TITIES TTO-201)	4, 400, 929	333, 040	1 07, 123	77,090	55, 242	1202. UU

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0175

CAPETERIA NURSING CAPETERIA NURSING SERVICES & LIBRARY CEGAR SERVICES & LIBRARY CEGAR					10	09/30/2016	2/27/2017 2:0	
CENERAL SERVICE COST CENTERS 11.00 13.00 14.00 15.00 16.00 1.00		Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY		, p
CEMERAL SERVICE COST CENTERS		'		ADMI NI STRATI ON	SERVICES &		RECORDS &	
ERNERAL SERVICE COST CENTERS					SUPPLY		LI BRARY	
1.00			11. 00	13. 00	14.00	15. 00	16. 00	
2.00								
4.00 00400 EMPLOYCE BENEFITS DEPARTMENT								
5.00								
7. 0.0 7. 0.0 7. 0.0 7. 0.0 8. 0.0 8. 0.0 8. 0.0 9. 0.0 9. 0.0 9. 0.0 9. 0.0 11. 0								l
8. 00 00800 LAUNDRY & LINEN SERVICE	5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
9. 00 00900 HOUSEKEEPING								
10.00								
11.00								
13.0 0 1300 NURSI NG ADMIN STRATI ON 0 86, 494	10.00							10.00
14. 00			149, 197					
15. 00 01500 PHARMACY 0 0 0 194 70,734 15. 00 16. 00 01600 MEDICAL RECORDS & LI BRARY 0 0 0 0 0 0 0 0 0			0	86, 494				
16. 00 01-00 MEDI CAL RECORDS & LI BRARY 0 0 0 0 0 159, 928 16. 00 17.	14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	80, 025			14. 00
17. 00	15. 00		0	0	194	70, 734		15. 00
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 ADOLIT'S & PEDIATRIC S 65,342 37,912 1,406 0 11,956 ANCI LLARY SERVICE COST CENTERS 50.00 CS000 OPERATING ROOM 11,217 6,509 7,962 0 18,434 50.00 60.00 OPERATING ROOM 11,217 6,509 7,962 0 18,434 50.00 0.00 OPERATING ROOM 10,000 OPERATING ROOM 10,000 OPERATING ROOM 0 0 0 0 0 0 0 0 0	16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	159, 928	16. 00
30. 00	17. 00		0	0	0	0	0	17. 00
ANCILLARY SERVICE COST CENTERS			1					
50. 00 05000 0FERATING ROOM 11, 217 6, 509 7, 962 0 18, 434 50. 00 54. 00 05400 RADI OLLOGY-DI AGNOSTIC 109 0 0 0 0 9, 617 54. 00 05900 CARDIAC CATHETERI ZATION 38, 661 22, 402 399 0 55, 056 59. 00 60. 00 0 0 0 0 7, 486 60. 00 60. 00 0 0 0 0 0 7, 486 60. 00 60. 00 0 0 0 0 0 0 0 0	30.00		65, 342	37, 912	1, 406	0	11, 956	30. 00
54.00								
59, 00 05900 CARDI AC CATHETERI ZATI ON 38, 661 22, 402 399 0 55, 056 59, 00				·				
60. 00 06000 LABORATORY 0 0 0 0 7, 486 60. 00 64. 00 06400 INTRAVENOUS THERAPY 8, 494 4, 952 292 0 1, 364 64. 00 65. 00 06500 RSPI RATORY THERAPY 0 0 0 0 3 0 2, 549 65. 00 06500 RSPI RATORY THERAPY 0 0 0 0 0 0 0 1, 537 66. 00 69. 00 06900 ELECTROCARDI OLOGY 14, 157 8, 192 453 0 19, 565 69. 00 69. 01 06901 CARDI OLOGY 14, 157 8, 192 453 0 19, 565 69. 00 69. 01 06901 CARDI OLOGY 14, 157 8, 192 453 0 19, 565 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 19, 524 0 2, 798 71. 00 72. 00 73.00 DRUGS CHARGED TO PATI ENTS 0 0 49, 766 0 17, 142 72. 00 73. 00 07400 RENAL DI ALYSI S 436 273 0 0 70, 734 10, 623 73. 00 74. 00 07400 RENAL DI ALYSI S 436 273 0 0 0 0 0 200 00 00				ĭ				ł
64. 00 06400 INTRAVENOUS THERAPY 8, 494 4, 952 292 0 1, 364 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 3 0 2, 549 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 14, 157 8, 192 453 0 19, 555 69. 00 69. 01 06901 CARDI AC REHAB 10, 781 6, 254 26 0 1, 536 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 19, 524 0 2, 798 71. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 49, 766 0 17, 142 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 436 273 0 0 0 265 74. 00 74. 00 07400 RENAL DI ALYSI S 436 273 0 0 0 265 74. 00 75. 00 07400 RENAL DI ALYSI S 436 273 0 0 0 0 76. 00 07400 RENAL DI ALYSI S 436 273 0 0 0 0 76. 00 07400 RENAL DI ALYSI S 436 273 0 0 0 0 77. 00 07900 085ERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 78. 00 0900 085ERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 792. 00 19000 01 01 01 01 01 0			38, 661	22, 402		0		
65. 00			0	0	٧,	0		ł
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 0 1,537 66. 00 69. 00 06900 ELECTROCARDI OLOGY 14,157 8, 192 453 0 19,565 69. 00 69. 01 06901 CARDI AC REHAB 10,781 6,254 26 0 1,536 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 19,524 0 2,798 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 19,524 0 2,798 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 49,766 0 17,142 72. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 70,734 10,623 73. 00 00 07400 RENAL DI ALYSIS 436 273 0 0 0 265 74. 00 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 149,197 86,494 80,025 70,734 159,928 118. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 00 194. 00 07954 MI SC. NONREI MBURSABLE 0 0 0 0 0 0 0 0 194. 00 194. 01 07951 VI SI TOR ASSI STANTS 0 0 0 0 0 0 0 0 194. 01 194. 02 07952 PUBLI C RELATI ONS 0 0 0 0 0 0 0 0 0 0 0 194. 02 194. 03 07953 DEACONESS HOSPI TAL 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1			0		
69. 00 06900 ELECTROCARDI OLOGY 14, 157 8, 192 453 0 19, 565 69. 00 69. 01 06901 CARDI AC REHAB 10, 781 6, 254 26 0 1, 536 69. 01 71. 00 70. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 19, 524 0 2, 798 71. 00 72. 00 72.00 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 49, 766 0 17, 142 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 70, 734 10, 623 73. 00 07400 RENAL DI ALYSI S 436 273 0 0 0 265 74. 00 00 00 00 00 00 00 00			0	0		0		
69. 01 06901 CARDI AC REHAB 10, 781 0, 254 26 0 1, 536 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 19, 524 0 2, 798 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 49, 766 0 17, 142 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 70, 734 10, 623 73. 00 74. 00 07400 RENAL DI ALYSIS 436 273 0 0 265 74. 00 74. 00 07400 RENAL DI ALYSIS 436 273 0 0 265 74. 00 00 00 00 00 00 00 265 74. 00 00 00 00 00 00 00 0			0	0	-	0	· ·	
71. 00			1			0		ı
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 49,766 0 17,142 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 70,734 10,623 73. 00 07400 RENAL DI ALYSIS 436 273 0 0 0 265 74. 00 07400 RENAL DI ALYSIS 436 273 0 0 0 265 74. 00 07400 RENAL DI ALYSIS 436 273 0 0 0 265 74. 00 07400 RENAL DI ALYSIS 436 273 0 0 0 265 74. 00 07400 RENAL DI ALYSIS 74. 00 0 0 0 0 0 0 0 0 0				6, 254		0		
73. 00			_	0	· ·	0		l
74. 00 07400 RENAL DI ALYSIS 436 273 0 0 265 74. 00			_	0		٩		
92.00			T	0	-			
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 149, 197 86, 494 80, 025 70, 734 159, 928 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 192. 00 194. 00 07954 MI SC NONREI MBURSABLE 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 PUBLI C RELATI ONS 0 0 0 0 0 194. 02 194. 03 07953 DEACONESS HOSPI TAL 0 0 0 0 0 0 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00	74. 00		436	273	0	0	265	74.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 149, 197 86, 494 80, 025 70, 734 159, 928 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 192. 00 192. 00 19200 194. 00 19700	00.00							00.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 149, 197 86, 494 80, 025 70, 734 159, 928 118.00	92.00							92.00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 194. 00 07954 MI SC NONREI MBURSABLE 0 0 0 0 0 194. 01 07955 VI SI TOR ASSI STANTS 0 0 0 0 194. 02 07952 PUBLI C RELATI ONS 0 0 0 0 194. 03 07953 DEACONESS HOSPI TAL 0 0 0 0 200. 00 Negati ve Cost Centers 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 202. 00 0 0 0 203. 00 0 0 0 204. 00 0 0 0 206. 00 0 0 0 207. 00 0 0 208. 00 0 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 0 209. 00	110 00		140 107	07 404	00 025	70. 724	150,000	110 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 192. 00 192.00 19200	118.00		149, 197	80, 494	80, 025	70, 734	159, 928	1118.00
192.00 19200	100 00			ام	0	ام		100 00
194. 00 07954 MI SC NONREI MBURSABLE 0 0 0 0 194. 00 194. 01 07951 VI SI TOR ASSI STANTS 0 0 0 0 194. 01 194. 02 07952 PUBLI C RELATI ONS 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 0 0 0 0 0 0 0 201. 00				0	-	-		
194. 01 07951 VI SI TOR ASSI STANTS			0	0	0	0		
194. 02 07952 PUBLI C RELATIONS 0 0 0 0 194. 02 194. 03 07953 DEACONESS HOSPITAL 0 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 200. 00 0 0 0 0 0 0 0 0 0 0 201. 00			0	0	0	0		
194. 03 07953 DEACONESS HOSPITAL 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 200. 00 0 0 0 0 0 0 0 0 0 0 201. 00			0	0	0	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0			0	0	0	0		
201.00 Negative Cost Centers 0 0 0 0 201.00				١	٩	٩	U	
		,	0	٥	0	n	Λ	
202.00 1017/2 (30/// 11//03 110 201) 147, 177 00, 474 00, 025 70, 704 137, 720 202.00			149 197	86 494	80 025	70 734		
	232.00	1.5 (53 1.1.55 110 201)	1 17,177	00, 174	33, 323	, 5, , 54	107, 720	,_02. 00

Health Financial Systems HEART HOSPITAL AT DEACONESS GATEWAY In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0175 Peri od: Worksheet B From 10/01/2015 Part I 09/30/2016 Date/Time Prepared: 2/27/2017 2:04 pm Cost Center Description SOCIAL SERVICE Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 140, 945 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 8, 152, 853 30.00 0 30.00 138, 387 8, 152, 853 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 807, 052 0 3, 807, 052 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 698, 850 0 698, 850 54.00 05900 CARDI AC CATHETERI ZATI ON 8, 751, 063 0 8, 751, 063 59 00 2,558 59 00 0 60.00 06000 LABORATORY 0 2, 158, 389 2, 158, 389 60.00 06400 INTRAVENOUS THERAPY 0 1, 035, 689 1, 035, 689 64.00 64.00 06500 RESPIRATORY THERAPY 0 65.00 00000 687, 253 687, 253 65.00 0 06600 PHYSI CAL THERAPY 146, 340 146, 340 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 2, 426, 836 2, 426, 836 69.00 06901 CARDI AC REHAB 942, 514 0 942, 514 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 687, 714 0 1, 687, 714 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 9, 104, 640 9, 104, 640 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 191, 271 0 2, 191, 271 73.00 07400 RENAL DIALYSIS 85, 049 74.00 85,049 74.00 OUTPATIENT SERVICE COST CENTERS 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00

SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 140, 945 41, 875, 513 0 118.00 41, 875, 513 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN O 190 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1,745 0 1,745 192.00 194. 00 07954 MISC NONREI MBURSABLE 0 194.00 0 0 194. 01 07951 VI SI TOR ASSISTANTS 0 194. 01 0 194. 02 07952 PUBLIC RELATIONS 0 27, 915 0 27, 915 194.02 194. 03 07953 DEACONESS HOSPITAL 0 0 44, 653 194. 03 44, 653 200.00 0 0 0 Cross Foot Adjustments 200. 00 C 0 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118-201) 140, 945 41, 949, 826 41, 949, 826 202.00

| Period: | Worksheet B | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS HEART HOSPITAL AT DEACONESS GATEWAY

Provider CCN: 15-0175

				То	09/30/2016	Date/Time Prep 2/27/2017 2:04	
			CAPI TAL REL	_ATED COSTS			•
	Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost center bescriptron	Assigned New	DEDO & TIXI	WVDEL EQUIT	Subtotal	BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	,					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	1	0	0	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	8, 357		74, 040	0	5. 00
7. 00	00700 OPERATION OF PLANT	0	13, 432		13, 432	0	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9. 00	00900 HOUSEKEEPI NG	0	5, 288		5, 288	0	9. 00
10.00	01000 DI ETARY	0	0		0	0	10.00
11. 00	01100 CAFETERIA	0	0	0	0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	441	441	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	0	0	0	16. 00 17. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l ol	U	l d	υ	U	17.00
30. 00	03000 ADULTS & PEDIATRICS	0	420, 341	645, 539	1, 065, 880	0	30. 00
30.00	ANCI LLARY SERVICE COST CENTERS	ı o	420, 341	045, 559	1,005,660	U	30.00
50. 00	05000 OPERATI NG ROOM	0	136, 794	156, 023	292, 817	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	130, 774	150, 025	272, 017	Ö	54. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	309, 968	1	1, 581, 111	0	59. 00
60.00	06000 LABORATORY	0	007,700	0	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	18, 899	18, 899	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	O	o	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	129, 306	419, 668	548, 974	0	69. 00
69. 01	06901 CARDI AC REHAB	0	0	33, 654	33, 654	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 PATIENTS	O	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	O	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS	,					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		0	1, 023, 486	2, 611, 050	3, 634, 536	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	07954 MISC NONREI MBURSABLE	0	0	0	0		194. 00
	07951 VISITOR ASSISTANTS	0	0	0	0		194. 01
	07952 PUBLIC RELATIONS	0	0	0	0		194. 02
	07953 DEACONESS HOSPI TAL	0	0	0	0		194. 03
200.00	, , , , , , , , , , , , , , , , , , ,				0		200. 00
201.00			1 022 404	2 (11 050	0 (24 52)		201. 00
202.00	TOTAL (sum lines 118-201)	0	1, 023, 486	2, 611, 050	3, 634, 536	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0175

				''	0 09/30/2010	2/27/2017 2:0	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	74, 040					5.00
7.00	00700 OPERATION OF PLANT	589					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	157	0				8.00
9. 00	00900 HOUSEKEEPI NG	169	74		5, 531		9.00
10.00	01000 DI ETARY	97	0		0	97	
11. 00	01100 CAFETERI A	263	0	_	0	0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	153	0	ا م	0	0	
14. 00	01400 CENTRAL SERVICES & SUPPLY	141		٥	0	0	14. 00
15. 00	01500 PHARMACY	124		١	0	0	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	282		0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	249	-	_	0	0	1
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	247		0	U	0	17.00
30. 00	03000 ADULTS & PEDIATRICS	13, 429	5, 883	92	2, 333	95	30. 00
30.00	ANCI LLARY SERVI CE COST CENTERS	13, 427	5, 663	72	2, 333	75	30.00
50. 00	05000 OPERATING ROOM	6, 534	1, 915	3	759	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 216			737	0	54. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	14, 949			1, 721	2	59.00
60.00	06000 LABORATORY	3, 796			1, 721	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	1, 801		0	0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	1, 208	1		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	256			0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	4. 093		_	718	0	69.00
69. 00	06901 CARDI AC REHAB	1, 630		1	718	0	69.00
	I I	•		_	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 939		0	0	0	71. 00 72. 00
72.00		15, 963	l e	0	0		
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 723			0	0	73.00
74. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	148	0	0	U	0	74. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92.00							92.00
110 00	SPECIAL PURPOSE COST CENTERS	72 000	14 001	157	E E21	07	110 00
118. 00	,	73, 909	14, 021	157	5, 531	97	118. 00
400.00	NONREI MBURSABLE COST CENTERS						100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3	0	0	0		192. 00
	07954 MISC NONREI MBURSABLE	0	0	0	0		194. 00
	07951 VI SI TOR ASSI STANTS	0	0	0	0		194. 01
	07952 PUBLIC RELATIONS	49	0	0	0		194. 02
	07953 DEACONESS HOSPI TAL	79	0	0	0	0	194. 03
200.00	, , , , , , , , , , , , , , , , , , ,						200. 00
201.00	1 3	0	0	0	_ 0		201. 00
202.00	TOTAL (sum lines 118-201)	74, 040	14, 021	157	5, 531	97	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0175

			10	0 97 307 2010	2/27/2017 2:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON			RECORDS &	
			SUPPLY		LI BRARY	
DENIEDAL DEDULOS COOT DENIEDO	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						4 00
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 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 8. 00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	263	,				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	203					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY		1	141			14.00
15. 00 01500 PHARMACY		1	0	124		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY		1	0	0	282	16.00
17. 00 01700 SOCI AL SERVI CE		1	0	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS		yl O	U	<u> </u>	U	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	115	260	3	0	26	30.00
ANCI LLARY SERVI CE COST CENTERS	110	7 200	J	<u> </u>	20	30.00
50. 00 05000 OPERATING ROOM	20	45	14	0	41	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		1	0	Ö	21	
59. 00 05900 CARDI AC CATHETERI ZATI ON	68	1	1	0	52	59.00
60. 00 06000 LABORATORY		1	0	o	16	
64. 00 06400 I NTRAVENOUS THERAPY	15		1	o	3	64. 00
65. 00 06500 RESPI RATORY THERAPY	C		0	0	6	65. 00
66. 00 06600 PHYSI CAL THERAPY		1	0	o	3	66. 00
69. 00 06900 ELECTROCARDI OLOGY	25	56	1	0	43	69. 00
69. 01 06901 CARDI AC REHAB	19		0	0	3	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		36	0	6	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	ol	85	0	38	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		ol ol	0	124	23	73. 00
74.00 07400 RENAL DIALYSIS	1	2	0	0	1	74. 00
OUTPATIENT SERVICE COST CENTERS						1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	263	594	141	124	282	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	0	0	0	192. 00
194. 00 07954 MI SC NONREI MBURSABLE	C	0	0	0		194. 00
194.01 07951 VISITOR ASSISTANTS	C	0	0	0		194. 01
194. 02 07952 PUBLI C RELATIONS	C	이	0	0		194. 02
194. 03 07953 DEACONESS HOSPI TAL	C	이	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	1 -1	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	263	594	141	124	282	202. 00

Heal th Fi	nancial Systems HEAF	RT HOSPITAL AT DE	EACONESS GATEV	VAY	In Lie	u of Form CMS-	2552-10
ALLOCATIO	ON OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-0175	Peri od:	Worksheet B	
					From 10/01/2015	Part II	
					To 09/30/2016	Date/Time Pre	pared:
		000111 05011105			-	2/27/2017 2:0	04 pm
	Cost Center Description	SOCIAL SERVICE	Subtotal	Intern &	Total		
				Residents Cos	st		
				& Post			
				Stepdown			
				Adjustments			
		17. 00	24. 00	25. 00	26. 00		
	NERAL SERVICE COST CENTERS			T			4
1	100 CAP REL COSTS-BLDG & FIXT						1.00
	200 CAP REL COSTS-MVBLE EQUIP						2. 00
	400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
1	500 ADMINISTRATIVE & GENERAL						5. 00
1	700 OPERATION OF PLANT						7. 00
	800 LAUNDRY & LINEN SERVICE						8. 00
	900 HOUSEKEEPI NG						9. 00
10.00 01	000 DI ETARY						10.00
11.00 01	100 CAFETERI A						11. 00
13. 00 01	300 NURSING ADMINISTRATION						13. 00
14. 00 01	400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01	500 PHARMACY						15. 00
	600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00 01	700 SOCIAL SERVICE	249					17. 00
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	244	1, 088, 360		0 1, 088, 360		30.00
	CILLARY SERVICE COST CENTERS		.,,		., .,		1
	000 OPERATING ROOM	0	302, 148		0 302, 148		50.00
	400 RADI OLOGY-DI AGNOSTI C	o	1, 237	1	0 1, 237		54.00
	900 CARDI AC CATHETERI ZATI ON	5	1, 602, 448		0 1, 602, 448		59. 00
4	000 LABORATORY	o	3, 812	1	0 3, 812		60.00
	400 I NTRAVENOUS THERAPY		20, 753		0 20, 753		64. 00
1	500 RESPIRATORY THERAPY		1, 214		0 1, 214		65. 00
	600 PHYSI CAL THERAPY	0	259		0 259		66.00
	900 ELECTROCARDI OLOGY		555, 736	1	0 555, 736		69. 00
	901 CARDI AC REHAB		35, 730		0 35, 349		69. 01
1	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 981	1	0 2, 981		71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	1 -1					
		0	16, 086	1	0 16, 086		72. 00 73. 00
	300 DRUGS CHARGED TO PATIENTS		3, 870	1	0 3, 870		
	400 RENAL DIALYSIS TPATIENT SERVICE COST CENTERS	l d	152		0 152		74. 00
				T			1 00 00
	200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
	ECLAL PURPOSE COST CENTERS	240	2 (24 405	1	0 2 (24 405		110 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NREIMBURSABLE COST CENTERS	249	3, 634, 405	1	0 3, 634, 405		118. 00
				ı			100 00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0 0		190. 00
	200 PHYSI CI ANS' PRI VATE OFFI CES	0	3	1	0 3		192. 00
	954 MISC NONREI MBURSABLE	0	0		0 0		194. 00
	951 VISITOR ASSISTANTS	0	0		0 0		194. 01
	952 PUBLIC RELATIONS	0	49	1	0 49		194. 02
	953 DEACONESS HOSPI TAL	0	79	1	0 79		194. 03
200.00	Cross Foot Adjustments		0	1	0		200. 00
201. 00	Negative Cost Centers	0	0	1	0 0		201. 00
202. 00	TOTAL (sum lines 118-201)	249	3, 634, 536	1	0 3, 634, 536		202. 00

Heal th Fi	inancial Systems HEAR	T HOSPITAL AT I	DEACONESS GATEV	VAY	In Lie	eu of Form CMS-	2552-10
	OCATION - STATISTICAL BASIS		Provi der CO	CN: 15-0175 F	Peri od:	Worksheet B-1	
					rom 10/01/2015		
					Го 09/30/2016	Date/Time Pre	pared:
		CADITAL DEL	_ATED COSTS			2/27/2017 2:0	PH PIII
		CALLIAL KEI	LATED COSTS				
	Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	oost denter bescriptron	(SQUARE FEET)	(DOLLAR VALUE)		TOCONOT I TUETON	& GENERAL	
		(040/1112 / 221)	(5022/11 1/1202)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(1000)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5. 00	
GE	ENERAL SERVICE COST CENTERS	•					
	0100 CAP REL COSTS-BLDG & FLXT	53, 032					1.00
2.00 00	D200 CAP REL COSTS-MVBLE EQUIP		1, 688, 029				2. 00
	D400 EMPLOYEE BENEFITS DEPARTMENT	0	0	9, 237, 332	2		4. 00
	D500 ADMINISTRATIVE & GENERAL	433	42, 464			37, 462, 897	
	0700 OPERATION OF PLANT	696		, (0	297, 959	
	0800 LAUNDRY & LINEN SERVICE	0	0		0	l	1
	0900 HOUSEKEEPI NG	274	0		0	85, 674	
	1000 DI ETARY	0	0		0	49, 333	1
	1100 CAFETERI A	0	0			133, 239	1
	1300 NURSING ADMINISTRATION	0	285			77, 243	
	1400 CENTRAL SERVICES & SUPPLY	0	200			71, 466	1
	1500 PHARMACY	0	0			62, 995	
	1600 MEDICAL RECORDS & LIBRARY	0	0			l	
	1700 SOCI AL SERVI CE	0	0				
	NPATIENT ROUTINE SERVICE COST CENTERS	0			<u> </u>	125, 670	17.00
	BOOO ADULTS & PEDIATRICS	21, 780	417, 337	3, 326, 456	5 0	6, 795, 990	30.00
30.00	NCILLARY SERVICE COST CENTERS	21,700	417, 337	3, 320, 430	<u> </u>	0, 173, 770	30.00
	5000 OPERATING ROOM	7, 088	100, 868	645, 458	3 0	3, 306, 431	50.00
	5400 RADI OLOGY-DI AGNOSTI C	7,000	100,000	6, 076			
	5900 CARDI AC CATHETERI ZATI ON	16, 061	821, 787			l	1
	5000 LABORATORY	10,001	021,707	2, 343, 000		1, 920, 844	
	6400 INTRAVENOUS THERAPY		12, 218	589, 195		911, 426	
	5500 RESPIRATORY THERAPY	0	12, 210	307, 175		611, 466	
	6600 PHYSI CAL THERAPY		0			129, 315	
	5900 ELECTROCARDI OLOGY	6, 700	271, 313	825, 621		2, 071, 567	
	5901 CARDI AC REHAB	0,700	21, 757			825, 095	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		21, 737	407, 232		l	1
		0	0			1, 487, 263	1
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	0			8, 071, 062	
	7300 DRUGS CHARGED TO PATIENTS	0	0	20.75	0		
	7400 RENAL DIALYSIS JTPATIENT SERVICE COST CENTERS	0	0	30, 756	5 0	75, 082	74. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	PECIAL PURPOSE COST CENTERS						92.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	53, 032	1, 688, 029	9, 236, 583	-4, 486, 929	37, 396, 533	110 00
	DNREIMBURSABLE COST CENTERS	33,032	1,000,029	9, 230, 303	-4, 400, 929	37, 390, 333	1110.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0		190. 00
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	0	749			192. 00
	7954 MISC NONREIMBURSABLE	0	0	/49			194. 00
	7954 WISC NOWER MOURSABLE 7951 VISITOR ASSISTANTS	0	0				194. 00
		0	0		٥		194. 01
	7952 PUBLIC RELATIONS	0	0	(0	· ·	
	7953 DEACONESS HOSPI TAL	0	U		ا ا	39, 877	194. 03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	4 000 404	0 /44 050	0.000.404		4 407 000	201. 00
202. 00	Cost to be allocated (per Wkst. B,	1, 023, 486	2, 611, 050	2, 822, 626		4, 486, 929	202.00
202 20	Part I)	10.000/01	1 54/621	0.005515	7	0 440772	202 22
203. 00	Unit cost multiplier (Wkst. B, Part I)	19. 299404	1. 546804	0. 305567		0. 119770	
204. 00	Cost to be allocated (per Wkst. B,				ון	/4, 040	204. 00
20E 00	Part II)			0.00000		0.00107/	205 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000000	7	0. 001976	205.00
I	1117	I	ļ	I	1	ļ	I

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0175 Peri od: Worksheet B-1 From 10/01/2015 09/30/2016 Date/Time Prepared: 2/27/2017 2:04 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET) (MEALS SERVED) PLANT (FTE'S - A) (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 51, 903 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 186, 552 8.00 8.00 00900 HOUSEKEEPI NG 9.00 274 51,629 9.00 10.00 01000 DI ETARY 0 21, 387 10.00 11.00 01100 CAFETERI A 1, 370 0 11.00 01300 NURSING ADMINISTRATION 0 13.00 C 0 13.00 0 Λ 14.00 01400 CENTRAL SERVICES & SUPPLY 0 C 0 0 0 14.00 15.00 01500 PHARMACY 0 0 0 0 15.00 0 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 0 \cap 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 21, 780 109, 775 21, 780 20, 998 600 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7,088 3, 165 7,088 0 103 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05900 CARDIAC CATHETERIZATION 59.00 16,061 16,061 389 355 59.00 54, 683 06000 LABORATORY 60 00 60 00 C 0 0 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 78 64.00 06500 RESPIRATORY THERAPY 65.00 0 0 0 0 65.00 66 00 06600 PHYSI CAL THERAPY O Ω 66 00 0 06900 ELECTROCARDI OLOGY 130 69.00 6,700 18, 929 6,700 69.00 06901 CARDI AC REHAB 0 99 69.01 69.01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 0 72 00 Ω 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 0 0 73.00 07400 RENAL DIALYSIS 74.00 0 OUTPATIENT SERVICE COST CENTERS 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 51, 903 186, 552 51, 629 21, 387 1, 370 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 194. 00 07954 MISC NONREI MBURSABLE 0 0 0 0 0 194. 00 194.01 07951 VISITOR ASSISTANTS 0 0 0 194. 01 0 0 194. 02 07952 PUBLIC RELATIONS 0 O 0 0 194. 02 194. 03 07953 DEACONESS HOSPITAL 0 0 0 0 194. 03 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 149, 197 202. 00 202.00 Cost to be allocated (per Wkst. B, 333, 646 89, 125 97, 696 55, 242 Part I)

6. 428260

0. 270139

14.021

0.477749

0.000842

157

1.892270

0.107130

5.531

2.582971

0.004535

108. 902920 203. 00

0. 191971 205. 00

263 204.00

203.00

204.00

205.00

Unit cost multiplier (Wkst. B, Part I)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Part II)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0175 Peri od: Worksheet B-1 From 10/01/2015 09/30/2016 Date/Time Prepared: 2/27/2017 2:04 pm Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON (COSTED RECORDS & SERVICES & SUPPLY REQUIS.) LI BRARY (PATIENT DAYS) (DI RECT NURS. (COSTED (GROSS REQUIS.) CHARGES) HRS.) 17.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 284, 765 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14, 566, 111 14.00 15.00 01500 PHARMACY 0 35, 223 1, 884, 239 15.00 01600 MEDICAL RECORDS & LIBRARY 176, 220, 509 16 00 16 00 0 C 17.00 01700 SOCIAL SERVICE 0 7,054 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 6, 926 30.00 124, 815 255, 930 13, 167, 815 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 21, 429 1, 449, 143 0 20, 301, 419 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 10, 591, 509 54.00 0 05900 CARDIAC CATHETERIZATION 0 60, 724, 050 59 00 128 59 00 73.756 72, 627 0 60.00 06000 LABORATORY 8, 244, 076 0 60.00 16, 305 06400 INTRAVENOUS THERAPY 1, 501, 789 64.00 53, 138 0 64.00 65.00 06500 RESPIRATORY THERAPY 603 0 2, 807, 165 0 65.00 0 06600 PHYSI CAL THERAPY 1, 693, 053 66.00 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 26, 972 82, 445 21, 547, 205 0 69.00 4, 794 06901 CARDI AC REHAB 0 1, 691, 493 69.01 69.01 20, 590 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 553, 767 0 3, 081, 102 71.00 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 18, 878, 389 9, 058, 441 72.00 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 884, 239 11, 699, 711 0 73.00 07400 RENAL DIALYSIS 74.00 898 291, 733 74.00 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 1, 884, 239 7, 054 118. 00 118.00 284, 765 14, 566, 111 176, 220, 509 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 0 194. 00 07954 MISC NONREI MBURSABLE 0 0 0 194.00 0 0 194. 01 194. 01 07951 VISITOR ASSISTANTS 0 0 0 194. 02 07952 PUBLIC RELATIONS 0 0 0 0 0 194. 02 194. 03 07953 DEACONESS HOSPI TAL 0 0 0 0 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 86, 494 80,025 70, 734 159, 928 140, 945 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.303738 0.005494 0.037540 0.000908 19. 980862 203. 00 249 204. 00 204.00 Cost to be allocated (per Wkst. B, 594 141 124 282 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.002086 0.000010 0.000066 0.000002 0. 035299 205. 00 II)

Health Financial Systems HEART HOSPITAL AT DEAC			VAY	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-0175	Peri od: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Pre 2/27/2017 2:0		
		Ti tl e	· XVIII	Hospi tal	PPS		
				Costs			

						2/27/2017 2:0	4 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	TIENT ROUTINE SERVICE COST CENTERS	,					
	ADULTS & PEDIATRICS	8, 152, 853		8, 152, 85	3 0	8, 152, 853	30. 00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	3, 807, 052		3, 807, 05:	2 0	3, 807, 052	
	RADI OLOGY-DI AGNOSTI C	698, 850		698, 850		698, 850	
	CARDI AC CATHETERI ZATI ON	8, 751, 063		8, 751, 06	15, 983	8, 767, 046	
	LABORATORY	2, 158, 389		2, 158, 38	9 25	2, 158, 414	
	INTRAVENOUS THERAPY	1, 035, 689		1, 035, 68		1, 035, 689	
	RESPI RATORY THERAPY	687, 253	0	687, 25	3 0	687, 253	
	PHYSI CAL THERAPY	146, 340	0	146, 340		146, 340	
	ELECTROCARDI OLOGY	2, 426, 836		2, 426, 83	6 0	2, 426, 836	
69. 01 06901	I CARDI AC REHAB	942, 514		942, 51	4 0	942, 514	69. 01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 687, 714		1, 687, 71	4 0	1, 687, 714	71. 00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9, 104, 640		9, 104, 640	0	9, 104, 640	72. 00
73.00 07300	DRUGS CHARGED TO PATIENTS	2, 191, 271		2, 191, 27 ⁻	1 0	2, 191, 271	73. 00
74.00 07400	RENAL DIALYSIS	85, 049		85, 04	9 448	85, 497	74. 00
	ATLENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	845, 187		845, 18	7	845, 187	92. 00
200.00	Subtotal (see instructions)	42, 720, 700	0	42, 720, 70	16, 456	42, 737, 156	200. 00
201.00	Less Observation Beds	845, 187		845, 18	7	845, 187	
202. 00	Total (see instructions)	41, 875, 513	0	41, 875, 51	16, 456	41, 891, 969	202. 00

Health Financial Systems	HEART HOSPITAL AT DEACONESS GATEWAY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0175	Peri od:	Worksheet C

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Peri od: From 10/01/2015	Worksheet C Part I	
				To 09/30/2016	Date/Time Pre 2/27/2017 2:0	
		Title	XVIII	Hospi tal	PPS	4 piii
		Charges	7,4111	nospi tui	110	
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
'		·	+ col. 7)	Ratio	Inpati ent	
			Í		Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	12, 152, 308		12, 152, 30	8		30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	19, 183, 988	1, 117, 431	20, 301, 41	9 0. 187526	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 849, 473	6, 742, 036	10, 591, 50	9 0. 065982	0.000000	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	22, 411, 947	38, 312, 103	60, 724, 05	0. 144112	0.000000	59. 00
60. 00 06000 LABORATORY	7, 349, 091	894, 985	8, 244, 07	6 0. 261811	0.000000	60.00
64.00 06400 I NTRAVENOUS THERAPY	1, 479, 861	21, 928	1, 501, 78	9 0. 689637	0.000000	64. 00
65. 00 06500 RESPI RATORY THERAPY	2, 776, 555	30, 610	2, 807, 16	5 0. 244821	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 661, 119	31, 934	1, 693, 05	0. 086436	0.000000	66. 00
69. 00 06900 ELECTROCARDI OLOGY	11, 190, 811	10, 356, 394	21, 547, 20	5 0. 112629	0.000000	69. 00
69. 01 06901 CARDI AC REHAB	477	1, 691, 016	1, 691, 49	3 0. 557208	0.000000	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 411, 796	669, 306	3, 081, 10	2 0. 547763	0.000000	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	6, 150, 660	12, 727, 730	18, 878, 39	0. 482278	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 102, 132	2, 597, 580	11, 699, 71	2 0. 187293	0.000000	73. 00
74. 00 07400 RENAL DIALYSIS	269, 758	21, 975	291, 73	3 0. 291530	0.000000	74. 00
OUTPATIENT SERVICE COST CENTERS						
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	230, 102	785, 405	1, 015, 50	7 0. 832281	0.000000	
200.00 Subtotal (see instructions)	100, 220, 078	76, 000, 433	176, 220, 51	1		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	100, 220, 078	76, 000, 433	176, 220, 51	1		202. 00

Health Financial Systems	ACONESS GATEWAY	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0175	Peri od: From 10/01/2015	Worksheet C Part I	
			To 09/30/2016	Date/Time Prep 2/27/2017 2:04	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				

				2/2//201/ 2:04 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 187526			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 065982			54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 144375			59.00
60. 00 06000 LABORATORY	0. 261814			60.00
64.00 06400 INTRAVENOUS THERAPY	0. 689637			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 244821			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 086436			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 112629			69. 00
69. 01 06901 CARDI AC REHAB	0. 557208			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 547763			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 482278			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 187293			73. 00
74.00 07400 RENAL DIALYSIS	0. 293066			74. 00
OUTPATIENT SERVICE COST CENTERS				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 832281			92. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	HEART HOSPITAL AT DEAG	In Lie	u of Form CMS-2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0175	Peri od: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Prepared: 2/27/2017 2:04 pm
		Title XIX	Hosni tal	DDS

			'	0 077 307 2010	2/27/2017 2:0	
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDI ATRI CS	8, 152, 853		8, 152, 853	0	8, 152, 853	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	3, 807, 052		3, 807, 052	. 0	3, 807, 052	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	698, 850		698, 850		698, 850	
59. 00 05900 CARDI AC CATHETERI ZATI ON	8, 751, 063		8, 751, 063	15, 983	8, 767, 046	59. 00
60. 00 06000 LABORATORY	2, 158, 389		2, 158, 389	25	2, 158, 414	60.00
64. 00 06400 I NTRAVENOUS THERAPY	1, 035, 689		1, 035, 689	0	1, 035, 689	64. 00
65. 00 06500 RESPI RATORY THERAPY	687, 253	0	687, 253	0	687, 253	65. 00
66. 00 06600 PHYSI CAL THERAPY	146, 340	0	146, 340	0	146, 340	66. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 426, 836		2, 426, 836	0	2, 426, 836	69. 00
69. 01 06901 CARDI AC REHAB	942, 514		942, 514	0	942, 514	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 687, 714		1, 687, 714	0	1, 687, 714	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 104, 640		9, 104, 640	0	9, 104, 640	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 191, 271		2, 191, 271	0	2, 191, 271	73. 00
74. 00 07400 RENAL DIALYSIS	85, 049		85, 049	448	85, 497	74. 00
OUTPATIENT SERVICE COST CENTERS						
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	845, 187		845, 187		845, 187	92. 00
200.00 Subtotal (see instructions)	42, 720, 700	0	42, 720, 700	16, 456	42, 737, 156	200. 00
201.00 Less Observation Beds	845, 187		845, 187		845, 187	201.00
202.00 Total (see instructions)	41, 875, 513	0	41, 875, 513	16, 456	41, 891, 969	202. 00

Health Financial Systems	HEART HOSPITAL AT DEACONESS GATEWAY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0175	Peri od:	Worksheet C

From 10/01/2015 To 09/30/2016 Part I Date/Time Prepared: 2/27/2017 2:04 pm Title XIX Hospi tal PPS Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 12, 152, 308 12, 152, 308 30.00 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 19, 183, 988 1, 117, 431 20, 301, 419 0. 187526 0.000000 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 849, 473 6, 742, 036 10, 591, 509 0.065982 0.000000 54.00 22, 411, 947 0.000000 59.00 05900 CARDIAC CATHETERIZATION 38, 312, 103 60, 724, 050 0.144112 59.00 60.00 06000 LABORATORY 7, 349, 091 894, 985 8, 244, 076 0. 261811 0.000000 60.00 64.00 06400 I NTRAVENOUS THERAPY 1, 479, 861 21, 928 1, 501, 789 0.689637 0.000000 64.00 06500 RESPIRATORY THERAPY 30, 610 2, 807, 165 0. 244821 0.000000 65.00 2, 776, 555 65.00 06600 PHYSI CAL THERAPY 1, 693, 053 0.000000 66.00 1, 661, 119 31, 934 0.086436 66.00 69.00 06900 ELECTROCARDI OLOGY 11, 190, 811 10, 356, 394 21, 547, 205 0.112629 0.000000 69.00 69. 01 06901 CARDI AC REHAB 477 1, 691, 016 1, 691, 493 0. 557208 0.000000 69.01 2, 411, 796 3, 081, 102 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 669, 306 0.547763 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 6, 150, 660 12, 727, 730 18, 878, 390 0.482278 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 9, 102, 132 2, 597, 580 11, 699, 712 0. 187293 0.000000 73.00 07400 RENAL DIALYSIS 74.00 269, 758 21, 975 291, 733 0. 291530 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 230, 102 785, 405 1, 015, 507 0.832281 0.000000 92.00 200.00 Subtotal (see instructions) 100, 220, 078 76, 000, 433 176, 220, 511 200. 00 201.00 201. 00 Less Observation Beds 76, 000, 433 202.00 Total (see instructions) 100, 220, 078 176, 220, 511 202.00

Heal th Financia	I Systems	HEART HOSPITAL AT DEA	ACONESS GATEWAY	In Lie	2552-10	
COMPUTATION OF	RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0175	Peri od: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Pre 2/27/2017 2:0	pared: 4 pm
			Title XIX	Hospi tal	PPS	
Cos	st Center Description	PPS Inpatient				
		Ratio				
		11.00				
I NPATI EN	T ROUTINE SERVICE COST CENTERS	·	·			
20 00 02000 ADI	ILTC & DEDIATRICC					20 00

Cost Center Description	PPS Inpatient	
	Ratio	
	11. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00 03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS		
50.00 05000 OPERATING ROOM	0. 187526	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 065982	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 144375	59. 00
60. 00 06000 LABORATORY	0. 261814	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 689637	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 244821	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 086436	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 112629	69. 00
69. 01 06901 CARDI AC REHAB	0. 557208	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 547763	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 482278	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 187293	73. 00
74. 00 07400 RENAL DIALYSIS	0. 293066	74. 00
OUTPATIENT SERVICE COST CENTERS		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 832281	92. 00
200.00 Subtotal (see instructions)		200.00
201.00 Less Observation Beds		201. 00
202.00 Total (see instructions)		202. 00

Provi der CCN: 15-0175 REDUCTIONS FOR MEDICALD ONLY

Title XIX Hospital PPS Cost Center Description Total Cost Capital Cost Operating Cost Capital Operating Cost	
Cost Center Description Total Cost Capital Cost Operating Cost Capital Operating Cost	
(Wkst. B, Part (Wkst. B, Part Net of Capital Reduction Reduction	
I, col. 26) II col. 26) Cost (col. 1 - Amount	
col. 2)	
1.00 2.00 3.00 4.00 5.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 3, 807, 052 302, 148 3, 504, 904 0 0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 698, 850 1, 237 697, 613 0 0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 8, 751, 063 1, 602, 448 7, 148, 615 0 0	59. 00
60. 00 06000 LABORATORY 2, 158, 389 3, 812 2, 154, 577 0 0	60.00
64. 00 06400 I NTRAVENOUS THERAPY 1, 035, 689 20, 753 1, 014, 936 0 0	64.00
65. 00 06500 RESPI RATORY THERAPY 687, 253 1, 214 686, 039 0 0	65. 00
66. 00 06600 PHYSI CAL THERAPY 146, 340 259 146, 081 0 0	66.00
69. 00 06900 ELECTROCARDI OLOGY 2, 426, 836 555, 736 1, 871, 100 0 0	69.00
69. 01 06901 CARDI AC REHAB 942, 514 35, 349 907, 165 0 0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,687,714 2,981 1,684,733 0 0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 9, 104, 640 16, 086 9, 088, 554 0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 2,191,271 3,870 2,187,401 0 0	73.00
74. 00 07400 RENAL DI ALYSI S 85, 049 152 84, 897 0 0	74.00
OUTPATIENT SERVICE COST CENTERS	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 845, 187 112, 827 732, 360 0 0	92.00
200.00 Subtotal (sum of lines 50 thru 199) 34,567,847 2,658,872 31,908,975 0 0	200. 00
201.00 Less Observation Beds 845, 187 112, 827 732, 360 0 0	201. 00
202. 00 Total (Line 200 minus Line 201) 33, 722, 660 2, 546, 045 31, 176, 615 0 0	202. 00

Health Financial Systems	HEART HOSPITAL AT DEAC	CONESS GATEWAY	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE REDUCTIONS FOR MEDICALD ONLY	COST TO CHARGE RATIOS NET OF	Provider CCN: 15-0175	From 10/01/2015	Worksheet C Part II Date/Time Prepared:

						2/27/2017 2:04 pm	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charge	e		
		Operating Cost	Part I, column	Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 807, 052	20, 301, 419	0. 187526	6	50.0	00
54.00	05400 RADI OLOGY-DI AGNOSTI C	698, 850	10, 591, 509	0. 065982	2	54.0	00
59. 00	05900 CARDI AC CATHETERI ZATI ON	8, 751, 063	60, 724, 050	0. 144112	2	59. (00
60.00	06000 LABORATORY	2, 158, 389	8, 244, 076	0. 261811	1	60. (00
64.00	06400 I NTRAVENOUS THERAPY	1, 035, 689	1, 501, 789	0. 689637	7	64. (00
65.00	06500 RESPI RATORY THERAPY	687, 253	2, 807, 165	0. 244821	1	65. (00
66.00	06600 PHYSI CAL THERAPY	146, 340	1, 693, 053	0. 086436	5	66. (00
69. 00	06900 ELECTROCARDI OLOGY	2, 426, 836	21, 547, 205	0. 112629	9	69. (00
69. 01	06901 CARDI AC REHAB	942, 514	1, 691, 493	0. 557208	3	69. (01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 687, 714	3, 081, 102	0. 547763	3	71. (00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 104, 640	18, 878, 390	0. 482278	3	72. (00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 191, 271	11, 699, 712	0. 187293	3	73. 0	00
74.00	07400 RENAL DIALYSIS	85, 049	291, 733	0. 291530		74. (00
	OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	845, 187	1, 015, 507	0. 832281	1	92. (00
200.00	Subtotal (sum of lines 50 thru 199)	34, 567, 847	164, 068, 203			200. (00
201.00	Less Observation Beds	845, 187	0			201. (00
202.00	Total (line 200 minus line 201)	33, 722, 660	164, 068, 203			202.	00

Health Financial Systems HEAF	T HOSPITAL AT I	DEACONESS GATE	VAY	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od: From 10/01/2015	Worksheet D Part I	
					Date/Time Pre 2/27/2017 2:0	pared: 4 pm
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 088, 360	0	1, 088, 360	6, 926	157. 14	30.00
200.00 Total (lines 30-199)	1, 088, 360		1, 088, 360	6, 926		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 282	515, 733				30. 00
200.00 Total (lines 30-199)	3, 282	515, 733				200. 00

Heal th	Financial Systems HEAR	T HOSPITAL AT I	DEACONESS GATEV	VAY	In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0175	Peri od:	Worksheet D	
					From 10/01/2015		
					To 09/30/2016		pared:
			Ti +Lo	: XVIII	Hospi tal	2/27/2017 2: 0 PPS	4 piii
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	cost center bescription		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,				column 4)	
		Part II, col.	8)	2)	. Charges	Corumir 4)	
		26)	0)				
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
	05000 OPERATING ROOM	302, 148	20, 301, 419	0. 01488	8, 748, 996	130, 211	50.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 237					
	05900 CARDI AC CATHETERI ZATI ON	1, 602, 448		l .			
60.00	06000 LABORATORY	3, 812		l .			1
64.00	06400 I NTRAVENOUS THERAPY	20, 753		•		1	64.00
65. 00	06500 RESPIRATORY THERAPY	1, 214				551	65.00
66. 00	06600 PHYSI CAL THERAPY	259					66, 00
69.00	06900 ELECTROCARDI OLOGY	555, 736		•		l	69.00
69. 01	06901 CARDI AC REHAB	35, 349				0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 981				939	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	16, 086			3, 484, 511	2, 969	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 870					73. 00
74.00	07400 RENAL DIALYSIS	152		0. 00052			74. 00
	OUTPATIENT SERVICE COST CENTERS	•		•			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	112, 827	1, 015, 507	0. 11110	146, 165	16, 240	92.00
200.00		2, 658, 872			37, 650, 228		
				'			•

Health Financial Systems HEAR	T HOSPITAL AT I	DEAC	ONESS GATEW	VAY	In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS	Provi der CC		Period: From 10/01/2015 Fo 09/30/2016		
			Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Al I	Cost	All Other Medical Education Cos	Swing-Bed Adjustment t Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1. 00		2. 00	3, 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	0		0		0	0	30. 00
200.00 Total (lines 30-199)	0)	0			0	200. 00
Cost Center Description	Total Patient Days		Diem (col. ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x		
	6.00		7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30-199)	6, 926 6, 926	1	0. 00	3, 28 3, 28			30. 00 200. 00

Health Financial Systems	HEART HOSPITAL AT D	RT HOSPITAL AT DEACONESS GATEWAY			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CC	F	From 10/01/2015	Worksheet D Part IV Date/Time Prep 2/27/2017 2:04			
		Title	XVIII	Hospi tal	PPS			
Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost			
	Anesthetist	_		Medi cal	(sum of col 1			

			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
60.00	06000 LABORATORY	0	0	(0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	(0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	· C	0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0	l o	·	0	0	69. 00
69. 01	06901 CARDI AC REHAB	0			0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	l	1 0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	l 0		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	92.00
200.00	· · · · · · · · · · · · · · · · · · ·	0	0		0	0	200.00

Heal th	Financial Systems HEAL	RT HOSPITAL AT	DEACONESS GATEV	NAY	In lie	u of Form CMS-2	2552-10
APPOR	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI SH COSTS			CN: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV	pared:
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati 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		1				
50. 00	05000 OPERATING ROOM	0	20,00.,,	1		-,,	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	10, 591, 509	l .			
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	60, 724, 050	1			
60.00	06000 LABORATORY	0	8, 244, 076	1			60.00
64.00	06400 I NTRAVENOUS THERAPY	0	1, 501, 789	0.00000		· ·	64.00
65.00	06500 RESPI RATORY THERAPY	0	2, 807, 165	0.00000			65. 00
66.00	06600 PHYSI CAL THERAPY	0	1, 693, 053			1, 052, 118	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	21, 547, 205	0.00000	0.000000	1, 241, 708	69. 00
69. 01	06901 CARDI AC REHAB	0	1, 691, 493	0.00000	0.000000	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 081, 102	0.00000	0.000000	970, 237	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	18, 878, 390	0.00000	0.000000	3, 484, 511	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11, 699, 712	0.00000	0. 000000	4, 170, 077	73. 00
74.00	07400 RENAL DIALYSIS	0	291, 733	0.00000	0.000000	83, 180	74. 00

0.000000

1, 015, 507 164, 068, 203

0.000000

146, 165 92. 00 37, 650, 228 200. 00

92. 00 OUTPATI ENT SERVICE COST CENTERS
92. 00 O9200 OBSERVATI ON BEDS (NON-DI STINCT PART)
200. 00 Total (lines 50-199)

Health Financial Systems	HEART HOSPITAL AT	DEACONESS GATEWAY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PAS	S Provider CCN: 15-0175	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared:

					2/27/2017 2:0	J4 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9)		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	436, 974		O		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	977, 088		O		54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	16, 941, 550		O		59. 00
60. 00 06000 LABORATORY	0	345, 549		0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0		64. 00
65. 00 06500 RESPIRATORY THERAPY	0	8, 822		0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	6, 768		0		66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 743, 494		0		69. 00
69. 01 06901 CARDI AC REHAB	0	727, 749		O		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	198, 572		O		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	6, 300, 209		O		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	958, 939		O		73. 00
74. 00 07400 RENAL DI ALYSI S	o	3, 640		o		74. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		•	•		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	43, 744		O		92. 00
200.00 Total (lines 50-199)	o	28, 693, 098		o		200. 00
	. '		•	•		

Health Financial Systems	HEART HOSPITAL AT DEA	CONESS GATEWAY	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF MEDICAL	OTHER HEALTH CERVILORS AND MAGGINE COST	D ' I OON 45 0475	D	W I I I D

Health Financial Systems HEAR	T HOSPITAL AT [DEACONESS GATEW	IAY	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 10/01/2015 To 09/30/2016		
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(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	
ANCILLARY SERVICE COST CENTERS						1
50.00 05000 OPERATING ROOM	0. 187526			0	81, 944	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 065982			0	64, 470	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 144112			0 13, 259	2, 441, 481	
60. 00 06000 LABORATORY	0. 261811	345, 549		0	90, 469	
64. 00 06400 I NTRAVENOUS THERAPY	0. 689637	0		0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 244821	8, 822		0 0	2, 160	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 086436	6, 768		0 0	585	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 112629	1, 743, 494		0 491	196, 368	69. 00
69. 01 06901 CARDI AC REHAB	0. 557208	727, 749		0 0	405, 508	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 547763	198, 572		0 0	108, 770	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 482278	6, 300, 209		0 0	3, 038, 452	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 187293	958, 939		0 51, 545	179, 603	73.00
74.00 07400 RENAL DIALYSIS	0. 291530	3, 640		0 0	1, 061	74.00
OUTPATIENT SERVICE COST CENTERS						1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 832281	43, 744		0 0	36, 407	92. 00
200.00 Subtotal (see instructions)		28, 693, 098		0 65, 295	6, 647, 278	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		28, 693, 098		0 65, 295	6, 647, 278	202. 00

Health Financial Systems HEAR	T HOSPITAL AT	DEACONESS GATEV	VAY	In lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der CO	CN: 15-0175	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part V Date/Time Pro 2/27/2017 2:0	epared:
			XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)	-			
ANCI LLARY SERVI CE COST CENTERS	6. 00	7. 00				
50. 00 O5000 OPERATING ROOM			1			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0				54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1, 911				59.00
60. 00 06000 LABORATORY		1, 911				60.00
64. 00 06400 NTRAVENOUS THERAPY		0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
	0	0				66.00
	0	0				69.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	55				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0				71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	9, 654				73.00
74. 00 07400 RENAL DIALYSIS	0	9,004				74.00
OUTPATIENT SERVICE COST CENTERS	0	0				74.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
200.00 Subtotal (see instructions)	0	11, 620				200. 00
201.00 Less PBP Clinic Lab. Services-Program	1 0	1., 020				201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	11, 620				202. 00

Health Financial Systems HEAR	T HOSPITAL AT [DEACONESS GATEV	VAY	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	F	Period: From 10/01/2015		
			7	To 09/30/2016	Date/Time Pre 2/27/2017 2:0	pared: 4 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 088, 360	0	1, 088, 360	6, 926	157. 14	30.00
200.00 Total (lines 30-199)	1, 088, 360		1, 088, 360	6, 926		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	97	15, 243				30. 00
200.00 Total (lines 30-199)	97	15, 243				200. 00

Heal th	Financial Systems HEAR	RT HOSPITAL AT I	DEACONESS GATEV	WAY	In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co		Peri od:	Worksheet D	
					From 10/01/2015		
					To 09/30/2016		
			Ti +I	e XIX	Hospi tal	2/27/2017 2: 0 PPS	4 piii
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	cost center bescription		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,				column 4)	
		Part II, col.	8)	2)	. Charges	COT GIIIIT 4)	
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				<u> </u>		
50.00	05000 OPERATING ROOM	302, 148	20, 301, 419	0. 01488	1, 128, 914	16, 802	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 237	10, 591, 509	0. 00011	7 88, 861	10	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 602, 448	60, 724, 050	0. 02638	1, 000, 769	26, 409	59. 00
60.00	06000 LABORATORY	3, 812	8, 244, 076	0.00046	2 337, 577	156	60.00
64.00	06400 I NTRAVENOUS THERAPY	20, 753	1, 501, 789	0. 01381	9 8, 223	114	64.00
65.00	06500 RESPI RATORY THERAPY	1, 214	2, 807, 165	0.00043	2 105, 769	46	65. 00
66.00	06600 PHYSI CAL THERAPY	259	1, 693, 053	0.00015	3 45, 217	7	66.00
69.00	06900 ELECTROCARDI OLOGY	555, 736	21, 547, 205	0. 02579	2 122, 403	3, 157	69. 00
69. 01	06901 CARDI AC REHAB	35, 349	1, 691, 493	0. 02089	8 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 981	3, 081, 102	0.00096	8 25, 758	25	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16, 086	18, 878, 390	0. 00085	2 192, 327	164	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 870	11, 699, 712	0.00033	1 442, 940	147	73. 00
74.00	07400 RENAL DIALYSIS	152	291, 733	0. 00052	1 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	112, 827	1, 015, 507	0. 11110	11, 224	1, 247	92.00
200.00	Total (lines 50-199)	2, 658, 872	164, 068, 203		3, 509, 982	48, 284	200. 00

Health Financial Systems	HEART HOSPITAL AT D	EACONESS GATEW	VAY	In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COST		<u> </u>	Period: From 10/01/2015 To 09/30/2016		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t 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 F	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7. 00	8. 00	9. 00	1	
INPATIENT ROUTINE SERVICE COST CENTERS	·			·		
30. 00 03000 ADULTS & PEDIATRICS	6, 926	0.00	9	7 0)	30.00
200.00 Total (lines 30-199)	6, 926		9.	7 0		200. 00
			'	!	1	•

Health Financial Systems	HEART HOSPITAL AT DEA	ACONESS GATEWAY	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0175		From 10/01/2015 Part IV		
		Title XIX	Hospi tal	PPS	Pili	
Cost Center Description	Non Physician Nur Anesthetist	rsing School Allied Hea	th All Other Medical	Total Cost (sum of col 1		

		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	C	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(ol	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(ol	0	69. 00
69. 01 06901 CARDI AC REHAB	0	0	(ol ol	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(ol ol	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		ol	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		ol	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0		ol	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C	0	0	92. 00
200.00 Total (lines 50-199)	0	0		ol ol	0	200. 00

Health Financial Systems HEART HOSPITAL AT DEACONESS GATEWAY In Lieu of Form CMS-2552-1 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS THROUGH COSTS TO 09/30/2016 TO 09/30/2016 To 09/30/2016 To 09/30/2017 2: 04 pm Title XIX Hospital PPS				2552 10
		: 15-0175 Peri od: From 10/0	Worksheet D /2015 Part IV /2016 Date/Time Pre	pared:
	Title X	XIX Hospit	al PPS	
Cost Center Description Total Total Charges Ratio of Cost Outpatient Inpatient	cription Total Total Charges Rat	atio of Cost Outpati	ent Inpatient	
Outpatient (from Wkst. C, to Charges Ratio of Cost Program	Outpatient (from Wkst. C, t	to Charges Ratio of	Cost Program	
Cost (sum of Part I, col. (col. 5 ÷ col. to Charges Charges	Cost (sum of Part I, col. (co	col. 5 ÷ col. to Chai	ges Charges	
col . 2, 3 and 8) 7) (col . 6 ÷ col .	col. 2, 3 and 8)	7) (col. 6	· col .	
4) 7)	7	- '/		
6.00 7.00 8.00 9.00 10.00		8. 00 9. 00	10.00	
ANCI LLARY SERVI CE COST CENTERS				
		l l		
54. 00 05400 RADI 0LOGY - DI AGNOSTI C 0 10, 591, 509 0. 000000 0. 000000 88, 861 54. 00)STI C 0 10, 591, 509	0.000000 0.0	000000 88, 861	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 60, 724, 050 0. 000000 0. 000000 1, 000, 769 59. 00	RI ZATI ON 0 60, 724, 050	0. 000000 0. 0	1, 000, 769	59. 00
60. 00 06000 LABORATORY 0 8, 244, 076 0. 000000 0. 000000 337, 577 60. 00	0 8, 244, 076	0. 000000 0. 0	000000 337, 577	60.00
64. 00 06400 I NTRAVENOUS THERAPY 0 1, 501, 789 0. 000000 0. 000000 8, 223 64. 00	RAPY 0 1, 501, 789	0. 000000 0. 0	000000 8, 223	64.00
65. 00 06500 RESPI RATORY THERAPY 0 2, 807, 165 0. 000000 0. 000000 105, 769 65. 00	RAPY 0 2, 807, 165	0. 000000 0. 0	105, 769	65. 00
66. 00 06600 PHYSI CAL THERAPY 0 1, 693, 053 0. 000000 0. 000000 45, 217 66. 00	7 0 1, 693, 053	0. 000000 0. 0	000000 45, 217	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 21, 547, 205 0. 000000 0. 000000 122, 403 69. 00	3Y 0 21, 547, 205	0. 000000 0. 0	000000 122, 403	69. 00
69. 01 06901 CARDI AC REHAB 0 1, 691, 493 0. 000000 0. 000000 0 69. 0	0 1, 691, 493	0.000000 0.0	000000	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 3,081,102 0.000000 0.000000 25,758 71.00	S CHARGED TO PATIENTS 0 3,081,102	0.000000 0.0	000000 25, 758	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 18, 878, 390 0.000000 0.000000 192, 327 72. 00	GED TO PATIENTS 0 18,878,390	0.000000 0.0	000000 192, 327	72. 00
73. 00 07300 DRUGS CHARGED TO PATLENTS 0 11, 699, 712 0. 000000 0. 000000 442, 940 73. 00) PATIENTS 0 11, 699, 712	0.000000 0.0	000000 442, 940	73. 00
74. 00 07400 RENAL DIALYSIS 0 291, 733 0. 000000 0. 000000 0 74. 00	0 291, 733	0.000000 0.0	000000	74. 00

1, 015, 507 164, 068, 203

0.000000

0.000000

11, 224 92. 00 3, 509, 982 200. 00

92. 00 OUTPATI ENT SERVICE COST CENTERS
92. 00 O9200 OBSERVATI ON BEDS (NON-DI STINCT PART)
200. 00 Total (lines 50-199)

Health Financial Systems	HEART HOSPITAL AT D	EACONESS GATEWAY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0175		Worksheet D Part IV Date/Time Prepared: 2/27/2017 2:04 pm
		Ti +I o VI V	Heeni tel	DDC

					2/2//2017 2:0	J4 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0)		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0) c			54. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	0) c)		59. 00
60. 00 06000 LABORATORY	o	0) c)		60.00
64.00 06400 INTRAVENOUS THERAPY	o	0) c)		64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0) c			65. 00
66. 00 06600 PHYSI CAL THERAPY	o	0) c)		66. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0) c)		69. 00
69. 01 06901 CARDI AC REHAB	o	0) c)		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	O) c)		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	O) c)		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0				73. 00
74. 00 07400 RENAL DI ALYSI S	o	O) c)		74. 00
OUTPATIENT SERVICE COST CENTERS	'		•	•		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0) (92. 00
200.00 Total (lines 50-199)	0	0				200.00
	-1		'	!		

Health Financial Systems	HEART HOSPITAL AT DEA	HEART HOSPITAL AT DEACONESS GATEWAY		
ADDODTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0175	Pari ad:	Workshoot D

Health Financial Systems HEART HOSPITAL AT DEACONESS GATEWAY In Li				In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 10/01/2015 To 09/30/2016		pared: 4 pm
	1	Titl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	1.00	2.00	(see inst.)	(see inst.)	F 00	
ANOLLI ADV. CEDVI CE. COCT. CENTEDO	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50.00 O5000 OPERATING ROOM	0.10750/			0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 187526 0. 065982	l .		0 56, 295		54.00
				0 146, 650		59.00
	0. 144112	0		0 2, 579, 739	0	
	0. 261811	0		0 80, 298		60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 689637	0		0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 244821	0		0 3, 369	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 086436			0 4, 832	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 112629			0 448, 068	0	69.00
69. 01 06901 CARDI AC REHAB	0. 557208	l e		0 63, 568		69. 01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 547763	l e		0 54, 548		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 482278	l e		0 760, 065		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 187293			0 182, 831	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 291530	0		0 1, 998	0	74. 00
OUTPATIENT SERVICE COST CENTERS	0.000004			0 407 550		00.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	0. 832281	0		0 107, 550		92.00
200.00 Subtotal (see instructions)		0		0 4, 489, 811		200. 00
201.00 Less PBP Clinic Lab. Services-Program				U U		201. 00
Only Charges				4 400 011	0	202 00
202.00 Net Charges (line 200 +/- line 201)		l 0		0 4, 489, 811	1	202. 00

Health Financial Systems	HEART HOSPITAL AT DEA	CONESS GATEWAY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0175	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part V Date/Time Prepared: 2/27/2017 2:04 pm
		Title XIX	Hospi tal	PDS

					2/27/2017 2:04 pm	
		Ti tl	e XIX	Hospi tal	PPS	
	Co:	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	10, 557	•		50. (
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 676			54. (
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	371, 771			59. (
60. 00 06000 LABORATORY	0	21, 023			60. (
64. 00 06400 I NTRAVENOUS THERAPY	0	0			64. (00
65. 00 06500 RESPIRATORY THERAPY	0	825			65. (00
66. 00 06600 PHYSI CAL THERAPY	0	418			66. (00
69. 00 06900 ELECTROCARDI OLOGY	0	50, 465			69. (00
69. 01 06901 CARDI AC REHAB	0	35, 421			69. (
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29, 879			71. (00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0	366, 563			72. (
73.00 07300 DRUGS CHARGED TO PATIENTS	0	34, 243			73. (00
74. 00 07400 RENAL DIALYSIS	0	582			74. (00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	89, 512			92. 0	
200.00 Subtotal (see instructions)	0	1, 020, 935			200. (00
201.00 Less PBP Clinic Lab. Services-Program	0				201. (00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	1, 020, 935			202.	00

Health Financial Systems	HEART HOSPITAL AT DEA	CONESS GATEWAY	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0175	Peri od: From 10/01/2015	Worksheet D-1	
			To 09/30/2016	Date/Time Prep 2/27/2017 2:04	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)					1. 00
2.00 Inpatient days (including private room days, evaluding swing had and powhern days)					2 00

DART 1 - ALL PROFIDER COMPONENTS SPATITURE MAYS		Cost Center Description		
IMPARTIENT DAYS		PART I - ALL PROVIDER COMPONENTS	1. 00	
Impatient days (including private room days)				
Private room days (excluding swing-bed and observation bed days). If you have only private room days, decomplete this line. Semi-private room days (excluding swing-bed and observation bed days). Semi-private room days (excluding swing-bed and observation bed days). Semi-private room days (excluding swing-bed and observation bed days). From the control of the cost of the cost reporting period (if calendary sen, enter 0 on this line). Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendary sen, enter 0 on this line). Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendary sen, enter 0 on this line). Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary sen, enter 0 on this line). Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary sen, enter 0 on this line). Swing-bed NF type inpatient days applicable to ittle XVIII only (including private room days). Swing-bed NF type inpatient days applicable to title XVIII only (including private room days). Swing-bed NF type inpatient days applicable to title XVIII only (including private room days). Swing-bed NF type inpatient days applicable to title XVIII only (including private room days). In only becember 31 of the cost reporting period (if calendary sen, enter 0 on this line). In only becember 31 of the cost reporting period (if calendary sen, enter 0 on this line). In only becember 31 of the cost reporting period (if calendary sen, enter 0 on this line). In only becember 31 of the cost reporting period (if calendary sen, enter 0 on this line). In only becember 31 of the cost reporting period (if calendary sen, enter 0 on this line). In only becember 31 of the cost reporting period (if calendary sen, enter 0 on this line). In only becember 31 of the c	1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6, 926	1. 00
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32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 152, 853) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 37.00 Program general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 36.00 0.00	30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 152, 853) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 33.00 0.00 34.00 36.00 37.00 38.152,853 37.00 37.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 40.00	31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 152, 853) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 36.00 37.00 8, 152, 853 37.00 1, 177.14 38.00 3, 863, 373 39.00	32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 152, 853 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 152, 853 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 8, 152, 853 37.00	34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 152, 853 27.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 37	35.00	, , ,	0.00	
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	-	
PART II - HOSPITÁL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	37. 00		8, 152, 853	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,177.14 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,177.14 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,177.14 38.00 3,863,373 39.00 40.00				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 3,863,373 39.00 40.00	38 00		1 177 14	38. 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 3,863,373 41.00		, ,		
	41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 863, 373	41. 00

24.00	7 x line 19)	O	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8, 152, 853	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28. 00		0	28. 00
29. 00		0	29. 00
30.00		0	30.00
31. 00		0. 000000	
32.00		0. 00	32.00
33.00		0. 00	33.00
34.00			34.00
35. 00		0. 00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00		8, 152, 853	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	1, 177. 14	
39. 00		3, 863, 373	
40. 00		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 863, 373	41. 00

	Financial Systems FATION OF INPATIENT OPERATING COST	HEART HOSPITAL AT D		WAY CCN: 15-0175	Period:	u of Form CMS-2 Worksheet D-1	
. J 0 I	S S. Elwining 3001			10 0170	From 10/01/2015		
					To 09/30/2016	Date/Time Pre 2/27/2017 2:0	pared: 4 pm
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Average Per	5	Program Cost (col. 3 x col.	
		Impatrent cost	impatrent bays	col. 2)	-	4)	
	Town a sign of the same of the	1.00	2. 00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital U	ni to					42. 0
3. 00		III LS					43.0
4. 00							44. 0
5. 00							45. 0
6. 00							46.0
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
	<u>'</u>					1. 00	
8. 00	Program inpatient ancillary service cost	,		_		8, 048, 881	1
9. 00	Total Program inpatient costs (sum of li PASS THROUGH COST ADJUSTMENTS	nes 41 through 48)(see instructi	ons)		11, 912, 254	49.0
0.00	Pass through costs applicable to Program	inpatient routine	services (fro	m Wkst. D. sui	m of Parts I and	515, 733	50.0
	[111)	•	•				
1. 00	Pass through costs applicable to Program	inpatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	486, 751	51.0
2. 00	and IV) Total Program excludable cost (sum of li	nes 50 and 51)				1, 002, 484	52. 0
3. 00	Total Program inpatient operating cost e	xcluding capital re	lated, non-ph	ysician anest	hetist, and	10, 909, 770	•
	medical education costs (line 49 minus l	ine 52)					1
4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0] 54. 0
	Target amount per discharge						55.0
6. 00	Target amount (line 54 x line 55)						56. C
7. 00	, , ,	erating cost and ta	rget amount (ine 56 minus	line 53)	0	
8. 00 9. 00							
7. 00	market basket	it reporting perrou	charing 1770, 1	apaatea ana e	ompounded by the	0.00	59.0
0.00	Lesser of lines 53/54 or 55 from prior y						60.0
1. 00	If line 53/54 is less than the lower of which operating costs (line 53) are less					0	61.0
	amount (line 56), otherwise enter zero (S (TITIES 54 X	60), OI 1% O	i the target		
	Relief payment (see instructions)	•				0	
3. 00	Allowable Inpatient cost plus incentive		ctions)			0	63.0
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine		mber 31 of the	e cost report	ing period (See	0	64.0
	instructions)(title XVIII only)	· ·					
5. 00	Medicare swing-bed SNF inpatient routine	costs after Decemb	er 31 of the	cost reportin	g period (See	0	65.0
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient r	outine costs (line	64 plus line	65)(title XVI	II only). For	0	66.0
	CAH (see instructions)		- P	, (
7. 00		utine costs through	December 31	of the cost r	eporting period	0	67.0
8 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient ro	utine costs after D	ecember 31 of	the cost ren	orting period	0	68.0
0.00	(line 13 x line 20)	atine costs arter b	ccciniber or or	the cost rep	or tring period	Ü	00.0
9. 00	Total title V or XIX swing-bed NF inpati					0	69. 0
0. 00	PART III - SKILLED NURSING FACILITY, OTH Skilled nursing facility/other nursing f		•		\		70.0
1.00	Adjusted general inpatient routine servi	,		•	,		71.0
2. 00	Program routine service cost (line 9 x l	ine 71)					72. C
3.00	Medically necessary private room cost ap						73.0
4. 00 5. 00		•			Part II column		74. 0 75. 0
5. 00	26, line 45)	one routine service	50313 (1101111	NOT KSHOEL D,	art II, Corumili		, 3. 0
6. 00	Per diem capital-related costs (line 75	. *					76.0
7. 00 8. 00	Program capital -related costs (line 9 x Inpatient routine service cost (line 74	•					77. C
9. 00	,	· ·	rovi der recor	ds)			79. 0
	Total Program routine service costs for				nus line 79)		80.0
1.00	Inpatient routine service cost per diem		`				81. (
2. 00 3. 00	Inpatient routine service cost limitation	* .	* .				82.0
4. 00	Reasonable inpatient routine service cos Program inpatient ancillary services (se		3)				84.0
5. 00	Utilization review - physician compensat	ion (see instructio					85.0
86. 00	Total Program inpatient operating costs	(sum of lines 83 th					86.0
7 00	PART IV - COMPUTATION OF OBSERVATION BED					710	07 6
37. 00	Total observation bed days (see instruct Adjusted general inpatient routine cost		line 2)			1, 177. 14	87.0
88. 00	TAULUSTER RELIEFAL LIDATIENT LOUTINE COST						

Health Financial Systems HEAR	T HOSPITAL AT	DEACONESS GATEV	VAY	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 10/01/2015 To 09/30/2016	Date/Time Prep 2/27/2017 2:04	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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 O	COST					
90.00 Capital -related cost	1, 088, 360	8, 152, 853	0. 13349	4 845, 187	112, 827	90. 00
91.00 Nursing School cost	(8, 152, 853	0. 000000	845, 187	0	91.00
92.00 Allied health cost	(8, 152, 853	0. 000000	845, 187	0	92.00
93.00 All other Medical Education	(8, 152, 853	0. 000000	845, 187	0	93. 00

Heal th	Financial Systems HEART HOSPITAL AT DEA	ACONESS GATEWAY	In Lie	u of Form CMS-2	2552-10
СОМРИТ	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0175	Peri od: From 10/01/2015 To 09/30/2016	2/27/2017 2:04	
		Title XIX	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day			6, 926	1. 00
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		6, 926	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		6, 208	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8. 00

	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0175	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 10/01/2015 To 09/30/2016	Date/Time Pre 2/27/2017 2:0	
			Ti tl	e XIX	Hospi tal	PPS	, i piii
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days		5	Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
	Intensive Care Type Inpatient Hospital Units						
3. 00	INTENSIVE CARE UNIT						43
. 00	CORONARY CARE UNIT						44.
5. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
	1					1. 00	
. 00	Program inpatient ancillary service cost (Wks			na)		698, 857	
. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		813, 040	49
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D. su	m of Parts I and	15, 243	50
	[111)		•				
. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	48, 284	51
2. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				63, 527	52
3. 00	Total Program inpatient operating cost exclude		elated, non-phy	sician anest	hetist, and	749, 513	1
	medical education costs (line 49 minus line !				,	, 5 . 0]
	TARGET AMOUNT AND LIMIT COMPUTATION						4
. 00	1 3 1 1 3 1						54
. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	
. 00	Difference between adjusted inpatient operati	line 53)	0				
00	1		0				
. 00	Lesser of lines 53/54 or 55 from the cost rep	0. 00	59				
00	market basket		.da+ad by +ba m	ankat baakat		0.00	
. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines					0. 00 0	
. 00	which operating costs (line 53) are less than					Ŭ	"
	amount (line 56), otherwise enter zero (see i						
2. 00							62
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost report	ing period (See	0	64
	instructions)(title XVIII only)				5 1		
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reportin	g period (See	0	65
. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	no costs (lino	64 plus lino 6	5) (+i+l o V//	II only) For	0	66
. 00	CAH (see instructions)	ne costs (Title	04 prus rine 0	5)(title XVI	ii diliy). Tul	0	
7. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost r	eporting period	0	67
	(line 12 x line 19)					_	١
3. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (routine costs (line 67 + line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU					<u> </u>	"
0. 00	Skilled nursing facility/other nursing facili	-)		70
. 00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line 1) Medically necessary private room cost applications	,	(line 14 v li	ne 35)			72
. 00	Total Program general inpatient routine servi	9	•	116 33)			74
. 00	Capital -related cost allocated to inpatient	•	,	orksheet B,	Part II, column		75
	26, line 45)		•				
00	Per diem capital related costs (line 75 ÷ lin						76
. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77
. 00	Aggregate charges to beneficiaries for excess	,	rovi der record	s)			79
. 00	Total Program routine service costs for compa	, ,		*	nus line 79)		80
. 00	Inpatient routine service cost per diem limi						81
. 00	Inpatient routine service cost limitation (li		•				82
. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		is)				83
. 00	Utilization review - physician compensation		ons)				85
	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
						710	1 07
7. 00 3. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		1: 0)			1, 177. 14	87

Health Financial Systems HEAR	T HOSPITAL AT	DEACONESS GATEV	ΙΑΥ	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 10/01/2015 To 09/30/2016	Date/Time Prep 2/27/2017 2:04	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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	1, 088, 360	8, 152, 853	0. 13349	4 845, 187	112, 827	90. 00
91.00 Nursing School cost	(8, 152, 853	0. 000000	845, 187	0	91.00
92.00 Allied health cost	(8, 152, 853	0. 000000	845, 187	0	92.00
93.00 All other Medical Education	(8, 152, 853	0. 000000	845, 187	0	93. 00

Health Fina	ncial Systems HEART HOSPITAL AT DEA	CONESS GATE	NAY	In Lie	eu of Form CMS-2	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0175	Peri od:	Worksheet D-3	
				From 10/01/2015 To 09/30/2016	Date/Time Pre 2/27/2017 2:0	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS				•	
30. 00 0300	O ADULTS & PEDIATRICS			6, 122, 079		30.00
ANCI	LLARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 18752			1
	O RADI OLOGY-DI AGNOSTI C		0. 06598			1
	O CARDI AC CATHETERI ZATI ON		0. 14437			•
	0 LABORATORY		0. 26181		957, 899	1
	O I NTRAVENOUS THERAPY		0. 68963			1
	O RESPI RATORY THERAPY		0. 24482			1
	O PHYSI CAL THERAPY		0. 08643			66. 00
	0 ELECTROCARDI OLOGY		0. 11262		139, 852	
	1 CARDI AC REHAB		0. 55720		0	69. 01
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 54776			1
	O IMPL. DEV. CHARGED TO PATIENTS		0. 48227			1
	O DRUGS CHARGED TO PATIENTS		0. 18729			
	O RENAL DIALYSIS		0. 29306	6 83, 180	24, 377	74. 00
	ATIENT SERVICE COST CENTERS					
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 83228			1
200. 00	Total (sum of lines 50-94 and 96-98)			37, 650, 228		•
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	l	201. 00
202. 00	Net Charges (line 200 minus line 201)			37, 650, 228		202. 00

Health Financial Systems HEART HOSPITAL AT DEACONESS GATEWAY In Lieu of Form CMS-2552-10						
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co	CN: 15-0175	Peri od:	Worksheet D-3	
				From 10/01/2015 To 09/30/2016	Date/Time Prep 2/27/2017 2:04	
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS			542, 954		30. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS		0 1075	1 120 014	211 701	FO 00
50.00	O5000 OPERATI NG ROOM O5400 RADI OLOGY-DI AGNOSTI C		0. 18752		211, 701	50.00
54. 00 59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 06598 0. 14437	· ·	5, 863 144, 486	54. 00 59. 00
60.00	06000 LABORATORY		0. 14437		88, 382	60.00
64. 00	06400 I NTRAVENOUS THERAPY		0. 68963		5, 671	64. 00
65. 00	06500 RESPI RATORY THERAPY		0. 24482	· ·	25, 894	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 08643	· ·	3, 908	66.00
69. 00	06900 ELECTROCARDI OLOGY		0. 11262	· ·	13, 786	
69. 01	06901 CARDI AC REHAB		0. 55720	· ·	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 54776		14, 109	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 48227	192, 327	92, 755	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 18729	442, 940	82, 960	73. 00
74.00	07400 RENAL DIALYSIS		0. 29306	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 83228	11, 224	9, 342	
200.00				3, 509, 982	698, 857	
201.00		(line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)			3, 509, 982		202. 00

Health Financial Systems	HEART HOSPITAL AT DEAC	ONESS GATEWAY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0175	Peri od: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/27/2017 2:04 pm

			10 04/30/2010	2/27/2017 2:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1.01	DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see	0	1. 01
	instructions)				
1. 02	DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (see	10, 443, 696	1. 02
	instructions)				
1. 03	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring p	orior to October	0	1. 03
4 0 4	1 (see instructions)		61	0	4 04
1. 04	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring o	on or arter	0	1. 04
2 00	October 1 (see instructions)			107 074	2 00
2.00	Outlier payments for discharges. (see instructions)			127, 974	2.00
2. 01	Outlier reconciliation amount	ana)		0	2. 01 2. 02
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	UIIS)		0	
3.00	Managed Care Simulated Payments	sting ported (see instru	ati ana)		3.00
4. 00	Bed days available divided by number of days in the cost report	tring period (see instruc	ctrons)	22. 04	4. 00
F 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	t recent eact reporting	aniad andina an	0.00	F 00
5.00	or before 12/31/1996. (see instructions)	recent cost reporting p	berroa enarng on	0. 00	5. 00
4 00	1	the criteria for an add o	on to the con	0.00	6. 00
6. 00	FTE count for allopathic and osteopathic programs which meet if for new programs in accordance with 42 CFR 413.79(e)	the Criteria for all add-0	on to the cap	0.00	0.00
7.00	MMA Section 422 reduction amount to the IME cap as specified u	under 42 CED \$412 10E(f)	(1) (i v) (D) (1)	0.00	7. 00
7. 00	ACA Section 5503 reduction amount to the IME cap as specified	under 42 CFR 8412.105(1)	(1)(1 V)(D)(1)	0.00	7. 00
7.01	If the cost report straddles July 1, 2011 then see instruction)(I)(IV)(B)(2)	0.00	7.01
8. 00	Adjustment (increase or decrease) to the FTE count for allopa		arame for	0.00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	0.00
	1998), and 67 FR 50069 (August 1, 2002).	79(C)(2)(1V), 04 1K 2034	(way 12,		
8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under section 5503 of	F the ACA IF	0.00	8. 01
0.01	the cost report straddles July 1, 2011, see instructions.	ots under section 5505 0	the ACA. II	0.00	0.01
8. 02	The amount of increase if the hospital was awarded FTE cap slo	nts from a closed teachi	na hosnital	0.00	8. 02
0.02	under section 5506 of ACA. (see instructions)	ors from a crosed reaching	ig nospi tai	0.00	0. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8 8 01 and 8 02) (See	0.00	9. 00
,, 00	instructions)	35 (6) 6) 6: 4:14 6) 62)		0.00	7. 00
10.00	FTE count for allopathic and osteopathic programs in the curre	ent vear from vour recor	ds	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.				11. 00
12.00	Current year allowable FTE (see instructions)				12. 00
13. 00	Total allowable FTE count for the prior year.			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sep	tember 30. 1997.	0.00	
	otherwise enter zero.				
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16.00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18.00	Adjusted rolling average FTE count			0.00	18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4)).		0.000000	
20. 00	Prior year resident to bed ratio (see instructions)			0.000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	
	Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE reside		ec. 412, 105	0.00	23. 00
	(f)(1)(iv)(C).				
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25.00	If the amount on line 24 is greater than -0-, then enter the I	ower of line 23 or line	24 (see		25. 00
	instructions)		`		
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28.00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions))		0	
29.00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29. 01
	Di sproporti onate Share Adjustment	,			
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	0.00	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)		- /	0.00	
32. 00	Sum of lines 30 and 31			0.00	
33. 00	Allowable disproportionate share percentage (see instructions))			33. 00
	Disproportionate share adjustment (see instructions)				34. 00
	· · · · · · · · · · · · · · · · · · ·		'		•

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0175	Period: From 10/01/2015 To 09/30/2016		
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment				
5. 00	Total uncompensated care amount (see instructions)		0		
5. 01	Factor 3 (see instructions)		0. 000000000	1	
5. 02		ter zero on this line)	0	0	35.
5. 03	(see instructions) Pro rata share of the hospital uncompensated care payment amount amount of the hospital uncompensated care payment of the hospital uncompensated care payment amount of the hospital uncompensated care payment of the hospital uncompensated	ount (coo instructions)	0	0	35.
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		0	U	36.
0. 00	Additional payment for high percentage of ESRD beneficiary di				30.
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.
	652, 682, 683, 684 and 685 (see instructions)				
			Before 1/1	On/After 1/1	
			1. 00	1. 01	
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0	0	41.
	instructions)	DD0 /F0			
1. 01		-DRGS 652, 682, 683, 684	4 0	0	41.
12. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not quali	ify for adjustment)	0.00		42.
13.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68				43.
3.00	instructions)	32, 003, 004 dii 003. (3c)			75.
4. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
	days)	.,			
5. 00	Average weekly cost for dialysis treatments (see instructions	s)	0.00	0.00	45.
6. 00	Total additional payment (line 45 times line 44 times line 41	1. 01)	0		46.
7. 00	Subtotal (see instructions)		10, 571, 670		47.
8. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48.
	only. (see instructions)			Amount	
				Amount 1.00	
19. 00	Total payment for inpatient operating costs (see instructions	s)		10, 571, 670	49.
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar	•)	845, 724	50.
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt.		•	0	51.
2.00	Direct graduate medical education payment (from Wkst. E-4, li	ine 49 see instructions).		0	52.
3. 00	Nursing and Allied Health Managed Care payment			0	53.
4. 00	Special add-on payments for new technologies			0	54.
4. 01	Islet isolation add-on payment				54.
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	•		0	
6.00	Cost of physicians' services in a teaching hospital (see intr	•	through 2E)	0	56.
8. 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt.		through 35).	0	57. 58.
9. 00	Total (sum of amounts on lines 49 through 58)	TV, COI. IT TITLE 200)		11, 417, 394	
0. 00	Primary payer payments			0	60.
1. 00		s line 60)		11, 417, 394	
2. 00	1 3 1 3			763, 532	
3. 00	Coinsurance billed to program beneficiaries			6, 342	
	Allowable bad debts (see instructions)			43, 311	
	Adjusted reimbursable bad debts (see instructions)			28, 152	65.
	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		27, 692	66.
5. 00 6. 00				10, 675, 672	
5. 00 6. 00 7. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	applicable to MS-DRGs (s	,	3, 132	
5. 00 6. 00 7. 00 8. 00	Credits received from manufacturers for replaced devices for	(F. 0011 1 1 11 11	151	0	
5. 00 6. 00 7. 00 8. 00 9. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	13)	_	
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	.(For SCH see instruction	,	0	
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT	.(For SCH see instruction	,	0	70.
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 88	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment			0	70. 70.
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 88 0. 89	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see inst		15)	0	70. 70. 70.
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 88 0. 89 0. 90	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 70. 70. 70.
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 88 0. 89 0. 90 0. 91	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see inst			0 0	70. 70. 70. 70.
55. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 89 70. 89 70. 90 70. 91 70. 92	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0 0 0 0	70. 70. 70. 70. 70. 70.
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 88 0. 89 0. 90 0. 91 0. 92 0. 93	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0 0 0 0 0 0 95, 485 -40, 730	70. 70. 70. 70. 70. 70. 70.

	Financial Systems HEART HOSPITAL AT DEAC ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co		Peri od:	u of Form CMS-2 Worksheet E	2002 10
CALCUL	ATTON OF REIMBORSEMENT SETTLEMENT	Provider Co	JN. 13-0173	From 10/01/2015		
				To 09/30/2016		
		Title	XVIII	Hospi tal	PPS	4 рііі
				(уууу)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	1			0	0	70. 97
	the corresponding federal year for the period ending on or after	er 10/1)				
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				0	,
71.00		9 & 70)			10, 727, 295	
71. 01	Sequestration adjustment (see instructions)				214, 546	
	Interim payments				10, 485, 160	
	Tentative settlement (for contractor use only)	72)			0	
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, Protested amounts (nonallowable cost report items) in accordance				27, 589	
75. 00	CMS Pub. 15-2, chapter 1, §115.2	e with			20, 887	/5.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90. 00	, , , , , , , , , , , , , , , , , , , ,	ructions)			0	90.00
91. 00		de ti ons)			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instruc	rtions)			0	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instructi				0	93.00
	The rate used to calculate the time value of money (see instruc				0.00	94.00
	Time value of money for operating expenses (see instructions)	,			0	
	Time value of money for capital related expenses (see instructi	ons)			0	96.00
				Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)				0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)				0.0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)				0	102. 00
102 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)				0.0000	102 0
	HORK AUTUSTINEUT TACTUL USEE TUSTITUCITOUS)			1	() ()()()()	

103.00 HRR adjustment factor (see instructions)
104.00 HRR adjustment amount for HSP bonus payment (see instructions)

0. 0000 103. 00 0 104. 00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0175

					10	0 09/30/2016	Date/lime Prep 2/27/2017 2:04	
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2. 00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	0	0	0		0	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	10, 443, 696	0		10, 443, 696	10, 443, 696	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for	2. 00	127, 974	0	0	127, 974	127, 974	2. 00
2. 01	discharges (see instructions) Outlier payments for	2. 02	0	0	0	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adju							
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions) Indirect Medical Education Adju	istment for the	e Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000		0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	O	0	0	O	0	8. 01
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	O	0	9. 01
	8.01) Disproportionate Share Adjustme	ent						
10. 00	Allowable disproportionate share percentage (see	33.00	0. 0000	0.0000	0. 0000	0. 0000		10. 00
11. 00	instructions) Disproportionate share	34. 00	0	0	0	0	0	11. 00
11. 01	adjustment (see instructions) Uncompensated care payments	36. 00	0	0	0	0	0	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESI 46.00	RD beneficiary	di scharges 0	0	0	0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	10, 571, 670	0	0	10, 571, 670		
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48. 00	0	0	_	0, 371, 670	10, 371, 870	
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	10, 571, 670	0	О	10, 571, 670	10, 571, 670	15. 00
16. 00	Payment for inpatient program capital	50. 00	845, 724	0	0	845, 724	845, 724	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from	55. 00 68. 00	0 3, 132	0	0	0	0	17. 01 17. 02
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation	93. 00	0	0	0	0	0	
	adjustment amount (see instructions)							

Health Financial Systems	HEAR	I HUSPITAL AT L	DEACONESS GATEV	IAY	In Lie	eu of Form CMS-2	2552-10
LOW VOLUME CALCULATION EXHIBIT 4			Provider Co		Period: From 10/01/2015 To 09/30/2016	Date/Time Prep 2/27/2017 2:04	pared:
			Title	XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	0	1.00	2. 00	3. 00	4. 00	5. 00	
19. 00 SUBTOTAL			0		0 11, 417, 394	11, 417, 394	19. 00
	W/S L, line	(Amounts from L)					
	0	1.00	2. 00	3. 00	4. 00	5. 00	
20.00 Capital DRG other than outlie	r 1.00	830, 461	0		0 830, 461	830, 461	20.00
20.01 Model 4 BPCI Capital DRG othe than outlier	r 1.01	0	0		0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	15, 263	0		0 15, 263	15, 263	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0.0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	0	1	0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0. 000	0. 0000		24. 00
25.00 Disproportionate share adjustment (see instructions)	11.00	0	0	1	0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	845, 724	0	1	0 845, 724	845, 724	26. 00
	W/S E, Part A	(Amounts to E,					
	line	Part A)					
	0	1.00	2.00	3.00	4. 00	5. 00	
27.00 Low volume adjustment factor				0.00000	0. 107679		27. 00
28.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0	O	28. 00
29.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				1, 229, 414	1, 229, 414	29. 00
100.00 Transfer low volume adjustments to Wkst. E, Pt. A		Y					100. 00

Provider CCN: 15-0175

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

From 10/01/2015 09/30/2016 Date/Time Prepared: 2/27/2017 2:04 pm Title XVIII Hospi tal PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 1.00 2.00 3. 00 4. 00 0 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 0 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 10, 443, 696 10, 443, 696 10, 443, 696 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 127, 974 127, 974 127, 974 2.00 0 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 C 0 2.01 0 Operating outlier reconciliation 3 00 2 01 O 0 0 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 22.01 0 0 6.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 0.0000 0.0000 0.0000 10.00 33.00 (see instructions) 11.00 Disproportionate share adjustment (see 34 00 0 0 Ω 11.00 instructions) 11.01 Uncompensated care payments 36.00 0 0 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see O 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 10, 571, 670 0 10, 571, 670 10, 571, 670 13.00 14.00 Hospital specific payments (completed by SCH 48.00 0 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 0 10, 571, 670 15.00 49.00 10, 571, 670 10, 571, 670 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 845, 724 845, 724 845, 724 16.00 Special add-on payments for new technologies 17.00 54.00 0 17.00 55.00 Net organ acquisition cost 0 17.01 17.01 0 17.02 Credits received from manufacturers for 68.00 3, 132 0 3, 132 3, 132 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 0 18.00 amount (see instructions) SUBTOTAL 19 00 O 11 420 526 11, 420, 526 19. 00

Health Financial Systems HEART HOSPITAL AT DEACONESS GATEWAY In Lieu of Form CMS-2552-10 HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0175 Peri od: Worksheet E From 10/01/2015 To 09/30/2016 Part A Exhibit 5 Date/Time Prepared: 2/27/2017 2:04 pm Titl<u>e XVIII</u> Hospi tal PPS (Amt. from Wkst. L, line L) Wkst. 2.00 3. 00 4.00 n 1 00 20.00 Capital DRG other than outlier 1.00 830, 461 0 830, 461 830, 461 20.00 20. 01 Model 4 BPCI Capital DRG other than outlier 1.01 0 20.01 21.00 Capital DRG outlier payments 2.00 15, 263 0 15, 263 15, 263 21.00 Model 4 BPCI Capital DRG outlier payments 21.01 2.01 0 21.01 0 22.00 Indirect medical education percentage (see 5.00 0.0000 0.0000 0.0000 22.00 instructions) 23.00 Indirect medical education adjustment (see 6.00 23.00 instructions) 0.0000 0.0000 24 00 Allowable disproportionate share percentage 10 00 0 0000 24 00 (see instructions) 25.00 Disproportionate share adjustment (see 11.00 0 0 25.00 instructions) Total prospective capital payments (see 12.00 845, 724 0 845, 724 845, 724 26.00 instructions) Wkst. E. Pt. (Amt. from A, line Wkst. E, Pt. 0 1.00 2.00 3.00 4.00 27. 00 27. 00 28.00 Low volume adjustment prior to October 1 70.96 0 0 28.00 29.00 Low volume adjustment on or after October 1 70.97 0 29.00 HVBP payment adjustment (see instructions) 70. 93 95, 485 0 95, 485 95, 485 30.00 30.00 HVBP payment adjustment for HSP bonus 30.01 70.90 0 30.01 payment (see instructions) 31.00 HRR adjustment (see instructions) 70.94 -40, 730 0 -40, 730 -40, 730 31.00 HRR adjustment for HSP bonus payment (see 70. 91 0 31.01 31.01 instructions) (Amt. to Wkst. Pt. A) Ε, 0 1.00 2.00 3.00 4.00 32.00 HAC Reduction Program adjustment (see 70.99 0 0 32.00 instructions) 100.00 Transfer HAC Reduction Program adjustment to Ν 100.00 Wkst. E, Pt. A.

Health Financial Systems	HEART HOSPITAL AT DEA	CONESS GATEWAY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0175	From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/27/2017 2:04 pm
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PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00			Title XVIII	Hospi tal		т рііі
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42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 46, 265 47.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 since the complete of the comp	40. 01	Sequestration adjustment (see instructions)			141, 171	40. 01
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 0	41.00	Interim payments			6, 871, 122	41.00
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\text{\$115.2}}{\text{TO BE COMPLETED BY CONTRACTOR}}\$ 90.00 Outlier reconciliation adjustment amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions)	42.00	Tentative settlement (for contractors use only)			0	42.00
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 01.00 Outlier reconciliation adjustment amount (see instructions) 0	43.00	Balance due provider/program (see instructions)			46, 265	43.00
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 0	44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 0	ļ					
91.00 Outlier reconciliation adjustment amount (see instructions)						
		, ,			0	
92.00 The rate used to calculate the Time Value of Money 0.00						
	1				1	92. 00
	1	· ·			l .	
94.00 Total (sum of lines 91 and 93) 0	94. 00	Total (sum of lines 91 and 93)			0	94.00

HEART HOST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED HEART HOSPITAL AT DEACONESS GATEWAY Provider CCN: 15-0175 Title XVIII Inpatient Part A Part B

		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		10, 485, 160		6, 871, 122	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment	•				3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02	THE CONTROL OF THE PROPERTY OF		l o		l ol	3. 02
3. 03			0		ا	3. 03
3. 04			l o		l ol	3. 04
3. 05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3.52			0		o	3. 52
3.53			0		0	3. 53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		10, 485, 160		6, 871, 122	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	1	T			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER	T	0		0	5. 01
5. 01	TENTATIVE TO PROVIDER		0			5. 02
5. 02			0		0	5. 02
3.03	Provider to Program		0		0	5. 05
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTITIVE TO TROOM III		l ő		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		27, 589		46, 265	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		10, 512, 749		6, 917, 387	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	I 1	()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems HEART HOSPITAL AT DEA	CONESS GATEWAY		u of Form CMS-2	<u> 2552-10</u>
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0175	Peri od:	Worksheet E-1	
			From 10/01/2015		
			To 09/30/2016	Date/Time Prep 2/27/2017 2:04	
		Title XVIII	Hospi tal	PPS	+ piii
		THE XVIII	nospi tai	113	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S 2 Dt L col 15 Lino	1./	1, 590	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8		14	3, 282	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	-12		3, 262 865	3. 00
4. 00	Total inpatient days from S-3, Pt. 1, col. 8 sum of lines 1, 8	12		6, 208	4. 00
5.00	1	-12		176, 220, 511	
	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	ina 20			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l			1, 217, 147	
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HII technology	WKST. S-2, PT. I	U	7. 00
0 00	line 168				0.00
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	Sequestration adjustment amount (see instructions)			0	9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)		0	10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)			0	30.00
	Other Adjustment (specify)			0	31.00
22 00	Dalamas dus providor (line 0 (or line 10) minus line 20 and l	ina 21) (aaa inatrustian	~)	Λ.	22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

0 30.00 0 31.00 0 32.00

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-0175

| Period: | Worksheet G | From 10/01/2015 | To 09/30/2016 | Date/Time Prepared: 2/27/2017 2:04 pm |

In Lieu of Form CMS-2552-10

oni y)					2/27/2017 2:0	4 pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	С	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes recei vabl e	0	0	0	0	3. 00
4.00	Accounts receivable	16, 749, 249	0	0	0	
5.00	Other receivable	0	0	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-8, 752, 216 1, 481, 222		0	0	
7. 00 8. 00	Inventory Prepaid expenses	1, 481, 222		0	0	
9. 00	Other current assets	120, 627		0	0	
10. 00	Due from other funds	0		0	0	
11. 00	Total current assets (sum of lines 1-10)	9, 792, 881	0	0	0	11. 00
	FIXED ASSETS					
12.00	Land	0			0	1
13.00	Land improvements	0	1	0	0	
14.00	Accumulated depreciation		0	0	0	
15. 00 16. 00	Buildings Accumulated depreciation		0	0	0	
17. 00	Leasehold improvements		0	0	0	17. 00
18. 00	Accumulated depreciation		0	0	0	
19. 00	Fi xed equipment	14, 633, 894	0	0	0	1
20.00	Accumulated depreciation	-7, 096, 250	0	0	0	20. 00
21. 00	Automobiles and trucks	0	1	0	0	
22. 00	Accumulated depreciation	0	0	0	0	
23. 00	Major movable equipment	0	0	0	0	1
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable		0	0	0	24. 00 25. 00
26. 00	Accumulated depreciation		0	0	0	26.00
27. 00	HIT designated Assets		0	0	0	1
28. 00	Accumulated depreciation		Ō	0	0	1
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	7, 537, 644	0	0	0	30.00
	OTHER ASSETS	1	1			
31.00	Investments	0	_	0	0	
32. 00 33. 00	Deposits on leases Due from owners/officers	0	0	0	0	32. 00 33. 00
34. 00	Other assets	6, 926, 347	0	0	0	1
35. 00	Total other assets (sum of lines 31-34)	6, 926, 347		0	0	
36.00	Total assets (sum of lines 11, 30, and 35)	24, 256, 872	1	0	0	1
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	2, 643, 955			0	1
38. 00	Salaries, wages, and fees payable	1, 019, 612	0	0	0	
39.00	Payroll taxes payable (chart taxm)	004 073	0	0	0	
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	904, 873	0	0	0	40.00
42. 00	Accel erated payments			J	O	42. 00
43. 00	Due to other funds		0	0	0	1
44.00	Other current liabilities	1, 614, 447	0	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	6, 182, 887	0	0	0	45. 00
:	LONG TERM LIABILITIES					
46.00	Mortgage payable	1 (0) 37	0	0	0	
47. 00 48. 00	Notes payable Unsecured Loans	1, 696, 376	0	0	0	1
49. 00	Other long term liabilities		0	0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	1, 696, 376	1	0	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	7, 879, 263			0	
	CAPI TAL ACCOUNTS					
52.00	General fund balance	16, 377, 609				52. 00
53. 00	Specific purpose fund		0	_		53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	1
55. 55	replacement, and expansion					55. 55
59. 00	Total fund balances (sum of lines 52 thru 58)	16, 377, 609	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	24, 256, 872	0	0	0	60. 00
	[59]	l	l			l

13.00

14.00

15.00

16.00

17.00

18.00

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0175 Peri od: Worksheet G-1 From 10/01/2015 09/30/2016 Date/Time Prepared: 2/27/2017 2:04 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 15, 494, 369 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 14, 037, 529 2.00 3.00 Total (sum of line 1 and line 2) 29, 531, 898 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 29, 531, 898 11.00 0 11.00 DI STRI BUTI ONS 12.00 13, 154, 291 0 12.00 13.00 ROUNDI NG 13.00 14.00 0 0 0 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 13, 154, 289 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 16, 377, 609 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 DI STRI BUTI ONS 12.00

0

0

0

0

0

13.00

14.00

15. 00 16. 00

17.00

18.00

19.00

ROUNDI NG

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

 Heal th Financial
 Systems
 HEART

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 15-0175

		To	09/30/2016	Date/Time Pre 2/27/2017 2:0	
	Cost Center Description	Inpati ent	Outpati ent	Total	, p
	<u> </u>	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	12, 382, 410		12, 382, 410	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	0.00
7. 00	SKILLED NURSING FACILITY				7. 00
8. 00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE	40.000.440		40.000.440	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	12, 382, 410		12, 382, 410	10. 00
44.00	Intensive Care Type Inpatient Hospital Services				44.00
11.00	INTENSIVE CARE UNIT				11. 00
12.00	CORONARY CARE UNIT				12.00
13. 00 14. 00	BURN INTENSIVE CARE UNIT				13. 00 14. 00
15. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				15. 00
	· /	0		0	
10.00	Total intensive care type inpatient hospital services (sum of lines 11-15)			U	16.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	12, 382, 410		12, 382, 410	17. 00
18. 00	Ancillary services	78, 759, 585	66, 245, 142	145, 004, 727	18.00
19. 00	Outpatient services	70, 737, 303	785, 405	785, 405	
	RURAL HEALTH CLINIC	0	703, 403	703, 403	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	0	21. 00
22. 00	HOME HEALTH AGENCY		ŭ,	· ·	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)	0	o	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	91, 141, 995	67, 030, 547	158, 172, 542	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		46, 116, 417		29. 00
30.00	ROUNGI NG	1			30. 00
31. 00		0			31. 00
32.00		0			32. 00
33. 00		0			33. 00
34. 00		0			34. 00
35. 00		0			35. 00
36. 00	Total additions (sum of lines 30-35)		1		36. 00
37. 00	GROSS UP FOR CREDITS FOR SERVICES TO	3, 148, 529			37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40.00
41. 00	Total deductions (sum of lines 27 41)	0	2 140 520		41. 00 42. 00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		3, 148, 529 42, 967, 889		42.00
43.00	to Wkst. G-3, line 4)		42, 701, 009		43.00
	110	1	1		ı

	51 J. J. G. G. J. G.			6.5. 040.4	
	Financial Systems HEART HOSPITAL AT DE			u of Form CMS-2	
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0175	Peri od: From 10/01/2015	Worksheet G-3	
			To 09/30/2016	Date/Time Pre	nared:
			10 07/30/2010	2/27/2017 2:0	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii	ne 28)		158, 172, 542	1. 00
2.00	Less contractual allowances and discounts on patients' accou	nts		101, 285, 814	2.00
3.00	Net patient revenues (line 1 minus line 2)			56, 886, 728	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		42, 967, 889	4.00
5.00	Net income from service to patients (line 3 minus line 4)			13, 918, 839	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			15	7. 00
8.00	Revenues from telephone and other miscellaneous communicatio	n services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	1 .0.00
16. 00	Revenue from sale of medical and surgical supplies to other	than patients		0	
17. 00	Revenue from sale of drugs to other than patients			0	1
18. 00	Revenue from sale of medical records and abstracts			0	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24. 00	OTHER OPERATING REVENUE			118, 675	24. 00

118, 690 14, 037, 529

0 27.00

14, 037, 529 29. 00

25. 00 26. 00

28.00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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

27. 00 OTHER EXPENSES (SPECIFY)

	Financial Systems HEART HOSPITAL AT DE ATLON OF CAPITAL PAYMENT	Provi der CCN: 15-0175	Peri od:	u of Form CMS-2 Worksheet L	1002 10
ONLOGE	THE TAIMEN	Treviaci com le cive	From 10/01/2015 To 09/30/2016	Parts I-III Date/Time Pre	
		T: 11 20/11		2/27/2017 2:04	4 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			830, 461	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			15, 263	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost r	eporting period (see inst	ructi ons)	16. 96	3. 00
4.00	Number of interns & residents (see instructions)			0. 00	
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6. 00	Indirect medical education adjustment (multiply line 5 by th 1.01) (see instructions)			0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet E	, part A line	0. 00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	ructions)		0. 00	
9. 00	Sum of lines 7 and 8	_		0.00	
10.00	Allowable disproportionate share percentage (see instruction	s)		0.00	
11.00	Disproportionate share adjustment (see instructions)			0	11.00
12. 00	Total prospective capital payments (see instructions)			845, 724	12. 00
				1. 00	
4 00	PART II - PAYMENT UNDER REASONABLE COST				
1.00				0	1 00
	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
2. 00 3. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0	2. 00 3. 00
2. 00 3. 00 4. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0	2. 00 3. 00 4. 00
2. 00 3. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0	2. 00 3. 00
2. 00 3. 00 4. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS			0 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			1.00	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan	ces (see instructions)		1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2)	ces (see instructions)		1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	ces (see instructions)		1.00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	,		1.00 0 0 0 0 0 0 0.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i	nstructions)	Line 6)	1.00 0 0 0 0 0 0 0 0 0.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar	nstructions)	line 6)	0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 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	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstant Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7)	nstructions) y circumstances (line 2 x	line 6)	0 0 0 0 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
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	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl	nstructions) y circumstances (line 2 x icable)	ŕ	0 0 0 0 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
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to	nstructions) y circumstances (line 2 x icable) capital payments (line 8	less line 9)	0 0 0 0 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
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	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl	nstructions) y circumstances (line 2 x icable) capital payments (line 8	less line 9)	1.00 0 0 0 0 0 0 0.00 0 0.00 0	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
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	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	nstructions) y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri	less line 9) or year	1.00 0 0 0 0 0 0 0.00 0 0.00 0	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
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	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	nstructions) y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus lir	less line 9) or year e 11)	0 0 0 0 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
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	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (see instructions)	nstructions) y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus lir r the amount on this line	less line 9) or year e 11)	0 0 0 0 0 0 0 0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00

15.00 0 16.00 0 17.00

(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)