Health Financial Systems	ST ELIZABETH DEA			J of Form CMS-2552-10
This report is required by law (42 USC 1395g;				
payments made since the beginning of the cost	reporting period being c	deemed overpayments (42	USC 1395g).	OMB NO. 0938-0050
				EXPIRES 03-31-2022
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST	F REPORT CERTIFICATION	Provider CCN: 15-0086	Peri od:	Worksheet S
AND SETTLEMENT SUMMARY			From 11/01/2020 To 12/31/2020	Parts I-III Date/Time Prepared:
			10 12/31/2020	7/28/2021 2:53 pm
PART I - COST REPORT STATUS				772072021 2100 pm
Provider 1. [X] Electronically prepared	cost report		Date: 7/28/202	21 Time: 2:53 pm
use only 2. [] Manually prepared cost	report			
3.[0]If this is an amended r 4.[F]Medicare Utilization. E	eport enter the number o	f times the provider re	submitted this co	ost report
4. [ F ] Medicare Utilization. E	nter "F" for full or "L"	for low.		·
	Date Received:		PR Date:	
use only (1) As Submitted 7.	Contractor No.		ontractor's Vendo	r Code: 4
(2) Settled without Audit 8.	[ N ] Final Report for the	bis Provider CCN	U JIT IINE 5, CO	iumn i is 4: Enter
(3) Settred with Addit			number of tim	es reopened = 0-9.
(4) Reopened				
(5) Amended				
PART II - CERTIFICATION				
MISREPRESENTATION OR FALSIFICATION OF ANY INFO	DRMATION CONTAINED IN THE	IS COST REPORT MAY BE P	UNISHABLE BY CRIM	INAL, CIVIL AND
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMEN	NT UNDER FEDERAL LAW. FL	URTHERMORE, IF SERVICES	IDENTIFIED IN TH	IS REPORT WERE
PROVIDED OR PROCURED THROUGH THE PAYMENT DIREC	CTLY OR INDIRECTLY OF A K	KICKBACK OR WERE OTHERW	ISE ILLEGAL, CRIM	INAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONME	ENT MAY RESULT.			
CERTIFICATION BY CHIEF FINANCIAL OFFI	CER OR ADMINISTRATOR OF	PROVI DER(S)		
I HEREBY CERTIFY that I have read the	above certification sta	tement and that I have	evamined the acco	mpanyi ng
electronically filed or manually subm				
Expenses prepared by ST ELIZABETH DEA				
ending 12/31/2020 and to the best of				
complete and prepared from the books				
except as noted. I further certify t				
health care services, and that the se				
laws and regulations.				
[ ]I have read and agree with the a	hove certification state	ment   certify that	intend my electro	ni c
signature on this certification				

(Si	aned)	

0ffi cer	or	Admi ni strator	of	Provider(s)

CFO

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY					_	
1.00	Hospi tal	0	-3, 162	10, 755	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-3, 162	10, 755	0	0	200.00

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

MCRI F32 - 16. 10. 172. 3

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX II	DENTIFICATION DA	ATA	Provi der	CCN: 1	15-0086	Period: From 11/0	1/2020		eet S-2	2
								1/2020	Date/T	ime Pre	
	1.00	2	. 00	3.	00			4.00	//28/2	021 2:5	os pr
	Hospital and Hospital Health Care Com										
0	Street: 600 WILSON CREEK ROAD	PO Box:									1
0	City: LAWRENCEBURG	State: Component N		Zip Code: CCN	47025 CBSA	Provi de	nty: DEARBO r Date		ent Syst	tem (P	2.
		component n			lumber	Type	Certifie		r, 0, or		
								V	XVIII	XIX	]
		1.00		2.00	3.00	4.00	5.00	6.00	0 7.00	8.00	
C	Hospital and Hospital-Based Component Hospital	T ELIZABETH DEA		150086	17140	1	07/01/19	66 N	P	0	3
5	Subprovider - IPF			100000	17140	1	0//01/1/				4
C	Subprovider - IRF										5
)	Subprovider - (Other)										6
) )	Swing Beds - SNF Swing Beds - NF										7
)	Hospi tal -Based SNF										9
00	Hospital-Based NF										10
00	Hospital-Based OLTC										11
00	Hospital-Based HHA Separately Certified ASC										12
	Hospi tal -Based Hospi ce										14
	Hospital-Based Health Clinic - RHC										15
	Hospital-Based Health Clinic - FQHC										16
	Hospital-Based (CMHC)   Hospital-Based (CORF)										17
	Renal Dialysis										18
	Other										19
							Fro				-
00	Cost Reporting Period (mm/dd/yyyy)						1.		2. 12/31		20
	Type of Control (see instructions)						1			/ 2020	21
											_
	Inpatient PPS Information					1.00	2.	00	3.	00	
00	Does this facility qualify and is it	currently recei	ving payme	ents for		Y	N	1			22.
	disproportionate share hospital adjus	tment, in accor	dance with	42 CFR							
	§412.106? In column 1, enter "Y" for										
	facility subject to 42 CFR Section §4 hospital?) In column 2, enter "Y" for			lment							
01	Did this hospital receive interim unc	ompensated care	payments			Y	1	/			22
	cost reporting period? Enter in colum										
	the portion of the cost reporting per Enter in column 2, "Y" for yes or "N"				+						
	reporting period occurring on or afte										
)2	Is this a newly merged hospital that					Ν	N	1			22
	payments to be determined at cost rep Enter in column 1, "Y" for yes or "N"										
	cost reporting period prior to Octobe				s						
	or "N" for no, for the portion of the										
יי	October 1. Did this bospital receive a geographi	o rock acci fi att	ion from	urban ta		N		ı		J	1 22
13	Did this hospital receive a geographi rural as a result of the OMB standard				s	Ν	Ν	4	<sup>r</sup>	N	22
	adopted by CMS in FY2015? Enter in co				-						
	for the portion of the cost reporting										
	in column 2, "Y" for yes or "N" for n reporting period occurring on or afte										
	Does this hospital contain at least 1										
	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 Med	icaid dave on l	ince 24 an	d/or 25			3 N	I			23
0		,			3		5 1	•			25.
00	below? In column 1, enter 1 if date o		2		t						
00	below? In column 1, enter 1 if date o if date of discharge. Is the method o	5 5		ost							
00	below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period different from the m	ethod used in t						Medi ca	aid C	)ther	1
00	below? In column 1, enter 1 if date o if date of discharge. Is the method o	ethod used in t	"N" for n	10.	telo	)ut-of	UUT-OT				
00	below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period different from the m	ethod used in t		io. In-Stat		Out-of State	Out-of State	HMO da		di cai d	
00	below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period different from the m	ethod used in t	"N" for n In-State	io. In-Stat Medicai seligibl	d : e Me	State edi cai d	State Medi cai d		ays Me		
00	below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period different from the m	ethod used in t	"N" for n In-State Medicaid	io. In-Stat Medicai seligibl unpaic	d : e Me	State	State Medicaid eligible		ays Me	di cai d	
00	below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period different from the m	ethod used in t	"N" for n In-State Medicaid paid days	ID. In-Stat Medicai seligibl unpaic days	d : e Me d pai	State edicaid id days	State Medi cai d el i gi bl e unpai d	HMO da	ays Me	di cai d days	
	below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period different from the m	ethod used in t "Y" for yes or	"N" for n In-State Medicaid paid days	io. In-Stat Medicai seligibl unpaic	d : e Me d pai	State edi cai d	State Medicaid eligible		ays Me	di cai d days 6. 00	) 24.
	below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period different from the m reporting period? In column 2, enter If this provider is an IPPS hospital, in-state Medicaid paid days in column	ethod used in t "Y" for yes or enter the 1, in-state	"N" for n In-State Medicaid paid days	io. In-Stat Medicai s eligibl unpaic days 2.00	d : e Me d pai	State edicaid id days 3.00	State Medi cai d el i gi bl e unpai d	HMO da	ays Me	di cai d days 6. 00	) 24.
	below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period different from the m reporting period? In column 2, enter If this provider is an IPPS hospital, in-state Medicaid paid days in column Medicaid eligible unpaid days in colu	ethod used in t "Y" for yes or enter the 1, in-state mn 2,	"N" for n In-State Medicaid paid days	io. In-Stat Medicai s eligibl unpaic days 2.00	d : e Me d pai	State edicaid id days 3.00	State Medi cai d el i gi bl e unpai d	HMO da	ays Me	di cai d days 6. 00	) 24.
	below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period different from the m reporting period? In column 2, enter If this provider is an IPPS hospital, in-state Medicaid paid days in column	ethod used in t "Y" for yes or enter the 1, in-state mn 2, lumn 3,	"N" for n In-State Medicaid paid days 1.00 6	io. In-Stat Medicai s eligibl unpaic days 2.00	d : e Me d pai	State edicaid id days 3.00	State Medi cai d el i gi bl e unpai d	HMO da	ays Me	di cai d days 6. 00	) 24.

DSPI 1	Financial Systems ST EL TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	N: 15-0086	Peri od:		u of For Workshe		
					From 11/0 To 12/3		Part I Date/Ti 7/28/20		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medi ca HMO da	id 0 ys Mec	ther li cai d lays	
		1.00	days 2.00	3.00	unpai d 4.00	5.00		5.00	-
5. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0			0	Rural S	0		25.
					1.		2.0		
5. 00 7. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural.		, 0		1			26. 27.
. 00	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	~"2" for r cation in	ural. If ap column 2.	pplicable,		0			35.
. 00	effect in the cost reporting period.					-	Endi	201	35.
					Begi n 1.		Endi 2. (		
5.00 7.00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.				0			36. 37.
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" for								37.
. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
					Y/ 1.		Y/ 2. (		-
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet to accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)	), (ii), or the mileage	(iii)? Ent requiremer	er in colum nts in	ne Y	(	<u> </u>		39.
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r"Y" for y			/	N XVIII	XIX	40.
						1.00	2.00	3.00	
5.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	e share in	accordance	N	N	N	45.
5. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46.
7.00 3.00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals	•		5		N N	N N	N N	47. 48.
o. 00	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	mpacted by	CR 11642 (						56.
. 00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	r yes or "N th of this Y", complet ∣, if appli	" for no ir cost report e Worksheet cable.	n column 1. ing period? E-4. If co	lf column Enter "Y lumn 2 is				57.
. 00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		s as				58.
. 00	Are costs claimed on line 100 of Worksheet A? If yes	s <u>, complete</u>	Wkst. D-2,	NAHE 413.8 Y/N	Lin		Pass-Tl Qualifi Criterio	cation on Code	
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	85? (see umn 1. If CR) NAHE MA umn 2.	column 1 payment	1.00 Y	2. 	-	3. (		60.
. 01	If line 60 is yes, complete columns 2 and 3 for each	program. (	see			23.00	1		60

	Financial Systems ST EL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 11/01/2020 o 12/31/2020		pared:
		Y/N	IME	Direct GME	IME	Direct GME	
1 00		1.00	2.00	3.00	4.00	5.00	(1.0
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			0.00	J U. UL	61. C
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1
	Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 1
						1.00	
	ACA Provisions Affecting the Health Resources and Ser						
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teachi gram. (s	ng Health Cent see instructior	ter (THC) into			62.C
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co	67. (see instru	ictions)	N	63. C
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	_
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00	<u> </u>	
4.00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. med residents ry care provider rimary care n 3 the ratio	0. 00	-		64.0

				om 11/01/2020	Worksheet S-2 Part I	
			To	12/31/2020	Date/Time Pre 7/28/2021 2:5	pared 3 pm
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	позрі таї	4))	
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
			Unwei ghted	Unwei ghted	Ratio (col. 1/	,
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current Y	Year FTE Residents i	n Nonprovider Settir				
00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column :	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0.000000 Ratio (col. 3/	
	Program Name	Program Code	FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der Si te	Hospi tal	4))	
	1.00	2.00	Nonprovi der		4))	67.0
.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00	4))	67. (
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00	4))	67.1
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	25		Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u>	4)) 5.00 0.000000 0.000000	
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	PS ychiatric Facility ( the facility have a ∋fore November 15, 2 umn 2: Did this fac ≷ 412.424 (d)(1)(iii ;ate which program y	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for	Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	Hospi tal 4.00 0.00 1.00 rovi der? N he most b. (see ing 0.	4)) 5.00 0.000000 0.000000	70.
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	2S ychiatric Facility ( the facility have an efore November 15, 2 umn 2: Did this fac ₹ 412.424 (d)(1)(iii) cate which program you y PPS nabilitation Facility	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for ear began during thi	Nonprovi der Si te         3.00         0.00         tain an IPF subp         ing program in t         yes or "N" for m         s in a new teach         yes or "N" for m         s cost reporting	Hospi tal 4.00 0.00 1.00 rovi der? N he most b. (see ing 0.	4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000	- - - - 70. ( 71. (

Health Financial Systems         ST ELIZABETH DEARBOI           HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA         Prov	RN ider CCN: 15-0086	In Lie Period: From 11/01/2020 To 12/31/2020	u of Form CMS Worksheet S- Part I Date/Time Pr 7/28/2021 2:	2 epared:
			1.00	
Long Term Care Hospital PPS80.00Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N81.00Is this a LTCH co-located within another hospital for part or all o"Y" for yes and "N" for no.		ng period? Enter	N N	80.00 81.00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA?86.00Did this facility establish a new Other subprovider (excluded unit) §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	2		N	85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital class 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ified under section	I	Ν	87.00
		V 1.00	XI X 2.00	-
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital servi	ces? Enter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 [Is this hospital reimbursed for title V and/or XIX through the cost		N	Y	91.00
full or in part? Enter "Y" for yes or "N" for no in the applicable 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual cert	column.		N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicable col	umn.	N	N	93.00
"Y" for yes or "N" for no in the applicable column.				
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" applicable column.		N	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the applicable 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N"		0. 00 N	0. 00 N	95.00 96.00
applicable column. 97.00   f line 96 is "Y", enter the reduction percentage in the applicable 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns a stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes	nd residents post	0. 00 Y	0. 00 Y	97.00 98.00
<ul> <li>column 1 for title V, and in column 2 for title XIX.</li> <li>98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,</li> </ul>			Y	98. 01
<pre>title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculati bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" f</pre>		Y	Y	98. 02
<ul> <li>for title V, and in column 2 for title XIX.</li> <li>98.03 Does title V or XIX follow Medicare (title XVIII) for a critical ac reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N</li> </ul>			Ν	98.03
<pre>for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbur outpatient services cost? Enter "Y" for yes or "N" for no in column</pre>		N	Ν	98.04
<pre>in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 </pre>			Y	98.05
<ul> <li>column 2 for title XIX.</li> <li>98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbur Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX.</li> </ul>		Y	Y	98.06
Rural Providers 105.00 Does this hospital qualify as a CAH?		N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all-inclusi for outpatient services? (see instructions)	ve method of paymen	nt N		106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reim training programs? Enter "Y" for yes or "N" for no in column 1. (s Column 2: If column 1 is Y and line 70 or line 75 is Y, do you tra approved medical education program in the CAH's excluded IPF and/o	ee instructions) in l&Rs in an	N		107.00
Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fe	e schedul e? See 42	N N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Respi ratory	
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		3.00 N	4.00 N	109.00
			1.00	-
110.00 Did this hospital participate in the Rural Community Hospital Demon Demonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Worksheet applicable.	yes or "N" for no.	lf yes,	Ν	110.00

leal th Financial Systems ST ELIZABETH DEARBORN			eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider (	CCN: 15-0086	Period: From 11/01/2020 To 12/31/2020		epared:
		1.00		-
111.00 If this facility qualifies as a CAH, did it participate in the Frontier ( Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the ו column 2.	1.00 N	2.00	111.00
	1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1	Image: Description of the current cost reporting period?         N         10         2.00         3.00           or 'W' for no in column 1. If column 1 is 'Y', enter date the hospital began participating in the noclum 3, enter the date the hospital ceased         N         11           noclum 1. graphicable.         t. Reporting information         11         11           clust version of the current cost reporting period?         N         0         11           out motion 1. if column 1 is 'Y', enter         N         0         11           clust version 1. if applicable.         t. Reporting information         11         11           clust version 2.         See, enter the method used (A, B, or E only)         N         0         0         11           olum 1 is yes, enter the oft olong term care (Includes bilitation and long term hospitals providers) based on CMS Pub. 15-1. chapter 22.         N         11           classified as a referral center? Enter 'Y' for yes or 'N' for no.         N         11         11           classified as a referral center? Enter 'Y' for yes or 'N' for no.         N         11         11           classified as a referral center? Enter 'Y' for yes or 'N' for no.         N         11         11           classified as a referral center? Enter 'Y' for yes or 'N' for no.         N         11         11           claint-mad	118.00		
	Premi ums	Losses	Insurance	
	1.00			_
118.01 List amounts of malpractice premiums and paid losses:		0 11, 21	7 36, 28	9 118. 01
			2.00	-
Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, " "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see inst	cost centers ovision in ACA (" for yes or the Outpatient	. N	N	118. 02 119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable device	es charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 22.00Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.			5.00	122.00
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for yes and "N'	'forno.lf	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the certi				126.00
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certified	fication 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, enter the certified liver transplant center.				128.00
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certifi	cation date i	n		129.00
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the center of the center	ti fi cati on			130. 00
date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the d	certification			131.00
date in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare certified islet transplant center, enter the certified				132.00
<ul> <li>in column 1 and termination date, if applicable, in column 2.</li> <li>33.00 Removed and reserved</li> <li>34.00 If this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2.</li> </ul>				133. 00 134. 00
All Providers 140.00 Are there any related organization or home office costs as defined in CMS	Dub 15 1	Y	HB0843	140.00

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX		IZABETH DEAR TA Pr		N: 15-0086	Peri od	:	u of Form CMS Worksheet S-	
						1/01/2020 2/31/2020		
1.00		2.00				3.00	7/28/2021 2:	<u>53 pm</u>
If this facility is part of a chain		er on lines			name and		of the	
home office and enter the home offi 41.00 Name: ST. ELIZABETH HEALTHCARE	<u>ce contractor name</u> Contractor's N		tor numbe		ctor's Nu	mber: 1510	1	141. (
CORPORATE 42.00 Street: 1 MEDICAL VILLAGE DRIVE	PO Box:							142. (
43.00 City: EDGEWOOD	State:	КҮ		Zip Co	de:	4101	7	143. (
							1.00	_
44.00 Are provider based physicians' cost	s included in Work	sheet A?					Y	144.
						1.00	2.00	
45.00 If costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f	for yes or "N" for ude Medicare utili	no in colum zation for t	n 1. lf c	olumn 1 is				145.
46.00 Has the cost allocation methodol ogy Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	changed from the column 1. (See CMS	previously f Pub. 15-2,			lf	N		146. (
							1.00	-
47.00 Was there a change in the statistic	al basis? Enter "Y	" for yes or	"N" for	no.			N 1.00	147. (
48.00 Was there a change in the order of 49.00 Was there a change to the simplifie	allocation? Enter	"Y" for yes	or "N" fo	or no.			N	148.
19. Oolwas there a change to the shipitite	a cost finding met		art A	Part B		itle V	Title XIX	149. (
			1.00	2.00		3.00	4.00	
Does this facility contain a provid or charges? Enter "Y" for yes or "N								
55.00 Hospi tal		component re	N	N N	. (366 4.	N	N	155.
56.00 Subprovider - IPF			N	N		Ν	N	156.
57.00 Subprovider - IRF			N	N		N	N	157.
58. 00 SUBPROVI DER 59. 00 SNF			N	N		Ν	N	158. 159.
50.00 HOME HEALTH AGENCY			N	N		N	N	160.
51. 00 CMHC				N		Ν	N	161. (
61. 10 CORF				N		N	N	161.
he							1.00	
Multicampus 65.00 s this hospital part of a Multicam	pus hospital that	has one or n	ore campu	ıses in dif	ferent CE	3SAs?	N	165.
Enter "Y" for yes or "N" for no.	Name	Col	nty	State	Zip Code	CBSA	FTE/Campus	
	0	1.	00	2.00	3.00	4.00	5.00	
56.00 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)							0. 0	00166.
							1.00	-
Health Information Technology (HIT)	incentive in the	American Red	overy and	d Reinvestm	ent Act			
o7.00ls this provider a meaningful user o8.00lf this provider is a CAH (line 105					"), enter	the	Y	167. 168.
reasonable cost incurred for the HI 8.01 If this provider is a CAH and is no	T assets (see inst	ructions)						168.
exception under §413.70(a)(6)(ii)?	Enter "Y" for yes	or "N" for r	o. (see i	nstruction	s)	·		
99.00 If this provider is a meaningful us transition factor. (see instruction		") and is no	t a CAH (	line 105 i	s "N"), €	enter the		99169.
					Be	gi nni ng 1. 00	Endi ng 2. 00	_
70.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	ginning date and e	nding date f	or the re	eporti ng		1.00	2.00	170.
						1 00	2.02	_
				Last in		1.00 N	2.00	0171.(
71.00  fline 167 is "Y", does this provi	der have anv dave	TOP I DOLVIOU	als enroi	leain				

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0086	Period: From 11/01/2020 To 12/31/2020	Date/Time Pre 7/28/2021 2:5	epared
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO ro	sponsos Ento	1.00	2.00	-
	COMPLETED BY ALL HOSPITALS		sponses. Ente			-
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			Y	11/01/2020	1.
	reporting period? If yes, enter the date of the change in co	Ji unin 2. (See	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column	rogram?lf n 3, "V" for	N			2.
. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi	fied Public	Y	Α		4.
. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, lable in		A		
. 00	Are the cost report total expenses and total revenues differ		N			5.
	those on the filed financial statements? If yes, submit reco	onciliation.		Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lf yes, is th	ne provider is	s N		6.
00	the legal operator of the program?	atruati ana		V		-
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		during the	Y Y		7. 8.
. 00	Are costs claimed for Interns and Residents in an approved oprogram in the current cost report? If yes, see instructions		cal education	N		9.
0. 00	Was an approved Intern and Resident GME program initiated or		the current	Ν		10.
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.
	redening Hogram on worksheet A: Hi yes, see thist detrons.				Y/N	
					1.00	
	Bad Debts					1
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y Y	12. 13.
4.00	If line 12 is yes, were patient deductibles and/or co-payment	nts waived? If	°yes, see ins	tructions.	Ν	14.
5.00	Bed Complement Did total beds available change from the prior cost reportin	<u>v</u> 1	yes, see inst t A	ructions. Par	N t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R DataWas the cost report prepared using the PS&R Report only?If either column 1 or 3 is yes, enter the paid-throughdate of the PS&R Report used in columns 2 and 4 .(see	Y	06/29/2021	Y	06/29/2021	16.
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.
B. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

## ST ELI ZABETH DEARBORN

Health Financial Systems ST ELIZABE	ETH DEARBORN		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 11/01/2020 To 12/31/2020	Worksheet S-2 Part II	2 epared:
	Descr	i pti on	Y/N	Y/N	
		<u>,</u>	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	Ν	20.00
	Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EX	CEPT CHILDRENS H	OSPLTALS)		1.00	
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes, s	ee instructions				22.00
23.00 Have changes occurred in the Medicare depreciation expensive reporting period? If yes, see instructions.		als made duri	ng the cost		23.00
24.00 Were new leases and/or amendments to existing leases enter If yes, see instructions	ered into during	this cost rep	orting period?		24.00
25.00 Have there been new capitalized leases entered into durin instructions.	ng the cost repor	ting period?	lf yes, see		25.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during instructions.	the cost reporti	ng period? If	yes, see		26.00
27.00 Has the provider's capitalization policy changed during t copy.	he cost reportir	ng period?lf	yes, submit		27.00
Interest Expense					
28.00 Were new loans, mortgage agreements or letters of credit period? If yes, see instructions.	entered into dur	ing the cost	reporting		28.00
29.00 Did the provider have a funded depreciation account and/o treated as a funded depreciation account? If yes, see ins		bt Service Re	serve Fund)		29.00
30.00 Has existing debt been replaced prior to its scheduled ma		debt? If yes,	see		30.00
31.00 Has debt been recalled before scheduled maturity without instructions.	issuance of new	debt? If yes,	see		31.00
Purchased Servi ces					
32.00 Have changes or new agreements occurred in patient care s arrangements with suppliers of services? If yes, see inst	ructions.	0			32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 a no, see instructions.	upplied pertainir	ig to competit	ive bidding? If		33.00
Provider-Based Physicians 34.00 Are services furnished at the provider facility under an	arrangement with	nrovi der-bas	ed physicians?		34.00
If yes, see instructions.	arrangement with				34.00
35.00 If I ine 34 is yes, were there new agreements or amended e physicians during the cost reporting period? If yes, see		ts with the p	rovi der-based		35.00
			Y/N	Date	
llama Offica Casta			1.00	2.00	-
Home Office Costs 36.00 Were home office costs claimed on the cost report?			Y		36.00
37.00 If line 36 is yes, has a home office cost statement been If yes, see instructions.	prepared by the	home office?	Ŷ		37.00
38.00 If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year e	office different	from that of	Ν		38.00
39.00 If line 36 is yes, did the provider render services to ot see instructions.			Ν		39.00
40.00 If line 36 is yes, did the provider render services to th instructions.	ne home office?	lf yes, see	Ν		40.00
	1.	00	2.	00	-
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RON		HORNBERGER		41.00
42.00 Enter the employer/company name of the cost report	ST. ELI ZABETH	HEALTHCARE			42.00
43.00 Enter the telephone number and email address of the cost	(859)655-7831		RON. HORNBERGER	@STELI ZABETH. C	43.00
report preparer in columns 1 and 2, respectively.			OM		ll

Heal th	Financial Systems ST ELIZA	BETH	I DEARBORN		In Lie	u of Form CMS	-2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0086		ri od:	Worksheet S	-2
				To	om 11/01/2020 12/31/2020		repared: 53 pm
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position		REIMBURSEMENT MANAGER				41.00
	held by the cost report preparer in columns 1, 2, and 3,	,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cost	t					43.00
	report preparer in columns 1 and 2, respectively.						

HOSPI TAL AND HOSPI T	TAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-0086	Period: From 11/01/2020 To 12/31/2020		
			·			I/P Days / O/P	
Compone	ent	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	<u>Visits / Trips</u> Title V	
		1.00	2.00	3.00	4.00	5.00	
8 exclude Sw Hospice days for the port 1.00 HMO IRF Subp 3.00 HMO IRF Subp 5.00 Hospital Adu 6.00 Hospital Adu 6.00 Hospital Adu 7.00 Total Adults beds) (see 8.00 INTENSIVE CA 9.00 CORONARY CAR 10.00 BURN INTENSI 11.00 SURGICAL INT 12.00 OTHER SPECIA 13.00 NURSERY 14.00 Total (see 15.00 CAH visits 15.00 SUBPROVIDER 15.00 SUBPROVIDER 17.00 SUBPROVIDER 18.00 SUBPROVIDER 19.00 SKILLED NURS 20.00 NURSING FACI 21.00 OTHER LONG T 22.00 HOME HEALTH 23.00 AMBULATORY S 24.00 HOSPICE	rovider Its & Peds. Swing Bed SNF Its & Peds. (exclude observation nstructions) RE UNIT YE UNIT YE CARE UNIT L CARE (SPECIFY) nstructions) - IPF - IRF ING FACILITY LITY ERM CARE	1.00 30.00 31.00 32.00 33.00 34.00 43.00 43.00 41.00 44.00 45.00 46.00 101.00 115.00 116.00 30.00	2.00 54 54 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 24 3, 24 41 3, 74	94 0.00 94 0.00 88 0.00 0 0.00 0 0.00 0 0.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 14. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 24. 10 24. 00 24. 10 24. 00 24. 10 24. 00 24. 00
25.00         CMHC - CMHC           25.10         CMHC - CORF           26.00         RURAL HEALTH           26.25         FEDERALLY OU           7.00         Total (sum o           28.00         Observation           29.00         Ambulance Tr           30.00         Employee dis           31.00         Employee dis           32.01         Total ancill           outpatient d         33.00	I CLINIC ALIFIED HEALTH CENTER if lines 14-26) Bed Days ips count days (see instruction) count days - IRF very days (see instructions) ary labor & delivery room lays (see instructions)	99.00 99.10 88.00 89.00	62 0		0	0 0 0 0	25. 00 25. 10 26. 00 26. 22 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 00 33. 00 33. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 11/01/2020 To 12/31/2020		pared:
	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
<ul> <li>Hospital Adults &amp; Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)</li> <li>HMO and other (see instructions)</li> <li>HMO 1PF Subprovider</li> <li>HMO 1RF Subprovider</li> <li>HMO HASP tal Adults &amp; Peds. Swing Bed SNF</li> <li>Hospital Adults &amp; Peds. Swing Bed NF</li> <li>Total Adults and Peds. (exclude observation beds) (see instructions)</li> <li>O INTENSIVE CARE UNIT</li> <li>CO CORONARY CARE UNIT</li> <li>O UBURN INTENSIVE CARE UNIT</li> <li>O OTHER SPECIAL CARE (SPECIFY)</li> <li>NURSERY</li> <li>O Total (see instructions)</li> <li>O Total (see instructions)</li> <li>O Total (see instructions)</li> <li>O SUBPROVIDER - IPF</li> <li>O SUBPROVIDER - IPF</li> <li>O SUBPROVIDER - IPF</li> <li>O SUBPROVIDER ACILITY</li> <li>O OTHER LONG TERM CARE</li> <li>O ONURSING FACILITY</li> <li>O ONURSING FACILI</li></ul>	837 364 0 0 837 176 0 0 0 1, 013 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	127 98 0 0 0 127 0 0 0 0 127 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 66 39 8 2, 14	0 0 3 9 9 0 0 5 7 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 25.10 25.00 26.25
<ul> <li>29.00 Ambulance Trips</li> <li>30.00 Employee discount days (see instruction)</li> <li>31.00 Employee discount days - IRF</li> <li>32.00 Labor &amp; delivery days (see instructions)</li> <li>32.01 Total ancillary labor &amp; delivery room</li> <li>autoticat days (see instructions)</li> </ul>	0	47	9	0 0 3 0		29.00 30.00 31.00 32.00 32.0
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges	0 0					33. 0 33. 0

	<u>Financial Systems</u> TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	ST ELIZABETH AL DATA	Provider C	CN: 15-0086	Period: From 11/01/2020 To 12/31/2020		pared:
		Full Time		Di s	charges	172072021 2.5	s pili
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER FACILITY NURSING FACILITY OTHER LONG TERM CARE	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0	2.	11     27       70     69       0     0       0     0       0     0	525	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 15.00 15.00 15.00 21.00
22. 00 23. 00 24. 00 24. 10 25. 10 25. 10 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01 33. 00 33. 01	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC CMHC - CORF RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			000		22. 00 23. 00 24. 00 25. 10 25. 10 25. 10 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01 33. 00 33. 01

SPI TAL	inancial Systems .WAGE INDEX INFORMATION			H DEARBORN Provider C(	F	Period: From 11/01/2020 To 12/31/2020	Worksheet S-3 Part II Date/Time Prep 7/28/2021 2:53	pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	ART II – WAGE DATA ALARIES							1
00 T	otal salaries (see	200. 00	4, 196, 452	0	4, 196, 452	2 134, 401. 00	31. 22	1.
	nstructions) Ion-physician anesthetist Part		C	0	l c	0.00	0. 00	2.
A			C			0.00	0.00	2.
00 N	on-physician anesthetist Part		C	0	C	0.00	0.00	3.
00   PI   B	hysician-Part A -		C	0		0.00	0.00	4.
A	dministrative		c c				0100	
	hysicians - Part A - Teaching		C	-	-			
	hysician and Non hysician-Part B		C	0		0.00	0.00	5.
00 N	on-physician-Part B for		C	0	c	0.00	0.00	6.
	ospital-based RHC and FQHC ervices							
	nterns & residents (in an	21.00	C	0	C	0.00	0. 00	7.
	pproved program)		_	_				_
	contracted interns and residents (in an approved		C	0		0.00	0.00	7.
	programs)							
	ome office and/or related		C	0	C	0.00	0.00	8
	rganization personnel NF	44.00	C	0	C	0.00	0.00	9
	xcluded area salaries (see		17, 429	12, 849	30, 278			
	nstructions) THER WAGES & RELATED COSTS							
	contract labor: Direct Patient		C	0	C	0.00	0.00	11
	are							
	ontract labor: Top level anagement and other		C	0	C	0.00	0.00	12
	anagement and administrative							
	ervices						0.00	1.2
	ontract labor: Physician-Part - Administrative		C	0	C	0.00	0.00	13
оо  н	ome office and/or related		C	0	C	0.00	0. 00	14
	rganization salaries and age-related costs							
	lome office salaries		C	0	C	0. 00	0. 00	14
	elated organization salaries		C	0	C	0.00		
	ome office: Physician Part A Administrative		C			0.00	0.00	15
00 H	ome office and Contract		C	0	C	0.00	0.00	16
	hysicians Part A - Teaching						0.00	11
	ome office Physicians Part A Teaching		C	0		0.00	0.00	10
02 H	ome office contract		C	0	C	0.00	0. 00	16
	<u>hysicians Part A – Teaching</u> AGE-RELATED COSTS							
	age-related costs (core) (see		939, 238	0	939, 238	3		17
	nstructions)							10
	age-related costs (other) see instructions)							18
00 E	xcluded areas		5, 273	0	5, 273	3		19
00 N	on-physician anesthetist Part		C	0	C			20
00 N	on-physician anesthetist Part		C	0	c c	þ		21
B			~		-			
	hysician Part A – dministrative		C	0		J		22
01 P	hysician Part A - Teaching		C	0	c	þ		22
	hysician Part B		C	0				23
	age-related costs (RHC/FQHC) nterns & residents (in an		C					24 25
а	pproved program)		-					
	ome office wage-related core)		C	0	C			25
51 R	elated organization		C	0	c			25
w	age-related (core)		-					
	ome office: Physician Part A Administrative -		C	0	C	נ		25
	age-related (core)							

	Financial Systems		ST ELIZABETH				u of Form CMS-2	
	AL WAGE INDEX INFORMATION			Provider CO		Period: From 11/01/2020 To 12/31/2020	Worksheet S-3 Part II Date/Time Pre 7/28/2021 2:53	pared:
		Wkst. A Line		Reclassi fi cati	Adj usted		Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col. 3)		col. 5)	
		1,00	2.00	A-6) 3.00	4,00	<u>col. 4</u> 5. 00	6. 00	
25. 53	Home office: Physicians Part A		2.00	3.00		0	0.00	25.53
20.00	- Teaching - wage-related		0	0		0		25.55
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE	ËS						
26.00	Employee Benefits Department	4.00	0	0		0.00	0.00	26.00
27.00	Administrative & General	5.00	283, 681	-57, 891	225, 79	9, 133. 00	24. 72	27.00
28.00	Administrative & General under		0	0		0.00	0.00	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	93, 812	2, 680	96, 49	2 2, 899. 00	33. 28	29.00
30.00	Operation of Plant	7.00	36, 906	721	37, 62	7 1, 386. 00	27. 15	30.00
31.00	Laundry & Linen Service	8.00	14, 703	368				
32.00	Housekeepi ng	9.00	168, 274	3, 893	172, 16	7 10, 810. 00	15. 93	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	112, 360	-66, 138	46, 22	2 2, 328. 00	19.85	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	68, 916	68, 91	6 3, 692. 00	18.67	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00		37.00
38.00	Nursing Administration	13.00	172, 412	1, 449	173, 86	1 4, 421.00	39. 33	38.00
39.00	Central Services and Supply	14.00	0	0		0 0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0		0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0		0.00		41.00
42.00	Soci al Servi ce	17.00	90, 376	1, 996	92, 37	2 2, 495.00	37.02	42.00
43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Heal th	Financial Systems		ST ELI ZABETI	H DEARBORN		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 11/01/2020 To 12/31/2020		
		Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		4, 196, 452	0	4, 196, 45	2 134, 401. 00	31.22	1.00
	instructions)							
2.00	Excluded area salaries (see		17, 429	12, 849	30, 27	B 640.00	47.31	2.00
	instructions)							
3.00	Subtotal salaries (line 1		4, 179, 023	-12, 849	4, 166, 17	4 133, 761. 00	31. 15	3.00
	minus line 2)							
4.00	Subtotal other wages & related costs (see inst.)		0	0		0.00	0.00	4.00
5.00	Subtotal wage-related costs		939, 238	0	939, 23	в 0.00	22. 54	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		5, 118, 261	-12, 849	5, 105, 41	2 133, 761. 00	38. 17	6.00
7.00	Total overhead cost (see		972, 524	-44,006	928, 51	8 38, 135. 00	24.35	7.00
	instructions)							

Heal th	Financial Systems	ST ELIZABETH D	DEARBORN		In Lie	eu of Form CMS-	2552-10
	AL WAGE RELATED COSTS		Provider CCN:	15-0086	Period: From 11/01/2020 To 12/31/2020		pared:
						Amount	
						Reported 1.00	
	PART IV - WAGE RELATED COSTS					1.00	
	Part A - Core List						1
	RETI REMENT COST						1
1.00	401K Employer Contributions					0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribu	ution				0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see i	instructions)				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see inst	tructions)				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External C	Organi zati on)					
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	n				0	6.00
7.00	Employee Managed Care Program Administration	Fees				0	7.00
	HEALTH AND INSURANCE COST					_	
8.00	Health Insurance (Purchased or Self Funded)					0	8.00
8.01	Health Insurance (Self Funded without a Third					0	
8.02	Health Insurance (Self Funded with a Third Pa	arty Administrato	r)			618, 732	8.02
8.03	Health Insurance (Purchased)					0	8.03
9.00	Prescription Drug Plan					0	
10.00	Dental, Hearing and Vision Plan					9, 802	
11.00	Life Insurance (If employee is owner or benef					2, 028	11.00
12.00	Accident Insurance (If employee is owner or b					0	
13.00	Disability Insurance (If employee is owner or					10, 648	1
14.00		er or beneficiary	)			0	
15.00	'Workers' Compensation Insurance					0	
16.00		ar, not the extra	ordi nary accru	al require	d by FASB 106.	0	16.00
	Non cumulative portion)						_
17 00	TAXES						1 4 7 6 6
	FICA-Employers Portion Only					303, 302	1
18.00	Medicare Taxes - Employers Portion Only					0	
19.00	Unemployment Insurance					0	
20.00	State or Federal Unemployment Taxes OTHER					0	20.00
21 00	Executive Deferred Compensation (Other Than F	Dati nomant Coat D	operted on lin	an 1 throu	ah 1 ahaya (asa	0	21.00
21.00	instructions))	Retirement Cost R	eported on TIN	es i throu	ign 4 above. (See	0	21.00
22 00	Day Care Cost and Allowances					0	22.00
	Tuition Reimbursement					0	1
	Total Wage Related cost (Sum of lines 1 -23)					944, 512	
250	Part B - Other than Core Related Cost					,,,,,,,,,	
25, 00	OTHER WAGE RELATED COSTS (SPECIFY)						25.00

Heal th	Financial Systems	ST ELIZABETH DEARBORN	In Lieu	of Form CMS-2	2552-10
HOSPI T	TAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0086	From 11/01/2020	Worksheet S-3 Part V Date/Time Prep	hared.
				7/28/2021 2:53	
	Cost Center Description		Contract Labor I	Benefit Cost	
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identif	ïcation:			
1.00	Total facility's contract labor and benefit of	cost	0	0	1.00
2.00	Hospi tal		0	0	2.00
3.00	Subprovider - IPF		0	0	3.00
4.00	Subprovider - IRF		0	0	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF		0	0	8.00
9.00	Hospital-Based NF		0	0	9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA		0	0	11.00
12.00	Separately Certified ASC		0	0	12.00
13.00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
15.00	Hospital-Based Health Clinic FQHC		0	0	15.00
16.00	Hospi tal -Based-CMHC		0	0	16.00
	Hospital-Based-CMHC 10		0	0	16. 10
	Renal Dialysis		0	0	17.00
18.00	Other		0	0	18.00

Heal th	Financial Systems ST ELIZABETH DE	EARBORN		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN	N: 15-0086	Peri od:	Worksheet S-1	0
				From 11/01/2020 To 12/31/2020		
					172072021 2.3	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by line	e 202 columr	n 8)	0. 303622	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				836, 815	
3.00	Did you receive DSH or supplemental payments from Medicaid?		с и I	. 10	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen			11 d?	N	4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments f Medicaid charges	rom medicald			0 6, 599, 554	
7.00	Medicaid cost (line 1 times line 6)				2, 003, 770	•
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minu	s sum of lir	ues 2 and 5 if	1, 166, 955	
0.00	< zero then enter zero)				1, 100, 700	0.00
	Children's Health Insurance Program (CHIP) (see instructions f	or each line	)			1
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 min	us line 9; i	f < zero then	0	12.00
	enter zero)					-
12 00	Other state or local government indigent care program (see ins Net revenue from state or local indigent care program (Not inc				0	13.00
13.00 14.00	Charges for patients covered under state or local indigent care				0	
14.00	10)			III IIIes 0 01	0	14.00
15.00	State or local indigent care program cost (line 1 times line 1	4)			0	15.00
16.00	Difference between net revenue and costs for state or local in		program (lir	ne 15 minus line	0	
	13; if < zero then enter zero)	0				
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and state,	/local indig	jent care program	ns (see	
17 00	instructions for each line)					1 4 7 00
17.00 18.00	Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of				0	
18.00	Total unreimbursed cost for Medicaid , CHIP and state and loca			(cum of lines	1, 166, 955	
19.00	8, 12 and 16)	i murgent ca	are programs	s (suil of filles	1, 100, 955	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line)		24.20	15 007	F0.0(0	1 20 00
20.00	Charity care charges and uninsured discounts for the entire fa (see instructions)	CITITY	34, 35	55 15, 907	50, 262	20.00
21.00	Cost of patients approved for charity care and uninsured disco	unts (see	10, 43	15, 907	26, 338	21.00
21.00	instructions)		10, 10		20,000	21.00
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
	chari ty care					
23.00	Cost of charity care (line 21 minus line 22)		10, 43	31 15, 907	26, 338	23.00
				<u> </u>	1.00	
24.00	Does the amount on line 20 column 2, include charges for patie		nd a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t		caro program	's longth of	0	25.00
23.00	stay limit	ne margent v		i s rength of	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see in	structions)			182, 566	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex		uctions)		73, 207	
27.01	Medicare allowable bad debts for the entire hospital complex (				112, 626	
28.00	Non-Medicare bad debt expense (see instructions)				69, 940	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see i	nstructions)		60, 654	•
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				86, 992	•
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			1, 253, 947	31.00

						7/28/2021 2:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	OFNERAL OFRICAS OOOT OFNITERO	1.00	2.00	3.00	4.00	5.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1	49, 436	49, 436	0	49, 436	1.
00	00200 CAP REL COSTS-MVBLE EQUIP		121, 193		0		
0	00300 OTHER CAP REL COSTS		0	0	0	0	
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	107, 013		0		
)0 )0	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	283, 681 93, 812	294, 974 216, 872		-61, 688 2, 679		
0	00700 OPERATION OF PLANT	36, 906	19, 478		721		
0	00800 LAUNDRY & LINEN SERVICE	14, 703	44, 874		368	59, 945	
0	00900 HOUSEKEEPI NG	168, 274	73, 541	241, 815	-6, 796		
00		112, 360	65, 252		-109, 021		
00 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	0	0	108, 938 0		1
00	01300 NURSI NG ADMI NI STRATI ON	172, 412	30, 717	203, 129	499	-	
00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	1
00	01500 PHARMACY	0	0	0	0	0	
00 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 90, 376	0 22, 117	0 112, 493	0 1, 994		1 .
00	01850 OTHER GENERAL SERVICE (SPECIFY)	90, 378	22, 117	112, 493	1, 994	0	
00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
00	02000 NURSI NG SCHOOL	0	0	0	0	0	
00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	2
00 00	02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY)	0 17, 429	0 6, 708	0 24, 137	0 13, 549	0 37, 686	
00	INPATIENT ROUTINE SERVICE COST CENTERS	17,427	0,700	24, 137	15, 547	57,000	1 2
00	03000 ADULTS & PEDIATRICS	348, 143	515, 916	864, 059	-1, 850	862, 209	3
00	03100 I NTENSI VE CARE UNI T	274, 181	111, 897	386, 078	-31,007		
00	03200 CORONARY CARE UNIT	0	0	0	0	0	
00 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
00	04000 SUBPROVIDER - IPF	0	0	0	0	0	4
00	04100 SUBPROVI DER – I RF	0	0	0	0	0	4
00	04300 NURSERY	0	0	0	65, 897		
00 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	
00	04600 OTHER LONG TERM CARE	0	0	0	0	0	
	ANCILLARY SERVICE COST CENTERS						
00	05000 OPERATING ROOM	604, 689	1, 348, 905	1, 953, 594	-1, 186, 759		
00 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 196, 088	0 81, 015	0 277, 103	0 - 148, 506	0 128, 597	
00	05300 ANESTHESI OLOGY	190,000	338, 773		-23, 719		
00	05400 RADI OLOGY-DI AGNOSTI C	275, 355	327, 758				
00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
00 00	05600 RADI 0I SOTOPE 05700 CT SCAN	0 81, 265	0 81, 261	0 162, 526	0 142, 700	0 305, 226	
00	05800 MAGNETIC RESONANCE IMAGING (MRI)	45, 026	15, 055		29, 048		
00	05900 CARDI AC CATHETERI ZATI ON	56,060	35, 492		-22, 270		
00	06000 LABORATORY	305, 597	632, 722	938, 319	-49, 757		6
01	06001 BLOOD LABORATORY	0	0	0	0	0	6
00 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	
00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	6
00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
00	06500 RESPI RATORY THERAPY	107, 543	68, 515		-18, 998		
00 00	06600 PHYSI CAL THERAPY	271,857	65, 450		835		
00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	37, 398 30, 673	9, 359 5, 295		-188 203		
00	06900 ELECTROCARDI OLOGY	66, 775	30, 389		-757		
00	07000 ELECTROENCEPHALOGRAPHY	438	36	474	0	474	7
00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	39, 279	16, 992		959, 758		
00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	103 113	0 701 205	0 0 0	672, 292		
00 00	07300 DRUGS CHARGED TO PATTENTS 07400 RENAL DIALYSIS	193, 113 0	784, 325 0	977, 438 0	-15, 810 0	961, 628	
00	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	
00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS	1				1	Ι.
00	08800 RURAL HEALTH CLINIC	0	0	0	0		
00 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0		0	0	
			0	0	0	. 0	
00	09100 EMERGENCY	273, 019	718, 483	991, 502	-51, 390	940, 112	9

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Peri od:	Worksheet A	
				From 11/01/2020 To 12/31/2020	Date/Time Pre	narod
				10 12/31/2020	7/28/2021 2:5	
Cost Center Description	Sal ari es	Other	Total (col.	1 Recl assi fi cati		
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
	1.00	0.00		1.00	col . 4)	
OTHER REIMBURSABLE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0			0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	o	o		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	o	0		0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	r					
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON	0	0		0 0		110. 00 111. 00
113. 00 11300 INTEREST EXPENSE	0	0		0 0		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0		114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 196, 452	6, 239, 813	10, 436, 26	5 0	10, 436, 265	
NONREI MBURSABLE COST CENTERS	.,					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	772	77	2 0	772	192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
200.00   TOTAL (SUM OF LINES 118 through 199)	4, 196, 452	6, 240, 585	10, 437, 03	0	10, 437, 037	200. 00

				To 12/31/2020		
	Cost Center Description	Adjustments	Net Expenses		7/28/2021 2:	53 pm
	•	(See A-8)	For Allocation			
0	GENERAL SERVICE COST CENTERS	6.00	7.00			
	DO100 CAP REL COSTS-BLDG & FIXT	78, 956	128, 392			1.
00 0	DO200 CAP REL COSTS-MVBLE EQUIP	132, 981	254, 174			2.
	DO300 OTHER CAP REL COSTS	C	-			3.
	DO400 EMPLOYEE BENEFITS DEPARTMENT	0	107, 013			4.
	DO500 ADMINI STRATI VE & GENERAL	2, 668, 055				5
	DO600 MAINTENANCE & REPAIRS DO700 OPERATION OF PLANT		313, 363 57, 105			6
	DO800 LAUNDRY & LINEN SERVICE		59, 945			8
	DO900 HOUSEKEEPING		235, 019			9
	D1000 DI ETARY	-31, 170				10
. 00 0	D1100 CAFETERI A	C	108, 938			11
1	D1200 MAINTENANCE OF PERSONNEL	C	0			12
1	01300 NURSI NG ADMI NI STRATI ON	0	203, 628			13
1	01400 CENTRAL SERVICES & SUPPLY	0				14
	D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY					15
1	D1700 SOCIAL SERVICE	-29, 952	84, 535			17
	01850 OTHER GENERAL SERVICE (SPECIFY)	27,732	0,000			18
	D1900 NONPHYSI CI AN ANESTHETI STS		o o			19
	D2000 NURSI NG SCHOOL	C	0			20
. 00 0	D2100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0 0			21
1	D2200 I &R SERVICES-OTHER PRGM COSTS APPRVD	C	0 0			22
	02300 PARAMED ED PRGM- (SPECIFY)	0	37, 686			23
-	NPATIENT ROUTINE SERVICE COST CENTERS	251 001	510, 328			
	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT	-351, 881	355, 071			30
1	D3200 CORONARY CARE UNI T					32
1	03300 BURN INTENSIVE CARE UNIT		0			33
. 00 0	03400 SURGICAL INTENSIVE CARE UNIT	0	0			34
	D4000 SUBPROVI DER – I PF	C	0 0			40
	04100 SUBPROVI DER – I RF	C	0 0			41
	04300 NURSERY	0	65, 897			43
	04400 SKI LLED NURSI NG FACI LI TY					44
	D4500 NURSING FACILITY D4600 OTHER LONG TERM CARE					45
	ANCI LLARY SERVICE COST CENTERS		,			0
	D5000 OPERATI NG ROOM	0	766, 835			50
. 00 0	D5100 RECOVERY ROOM	0	0 0			51
	D5200 DELIVERY ROOM & LABOR ROOM	C	128, 597			52
	05300 ANESTHESI OLOGY	0	315, 054			53
	D5400 RADI OLOGY-DI AGNOSTI C	-15, 617	316, 531			54
	D5500 RADI OLOGY-THERAPEUTI C D5600 RADI OI SOTOPE					55
	55700 CT SCAN		305, 226			57
	D5800 MAGNETIC RESONANCE IMAGING (MRI)		89, 129			58
	05900 CARDI AC CATHETERI ZATI ON	C				59
. 00 0	D6000 LABORATORY	-26, 775	861, 787			60
. 01 0	D6001 BLOOD LABORATORY	C	0 0			60
1	D6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	C	0 0			61
1	D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62
1	D6300 BLOOD STORING, PROCESSING & TRANS. D6400 INTRAVENOUS THERAPY					63
	06500 RESPIRATORY THERAPY		157,060			65
1	D6600 PHYSI CAL THERAPY		338, 142			66
	D6700 OCCUPATI ONAL THERAPY		46, 569			67
	D6800 SPEECH PATHOLOGY	0	36, 171			68
. 00  0	D6900 ELECTROCARDI OLOGY	-11, 973				69
	D7000 ELECTROENCEPHALOGRAPHY	0	474			70
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	1,016,029			71
	07200 IMPL. DEV. CHARGED TO PATIENTS		672, 292			72
	07300 DRUGS CHARGED TO PATIENTS	-22, 754	938, 874			73
1	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)		-			74
	D7700 ALLOGENEIC STEM CELL ACQUISITION					77
	DUTPATIENT SERVICE COST CENTERS					$\dashv$ ''
	D8800 RURAL HEALTH CLINIC	(	0			88
1	08900 FEDERALLY QUALIFIED HEALTH CENTER					89
	09000 CLINIC	C	0			90
1	D9100 EMERGENCY	-607, 560	332, 552			91
-	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS	1				
. 00 0	09400 HOME PROGRAM DIALYSIS	0				94

ST ELIZABETH DEARBORN

In Lieu of Form CMS-2552-10

Health Financial Systems

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-2	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 1	5-0086	Peri od:	Worksheet A	
				From 11/01/2020 To 12/31/2020	Date/Time Prep	pared.
					7/28/2021 2:53	
Cost Center Description		Net Expenses				
		or Allocation				
	6.00	7.00		1		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0				97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
99.00 09900 CMHC	0	0				99.00
99.10 09910 CORF	0	0				99.10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	U U	U				101. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0				105.00
106. 00 10600 HEART ACQUISITION	0	0				105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				107.00
108. 00 10800 LUNG ACQUISITION	0	0				107.00
109. 00 10900 PANCREAS ACQUISITION	0	0				108.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0				110,00
111. 00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113. 00 11300 I NTEREST EXPENSE	0	0				113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0				115.00
116. 00 11600 H0SPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 782, 310	12, 218, 575				118.00
NONREI MBURSABLE COST CENTERS		.=, = ,				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
191. 00 19100 RESEARCH	0	0				191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	772				192.00
193.00 19300 NONPALD WORKERS	0	0				193.00
200.00 TOTAL (SUM OF LINES 118 through 199)	1, 782, 310	12, 219, 347				200. 00
	•					

	Financial Systems IFICATIONS		ST ELI ZABETH	Provi der CCN: 15-00	86 Period:	u of Form CMS-2552- Worksheet A-6
					From 11/01/2020 To 12/31/2020	Date/Time Prepared
		Increases				7/28/2021 2:53 pm
	Cost Center	Line #	Salary	Other		
-	2.00 A - DRUGS TO PHARMACY	3.00	4.00	5.00	<u> </u>	
	DRUGS CHARGED TO PATIENTS	73.00	0	7, 270		1.
		0.00	0	0		2.
		0.00 0.00	0	0		3.
		0.00	0	0		4.
		0.00	Ö	Ő		6.
		0.00	<u>o</u>	<u>0</u>		7.
	TOTALS B - CAFETERIA		0	7, 270		
÷	CAFETERIA	11.00	68, 916	40, 022		1.
ł	TOTALS		68, 916	40, 022		
	C - SUPPLIES & IMPLANTS					
	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	966, 178		1.
	IMPL. DEV. CHARGED TO	72.00	0	672, 292		2.
	PATI ENTS					
		0.00	0	0		3.
		0.00 0.00	0	0		4.
		0.00	0	Ö		6.
		0.00	0	0		7.
		0.00	0	0		8
		0.00 0.00	0	0		9.
		0.00	0	0		11
		0.00	0	0		12
		0.00	0	0		13
		0.00 0.00	0	0 0		14
		0.00	0	0		16
		0.00	0	0		17
		0.00	0	0		18
		0.00 0.00	0	0		19.
		0.00	0	0		21
		0.00	0	0		22
		0.00	0	0		23
	TOTALS		0	0 1,638,470		24.
	D - LABOR & DELIVERY ROOM			1,000,170		
	ADULTS & PEDIATRICS	30.00	53, 532	18, 399		1.
	NURSERY	43.00	49,042	1 <u>6, 855</u> 35, 254		2
	TOTALS E - RADIOLOGY ADMIN		102, 574	35, 254		
	CT SCAN	57.00	74, 280	135, 779		1.
	MAGNETIC RESONANCE IMAGING	58.00	12, 312	22, 505		2.
	( <u>MR</u> I )	+	86, 592	158, 284		
	F - PHARMACY RESIDENCY PROGRA	M	80, 372	150, 204		
	PARAMED_ED_PRGM-(SPECIFY)	23.00	<u> </u>	700		1.
	TOTALS		12, 607	700		
	G – GAI NSHARI NG ADMI NI STRATI VE & GENERAL	5.00	4, 479	0		1.
- 1	MAINTENANCE & REPAIRS	6.00	2, 680	0		2.
- 1	OPERATION OF PLANT	7.00	721	0		3
- 1	LAUNDRY & LINEN SERVICE	8.00	368	0		4
	HOUSEKEEPI NG DI ETARY	9.00 10.00	3, 893 2, 778	0		5
	NURSING ADMINISTRATION	13.00	2,778	0		7
	SOCI AL SERVI CE	17.00	1, 996	0		8
	PARAMED ED PRGM- (SPECI FY)	23.00	242	0		9.
	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00 31.00	5, 687 3, 087	0 0		10
	OPERATING ROOM	50.00	9, 125	0		12
- 1	DELIVERY ROOM & LABOR ROOM	52.00	2, 943	0		13
	RADI OLOGY-DI AGNOSTI C	54.00	3, 514	0		14
- 1	CT SCAN	57.00	945	0		15
	MAGNETIC RESONANCE IMAGING (MRI)	58.00	362	0		16.
	CARDI AC CATHETERI ZATI ON	59.00	622	0		17.
	LABORATORY	60.00	3, 354	0		18.
	RESPI RATORY THERAPY	65.00	1, 657			19.

Health Financial Systems		ST ELI ZABET	H DEARBORN		In Lieu	u of Form CMS-	2552-10
RECLASSI FI CATI ONS			Provider C	CN: 15-0086	Period: From 11/01/2020	Worksheet A-	5
					To 12/31/2020	Date/Time Pro 7/28/2021 2:	
In	creases						
Cost Center L	ine #	Sal ary	0ther				
2.00	3.00	4.00	5.00				
21.00 OCCUPATI ONAL THERAPY	67.00	594	0				21.00
22.00 SPEECH PATHOLOGY	68.00	265	0				22.00
23.00 ELECTROCARDI OLOGY	69.00	970	0				23.00
24.00 MEDICAL SUPPLIES CHARGED TO	71.00	797	0				24.00
PATI ENTS							
25.00 DRUGS CHARGED TO PATIENTS	73.00	2, 765	0				25.00
26.00 EMERGENCY	91.00	3, 783	0				26.00
TOTALS		62, 370	0				
500.00 Grand Total: Increases		333, 059	1, 880, 000				500.00

CLASSI FI CATI	ONS		01 221218211	Provider (	CCN: 15-0086	Peri od:	Worksheet A-6
2.1001110.111						From 11/01/2020 To 12/31/2020	Date/Time Prepare
		Deersees				10 12/31/2020	7/28/2021 2:53 pr
	Cost Center	Decreases	Salary	Other	Wkst. A-7 Ref	.	
	6. 00	7.00	8.00	9.00	10.00	·	
	IGS TO PHARMACY						
	NG ROOM	50.00	0	3, 471		0	1
	Y ROOM & LABOR ROOM	52.00	0	555		0	2
	SIOLOGY	53.00	0	2, 123		0	3
00 LABORAT 00 OCCUPAT	IONAL THERAPY	60.00 67.00	0	221 g		0	4
	SUPPLIES CHARGED TO	71.00	0	58		0	6
PATI ENT		71.00	Ű	50		0	
O EMERGEN		91.00	о	833		0	7
TOTALS			o	7,270		7	
B – CAF	ETERI A						
DO <u>DIETARY</u>	·		6 <u>8, 9</u> 16	40, 022		<u>o</u>	1
TOTALS			68, 916	40, 022			
	PLIES & IMPLANTS	5.00	0	3, 797		0	1
	ANCE & REPAIRS	6.00	0	3, 797		0	2
O HOUSEKE		9.00	0	10, 689		0	3
DO DI ETARY		10.00	o	2, 861		0	4
	ADMI NI STRATI ON	13.00	0	950		0	5
SOCIAL	SERVI CE	17.00	0	2		0	6
	& PEDIATRICS	30.00	0	79, 468		0	7
	VE CARE UNIT	31.00	0	34, 094		0	8
00 OPERATI		50.00	0	1, 192, 413		0	9
	Y ROOM & LABOR ROOM	52.00	0	13, 066		0	10
	SIOLOGY	53.00	0	21, 596		0	11
	GY-DI AGNOSTI C	54.00	0	29, 603		0	12
00 CT SCAN 00 MAGNETI	C RESONANCE I MAGING	57.00 58.00	0	68, 304 6, 131		0	13
(MRI)	C RESUMANCE TWASTING	58.00	0	0, 131		0	14
	CATHETERI ZATI ON	59.00	o	22, 892		0	15
00 LABORAT		60.00	0	52, 890		0	16
00 RESPIRA	TORY THERAPY	65.00	0	20, 655		0	17
00 PHYSICA	L THERAPY	66.00	0	2, 459		0	18
	I ONAL THERAPY	67.00	0	773		0	19
	PATHOLOGY	68.00	0	62		0	20
	CARDI OLOGY	69.00	0	1, 727		0	21
00 MEDI CAL PATI ENT	SUPPLIES CHARGED TO	71.00	0	7, 159		0	22
	HARGED TO PATIENTS	73.00	0	12, 538		0	23
00 EMERGEN		91.00	o	54, 340		0	24
TOTALS			— — — <del>-</del>	1, 638, 470		-	
D – LAB	OR & DELIVERY ROOM						
	Y ROOM & LABOR ROOM	52.00	102, 574	35, 254		0	1
		0.00				Q	2
TOTALS	I OLOGY ADMIN		102, 574	35, 254			
	GY-DI AGNOSTI C	54.00	86, 592	158, 284		0	1
00		0.00	0	C		0	2
TOTALS			86, 592	158, 284		1	
	RMACY RESIDENCY PROGRA		10.(07		1		
0 DRUGS C TOTALS	HARGED TO PATIENTS		<u>12, 607</u> 12, 607			Q	1
	NSHARI NG		12,007	700			
	TRATIVE & GENERAL	5.00	62, 370	C		0	1
0		0.00	0	C		0	2
00		0.00	0	C		0	3
0		0.00	О	C		0	4
0		0.00	0	C		0	5
00		0.00	0	C		0	6
00		0.00	0	C		0	7
0		0. 00 0. 00	0	C		0	8
00		0.00	0	C		0	9
00		0.00	0	C		0	11
00		0.00	0	0		0	12
00		0.00	0	C		0	13
00		0.00	0	C		0	14
00		0.00	0	C		0	15
00		0.00	О	C		0	16
00		0.00	О	C		0	17
00		0.00	0	C		0	18
00		0.00	0	C		0	19
		0.00	0	C	1	0	20
00		0.00	0	C		0	21

In Lieu of Form CMS-2552-10

Health Financial Systems ST ELIZABETH DEARBORN

Heal th	Financial Systems		ST ELI ZABET	H DEARBORN		In Lie	u of Form CMS-2	2552-10
RECLASS	I FI CATI ONS			Provi der	CCN: 15-0086	Peri od:	Worksheet A-6	
						From 11/01/2020 To 12/31/2020	Date/Time Prep 7/28/2021 2:53	pared: 3 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	·		
	6. 00	7.00	8.00	9.00	10.00			
22.00		0.00	0	C	)	0		22.00
23.00		0.00	0	C	)	0		23.00
24.00		0.00	0	C	)	0		24.00
25.00		0.00	0	C	)	0		25.00
26.00		0.00	0	0	)	0		26.00
	TOTALS		62, 370		)			
500.00	Grand Total: Decreases		333, 059	1, 880, 000				500.00

Hoal th	Financial Systems	ST ELI ZABETH			Inlie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 11/01/2020 To 12/31/2020	Worksheet A-7 Part I	pared:
				Acquisition:			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES				-	
1.00	Land	1, 949, 066	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	7, 328, 967	0		0 0	0	3.00
4.00	Building Improvements	2,040,779	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	2,906,362	80, 000		0 80,000	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14, 225, 174	80, 000		0 80,000	0	8.00
9.00	Reconciling Items	0	0		0 0	0	9,00
10.00	Total (line 8 minus line 9)	14, 225, 174	80, 000		0 80, 000	0	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
		6,00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES				-	
1.00	Land	1, 949, 066	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	7, 328, 967	0				3.00
4.00	Building Improvements	2,040,779	0				4.00
5.00	Fixed Equipment	2,010,777	0				5.00
6.00	Movable Equipment	2, 986, 362	0				6,00
7.00	HIT designated Assets	2, ,00, 002	0				7.00
8.00	Subtotal (sum of lines 1-7)	14, 305, 174	0				8.00
9.00	Reconciling Items	14, 303, 174	0				9.00
10.00	Total (line 8 minus line 9)	14, 305, 174	0				10.00
10.00		14, 303, 174	0	1			1 10.00

Heal th	Financial Systems	ST ELI ZABETH	I DEARBORN		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0086	Period:	Worksheet A-7	
					From 11/01/2020 To 12/31/2020		narod
					10 12/31/2020	7/28/2021 2:53	
			SL	JMMARY OF CAP	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			nd 2			1 00
1.00	CAP REL COSTS-BLDG & FIXT	49, 436			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	121, 193			0 0	0	2.00
3.00	Total (sum of lines 1-2)	170, 629			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			_
1.00	CAP REL COSTS-BLDG & FIXT	0	49, 436				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	121, 193				2.00
3.00	Total (sum of lines 1-2)	0	170, 629				3.00

Health Financial Systems	ST ELI ZABETH	H DEARBORN		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 11/01/2020 To 12/31/2020		pared: 3 pm
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				0 701000		
1.00 CAP REL COSTS-BLDG & FIXT	11, 318, 812				0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	2, 986, 362				0	2.00
3.00 Total (sum of lines 1-2)	14, 305, 174	TION OF OTHER (	14, 305, 17		F CAPITAL	3.00
	ALLUCA	ITON OF OTHER (	JAPITAL	SUMMART	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
		Capi tal -Rel ate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 127, 816	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 254, 174	0	2.00
3.00 Total (sum of lines 1-2)	0	0		0 381, 990	0	3.00
		SL	JMMARY OF CAPI	TAL		
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 CE	INTERS 576	0		0 0	128, 392	1.00
2.00 CAP REL COSTS-BEDG & FIXT	0			0 0	254, 174	2.00
3.00 Total (sum of lines 1-2)	576	-		0 0	382, 566	2.00
3.00 [10tal (Suil 01 11165 1-2)	570	1 0	1	0 0	302, 300	3.00

Health Financial Systems ADJUSTMENTS TO EXPENSES		ST ELI ZABETH	DEARBORN Provider CCN: 15-0086	In Lie Period:	u of Form CMS-2 Worksheet A-8	2552-10
ADJUSTINIENTS TO EXTENSES				From 11/01/2020 To 12/31/2020		
		Т	Expense Classification o/From Which the Amount		172072021 2. 3	<u>5 piii</u>
		1	of the Amount	is to be Aujusted		
Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00 Investment income - CAP REL	1.00 B	2.00 576C	3.00 AP REL COSTS-BLDG & FIXT	4.00	5. 00 11	1.00
2.00 COSTS-BLDG & FIXT (chapter 2) 1 Investment income - CAP REL		oc	AP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 COSTS-MVBLE EQUIP (chapter 2)		0		0.00		3.00
(chapter 2) 4.00 Trade, quantity, and time		0		0.00		4.00
di scounts (chapter 8) 5.00 Refunds and rebates of		0		0.00		5.00
expenses (chapter 8) 6.00 Rental of provider space by				0.00		6.00
suppliers (chapter 8) 7.00 Telephone services (pay		0		0.00		7.00
stations excluded) (chapter		0		0.00	0	7.00
8.00 Tel evi si on and radio service		0		0.00	0	8.00
(chapter 21) 9.00 Parking lot (chapter 21)		0		0.00		9.00
10.00 Provider-based physician adjustment	A-8-2	-1, 067, 473			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	2, 934, 487			0	12.00
13.00 Laundry and Linen service 14.00 Cafeteria-employees and guests	s B	0 -31, 170D	IETARY	0.00 10.00		13.00 14.00
15.00 Rental of quarters to employed and others		0		0.00		15.00
16.00 Sale of medical and surgical supplies to other than		0		0.00	0	16.00
patients 17.00 Sale of drugs to other than	В	-22, 754D	RUGS CHARGED TO PATIENTS	73.00	0	17.00
patients 18.00 Sale of medical records and	В		DMI NI STRATI VE & GENERAL	5.00		18.00
abstracts 19.00 Nursing and allied health		0		0.00		19.00
education (tuition, fees, books, etc.)		_				
20.00 Vending machines 21.00 Income from imposition of		0		0. 00 0. 00		20. 00 21. 00
interest, finance or penalty		0		0.00	0	21.00
charges (chapter 21) 22.00 Interest expense on Medicare		0		0.00	0	22.00
overpayments and borrowings to repay Medicare overpayments				(5.00		
23.00 Adjustment for respiratory therapy costs in excess of	A-8-3	OR	ESPI RATORY THERAPY	65.00		23.00
limitation (chapter 14) 24.00 Adjustment for physical	A-8-3	0 P	HYSICAL THERAPY	66.00		24.00
therapy costs in excess of limitation (chapter 14)						
25.00 Utilization review - physicians' compensation		OU	TILIZATION REVIEW-SNF	114.00		25.00
(chapter 21) 26.00 Depreciation - CAP REL		oc	AP REL COSTS-BLDG & FIXT	1.00	0	26.00
COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL		OC	AP REL COSTS-MVBLE EQUIP	2.00	0	27.00
COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist		ON	ONPHYSI CI AN ANESTHETI STS	19.00		28.00
29.00 Physicians' assistant 30.00 Adjustment for occupational	A-8-3	0	CCUPATI ONAL THERAPY	0.00 67.00		29. 00 30. 00
therapy costs in excess of limitation (chapter 14)						
30. 99 Hospice (non-distinct) (see instructions)		OA	DULTS & PEDIATRICS	30.00		30. 99
31.00 Adjustment for speech pathology costs in excess of	A-8-3	0 S	PEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest 33.00 LEASE REVENUE	В	-1, 384 A	DMI NI STRATI VE & GENERAL	5.00	0	33.00

Health Financial Systems		ST ELI ZABETH	DEARBORN	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0086	Peri od:	Worksheet A-8	
				From 11/01/2020 To 12/31/2020	Date/Time Prep 7/28/2021 2:53	
			Expense Classification			
			To/From Which the Amount i	s to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
· · · · · · · · · · · · · · · · · · ·	1.00	2.00	3.00	4.00	5.00	
33.01 SALE OF ASSETS/REBATES	В	-29, 952	SOCI AL SERVI CE	17.00	0	
33. 02 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	33. 02
(3) 33. 03 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.03
(3)						
33. 04 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.04
(3) 33. 05 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.05
(3)		-				
33. 06 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.06
(3) 33. 07 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 07
(3)		Ū		0.00	Ű	00.07
33. 08 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.08
(3) 33. 09 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.09
(3)		Ũ		0.00	Ű	00.07
33. 10 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.10
(3) 33. 11 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 11
(3)		0		0.00	0	55.11
33. 12 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 12
(3) 33. 13 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 13
(3)		0		0.00	0	55.10
33. 14 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 14
(3) 33. 15 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 15
(3)		0		0.00	0	33.13
33. 16 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.16
(3) 33. 17 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	33. 17
(3)		0		0.00	0	33.17
33. 18 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 18
(3)		~		0.00	_	22.40
33. 19 OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33. 19
33. 20 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 20
		4 700 01-				F0 07
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		1, 782, 310				50.00
column 6, line 200.)						

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

Heal th	Financial Systems	ST_ELI ZABE	TH DEARBORN	In Lie	eu of Form CMS-	2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOM			ME Provider CCN: 15-0086	Period: From 11/01/2020	Worksheet A-8	-1
OFFICE				To 12/31/2020		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00 2.00		3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAI MED		
	HOME OFFICE COSTS:		-			
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE COST	78, 380	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE COST	132, 981	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	2, 723, 126	0	3.00
4.00	0.00 TOTALS (sum of lines 1-4).			0	0	4.00
5.00				2, 934, 487	0	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas not	Deen posteu to worksheet A,	corumns ranu/or z, the amount	it allowable si		or this part.			
				Related Organization(s) and/	or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	1.00	2.00	3.00	4.00	5.00			
	R INTERPELATIONSHIP TO DELATED OPCANIZATION(S) AND/OP HOME OFFICE							

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

6.00	В	0. 00 ST. ELI ZABETH	100.00	6.00
7.00		0.00	0.00	7.00
8.00		0.00	0.00	8.00
9.00		0.00	0.00	9.00
10.00		0.00	0.00	10.00
100.00 G. 0the	er (financial or			100.00
non-fi r	nancial) specify:			1

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

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

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

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

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

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

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

Health Financial Systems ST ELIZABE	H DEARBORN	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HO	IE Provider CCN: 15-0086	Peri od:	Worksheet A-8-1	
OFFICE COSTS		From 11/01/2020 To 12/31/2020	Date/Time Prepared:	

			7/28/2021 2:	53 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	78, 380	9		1.00
2.00	132, 981	9		2.00
3.00	2, 723, 126	0		3.00
4.00	0	0		4.00
5.00	2, 934, 487			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.

110	as not	been posted to worksheet A,		the amount			tin s part.	
		Related Organization(s)						
		and/or Home Office						
		Type of Business						
		51						
		6, 00	1					
-			· · · · · · · · · · · · · · · · · · ·					
		B. INTERRELATIONSHIP TO RELATIONSHIP	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.

6.00 7.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
8. 00 9. 00 10. 00 <u>100. 00</u>	100.00

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

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

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

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

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

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

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

Heal th	Financial Syste	ems	ST ELI ZABET	TH DEARBORN		In Lie	eu of Form CMS-	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT			Provider (	CCN: 15-0086	Peri od:	Worksheet A-8	3-2	
						From 11/01/2020 To 12/31/2020		nared
						7/28/2021 2:5	3 pm	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
	1.00	0.00	0.00		5.00	(	Hours	
1 00	1.00		3.00	4.00	5.00	6.00	7.00	1.00
1.00		ADMINI STRATI VE & GENERAL	53, 667	53, 667	(		0	1.00
2.00		ADULTS & PEDIATRICS	351, 881	351, 881			0	2.00
3.00		RADI OLOGY-DI AGNOSTI C LABORATORY	15, 617	15, 617 0	41, 66	y v	0 119	3.00
4.00			41, 667					4.00
5.00		ELECTROCARDI OLOGY	11, 973			-	0	5.00
6.00 7.00	0.00	EMERGENCY	607, 560 0			-	0	6.00 7.00
7.00 8.00	0.00		0	, i i i i i i i i i i i i i i i i i i i		°	0	7.00 8.00
8.00 9.00	0.00		0			-	0	8.00 9.00
9.00 10.00	0.00		0	0			0	9.00 10.00
200.00	0.00		1, 082, 365	1, 040, 698	41, 66		119	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	WRSt. A LINC #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		T don't i i oi		Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMI NI STRATI VE & GENERAL	0	0	(	0 0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0			0	2.00
3.00		RADI OLOGY-DI AGNOSTI C	0	, v			0	3.00
4.00		LABORATORY	14, 892	745	(	0 0	0	4.00
5.00		ELECTROCARDI OLOGY	0	-		0 0	0	5.00
6.00		EMERGENCY	0	0	(		0	6.00
7.00	0.00		0	0	(	°	0	7.00
8.00	0.00		0	0	(	-	0	8.00
9.00	0.00		0	0	(	°	0	9.00
10.00	0.00		0	Ŭ			0	10.00
200.00			14, 892	745		-	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMI NI STRATI VE & GENERAL	0		(			1.00
2.00		ADULTS & PEDIATRICS	0	0	(			2.00
3.00		RADI OLOGY-DI AGNOSTI C	0					3.00
4.00		LABORATORY	0	14, 892	26, 77	26,775		4.00
5.00	69.00	ELECTROCARDI OLOGY	0	0	. (	11, 973		5.00
6.00		EMERGENCY	0	0	(			6.00
7.00	0.00		0	0	(			7.00
8.00	0.00		0	0	(	o o		8.00
9.00	0.00		0	0	(	o o		9.00
10.00	0.00		0	0	(	0 0		10.00
200.00			0	14, 892	26, 77	5 1, 067, 473		200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ST ELIZABETH	H DEARBORN Provider CO		In Lie eriod: rom 11/01/2020	u of Form CMS-: Worksheet B Part I	2552-10
					o 12/31/2020	Date/Time Pre 7/28/2021 2:5	
			CAPI TAL REL	LATED COSTS		172872021 2.5	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
1 00	GENERAL SERVICE COST CENTERS	400,000	400,000	1			1.00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	128, 392 254, 174	128, 392	254, 174			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	107, 013	0	0	107, 013		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 185, 022	19, 546		5, 758	3, 249, 021	5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	313, 363 57, 105	41, 064 15	81, 292 30	2, 461 960	438, 180 58, 110	•
8.00	00800 LAUNDRY & LINEN SERVICE	59,945	670		384	62, 326	•
9.00	00900 HOUSEKEEPI NG	235, 019	496		4, 390	240, 887	9.00
10.00	01000 DI ETARY	37, 421	1, 684		1, 179	43, 617	•
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	108, 938	1, 194 0	2, 364	1, 757 0	114, 253 0	11.00
12.00	01300 NURSI NG ADMI NI STRATI ON	203, 628	966	1, 912	4, 434	210, 940	•
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	01600 MEDICAL RECORDS & LIBRARY	04 525	0	0	0	0 157	16.00
17.00 18.00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	84, 535 0	425	841	2, 356 0	88, 157 0	1
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	•
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 23.00	02200 I & SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	37, 686	123	244	0 772	0 38, 825	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	57,000	123		112	50, 023	23.00
30.00	03000 ADULTS & PEDIATRICS	510, 328	16, 772		10, 388	570, 692	•
31.00	03100 I NTENSI VE CARE UNI T	355, 071	3, 115		7, 071	371, 423	•
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	65, 897	0	0	1, 251	67, 148 0	43.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
F0 00	ANCI LLARY SERVICE COST CENTERS	7// 025	14 001	29, 341	15 ( 40	026 646	
50.00 51.00	05100 RECOVERY ROOM	766, 835 0	14, 821 0		15, 649 0	826, 646 0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	128, 597	4, 139		-	143, 389	
53.00	05300 ANESTHESI OLOGY	315, 054	0	0	0	315, 054	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	316, 531	6, 128	12, 132	4, 903	339, 694 0	54.00 55.00
55.00 56.00	05600 RADI OLOGI - THERAPEUTI C	0	0	0	0	0	56.00
57.00	05700 CT SCAN	305, 226	0	0	3, 991	309, 217	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	89, 129	338		1, 471	91, 607	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	69, 282 861, 787	486 2, 829		1, 445 7, 879	72, 175 878, 095	59.00 60.00
60. 00	06001 BLOOD LABORATORY	001,707	2, 829	5, 800	7, 879	878, 0 <del>9</del> 3 0	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	_	_	-	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00 64.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	157,060	490	970	0 2, 785	161, 305	
66.00	06600 PHYSI CAL THERAPY	338, 142	3, 184		7,017	354, 646	•
67.00	06700 OCCUPATI ONAL THERAPY	46, 569	334	662	969	48, 534	67.00
68.00	06800 SPEECH PATHOLOGY	36, 171	178		789	37, 491	68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	84, 434 474	1, 373	2, 717	1, 728 11	90, 252 485	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 016, 029	3, 322	6, 576	1, 022	1, 026, 949	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	672, 292	0	0	0	672, 292	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	938, 874	624	1, 236	4, 674	945, 408	
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0		0	0	0	74.00 75.00
75.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	1
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·	~	· ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~			1
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89.00 90.00
90.00 91.00	09100 EMERGENCY	332, 552	4, 076	8, 070	7, 059	351, 757	
	1 I			1 27.21			

Health Financial Systems	ST ELI ZABETH	I DEARBORN		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	1	Provider C		Period: From 11/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Pre 7/28/2021 2:5	epared: 53 pm
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					(	92.00
OTHER REIMBURSABLE COST CENTERS		-		-	-	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	(	
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	(	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	(	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	(	
98.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC	0	0		0 0	(	
99. 00 09900 CMHC 99. 10 09910 CORF	0	0		0 0	(	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
SPECIAL PURPOSE COST CENTERS	0	0		0 0	L (	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	[	0 0	(	0 105.00
106. 00 10600 HEART ACQUISITION	0	0		0 0		105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		0 0		107.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0				109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0				110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0				)111.00
113. 00 11300 I NTEREST EXPENSE	Ŭ	0		0		113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0 0	C	115.00
116. 00/11600/H0SPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	12, 218, 575	128, 392	254, 17	107,013		
NONREI MBURSABLE COST CENTERS	12/210/0/0	1207072	201,11	1 1077010	12,210,070	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	(	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	772	0		0 0	772	2 192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
200.00 Cross Foot Adjustments		-				200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	12, 219, 347	128, 392	254, 17	107, 013	12, 219, 347	202.00

COST A	I Financial Systems ALLOCATION - GENERAL SERVICE COSTS	ST ELIZABETH	Provider CO		eriod: rom 11/01/2020	u of Form CMS-2 Worksheet B Part I Date/Time Pre 7/28/2021 2:5	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	3 pm
		5.00	6.00	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 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	3, 249, 021					5.00
6.00	00600 MAINTENANCE & REPAIRS	158, 707	596, 887	70.000			6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	21, 047 22, 574	133 5, 901	79, 290 784	91, 585		7.00
8.00 9.00	00900 HOUSEKEEPING	87, 249	4, 366	580	91, 565	333, 082	9.00
10.00	01000 DI ETARY	15, 798	14, 827	1, 970	906	8, 420	
11.00	01100 CAFETERI A	41, 382	10, 516	1, 397	1, 571	5, 972	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	76, 402	8, 507	1, 130	0	4, 831	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	15.00 16.00
17.00	01700 SOCIAL SERVICE	31, 930	3, 740	497	0	2, 124	
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	3, 740	0	0	2, 124	18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200 I & SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	14,062	1, 086	144	0	617	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	206, 703	147, 697	19, 627	37, 174	83, 883	30.00
31.00	03100 I NTENSI VE CARE UNI T	134, 528	27, 429	3, 645	6, 437	15, 578	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0	0	0	0	34.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	24, 321	0	0	0	0	43.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	299, 409	130, 515	17, 341	10, 849	74, 123	
51.00	05100 RECOVERY ROOM	0 F1 025	0	0	0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	51, 935 114, 112	36, 444	4, 842	0	20, 698 0	52.00 53.00
54.00	05400 RADI OLOGY – DI AGNOSTI C	123, 036	53, 965	7, 170	7, 733	30, 648	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	00, 700	0	0	00,010	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	
57.00	05700 CT SCAN	111, 997	0	0	0	0	57.00
58.00		33, 180	2, 976	395	0	1, 690	
59.00	05900 CARDI AC CATHETERI ZATI ON	26, 142	4, 281	569	468	2, 431	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	318, 043	24, 909	3, 310	20	14, 146 0	60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	58, 424	4, 315		0	2,450	
66.00	06600 PHYSI CAL THERAPY	128, 452	28, 037	3, 725	1, 542	15, 923	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	17, 579 13, 579	2, 943 1, 572	391 209	221 0	1, 671 893	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	32, 689	1, 572	1, 606	421	6, 865	
70.00	07000 ELECTROENCEPHALOGRAPHY	176	12,007	0	-21	0, 005	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	371, 954	29, 249	3, 886	1, 225	16, 611	71.00
72.00		243, 502	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	342, 424	5, 497	730	0	3, 122	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 77.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
11.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	L U	0	0	77.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	127, 405	35, 895	4, 769	20, 350	20, 386	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
04 00	OTHER REIMBURSABLE COST CENTERS		-			-	04.00
94.00 95.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0	0 0	0	0	94.00 95.00
7J. UU	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	

COST ALLOCATION - GENERAL SERVICE COSTS         Provider CN: 15-0086         Period: From 11/01/2020 To 12/31/2020         Worksheet B Part 1 Date/Time Prepared: 72/31/2020           Cost Center Description         ADMINISTRATIVE & GENERAL         ADMINISTRATIVE REPAIRS         OPERATION OF PLANT         LUNDRY & LUNDRY & LUNDRY & PLANT         HOUSEKEEPINC           97.00         07000         DURABLE WEDICAL EQUIP-SOLD         0	Heal th Finar	ncial Systems	ST ELI ZABETH	DEARBORN			In Lie	u of Form CMS-:	2552-10
Cost Center Description         ADMI NI STRATI VE & CENERAL         MITERNANCE & REPAIRS         OPERATION OF PLANT         LAUNDRY & LI NEN SERVICE         HOUSEKEEPI NG           97. 00         09700         DURABLE MEDI CAL EQUI P-SOLD         0	COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der	CCN:				
Cost Center Description         ADMI NI STRATI VE & GENERAL         MAI NTENANCE & REPAIRS         OPERATION OF PLANT         LAUNDRY & LINEN SERVICE         HOUSEKEEPING           97.00         09700         DURABLE MEDI CAL EQUI P-SOLD         0									
Cost Center Description         ADMI NI STRATI VE & GENERAL         MAI NTENANCE & PLANT         OPERATI ON OF LINEN SERVICE         HOUSEKEEPING           97.00         09700         DURABLE MEDI CAL EQUI P-SOLD         0         0         0         0         0         9.00         98.00         0         0         0         0         0         0         0         0         0         0         98.00         0         0         0         0         0         0         0         99.00         99.00         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>  1</td> <td>0 12/31/2020</td> <td></td> <td></td>						1	0 12/31/2020		
bit Note         bit State         REPAIRS         PLANT         LINEN SERVICE         PLANT         LINEN SERVICE           97.00         09700         DURABLE MEDICAL EQUIP-SOLD         0         0.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         0         0         0         0         0         0         0         9.00         9.00         99.00         99.00         99.00         99.00         99.00         99.00         0         0         0         0         0         99.00         0		Cost Center Description	ADMI NI STRATI VE	MALNTENANCE	& 0	PERATION OF	LAUNDRY &		
5.00         6.00         7.00         8.00         9.00           97.00         09700         DURABLE MEDI CAL EQUI P-SOLD         0         <		best benter bescription			ũ			HOUSEREEFTING	
97.00         09700         DURABLE MEDICAL EQUIP-SOLD         0								9,00	
99.00         09900         CMHC         0 <t< td=""><td>97.00 09700</td><td>DURABLE MEDICAL EQUIP-SOLD</td><td>0</td><td></td><td>0</td><td></td><td></td><td>0</td><td>97.00</td></t<>	97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0		0			0	97.00
99.10         09910         CORF         0         0         0         0         0         0         0         0         0         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         0	98.00 09850	OTHER REIMBURSABLE COST CENTERS	0		0	C	0 0	0	98.00
100.00         100.00         1&R SERVICES-NOT APPRVD PRGM         0	99.00 09900	CMHC	0		0	C	0 0	0	99.00
101.00         HOME HEALTH AGENCY         0	99.10 09910	CORF	0		0	C	0 0	0	99.10
SPECIAL PURPOSE COST CENTERS           105. 00         NDREY ACQUI SI TI ON         0	100.0010000	I&R SERVICES-NOT APPRVD PRGM	0		0	C	0 0	0	100.00
105.00         10500         KIDNEY         ACQUISITION         0 <td>101.0010100</td> <td>HOME HEALTH AGENCY</td> <td>0</td> <td></td> <td>0</td> <td>C</td> <td>0 0</td> <td>0</td> <td>101.00</td>	101.0010100	HOME HEALTH AGENCY	0		0	C	0 0	0	101.00
106.00         106.00         HEART ACQUI SI TI ON         0         0         0         0         0         106.00           107.00         LIVER ACQUI SI TI ON         0	SPECI	AL PURPOSE COST CENTERS	· · · · · ·						
107.00         107.00         LI VER ACQUI SI TI ON         0         0         0         0         107.00           108.00         10800         LUNG ACQUI SI TI ON         0         110.00         111.00         115.00         0         0<	105.0010500	KIDNEY ACQUISITION	0		0	(	0 0	0	105.00
108.00         10800         LUNG ACQUI SI TI ON         0         0         0         0         108.00           109.00         10900         PANCREAS ACQUI SI TI ON         0 </td <td>106.00 10600</td> <td>HEART ACQUISITION</td> <td>0</td> <td></td> <td>0</td> <td>C</td> <td>0 0</td> <td>0</td> <td>106.00</td>	106.00 10600	HEART ACQUISITION	0		0	C	0 0	0	106.00
109.00         PANCREAS ACQUISITION         0         0         0         0         109.00           110.00         INTESTINAL ACQUISITION         0         0         0         0         0         110.00           111.00         INTESTINAL ACQUISITION         0         0         0         0         0         110.00           111.00         ISLET ACQUISITION         0         0         0         0         0         111.00           113.00         INTERST EXPENSE	107.0010700	LIVER ACQUISITION	0		0	C	0 0	0	107.00
110.00       INTESTINAL ACQUISITION       0       0       0       0       110.00         111.00       ISLET ACQUISITION       0       0       0       0       0       111.00         113.00       INTEREST EXPENSE       113.00       11400       INTEREST EXPENSE       113.00         114.00       11400       UTILIZATION REVIEW-SNF       114.00       114.00         115.00       11500       AMBULATORY SURGICAL CENTER (D.P.)       0       0       0       116.00         116.00       1600       HOSPICE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       3, 248, 741       596, 887       79, 290       88, 917       333, 082       118.00         190.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00         191.00       19200       PHYSI CI ANS' PRI VATE OFFICES       280       0       0       191.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       280       0       0       193.00         193.00       19300       NONPAID WORKERS       0       0       0       193.00       193.00       193.00       193.00	108.00 10800	LUNG ACQUISITION	0		0	C	0 0	0	108.00
111.00       1SLET ACQUISITION       0       0       0       0       111.00         113.00       11300       INTEREST EXPENSE       113.00       113.00       113.00       113.00         114.00       11400       UTILIZATION REVIEW-SNF       114.00       114.00       114.00         115.00       11500       AMBULATORY SURGICAL CENTER (D. P. )       0       0       0       115.00         116.00       1060       HOSPICE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       3,248,741       596,887       79,290       88,917       333,082       118.00         NONREI MBURSABLE COST CENTERS       0       0       0       0       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       0       0       0       0       0       190.00       190.00       191.00       190.00       190.00       0       0       0       190.00       191.00       191.00       191.00       191.00       191.00       191.00       191.00       192.00       193.00       193.00       19	109.0010900	PANCREAS ACQUISITION	0		0	C	0 0	0	109.00
113.00       11300       INTEREST EXPENSE       113.00       113.00         114.00       11400       UTI LI ZATI ON REVI EW-SNF       114.00         115.00       11500       AMBULATORY SURGI CAL CENTER (D.P.)       0       0       0       114.00         116.00       11600       HOSPI CE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       3,248,741       596,887       79,290       88,917       333,082       118.00         NONREI MBURSABLE COST CENTERS         190.00       19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00       191.00       192.00       192.00       192.00       192.00       192.00       192.00       0       0       0       192.00       0       193.00       200.00       0       0       193.00       200.00       201.00       201.00       201.00       0       0       0       200.00       201.00	110.0011000	INTESTINAL ACQUISITION	0		0	C	0 0	0	110.00
114.00       11400       UTI LI ZATI ON REVI EW-SNF       114.00         115.00       11500       AMBULATORY SURGI CAL CENTER (D. P.)       0       0       0       0       115.00         116.00       11600       HOSPI CE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       3, 248, 741       596, 887       79, 290       88, 917       333, 082       118.00         NONRET IMBURSABLE COST CENTERS         190.00       19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00       191.00         191.00       19200       PHYSI CI ANS' PRI VATE OFFICES       280       0       0       2, 668       192.00         193.00       19300       NONRERS       0       0       0       0       193.00         200.00       Cross Foot Adj ustments       0       0       0       0       200.00         201.00       Negati ve Cost Centers       0       0       0       0       201.00	111.0011100	I SLET ACQUI SI TI ON	0		0	C	0 0	0	111.00
115.00       11500       AMBULATORY SURGICAL CENTER (D. P.)       0       0       0       0       115.00         116.00       11600       HOSPICE       0       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       3, 248, 741       596, 887       79, 290       88, 917       333, 082       118.00         NONREL MBURSABLE COST CENTERS         190.00       19100       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00       191.00       191.00       191.00       192.00       192.00       192.00       0       191.00       191.00       191.00       192.00       192.00       193.00       20.00       0       0       0       0       192.00         193.00       19300       NORKERS       0       0       0       0       193.00       200.00       200.00       200.00       201.00       0       0       0       200.00       0       0       200.00	113.00 11300	INTEREST EXPENSE							113.00
116.00         11600         HOSPICE         0         0         0         0         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         3, 248, 741         596, 887         79, 290         88, 917         333, 082         118.00           NONREI MBURSABLE COST CENTERS           190.00         19100         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           191.00         19100         RESEARCH         0         0         0         0         191.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         280         0         0         2, 668         0         192.00           193.00         19300         NONPAI D WORKERS         0         0         0         0         193.00           200.00         Cross Foot Adj ustments         0         0         0         0         200.00           201.00         Negati ve Cost Centers         0         0         0         0         201.00	114.0011400	UTILIZATION REVIEW-SNF							114.00
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         3, 248, 741         596, 887         79, 290         88, 917         333, 082         118.00           NONREL MBURSABLE COST CENTERS         NONREL MBURSABLE COST CENTERS         0         0         0         0         190.00           190.00         19100         RESEARCH         0         0         0         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         280         0         0         192.00         192.00           193.00         193000         NONPAI D WORKERS         0         0         0         193.00         193.00         200.00         200.00         200.00         200.00         200.00         201.00         0         0         0         0         200.00	115.00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0		0	C	0 0	0	115.00
NONREI MBURSABLE COST CENTERS           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         190.00           191.00         19200         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         280         0         0         2, 668         0         192.00           193.00         NONPAI D WORKERS         0         0         0         0         193.00           200.00         Cross Foot Adj ustments         200.00         201.00         0         0         0         201.00	116.0011600	HOSPI CE	0		0	C	0 0	0	116.00
190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         191.00       19100       RESEARCH       0       0       0       0       191.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       280       0       0       2, 668       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         200.00       Cross Foot Adj ustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 248, 741	596, 8	87	79, 290	88, 917	333, 082	118.00
191.00       RESEARCH       0       0       0       0       191.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       280       0       0       2, 668       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00									
192.00       PHYSICIANS' PRIVATE OFFICES       280       0       2,668       0       192.00         193.00       19300       NONPAID WORKERS       0       0       0       0       193.00         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00			0		0	C	0 0		
193.00         19300         NONPAI D WORKERS         0         0         0         193.00           200.00         Cross Foot Adjustments         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         201.00         0         0         0         0         0         201.00         201			0		0	C	0 0		
200.00         Cross Foot Adjustments         200.00			280		0	C	2, 668		1
201.00         Negative Cost Centers         0         0         0         0         0         0         201.00			0		0	C	0 0	0	
									1
202.00   TOTAL (sum lines 118 through 201)   3,249,021  596,887  79,290  91,585  333,082 202.00			0		0	C	0		
	202.00	TOTAL (sum lines 118 through 201)	3, 249, 021	596, 8	87	79, 290	91, 585	333, 082	202.00

Health Financial Systems	ST ELIZABETH	DEARBORN		_	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0086		1/01/2020	Worksheet B Part I	
				To 12	2/31/2020	Date/Time Pre 7/28/2021 2:5	
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE PERSONNEL	-	JRSI NG I STRATI ON	CENTRAL SERVI CES &	
	10.00	11.00				SUPPLY	
GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	1	13.00	14.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT							2.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL							5.00
6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT							6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE							7.00 8.00
9. 00 00900 HOUSEKEEPI NG							9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	85, 538 0	175, 091					10.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0		0			12.00
13. 00 01300 NURSING ADMINISTRATION	0	7, 589		0	309, 399	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0			0	0	0	14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	C		0	0	0	16.00
17.00 01700 SOCIAL SERVICE 18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	4, 337		0	4, 911	0	17.00 18.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	C		0	0	0	19.00
20.00 02000 NURSING SCHOOL	0	0		0	0	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	0	0 0	21.00 22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	1, 084	L.	0	0	0	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS	41, 981	19, 515		0	66, 300	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 997	13, 010		0	49, 111	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0		0	0	0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0			0	0	0	33.00 34.00
40. 00 04000 SUBPROVIDER - IPF	0	C		0	0	0	40.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0	0		0	0	0	41.00 43.00
44. 00 04400 SKI LLED NURSING FACILITY	0	0		0	0	0	43.00
45.00 04500 NURSING FACILITY	0	C		0	0	0	45.00
46. 00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C	2	0	0	0	46.00
50. 00 05000 OPERATI NG ROOM	29, 283	31, 442		0	88, 400	0	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0 2, 983	0 9, 215		0	0 36, 833	0	51.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	00,000	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	13, 552		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	55.00 56.00
57.00 05700 CT SCAN	0	3, 252		0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON	0	2, 168 2, 168		0	0 4, 911	0	58.00 59.00
60. 00 06000 LABORATORY	0	18, 973		0	0	0	60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	O		0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0	0	0	61.00 62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0 5, 421		0	0	0	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	13, 010		0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1, 626		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	1, 084 3, 252		0	0 7, 367	0	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS	0	3, 252		0	0	0	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	7, 047		ŏ	0	0	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART) 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0	0	75.00 77.00
OUTPATIENT SERVICE COST CENTERS			1	-1		-	
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	88.00 89.00
90. 00  09000  FEDERALLY QUALIFIED HEALTH CENTER 90. 00  09000  CLINIC	0	0		0	0	0	90.00
91. 00 09100 EMERGENCY	5, 294	14, 094		0	51, 566	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS							92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0	0	0	
95. 00 09500 AMBULANCE SERVICES	0	C		0	0	0	95.00

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0086	Peri od:	Worksheet B	
				From 11/01/2020 To 12/31/2020		narod
				10 12/31/2020	7/28/2021 2:5	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE (	OF NURSI NG	CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	D	0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	D	0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C	D	0 0	0	98.00
99. 00 09900 CMHC	0	C	D	0 0	0	99.00
99. 10 09910 CORF	0	0	D	0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	D	0 0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	)	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS				-		
105.00 10500 KIDNEY ACQUISITION	0	C	D	0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	C	D	0 0		106. 00
107.00 10700 LIVER ACQUISITION	0	C	D	0 0		107.00
108.00 10800 LUNG ACQUISITION	0	C	D	0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	C	D	0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	C	D	0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	C	D	0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	C		0 0		115.00
116. 00 11600 HOSPI CE	0	C		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	85, 538	175, 091		0 309, 399	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2	0 0		190.00
191.00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193.00 19300 NONPAID WORKERS	0	Ŭ	1	0 0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		175 001	1	0 200 200		201.00
202.00   TOTAL (sum lines 118 through 201)	85, 538	175, 091	II	0 309, 399	0	202.00

OST ALI	Financial Systems LOCATION - GENERAL SERVICE COSTS	ST ELI ZABETH		CCN: 15-0086	Peri od:	Worksheet B	
					From 11/01/2020 To 12/31/2020	Date/Time Pre	
					OTHER GENERAL	7/28/2021 2:5	<u>3 pm</u>
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVI	CE (SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
		15.00	16.00	17.00	18.00	19.00	
	ENERAL SERVICE COST CENTERS					1	1 1.
00         0           00         0	00100       CAP       REL       COSTS-BLDG # TEAT         00200       CAP       REL       COSTS-MVBLE       EQUI P         00400       EMPLOYEE       BENEFITS       DEPARTMENT         00500       ADMI NI STRATI VE       & GENERAL         00600       MAI NTENANCE       REPAI RS         00700       OPERATI ON       OF       PLANT         00800       LAUNDRY & LI NEN       SERVI CE         00900       HOUSEKEEPI NG       DI ETARY         011000       DI ETARY       MAI NTENANCE       OF         011200       MAI NTENANCE OF       PERSONNEL         01300       NURSI NG       ADMI NI STRATI ON         01400       CENTRAL       SERVI CES       & SUPPLY         01500       PHARMACY       DI HARMACY         01600       MEDI CAL       RECORDS & LI BRARY         01700       SOCI AL       SERVI CE       DI SO         01850       OTHER       GENERAL       SERVI CE       (SPECI FY)         01850       OTHER GENERAL       SERVI CE       (SPECI FY)         01900       NONPHYSI CI AN       ANESTHETI STS       D2000       NURSI NG       SCHOOL	0 0 0 0 0 0 0		0 0 135, 6 0 0	96 0 0 0 0 0 0	0	2. 4. 5. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18.
. 00 0 2. 00 0 3. 00 0	02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	0 0 0		0 0 0	0 0 0 0 0 0		21. 22. 23.
	NPATIENT ROUTINE SERVICE COST CENTERS	0		0 7,7	78 0	0	30.
. 00  0	3100 INTENSIVE CARE UNIT	0		0 9, 7	22 0	0	31.
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0		0	0 0	0	
	03400 SURGI CAL I NTENSI VE CARE UNI T	0		0	0 0	0	
	04000 SUBPROVI DER – I PF	0		o	0 0	0	
	04100 SUBPROVIDER - IRF	0		0	0 0	0	
	)4300 NURSERY )4400 SKILLED NURSING FACILITY	0		0		0	
	04500 NURSING FACILITY	0		0	0 0		
	04600 OTHER LONG TERM CARE	0		0	0 0	0	46
	NCILLARY SERVICE COST CENTERS	0		0 41, 9	46 0	0	50
	05100 RECOVERY ROOM	0		0	0 0		
	05200 DELIVERY ROOM & LABOR ROOM	0		0 2, 1		0	
	05300 ANESTHESI OLOGY	0		0 3, 0			
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0		0 10, 5	0900	0	
	05600 RADI OLOGI TITLIKALEUTTE	0		0	0 0	0	
	D5700 CT SCAN	0		0 12, 0	37 0	0	57
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0 1,9		0	
	05900 CARDI AC CATHETERI ZATI ON	0		0 1,8		0	
	06000 LABORATORY 06001 BLOOD LABORATORY	0		0 12, 5		0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	,		0		61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0 0	0	
00 0	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0 0	0	63
	06400 I NTRAVENOUS THERAPY	0		0	0 0	0	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0		0 4,3		0	
	06700 OCCUPATIONAL THERAPY	0		0 2,6	02 0	0	
	06800 SPEECH PATHOLOGY	o			24 0	0	
	06900 ELECTROCARDI OLOGY	0		0 1,4		0	
00 0	07000 ELECTROENCEPHALOGRAPHY	0		0	0 0	0	70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0 4	17 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0		0 7,5	40 0	0	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0		0		0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	0 0	-	
_	DUTPATIENT SERVICE COST CENTERS	U0		<u>ч</u>			$\uparrow$
	08800 RURAL HEALTH CLINIC	0		0	0 0	0	88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0 0	0	
. 00  0	09000 CLINIC	0		0	0 0	0	
	09100 EMERGENCY	0		0 14, 7	69 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			1		1	92

Health Financial Systems	ST ELIZABETH I	DEARBORN		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0086	Period: From 11/01/2020 To 12/31/2020	Date/Time Pre 7/28/2021 2:5	
Cost Center Description	PHARMACY	RECORDS & LI BRARY	SOCIAL SERVI		NONPHYSI CI AN ANESTHETI STS	
	15.00	16.00	17.00	18.00	19.00	
OTHER REIMBURSABLE COST CENTERS			1			
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	-	
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	, s	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0			0	
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 98.00 09850 OTHER REI MBURSABLE COST CENTERS	0	0				
98.00 09980 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC	0	0				
99. 10 09900 CMHC 99. 10 09910 CORF	0	0				
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	0				100.00
SPECIAL PURPOSE COST CENTERS	0	0	1	0 0		101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	-	106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE				-		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	c c	115.00
116. 00 11600 H0SPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	135, 6	96 C	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0 0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS	0	0		0 C		193.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	135, 6	96 C	) C	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	ST ELI ZABET	Provider C	CN: 15-0086	De	eri od:	u of Form CMS-: Worksheet B	2552-10
,031 F	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN. 15-0080		om 11/01/2020	Part I Date/Time Pre	pared:
			INTERNS &	RESI DENTS	-		7/28/2021 2:5	3 pm
	Cost Center Description	NURSING SCHOOL	SERVICES-SALAR			PARAMED ED	Subtotal	
		20.00	Y & FRI NGES 21.00	PRGM COSTS 22.00	>	PRGM 23.00	24.00	
	GENERAL SERVICE COST CENTERS	1						
. 00	00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT							2.00 4.00
5.00	00500 ADMINI STRATI VE & GENERAL							5.00
5. 00 5. 00	00600 MAI NTENANCE & REPAI RS							6.00
. 00	00700 OPERATION OF PLANT							7.00
3.00	00800 LAUNDRY & LINEN SERVICE							8.00
9.00	00900 HOUSEKEEPING							9.00
0.00	01000 DI ETARY 01100 CAFETERI A							10.0
2.00	01200 MAINTENANCE OF PERSONNEL							12.0
3.00	01300 NURSING ADMINISTRATION							13.00
4.00	01400 CENTRAL SERVICES & SUPPLY							14.00
5.00	01500 PHARMACY							15.00
6.00 7.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE							16.00 17.00
8.00	01850 OTHER GENERAL SERVICE (SPECIFY)							18.00
9.00	01900 NONPHYSI CI AN ANESTHETI STS							19.00
20.00	02000 NURSI NG SCHOOL	C						20.00
21.00	02100 I & R SERVI CES-SALARY & FRINGES APPRVD		0		~			21.00
22.00 23.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)				0	EE 010		22.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS					55, 818		23.00
30.00	03000 ADULTS & PEDIATRICS	0	C	)	0	0	1, 201, 350	30.00
31.00	03100 I NTENSI VE CARE UNI T	C	0 0	)	0	0	636, 880	
32.00	03200 CORONARY CARE UNI T	C	C	)	0	0	0	
33.00	03300 BURN I NTENSI VE CARE UNI T	0	0		0	0	0	
34.00 10.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF				0	0	0	
1.00	04100 SUBPROVI DER – I RF				0	0	0	
3.00	04300 NURSERY	C	0	)	0	0	91, 469	
4.00	04400 SKILLED NURSING FACILITY	C	-		0	0	0	
5.00	04500 NURSING FACILITY	C	-		0	0	0	
6.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0		1	0	0	0	46.00
50.00	05000 OPERATI NG ROOM	0	C		0	0	1, 549, 954	50.00
51.00	05100 RECOVERY ROOM	C	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	0		0	0	308, 469	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C				0	0	432, 175 586, 307	
	05500 RADI OLOGY-THERAPEUTI C				0	0	560, 307	
6. 00	05600 RADI OI SOTOPE				0	0	0	
57.00	05700 CT SCAN	C	0	)	0	0	436, 503	57.00
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C	0		0	0	134, 007	
9.00	05900 CARDI AC CATHETERI ZATI ON				0	0	114,997	
0. 00 0. 01	06000 LABORATORY 06001 BLOOD LABORATORY				0	0	1, 269, 996 0	
51.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				Ŭ	0	0	
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	0 0	)	0	0	0	
3. 00	06300 BLOOD STORING, PROCESSING & TRANS.	C	C	)	0	0	0	
4.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
5.00 6.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY				0	0	236, 886 548, 020	
6.00 7.00	06700 OCCUPATIONAL THERAPY				0	0	548, 020 73, 567	
8.00	06800 SPEECH PATHOLOGY	0			0	0	55, 152	
9. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	156, 020	69.00
0.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	661	
1.00 2.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS				0	0	1, 453, 543 915, 794	
3.00	07200 TMPL. DEV. CHARGED TO PATTENTS				0	55, 818	1, 367, 592	
	07400 RENAL DI ALYSI S				õ	0	1, 307, 372	1
5.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	0	
7.00	07700 ALLOGENEIC STEM CELL ACQUISITION	C	0 0		0	0	0	77.00
0.00	OUTPATIENT SERVICE COST CENTERS	-	-		~	-1	-	00.5
38.00 39.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	0	88.00 89.00
90.00	09000 CLINIC				0	0	0	90.00
1.00	09100 EMERGENCY				õ	0	646, 285	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	C	0	1	0	0	0	94.0

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	ieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 11/01/2020 To 12/31/2020			
					7/28/2021 2:53 pm		
		INTERNS &	RESI DENTS				
Cost Center Description	NURSING SCHOOLS				Subtotal		
		Y & FRI NGES	PRGM COSTS	PRGM			
	20.00	21.00	22.00	23.00	24.00		
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0 95.00		
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0 96.00		
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0 97.00		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0 98.00		
99. 00 09900 CMHC	0	0		0 0	0 99.00		
99. 10 09910 CORF	0	0		0 0	0 99.10		
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0 100. 00		
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0 101.00		
SPECIAL PURPOSE COST CENTERS	TT		1				
105.00 10500 KIDNEY ACQUISITION	0	0		0 0			
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0 106.00		
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0	0 107.00		
108.00 10800 LUNG ACQUISITION	0	0		0 0	0 108.00		
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0 109.00		
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0 110.00		
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0 111.00		
113.00 11300 INTEREST EXPENSE					113.00		
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00		
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0 115.00		
116. 00 11600 HOSPI CE	0			0	0 116.00		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 55, 818	12, 215, 627 118. 00		
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0 190. 00		
191. 00 19100 RESEARCH	0	0		0 0	0 191.00		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	3, 720 192. 00		
193. 00 19300 NONPALD WORKERS	0	0		0 0	0 193.00		
200.00 Cross Foot Adjustments	0	0		0 0	0 200. 00		
201.00 Negative Cost Centers	0	0		0 0	0 201.00		
202.00 TOTAL (sum lines 118 through 201)	0	0		0 55, 818	12, 219, 347 202. 00		

COST AL	LOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-008	From 11/01/2020	Worksheet B Part I
				To 12/31/2020	Date/Time Prepare 7/28/2021 2:53 pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
	GENERAL SERVICE COST CENTERS				
2.00     4.00       4.00     6.00       5.00     6.00       6.00     6.00       7.00     6.00       8.00     6.00       10.00     11.00       11.00     13.00       14.00     15.00       15.00     16.00       17.00     18.00       19.00     19.00       21.00     21.00	D0100       CAP       REL       COSTS-BLDG & FIXT         D0200       CAP       REL       COSTS-MVBLE       EQUIP         D0400       EMPLOYEE       BENEFITS       DEPARTMENT         D0500       ADMINISTRATIVE & GENERAL         D0600       MAINTENANCE & REPAIRS         D0700       OPERATION OF PLANT         D0800       LAUNDRY & LINEN SERVICE         D0900       HOUSEKEEPING         D1000       DI ETARY         D1100       CAFETERIA         D1200       MAINTENANCE OF PERSONNEL         D1300       NURSI NG ADMINISTRATION         D1400       CENTRAL SERVICES & SUPPLY         D1500       PHARMACY         D1600       MEDI CAL         MEDI CAL SERVICE       (SPECI FY)         D1700       SOCI AL         D1700       NONPHYSICI AN ANESTHETISTS         D1900       NONPHYSICI AN ANESTHETISTS         D1900       NURSI NG SCHOOL         D21001       I&R SERVICES-SALARY & FRINGES APPRVD         D22001       I&R SERVICES-OTHER				1. 2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22.
	D2300 PARAMED ED PRGM-(SPECIFY)				22.
-	INPATIENT ROUTINE SERVICE COST CENTERS		1		20.
31.00     0       32.00     0       33.00     0       34.00     0       40.00     0       41.00     0       43.00     0       44.00     0       44.00     0       44.00     0       45.00     0	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04600 OTHER LONG TERM CARE	0 0 0 0 0 0 0 0 0 0 0	1, 201, 350 636, 880 0 0 0 0 91, 469 0 0 0		30. 31. 32. 33. 34. 40. 41. 43. 44. 45. 46.
	ANCI LLARY SERVICE COST CENTERS		1.540.054		
51.00       6         52.00       6         53.00       6         55.00       6         60.00       6         57.00       6         58.00       6         57.00       6         58.00       6         59.00       6         60.01       6         51.00       6         52.00       6         53.00       6         54.00       6         55.00       6         64.00       6         57.00       6         68.00       6         69.00       6         70.00       7         71.00       7         72.00       7         74.00       7         77.00       7	D5000 OPERATING ROOM D5100 RECOVERY ROOM D5200 DELIVERY ROOM & LABOR ROOM D5200 DELIVERY ROOM & LABOR ROOM D5200 RADIOLOGY-DIAGNOSTIC D5500 RADIOLOGY-THERAPEUTIC D5600 RADIOLOGY-THERAPEUTIC D5600 RADIOLOGY-THERAPEUTIC D5600 CARDIAC CATHETERIZATION D5800 CARDIAC CATHETERIZATION D6000 LABORATORY D6000 BLOOD LABORATORY D6000 BLOOD LABORATORY D6000 BLOOD LABORATORY D6000 BLOOD STORING, PROCESSING & TRANS. D6400 INTRAVENOUS THERAPY D6500 RESPIRATORY THERAPY D6600 PHYSICAL THERAPY D6600 PHYSICAL THERAPY D6600 SPEECH PATHOLOGY D6600 SPEECH PATHOLOGY D6600 SPEECH PATHOLOGY D6000 ELECTROCARDIOLOGY D7000 CCUPATIONAL THERAPY D6600 SPEECH PATHOLOGY D6000 ELECTROCARDIOLOGY D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS D7200 INPL. DEV. CHARGED TO PATIENTS D7200 INPL. DEV. CHARGED TO PATIENTS D7400 RENAL DIALYSIS D7500 ASC (NON-DISTINCT PART) D7700 ALLOGENEIC STEM CELL ACQUISITION DUTPATIENT SERVICE COST CENTERS		$\begin{array}{c} 1, 549, 954 \\ 0 \\ 308, 469 \\ 432, 175 \\ 586, 307 \\ 0 \\ 0 \\ 436, 503 \\ 134, 007 \\ 114, 997 \\ 1, 269, 996 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 236, 886 \\ 548, 020 \\ 73, 567 \\ 55, 152 \\ 156, 020 \\ 661 \\ 1, 453, 543 \\ 915, 794 \\ 1, 367, 592 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ $		50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 60. 61. 62. 63. 64. 65. 66. 67. 68. 64. 65. 70. 71. 72. 73. 74. 75.
8.00 9.00 0.00 1.00	03800 RURAL HEALTH CLINIC D8900 FEDERALLY QUALIFIED HEALTH CENTER D9000 CLINIC D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0 0	0 0 0 646, 285		88. 89. 90. 91. 92.

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0086	Peri od: From 11/01/2020 To 12/31/2020	Worksheet B Part I	pared:
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26.00				
OTHER REIMBURSABLE COST CENTERS	23.00	20.00				
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0				94.00
95. 00 09500 AMBULANCE SERVICES	0	0				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
99. 00 09900 CMHC	0	0				99.00
99. 10 09910 CORF	0	0				99, 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	o				101.00
SPECIAL PURPOSE COST CENTERS	-	-1				
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0				105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0				106.00
107.00 10700 LIVER ACQUISITION	0	0				107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0				108.00
109.00 10900 PANCREAS ACQUISITION	0	o				109.00
110.00 11000 INTESTINAL ACQUISITION	0	0				110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0				115.00
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	12, 215, 627				118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
191. 00 19100 RESEARCH	o	o				191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 720				192.00
193. 00 19300 NONPAI D WORKERS	0	o				193.00
200.00 Cross Foot Adjustments	0	o				200. 00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118 through 201)	0	12, 219, 347				202.00

LOCA	Financial Systems TION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 11/01/2020 To 12/31/2020	u of Form CMS-: Worksheet B Part II Date/Time Pre	
			CAPI TAL REL	ATED COSTS		7/28/2021 2:5	
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	1					
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.0 2.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	(	0 0	0	4.0
00	00500 ADMINI STRATI VE & GENERAL	0	19, 546	38, 695	5 58, 241	0	5. C
00	00600 MAINTENANCE & REPAIRS	0	41, 064	81, 292		0	6.0
00 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	15 670	30 1, 327		0	7. C 8. C
00	00900 HOUSEKEEPING	0	496	982		0	9.0
. 00	01000 DI ETARY	0	1, 684	3, 333		0	10. C
. 00	01100 CAFETERI A	0	1, 194			0	11. C
. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	0 966	( 1, 912	-	0	12.0 13.0
. 00	01400 CENTRAL SERVICES & SUPPLY	0	900	1, 912		0	14.0
. 00	01500 PHARMACY	0	0	(	0	0	15.0
. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	(	-	0	16.0
. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	0	425 0	841	1, 266	0	17.0
. 00 . 00	01900 NONPHYSICIAN ANESTHETISTS	0	0			0	18. C
. 00	02000 NURSI NG SCHOOL	0	0	(		0	20.0
. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	(	0 0	0	21.0
. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	(	-	0	22.0
. 00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	123	244	4 367	0	23.0
. 00	03000 ADULTS & PEDIATRICS	0	16, 772	33, 204	49,976	0	30.0
. 00	03100 I NTENSI VE CARE UNI T	0	3, 115	6, 166		0	31.0
. 00	03200 CORONARY CARE UNI T	0	0	(	0 0	0	32.0
. 00	03300 BURN INTENSIVE CARE UNIT	0	0	(	0	0	33.0
. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0			0	34. C
. 00	04100 SUBPROVI DER – I RF	0	0	(		0	41.0
. 00	04300 NURSERY	0	0	(	0 0	0	43.0
. 00	04400 SKILLED NURSING FACILITY	0	0	(	0 0	0	44. C
. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0			0	45. C
. 00	ANCI LLARY SERVICE COST CENTERS	0	0		<u> </u>	0	40. U
. 00	05000 OPERATI NG ROOM	0	14, 821	29, 341	44, 162	0	50. C
. 00	05100 RECOVERY ROOM	0	0	(	1 Y	0	51. C
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	4, 139	8, 193		0	
	05400 RADI OLOGY-DI AGNOSTI C	11, 207	0 6, 128	12, 132	0 0 2 29,467	0	53. C
. 00	05500 RADI OLOGY-THERAPEUTI C	0	0, 120	(	0	0	55.0
. 00	05600 RADI OI SOTOPE	0	0	(	0 0	0	56.0
. 00	05700 CT SCAN	0	0	(	0 0	0	57.0
. 00 . 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	338 486	669		0	58. 0 59. 0
. 00	06000 LABORATORY	9, 142	2, 829	5, 600		0	60.0
. 01	06001 BLOOD LABORATORY	0	0	(	0 0	0	60.0
. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	_	61.0
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			0	62.0
. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		0			0	63.0 64.0
. 00	06500 RESPI RATORY THERAPY	0	490	970	1, 460	0	65.0
. 00	06600 PHYSI CAL THERAPY	10, 420	3, 184		3 19, 907	0	66.0
. 00	06700 OCCUPATI ONAL THERAPY	0	334	662		0	67.0
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	178 1, 373	353 2, 717		0	68. 0 69. 0
	07000 ELECTROCARDI OLOGY	0	1, 373 N	2,71	4,090	0	70. 0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 322	6, 576	9, 898	0	71.0
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0 0	0	72.
	07300 DRUGS CHARGED TO PATIENTS	0	624	1, 236	1, 860	0	73.
	07400 RENAL DIALYSIS	0	0			0	74.
. 00	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0			0	75. 77.
. 50	OUTPATIENT SERVICE COST CENTERS		0			0	1 ' ' '
	08800 RURAL HEALTH CLINIC	0	0	(	0 0	0	88. (
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(	) ၀	0	89.0
	09000 CLINIC 09100 EMERGENCY	0	0 4, 076	( 8, 070	0 0 0 12, 146	0	90. 0 91. 0
. 00							

Health Financial Systems	ST ELI ZABETH	I DEARBORN		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 11/01/2020 To 12/31/2020		
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	9 Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	-	
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	-	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0 0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
99.00 09900 CMHC	0	0		0 0		
99. 10 09910 CORF	0	0		0 0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0 0	101.00
SPECIAL PURPOSE COST CENTERS						1405 00
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF		0		0		114.00 115.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	30, 769	128, 392	254, 1	74 413, 335		116.00
NONREI MBURSABLE COST CENTERS	30,709	120, 392	204, 1	14 415, 550		1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0				191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
193. 00 19300 NONPALD WORKERS	0	0				193.00
200.00 Cross Foot Adjustments	0	0				200.00
201.00 Negative Cost Centers		٥		0 0	, c	200.00
202.00   TOTAL (sum Lines 118 through 201)	30, 769	128, 392	254, 1	74 413, 335		202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	ST ELI ZABETH	DEARBORN	CN: 15 0096 D		u of Form CMS-2	2552-10
ALLUUF	ATTON OF CAFTIAL RELATED CUSTS		FI UVI der CC		eriod: rom 11/01/2020 o 12/31/2020	Worksheet B Part II Date/Time Pre	pared.
						7/28/2021 2:5	3 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
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	50.041					4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	58, 241 2, 845	125, 201				5.00 6.00
7.00	00700 OPERATI ON OF PLANT	377	28	450			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	405	1, 238		3, 644		8.00
9.00	00900 HOUSEKEEPI NG	1, 564	916	3	0	3, 961	9.00
10.00	01000 DI ETARY	283	3, 110		36	100	
11.00	01100 CAFETERIA	742	2, 206		63	71	11.00
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	1, 370	0 1, 784		0	0 57	12.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 704	0	0	0	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0	0	16.00
17.00	01700 SOCIAL SERVICE	572	784		0	25	17.00
18.00 19.00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18.00 19.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I & SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	252	228	1	0	7	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 706	30, 982	114	1, 477	1,000	30.00
30.00	03100 I NTENSI VE CARE UNI T	2, 412	5, 753		256	1,000	
32.00	03200 CORONARY CARE UNI T	0	0		0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0	0	0	0	40.00
41.00	04300 NURSERY	436	0	0	0	0	41.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
F0 00	ANCILLARY SERVICE COST CENTERS	E 2/7	27.27(	00	422	001	50.00
50.00 51.00	05100 RECOVERY ROOM	5, 367	27, 376 0	98	432 0	881 0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	931	7,644		0	246	
53.00	05300 ANESTHESI OLOGY	2,046	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 206	11, 320		308	364	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
	05600 RADI 0I SOTOPE 05700 CT SCAN	02,008	0	0	0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	595	624	2	0	20	
59.00	05900 CARDI AC CATHETERI ZATI ON	469	898		19	29	
60.00	06000 LABORATORY	5, 701	5, 225		1	168	
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01 61.00
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	1,047	905		0	29	65.00
66.00	06600 PHYSI CAL THERAPY	2, 303	5, 881	21	61	189	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	315 243	617 330		9	20 11	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	586	2, 535		17	82	
70.00	07000 ELECTROENCEPHALOGRAPHY	3	2,000		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 664	6, 135		49	198	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 365	0	0	0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	6, 139	1, 153 0	4	0	37 0	73.00
74.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS	1					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0 2, 284	0 7, 529	0 27	0 810	0 242	90.00 91.00
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,204	1, 529	27	610	242	91.00
2.00	OTHER REIMBURSABLE COST CENTERS			·			
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
96.00							

ALLOCATION OF CAPITAL RELATED COSTS         Provider CCN: 15-0086         Period: From 11/01/2020 To 12/31/2020         Worksheet B From 11/01/2020 To 12/31/2020           Cost Center Description         ADMINISTRATIVE MAINTENANCE & & GENERAL         OPERATION OF LUNEN SERVICE         HOUSEKEEPING           97.00         09700 DURABLE WEDICAL EQUIP-SOLD         0         0         0         0         9.00           99.00         09850 OTHER REIMBURSABLE COST CENTERS         0         0         0         0         0         0         0         9.00         99.00           99.10         09901 CMHC         0         0         0         0         0         0         0         99.00           100.001000 LAR SERVICES-NOT APPRVD PRCM         0 <th>Health Financial Systems</th> <th>ST ELI ZABETH</th> <th>DEARBORN</th> <th></th> <th>In Lie</th> <th>u of Form CMS-3</th> <th>2552-10</th>	Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-3	2552-10
Cost Center Description         ADMI NI STRATI VE & GENERAL         MAI NTENANCE & REPAIRS         OPERATION OF PLANT         LAUNDRY & L AUNDRY & L A	ALLOCATION OF CAPITAL RELATED COSTS		Provider C	F	rom 11/01/2020	Part II	
Cost Center Description         ADMI NI STRATI VE & GENERAL         MAI NI STRATI VE REPAIRS         OPERATION OF PLANT         LINEN SERVICE LINEN SERVICE         HOUSEKEEPING           97.00         09700         DURABLE MEDICAL EQUIP-SOLD         0 </td <td></td> <td></td> <td></td> <td>  1</td> <td>0 12/31/2020</td> <td></td> <td></td>				1	0 12/31/2020		
5.00         6.00         7.00         8.00         9.00           97.00         09700         DURABLE MEDI CAL EQUI P-SOLD         0         <	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &		
97.00         09700         DURABLE MEDICAL EQUIP-SOLD         0							
98.00         09850         OTHER REIMBURSABLE COST CENTERS         0         0         0         0         0         0         99.00         99.00         09900         CMHC         0		5.00	6.00	7.00	8.00	9.00	
99.00         09900         CMHC         0 <t< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td>0</td><td></td></t<>		0	C		0 0	0	
99.10         O9910         CORF         0 <t< td=""><td></td><td>0</td><td>C</td><td>0 0</td><td>0 0</td><td>0</td><td></td></t<>		0	C	0 0	0 0	0	
100.00         100.00         1&R SERVICES-NOT APPRVD PRGM         0		0	C		0 0	0	
101.00         HOME         HEALTH         AGENCY         0		0	C		0 0	0	
SPECIAL PURPOSE COST CENTERS           105: 00         105:00         KIDNEY ACQUI SI TI ON         0		0	C		0 0		
105.00         10500         KI DNEY         ACQUI SI TI ON         0		0	C	) (	0 0	0	101.00
106.00         10600         HEART ACQUI SI TI ON         0         0         0         0         0         106.00           107.00         10700         LI VER ACQUI SI TI ON         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
107.00         107.00         LIVER ACQUI SI TI ON         0         0         0         0         107.00           108.00         10800         LUNG ACQUI SI TI ON         0 <td></td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td></td> <td></td>		0	C		0 0		
108.00         10800         LUNG ACQUI SI TI ON         0         0         0         108.00           109.00         10900         PANCREAS ACQUI SI TI ON         0 </td <td></td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>106.00</td>		0	C		0 0	0	106.00
109.00         PANCREAS         ACQUISITION         0         0         0         0         109.00           110.00         INTESTINAL         ACQUISITION         0         0         0         0         110.00           111.00         ISLET         ACQUISITION         0         0         0         0         110.00           111.00         ISLET         ACQUISITION         0         0         0         0         111.00           113.00         INTERST         EXPENSE	107.00 10700 LIVER ACQUISITION	0	C		0 0		
110.00       INTESTINAL ACQUISITION       0       0       0       0       110.00         111.00       ISLET ACQUISITION       0       0       0       0       0       111.00         113.00       INTEREST EXPENSE       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       115.00       116.00       0       0       0       0       116.00       190.00       116	108.00 10800 LUNG ACQUISITION	0	C		0 0	0	108.00
111.00       1SET ACQUISITION       0       0       0       0       111.00         113.00       11300       INTEREST EXPENSE       113.00       113.00       113.00       113.00         114.00       11400       UTILIZATION REVIEW-SNF       114.00       114.00       114.00         115.00       11500       AMBULATORY SURGICAL CENTER (D. P. )       0       0       0       115.00         116.00       11600       HOSPICE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       58,236       125,201       450       3,538       3,961       118.00         190.00       IPODO GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         191.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00         192.00       19200       PHYSI CI ANS' PRIVATE OFFICES       5       0       0       192.00       192.00         193.00       19300       NONPAID WORKERS       0       0       0       0       193.00         200.00       Negative Cost Centers       0       0       0       0       200.00       201.00	109.00 10900 PANCREAS ACQUISITION	0	C	) (	0 0	0	109.00
113.00       11300       INTEREST EXPENSE       113.00       113.00         114.00       11400       UTI LI ZATI ON REVI EW-SNF       114.00         115.00       11500       AMBULATORY SURGI CAL CENTER (D. P. )       0       0       0       114.00         116.00       11600       HOSPI CE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       58,236       125,201       450       3,538       3,961       118.00         NONREI MBURSABLE COST CENTERS         190.00       1970.00       0       0       0       0       190.00       191.00       191.00       191.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       0       0       0       0       192.00         192.00       19300       NONREIRS       0       0       0       0       193.00       200.00       0       0       193.00       200.00         200.00       Vegative Cost Centers       0       0       0       0       200.00       201.00	110.00 11000 INTESTINAL ACQUISITION	0	C	) (	0 0	0	110. 00
114.00       11400       UTI LI ZATI ON REVI EW-SNF       114.00         115.00       11500       AMBULATORY SURGI CAL CENTER (D. P.)       0       0       0       0       115.00         116.00       11600       HOSPI CE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       58,236       125,201       450       3,538       3,961       118.00         NONREI MBURSABLE COST CENTERS         190.00       1900 GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         191.00       19200       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00       191.00         192.01       19200       PHYSI CI ANS' PRI VATE OFFICES       5       0       0       0       192.00         192.00       19300       NONREI MUNCKERS       0       0       0       193.00       0       0       193.00       0       0       0       200.00         200.00       Cross Foot Adj ustments       0       0       0       0       0       201.00         201.00       Negati ve Cost Centers       0       0       0       0	111.00 11100 I SLET ACQUI SI TI ON	0	C	) (	0 0	0	111.00
115.00       11500       AMBULATORY SURGICAL CENTER (D. P.)       0       0       0       0       115.00         116.00       11600       HOSPICE       0       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       58,236       125,201       450       3,538       3,961       118.00         NONREI MBURSABLE COST CENTERS         190.00       190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         191.00       19100       RESEARCH       0       0       0       0       191.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       5       0       0       192.00         193.00       19300       NONRELS       0       0       0       193.00         200.00       Cross Foot Adj ustments       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       201.00	113.00 11300 INTEREST EXPENSE						113.00
116.00         11600         HOSPICE         0         0         0         0         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         58,236         125,201         450         3,538         3,961         118.00           NONREI MBURSABLE COST CENTERS           190.00         19100         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           191.00         19100         RESEARCH         0         0         0         0         191.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         5         0         0         192.00           193.00         19300         NONPAI D WORKERS         0         0         0         193.00           200.00         Cross Foot Adj ustments         0         0         0         200.00         201.00	114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         58,236         125,201         450         3,538         3,961         118.00           NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         0         0         0         0         190.00         190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00         190.00         191.00         192.00         192.00         192.00         0         0         191.00         192.00         192.00         192.00         192.00         192.00         192.00         193.00         193.00         193.00         193.00         0         0         0         0         193.00         200.00         200.00         200.00         200.00         201.00         0         0         0         0         200.00	115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C	0 0	0 0	0	115.00
NONREI MBURSABLE COST CENTERS         O <tho< th="">         O         <tho<< td=""><td>116. 00 11600 H0SPI CE</td><td>0</td><td>C</td><td>) (</td><td>0 0</td><td>0</td><td>116.00</td></tho<<></tho<>	116. 00 11600 H0SPI CE	0	C	) (	0 0	0	116.00
190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         191.00       19100       RESEARCH       0       0       0       0       191.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       5       0       0       106       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	58, 236	125, 201	450	3, 538	3, 961	118.00
191.00       RESEARCH       0       0       0       191.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       5       0       0       106       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00	NONREI MBURSABLE COST CENTERS						
192.00       19200       PHYSICIANS' PRIVATE OFFICES       5       0       0       106       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         200.00       Cross Foot Adjustments       201.00       0       0       0       0       201.00	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	) (	0 0	0	190. 00
193.00         19300         NONPAI D WORKERS         0         0         0         193.00           200.00         Cross Foot Adjustments         201.00         0         0         0         0         201.00		0	C	) (	0 0	0	191.00
200.00         Cross Foot Adjustments         200.00         200.00         200.00         200.00         201.00         0	192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	5	C	0 0	106	0	192.00
201.00         Negative Cost Centers         0 </td <td>193.00 19300 NONPALD WORKERS</td> <td>0</td> <td>C</td> <td>0 0</td> <td>0 0</td> <td>0</td> <td>193.00</td>	193.00 19300 NONPALD WORKERS	0	C	0 0	0 0	0	193.00
	200.00 Cross Foot Adjustments						200. 00
202.00         TOTAL (sum lines 118 through 201)         58, 241         125, 201         450         3, 644         3, 961         202.00	201.00 Negative Cost Centers	0	C	) (	0	0	201.00
	202.00 TOTAL (sum lines 118 through 201)	58, 241	125, 201	450	3, 644	3, 961	202.00

Heal th	Financial Systems	ST ELI ZABETH	I DEARBORN		In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 11/01/2020	Worksheet B Part II	
					To 12/31/2020	Date/Time Pre	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE C	F NURSI NG	7/28/2021 2:5 CENTRAL	3 pm
				PERSONNEL	ADMI NI STRATI ON	SERVICES &	
		10.00	11.00	12.00	13.00	SUPPLY 14.00	
	GENERAL SERVICE COST CENTERS	1		1			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	8, 557 0	6, 648				10.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0, 040		0		12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	288		0 6, 383		13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0			0	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
17.00	01700 SOCIAL SERVICE	0	165		0 101	0	
18.00 19.00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	1
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0 0	0	
22.00	02200 I & SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	0	0 41		0 0	0	1
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	41		0 0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	4, 200	741		0 1, 368	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	600	494 0		0 1,013	0	
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	)	0 0	0	
40.00	04000 SUBPROVIDER - IPF	0	0		0 0	0	
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0	0			0	
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	
45.00	04500 NURSI NG FACI LI TY	0	0		0 0	0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	1	0 0	0	46.00
50.00	05000 OPERATI NG ROOM	2, 929	1, 195		0 1, 824	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	298 0	350 0	1	0 760 0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	515		0 0	0	1
55.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		0 0	0	
56.00 57.00	05700 CT SCAN	0	123		0 0	0	56.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	82		0 0	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	82		0 101	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	720 0		0 0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	Ŭ	J. J			0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	1
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	0			0	
65.00	06500 RESPI RATORY THERAPY	0	206		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	494		0 0	0	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	62 41	1	0 0	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0	123	1	0 152	0	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	123 0	1	0 0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	268		0 0	0	1
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	
	07500 ASC (NON-DI STI NCT PART)	0	0	1	0 0 0 0	0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0	0	] //.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0 0	0	
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0 530	0 535		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				1,004		92.00
04 00	OTHER REIMBURSABLE COST CENTERS						04.00
	09500 AMBULANCE SERVICES	0	0 0		0 0 0 0	0 0	1
	r	, -1			, -1	-	

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 11/01/2020 To 12/31/2020		pared: 3 pm
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O PERSONNEL	IF NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 557	6, 648		0 6, 383	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00  TOTAL (sum lines 118 through 201)	8, 557	6, 648		0 6, 383	0	202.00

	Financial Systems	ST ELI ZABETH		CN: 15-0086 P	eriod:	u of Form CMS-: Worksheet B	2002-10
ALLOU	ATTON OF CALLIAL RELATED COSTS			F	rom 11/01/2020	Part II	parad
					o 12/31/2020	Date/Time Pre 7/28/2021 2:5	
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CE (SPECI FY)	NONPHYSI CI AN	
			RECORDS &		(	ANESTHETI STS	
		15.00	LIBRARY	17.00	10.00	10.00	
	GENERAL SERVICE COST CENTERS	15.00	16.00	17.00	18.00	19.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00							13.00
14.00							14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	C				15.00 16.00
17.00	01700 SOCIAL SERVICE	0		2,916			17.00
18.00		0	C	0	0		18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	C	0	0	0	
20.00		0	C	0	0		20.00
21.00 22.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	C	-	0		21.00
22.00		0	C	-	-		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1	-				
30.00	03000 ADULTS & PEDIATRICS	0	C		0		30.00
31.00 32.00		0	C	209 0	0		31.00 32.00
32.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0			0		32.00
34.00		0	C	0	0		34.00
40.00	04000 SUBPROVI DER – I PF	0	C	0	0		40.00
41.00	04100 SUBPROVIDER - IRF	0	C	0	0		41.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	C C		0		43.00
45.00	04500 NURSING FACILITY	0	C		0		45.00
46.00		0	C	0	0		46.00
50.00	ANCI LLARY SERVICE COST CENTERS						50.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	C				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	46	0		52.00
53.00	05300 ANESTHESI OLOGY	0	C	65	0		53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	C	226	0		54.00
55.00 56.00		0	C		0		55.00 56.00
57.00		0		259	0		57.00
58.00		0	C	43	0		58.00
59.00		0	C	40			59.00
60.00		0	C	269			60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	Ĺ	0	0		60.01 61.00
62.00		0	C	0	0		62.00
63.00		0	C	0	0		63.00
64.00		0	C	0	0		64.00
65.00		0	C	95 95	0		65.00
66.00 67.00		0		13			66.00 67.00
68.00		0	C	7	0		68.00
69.00		0	C	32	0		69.00
70.00		0	C	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0		9	0		71.00
	07300 DRUGS CHARGED TO PATIENTS	0	C	162	0		73.00
74.00		Ő	C	0	0		74.00
	07500 ASC (NON-DI STI NCT PART)	0	C	0	0		75.00
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	C	0 0	0		77.00
88 00	OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC	0	C	0	0		88.00
89.00		0	C		0		89.00
	09000 CLI NI C	0	C	0	0		90.00
90.00 91.00 92.00	09100 EMERGENCY	0	C	317	0		91.00 92.00

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0086	Period: From 11/01/2020 To 12/31/2020		epared: 53 pm
Cost Center Description	PHARMACY	RECORDS & LI BRARY	SOCI AL SERVI		NONPHYSI CI AN ANESTHETI STS	
	15.00	16.00	17.00	18.00	19.00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0		96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0		98.00
99. 00 09900 CMHC	0	0		0 0		99.00
99. 10 09910 CORF	0	0		0 0		99.10
100.00 10000 I & R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	2, 9	16 0	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	2,9	16 0	0	202.00

_OCA	Financial Systems TION OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	255
					From 11/01/2020 To 12/31/2020	Part II Date/Time Pre	epa
				RESI DENTS		7/28/2021 2:5	
				1			
	Cost Center Description	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHE PRGM COSTS	R PARAMED ED PRGM	Subtotal	
		20.00	21.00	22.00	23.00	24.00	
	GENERAL SERVICE COST CENTERS				1		4.
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						
00	00400 EMPLOYEE BENEFITS DEPARTMENT						
00	00500 ADMINI STRATI VE & GENERAL						
00	00600 MAI NTENANCE & REPAI RS						
00	00700 OPERATION OF PLANT						
00 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						
00	01000 DI ETARY						1
00	01100 CAFETERI A						1
00	01200 MAINTENANCE OF PERSONNEL						1
00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						1
00	01500 PHARMACY						1
00	01600 MEDI CAL RECORDS & LI BRARY						1
00	01700 SOCIAL SERVICE						1
00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS						1
00	02000 NURSING SCHOOL	0					2
00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		C				2
00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD				0		2
00	02300 PARAMED ED PRGM-(SPECIFY)				896		2
00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS					93, 731	3
00	03100 I NTENSI VE CARE UNI T					20, 224	
00	03200 CORONARY CARE UNI T					0	) 3
00	03300 BURN INTENSIVE CARE UNIT					0	
00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF					0	
00	04100 SUBPROVIDER - IRF					0	
00	04300 NURSERY					436	
00	04400 SKILLED NURSING FACILITY					0	
00	04500 NURSING FACILITY					0	
00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS					0	4
00	05000 OPERATI NG ROOM					85, 163	3 5
00	05100 RECOVERY ROOM					0	
00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY					22, 634	
00	05400 RADI OLOGY - DI AGNOSTI C					2, 111 44, 447	
	05500 RADI OLOGY-THERAPEUTI C					0	
00	05600 RADI OI SOTOPE					0	
00	05700 CT SCAN					2, 390	
00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION					2, 373 3, 089	
00	06000 LABORATORY					29, 674	
01	06001 BLOOD LABORATORY					0	
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						6
00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					0	
00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY					0	
00	06500 RESPIRATORY THERAPY					3, 745	
00	06600 PHYSI CAL THERAPY					28, 914	1 6
00	06700 OCCUPATIONAL THERAPY					2, 034	
00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY					1, 164	
00	07000 ELECTROCARDI OLOGY					7, 626 3	
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					23, 098	
00	07200 IMPL. DEV. CHARGED TO PATIENTS					4, 365	5 7
	07300 DRUGS CHARGED TO PATIENTS					9, 623	
	07400 RENAL DIALYSIS					0	
00	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC STEM CELL ACQUISITION					0	
00	OUTPATIENT SERVICE COST CENTERS		1	1		0	4 1
00	08800 RURAL HEALTH CLINIC					0	
00	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
00						0 25 484	·   ·
00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)					25, 484	1 9 9
00							

Health Financial Systems	ST ELI ZABETH	I DEARBORN		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 11/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 7/28/2021 2:53 pm
		INTERNS &	RESI DENTS		772072021 2.35 pm
Cost Center Description	NURSING SCHOOL	SERVI CES-SALAR		ER PARAMED ED	Subtotal
		Y & FRINGES	PRGM COSTS	PRGM	
	20.00	21.00	22.00	23.00	24.00
95. 00 09500 AMBULANCE SERVI CES					0 95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED					0 96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD					0 97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS					0 98.00
99.00 09900 CMHC					0 99.00
99. 10 09910 CORF					0 99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM					0 100.00
101.00 10100 HOME HEALTH AGENCY					0 101.00
SPECIAL PURPOSE COST CENTERS			1		
105.00 10500 KIDNEY ACQUISITION					0 105.00
106. 00 10600 HEART ACQUI SI TI ON					0 106.00
107.00 10700 LIVER ACQUISITION					0 107.00
108.00 10800 LUNG ACQUISITION					0 108.00
109.00 10900 PANCREAS ACQUISITION					0 109.00
110.00 11000 INTESTINAL ACQUISITION					0 110.00
111.00 11100 I SLET ACQUI SI TI ON					0 111.00
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTILIZATION REVIEW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)					0 115.00
116. 00 11600 HOSPI CE					0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 0	412, 328 118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					0 190.00
191. 00 19100 RESEARCH					0 191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES					111 192.00
193. 00 19300 NONPALD WORKERS					0 193.00
200.00 Cross Foot Adjustments	0	0		0 896	896 200. 00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	0	0		0 896	413, 335 202. 00

LLOCAT	inancial Systems ION OF CAPITAL RELATED COSTS	ST ELI ZABETH	Provider CCN: 15-	From 11/01/2020 Part II To 12/31/2020 Date/Time	B Prepare
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total	7/28/2021 .	<u>2:53 pm</u>
		Adjustments			
C		25.00	26.00		_
	ENERAL SERVICE COST CENTERS				1.
	0200 CAP REL COSTS-MVBLE EQUIP				2.
	00400 EMPLOYEE BENEFITS DEPARTMENT				4.
	00500 ADMINI STRATI VE & GENERAL				5.
	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT				6. 7.
	0800 LAUNDRY & LINEN SERVICE				8.
	00900 HOUSEKEEPI NG				9.
	1000 DI ETARY				10.
					11.
	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON				12.
	1400 CENTRAL SERVICES & SUPPLY				14.
5.00 0	1500 PHARMACY				15.
	1600 MEDICAL RECORDS & LIBRARY				16.
1	1700 SOCIAL SERVICE				17.
	1850 OTHER GENERAL SERVICE (SPECIFY) 1900 NONPHYSICIAN ANESTHETISTS				18. 19.
	2000 NURSI NG SCHOOL				20.
1. 00 0	2100 I&R SERVICES-SALARY & FRINGES APPRVD				21.
1	2200 I &R SERVICES-OTHER PRGM COSTS APPRVD				22.
	2300 PARAMED ED PRGM-(SPECIFY)				23.
	NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	93, 731		30.
	3100 I NTENSI VE CARE UNI T	0	20, 224		31.
	3200 CORONARY CARE UNI T	0	0		32.
1	3300 BURN INTENSIVE CARE UNIT	0	0		33.
	)3400 SURGI CAL INTENSI VE CARE UNI T )4000 SUBPROVI DER – I PF	0	0		34. 40.
	4100 SUBPROVIDER - IRF	0	0		41.
3.00 0	04300 NURSERY	0	436		43.
	04400 SKILLED NURSING FACILITY	0	0		44.
	)4500 NURSING FACILITY )4600 OTHER LONG TERM CARE	0	0		45. 46.
-	NCI LLARY SERVICE COST CENTERS	<u> </u>			- 10.
	5000 OPERATI NG ROOM	0	85, 163		50.
	DELLAYERY ROOM	0	0		51.
	15200 DELIVERY ROOM & LABOR ROOM 15300 ANESTHESI OLOGY	0	22, 634 2, 111		52. 53.
	05400 RADI OLOGY-DI AGNOSTI C	0	44, 447		54.
	5500 RADI OLOGY-THERAPEUTI C	0	0		55.
	05600 RADI OI SOTOPE	0	0		56.
	15700 CT SCAN 15800 MAGNETIC RESONANCE IMAGING (MRI)	0	2, 390 2, 373		57. 58.
	05900 CARDI AC CATHETERI ZATI ON	0	3, 089		59.
	6000 LABORATORY	0	29, 674		60.
	6001 BLOOD LABORATORY	0	0		60.
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		61.
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		62. 63.
	6400 I NTRAVENOUS THERAPY	0	0		64.
5.00 0	06500 RESPI RATORY THERAPY	0	3, 745		65.
	06600 PHYSI CAL THERAPY	0	28, 914		66.
		0	2,034		67. 68.
	16800  SPEECH PATHOLOGY 16900  ELECTROCARDI OLOGY	0	1, 164 7, 626		69.
	07000 ELECTROENCEPHALOGRAPHY	0	3		70.
I. OO   O	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23, 098		71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 365		72.
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	9, 623 0		73.
	07500 ASC (NON-DI STINCT PART)	0	0		74.
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.
_	UTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0	0		88.
	18900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 90.
	09100 EMERGENCY	0	25, 484		90.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.

Health Financial Systems	ST ELIZABETH I	DEARBORN	Inlie	J of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0086	Period: From 11/01/2020	Worksheet B Part II Date/Time Prepared: 7/28/2021 2:53 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	25.00	26.00		
OTHER REIMBURSABLE COST CENTERS	TT	1		
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
99.00 09900 CMHC	0	0		99.00
99. 10 09910 CORF	0	0		99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		101.00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		106.00
107.00 10700 LIVER ACQUISITION	0	0		107.00
108.00 10800 LUNG ACQUISITION	0	0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111.00
113.00 11300 INTEREST EXPENSE				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116. 00 11600 HOSPI CE	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	412, 328		118.00
NONREI MBURSABLE COST CENTERS	1 1	1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191. 00 19100 RESEARCH	0	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	111		192.00
193.00 19300 NONPALD WORKERS	0	0		193.00
200.00 Cross Foot Adjustments	0	896		200.00
201.00 Negative Cost Centers	0	0		201.00
202.00   TOTAL (sum lines 118 through 201)	0	413, 335		202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	ST ELI ZABET	H DEARBORN Provider C		Period:	u of Form CMS-: Worksheet B-1	
					rom 11/01/2020 o 12/31/2020		
		CAPITAL RE	LATED COSTS			7/28/2021 2:5	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	305, 022	1	1			1.00
2.00 4.00 5.00 6.00 7.00 8.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 46, 436 97, 555 36 1, 592	97, 555 36	4, 196, 452 225, 790 96, 492 37, 627	-3, 249, 021 0 0	8, 970, 326 438, 180 58, 110 62, 326	6.00 7.00
9.00 10.00 11.00 12.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	1, 178 4, 000 2, 837 0	1, 178 4, 000 2, 837 0	8 172, 167 46, 222 68, 916		240, 887 43, 617 114, 253 0	9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	2, 295 0 0 0 0 1, 009			0 0 0 0	210, 940 0 0 88, 157	14.00 15.00 16.00
18.00 19.00 20.00 21.00 22.00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD					0 0 0 0 0	19.00 20.00 21.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	293	293	30, 278	0	38, 825	23.00
30. 00 31. 00 32. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	39, 846 7, 400 0	7, 400	277, 268	0	570, 692 371, 423 0	31.00
33.00 34.00 40.00	03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF					0 0 0	33.00 34.00 40.00
41.00 43.00 44.00 45.00	04100 SUBPROVI DER – I RF 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY			0 C 49, 042 0 C	2 O O O	0 67, 148 0 0	43.00 44.00
46.00	04600 OTHER LONG TERM CARE	0	-			0	
50.00	ANCILLARY SERVICE COST CENTERS	35, 211	35, 211	613, 814	0	826, 646	50.00
		9, 832 0 14, 559	0 9, 832 0	C 96, 457 C	0 0 0 0	0	51.00 52.00 53.00
55.00 56.00 57.00 58.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI)			0 C C 156, 490	0 0 0 0 0 0	0 0 309, 217	55.00 56.00 57.00
59.00 60.00 60.01 61.00	05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	803 1, 155 6, 720 0	1, 155	56, 682	2 O 0	91, 607 72, 175 878, 095 0	59.00 60.00 60.01 61.00
62.00 63.00 64.00 65.00 66.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 0 0 1, 164 7, 564				0 0 161, 305 354, 646	63.00 64.00 65.00
67.00 68.00 69.00 70.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	794 424 3, 261 0	794 424 3, 261 0	37, 992 30, 938 67, 745 438	2 0 0 0 5 0 8 0	48, 534 37, 491 90, 252 485	67.00 68.00 69.00 70.00
71.00 72.00 73.00 74.00 75.00 77.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC STEM CELL ACQUISITION	7, 891 0 1, 483 0 0 0	0 1, 483 0 0 0	0 C 183, 271 0 C 0 C		1, 026, 949 672, 292 945, 408 0 0	72.00 73.00 74.00 75.00
88.00 89.00 90.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC					000000000000000000000000000000000000000	88.00 89.00 90.00
91.00	09100 EMERGENCY	9, 684	9, 684	276, 802	0	351, 757	91.00

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-0086	Period:	Worksheet B-1	
				From 11/01/2020		
				To 12/31/2020	Date/Time Pre 7/28/2021 2:5	
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
cost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	Reconciliation	& GENERAL	
	(0000/11/2 1 221)	(000/11/2 1 221)	DEPARTMENT		(ACCUM. COST)	
			(GROSS		(//000000.00001)	
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVI CES	0	0		0 0	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
99. 00 09900 CMHC	0	0		0 0	0	
99. 10 09910 CORF	0	0		0 0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.0010100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	-	107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0		0	0	114.00 115.00
116. 00 11600 H0SPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	305, 022	305, 022	4, 196, 45	-3, 249, 021	8, 969, 554	•
NONREI MBURSABLE COST CENTERS	303, 022	303, 022	4, 170, 40	-5, 247, 021	0, 707, 334	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
200.00 Cross Foot Adjustments	_	-		-	-	200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	128, 392	254, 174	107, 01	3	3, 249, 021	•
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 420927	0. 833297	0. 02550	)1	0. 362197	
204.00 Cost to be allocated (per Wkst. B,				0	58, 241	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0.00000	00	0. 006493	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						200.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						
	· · ·	1		1	1	1

	Financial Systems	ST ELI ZABETI				u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 11/01/2020	Worksheet B-1	
		1		T	o 12/31/2020	Date/Time Pre 7/28/2021 2:5	
	Cost Center Description	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)			
		6.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	161, 031					5.00 6.00
7.00	00700 OPERATION OF PLANT	36	160, 995				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 592	1, 592				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 178	1, 178 4, 000		158, 225 4, 000	5, 591	9.00 10.00
11.00	01100 CAFETERI A	2, 837	2, 837			0	11.00
	01200 MAINTENANCE OF PERSONNEL	0	0	-	0	0	12.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	2, 295	2, 295 0		2, 295 0	0	13.00 14.00
15.00	01500 PHARMACY	0	0		0	0	15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0 1, 009	-	0 1, 009	0	16.00 17.00
	01850 OTHER GENERAL SERVICE (SPECIFY)	1,009	1,009	0	1,009	0	17.00
	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD	0		0	0	0	21.00 22.00
	02300 PARAMED ED PRGM-(SPECIFY)	293	293		293	0	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20.04/	20.04/	100.001	20.04/	0.744	20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	39, 846 7, 400	39, 846 7, 400		39, 846 7, 400	2, 744 392	30.00
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	32.00
	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0		0	0	0	34.00 40.00
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
	04300 NURSERY	0	0	0	0	0	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44.00
	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
F0.00		25 211	25 211	27 742	25 211	1 014	
	05000 OPERATING ROOM 05100 RECOVERY ROOM	35, 211	35, 211 0	37, 742 0	35, 211 0	1, 914 0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 832	9, 832	0	9, 832	195	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 14, 559	0 14, 559	0 26, 903	0 14, 559	0	53.00 54.00
	05500 RADI OLOGY-THERAPEUTI C	14, 559	14, 559	20, 903	14, 559	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	803	0 803		0 803	0	57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	1, 155				0	59.00
60.00	06000 LABORATORY	6, 720	6, 720			0	60.00
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60.01 61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	о	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	-	0	0	64.00 65.00
	06600 PHYSI CAL THERAPY	1, 164	1, 164 7, 564		1, 164 7, 564	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	794	794	768	794	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	424 3, 261	424 3, 261		424 3, 261	0	68.00 69.00
	07000 ELECTROENCEPHALOGRAPHY	3, 261	3, 261	1, 465 0	3, 201	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 891	7, 891	4, 262	7, 891	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	1 402	0	0	0	72.00
	07300 DRUGS CHARGED TO PATTENTS 07400 RENAL DIALYSIS	1,483	1, 483 0	0	1, 483 0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75.00
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0	0	0	0	77.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	o	0	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0	0	0	89.00
		0	0	0	0	0	90.00
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	9, 684	9, 684	70, 797	9, 684	346	91.00 92.00
00	OTHER REIMBURSABLE COST CENTERS	1	L		ıI		1
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0		94.00

Health Financial Systems	ST ELI ZABETI	H DEARBORN		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 11/01/2020 To 12/31/2020		narod
				10 12/31/2020	7/28/2021 2:5	
Cost Center Description	MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT		E (SQUARE FEET)	(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
	( 00	7.00	LAUNDRY) 8.00	9.00	10.00	
95. 00 09500 AMBULANCE SERVI CES	6.00	7.00		9.00	10.00	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
99. 00 09900 CMHC	0	0		0 0	0	
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	_			_		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0 0		115.00
116.00 11600 HOSPI CE	0	, °		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	161, 031	160, 995	309, 34	1 158, 225	5, 591	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
190.0019000 GFFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
191.00 19100 RESEARCH 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	9, 28	0		191.00
193. 00 19300 NONPALD WORKERS	0	0	7,20	2 0		193.00
200.00 Cross Foot Adjustments	0			0	0	200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	596, 887	79, 290	91, 58	5 333, 082	85 538	202.00
Part I)	0,0,00,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,	000,002	00,000	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	3. 706659	0. 492500	0. 28744	0 2.105116	15. 299231	203.00
204.00 Cost to be allocated (per Wkst. B,	125, 201	450	3, 64	4 3, 961	8, 557	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 777496	0. 002795	0. 01143	7 0. 025034	1. 530495	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						007.05
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)	I	I	I	1	I	I

	Financial Systems	ST ELI ZABETH				eu of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provider (	CCN: 15-0086	Period: From 11/01/2020 To 12/31/2020		
	Cost Center Description	CAFETERI A (FTES)	MAINTENANCE OF PERSONNEL	NURSING	CENTRAL DN SERVICES &	7/28/2021 2:5 PHARMACY (COSTED	53 pm
			(NUMBER HOUSED)	(NURSING FTE	SUPPLY S) (COSTED REQUIS.)	REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 CAP REL COSTS-BEDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	323					11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	(	-			12.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	14 0	(		26 0 0		13.00 14.00
15.00	01500 PHARMACY	0	(		0 0	0	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0	(		0 0	C	
17.00	01700 SOCIAL SERVICE	8	(	D	2 0	0	
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	(		0 0	0	
19.00 20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	(		0 0		
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	(		0 0		
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	(	D	0 0	0	1
23.00		2	(	0	0 0		23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	24					20.00
30.00 31.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	36 24			27 0 20 0		1
32.00		0	(		0 0		1
33.00	03300 BURN INTENSIVE CARE UNIT	0	(	D	0 0	0	33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	(	D	0 0	(	
40.00	04000 SUBPROVIDER - IPF	0	(				1
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	0	(				
44.00	04400 SKILLED NURSING FACILITY	0	(		0 0	0	1
45.00	04500 NURSING FACILITY	0	(		0 0	0	1
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	(	<u>ן</u>	0 0	(	46.00
50.00	05000 OPERATING ROOM	58	(		36 0	0	50, 00
51.00	05100 RECOVERY ROOM	0	(		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	17	(		15 0	0	
53.00	05300 ANESTHESI OLOGY	0	(	D	0 0	(	
54.00 55.00		25	(				) 54.00 ) 55.00
	05600 RADI OLOGI PITILIKALEUTTE	0	(		0 0		
	05700 CT SCAN	6	(	D	0 0	0	
	05800 MAGNETIC RESONANCE I MAGING (MRI)	4	(	D	0 0	0	
59.00		4 35	(	2	2 0		
60. 00 60. 01	06001 BLOOD LABORATORY	0	(				
61.00		, , , , , , , , , , , , , , , , , , ,	·				61.00
62.00		0	(	D	0 0	0	
63.00		0	(		0 0	(	
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	10	(				
	06600 PHYSI CAL THERAPY	24	(		0 0		
	06700 OCCUPATI ONAL THERAPY	3	(	D I	0 0	0	
	06800 SPEECH PATHOLOGY	2	(		0 0	(	
		6	(		3 0		
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(				
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(		0 0		1
73.00	07300 DRUGS CHARGED TO PATIENTS	13	(	D	0 0	(	73.00
	07400 RENAL DI ALYSI S	0	(	2 2	0 0	(	
	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC STEM CELL ACQUISITION	0	(	-			
77.00	OUTPATIENT SERVICE COST CENTERS			기	<u> </u>	<u> </u>	, ,,
88.00	08800 RURAL HEALTH CLINIC	0	(	2	0 0	0	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	(	כ	0 0	0	
		0	(				
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	26	(	ار	21 0	(	91.00
00		· ·			I	I	1 00

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-0086	Peri od:	Worksheet B-1	
				From 11/01/2020		
				To 12/31/2020	Date/Time Pre	
Cost Conton Deceription	CAFETERIA M	AINTENANCE OF	NURSI NG	CENTRAL	7/28/2021 2:5 PHARMACY	<u>3 pm</u>
Cost Center Description	(FTES)		ADMI NI STRATI O		(COSTED	
	(1123)	(NUMBER		SUPPLY	REQUIS.)	
			(NURSING FTES		KLQ013.)	
		HOUSED)		REQUIS.)		
	11.00	12.00	13.00	14.00	15.00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD	0	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	o	o		0 0	0	98.00
99. 00 09900 CMHC	o	o		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	
100.00 10000 I & SERVICES-NOT APPRVD PRGM	0	ō		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	· · · · · ·					
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	o	o		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	o	o		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	o	o		0 0	0	109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE	-	-		-	-	113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0		0 0	0	115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	323	0	12	6 0		118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	175, 091	0	309, 39	9 0	0	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	542.077399	0. 000000	2, 455. 54761	9 0. 000000	0.00000	203.00
204.00 Cost to be allocated (per Wkst. B,	6, 648	0	6, 38	3 0	0	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	20. 582043	0. 000000	50. 65873	0 0. 000000	0. 000000	205.00
1)						
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)	I I	I				I

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	ST ELI ZABETI	H DEARBORN Provider CO		Period:	eu of Form CMS-25 Worksheet B-1	52-10
				From 11/01/2020 To 12/31/2020		
Cost Center Description	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 16. 00	SOCI AL SERVI CE (TI ME SPENT) 17.00	OTHER GENERAL SERVI CE (SPECI FY) (TI ME SPENT) 18.00	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME) 19.00	NURSI NG SCHOOL (ASSI GNED TI ME) 20.00	<u>pm</u>
GENERAL SERVICE COST CENTERS						
1.00       00100       CAP REL COSTS-BLDG & FIXT         2.00       00200       CAP REL COSTS-MVBLE EQUIP         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.00       00500       ADMI NI STRATI VE & GENERAL         6.00       00600       MAI NTENANCE & REPAIRS         7.00       00700       OPERATI ON OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVICE         9.00       00900       HOUSEKEEPI NG         10.00       01000       DI ETARY         11.00       CAFETERIA         12.00       01200         MAI NTENANCE OF PERSONNEL         13.00       01300         NURSI NG ADMI NI STRATI ON         14.00       01400         CENTRAL SERVICES & SUPPLY         15.00       01500         PHARMACY         16.00       01600         MEDI CAL RECORDS & LI BRARY         17.00       001300         01700       SOCI AL SERVICE         18.00       01850	000000000000000000000000000000000000000	2, 931 0			1 1 1 1 1 1 1 1 1	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
19.00       01900       NONPHYSICIAN ANESTHETISTS         20.00       02000       NURSING SCHOOL         21.00       02100       I&R SERVICES-SALARY & FRINGES APPRVD         22.00       02200       I&R SERVICES-OTHER PRGM COSTS APPRVD         23.00       02300       PARAMED ED PRGM-(SPECIFY)         23.00       CONTENT FOR COST CONTENT	0 0 0 0	0 0 0 0	(		0 2	19.00 20.00 21.00 22.00 23.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         INTENSI VE CARE UNI T           32. 00         03200         CORONARY CARE UNI T           33. 00         03000         BURN I NTENSI VE CARE UNI T           34. 00         03400         SURGI CAL I NTENSI VE CARE UNI T           40. 00         04000         SUBPROVI DER - I PF           41. 00         04100         SUBPROVI DER - I RF           43. 00         04300         NURSERY           44. 00         04400         SKI LLED NURSI NG FACI LI TY           45. 00         04500         NURSI NG FACI LI TY           45. 00         04600         OTHER LONG TERM CARE           ANCI LI ARY SERVI CE COST CENTERS         ANCI LI ARY SERVI CE		210 0 0 0 0 0 0 0 0 0 0 0 0 0			0 3 0 3 0 3 0 4 0 4 0 4 0 4 0 4 0 4	30. 00         31. 00         32. 00         33. 00         34. 00         40. 00         41. 00         43. 00         44. 00         45. 00         46. 00
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM           51.00         05100         RECOVERY ROOM           52.00         0ELI VERY ROOM & LABOR ROOM           53.00         05300         ANESTHESI OLOGY           54.00         05400         RADI OLOGY-DI AGNOSTI C           55.00         05500         RADI OLOGY-THERAPEUTI C           56.00         05600         RADI OLOGY-THERAPEUTI C           56.00         05600         RADI OLOGY-THERAPEUTI C           57.00         05700         CT SCAN           58.00         05800         MAGNETI C           59.00         05900         CARDI AC CATHETERI ZATI ON           60.01         06001         BLOOD LABORATORY           60.01         06001         BLOOD LABORATORY           61.00         06100         PBP CLI NI CAL LAB SERVI CES-PRGM ONLY           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS           63.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.           64.00         06400         INTRAVENOUS THERAPY           65.00         06500         RESPI RATORY THERAPY           66.00         06600         SPEECH PATHOLOGY           6		0 46 65 227 0 260 43 40 270 0 260 43 40 270 0 0 0 0 0 0 95 58 13 7 7 32 0 9 9 0 163 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50. 00 51. 00 52. 00 53. 00 55. 00 55. 00 55. 00 55. 00 57. 00 59. 00 60. 01 61. 00 62. 00 64. 00 64. 00 65. 00 66. 00 66. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 74. 00 75. 00 75. 00 74. 00 75. 00 75. 00 73. 00 74. 00 75. 00
89.00         08900         FEDERALLY         QUALIFIED         HEALTH         CENTER           90.00         09000         CLINIC         91.00         09100         EMERGENCY           92.00         09200         OBSERVATION         BEDS         (NON-DISTINCT         PART)	000000000000000000000000000000000000000	0 0 319			0 9	89.00 90.00 91.00 92.00

Health Fir	nancial Systems	ST ELI ZABETI	H DEARBORN		In Lie	u of Form CMS-2552-
COST ALLO	CATION - STATISTICAL BASIS		Provider C		eriod:	Worksheet B-1
					rom 11/01/2020	
					0 12/31/2020	Date/Time Prepared
				OTHER GENERAL		7/28/2021 2:53 pm
				SERVI CE		
	Cast Cantar Description	MEDI CAL	SOCI AL SERVI CE			NURSING SCHOOL
	Cost Center Description		SUCIAL SERVICE			NURSING SCHOOL
		RECORDS &		(TIME SPENT)	ANESTHETI STS	
			(TIME SPENT)		(ASSI GNED	(ASSI GNED
		(TIME SPENT) 16.00	17.00	18.00	TIME) 19.00	TI ME) 20. 00
OTL	HER REIMBURSABLE COST CENTERS	10.00	17.00	16.00	19.00	20.00
	400 HOME PROGRAM DI ALYSI S	0	0	C	0	0 94.
	500 AMBULANCE SERVICES				-	0 94.
		0		-	-	
	500 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0 96.
	700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0 97.
	350 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.
	POO CMHC	0	0	C	0	0 99.
99.10 099		0	0	C	0	0 99.
	DOO I&R SERVICES-NOT APPRVD PRGM	0	0			0 100.
	100 HOME HEALTH AGENCY	0	0	C	0	0 101.
	ECIAL PURPOSE COST CENTERS	i				
	500 KIDNEY ACQUISITION	0	0	C	0	0 105.
106.00 106	500 HEART ACQUISITION	0	0	C	0	0 106.
107.00107	700 LIVER ACQUISITION	0	0	C	0	0 107.
108.00 108	BOO LUNG ACQUISITION	0	0	C	0	0 108.
109.00109	POO PANCREAS ACQUISITION	0	0	l c	0	0 109.
110.00 110	DOO INTESTINAL ACQUISITION	0	0	l c	0	0 110.
111.00111	100 I SLET ACQUISITION	0	l o	l c	0	0 111.
113.00113	300 INTEREST EXPENSE					113.
	400 UTI LI ZATI ON REVIEW-SNF					114.
	500 AMBULATORY SURGICAL CENTER (D. P. )	0	0	0	0	0115.
	500 HOSPI CE	0			0	0 116.
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 931			0118.
	REIMBURSABLE COST CENTERS	0	2,731		0	0 110.
	DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0 190.
	100 RESEARCH	0				0 191.
	200 PHYSI CLANS' PRI VATE OFFI CES	0			0	0 192.
	300 NONPAID WORKERS	0			0	0 193.
		0	0		0	
200.00	Cross Foot Adjustments					200.
201.00	Negative Cost Centers		105 101			201.
202.00	Cost to be allocated (per Wkst. B,	0	135, 696	C	0	0 202.
	Part I)	0 00000	44 0045		0 0000	0.000000
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000				0. 000000 203.
204.00	Cost to be allocated (per Wkst. B,	0	2, 916	C	0	0 204.
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 994882	0.000000	0. 000000	0. 000000 205.
	11)					
206.00	NAHE adjustment amount to be allocated					0 206.
	(per Wkst. B-2)					
		1	1	1	1	0.000000 207.
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.0000001207.

	Financial Systems LLOCATION - STATISTICAL BASIS	ST ELI ZABETH	I DEARBORN Provider CC	`N 15_0086	In Lie Period:	u of Form CMS-2 Worksheet B-1	
00017					From 11/01/2020 To 12/31/2020		
		INTERNS &	RESIDENTS			7/28/2021 2:5	
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED			
		Y & FRI NGES (ASSI GNED TI ME) 21. 00	PRGM COSTS (ASSI GNED TIME) 22.00	PRGM (ASSI GNED TI ME) 23.00	_		
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01850 OTHER GENERAL SERVI CE (SPECI FY) 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0					$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		0	10	0		22.00
23. 00 30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 46. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS			10			23.00 30.00 31.00 32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00 46.00
50.00	05000 OPERATI NG ROOM	0	0		0		50.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ \end{array}$	05000 0FLNATING VOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM 05200 DELIVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI ) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06000 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 IMPL. DEV. CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C			10	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		51.00         52.00         53.00         54.00         55.00         56.00         57.00         58.00         59.00         60.01         61.00         62.00         63.00         64.00         65.00         66.00         67.00         68.00         70.00         71.00         72.00         73.00         74.00         75.00         88.00
89.00 90.00 91.00	08800 RORAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0 0 0		0 0 0		88.00 89.00 90.00 91.00 92.00

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-2552-1
COST ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-0086	Peri od:	Worksheet B-1
				From 11/01/2020 To 12/31/2020	
	INTERNS & R	RESIDENTS			172072021 2.05 pm
Cost Center Description	SERVI CES-SALARS				
	Y & FRINGES	PRGM COSTS	PRGM		
	(ASSI GNED	(ASSI GNED	(ASSI GNED		
	TIME) 21.00	TIME) 22.00	TIME) 23.00		
OTHER REIMBURSABLE COST CENTERS	21.00	22.00	23.00		
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0	94.0
95. 00 09500 AMBULANCE SERVICES	0	0		0	95.0
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	96.0
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	97.0
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	98.0
99. 00 09900 CMHC	0	0		0	99.0
99. 10 09910 CORF	0	0		0	99.1
100.0010000 I &R SERVICES-NOT APPRVD PRGM	0	0		0	100. 0
101. 00 10100 HOME HEALTH AGENCY	0	0		0	101. 0
SPECIAL PURPOSE COST CENTERS					101.05
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0	105. 0
106. 00 10600 HEART ACQUI SI TI ON	0	0		0	106.0
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0	107. 0
108.00 10800 LUNG ACQUI SI TI ON	0	0		0	108.0
109. 00 10900 PANCREAS ACQUISITION	0	0		0	109.0
110.00 11000 INTESTINAL ACQUISITION	0	0		0	110. 0
111.00 11100 I SLET ACQUI SI TI ON	0	0		0	111.0
113.00 11300 INTEREST EXPENSE					113.0
114.00 11400 UTI LI ZATI ON REVIEW-SNF					114.0
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	115.0
116. 00 11600 HOSPI CE				0	116. 0
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1	00	118.0
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190. 0
191. 00 19100 RESEARCH	0	0		0	191. 0
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192. 0
193.00 19300 NONPALD WORKERS	0	0		0	193. 0
200.00 Cross Foot Adjustments					200. 0
201.00 Negative Cost Centers					201.0
202.00 Cost to be allocated (per Wkst. B,	0	0	55, 8	18	202. 0
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)		0. 000000			203. 0
204.00 Cost to be allocated (per Wkst. B, Part II)	0	0	8	96	204. 0
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	8. 9600	00	205. 0
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206. 0
207.00 NAHE unit cost multiplier (Wkst. D,			0.0000	00	207. 0
Parts III and IV)	I I				

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	ST ELI ZABETI	H DEARBORN Provider C	F	In Lie Period: From 11/01/2020 To 12/31/2020	u of Form CMS-2 Worksheet C Part I Date/Time Pre 7/28/2021 2:5	pared:
			Title	× XVIII	Hospi tal	PPS	5 piii
					Costs	•	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	1, 201, 350		1, 201, 350		1, 201, 350	
	03100 I NTENSI VE CARE UNI T	636, 880		636, 880		636, 880	31.00
	03200 CORONARY CARE UNIT	0			0	0	32.00
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0				0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF					0	40.00
	04100 SUBPROVIDER - IRF	0				0	40.00
	04300 NURSERY	91, 469		91, 469	-	91, 469	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0		(		0	44.00
45.00	04500 NURSING FACILITY	0		0	0 0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0		(	0 0	0	46.00
	ANCI LLARY SERVI CE COST CENTERS	1	1				
	05000 OPERATING ROOM	1, 549, 954		1, 549, 954		1, 549, 954	50.00
	05100 RECOVERY ROOM	209 460		209.460		0 209 460	51.00
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	308, 469 432, 175		308, 469 432, 175		308, 469 432, 175	52.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C	586, 307		586, 307		586, 307	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		(		0	55.00
56.00	05600 RADI OI SOTOPE	0		0	0 0	0	56.00
57.00	05700 CT SCAN	436, 503		436, 503	3 0	436, 503	57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	134,007		134, 007		134, 007	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	114, 997		114, 997		114, 997	59.00
		1, 269, 996		1, 269, 996	_	1, 296, 771	60.00
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0				0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0				0	62.00
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0			0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0			0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	236, 886	C	236, 886	6 0	236, 886	65.00
66.00	06600 PHYSI CAL THERAPY	548, 020		548, 020		548, 020	
67.00	06700 OCCUPATIONAL THERAPY	73, 567		73, 56		73, 567	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	55, 152 156, 020		55, 152 156, 020		55, 152 156, 020	68.00 69.00
	07000 ELECTROENCEPHALOGRAPHY	661		66		661	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 453, 543		1, 453, 543	, v	1, 453, 543	
	07200 IMPL. DEV. CHARGED TO PATIENTS	915, 794		915, 794		915, 794	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 367, 592		1, 367, 592	2 0	1, 367, 592	73.00
	07400 RENAL DI ALYSI S	0		0		0	74.00
	07500 ASC (NON-DI STI NCT PART)	0		(	, v	0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0		(	0 0	0	77.00
88.00	08800 RURAL HEALTH CLINIC	0				0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89.00
90.00	09000 CLINIC	0			0 0	0	90.00
	09100 EMERGENCY	646, 285		646, 285		646, 285	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	139, 796		139, 796		139, 796	92.00
01 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0			ol ol	0	94.00
	09500 AMBULANCE SERVICES					0	94.00 95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0				0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0 0	0	98.00
	09900 CMHC	0				0	99.00
	09910 CORF	0		(	2	0	99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0					100.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	1	(		0	101.00
105.00	10500 KIDNEY ACQUISITION	0				0	105.00
	10600 HEART ACQUI SI TI ON	0		0		0	106.00
107.00	10700 LIVER ACQUISITION	0		(		0	107.00
	10800 LUNG ACQUI SI TI ON	0		(			108.00
	10900 PANCREAS ACQUI SI TI ON	0					109.00
	11000 INTESTINAL ACQUISITION						110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0				0	111.00 113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P. )	0		(		0	115.00
	11600 HOSPI CE	0					116. 00
200.00	Subtotal (see instructions)	12, 355, 423	0	12, 355, 423	3 26, 775	12, 382, 198	200. 00

Health Fina	ancial Systems	ST ELI ZABETH	H DEARBORN		In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider C	Provider CCN: 15-0086		Worksheet C Part I Date/Time Pre 7/28/2021 2:5	pared: 3 pm	
			Title	XVIII	Hospi tal	PPS		
					Costs			
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
201.00	Less Observation Beds	139, 796		139, 79	96	139, 796	201.00	
202.00	Total (see instructions)	12, 215, 627	0	12, 215, 62	26, 775	12, 242, 402	202.00	

	Financial Systems	ST ELI ZABETH				u of Form CMS-	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	F	eriod: rom 11/01/2020 o 12/31/2020	Worksheet C Part I Date/Time Pre	pared:
			Title	e XVIII	Hospi tal	7/28/2021 2:5 PPS	3 pm
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.04/ (52)		1.04/ (52			1 20 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 946, 653 2, 840, 058		1, 946, 653 2, 840, 058			30.00 31.00
	03200 CORONARY CARE UNIT	2, 840, 038		2, 840, 038			32.00
	03300 BURN INTENSIVE CARE UNIT	0					33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0		0			34.00
	04000 SUBPROVI DER – I PF	0		0			40.00
	04100 SUBPROVIDER - IRF	0		0			41.00
	04300 NURSERY	150, 694		150, 694			43.00
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0					44.00 45.00
	04600 OTHER LONG TERM CARE	0					45.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 242, 519	6, 423, 101	9, 665, 620	0. 160357	0. 000000	50.00
	05100 RECOVERY ROOM	0	0			0.00000	1
	05200 DELIVERY ROOM & LABOR ROOM	287, 239	21, 461			0.000000	1
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	199, 012 682, 770	694, 402 2, 389, 849			0. 000000 0. 000000	1
	05500 RADI OLOGY-THERAPEUTI C	082,770	2, 307, 047	-		0. 000000	1
	05600 RADI OI SOTOPE	0	Ő			0. 000000	
	05700 CT SCAN	881, 485	2, 714, 037	3, 595, 522		0. 000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	51, 899	531, 323			0. 000000	1
	05900 CARDI AC CATHETERI ZATI ON	215, 738	260, 448			0.00000	1
		1, 682, 521	2, 049, 378			0.00000	1
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0. 000000 0. 000000	0. 000000 0. 000000	1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0. 000000	0. 000000	1
	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0		0. 000000	1
	06400 I NTRAVENOUS THERAPY	0	C	0		0.000000	
	06500 RESPI RATORY THERAPY	540, 236	200, 843	741, 079	0. 319650	0. 000000	65.00
	06600 PHYSI CAL THERAPY	131, 957	667, 667			0.00000	1
		81, 380	98, 294			0.00000	1
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	26, 582 98, 736	68, 090 344, 373			0. 000000 0. 000000	1
	07000 ELECTROENCEPHALOGRAPHY	1,049	3, 148			0.000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	810, 409	475, 718			0.000000	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	837, 902	1, 245, 921			0. 000000	1
	07300 DRUGS CHARGED TO PATIENTS	1, 793, 983	1,003,468	2, 797, 451		0.00000	1
	07400 RENAL DI ALYSI S	0	C C		0.000000	0. 000000 0. 000000	
	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0. 000000 0. 000000		
	DUTPATIENT SERVICE COST CENTERS	<u> </u>			0.000000	0.000000	//.00
	08800 RURAL HEALTH CLINIC	0	C	0			88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
	09000 CLINIC	0	0	-			1
	09100 EMERGENCY	929, 025	3, 310, 597			0.00000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	82, 741	216, 358	299, 099	0. 467390	0.00000	92.00
-	09400 HOME PROGRAM DI ALYSI S	0	C	0	0.000000	0.00000	94.00
	09500 AMBULANCE SERVICES	0	C	0	0. 000000	0. 000000	1
	09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0	0. 000000	0. 000000	1
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0. 000000	0.00000	1
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0. 000000	0. 000000	
	09900 CMHC 09910 CORF	0	0				99.00 99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
	10100 HOME HEALTH AGENCY	0	0	-			101.00
¢,	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	0	C	1			105.00
	10600 HEART ACQUI SI TI ON	0	0	0			106.00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0	0	0			107.00 108.00
	10900 PANCREAS ACQUISITION						108.00
1	11000 INTESTINAL ACQUISITION	0	0	0			110.00
1	11100 I SLET ACQUI SI TI ON	0	0	0			111.00
	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115.00
116.00 200.00	11600 HOSPICE Subtotal (see instructions)	0 17, 514, 588	0 22, 718, 476	0 40, 233, 064			116.00 200.00
200.00	Less Observation Beds	17, 514, 588	ZZ, / 18, 4/0	40,233,064			200.00
2011.00		I		1	1	1	

Health Fina	ancial Systems	ST ELI ZABETH	ST ELIZABETH DEARBORN			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES					Period: From 11/01/2020	Worksheet C Part I		
					To 12/31/2020		epared: 53 pm	
			Title XVIII			PPS		
			Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA		
				+ col. 7)	Rati o	Inpati ent		
						Rati o		
		6.00	7.00	8.00	9.00	10.00		
202.00	Total (see instructions)	17, 514, 588	22, 718, 476	40, 233, 06	4		202.00	

alth Financial Systems		ST ELI ZABETH			u of Form CMS-2552-
OMPUTATION OF RATIO OF CO	JSIS IU CHAKGES		Provider CCN: 15-0086	Period: From 11/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared
			Title XVIII	Hospi tal	7/28/2021 2:53 pm PPS
Cost Center De	escription	PPS Inpatient			
		Rati o 11.00			
INPATIENT ROUTINE S	ERVICE COST CENTERS	11.00			
. 00 03000 ADULTS & PEDI A					30. 0
. 00 03100 INTENSIVE CARE	E UNIT				31. (
2. 00 03200 CORONARY CARE	UNI T				32.0
. 00 03300 BURN INTENSIVE					33. 0
. 00 03400 SURGI CAL INTER					34.0
00 04000 SUBPROVIDER -	I PF				40.0
00 04100 SUBPROVIDER -	I RF				41.0
. 00 04300 NURSERY					43.0
. 00 04400 SKILLED NURSIN	NG FACILITY				44.0
00 04500 NURSING FACILI	TY				45.0
. 00 04600 OTHER LONG TEF	RM CARE				46.0
ANCILLARY SERVICE C	OST CENTERS				
. 00 05000 OPERATING ROOM	Л	0. 160357			50.0
00 05100 RECOVERY ROOM		0. 000000			51.0
. 00 05200 DELIVERY ROOM	& LABOR ROOM	0. 999252			52.0
. 00 05300 ANESTHESI OLOG		0. 483734			53.0
. 00 05400 RADI OLOGY-DI A0		0. 190817			54.0
00 05500 RADI OLOGY-THE	RAPEUTI C	0. 000000			55.0
. 00 05600 RADI 0I SOTOPE		0. 000000			56.0
00 05700 CT SCAN		0. 121402			57.0
00 05800 MAGNETIC RESON		0. 229770			58.0
00 05900 CARDI AC CATHE	FERI ZATI ON	0. 241496			59. (
00 06000 LABORATORY		0. 347483			60.0
01 06001 BLOOD LABORATO		0. 000000			60. 0
	_AB SERVICES-PRGM ONLY	0. 000000			61. (
	PACKED RED BLOOD CELLS	0. 000000			62.0
	PROCESSING & TRANS.	0. 000000			63.0
00 06400 I NTRAVENOUS TH		0. 000000			64.0
00 06500 RESPI RATORY TH		0. 319650			65. (
. 00 06600 PHYSI CAL THER		0. 685347			66. (
. 00 06700 0CCUPATI ONAL		0. 409447			67.0
. 00 06800 SPEECH PATHOL		0. 582559			68. (
. 00 06900 ELECTROCARDI OL		0. 352103			69.0
. 00 07000 ELECTROENCEPH		0. 157493			70. (
	ES CHARGED TO PATIENTS	1. 130171			71.0
		0. 439478 0. 488871			72.0
. 00 07300 DRUGS CHARGED . 00 07400 RENAL DIALYSIS		0. 488871			73.0
. 00 07500 ASC (NON-DI STI		0. 000000			74.0
. 00 07700 ALLOGENEI C STE		0. 000000			75.0
OUTPATIENT SERVICE		0.000000			
. 00 08800 RURAL HEALTH (					88.0
. 00 08900 FEDERALLY QUAI					89.0
. 00 089001 EDERALET COAL	L. LE HEALTH VENTER	0, 000000			90.0
00 09100 EMERGENCY		0. 152439			90.0
	EDS (NON-DISTINCT PART)	0. 467390			92.0
OTHER REIMBURSABLE					
00 09400 HOME PROGRAM I		0. 000000			94. (
00 09500 AMBULANCE SER		0. 000000			95.0
. 00 09600 DURABLE MEDICA		0. 000000			96.0
. 00 09700 DURABLE MEDICA		0. 000000			97.0
00 09850 OTHER REIMBURS	SABLE COST CENTERS	0. 000000			98. (
00 09900 CMHC					99. (
. 10 09910 CORF					99. 1
D. 00 10000 I &R SERVICES-1					100. (
1.00 10100 HOME HEALTH AG					101. (
SPECIAL PURPOSE COS					
5. 00 10500 KI DNEY ACQUI SI					105. (
6. 00 10600 HEART ACQUI SI					106. 0
7.00 10700 LIVER ACQUISI					107. (
3. 00 10800 LUNG ACQUI SI TI					108. (
9.00 10900 PANCREAS ACQUI					109. (
0.0011000INTESTINAL ACC					110. (
1.00 11100 ISLET ACQUISI					111. (
3.00 11300 INTEREST EXPE					113. (
4.00 11400 UTILIZATION RE					114. (
5.00 11500 AMBULATORY SUF	RGICAL CENTER (D.P.)				115. (
6. 00 11600 HOSPI CE					116. (
0.00 Subtotal (see	•				200. 0
1.00 Less Observati					201. (
2.00 Total (see ins	structions)	1			202. 0

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	ST ELIZABETI	Provider C		Period: From 11/01/2020 To 12/31/2020	u of Form CMS-: Worksheet C Part I Date/Time Pre 7/28/2021 2:5	pared:
				e XIX	Hospi tal	Cost	<u>5 piii</u>
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	r	1.00	2.00	3.00	4.00	5.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 201, 350	1	1, 201, 35	0 0	1, 201, 350	30.00
	03100 I NTENSI VE CARE UNI T	636, 880		636, 88		636, 880	
	03200 CORONARY CARE UNI T	0			0 0	0	32.00
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	33.00 34.00
	04000 SUBPROVIDER - IPF	0			0 0	0	40.00
41.00	04100 SUBPROVI DER – I RF	0			0 0	0	41.00
	04300 NURSERY	91, 469		91, 46		91, 469	
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0			0 0 0 0	0	44.00
	04600 OTHER LONG TERM CARE	0			0 0	0	46.00
	ANCI LLARY SERVI CE COST CENTERS	1 5 40 05 4	1	1 5 4 9 9 5		4 5 40 05 4	
	05000 OPERATING ROOM 05100 RECOVERY ROOM	1, 549, 954 0		1, 549, 95	4 0 0 0	1, 549, 954 0	50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM	308, 469		308, 46	-	308, 469	•
	05300 ANESTHESI OLOGY	432, 175		432, 17		432, 175	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	586, 307 0		586, 30	7 0 0 0	586, 307 0	54.00 55.00
	05600 RADI OLOGI - THERAFLUTTC	0			0 0	0	56.00
	05700 CT SCAN	436, 503		436, 50		436, 503	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	134,007		134,00		134,007	58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	114, 997 1, 269, 996		114, 99 1, 269, 99		114, 997 1, 296, 771	59.00 60.00
	06001 BLOOD LABORATORY	0		., 20, , , ,	0 0	0	60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	62.00 63.00
	06400 I NTRAVENOUS THERAPY	0			0 0	0	64.00
	06500 RESPI RATORY THERAPY	236, 886				236, 886	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	548, 020 73, 567		548, 02 73, 56		548, 020 73, 567	1
	06800 SPEECH PATHOLOGY	55, 152		55, 15		55, 152	•
	06900 ELECTROCARDI OLOGY	156, 020		156, 02		156, 020	1
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	661 1, 453, 543		66 1, 453, 54		661 1, 453, 543	
	07200 I MPL. DEV. CHARGED TO PATIENTS	915, 794		915, 79		915, 794	•
	07300 DRUGS CHARGED TO PATIENTS	1, 367, 592		1, 367, 59		1, 367, 592	
	07400 RENAL DI ALYSI S	0			0 0	0	
75.00	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC STEM CELL ACQUISITION				0 0 0 0	0	10100
	OUTPATIENT SERVICE COST CENTERS	-	1		-		1
	08800 RURAL HEALTH CLINIC	0			0 0	0	88.00 89.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0			0 0	0	90.00
91.00	09100 EMERGENCY	646, 285		646, 28	5 0	646, 285	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	139, 796		139, 79	6	139, 796	92.00
94,00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0			0 0	0	94.00
95.00	09500 AMBULANCE SERVI CES	0			0 0	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0				0	97.00 98.00
	09900 CMHC	0			0	0	99.00
	09910 CORF	0			0	0	99.10
	10000 I &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0			0		100.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	1	I	0	0	101.00
	10500 KIDNEY ACQUISITION	0			0		105.00
	10600 HEART ACQUISITION	0			0		106.00 107.00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION				0		107.00
109.00	10900 PANCREAS ACQUISITION	0			0	0	109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0			0		110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0	1		U	0	111.00 113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0		115.00
116.00 200.00	11600 HOSPICE Subtotal (see instructions)	0 12, 355, 423	o	12, 355, 42	0 3 26, 775		116.00
∠00.00	Subtotal (See LIISTIUCTIONS)	IZ, ວິວວ, 4Z3	1 0	1 12, 300, 42	20, 775	12, 302, 198	1200.00

Health Fina	ancial Systems	ST ELI ZABETH	H DEARBORN		In Lie	u of Form CMS-:	2552-10
COMPUTATIO	DN OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 11/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/28/2021 2:5	pared: 3 pm
			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
201.00	Less Observation Beds	139, 796		139, 79	96	139, 796	201.00
202.00	Total (see instructions)	12, 215, 627	0	12, 215, 62	27 26, 775	12, 242, 402	202.00

	nancial Systems	ST ELI ZABETH				u of Form CMS-	2552-10
COMPUTATI	ION OF RATIO OF COSTS TO CHARGES		Provider C	F	Period: From 11/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre	pared:
			Titl	e XIX	Hospi tal	7/28/2021 2:5 Cost	3 pili
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	PATI ENT_ROUTI NE_SERVI CE_COST_CENTERS	1, 946, 653		1 044 453		-	30.00
	100 INTENSIVE CARE UNIT	2, 840, 058		1, 946, 653 2, 840, 058			31.00
	200 CORONARY CARE UNIT	2,010,000		2,010,000			32.00
	300 BURN INTENSIVE CARE UNIT	0		C	)		33.00
	400 SURGI CAL I NTENSI VE CARE UNI T	0		C	)		34.00
	000 SUBPROVIDER - IPF	0		C	)		40.00
	100 SUBPROVI DER – I RF 300 NURSERY	0 150, 694		C 150, 694			41.00 43.00
	400 SKILLED NURSING FACILITY	150, 094		150, 094			43.00
	500 NURSI NG FACILITY	0		C C			45.00
	600 OTHER LONG TERM CARE	0		C	)		46.00
	CILLARY SERVICE COST CENTERS						
	000 OPERATING ROOM 100 RECOVERY ROOM	3, 242, 519 0	6, 423, 101 0			0.00000	1
	200 DELIVERY ROOM & LABOR ROOM	287, 239	21, 461			0. 000000 0. 000000	
	300 ANESTHESI OLOGY	199, 012	694, 402			0. 000000	
	400 RADI OLOGY-DI AGNOSTI C	682, 770	2, 389, 849	3, 072, 619	0. 190817	0. 000000	54.00
	500 RADI OLOGY-THERAPEUTI C	0	0			0.00000	
	600 RADI OI SOTOPE	0	0	-		0.00000	
	700 CT SCAN 1800 MAGNETIC RESONANCE IMAGING (MRI)	881, 485 51, 899	2, 714, 037 531, 323			0. 000000 0. 000000	1
	1900 CARDI AC CATHETERI ZATI ON	215, 738	260, 448			0. 000000	
	0000 LABORATORY	1, 682, 521	2,049,378			0. 000000	
	001 BLOOD LABORATORY	0	C	C		0. 000000	
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	C		0.000000	
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS 300 BLOOD STORING, PROCESSING & TRANS.	0	C		0. 000000	0. 000000 0. 000000	
	400 INTRAVENOUS THERAPY	0	0	-		0. 000000	
	500 RESPIRATORY THERAPY	540, 236	200, 843	-		0. 000000	
	600 PHYSI CAL THERAPY	131, 957	667, 667			0. 000000	
	700 OCCUPATI ONAL THERAPY	81, 380	98, 294			0. 000000	
	800 SPEECH PATHOLOGY	26, 582	68, 090			0.000000	
	900 ELECTROCARDI OLOGY 1000 ELECTROENCEPHALOGRAPHY	98, 736 1, 049	344, 373 3, 148			0. 000000 0. 000000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	810, 409	475, 718			0.000000	
72.00 07	200 IMPL. DEV. CHARGED TO PATIENTS	837, 902	1, 245, 921			0. 000000	
	300 DRUGS CHARGED TO PATIENTS	1, 793, 983	1, 003, 468	2, 797, 451		0. 000000	
	400 RENAL DIALYSIS	0	0		0.00000	0. 000000 0. 000000	
	500 ASC (NON-DISTINCT PART) 700 ALLOGENEIC STEM CELL ACQUISITION	0			0. 000000 0. 000000		
	TPATIENT SERVICE COST CENTERS				0.000000	0.00000	1 / / . 00
88.00 08	800 RURAL HEALTH CLINIC	0	C	C		0. 000000	88.00
	900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0.000000	
	2000 CLINIC 2100 EMERGENCY	0 929, 025	0 3, 310, 597	-		0. 000000 0. 000000	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	82, 741	216, 358			0. 000000	
	HER REIMBURSABLE COST CENTERS						
	400 HOME PROGRAM DI ALYSI S	0	0			0.00000	
	2500 AMBULANCE SERVICES	0	0		0.00000	0.00000	
	1600 DURABLE MEDI CAL EQUI P-RENTED 1700 DURABLE MEDI CAL EQUI P-SOLD	0			0.000000 0.000000	0. 000000 0. 000000	
	1850 OTHER REIMBURSABLE COST CENTERS	0	C	C		0. 000000	
	900 CMHC	0	C	C	)		99.00
99.10 09		0	0	C	)		99.10
	0000 I &R SERVICES-NOT APPRVD PRGM	0	0	-			100.00
	100 HOME HEALTH AGENCY ECIAL PURPOSE COST CENTERS	0	C	C			101.00
	1500 KIDNEY ACQUISITION	0	C	C	)		105.00
106.0010	600 HEART ACQUISITION	0	C	C	)		106.00
	1700 LIVER ACQUISITION	0	C	C			107.00
	1800 LUNG ACQUI SI TI ON	0	0				108.00
	900 PANCREAS ACQUISITION 000 INTESTINAL ACQUISITION	0	U O				109. 00 110. 00
	100 I SLET ACQUI SI TI ON	0	0				111.00
	300 I NTEREST EXPENSE		-				113.00
	400 UTI LI ZATI ON REVI EW-SNF						114.00
	500 AMBULATORY SURGICAL CENTER (D. P. )	0	0	C C			115.00
200.00	600 HOSPICE Subtotal (see instructions)	0 17, 514, 588	22, 718, 476	40, 233, 064	L		116. 00 200. 00
200.00	Less Observation Beds	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	22, 710, 470	.0, 200, 004			201.00
	·	· I		•			· · · · ·

Health Fina	leal th Financial Systems ST ELIZABETH DEARBORN				In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES					Period: From 11/01/2020	Worksheet C Part I		
					To 12/31/2020			
			Ti tl	e XIX	Hospi tal	Cost		
			Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA		
				+ col. 7)	Ratio	Inpati ent		
						Ratio		
		6.00	7.00	8.00	9.00	10.00		
202.00	Total (see instructions)	17, 514, 588	22, 718, 476	40, 233, 06	4		202.00	

OMPUT	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	ST ELI ZABETH	Provider CCN: 15-0086	Peri od:	u of Form CMS-2552-1 Worksheet C
				From 11/01/2020 To 12/31/2020	Part I Date/Time Prepared 7/28/2021 2:53 pm
		- 1	Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient Ratio			
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
0. 00	03000 ADULTS & PEDI ATRI CS				30.0
1.00	03100 INTENSIVE CARE UNIT				31. C
2.00	03200 CORONARY CARE UNI T				32.0
3.00	03300 BURN INTENSIVE CARE UNIT				33. C
1.00	03400 SURGICAL INTENSIVE CARE UNIT				34.0
0.00	04000 SUBPROVIDER - IPF				40.0
. 00	04100 SUBPROVIDER - IRF				41.0
8.00 .00	04300 NURSERY 04400 SKILLED NURSING FACILITY				43.0
5.00	04500 NURSING FACILITY				45.0
5.00	04600 OTHER LONG TERM CARE				46.0
	ANCI LLARY SERVICE COST CENTERS				
0. 00	05000 OPERATING ROOM	0. 000000			50. C
I. 00	05100 RECOVERY ROOM	0. 000000			51. C
2.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
3.00	05300 ANESTHESI OLOGY	0. 000000			53. C
4.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
5.00 5.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0. 000000			55. 0 56. 0
7.00	05700 CT SCAN	0.000000			56.0
3.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.0
D. 00	06000 LABORATORY	0. 000000			60.0
D. 01	06001 BLOOD LABORATORY	0. 000000			60.0
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. C
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. C
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.0
4.00 5.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0. 000000			64. 0 65. 0
6. 00	06600 PHYSI CAL THERAPY	0.000000			66.0
7.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
8.00	06800 SPEECH PATHOLOGY	0. 000000			68.0
9.00	06900 ELECTROCARDI OLOGY	0. 000000			69.0
0. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0
3.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0. 000000			73.0
4.00 5.00	07500 ASC (NON-DISTINCT PART)	0. 000000			74. C 75. C
7.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77.0
	OUTPATIENT SERVICE COST CENTERS	01000000			
8.00	08800 RURAL HEALTH CLINIC	0. 000000			88. C
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. C
0. 00	09000 CLINIC	0. 000000			90. C
1.00	09100 EMERGENCY	0. 000000			91.0
2.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000			92.0
4.00	OTHER REIMBURSABLE COST CENTERS	0. 000000			94.0
	09500 AMBULANCE SERVICES	0.000000			94.0
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.0
	09700 DURABLE MEDICAL EQUI P-SOLD	0. 000000			97.0
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98.0
	09900 СМНС				99. C
	09910 CORF				99. 1
	10000 I &R SERVICES-NOT APPRVD PRGM				100. 0
J1. 00	10100 HOME HEALTH AGENCY				101. 0
15 00	SPECIAL PURPOSE COST CENTERS				105. 0
	10500 REDITE ACQUISITION				105.0
	10000 LIVER ACQUISITION				100. 0
	10800 LUNG ACQUISITION				107.0
	10900 PANCREAS ACQUISITION				109.0
	11000 I NTESTI NAL ACQUI SI TI ON				110. 0
	11100 I SLET ACQUI SI TI ON				111. 0
	11300 INTEREST EXPENSE				113. 0
	11400 UTI LI ZATI ON REVI EW-SNF				114. (
15.00	11500 AMBULATORY SURGICAL CENTER (D. P.)				115. C
	11600 HOSPI CE				116.0
16.00 00.00 01.00	Subtotal (see instructions)				200. 0 201. 0

Health Financial Systems	ST ELI ZABETH				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPITAL COSTS	Provider C		Period: From 11/01/2020 To 12/31/2020		pared: 3 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)	Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTE			1			
30. 00         ADULTS & PEDIATRICS           31. 00         INTENSIVE CARE UNIT           32. 00         CORONARY CARE UNIT	93, 731 20, 224 0	0	93, 73 20, 22		50. 69	31.00
33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF	0	0		0 0 0 0 0 0	0.00 0.00 0.00	
41. 00 SUBPROVI DER – I RF 43. 00 NURSERY	0436	0	43		0. 00 5. 13	41.00 43.00
44.00   SKILLED NURSING FACILITY 45.00   NURSING FACILITY 200.00   Total (lines 30 through 199)	0 0 114, 391		114, 39	0 0 0 0 2, 366	0.00	44.00 45.00 200.00
Cost Center Description		Inpatient Program Capital Cost (col. 5 x col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTE 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)	RS 837 176 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41, 683 8, 921 0 0 0 0 0 0 0 0 0 0 0 50, 604				30. 00 31. 00 32. 00 33. 00 40. 00 41. 00 43. 00 44. 00 45. 00 200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAR		H DEARBORN	CNI. 1E 0007		u of Form CMS-	2002 10
APPORTIONMENT OF INPATIENT ANGILLARY SERVICE CA	TTAL COSTS	Provider C	CN: 15-0086	Period: From 11/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Pre 7/28/2021 2:5	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS					0.0/0	
50. 00 05000 OPERATI NG ROOM	85, 163				9, 360	
51.00 05100 RECOVERY ROOM	0		0.0000		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	22, 634				43	
53. 00 05300 ANESTHESI OLOGY	2, 111				252	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	44, 447				5, 247	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0.0000		0	
56. 00 05600 RADI OI SOTOPE	0		0.0000		0	
57.00 05700 CT SCAN	2, 390				325	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 373				141	
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 089				528	
60. 00 06000 LABORATORY	29, 674	3, 731, 899			6, 883	
60. 01 06001 BLOOD LABORATORY	0	C	0. 00000	0 00	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	S O	C	0.0000	0 00	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0.0000	0 00	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	C	0.0000	0 00	0	64.00
65. 00 06500 RESPI RATORY THERAPY	3, 745	741, 079	0. 00505	53 296, 617	1, 499	65.00
66. 00 06600 PHYSI CAL THERAPY	28, 914	799, 624	0. 0361	59 68, 809	2, 488	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2,034	179, 674	0. 01132	21 49, 163	557	67.00
68.00 06800 SPEECH PATHOLOGY	1, 164	94, 672	0. 01229	95 14, 566	179	68.00
69. 00 06900 ELECTROCARDI OLOGY	7,626	443, 109	0. 0172	10 50, 083	862	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	3	4, 197	0.0007	15 1, 049	1	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	S 23, 098	1, 286, 127	0. 0179	59 411, 479	7, 390	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 365	2, 083, 823	0. 00209	95 393, 299	824	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 623	2, 797, 451	0.00344	40 841, 899	2, 896	73.00
74.00 07400 RENAL DIALYSIS	0	C	0. 00000	0 00	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C	0. 00000	0 00	0	75.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0.0000	0 00	0	77.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C			0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	
90. 00 09000 CLINIC	0	C	0.0000	0 00	0	90.00
91.00 09100 EMERGENCY	25, 484	4, 239, 622	0. 0060	11 485, 910	2, 921	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	) 10, 907	299, 099	0. 03640	56 38, 236	1, 394	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	0 00	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0.0000	0 00	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C	0.0000	0 00	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C	0.0000	0 00	0	98.00
				5, 654, 191		

Health Financial Systems	ST ELI ZABETH			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	rs Provider C	F	Period: From 11/01/2020 To 12/31/2020		pared: 3 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		<u> </u>
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0				
32. 00 03200 CORONARY CARE UNIT	0	0				
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		-	0	
	0	0		, e		
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	(	, e	0	
40. 00 04000 SUBPROVIDER - IPF	0	0	(	, 0	0	
41.00 04100 SUBPROVIDER - IRF	0	0	0	, 0	0	
43. 00 04300 NURSERY	0	0	(	0 0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0	(	0 0		44.00
45.00 04500 NURSING FACILITY	0	0	0	0 0		45.00
200.00 Total (lines 30 through 199)	0	0	(	0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,			· · · · · · · · · · · · · · · · · · ·	
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0100	1100	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	1, 882	0.00	837	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0				•
32. 00 03200 CORONARY CARE UNIT		0			-	
		0				
		0				•
34.00 03400 SURGI CAL INTENSI VE CARE UNIT		0	(			
40. 00 04000 SUBPROVIDER - IPF	0	0	(			
41.00 04100 SUBPROVIDER - IRF	0	0	0			
43. 00 04300 NURSERY		0	85	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	(	0.00	0	44.00
45.00 04500 NURSING FACILITY		0	(	0.00	0	45.00
200.00 Total (lines 30 through 199)		0	2, 366	b	1, 013	200.00
Cost Center Description	I npati ent		•			
·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
32. 00 03200 CORONARY CARE UNIT	0					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0					33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T						34.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
41. 00 O4100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
45.00 04500 NURSING FACILITY	0					45.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	ST ELI ZABETH	I DEARBORN		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS			Period: From 11/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre 7/28/2021 2:5	
			XVIII	Hospi tal	PPS	
Cost Center Description			Nursing Schoo	I Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	C		0 0	0	56.00
57. 00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	C C		0 0	0	60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C C		0 0	0	61.00
	0	C		0 0	0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	-			0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	C		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	C		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	55, 818	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0	0	75.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	0	1 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0	89.00
90. 00 09000 CLINIC	0	C		0 0	0	90.00
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C C		0	0	92.00
OTHER REIMBURSABLE COST CENTERS	<u>ч</u>			0	0	/2.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C	1	0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0				0	94.00
95. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	
					-	
	0	-		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C		0 0		98.00
200.00   Total (lines 50 through 199)	0	C	1	0 0	55, 818	200. 00

Health Financial S	Systems	ST ELI ZABET	H DEARBORN		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF THROUGH COSTS	INPATI ENT/OUTPATI ENT ANCI LLARY SI	ERVICE OTHER PAS	S Provider C	1	Period: From 11/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre	nared
					10 12/31/2020	7/28/2021 2:5	3 pm
				XVIII	Hospi tal	PPS	
Cost	Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3, and 4)	8)	7) (see	
				anu 4)		instructions)	
		4,00	5.00	6.00	7.00	8.00	
ANCI LLARY S	ERVICE COST CENTERS						
50.00 05000 OPERA	TING ROOM	0	0		0 9, 665, 620	0.00000	50.00
51.00 05100 RECOV	ERY ROOM	0	0		0 0	0. 000000	51.00
52.00 05200 DELIV	ERY ROOM & LABOR ROOM	0	0		0 308, 700	0.00000	52.00
53.00 05300 ANEST	HESI OLOGY	0	0		0 893, 414	0.00000	53.00
	LOGY-DI AGNOSTI C	0	0		0 3, 072, 619	0.00000	54.00
55.00 05500 RADI 0	LOGY-THERAPEUTI C	0	0		0 0	0.00000	55.00
56.00 05600 RADI 0	I SOTOPE	0	0		0 0	0.00000	56.00
57.00 05700 CT SC		0	0		0 3, 595, 522	0.00000	57.00
	TIC RESONANCE IMAGING (MRI)	0	0		0 583, 222	0.00000	58.00
	AC CATHETERI ZATI ON	0	0		0 476, 186	0. 000000	59.00
60.00 06000 LABOR		0	0		0 3, 731, 899	0. 000000	60.00
60.01 06001 BL00D		0	0		0 0	0. 000000	60.01
	LINICAL LAB SERVICES-PRGM ONLY						61.00
	BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0.00000	
	STORING, PROCESSING & TRANS.	0	0		0 0	0.00000	•
	VENOUS THERAPY	0	0		0 0	0.00000	
	RATORY THERAPY	0	0		0 741,079	0.00000	•
66.00 06600 PHYSI		0	0		0 799, 624	0.000000	•
	ATIONAL THERAPY	0	0		0 179, 674	0.000000	
68.00 06800 SPEEC		0	0		0 94, 672	0.000000	•
		0			0 443, 109 0 4 197	0.000000	
	ROENCEPHALOGRAPHY AL SUPPLIES CHARGED TO PATIENTS	0			.,	0.000000	•
	DEV. CHARGED TO PATIENTS	0			0 1, 286, 127 0 2, 083, 823	0. 000000 0. 000000	
	CHARGED TO PATTENTS CHARGED TO PATTENTS	0	55, 818			0.000000	
74.00 07400 RENAL		0	0		0 2, 797, 431	0.000000	
	NON-DISTINCT PART)	0	0		0 0	0.000000	
	ENELC STEM CELL ACQUISITION	0			0 0	0.000000	
	SERVICE COST CENTERS				<u> </u>	0.000000	///.00
	HEALTH CLINIC	0	0		0 0	0, 000000	88.00
	ALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	89.00
90.00 09000 CLINI		0	0		0 0	0.000000	90.00
91.00 09100 EMERG		0	0		4, 239, 622	0.000000	91.00
	VATION BEDS (NON-DISTINCT PART)	0	0		0 299,099	0.000000	
	URSABLE COST CENTERS						1
94.00 09400 HOME	PROGRAM DI ALYSI S	0	0		0 0	0. 000000	94.00
	ANCE SERVICES						95.00
96.00 09600 DURAB	LE MEDICAL EQUIP-RENTED	0	0		0 0	0. 000000	96.00
	LE MEDICAL EQUIP-SOLD	0	0		0 0	0. 000000	97.00
98.00 09850 OTHER	REIMBURSABLE COST CENTERS	0	0		0 0	0.000000	98.00
90.00 09000000		0				01000000	

Health Financial Systems	ST ELI ZABETH				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0086	Period: From 11/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre 7/28/2021 2:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000	1 0(2 20)	1	0 1 500 (45	0	
50. 00 05000 OPERATING ROOM	0.000000	1, 062, 286		0 1, 523, 645	0	
51.00 O5100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0.000000	582		0 15,097	0	52.00
53. 00 05300 ANESTHESI OLOGY	0.000000	106, 644		0 144, 459	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	362, 723		0 746, 306	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.00000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0.00000	0		0 0	0	56.00
57.00 05700 CT SCAN	0.00000	489, 260		0 728, 488	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.00000	34, 557		0 152, 938	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.00000	81, 328		0 47, 936	0	59.00
60. 00 06000 LABORATORY	0. 000000	865, 701		0 271, 458	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	296, 617		0 31, 705	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	68, 809		0 3, 694	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	49, 163		0 2,840	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	14, 566		0 1, 230	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	50, 083		0 101, 245	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 049		0 525	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	411, 479		0 75, 544	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	393, 299		0 277, 287	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 019953	841, 899			4, 892	1
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS			1		-	
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	485, 910		0 560, 001	0	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000	38, 236		0 72, 839	0	92.00
OTHER REIMBURSABLE COST CENTERS			1	-	_	
94.00 09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0	
95.00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	
200.00  Total (lines 50 through 199)	1	5, 654, 191	16, 79	5, 002, 417	4, 892	200. 00

Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ST ELIZABET	Provi der C	CN: 15 0096	Peri od:	eu of Form CMS-: Worksheet D	2002-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	IND VACCINE COST	Provider C	CN. 15-0080	From 11/01/2020	Part V	
				To 12/31/2020	Date/Time Pre 7/28/2021 2:5	pared: 3 pm
		Title	× XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Ratio From	PPS Reimbursed		Cost Reimbursed	PPS Services (see inst.)	
	Worksheet C,	Services (see inst.)	Servi ces	Services Not	(See Thst.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0. 160357	1, 523, 645		0 0	244, 327	50.00
51. 00 05100 RECOVERY ROOM	0. 000000		1	0 0		1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 999252			0 0		
53. 00 05300 ANESTHESI OLOGY	0. 483734			0 0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 190817			0 0		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000		1	0 0		
56. 00 05600 RADI OI SOTOPE	0. 000000	C	)	0 0	0	56.00
57.00 05700 CT SCAN	0. 121402	728, 488		0 0	88, 440	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 229770	152, 938		0 0	35, 141	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 241496	47, 936		0 0	11, 576	59.00
60. 00 06000 LABORATORY	0. 340308			0 0	,	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			0 0		
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			0 0		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.00000			0 0	-	
64.00 06400 INTRAVENOUS THERAPY	0.00000			0 0	-	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 319650 0. 685347			0 0		
67. 00 06700 OCCUPATI ONAL THERAPY	0. 409447			0 0		
68. 00 06800 SPEECH PATHOLOGY	0. 582559		1	0 0		
69. 00 06900 ELECTROCARDI OLOGY	0. 352103			0 0		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 157493			0 0		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 130171			0 0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 439478	277, 287		0 0	121, 862	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 488871	245, 180		0 463	119, 861	73.00
74.00 07400 RENAL DIALYSIS	0. 000000			0 0		
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			0 0		
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	C		0 0	0	77.00
OUTPATI ENT SERVICE COST CENTERS           88.00         RURAL HEALTH CLINIC		1				88.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 009000 CLINIC	0. 000000			0 0	0	
91. 00 09100 EMERGENCY	0. 152439		,	0 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 467390		1	0 0		
OTHER REIMBURSABLE COST CENTERS	0. 10/0/0	1 72,007			01,011	/2.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000			0 0		94.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0.00000	C		0 0	-	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			0 0		
200.00 Subtotal (see instructions)		5, 002, 417		0 463		
201.00 Less PBP Clinic Lab. Services-Program	ו			0 0		201.00
Only Charges		E 000 417			1 104 007	202 00
202.00 Net Charges (line 200 - line 201)		5, 002, 417	1	0 463	1, 196, 027	1202. 00

APPORT	Financial Systems IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	ST ELIZABETH VACCINE COST	Provi der C	CN: 15-0086	Peri od:	u of Form CMS- Worksheet D	2002 10
					From 11/01/2020 To 12/31/2020	Part V Date/Time Pre	
			Title	XVIII	Hospi tal	7/28/2021 2: PPS	53 pm
		Cost			noopritui		
	Cost Center Description	Cost	Cost	1			
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)	-			
		6.00	7.00				
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	0				50.00
50.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0				55.00
56.00	05600 RADI OL SOTOPE	0	0	1			56.00
57.00	05700 CT SCAN	0	0	1			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	0	0				60.00
60.01	06001 BLOOD LABORATORY	0	0				60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00	06500 RESPI RATORY THERAPY	0	0				65.00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
69.00	06900 ELECTROCARDI OLOGY	0	0				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	226				73.00
	07400 RENAL DI ALYSI S	0	0	1			74.00
	07500 ASC (NON-DISTINCT PART)	0	0	1			75.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
~ ~ ~	OUTPATIENT SERVICE COST CENTERS	· · · · · ·		1			
	08800 RURAL HEALTH CLINIC						88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0				89.00
90.00		0	0	1			90.00
91.00 92.00	09100 EMERGENCY	0	0	1			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	UU	0	1			92.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0				94.00
	09500 AMBULANCE SERVICES	0	0				95.00
96.00 96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
90.00 97.00	09700 DURABLE MEDICAL EQUITERENTED	0	0				97.00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
200.00		0	226				200.00
200.00		0	220				201.00
	Only Charges						
	Net Charges (line 200 - line 201)	0	226	1			202.00

)MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0086	Period: From 11/01/2020 To 12/31/2020 Hospital	Worksheet D-1 Date/Time Prep 7/28/2021 2:53 PPS	pare 3 pm
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		1, 882	1.
00	Inpatient days (including private room days, excluding swing-be			1, 882	2.
00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bea	t davs)		1, 663	4
00	Total swing-bed SNF type inpatient days (including private roor		er 31 of the cost	0	5
	reporting period		04 6 11		
00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
	reporting period			_	_
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	837	9
	newborn days) (see instructions)				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, en				
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar year	ar, enter O on this lir	ie)		
	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	n (excluding swing-bed	days)	0	14 15
	Nursery days (title V or XIX only)			0	-
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 c	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instructions)		ing pariod (line	1, 201, 350	
. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	31 OF the cost report	ing period (ine	0	22
. 00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportin	ng period (line 6	0	23
00	x line 18) Swige had and and included to NE type and include through December	01 - E the sect mean t:			~
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 OF the cost report	ng period (inne	0	24
. 00	Swing-bed cost applicable to NF type services after December 3	of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)			
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	29 30
00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	is line 33)(see instruc	tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x line	, ,		0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost ar 27 minus line 36)	nd private room cost di	tterential (line	1, 201, 350	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
	Adjusted general inpatient routine service cost per diem (see i	-		638.34	
	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			534, 291 0	39 40
	Total Program general inpatient routine service cost (line 39 -	, , ,		534, 291	

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0086	Period: From 11/01/2020	Worksheet D-	1
					To 12/31/2020		
		<b>T</b>		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0	C	0.0	00 0	) (	0 42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	636, 880	399	1, 596. 1	19 176	280, 929	9 43.
00	CORONARY CARE UNIT	030, 880	399 0				0 44
00	BURN INTENSIVE CARE UNIT	0	0				0 45
00	SURGI CAL I NTENSI VE CARE UNI T	0	C	0.0	0 0	) (	0 46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)	-		2, 009, 319	9 48
00	Total Program inpatient costs (sum of lines 4	1 through 48)(s	see instructio	ns)		2, 824, 539	9 49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routino a	orvicos (from		of Parts L and	50, 604	4 50
00	(111)	attent foutine s	Services (110	IWKSL. D, SUN	I UI FAILS I ANU	50, 002	4 30
00	Pass through costs applicable to Program inpa	atient ancillary	/ services (fr	om Wkst. D, s	sum of Parts II	60, 588	8 51
00	and IV)	0 and 51					
00 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclud		ated non-nh	sician anos+h	netist and	111, 192 2, 713, 347	
50	medical education costs (line 49 minus line 5					2, 713, 34	. 33
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
	Program di scharges						
00 00	Target amount per discharge Target amount (line 54 x line 55)						0 55 0 56
00	Difference between adjusted inpatient operati	ng cost and tar	aet amount (I	ine 56 minus	line 53)		0 57
00	Bonus payment (see instructions)	5	<u>j</u>			0	0 58
00	Lesser of lines 53/54 or 55 from the cost rep	oorting period e	ending 1996, ι	pdated and co	ompounded by the	0.00	0 59
00	market basket Lesser of lines 53/54 or 55 from prior year o	ost report upo	lated by the m	arket hasket		0.00	0 60
00	If line 53/54 is less than the lower of lines				the amount by		0 61
	which operating costs (line 53) are less than	n expected costs					
~~	amount (line 56), otherwise enter zero (see i	nstructions)					
00 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ant (see instruc	tions)				0 62 0 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cost	s through Decem	nber 31 of the	e cost reporti	ng period (See	(	0 64
00	instructions)(title XVIII only)	a after December	n 21 of the c	aat manamti na	nonied (Coo		
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s arter becembe	er si or the c	ost reporting	period (see		0 65
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line é	64 plus line 6	5)(title XVII	l only). For		0 66
~~	CAH (see instructions)			<b>C</b> 11			
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period		0 67
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period		0 68
	(line 13 x line 20)				0.1		
. 00	Total title V or XIX swing-bed NF inpatient i			,		(	0 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili					1	70
00	Adjusted general inpatient routine service of						71
. 00	Program routine service cost (line 9 x line 3	/1)					72
00	Medically necessary private room cost applica						73
00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r				Part II column		74
. 00	26, line 45)	outifie service		IOT KSHEET D, T			' 5
00	Per diem capital-related costs (line 75 ÷ lin						76
00	Program capital -related costs (line 9 x line						77
00 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess	,	ovider rocord	le)			78
00	Total Program routine service costs for compa	• •		· · · · · · · · · · · · · · · · · · ·	us line 79)		80
00	Inpatient routine service cost per diem limit			、 . <u>.</u> . o			81
00	Inpatient routine service cost limitation (li	,					82
00	Reasonable inpatient routine service costs (s		5)				83
00 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		)				84
. 00	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
	Total observation bed days (see instructions)					219	9 87
. 00 . 00	Adjusted general inpatient routine cost per d					638.34	4 88

Health Financial Systems	ST ELI ZABETH	H DEARBORN		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 11/01/2020 To 12/31/2020		pared: 3 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	93, 731	1, 201, 350	0. 07802	1 139, 796	10, 907	90.00
91.00 Nursing School cost	0	1, 201, 350	0.00000	0 139, 796	0	91.00
92.00 Allied health cost	0	1, 201, 350	0.00000	0 139, 796	0	92.00
93.00 All other Medical Education	0	1, 201, 350	0. 00000	0 139, 796	0	93.00

Health Financial Systems ST ELIZABETH DE	EARBORN		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	CN: 15-0086	Peri od:	Worksheet D-3	
			From 11/01/2020 To 12/31/2020		nared
			10 12/31/2020	7/28/2021 2:5	
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			1, 505, 661		30.00
31. 00 03100 I NTENSI VE CARE UNI T			1, 144, 864		31.00
32. 00 03200 CORONARY CARE UNI T 33. 00 03300 BURN I NTENSI VE CARE UNI T			0		32.00 33.00
33. 00 03300 BURN TNTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT			0		33.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 04100 SUBPROVIDER - IRF			0		41.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS		I			10.00
50. 00 05000 0PERATI NG ROOM		0. 1603	57 1, 062, 286	170, 345	50.00
51.00 05100 RECOVERY ROOM		0.00000			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 9992			1
53. 00 05300 ANESTHESI OLOGY		0. 48373	34 106, 644	51, 587	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1908	17 362, 723	69, 214	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000	0 00	0	55.00
56. 00 05600 RADI 0I SOTOPE		0.0000	0 00	0	56.00
57.00 05700 CT SCAN		0. 12140	02 489, 260	59, 397	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2297	70 34, 557	7, 940	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 2414	96 81, 328	19, 640	59.00
60. 00 06000 LABORATORY		0. 34748		300, 816	1
60. 01 06001 BLOOD LABORATORY		0.0000		0	1
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000			
64. 00 06400 I NTRAVENOUS THERAPY		0.0000		-	
65. 00 06500 RESPIRATORY THERAPY		0. 3196			
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		0. 68534			
68. 00 06800 SPEECH PATHOLOGY		0. 58255			1
69. 00 06900 ELECTROCARDI OLOGY		0.35210			1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 15749			1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1301			1
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4394			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4888			
74.00 07400 RENAL DIALYSIS		0.0000			1
75.00 07500 ASC (NON-DI STINCT PART)		0.0000	0 00	0	75.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000	0 00	0	77.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLINIC		0.0000		0	1
91.00 09100 EMERGENCY		0. 15243			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0.4673	38, 236	17, 871	92.00
OTHER REIMBURSABLE COST CENTERS		0.0000			04.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.0000	0 00	0	1
95. 00 09500 AMBULANCE SERVICES		0.0000	~	_	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.0000		0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000		0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS 200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.0000	5, 654, 191	0 2, 009, 319	
200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		5, 054, 191	2,009,319	200.00
202.00 Net charges (line 200 minus line 201)			5, 654, 191		201.00
		I	1 0,004,171	I	1-02.00

Health Financial Systems ST ELIZABETH	DEARBORN		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-0086	Period:	Worksheet D-3	
			From 11/01/2020 To 12/31/2020		narod
			10 12/31/2020	7/28/2021 2:5	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			65, 775		30.00
31. 00 03100 I NTENSI VE CARE UNI T			105, 893		31.00
32. 00 03200 CORONARY CARE UNI T			0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00  04100  SUBPROVI DER – I RF 43. 00  04300  NURSERY			0		41.00 43.00
ANCI LLARY SERVI CE COST CENTERS			0	1	43.00
50. 00 05000 OPERATI NG ROOM		0. 16035	6, 250	1,002	50.00
51.00 05100 RECOVERY ROOM		0.0000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 99925	52 39	39	52.00
53. 00 05300 ANESTHESI OLOGY		0. 48373		-	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1908			1
55. 00 O5500 RADI OLOGY-THERAPEUTI C		0.0000			55.00
56. 00 05600 RADI 0I SOTOPE		0. 00000 0. 12140		-	56.00
57.00  05700 CT SCAN 58.00  05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 12140			57.00 58.00
59. 00 05900 CARDIAC CATHETERIZATION		0. 24149			59.00
60. 00 06000 LABORATORY		0. 34030			
60. 01 06001 BLOOD LABORATORY		0.0000			60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000	0 0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000	0 0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000			63.00
64.00 06400 I NTRAVENOUS THERAPY		0.0000		-	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 31965 0. 68534			65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 40944			1
68. 00 06800 SPEECH PATHOLOGY		0. 58255			1
69. 00 06900 ELECTROCARDI OLOGY		0. 35210			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 15749	93 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1301		7, 661	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4394		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 48887			1
74. 00   07400   RENAL_DIALYSIS 75. 00   07500   ASC_(NON-DISTINCT_PART)		0.0000			74.00 75.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000			77.00
OUTPATIENT SERVICE COST CENTERS		0.00000	50 0	<u> </u>	///.00
88.00 08800 RURAL HEALTH CLINIC		0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	1
90. 00 09000 CLINIC		0.0000		0	
91.00 09100 EMERGENCY		0. 15243			1
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 46739	2, 899	1, 355	92.00
0THER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S		0.0000	0 00	0	94.00
95. 00 09500 AMBULANCE SERVI CES		0.00000		1	94.00 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 00000	0 00	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0. 00000		0	1
98.00 09850 OTHER REIMBURSABLE COST CENTERS		0.0000		0	98.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			157, 478	56, 042	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	157, 478	1	202.00

CALCUL	Financial Systems ST ELIZABETH ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0086	Peri od: From 11/01/2020 To 12/31/2020	Date/Time Pre	pared:
		Title XVIII	Hospi tal	7/28/2021 2:5 PPS	3 pm
			noopritai		
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurs	ring prior to October 1 (	see	0 2, 224, 390	1.00 1.01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurr	ring on or after October	1 (see	0	1. 02
1.03	instructions) DRG for federal specific operating payment for Model 4 BPCI 1 1 (see instructions)	for di scharges occurri ng	prior to October	0	1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCI t October 1 (see instructions)	for discharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)			0	2.00
2.01 2.02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	tions)		0	2.01 2.02
2.03	Outlier payments for discharges occurring prior to October 1			70, 675	2.03
2.04	Outlier payments for discharges occurring on or after October	r 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	orting period (see institu		58. 41	4.00
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0.00	5.00
6. 00	FTE count for allopathic and osteopathic programs that meet $^{\rm o}$ new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.			0.00 0.00	7.00 7.01
8. 00	Adjustment (increase or decrease) to the FTE count for allops affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
B. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	lots under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slunder $\S$ 5506 of ACA. (see instructions)		0	0.00	8. 02
9.00 10.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions) FTE count for allopathic and osteopathic programs in the cur			0.00	
11.00	FTE count for residents in dental and podiatric programs.	Tent year from your recor	45	0.00	
12.00	Current year allowable FTE (see instructions)			0.00	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 otherwise enter zero.	ear ended on or after Sep	otember 30, 1997,	0.00	14.00
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			0.00	
17.00 18.00	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	osure		0.00	17.0 18.0
	Current year resident to bed ratio (line 18 divided by line 4	4)		0.00000	
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	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42			0	
23.00 24.00	Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)	uent cap slots under 42 (	лнк 412.105	0.00	
25.00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
27.00	IME payments adjustment factor. (see instructions)			0.000000	
28.00	IME add-on adjustment amount (see instructions)	2)		0	28.0
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions Total IME payment ( sum of lines 22 and 28)	5)		0	28.0 <sup>°</sup> 29.00
29.00 29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	01)		0	29.00 29.0
30. 00	Percentage of SSI recipient patient days to Medicare Part A	patient days (see instruc	ctions)	3.93	30.00
31.00	Percentage of Medicaid patient days (see instructions)			12.14	31.00
32.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions	- )		16.07	32.00 33.00
33.00					

	Financial Systems ST ELIZABETH D ATION OF REIMBURSEMENT SETTLEMENT		Peri od:	u of Form CMS-2 Worksheet E	
			From 11/01/2020 To 12/31/2020	Part A Date/Time Prep 7/28/2021 2:53	
		Title XVIII	Hospi tal	PPS	5 pili
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
00	Uncompensated Care Adjustment			0	0.5
. 00	Total uncompensated care amount (see instructions)		0	0	35.0
. 01 . 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter	r zoro on this line) (soo	0. 000000000	0.000000000	35. ( 35. (
. 02	instructions)	i zelo oli tilis i ile) (see	773,070	0	35.1
03	Pro rata share of the hospital uncompensated care payment amou	unt (see instructions)	162, 757	0	35.
. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		162, 757		36.
	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throug	h 46)		
00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 68	84 and 685. (see	0		40.
~ ~	instructions)				
00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	83, 684 an 685. (see	0		41.
01	instructions)		0		11
01	Total ESRD Medicare covered and paid discharges excluding MS-I an 685. (see instructions)	UNUS UJZ, UGZ, 083, 084	0		41.
00	Divide line 41 by line 40 (if less than 10%, you do not qualit	fv for adjustment)	0.00		42.
00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682		0		43.
	instructions)				
00	Ratio of average length of stay to one week (line 43 divided l	by line 41 divided by 7	0. 000000		44.
	days)				
00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.
00	Total additional payment (line 45 times line 44 times line 41.	. 01)	2 471 550		46. 47.
00 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, sr	mall rural bosnitals	2, 471, 558		47. 48.
00	only. (see instructions)		0		40.
				Amount	
				1.00	
00	Total payment for inpatient operating costs (see instructions)	)		2, 471, 558	49.
00	Payment for inpatient program capital (from Wkst. L, Pt. I and			177, 205	
	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.
	Direct graduate medical education payment (from Wkst. E-4, lin	ne 49 see instructions).		0	52.
00 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 104, 675	53. 54.
00	Islet isolation add-on payment			104, 075	54
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 64	9)		0	55
. 00	Cost of physicians' services in a teaching hospital (see intru			Ő	56
00	Routine service other pass through costs (from Wkst. D, Pt. 1)		rough 35).	0	57
00	Ancillary service other pass through costs from Wkst. D, Pt. 1	IV, col. 11 line 200)	<b>3</b>	16, 798	58
00	Total (sum of amounts on lines 49 through 58)			2, 770, 236	59
	Primary payer payments			0	60
00	Total amount payable for program beneficiaries (line 59 minus	line 60)		2, 770, 236	
00				190, 080	62
00 00	Deductibles billed to program beneficiaries				
00 00 00	Coinsurance billed to program beneficiaries			17, 248	63
00 00 00 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			59, 359	63 64
00 00 00 00 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	ructione)		59, 359 38, 583	63 64 65
00 00 00 00 00 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		59, 359 38, 583 4, 739	63. 64. 65. 66.
00 00 00 00 00 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63)		e instructions)	59, 359 38, 583 4, 739 2, 601, 491	63 64 65 66 67
00 00 00 00 00 00 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	applicable to MS-DRGs (se		59, 359 38, 583 4, 739	63 64 65 66 67 68
00 00 00 00 00 00 00 00 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a	applicable to MS-DRGs (se		59, 359 38, 583 4, 739 2, 601, 491 0	63 64 65 66 67 68 69
00 00 00 00 00 00 00 00 00 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).	applicable to MS-DRGs (se (For SCH see instructions	)	59, 359 38, 583 4, 739 2, 601, 491 0 0	63 64 65 66 67 68 69 70
00 00 00 00 00 00 00 00 00 00 50 87	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration	applicable to MS-DRGs (se (For SCH see instructions	)	59, 359 38, 583 4, 739 2, 601, 491 0 0 0	63 64 65 66 67 68 69 70 70 70
00 00 00 00 00 00 00 00 00 50 87 88	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	)	59, 359 38, 583 4, 739 2, 601, 491 0 0 0 0	63. 64. 65. 66. 67. 68. 69. 70. 70. 70. 70.
00 00 00 00 00 00 00 00 50 87 88 89	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instr	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	)	59, 359 38, 583 4, 739 2, 601, 491 0 0 0 0 0 0 0 0 0 0	63 64 65 66 67 68 69 70 70 70 70 70
00 00 00 00 00 00 00 00 00 50 87 88 89 90	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	)	59, 359 38, 583 4, 739 2, 601, 491 0 0 0 0 0 0 0 0 0 0	63. 64. 65. 66. 68. 69. 70. 70. 70. 70. 70. 70. 70.
00 00 00 00 00 00 00 00 00 50 88 89 90 91	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	)	59, 359 38, 583 4, 739 2, 601, 491 0 0 0 0 0 0 0 0 0 0 0 0 0 0	<ul> <li>63.</li> <li>64.</li> <li>65.</li> <li>66.</li> <li>67.</li> <li>68.</li> <li>69.</li> <li>70.</li> </ul>
. 00 00 00 00 00 00 00 00 00 00 00 00 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	)	59, 359 38, 583 4, 739 2, 601, 491 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	<ul> <li>63.</li> <li>64.</li> <li>65.</li> <li>66.</li> <li>67.</li> <li>68.</li> <li>69.</li> <li>70.</li> <li>70.</li></ul>
. 00 . 00 . 00 . 00 . 00 . 00 . 50 . 87 . 88 . 89 . 90 . 91 . 92 . 93	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	)	59, 359 38, 583 4, 739 2, 601, 491 0 0 0 0 0 0 0 0 0 0 0 0 0 0	<ul> <li>63.</li> <li>64.</li> <li>65.</li> <li>66.</li> <li>67.</li> <li>68.</li> <li>69.</li> <li>70.</li> <li>70.</li></ul>

ALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CO		Period: From 11/01/2020 To 12/31/2020		pared: 3 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	<u>(</u> (уууу)	Amount	
70.96 Lov	v volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		0 2021	1. 00 181, 267	70.96
	e corresponding federal year for the period prior to 10/1)			2021	101, 207	/0. /0
'0. 97 Lov	v volume adjustment for federal fiscal year (yyyy) (Enter i			2021	0	70.97
	e corresponding federal year for the period ending on or a v Volume Payment-3	iter 10/1)			0	70.98
	C adjustment amount (see instructions)				0	
	ount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			2, 765, 391	
	questration adjustment (see instructions)				0	71.01
	nonstration payment adjustment amount after sequestration				0	71.02
	questration adjustment-PARHM pass-throughs				2 7/0 552	71.03
	terim payments terim payments-PARHM				2, 768, 553	72.00 72.0
	ntative settlement (for contractor use only)				0	
	ntative settlement-PARHM (for contractor use only)					73.01
4.00 Bal	ance due provider/program (line 71 minus lines 71.01, 71.0	02, 72, and			-3, 162	74.00
73)						
	ance due provider/program-PARHM (see instructions)	anaa with			0	74.01
	ptested amounts (nonallowable cost report items) in accorda S Pub. 15-2, chapter 1, §115.2	ance with			0	75.00
	BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00 Ope	erating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
	us 2.04 (see instructions)					
	bital outlier from Wkst. L, Pt. I, line 2				0	
	erating outlier reconciliation adjustment amount (see instruction outlier reconciliation adjustment amount (see instruction)				0	
	e rate used to calculate the time value of money (see institute				0.00	
	ne value of money for operating expenses (see instructions)				0	95.00
96.00 Tin	me value of money for capital related expenses (see instru	ctions)			0	96.00
				Prior to 10/1 1.00	0n/After 10/1 2.00	
HSP	P Bonus Payment Amount			1.00	2.00	
	p bonus amount (see instructions)			0	0	]100. 00
	P Adjustment for HSP Bonus Payment					
	3P adjustment factor (see instructions)	>		0.000000000		
	3P adjustment amount for HSP bonus payment (see instruction 2 Adjustment for HSP Bonus Payment	ns)		0	0	102.00
	R adjustment factor (see instructions)			0.0000	0.0000	103.00
	R adjustment amount for HSP bonus payment (see instruction	s)		0		104.00
Rur	al Community Hospital Demonstration Project (§410A Demons					
	this the first year of the current 5-year demonstration pe	eriod under t	he 21st			200.00
	ntury Cures Act? Enter "Y" for yes or "N" for no. It Reimbursement					-
Cer						201.00
Cer Cos		ne 49)				
Cer Cos 01.00 Med	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions)	ne 49)				202.00
Cer Cos 01.00 Mec 02.00 Mec 03.00 Cas	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions)				-	
Cer Cos 01.00 Mec 02.00 Mec 03.00 Cas Com	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in		of the curre	nt 5-year demonst	tration	
Cer Cos 01.00 Mec 02.00 Mec 03.00 Cas Com per	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in iod)		of the curre	nt 5-year demonst		203.00
Cer Cos 01.00 Mec 02.00 Mec 03.00 Cas Com per 04.00 Mec	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mutation of Demonstration Target Amount Limitation (N/A in iod) dicare target amount		of the curre	nt 5-year demonst		203. 00 204. 00
Cer Cos 01.00 Mec 02.00 Mec 03.00 Cas Com per 04.00 Mec 05.00 Cas	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) uputation of Demonstration Target Amount Limitation (N/A in iod) dicare target amount se-mix adjusted target amount (line 203 times line 204)	n first year	of the curre	nt 5-year demonst		202. 00 203. 00 204. 00 205. 00 206. 00
Cer Cos 01.00 Mec 02.00 Mec 03.00 Cas 04.00 Mec 05.00 Cas 06.00 Mec Adj	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) uputation of Demonstration Target Amount Limitation (N/A in iod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement	n first year )	of the curre	nt 5-year demonst		203. 00 204. 00 205. 00
Cer Cos 01. 00 Mec 02. 00 Mec 03. 00 Cas 06 Mec 05. 00 Cas 06. 00 Mec 05. 00 Cas 06. 00 Mec 05. 00 Cas 06. 00 Mec 05. 00 Cas 06. 00 Mec	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) uputation of Demonstration Target Amount Limitation (N/A in iod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see inst	n first year ) tructions)	of the curre	nt 5-year demonst		203. 00 204. 00 205. 00 206. 00 207. 00
Cer Cos Cos Cos Com Com Com Com Com Com Cos Com Cos Com Cos Cos Cos Com Cos Cos Cos Cos Cos Cos Cos Cos Cos Cos	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) uputation of Demonstration Target Amount Limitation (N/A in iod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see inst dicare Part A inpatient service costs (from Wkst. E, Pt. A	n first year ) tructions)	of the curre	nt 5-year demonst		203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
Cer           Cos           01.00           02.00           03.00           Cas           04.00           05.00           06.00           07.00           08.00           09.00           00	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) uputation of Demonstration Target Amount Limitation (N/A in iod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see ins dicare Part A inpatient service costs (from Wkst. E, Pt. A, ustment to Medicare IPPS payments (see instructions)	n first year ) tructions)	of the curre	nt 5-year demonst		203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
Cer Cos Cos Cos Cos Cos Cos Cos Cos Cos Cos	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) uputation of Demonstration Target Amount Limitation (N/A in iod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see ins dicare Part A inpatient service costs (from Wkst. E, Pt. A ustment to Medicare IPPS payments (see instructions) served for future use	n first year ) tructions) , line 59)	of the curre	nt 5-year demonst		203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
Cer           Cos           01.00           02.00           03.00           Com           per           04.00           05.00           06.00           07.00           08.00           09.00           00.00           00.00	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) uputation of Demonstration Target Amount Limitation (N/A in iod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see ins dicare Part A inpatient service costs (from Wkst. E, Pt. A, ustment to Medicare IPPS payments (see instructions)	n first year ) tructions) , line 59)	of the curre	nt 5-year demonst		203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
Cer           Cos           01.00           02.00           03.00           Com           per           04.00           05.00           06.00           Mec           07.00           08.00           Mec           07.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) sputation of Demonstration Target Amount Limitation (N/A in iod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see ins dicare Part A inpatient service costs (from Wkst. E, Pt. A ustment to Medicare IPPS payments (see instructions) served for future use tal adjustment to Medicare IPPS payments (see instructions)	h first year ) tructions) , line 59) )	of the curre	nt 5-year demonst		203. 00 204. 00 205. 00 206. 00
Cer           Cos           01.00           02.00           03.00           Cas           04.00           05.00           06.00           07.00           08.00           09.00           00           00           01           02.00           03.00           04.00           05.00           07.00           07.00           07.00           07.00           07.00           07.00           07.00  <	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) uputation of Demonstration Target Amount Limitation (N/A in iod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see ins dicare Part A inpatient service costs (from Wkst. E, Pt. A ustment to Medicare IPPS payments (see instructions) served for future use tal adjustment to Medicare IPPS payments (see instructions) ustment to Medicare IPPS payments (see instructions)	h first year ) tructions) , line 59) ) 211)		nt 5-year demonst		203. 0 204. 0 205. 0 206. 0 208. 0 209. 0 210. 0 211. 0

	Financial Systems			Provider CC		Period: From 11/01/2020 To 12/31/2020	Date/Time Prep	pai
				Titlo	XVIII	Hospi tal	7/28/2021 2:53 PPS	3
		W/S F Part A	Amounts (from	Pre/Post	Period Prior		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	
)	DRG amounts other than outlier	1.00	0	0		0 0	0	
I	payments DRG amounts other than outlier	1. 01	2, 224, 390	0	2, 224, 39	0	2, 224, 390	
2	payments for discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	0	0		0	0	
3	DRG for Federal specific operating payment for Model 4	1. 03	0	0		0	0	
1	BPCI occurring prior to October 1 DRG for Federal specific	1. 04	0	0		0	0	
	operating payment for Model 4 BPCI occurring on or after October 1							
)	Outlier payments for	2.00						
I	discharges (see instructions) Outlier payments for	2. 02	0	0		0 0	0	
2	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	70, 675	0	70, 67	5	70, 675	
3	Outlier payments for discharges occurring on or after October 1 (see	2. 04	0	0		0	О	
)	instructions) Operating outlier	2. 01	0	0		o o	О	
)	reconciliation Managed care simulated	3.00	0	0		0 0	0	
	payments Indirect Medical Education Adju	ictmont						1
)	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0 0. 000000		1
)	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		0 0	0	
I	instructions) IME payment adjustment for managed care (see	22.01	0	0		0 0	0	
	instructions)	intmont for the	Add on for Co	ation 122 of t	be MMA			1
	Indirect Medical Education Adju					0 000000		
)	IME payment adjustment factor (see instructions) IME adjustment (see	27.00 28.00	0. 000000	0. 000000		0 0.000000	0	
	instructions) IME payment adjustment add on	28.01	0	0		0 0	0	
)	for managed care (see instructions) Total IME payment (sum of	29.00	0	0		0 0	0	
I	lines 6 and 8) Total IME payment for managed	29. 01	0	0		0 0	0	
	care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustme	ent						
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0247	0. 0247	0. 024	7 0. 0247		1
00	Disproportionate share adjustment (see instructions)	34.00	13, 736	0	13, 73	6 0	13, 736	1
01	Uncompensated care payments Additional payment for high per		162, 757 D beneficiary	di scharges			162, 757	
00	Total ESRD additional payment (see instructions)	46.00	0	0		0 0		
00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	2, 471, 558 0	0 0	2, 471, 55	8 0 0 0	2, 471, 558 0	1
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	2, 471, 558	0	2, 471, 55	8 0	2, 471, 558	1
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	177, 205	0	177, 20	5 0	177, 205	1

	Financial Systems		ST ELI ZABETH		NI. 1E 0004		u of Form CMS-2	2002-1
LOW VC	DLUME CALCULATION EXHIBIT 4			Provider CC		Period: From 11/01/2020 To 12/31/2020	Worksheet E Part A Exhibi Date/Time Pre 7/28/2021 2:5	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	
17.00	Special add-on payments for new technologies	54.00	104, 675	0	104, 67	5 0	104, 675	
17.01	Net organ aquisition cost							17.0
17.02	Credits received from	68.00	0	0		0 0	0	17.0
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	0	0		0 0	0	18.0
	adjustment amount (see							
10 00	instructions) SUBTOTAL			0	2, 753, 43	8 0	2 752 420	10.0
19.00	JUBIUTAL	W/S L, line	(Amounts from	0	2, 755, 45	0 0	2, 753, 438	19.0
		117 O E, 11110	L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	164, 207	0	164, 20	7 0	164, 207	20.0
20. 01	Model 4 BPCI Capital DRG other	1.01	0	0		0 0	0	20. C
	than outlier							
21.00	Capital DRG outlier payments	2.00	12, 998		12, 99		12, 998	
21.01	Model 4 BPCI Capital DRG	2. 01	0	0		0 0	0	21.0
22.00	outlier payments Indirect medical education	5.00	0. 0000	0. 0000	0.000	0 0.0000		22.0
22.00	percentage (see instructions)	5.00	0.0000	0.0000	0.000	0.0000		22.0
23.00	Indirect medical education	6.00	0	0		o o	0	23. C
	adjustment (see instructions)		-	-		-	-	
24.00	Allowable disproportionate	10.00	0. 0000	0.0000	0.000	0.0000		24.0
	share percentage (see							
	instructions)							
25.00	Disproportionate share	11.00	0	0		0 0	0	25. C
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	177, 205	0	177, 20	5 0	177, 205	26. C
	payments (see instructions)	W/S E Dort A	(Amounts to E,					
			Part A)					
		0	1,00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor	-			0, 06583			27.0
28.00	Low volume adjustment	70, 96			181, 26		181, 267	
	(transfer amount to Wkst. E,						,20,	
	Pt. A, line)							
29.00	Low volume adjustment	70. 97				0	0	29.0
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Y					100.0
	adjustments to Wkst. E, Pt. A.							

SPI -	FAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 11/01/2020 To 12/31/2020	Date/Time Prep 7/28/2021 2:53	pare
			Title		Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	2, 224, 390	2, 224, 39	0	2, 224, 390	1. 1.
)2	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges exercise a prior ofter October 1	1.02	О		0	0	1
)3	discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1
)4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1
00	Outlier payments for discharges (see instructions)	2.00					2
)1	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	70, 675	70, 67	5	70, 675	2
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	
)0 )0	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0 0		0 0 0 0	0	3 4
0	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0.00000	0 0. 000000		5
)0 )1	(see instructions) IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0		0 0 0 0	0	6
	instructions)						
	Indirect Medical Education Adjustment for the						_
0	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 00000	0 0. 000000 0 0	0	7
10 1	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0	0 0	8 8
10 1	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.00 29.01	0 0		0 0 0 0	0 0	9 9
	Disproportionate Share Adjustment		1 1				
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0247	0. 024	7 0. 0247		10
00	Disproportionate share adjustment (see instructions)	34.00	13, 736	13, 73		13, 736	
01	Uncompensated care payments Additional payment for high percentage of ESR	36.00	162, 757	162, 75	7 0	162, 757	11
00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	2, 471, 558 0	2, 471, 55	8 0 0 0	2, 471, 558 0	13 14
00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	2, 471, 558	2, 471, 55	8 0	2, 471, 558	15
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	177, 205	177, 20	5 0	177, 205	16
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	104, 675	104, 67	5 0	104, 675	17 17
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17
00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	
	SUBTOTAL		1	2, 753, 43	8 0	2, 753, 438	1 4 0

Health Financial Systems	ST ELI ZABETI	H DEARBORN		In Lie	u of Form CMS-:	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULAT	TION EXHIBIT 5	Provider CC		Period: From 11/01/2020 To 12/31/2020		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	164, 207	164, 20	07 0	164, 207	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	12, 998	12, 9	98 0	12, 998	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	5.00	0.0000	0.000	0. 0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	177, 205	177, 20	05 0	177, 205	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70.96	181, 267	181, 20	67	181, 267	28.00
29.00 Low volume adjustment on or after October 1	70.97	0		0	0	
30.00 HVBP payment adjustment (see instructions)	70.93	1, 731	1, 7:	31 0	1, 731	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	1
31.00 HRR adjustment (see instructions)	70, 94	-19, 098	-19, 0	98 0	-19, 098	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	1
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70.99		29, 1	73 0	29, 173	32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Ν				100. 00

CULAT	ION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0086	Period: From 11/01/2020	Worksheet E	
			To 12/31/2020	Part B Date/Time Pre	
		Title XVIII	Hospi tal	7/28/2021 2:5 PPS	3 pm
				1.00	
PA	RT B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
	edical and other services (see instructions)	+:)		226	
	edical and other services reimbursed under OPPS (see instruc PPS payments	tions)		1, 191, 135 852, 145	
1	utlier payment (see instructions)			13, 387	
	utlier reconciliation amount (see instructions)			0	
	nter the hospital specific payment to cost ratio (see instru ne 2 times line 5	ctions)		0.000	
-	um of lines 3, 4, and 4.01, divided by line 6			0.00	
	ransitional corridor payment (see instructions)			0	
	ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions	IV, col. 13, line 200		4, 892 0	
	otal cost (sum of lines 1 and 10) (see instructions)			226	
	MPUTATION OF LESSER OF COST OR CHARGES			-	
	easonable charges			4/2	1 1 2 0
	ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		463 0	12.0 13.0
	tal reasonable charges (sum of lines 12 and 13)			463	
	istomary charges				
	ggregate amount actually collected from patients liable for mounts that would have been realized from patients liable fo			0	
	ad such payment been made in accordance with 42 CFR §413.13(		n a chai yebasi s	0	10.0
00 Ra	atio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	otal customary charges (see instructions)	ly if line 10 evenede li	no 11) (coo	463	
	<pre>kcess of customary charges over reasonable cost (complete on hstructions)</pre>	TY IT TIME 18 exceeds T	ne II) (see	237	19.0
	ccess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.0
	nstructions)			224	01
	esser of cost or charges (see instructions) nterns and residents (see instructions)			226	
	ost of physicians' services in a teaching hospital (see inst	ructions)		0	
	otal prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			870, 424	24. (
	MPUTATION OF REIMBURSEMENT SETTLEMENT eductibles and coinsurance amounts (for CAH, see instruction	s)		0	25. (
	eductibles and Coinsurance amounts relating to amount on lin	-	ructions)	158, 387	
	ubtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	2 and 23] (see	712, 263	27.0
1	nstructions) rect graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. (
	SRD direct medical education costs (from Wkst. E-4, line 36)			0	
	ubtotal (sum of lines 27 through 29)			712, 263	
	rimary payer payments ubtotal (line 30 minus line 31)			57 712, 206	
	LOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI)	CES)		712,200	52.0
	omposite rate ESRD (from Wkst. I-5, line 11)			0	
	lowable bad debts (see instructions) djusted reimbursable bad debts (see instructions)			53, 267 34, 624	
	lowable bad debts for dual eligible beneficiaries (see inst	ructions)		28, 282	
00 SL	ubtotal (see instructions)	,		746, 830	
	SP-LCC reconciliation amount from PS&R			0	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) oneer ACO demonstration payment adjustment (see instruction	s)		0	39.
	emonstration payment adjustment amount before sequestration	0)		0	
	artial or full credits received from manufacturers for repla	ced devices (see instruc	ctions)	0	
	ECOVERY OF ACCELERATED DEPRECIATION ubtotal (see instructions)			0 746, 830	
1	equestration adjustment (see instructions)			740, 830	
	emonstration payment adjustment amount after sequestration			0	
1	equestration adjustment-PARHM pass-throughs			72/ 075	40.
1	nterim payments nterim payments-PARHM			736, 075	41. 41.
	entative settlement (for contractors use only)			0	
1	entative settlement-PARHM (for contractor use only)			40 75-	42.0
	alance due provider/program (see instructions) alance due provider/program-PARHM (see instructions)			10, 755	43. ( 43. (
00 Pr §1	rotested amounts (nonallowable cost report items) in accorda 115.2	nce with CMS Pub. 15-2,	chapter 1,	0	
	) BE COMPLETED BY CONTRACTOR			2	00.
	riginal outlier amount (see instructions) utlier reconciliation adjustment amount (see instructions)			0	
	he rate used to calculate the Time Value of Money				92.0
	me Value of Money (see instructions)			0	
00 10	otal (sum of lines 91 and 93)			0	94.0

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	N: 15-0086	Period: From 11/01/2020 To 12/31/2020		
		Title		Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		2, 768, 5	53 0	736, 075 0	1. 0 2. 0 3. 0
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					0.0
. 01	ADJUSTMENTS TO PROVIDER			0	0	3. C
. 02				0	0	3.0
. 03 . 04				0	0	3. ( 3. (
. 04				0	0	3. 3.
. 00	Provider to Program	11				0.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52 53				0	0	3. 3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 768, 5	53	736, 075	4.
00	TO BE COMPLETED BY CONTRACTOR 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 PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.
50 51	TENTATIVE TO PROGRAM			0	0	5. 5.
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER			0	10, 755	6.
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		3, 10 2, 765, 39		0 746, 830	6. 7.
	Total meancare program traditity (see fistructions)		2, 705, 3	Contractor Number	NPR Date (Mo/Day/Yr)	/.
		0		1.00	2.00	

Heal th	Financial Systems ST ELIZABETH [	DEARBORN	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0086	Period: From 11/01/2020	Worksheet E-1 Part II	1
			To 12/31/2020		epared:
				7/28/2021 2:5	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
1.00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA §4102 from Wkst.		. 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8		14	l	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. 1, col. 6. line 2	-12		l	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12		l	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			l	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	ine 20		l	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	l	7.00
	line 168			l	
8.00	Calculation of the HIT incentive payment (see instructions)			l	8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		L	10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00 32.00	Other Adjustment (specify) Balance due provider (line 8 (or line 10) minus line 30 and l	ino 21) (coo instruction	c)		31.00 32.00
32.00	parance due provider (TTHE & (OF TTHE TO) MITHUS TTHE 30 and T	The sty (see Instruction	5)		32.00

	Financial Systems ST ELIZABE ATION OF REIMBURSEMENT SETTLEMENT	TH DEARBORN Provider CCN: 15-0086	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCUL	ATTON OF REIMBORSEMENT SETTLEMENT	PLOVI del CCN. 15-0086	From 11/01/2020	Part VII	
			To 12/31/2020	Date/Time Pre	
		Title XIX	Hospi tal	7/28/2021 2:5 Cost	3 pm
		II the AIA	Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALT	H SERVICES FOR TITLES V OR >	I X SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
. 00	Inpatient hospital/SNF/NF services		0	_	1.
00	Medical and other services			0	
00 00	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		0	0	3.
00	Inpatient primary payer payments		0	0	5
00	Outpatient primary payer payments		Ŭ	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				
00	Routine service charges		0		8
00	Ancillary service charges		157, 478	0	
0.00	Organ acquisition charges, net of revenue		0		10
1.00 2.00	Incentive from target amount computation		157, 478	0	11   12
. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		157,470	0	1 12
3.00	Amount actually collected from patients liable for paymen	t for services on a charge	0	0	13
	basi s		-	-	
. 00	Amounts that would have been realized from patients liabl	e for payment for services of	on O	0	14
	a charge basis had such payment been made in accordance w	ith 42 CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
5.00	Total customary charges (see instructions)		157, 478	0	
. 00	Excess of customary charges over reasonable cost (complet	e only if line 16 exceeds	157, 478	0	17
3. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complet	e only if line 4 exceeds lin		0	18
. 00	16) (see instructions)			0	
9.00	Interns and Residents (see instructions)		0	0	19
0. 00	Cost of physicians' services in a teaching hospital (see	instructions)	0	0	20
I. 00	Cost of covered services (enter the lesser of line 4 or l		0	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must onl	y be completed for PPS provi			
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments Capital exception payments (see instructions)		0		24
	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	
3.00	Customary charges (title V or XIX PPS covered services on	l y)	0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)	5.	0	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				]
0. 00	Excess of reasonable cost (from line 18)		0	0	
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 a	ind 6)	0	0	
2.00	Deductibles		0	0	
	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions) Utilization review		0	0	34 35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 3	2 and 33)	0	0	
. 00 . 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
3.00	Subtotal (line $36 \pm 1$ ine $37$ )		0	0	
. 00	Direct graduate medical education payments (from Wkst. E-		0	-	39
0. 00	Total amount payable to the provider (sum of lines 38 and	39)	0	0	40
I. 00	Interim payments		0	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
3.00	Protested amounts (nonallowable cost report items) in acc	ordance with CMS Pub 15-2	0	0	43

ALANCE	Financial Systems ST ELIZABETH SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the General Fund column	Provi der C		eriod: com 11/01/2020	u of Form CMS-2 Worksheet G	
nly)	pe accounting records, comprete the deneral rund cordinin		To		Date/Time Pre 7/28/2021 2:5	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
-	CURRENT ASSETS	20.450	0	0	0	1 1
	Cash on hand in banks Temporary investments	29, 459	0	0	0	
	Notes receivable		0	0	0	
	Accounts receivable	12, 900, 428	0	0	0	
	Other receivable	2, 053	0	0	0	
00 /	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.
	Inventory	2,004,897	0	0	0	
	Prepaid expenses	0	0	0	0	
	Other current assets Due from other funds	0	0	0	0	
	Total current assets (sum of lines 1-10)	14, 936, 837	0	0	0	
	TIXED ASSETS	11,700,007			0	1
	Land	0	0	0	0	12
	Land improvements	0	-	0	0	
	Accumulated depreciation	0	0	0	0	
	Buildings	0	0	0	0	
	Accumulated depreciation Leasehold improvements	-48, 860	0	0 O	0	
	Accumul ated depreciation		0	0	0	
	Fixed equipment		0	0	0	
	Accumul ated depreciation	0	0	Ő	0	
	Automobiles and trucks	0	0	0	0	
. 00 /	Accumul ated depreciation	0	0	0	0	22
1	Major movable equipment	3, 093, 669	0	0	0	
	Accumulated depreciation	-121, 193	0	0	0	
	Minor equipment depreciable	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	HIT designated Assets Accumulated depreciation		0	0	0	
	Mi nor equi pment-nondepreci abl e		0	0	0	
	Total fixed assets (sum of lines 12-29)	2, 923, 616		0	0	
	OTHER ASSETS			· · · · ·		1
. 00 🛛	Investments	0	0	0	0	31
	Deposits on leases	0	0	0	0	
	Due from owners/officers	-12, 883, 396		0	0	1
	Other assets Tatal ather assats (aum of Lines 21 24)	393, 954		0	0	
1	Total other assets (sum of lines 31-34) Total assets (sum of lines 11 20 and 25)	-12, 489, 442 5, 371, 011	0	0	0	
	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	5, 371, 011	0	U	0	1 30
	Accounts payable	2, 077, 506	0	0	0	37
	Salaries, wages, and fees payable	732, 318	-	Ő	0	
1	Payroll taxes payable	0		0	0	39
. 00  1	Notes and Loans payable (short term)	0	0	0	0	40
	Deferred income	0	0	0	0	
	Accelerated payments	0				42
	Due to other funds	0	0	0	0	
	Other current liabilities	161, 661 2, 971, 485		0	0	
	Total current liabilities (sum of lines 37 thru 44) .ONG TERM LIABILITIES	2,971,400	0	U	0	40
	Mortgage payable	0	0	0	0	46
	Notes payable	0	0	Ő	0	
1	Unsecured Loans	0	0	Ō	0	
	Other long term liabilities	192, 612	0	0	0	49
	Total long term liabilities (sum of lines 46 thru 49)	192, 612		0	0	
	Total liabilities (sum of lines 45 and 50)	3, 164, 097	0	0	0	51
	CAPITAL ACCOUNTS	2 204 014				1
	General fund balance Specific purpose fund	2, 206, 914	0			52
	Donor created - endowment fund balance - restricted		0	0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
I	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	2, 206, 914		0	0	
). 00	Total liabilities and fund balances (sum of lines 51 and	5, 371, 011	I 0	0	0	60

Heal th	Financial Systems	ST ELI ZABETH	DEARBORN			In Lie	u of Form CMS	-25	52-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0086		riod: om 11/01/2020 12/31/2020	Worksheet G- Date/Time Pr 7/28/2021 2:	1 epa 53	red:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fun	d	
		1.00	2.00	3.00		4.00	5.00	_	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) CHOW Total deductions (sum of lines 12-17) Fund balance at end of period per balance	49, 597, 076 0 0 0 0 0 0 0 0 0 0 0 0 0	49, 597, 081 2, 206, 909 51, 803, 990 51, 803, 990 51, 803, 990 49, 597, 076 2, 206, 914		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 1 0 1 0 1 0 1 0 1 1 0 1 1 0 1 1 0 1 1 0 1 1 0 1 1 0 1 1 0 1 0 1 1 0 1 0 1 0 1 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) CHOW Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0			1 1 1 1 1 1 1 1 1	0.00         1.00         2.00         3.00         4.00         5.00         6.00         7.00         8.00         9.00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES P	rovider CC	N: 15-0086	Period: From 11/01/2020 To 12/31/2020		epared:
	Cost Center Description	-	Inpatient 1.00	Outpatient 2.00	Total 3.00	<u> </u>
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					-
1.00	Hospi tal		2, 097, 34	17	2, 097, 347	1.00
2.00	SUBPROVIDER - IPF			0	0	
3.00	SUBPROVIDER - IRF			0	0	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
5.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	
3.00	NURSING FACILITY			0	0	
9.00	OTHER LONG TERM CARE			0	0	
10.00	Total general inpatient care services (sum of lines 1-9)		2, 097, 34	17	2, 097, 347	10.00
11 00	Intensive Care Type Inpatient Hospital Services		2 0 4 0 0		2 040 050	11 00
11.00	INTENSIVE CARE UNIT		2, 840, 05		2, 840, 058	
12.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT			0		
14.00	SURGICAL INTENSIVE CARE UNIT			0		
15.00	OTHER SPECIAL CARE (SPECIFY)			0		15.00
16.00	Total intensive care type inpatient hospital services (sum of li	nos	2, 840, 05	38	2, 840, 058	
10.00	11-15)	lies	2, 040, 00	00	2, 040, 030	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		4, 937, 40	)5	4, 937, 405	17.00
18.00	Ancillary services		11, 565, 41			
19.00	Outpati ent servi ces		1, 011, 76			
20.00	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	o c	21.00
22.00	HOME HEALTH AGENCY			C	0	22.00
23.00	AMBULANCE SERVICES			0 0	0	23.00
24.00	СМНС			C	0 0	24.00
24.10	CORF			0 0	-	
25.00	AMBULATORY SURGICAL CENTER (D. P.)			0 0		
26.00	HOSPICE			0 0	-	
27.00	OP ROUTINE			0 274, 256		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst.	17, 514, 58	38 22, 992, 732	40, 507, 320	28.00
	G-3, line 1) PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			10, 437, 037	7	29.00
30.00	ADD (SPECIFY)			0		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)			C		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
13.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(			10, 437, 037		43.00

		TH DEARBORN		u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0086	Peri od:	Worksheet G-3	
			From 11/01/2020 To 12/31/2020	Date/Time Pre	nared
			10 12/31/2020	7/28/2021 2:5	3 pm
				1.00	
. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,			40, 507, 320	1.0
2.00	Less contractual allowances and discounts on patients' ac	counts		27, 955, 731	2.0
3.00	Net patient revenues (line 1 minus line 2)			12, 551, 589	3. (
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		10, 437, 037	4.0
5.00	Net income from service to patients (line 3 minus line 4)			2, 114, 552	5.
	OTHER INCOME				
5.00	Contributions, donations, bequests, etc			0	6.1
7.00	Income from investments			0	7.
3.00	Revenues from telephone and other miscellaneous communica	tion services		0	8.
9.00	Revenue from television and radio service			0	
	Purchase di scounts			0	
	Rebates and refunds of expenses			0	11.
	Parking lot receipts			0	12.
	Revenue from laundry and linen service			0	13.
	Revenue from meals sold to employees and guests			31, 170	
	Revenue from rental of living quarters			0	15.
	Revenue from sale of medical and surgical supplies to oth	er than patients		0	16.
	Revenue from sale of drugs to other than patients			22, 754	
	Revenue from sale of medical records and abstracts			20	18.
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.
	Rental of vending machines			0	
	Rental of hospital space			1, 384	
	Governmental appropriations			0	23.
	GRANTS			37, 029	
	COVID-19 PHE Funding			0	24.
	Total other income (sum of lines 6-24)			92, 357	25.
	Total (line 5 plus line 25)			2, 206, 909	
	OTHER EXPENSES (SPECIFY)			0	27.
	Total other expenses (sum of line 27 and subscripts)			0	28.
29.00	Net income (or loss) for the period (line 26 minus line 2	8)		2, 206, 909	29.

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0086	Period: From 11/01/2020 To 12/31/2020		pared:
			11	7/28/2021 2:5	3 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
PART	I - FULLY PROSPECTIVE METHOD				
	AL FEDERAL AMOUNT				1
.00 Capit	Capital DRG other than outlier			164, 207	1.
.01 Model	Model 4 BPCI Capital DRG other than outlier			0	1.
.00 Capit	Capital DRG outlier payments			12, 998	2.
.01 Model	Model 4 BPCI Capital DRG outlier payments			0	2.
	Total inpatient days divided by number of days in the cost reporting period (see instructions)			35.33	
	Number of interns & residents (see instructions)			0.00	
					5.
	0 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)				6.
					7.
30) (	30) (see instructions)				
				0.00	
				0.00	
				0.00	
	00 Total prospective capital payments (see instructions)				
2.00  10tai	prospective capital payments (see ins	structions)		177, 205	12.
				1.00	
	II - PAYMENT UNDER REASONABLE COST				
	Program inpatient routine capital cost (see instructions)			0	
	Program inpatient ancillary capital cost (see instructions)			0	
				0	
	al cost payment factor (see instruction	•		0	
00 Total	inpatient program capital cost (line	3 x line 4)		0	5.
				1.00	
	III - COMPUTATION OF EXCEPTION PAYMENT			0	
5	ram inpatient capital costs (see instru			0	
		rdinary circumstances (see instructions)		0	-
	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0.00	-
	Capital cost for comparison to payments (line 3 x line 4)			0.00	
	Percentage adjustment for extraordinary circumstances (see instructions)			0.00	
		for extraordinary circumstances (line 2 x	line 6)	0.00	
	al minimum payment level (line 5 plus	3		0	
	ent year capital payments (from Part I,			0	
		payment level to capital payments (line 8 l	ess line 9)	0	1 .
.00 Carry				0	
		evel to capital payments (line 10 plus line	- 11)	0	12.
' ()() INPT (		is positive, enter the amount on this line)		0	
		ayment level over capital payment for the fo		0	
.00 Curre		agment rever ever capital payment rel the re	strong period	0	1 '7.
. 00 Curre . 00 Carry	· · · · · ·	on this line)			
3.00 Curre 4.00 Carry (if l	ine 12 is negative, enter the amount of			0	15.
3.00 Curre 4.00 Carry (if 1 5.00 Curre	· · · · · ·	al payment (see instructions)		0 0	

- 15.00 Current year allowable operating and capital payment (see in
   16.00 Current year operating and capital costs (see instructions)
   17.00 Current year exception offset amount (see instructions)