This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0086 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/23/2022 10:25 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/23/2022 Time: 10:25 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[19] 19. NPR Date:
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[16] 19. NPR Date:
[17] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date Contractor use only number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(3) Settled with Audit

(4) Reopened (5) Amended

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST ELIZABETH DEARBORN (15-0086) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title	CF0			3
4	Date				4

			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	-96, 095	-141, 452	0	411, 263	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	-96, 095	-141, 452	0	411, 263	200. 00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for th	e element of t	he above comple	ex 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.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I	ST ELIZABETH DENTIFICATION DATA			N: 15-0086	F	li eriod: rom 01/01/ o 12/31/	2021	of For Workshe Part I Date/Ti	et S-2 me Pre	pared:
	1.00	2.00		3. 00			4	4. 00	5/23/20	122 10	23 alli
	Hospital and Hospital Health Care Co										
1. 00 2. 00	Street: 600 WILSON CREEK ROAD City: LAWRENCEBURG	PO Box: State: IN	Zip Code	o. 470	25 0	ount.	. DEADBODN				1. 00 2. 00
2.00	CITY. LAWRENCEBURG	Component Name	CCN	CBS			v: DEARBORN Date	Payme	nt Syst	em (P	2.00
		Component name	Number	Numb			Certi fi ed		0, or	N)	
		1.00	2.00	3. 0	00 4.0	00	5. 00	6. 00	7. 00		
	Hospital and Hospital-Based Componen										
3.00	•	ST ELIZABETH DEARBORN	150086	171	40 1	(07/01/1966	N	P	0	3. 00
4. 00 5. 00	Subprovider - IPF Subprovider - IRF										4. 00 5. 00
6. 00	Subprovider - (Other)										6. 00
7. 00	Swing Beds - SNF										7. 00
8.00	Swing Beds - NF										8. 00
9.00	Hospi tal -Based SNF										9. 00
10.00	Hospital Based NF										10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA										11. 00 12. 00
13. 00	Separately Certified ASC										13. 00
14. 00	Hospi tal -Based Hospi ce										14. 00
15.00	Hospital-Based Health Clinic - RHC										15. 00
16. 00	Hospital-Based Health Clinic - FQHC										16. 00
17. 00	Hospital -Based (CMHC) I										17. 00
17. 10	Hospital -Based (CORF) I										17. 10
18. 00 19. 00	Renal Dialysis										18. 00 19. 00
17.00	other						From:		To	:	17.00
							1. 00		2. 0	00	
	Cost Reporting Period (mm/dd/yyyy)						01/01/2	021	12/31/	′2021	20. 00
21. 00	Type of Control (see instructions)						1				21. 00
				+	1. 00		2. 00		3. 0	00	
	Inpatient PPS Information						2.00		0.0	,,,	
22. 00	Does this facility qualify and is it				Υ		N				22. 00
	disproportionate share hospital adjus			?							
	§412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" for		municit								
22. 01	Did this hospital receive interim und		s for thi	s	Υ		Y				22. 01
	cost reporting period? Enter in colu										
	the portion of the cost reporting per										
	Enter in column 2, "Y" for yes or "N' reporting period occurring on or after			cost							
22 02	Is this a newly merged hospital that			-e	N		N				22. 02
22.02	payments to be determined at cost re										22.02
	Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octobe										
	or "N" for no, for the portion of the October 1.	e cost reporting period	on or aft	er							
22 03	Did this hospital receive a geographi	ic reclassification from	urban to	,	N		N		N		22. 03
22.00	rural as a result of the OMB standard										22.00
	adopted by CMS in FY2015? Enter in co										
	for the portion of the cost reporting			er							
	in column 2, "Y" for yes or "N" for a reporting period occurring on or after										
	Does this hospital contain at least	•	,	ns							
	counted in accordance with 42 CFR 413										
	yes or "N" for no.	·									
22. 04	Did this hospital receive a geographi				N		N		N		22. 04
	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in (
	for the portion of the cost reporting										
	in column 2, "Y" for yes or "N" for i			.							
	reporting period occurring on or after										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41:	2.105)? Enter in column	13, "Y" f	or							
23 00	yes or "N" for no. Which method is used to determine Med	dicaid days on lines 24	and/or 25	;		4	N N				23. 00
_5. 00	below? In column 1, enter 1 if date										
	if date of discharge. Is the method	of identifying the days	in this c								
	reporting period different from the										
	reporting period? In column 2, enter	i i ioi yesor Ni Tor	HO.	- 1			1	l			l

57.00 | If line 56 is yes, is this the first cost reporting period during which residents in approved

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

57 00

58 00

59.00

ealth Financial Systems ST EL OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	LIZABETH DEARBORN NTA Provider CCN: 15-0086		CN. 1F 000/	Peri od:	u of Form CMS-2 Worksheet S-2	
JSPITAL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA .	Provider C	CN. 15-0080	From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/23/2022 10:	pared
			NAHE 413.8 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2. 00	3.00	
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 colu 0.01 If line 60 is yes, complete columns 2 and 3 for each	85? (s umn 1. R) NAHE mn 2.	ee If column 1 MA payment	Y	N 23. 00	1	60.
i nstructi ons)	Y/N	I ME	Direct GME	I ME	Direct GME	
	1.00	2. 00	3.00	4.00	5. 00	-
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	N	5.00		0.00		61.
instructions) 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.
 .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) .04 Enter the number of unweighted primary care/or 						61.
surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61.
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) .06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
jour o or gomeral ourgery. (coo morraderene)	Pro	gram Name	Program Cod	de Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
10 00 11 575 1 11 (4 05		1.00	2. 00	3.00	4.00	(1
 .10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. .20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE 				0. 00		
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.						
					1. 00	
ACA Provisions Affecting the Health Resources and Ser OU Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructions)	trai ned			eriod for which	0.00	62.
.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	Teachi ram. (s	<u>ee instructio</u>		to your hospital	0.00	62.
Teaching Hospitals that Claim Residents in Nonprovide 8.00 Has your facility trained residents in nonprovider se			ost renorting	n neriod? Enter	N	63.

Heal th	n Financial Systems	ST FI	I ZABETH DEARBORN		Inlie	u of Form CMS-2	2552-10
	TAL AND HOSPITAL HEALTH CARE COMP				eri od:	Worksheet S-2	
				Fi	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre 5/23/2022 10:	25 am
				Unwei ghted	Unweighted	Ratio (col. 1/	
				FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovider Settings		•	•	
64. 00	period that begins on or after J Enter in column 1, if line 63 is			0.00	0.00	0. 000000	64. 00
	in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo	tations occurring in number of unweighted	all nonprovider d non-primary care				
	of (column 1 divided by (column		instructions)				
		Program Name	Program Code	Unwei ghted		Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
				Si te	nospi tai	4))	
		1.00	2.00	3. 00	4. 00	5. 00	
65. 00	Enter in column 1, if line 63			0.00	0. 00	0. 000000	65. 00
65.00	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	65.00
				1. 00	2.00	3.00	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting				
	beginning on or after July 1, 20		Thomprovider Setting	5 211001110 10	or cost reporti	ng perrous	
66. 00	Enter in column 1 the number of			0.00	0. 00	0. 000000	66. 00
	FTEs attributable to rotations of Enter in column 2 the number of						
	FTEs that trained in your hospit						
	(column 1 divided by (column 1 +						
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTES	FTEs in	(col. 3 + col.	
				Nonprovi der Si te	Hospi tal	4))	
		1. 00	2. 00	3. 00	4. 00	5. 00	
67. 00				0.00			67. 00
	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)						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0086 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/23/2022 10:25 am 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.

If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most N 75.00 75.00 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 'Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 N Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 86.00 \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 87.00 N XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν Υ 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 report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. N 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter Ν Ν 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" for no in the N N 94.00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 0 00 0 00 95 00 96.00 Ν N 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 98.00 Υ stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 Υ 98.02 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of Ν 98.04 N outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Ν 105.00 106.00 of this facility qualifies as a CAH, has it elected the all-inclusive method of payment N 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 Ν Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		eri od:	Worksheet S-	2
		F	rom 01/01/2021 o 12/31/2021	Date/Time Pro	
			V	5/23/2022 10	: 25 a
			1. 00	2. 00	
3.00 s this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	N		108
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4.00	
0.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109
				1. 00	+
Do Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	Y" for yes or	"N" for no. I	f yes,	N	110
			1 00	2.00	-
1.00 f this facility qualifies as a CAH, did it participate in t	he Frontier (Community	1. 00 N	2.00	111
Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Dumn 1 is Y, ticipating ir	period? Enter enter the column 2.	·		
		1. 00	2. 00	3.00	1
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cea	peri od? 5 "Y", enter ne	N			11:
participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information					
5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			011!
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	3" percent includes				
the definition in CMS Pub.15-1, chapter 22, §2208.1. 5.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			11
0.00 is this facility legally-required to carry malpractice insur	ance? Enter	Y			11
"Y" for yes or "N" for no. 3.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr	,		2		118
		Premi ums	Losses	Insurance	
8.01 List amounts of malpractice premiums and paid losses:		1.00	2. 00 5, 193	3.00	2 118
.01 List amounts of malpractice premiums and paid losses:		1.00	2. 00 5, 193	3. 00 3 183, 47	2 11
B.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched		1.00 (2.00	3.00	
Administrative and General? If yes, submit supporting sched and amounts contained therein. OD NOT USE THIS LINE OD Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quelid Hold Harmless provision in ACA §3121 and applicable amendmen	lule listing of Harmless pro column 1, "\ ualifies for t	than the cost centers ovision in ACA " for yes or the Outpatient	2. 00 5, 193	3. 00 3 183, 47	11:
Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. ODD NOT USE THIS LINE ODIS this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no.	lule listing of Harmless pro n column 1, "Y Halifies for t hts? (see inst	than the cost centers ovision in ACA (" for yes or the Outpatient cructions)	2. 00 5, 193 1. 00 N	3. 00 3 183, 47 2. 00	118
Administrative and General? If yes, submit supporting sched and amounts contained therein. ODD NOT USE THIS LINE OD Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold sold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Column 2, "Y" for yes or "N" for no. OD Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	lule listing of the last properties of the la	than the cost centers ovision in ACA " for yes or the Outpatient cructions) es charged to	2. 00 5, 193 1. 00 N	3. 00 3 183, 47 2. 00	118 119 120
Administrative and General? If yes, submit supporting sched and amounts contained therein. OD NOT USE THIS LINE ODIS this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Sold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. OD Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. OD Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	Hule listing of the l	than the cost centers ovision in ACA " for yes or the Outpatient cructions) es charged to 8(w)(3) of the	2. 00 5, 193 1. 00 N	3. 00 3 183, 47 2. 00	111 111 120
.02Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein00 DO NOT USE THIS LINE .00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	Harmless produced listing of the column 1, "Year lists? (see instantable deviced in \$1903 is "Y", enter	than the cost centers ovision in ACA " for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2	2. 00 5, 193 1. 00 N	3. 00 3 183, 47 2. 00	118 119 120 122 122
Administrative and General? If yes, submit supporting sched and amounts contained therein. ODDO NOT USE THIS LINE ODISTANT SCH OR EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in "ODD Hold Harmless provision in ACA §3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no. ODD Id this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. ODD Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information ODD Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	Harmless produced in the column 1, "Natifies for the column 1," into the column 1, "Natifies for the column 1, "Na	than the cost centers ovision in ACA " for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2	2.00 5,193 1.00 N	3. 00 3 183, 47 2. 00	118 119 120 121 122
Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. O OD NOT USE THIS LINE O OO Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that questionally Hold Harmless provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no. O OD Id this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. O OD Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information O OD Does this facility operate a transplant center? Enter "Y" foyes, enter certification date(s) (mm/dd/yyyy) below.	Harmless produced in the content of	than the cost centers ovision in ACA " for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2	2.00 5,193 1.00 N	3. 00 3 183, 47 2. 00	118 119 120 121 122
Administrative and General? If yes, submit supporting sched and amounts contained therein. O OD DO NOT USE THIS LINE O OD Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. O Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. O Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information O Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. O If this is a Medicare certified kidney transplant center, enter of this is a Medicare certified heart transplant center, enter of the content of the column 1 and termination date, if applicable, in column 2	Harmless produced in column 1, "Yellow in the column 1, "Yellow in the column 1, "Yellow in the column in the colu	than the cost centers ovision in ACA "for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 for no. If	2.00 5,193 1.00 N	3. 00 3 183, 47 2. 00	118 119 120 122 122 128
Administrative and General? If yes, submit supporting sched and amounts contained therein. O OD NOT USE THIS LINE O OO Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that questioned Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. O Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information O Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. O O If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2	Harmless produced in column 1, "Year lifes for the service instantable deviced in \$1903 is "Y", enterproduced in the certification in the certification is "Item to certification in the certification	than the cost centers ovision in ACA " for yes or the Outpatient cructions) as charged to B(w)(3) of the er in column 2 for no. If fication date	2.00 5,193 1.00 N	3. 00 3 183, 47 2. 00	118 119 120 122 122 128 126
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and amounts contained therein. 9.00 DO NOT USE THIS LINE D.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 7.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2 8.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2	Harmless produced in the control of	than the cost centers ovision in ACA " for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 for no. If fication date Fication date	2.00 5,193 1.00 N	3. 00 3 183, 47 2. 00	118 1119 120 122 122 121 120

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLE		ABETH DEARBORN Provider CC	N: 15-0086	From O			2 epared:
		·			1 00	2.00	
31.00 f this is a Medicare certified in	itestinal transplant co	enter enter the ce	rti fi cati d		1. 00	2. 00	131. 0
date in column 1 and termination of 32.00 If this is a Medicare certified is	late, if applicable, in Het transplant center,	n column 2. , enter the certifi					132. 0
in column 1 and termination date, 33.00 Removed and reserved							133. 0
34.00 If this is an organ procurement or and termination date, if applicabl All Providers		er the OPO number i	n coi umn				134. 0
40.00 Are there any related organization chapter 10? Enter "Y" for yes or 'are claimed, enter in column 2 the	N" for no in column 1.	. If yes, and home	office cos	l l	Υ	HB0843	140. C
1.00	TIONE OTTICE CHAITI HA	2. 00	1 0113)		3. 00		
If this facility is part of a chai				e name and	d address	of the	
home office and enter the home off 41.00 Name: ST. ELIZABETH HEALTHCARE	Contractor name a			nctor's Nu	mher: 1510	<u></u>	141. (
CORPORATE	COITT actor 3 Name	e. 003	Contra	ictor 3 Nu	iliber. 1510	51	141.0
42.00 Street: 1 MEDICAL VILLAGE DRIVE	PO Box:						142. (
43.00 City: EDGEWOOD	State:	KY	Zi p Co	ide:	4101	1 /	143. C
						1.00	
44.00 Are provider based physicians' cos	ts included in Worksho	eet A?				Y	144. C
					1 00	0.00	
5.00 f costs for renal services are cl	aimed on Wkst A line	o 74 and the costs	for		1. 00	2.00	145. (
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no lude Medicare utiliza	o in column 1. If c	olumn 1 is	5			145. (
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	y changed from the pro column 1. (See CMS Po			lf	N		146.
lyes, effect the approval date (min/c	iar yyyy) TTT COT amit 2.						
						1.00	
17.00 Was there a change in the statisti 18.00 Was there a change in the order of						N N	147. (148. (
49.00 Was there a change to the simplifi				for no.		N N	149. 0
	<u>J</u>	Part A	Part E		itle V	Title XIX	
Dana this facility contains a great		1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '							
5. 00 Hospi tal	11 101 110 101 00011 00	N N	N		N N	N	155.
6.00 Subprovider - IPF		N	N		N	N	156.
57. 00 Subprovi der – IRF		N	N		N	N	157.
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158. (159. (
50. OO HOME HEALTH AGENCY		N N	N		N	N	160. 0
51. 00 CMHC			N		N	N	161. (
51. 10 CORF			N		N	N	161. 1
						1. 00	
Multicampus	mnuc bocnital that be-	c one or mane estate	1505 lm d! 4	fforont CD	2542	NI NI	1/5
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ilipus nospitai that nas	s one or more campu	1562 IU 011	rerent CE	SAS	N	165. (
12co	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,						0.0	0 166.
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
Health Information Technology (HI) incentive in the Am	erican Pecovory and	1 Pai pyosti	ment Act		1.00	
Health Information Technology (HI 7.00 Is this provider a meaningful user	under §1886(n)? Ente	er "Y" for yes or "	N" for no.			Y	167.
8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			167 is "\	("), enter	the		168.
8.01 If this provider is a CAH and is r			qualify f	for a hard	lshi p		168.
exception under §413.70(a)(6)(ii)?	'Enter "Y" for yes or	"N" for no. (see i	nstruction	ns)	•		
9.00 If this provider is a meaningful utransition factor. (see instruction		and is not a CAH (line 105 i	s "N"), e	enter the	9.9	9169.

Health Financial Systems	ST ELIZABETH D	DEARBORN	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DATA	Provi der CCN: 15-0086	Peri od:	Worksheet S-2	
			From 01/01/2021	Part I	
			To 12/31/2021		epared:
				5/23/2022 10:	25 am_
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beging period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider	have any days for indiv	viduals enrolled in	N	C	171. 00
section 1876 Medicare cost plans repor	ted on Wkst. S-3, Pt. I,	line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1	l. If column 1 is yes, er	nter the number of section	n		
1876 Medicare days in column 2. (see i					

OSPI T	Financial Systems ST ELIZABETH AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0086	Period: From 01/01/2021 To 12/31/2021	u of Form CMS- Worksheet S- Part II Date/Time Pro 5/23/2022 10	2 epared:
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	esponses. 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 c	e beginning of	the cost	N		1.00
	reporting period: IT yes, enter the date of the change in c	orumir 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	9	N			2.00
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A		4.00
	those on the filed financial statements? If yes, submit rec					
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
. 00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	s the provider	^ N		6. 00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during the	e Y Y		7. 00 8. 00
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
D. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10. 0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	oroved	N	V /N	11. 00
					Y/N 1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.00
5. 00	Did total beds available change from the prior cost reporti		yes, see inst rt A	tructions.	t B	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	04/28/2022	Y	04/28/2022	16. 0
7. 00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17. 00
8. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18. 00
9. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

HBSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider COX: 15-0086 Period Peri	Heal th	Financial Systems ST ELIZABETI	H DEARBORN		In Lie	u of Form CMS-	2552-10
1.00 3.00	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CN: 15-0086	From 01/01/2021	Part II Date/Time Pre	epared:
Page			Descr	i pti on		Y/N	
Report data for Other? Describe the other adjustments: 1.00 2.00 3.00 4.00 2.00 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 2.100 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 3.00 4.00 3.00 3.00 4.00 3.00 3.00 4.00 3.00		10.11		0			100.00
21.00 Was the cost report propared only using the provider's N 2.00 3.00 4.00 1.00 1.00 1.00 1.00 1.00 1.00 1	20.00				N	N	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00 Complete Provider Fryes, see instructions. 1.00		Those Caded For Striot Posser De the Striot Cal as the inter-	Y/N	Date	Y/N	Date	
CAMPLETER BY COST RELIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Sopi tal Reliated Cost Sopi tal Reliated Sopi tal				2.00		4. 00	
Completed By COST RELIBBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Copited Related CoSt 22.00 Have assets been reliar for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare purposes? If yes, see instructions 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit copy. 29.00 Did the provider have a funded depreciation account? If yes, see instructions 30.00 Has the provider have a funded depreciation account? If yes, see instructions 30.00 Has debt been replaced prior to its scheduled mutrity with new debt? If yes, see instructions. 31.00 Has debt been replaced prior to its scheduled mutrity with new debt? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If I line 31 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see instructions. 34.00 Preservices furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. 35.00 If line 36 is yes, see instructions. 36.00 Were home office costs claimed on the cost report? 37.00 If I line 36 is yes, did the provider render services to other chain components? If yes, see Instructi	21. 00		N		N		21. 00
Completed By COST RELIBBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Copited Related CoSt 22.00 Have assets been reliar for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare purposes? If yes, see instructions 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit copy. 29.00 Did the provider have a funded depreciation account? If yes, see instructions 30.00 Has the provider have a funded depreciation account? If yes, see instructions 30.00 Has debt been replaced prior to its scheduled mutrity with new debt? If yes, see instructions. 31.00 Has debt been replaced prior to its scheduled mutrity with new debt? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If I line 31 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see instructions. 34.00 Preservices furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. 35.00 If line 36 is yes, see instructions. 36.00 Were home office costs claimed on the cost report? 37.00 If I line 36 is yes, did the provider render services to other chain components? If yes, see Instructi						1. 00	
22.00 lave assets been relifed for Medicare purposes? If yes, see instructions changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see Instructions. 25.00 Nave there been ene capital ized leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see leases entered into during the cost reporting period? If yes, see instructions. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account? If yes, see instructions. 30.00 Interest Expense 30.00 Interest		COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)			
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.							
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43.00 Enter the telephone number and email address of the cost (859)655-7831 RON. HORNBERGER®STELIZABETH. C 43.00	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			®STELI ZABETH. C	43.00

Heal th	Financial Systems	ST ELIZABETH	H DEARBORN	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT C	DUESTI ONNAI RE	Provi der CCN: 15-0086		riod: om 01/01/2021 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/23/2022 10:	pared:
			3.00				
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the ti held by the cost report preparer in column respectively.		REIMBURSEMENT MANAGER				41. 00
42. 00	Enter the employer/company name of the cospreparer.	t report					42. 00
43. 00	Enter the telephone number and email addre report preparer in columns 1 and 2, respec						43. 00

 Heal th Financial
 Systems
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | Date/Time Prepared: | Provider CCN: 15-0086

				1	0 12/31/2021	5/23/2022 10:	
						I/P Days / 0/P	25 4111
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		19, 345		0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		53	19, 345	0.00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31. 00		· · · ·			8. 00
9.00	CORONARY CARE UNIT	32. 00		ľ			9. 00
10. 00	BURN INTENSIVE CARE UNIT	33. 00					10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00	0	0	0.00	0	11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)		61	22, 265	0. 00		14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00				0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00	0	0		0	17. 00
18. 00	SUBPROVI DER		_	_		_	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		1		0	19. 00
20.00	NURSING FACILITY	45. 00	0			0	20.00
21. 00	OTHER LONG TERM CARE	46. 00	0	0			21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00					23. 00
24. 00	HOSPI CE	116. 00		0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	99. 00				0	25. 00
25. 10	CMHC - CORF	99. 10				0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00				0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		61			0	27. 00
28. 00	Observation Bed Days					U	28. 00
29. 00	Ambulance Trips						29. 00 30. 00
30.00	Employee discount days (see instruction)						
31.00	Employee discount days - IRF		0	0			31.00
32.00	Labor & delivery days (see instructions)		0				32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33 00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 00
33. 01	121011 of to floati air days and air sonai ges	I	ı	I	l	1	55. 61

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2021 | Part | | Date/Time Prepared: | 5/23/2022 10: 25 am | | Full Time Foulvalents I/P Days / O/P Visits / Trips Full Time Equivalents

Title XVIII
1.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00
1.00
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3, 236 1, 599 4.00 HM0 IPF Subprovider 4.00 HM0 IPF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 727 232 2, 452 8.00 SURRICAL INTENSIVE CARE UNIT 0 0 0 0 10.00 SURGICAL INTENSIVE CARE UNIT 10 UNGERY 11.00 Total (see instructions) 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 143 511 15.00 AH visits 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00
For the portion of LDP room available beds 2.00
2.00 HM0 and other (see instructions)
3.00
4. 00 HMO IRF Subprovider 0 0 0 4. 00 5. 00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 0 6. 00 6. 00 Hospital Adults & Peds. Swing Bed NF 0 0 0 6. 00 7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 4,594 626 11,188 7. 00 8. 00 INTENSIVE CARE UNIT 0 0 0 0 9. 00 9. 00 CORONARY CARE UNIT 0 0 0 0 9. 00 11. 00 BURN INTENSIVE CARE UNIT 0 0 0 0 10. 00 11. 00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 143 511 511 13. 00 14. 00 Total (see instructions) 5, 321 1, 001 14, 151 0. 00 431. 94 14. 00 15. 00 CAH visits 0 0 0 0 0. 00 0. 00 15. 00 16. 00 SUBPROVI DER - I RF 0
5. 00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 0 0 6. 00 7. 00 6. 00 7. 00 6. 00 7. 00 6. 00 7. 00 6. 00 7. 00 6. 00 7. 00 6. 00 7. 00 8. 00 7. 00 8. 00 7. 00 9. 00
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 9.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 143 511 14.00 Total (see instructions) 15.00 CAH visits 9.00 O 0 15.00 CAH visits 9.00 O 0 15.00 CAP visits 9.00 O 0 11.00 O 0 12.00 O 0 13.00 O 0 1431.94 14,001 O 0 15.00 CAP visits 9.00 O 0 15.00 O 0 15.00 O 0 17.00 SUBPROVIDER - IPF 9.00 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 9.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 143 511 14.00 Total (see instructions) 15.00 CAH visits 9.00 O 0 15.00 CAH visits 9.00 O 0 15.00 CAP visits 9.00 O 0 11.00 O 0 12.00 O 0 13.00 O 0 1431.94 14,001 O 0 15.00 CAP visits 9.00 O 0 15.00 O 0 15.00 O 0 17.00 SUBPROVIDER - IPF 9.00 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 4,594 626 11,188 7.00 8. 00 INTENSIVE CARE UNIT 727 232 2,452 8.00 9. 00 CORONARY CARE UNIT 0 0 0 9.00 10. 00 BURN INTENSIVE CARE UNIT 0 0 0 10.00 11. 00 SURGICAL INTENSIVE CARE UNIT 0 0 0 11.00 12. 00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 143 511 12.00 14.00 Total (see instructions) 5,321 1,001 14,151 0.00 431.94 14.00 15. 00 CAH visits 0 0 0 0 0 0.00 0.00 0.00 15.00 16. 00 SUBPROVIDER - IPF 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 17.00
B. 00
8. 00 INTENSIVE CARE UNIT 727 232 2, 452 9. 00 CORONARY CARE UNIT 0 0 0 10. 00 BURN INTENSIVE CARE UNIT 0 0 0 11. 00 SURGI CAL INTENSIVE CARE UNIT 0 0 0 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 13. 00 NURSERY 143 511 14. 00 Total (see instructions) 5, 321 1, 001 14, 151 0. 00 431. 94 14. 00 15. 00 CAH visits 0 0 0 0 0 0 0 0 15. 00 16. 00 SUBPROVI DER - I PF 0 0 0 0 0. 00 0. 00 0. 00 0
9. 00 CORONARY CARE UNIT 0 0 0 0 9. 00 10. 00 BURN INTENSIVE CARE UNIT 0 0 0 0 10. 00 11. 00 SURGI CAL INTENSIVE CARE UNIT 0 0 0 0 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 12. 00 13. 00 NURSERY 143 511 511 0. 00 431. 94 14. 00 15. 00 CAH visits 0 0 0 0 15. 00 16. 00 SUBPROVI DER - I PF 0 0 0 0. 00 0. 00 0. 00 16. 00 17. 00 SUBPROVI DER - I RF 0 0 0 0. 00 </td
10.00 BURN INTENSIVE CARE UNIT 0 0 0 0 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 143 511 13.00 14.00 Total (see instructions) 5,321 1,001 14,151 0.00 431.94 14.00 15.00 CAH visits 0 0 0 0 15.00 16.00 SUBPROVI DER - I PF 0 0 0 0.00 0.00 0.00 17.00 17.00 SUBPROVI DER - I RF 0 0 0 0.00 0.00 0.00 0.00 0.00 17.00
11. 00 SURGI CAL INTENSIVE CARE UNIT 0 0 0 0 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 143 511 13. 00 14. 00 Total (see instructions) 5, 321 1, 001 14, 151 0. 00 431. 94 14. 00 15. 00 CAH visits 0 0 0 0 0 15. 00 16. 00 SUBPROVI DER - I PF 0 0 0 0. 00 0. 00 0. 00 0. 00 16. 00 17. 00 SUBPROVI DER - I RF 0 0 0 0. 00 0. 00 0. 00 0. 00 17. 00
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 0 0 0 <t< td=""></t<>
13. 00 NURSERY 143 511 0.00 13. 00 14. 00 Total (see instructions) 5, 321 1,001 14, 151 0.00 431. 94 14. 00 15. 00 CAH visits 0 0 0 0 0 0.00 15. 00 16. 00 SUBPROVIDER - IPF 0 0 0 0 0.00 0.00 17. 00 17. 00 SUBPROVIDER - IRF 0 0 0 0 0.00 0.00 17. 00
14. 00 Total (see instructions) 5,321 1,001 14,151 0.00 431.94 14.00 15. 00 CAH visits 0 0 0 0 15.00 16. 00 SUBPROVI DER - I PF 0 0 0 0 0.00 0.00 16.00 17. 00 SUBPROVI DER - I RF 0 0 0 0.00 0.00 17.00
15.00 CAH visits 0 0 0 15.00 16.00 SUBPROVIDER - IPF 0 0 0 0.00 0.00 16.00 17.00 SUBPROVIDER - IRF 0 0 0 0.00 0.00 17.00
15.00 CAH visits 0 0 0 15.00 16.00 SUBPROVIDER - IPF 0 0 0 0.00 0.00 16.00 17.00 SUBPROVIDER - IRF 0 0 0 0.00 0.00 17.00
17. 00 SUBPROVI DER - I RF 0 0 0 0.00 0.00 17. 00
17. 00 SUBPROVI DER - I RF 0 0 0 0.00 0.00 17. 00
10: 00 DOB! NOT BEN
19.00 SKILLED NURSING FACILITY 0 0 0 0.00 19.00
20. 00 NURSI NG FACILITY
22. 00 1101112 1121117 11021101
23.00 AMBULATORY SURGICAL CENTER (D. P.) 0.00 0.00 23.00
24. 00 HOSPI CE 0 0 0 0. 00 24. 00
24. 10 HOSPI CE (non-distinct part) 0 24. 10
25.00 CMHC - CMHC 0 0 0 0 0.00 25.00
25. 10 CMHC - CORF 0 0 0 0 0.00 25. 10
26. 00 RURAL HEALTH CLINIC 0 0 0.00 26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 26. 25
27. 00 Total (sum of lines 14-26) 0.00 431. 94 27. 00
28. 00 Observation Bed Days 260 1,542 28. 00
29. 00 Ambul ance Tri ps 29. 00 29. 00
30.00 Employee discount days (see instruction)
31.00 Employee discount days - IRF
32.00 Labor & delivery days (see instructions) 0 37 588 32.00
32.01 Total ancillary labor & delivery room 0 32.01
outpatient days (see instructions)
33.00 LTCH non-covered days 0 33.00
33.01 LTCH site neutral days and discharges 0 33.01

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:
 Heal th Financial
 Systems
 ST EL

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-0086

				Ţ	o 12/31/2021	Date/Time Prep 5/23/2022 10:2	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	I	11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(0 1, 234	271	3, 517	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			625	445		2. 00
3.00	HMO IPF Subprovider			023	0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				J		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	(1, 234	271	3, 517	14.00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00		0	0	0	
17. 00	SUBPROVI DER - I RF	0. 00	(0	0	0	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY	0. 00				_	20. 00
21. 00	OTHER LONG TERM CARE	0.00				0	21. 00
22. 00	HOME HEALTH AGENCY	0.00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10 25. 00	HOSPICE (non-distinct part)	0. 00					24. 10 25. 00
25. 00	CMHC - CMHC CMHC - CORF	0.00					25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

Period: Worksheet S-3
From 01/01/2021 Part II
To 1/21/21/2021 Part/II me Propagad: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0086

Mart 11 - Martin							o 12/31/2021		pared:
NART II - WAGE DATA					on of Salaries	Sal ari es	Related to	5/23/2022 10: Average Hourly Wage (col. 4 ÷ col. 5)	25 am
MART 11 - NACE DATA SALANES SA			1. 00	2.00				6. 00	
1.00 Total salaries (See 200.00 29,918.062 0 29,918.062 898,432.00 33. 33. 33. 33. 33. 34. 3									
2.00 Non-physician anesthetist Part 0 0 0 0 0 0 0 0 0	1.00		200. 00	29, 918, 062	0	29, 918, 062	898, 432. 00	33. 30	1. 00
A	2 00			0		_	0.00	0. 00	2. 00
S		Α		_		_	2.22		
Admin istrative 4.0 Physicians - Part A - Teaching 5.00 Physician and Mon Physician - Part B 60 0 0 0 0 0 0 0 0	3.00	Non-physician anesthetist Part B		O	0	O	0.00	0. 00	3. 00
Physicians = Part A - Teaching 0 0 0 0 0 0 0 0 0	4. 00	-		0	0	0	0.00	0. 00	4. 00
Physical an-Part B 6		Physicians - Part A - Teaching		0	0	o			4. 01
Non-physician-Part B for hospital-based RHC and FORC services Non-physician-Part B for hospital-based RHC and FORC services Non-physician-Part B for hospital-based RHC and FORC services Non-physician-Part B for hospital-Pasce RHC services Non-physician-Part A Non	5. 00			0	0	0	0.00	0. 00	5. 00
7.01 Interns & residents (in an approved program) 7.01 Contracted interns and residents (in an approved program) 8.00 Home office and/or related organization personnel 9.00 SNF 9.00 SNF 9.00 SNF 10.00 Excluded area salaries (see 144.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	O	0.00	0.00	6. 00
7.01 Contracted interns and residents (in an approved programs) 8.00 Home office and/or related of the organization personnel organizatio	7. 00	Interns & residents (in an	21. 00	0	0	О	0.00	0. 00	7. 00
Drograms	7. 01			0	О	0	0.00	0. 00	7. 01
Home office and/or related organization personnel 44,00									
10.00 Excluded area salaries (see 116,641 49,961 166,602 6,297.00 26.		Home office and/or related organization personnel		0	0	0			8. 00
OTHER WAGES & RELATED COSTS			44.00	116, 641	49, 961	166, 602			9. 00 10. 00
11.00 Contract labor: Direct Patient									
12.00 Contract Labor: Top Level management and other management and other management and administrative services	11. 00	Contract Labor: Direct Patient		433, 726	0	433, 726	4, 750. 00	91. 31	11. 00
management and administrative services services	12. 00			0	0	О	0.00	0. 00	12. 00
13.00 Contract Labor: Physician-Part A - Administrative A - Teaching A		management and other management and administrative							
14.00 Home office and/or related organization salaries and wage-related costs 14.01 Home office salaries 0 0 0 0 0 0 0 0 0	13. 00	Contract Labor: Physician-Part		245, 165	0	245, 165	1, 382. 00	177. 40	13. 00
14.01 Home office salaries 0 0 0 0.00 0.10 14.02 Related organization salaries 0 0 0 0 0.00 15.00 Home office: Physician Part A	14. 00	Home office and/or related organization salaries and		0	0	O	0.00	0.00	14. 00
15.00 Home office: Physician Part A	14. 01	Home office salaries		0	О	0	0.00	0. 00	14. 01
- Administrative Home office and Contract Physicians Part A - Teaching Home office Physicians Part A - Teaching Home office Contract Physicians Part A - Teaching Home office Contract Physicians Part A - Teaching WAGE-RELATED COSTS 17. 00 Wage-related costs (core) (see instructions) 18. 00 Wage-related costs (other) (see instructions) 19. 00 Excluded areas 49,511 0 Non-physician anesthetist Part A 0 0 0 0 0 0 0 0 7, 369, 279 0 7, 369, 279 0 7, 369, 279 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0			
Physicians Part A - Teaching Home office Physicians Part A Description		- Administrative		_		_			
16. 01 Home office Physicians Part A 0 0 0 0 0.00	16. 00			0	0	0	0.00	0. 00	16. 00
16.02 Home office contract Physicians Part A - Teaching MAGE-RELATED COSTS	16. 01	Home office Physicians Part A		0	0	О	0.00	0. 00	16. 01
WAGE-RELATED COSTS Wage-related costs (core) (see instructions) 17, 369, 279 0 7, 369, 279 18. 00 Wage-related costs (other) (see instructions) 19. 00 Excluded areas 49, 511 0 49, 511 0 0 0 0 0 0 0 0 0	16. 02	Home office contract		0	0	0	0.00	0. 00	16. 02
17. 00 Wage-rel ated costs (core) (see instructions) 18. 00 Wage-rel ated costs (other) (see instructions) 19. 00 Excluded areas 49,511 0 49,511 20. 00 Non-physician anesthetist Part 0 0 0 21. 00 Non-physician anesthetist Part 0 0 0 B 22. 00 Physician Part A - 0 0 0 Administrative 22. 01 Physician Part B 0 0 0 23. 00 Physician Part B 0 0 0 24. 00 Wage-rel ated costs (RHC/FOHC) 0 0 25. 00 Interns & residents (in an approved program) 25. 50 Home office wage-related 0 0 0 27. 00 Total Residents (in an approved program) 0 0 0 28. 00 O O O O O 29. 00 O O O O 20. 00 O 20. 00 O O 20. 00 O 20. 00 O O 20. 00 O 20.									
18.00 Wage-related costs (other) (see instructions) 19.00 Excluded areas 49,511 0 49,511 0 0 0 0 0 0 0 0 0	17. 00	Wage-related costs (core) (see		7, 369, 279	0	7, 369, 279			17. 00
20. 00 Non-physician anesthetist Part		Wage-related costs (other) (see instructions)							18. 00
21.00 Non-physician anesthetist Part				49, 511 0	0	49, 511			19. 00 20. 00
Administrative 22. 01 Physician Part A - Teaching		A		0	0	0			21. 00
22. 01 Physician Part A - Teaching 0 0 0 23. 00 Physician Part B 0 0 0 24. 00 Wage-related costs (RHC/FQHC) 0 0 0 25. 00 Interns & residents (in an approved program) 0 0 0 25. 50 Home office wage-related 0 0 0	22. 00	Physician Part A -		0	0	0			22. 00
23.00 Physician Part B 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 ∩1			0	_	_			22. 01
25.00 Interns & residents (in an approved program) 25.50 Home office wage-related 0 0 0	23. 00	Physician Part B		0	ő	0			23. 00
approved program) 25.50 Home office wage-related 0 0 0				0	0	0 0			24. 00 25. 00
		approved program)		_		_			
		(core)		_					25. 50
25. 51 Related organization 0 0 0 wage-related (core)	25. 51			0	0	0			25. 51
25.52 Home office: Physician Part A	25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52

Period: Worksheet S-3
From 01/01/2021 Part II
To 1/21/21/2021 Part/II me Propagad:

					Т	o 12/31/2021	Date/Time Pre 5/23/2022 10:	
		Wkst. A Line		Recl assi fi cati		Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
27 00	OVERHEAD COSTS - DIRECT SALARIE					0.00	0.00	27.00
26. 00	Employee Benefits Department	4. 00	0.750.044	500 000	0 040 047	0.00		
27. 00	Administrative & General	5. 00	2, 758, 944	-539, 028		i i		
28. 00	Administrative & General under		121, 407	0	121, 407	971. 00	125. 03	28. 00
29. 00	contract (see inst.)	6. 00	754 422	12, 063	768, 496	25, 179. 00	20 52	29. 00
30.00	Maintenance & Repairs Operation of Plant	7.00	756, 433	7, 195	·	,		
31. 00	, ·	7. 00 8. 00	390, 621 97, 132			i i		
32.00	Laundry & Linen Service Housekeeping	9. 00	1, 176, 738		·	64, 195. 00		
32.00	, ,	9.00	1, 170, 730	30, 043	1, 212, 701	0.00		
33.00	Housekeeping under contract (see instructions)		U	U	٥	0.00	0.00	33.00
34.00	Di etary	10. 00	794, 368	-464, 003	330, 365	15, 464. 00	21. 36	34.00
35. 00	Di etary under contract (see instructions)		0	0	0	0. 00	0. 00	35. 00
36.00	Cafeteri a	11. 00	0	487, 223	487, 223	24, 530. 00	19. 86	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	818, 412	12, 218	830, 630	20, 084. 00	41. 36	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	0.00	0.00	40. 00
41.00	Medical Records & Medical	16. 00	426, 215	4, 221	430, 436	19, 794. 00	21. 75	41. 00
	Records Library							
42.00	Social Service	17. 00	559, 965	3, 816	563, 781	15, 476. 00	36. 43	42.00
43. 00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION ST ELIZABETH DEARBORN

In Lieu of Form CMS-2552-10
| Worksheet S-3
| Part III |
| Bate/Time Prepared: | 5/23/2022 10: 25 am |
| Hours | Average Hourly | Peri od: From 01/01/2021 To 12/31/2021 Provider CCN: 15-0086

			Worksheet A	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
			Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
					(from	(col.2 ± col.	Salaries in	col . 5)	
					Worksheet A-6)	3)	col. 4		
			1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
_		PART III - HOSPITAL WAGE INDEX	SUMMARY						
•	1.00	Net salaries (see		30, 039, 469	0	30, 039, 469	899, 403. 00	33. 40	1.00
		instructions)							
2	2.00	Excluded area salaries (see		116, 641	49, 961	166, 602	6, 297. 00	26. 46	2.00
		instructions)							
	3.00	Subtotal salaries (line 1		29, 922, 828	-49, 961	29, 872, 867	893, 106. 00	33. 45	3.00
		minus line 2)							
4	4.00	Subtotal other wages & related		678, 891	0	678, 891	6, 132. 00	110. 71	4.00
		costs (see inst.)							
í	5. 00	Subtotal wage-related costs		7, 369, 279	0	7, 369, 279	0.00	24. 67	5.00
		(see inst.)							
(6. 00	Total (sum of lines 3 thru 5)		37, 970, 998	-49, 961	37, 921, 037	899, 238. 00	42. 17	6.00
-	7. 00	Total overhead cost (see		7, 900, 235	-435, 273	7, 464, 962	257, 085. 00	29. 04	7.00
		instructions)							

Health Financial Systems	ST ELIZABETH DEARBORN	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0086	Peri od: Worksheet S-3 From 01/01/2021 Part IV To 12/31/2021 Date/Time Prepared:

	To 12/31/202	Date/Time Pre 5/23/2022 10:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	893, 988	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	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 Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4, 429, 890	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	62, 031	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12, 335	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	111, 163	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	75, 921	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00		2, 143, 581	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unemployment Insurance	0	19. 00
20.00		0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00		80	23. 00
24. 00		7, 728, 989	24. 00
50	Part B - Other than Core Related Cost	.,	
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	ST ELIZABETH DEARBORN	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0086	Period: Worksheet S-3 From 01/01/2021 Part V

		1 011 0 17 0 17 202 1	I di t v	
		o 12/31/2021	Date/Time Prep 5/23/2022 10:	
	Cost Center Description	Contract Labor		25 4111
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1. 00
2.00	Hospi tal	0	0	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (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	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF	0	0	9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -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
16. 10	Hospi tal -Based-CMHC 10	0	0	16. 10
	Renal Di al ysi s	0	0	17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems ST ELIZABETH D	FARRORN		In lie	eu of Form CMS-2	2552-10
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15	5-0086 F	eri od:	Worksheet S-10	
				rom 01/01/2021 o 12/31/2021	Date/Time Pre	oorod:
			'	0 12/31/2021	5/23/2022 10: 3	
	Name and the standard a				1. 00	
1. 00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by line 20	02 column	8)	0. 380429	1. 00
1.00	Medicaid (see instructions for each line)	vided by Title 20	02 COT UIIIT	0)	0.300427	1.00
2.00	Net revenue from Medicaid				11, 119, 193	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3. 00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		om Medicai	d?	N _	4. 00
5.00	If line 4 is no, then enter DSH and/or supplemental payments 1	from Medicaid			0 39, 894, 248	5. 00
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)				15, 176, 929	6. 00 7. 00
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 minus su	um of line	s 2 and 5: if	4, 057, 736	
	< zero then enter zero)				., ,	
	Children's Health Insurance Program (CHIP) (see instructions f	for each line)				
9.00	Net revenue from stand-alone CHIP				0	
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10. 00 11. 00
12. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 minus l	line 9: if	< zero then	0	12. 00
	enter zero)				_	
	Other state or local government indigent care program (see ins				_	
13.00	Net revenue from state or local indigent care program (Not ind					13.00
14. 00	Charges for patients covered under state or local indigent car 10)	re program (Not i	inci uded i	n Tines 6 or	0	14. 00
15. 00	State or local indigent care program cost (line 1 times line 1	14)			o	15. 00
16. 00						16. 00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, Chinstructions for each line)	HP and state/loo	cal indige	nt care progran	ns (see	
17. 00	·	funding charity of	care		0	17. 00
18. 00						18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and Loca	al indigent care	programs	(sum of lines	4, 057, 736	19. 00
	8, 12 and 16)	He	ni nsured	Insured	Total (col. 1	
			atients	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)					
20. 00	Charity care charges and uninsured discounts for the entire fa	acility	749, 450	230, 591	980, 041	20. 00
21. 00	(see instructions) Cost of patients approved for charity care and uninsured disco	ounts (see	285, 113	230, 591	515, 704	21. 00
21.00	instructions)	Junta (acc	200, 110	250, 571	313, 704	21.00
22. 00	Payments received from patients for amounts previously writter	n off as	C	0	0	22. 00
	charity care		005 440	000 504	545 704	
23. 00	Cost of charity care (line 21 minus line 22)		285, 113	230, 591	515, 704	23.00
					1. 00	
24. 00	Does the amount on line 20 column 2, include charges for patie	ent days beyond a	a length o	f stay limit	N	24. 00
	imposed on patients covered by Medicaid or other indigent care					
25. 00	If line 24 is yes, enter the charges for patient days beyond t	the indigent care	e program'	s length of	0	25. 00
26. 00	stay limit On Total bad debt expense for the entire hospital complex (see instructions) 1,873,590					
27. 00	Medicare reimbursable bad debts for the entire hospital complex	,	i ons)		140, 497	26. 00 27. 00
27. 01	Medicare allowable bad debts for the entire hospital complex (•			216, 149	27. 01
28. 00	Non-Medicare bad debt expense (see instructions)				1, 657, 441	28. 00
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	kpense (see insti	ructions)		706, 191	29. 00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			1, 221, 895 5, 279, 631	
31.00	Trotal differmodised and uncompensated care cost (Title 19 prus 1	1116 30)			J, 217, 031	31.00

	Financial Systems	ST ELIZABETH		N 15 000/		u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Period: From 01/01/2021	Worksheet A	
				-	Γο 12/31/2021	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	5/23/2022 10: Reclassi fi ed	25 alli
	, , , , , , , , , , , , , , , , , , ,			+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	11.00	2.00	0.00		0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		387, 790	387, 790		387, 790	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		966, 136	966, 136	5 0	966, 136 0	
3. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 457, 532	1, 457, 532		1, 457, 532	3. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 758, 944	7, 653, 824				
6.00	00600 MAINTENANCE & REPAIRS	756, 433	4, 001, 360				
7.00	00700 OPERATION OF PLANT	390, 621	123, 297	513, 918			
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	97, 132 1, 176, 738	262, 584 676, 439	359, 716 1, 853, 17		364, 695 1, 890, 054	
10.00	01000 DI ETARY	794, 368	619, 309			570, 198	
11. 00	01100 CAFETERI A	0	0		867, 074	867, 074	1
12.00	01200 MAI NTENANCE OF PERSONNEL	010 412	0	1 001 72	0	0	
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	818, 412	263, 325 0	1, 081, 73	7 12, 484	1, 094, 221 0	1
15. 00	01500 PHARMACY		0			0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	426, 215	129, 668	555, 883	4, 221	560, 104	16. 00
17.00	01700 SOCIAL SERVICE	559, 965	347, 035	907, 000	3, 817	910, 817	1
18. 00 19. 00	O1850 OTHER GENERAL SERVICE (SPECIFY) O1900 NONPHYSICIAN ANESTHETISTS	0	0			0	18. 00 19. 00
20. 00	02000 NURSI NG PROGRAM		0			0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	O	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) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	107, 945	16, 462	124, 40	7 51, 104	175, 511	23. 00
30. 00	03000 ADULTS & PEDIATRICS	2, 923, 972	2, 878, 394	5, 802, 366	564, 951	6, 367, 317	30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 958, 947	803, 990	2, 762, 93		2, 806, 232	
32. 00	03200 CORONARY CARE UNIT	0	0	(0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	(0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF		0) 0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	o	Ö		0	Ō	41. 00
43.00	04300 NURSERY	0	0	(524, 824	524, 824	
44. 00	04400 SKILLED NURSING FACILITY	0	0	(0	0	
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE		0			0	45. 00 46. 00
.0.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>		<u> </u>		10.00
50.00	05000 OPERATING ROOM	4, 497, 514	8, 270, 025	12, 767, 539	-3, 851, 977	8, 915, 562	1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	1, 427, 800	0 674, 061	2, 101, 86 ⁻	0 1 -1, 071, 704	0 1, 030, 157	
53. 00	05300 ANESTHESI OLOGY	1, 427, 800	1, 996, 293			1, 977, 762	
	05400 RADI OLOGY-DI AGNOSTI C	1, 768, 719	1, 011, 226				
	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55. 00
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	507, 315	0 206, 205	713, 520	0 177, 211	0 890, 731	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	216, 250	101, 913	318, 163		374, 338	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	339, 228	298, 728				
60.00	06000 LABORATORY	1, 606, 124	2, 197, 215	3, 803, 339	43, 110	3, 846, 449	
60. 01	06001 BLOOD LABORATORY	0	0	(0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			0	61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o o	O		0	Ō	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	(0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	752, 829	520, 807	1, 273, 630		1, 296, 341	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 488, 593 236, 093	490, 914 67, 419	1, 979, 50 303, 512		2, 013, 698 306, 491	1
68. 00	06800 SPEECH PATHOLOGY	185, 278	37, 760	223, 038		226, 385	
69. 00	06900 ELECTROCARDI OLOGY	343, 169	138, 749			492, 178	
70.00	07000 ELECTROENCEPHALOGRAPHY	6, 077	691	6, 768		6, 775	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	239, 580	105, 281	344, 86	1 -344, 861 0 4, 236, 627	0 4, 236, 627	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 300, 110	4, 582, 426	5, 882, 536			
74.00	07400 RENAL DIALYSIS	0	0	(0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	(0	0	
76. 97 77. 00	07697 CARDI AC REHABI LI TATI ON	94, 755	40, 303	135, 058	3 75 0 0		
77.00	O7700 ALLOGENEI C STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	ı U	<u>_</u>		J ₁ U	<u> </u>	77. 00
88. 00	08800 RURAL HEALTH CLINIC	O	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	0	
90.00	09000 CLI NI C 09100 EMERGENCY	2, 130, 240	0 1, 180, 377	3, 310, 61	0 7 51, 275	0 3, 361, 892	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 130, 240	1, 100, 377	3, 310, 01	31,273	3, 301, 092	91.00
	· · · · · · · · · · · · · · · · · · ·		'	•		•	

Health Financial Systems	ST ELIZABETH	DEARBORN		In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der CCN		Peri od:	Worksheet A	
				rom 01/01/2021		
				o 12/31/2021	Date/Time Pre 5/23/2022 10:	pared:
Cost Center Description	Sal ari es	Other T	otal (col 1	Recl assi fi cati	Reclassi fi ed	25 8111
cost center bescription	Sai ai i es	other [1	+ col . 2)	ons (See A-6)	Trial Balance	
			+ COI. 2)	0113 (See A-0)	(col. 3 +-	
					col . 4)	
	1.00	2.00	3. 00	4, 00	5. 00	
OTHER REIMBURSABLE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	٥	(0	94. 00
95. 00 09500 AMBULANCE SERVI CES	Ö	o	(ál ől	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	(ál ől	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	Ö	0	Č	ol ol	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	Ö	0	Č	ol ol	0	98.00
99. 00 09900 CMHC	Ö	0	Č	ol ol	0	99.00
99. 10 09910 CORF	ol o	0	(ól ől	0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	Ö	0	Č	ol ol	0	100.00
101. 00 10100 HOME HEALTH AGENCY	ol	o	Č	ol ol		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>			۰,		
105. 00 10500 KIDNEY ACQUISITION	0	0	(ol	0	105. 00
106. 00 10600 HEART ACQUISITION	ol	o	Ċ	ol ol	0	106. 00
107. 00 10700 LIVER ACQUISITION	ol	o	Ċ	ol ol		107. 00
108.00 10800 LUNG ACQUISITION	ol	o	Ċ	ol ol		108.00
109.00 10900 PANCREAS ACQUISITION	o	O	Ċ	ol		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	o	0	C	ol ol	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	o	0	C	ol	0	111. 00
113.00 11300 INTEREST EXPENSE		0	C	ol	0	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	o	0	C	ol	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0	C	o	0	115. 00
116. 00 11600 HOSPI CE	o	0	(ol	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	29, 909, 366	42, 507, 538	72, 416, 904	ı ol	72, 416, 904	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 696	33, 553	42, 249	0	42, 249	190. 00
191. 00 19100 RESEARCH	0	0	C	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	O	11, 434	11, 434	ı o	11, 434	192. 00
193. 00 19300 NONPALD WORKERS	0	0	C	0		193. 00
194. 00 07950 CMH	0	0	C	0	0	194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	29, 918, 062	42, 552, 525	72, 470, 587	o o	72, 470, 587	200. 00

Peri od: Worksheet A From 01/01/2021 To 12/31/2021 Date/Time Prepared:

				5/23/2022 10:	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
	CENEDAL CEDALCE COCT CENTEDO	6.00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	825, 401	1, 213, 191		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	760, 979	1, 727, 115		2.00
3. 00	00300 OTHER CAP REL COSTS	0	1, 727, 119		3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 457, 532		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	16, 506, 367	26, 380, 275		5. 00
6. 00	00600 MAINTENANCE & REPAIRS	-81, 779	4, 688, 082		6. 00
7.00	00700 OPERATION OF PLANT	-15	521, 129		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	-6, 487	358, 208		8. 00
9.00	00900 HOUSEKEEPI NG	-412	1, 889, 642		9. 00
10.00	01000 DI ETARY	-344, 259	225, 939		10.00
11. 00	01100 CAFETERI A	0	867, 074		11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		12. 00
13. 00		-229	1, 093, 992		13. 00
14. 00	l l	0	0		14. 00
15. 00	1 1	0	0		15. 00
16. 00	1 1	-1, 309	558, 795		16. 00
17. 00	I I	-157, 405	753, 412		17. 00
18. 00		0	0		18.00
19. 00 20. 00	1 1	0	O O		19. 00 20. 00
21. 00		0	0		21. 00
22. 00	1 1	0	0		22. 00
23. 00		0	175, 511		23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	170,011		20.00
30.00		-1, 570, 143	4, 797, 174		30.00
31.00	03100 INTENSIVE CARE UNIT	-3, 107	2, 803, 125		31. 00
32.00	03200 CORONARY CARE UNIT	0	0		32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
34.00		0	0		34.00
40. 00		0	0		40. 00
41. 00		0	0		41. 00
43. 00		0	524, 824		43. 00
44. 00		0	0		44.00
45. 00		0	0		45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0		46. 00
50. 00		-26, 962	8, 888, 600		50.00
51. 00	1 1	0	0,000,000		51.00
52. 00	1 1	-874	1, 029, 283		52. 00
53. 00	l l	-884	1, 976, 878		53. 00
54.00		-6, 949	2, 612, 550		54.00
55. 00		0	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0		56. 00
57.00		-1, 159	889, 572		57. 00
58. 00		-454	373, 884		58. 00
59. 00		-1, 806	617, 192		59. 00
	06000 LABORATORY	-2, 083	3, 844, 366		60. 00
60. 01	1 1	0	0		60. 01
61.00	l i	0	0		61.00
62.00		0	0		62.00
63. 00 64. 00		0	0		63. 00 64. 00
65. 00	l i	-1, 835	1, 294, 506		65. 00
66. 00	l l	-1, 835 -162	2, 013, 536		66. 00
67. 00		-102	306, 441		67. 00
		. 50	000, 441		1 () / () ()
68. NN		-4	226 381		
68. 00 69. 00	06800 SPEECH PATHOLOGY	-4 -2, 599	226, 381 489, 579		68. 00 69. 00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1			68. 00
69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	-2, 599	489, 579		68. 00 69. 00
69. 00 70. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-2, 599 -2	489, 579 6, 773		68. 00 69. 00 70. 00
69. 00 70. 00 71. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	-2, 599 -2	489, 579 6, 773 0		68. 00 69. 00 70. 00 71. 00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	-2, 599 -2 0 0	489, 579 6, 773 0 4, 236, 627		68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 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)	-2, 599 -2 0 0 -342, 311 0	489, 579 6, 773 0 4, 236, 627 5, 618, 159 0 0		68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 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) 07697 CARDIAC REHABILITATION	-2, 599 -2 0 0 -342, 311 0 0	489, 579 6, 773 0 4, 236, 627 5, 618, 159 0 0 135, 122		68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 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) 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	-2, 599 -2 0 0 -342, 311 0	489, 579 6, 773 0 4, 236, 627 5, 618, 159 0 0		68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 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) 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	-2, 599 -2 0 0 -342, 311 0 0	489, 579 6, 773 0 4, 236, 627 5, 618, 159 0 0 135, 122		68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 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) 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	-2, 599 -2 0 0 -342, 311 0 0	489, 579 6, 773 0 4, 236, 627 5, 618, 159 0 0 135, 122		68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00 88. 00 89. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 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) 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	-2, 599 -2 0 0 -342, 311 0 0	489, 579 6, 773 0 4, 236, 627 5, 618, 159 0 0 135, 122		68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00 88. 00 89. 00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00 88. 00 89. 00 90. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 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) 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	-2, 599 -2 0 0 -342, 311 0 0 -111 0	489, 579 6, 773 0 4, 236, 627 5, 618, 159 0 0 135, 122 0		68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00 88. 00 89. 00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00 88. 00 90. 00 91. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	-2, 599 -2 0 0 -342, 311 0 0	489, 579 6, 773 0 4, 236, 627 5, 618, 159 0 0 135, 122		68. 00 69. 00 70. 00 71. 00 72. 00 74. 00 75. 00 76. 97 77. 00 88. 00 89. 00 90. 00 91. 00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00 88. 00 89. 00 90. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 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) 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-2, 599 -2 0 0 -342, 311 0 0 -111 0	489, 579 6, 773 0 4, 236, 627 5, 618, 159 0 0 135, 122 0		68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00 88. 00 89. 00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 77. 00 88. 00 90. 00 91. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 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) 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS	-2, 599 -2 0 0 -342, 311 0 0 -111 0	489, 579 6, 773 0 4, 236, 627 5, 618, 159 0 0 135, 122 0		68. 00 69. 00 70. 00 71. 00 72. 00 74. 00 75. 00 76. 97 77. 00 88. 00 89. 00 90. 00 91. 00

 Health Financial
 Systems
 ST ELIZA

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10

Provi der CCN: 15-0086 Peri od: Worksheet A From 01/01/2021 To 12/31/2021 Date/Ti me Prepared:

			lo	12/31/2021	Date/lime Prepared: 5/23/2022 10:25 am
Cost Center Description	Adjustments	Net Expenses			
· ·		For Allocation			
	6. 00	7. 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	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 HOSPI CE	0	0			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 346, 513	87, 763, 417			118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42, 249			190. 00
191. 00 19100 RESEARCH	0	0			191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	11, 434			192. 00
193.00 19300 NONPALD WORKERS	0	0			193. 00
194. 00 07950 CMH	0	0			194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	15, 346, 513	87, 817, 100			200. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: | 5/23/2022 10: 25 am Provider CCN: 15-0086

COAX GONTON COAY CONTON COAY COAY COAY COAY COAY COAY COAY COAY							5/23/2022 10: 25 am
A _ 08UCS TO PMACHACY			Increases			· ·	
A - DRUSS TO PHARMACY			Li ne #	Sal ary	0ther		
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2 00							
3 00		DRUGS CHARGED TO PATIENTS					1
4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00							1
5.00							•
6.00 7.00 8.00 8.00 9.00				0			1
7.00 7.00			1	0			1
8.00 10.00 1	6.00			0			6. 00
9.00 10.00 11.00 10.00 11.00 10.00 11.00 1				0			7. 00
10.00 0.00 0.00 0.00 11.00 12.00 12.00 12.00 13.00	8.00		0.00	0	0		8. 00
11.00	9.00		0.00	0	0		9. 00
12.00	10.00		0.00	0	0		10.00
13.00	11.00		0.00	0	0		11. 00
14.00	12.00		0.00	0	0		12. 00
15.00	13.00		0.00	0	0		13.00
16.00	14.00		0.00	o	0		14. 00
TOTALS	15.00		0.00	o	0		15. 00
B - CAFETERIA	16.00		0.00	o	0		16. 00
1,00		TOTALS			99, 593		
TOTALS		B - CAFETERIA					
TOTALS	1.00	CAFETERI A	11. 00	487, 223	379, 851		1.00
C					379, 851		
1.00 MPL DEV. CHARGED TO							
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2.00		II II	72.00	آ	1,200,027		
3.00	2.00		0.00	0	0		2.00
1.00				- 1			1
5.00				Ō			1
TOTALS				0	0		H
1.00	0.00	TOTALS — — — —		— — — #	4 236 627		3. 88
1.00				9	1, 200, 027		
2.00 TOTALS	1 00		30.00	389 790	183 091		1 00
TOTALS			1				
Color Colo	2.00						2.00
1.00				740, 002	330, 023		
MAGNETIC RESONANCE IMAGING S8.00 30,089 20,113 (MRI) TOTALS 125,790 84,085 F - PHARMACY RESIDENCY PROGRAM 1.00 MRAMED ED PRGM_(SPECI FY) 23.00 48,339 1,143 1.143 TOTALS	1 00		57 00	05 701	63 072		1 00
CMR 1							
TOTALS	2.00	II II	36.00	30, 009	20, 113		2.00
T - PHARMACY RESIDENCY PROGRAM			+	125 700	84 085		i
1.00 PARAMED ED PRGM_(SPECI FY) 23.00 48,339 1,143 1.00 1.			M	123, 770	04, 003		
TOTALS	1 00			48 330	1 143		1 00
G - GALNSHARING ADMINISTRATIVE & GERRAL 2.00 MAINTENANCE & REPAIRS 6.00 12,052 0 3.00 0PERATION OF PLANT 7.00 7,122 0 3.00 0PERATION OF PLANT 7.00 0FLIVEN 1.00 5.00 1.00 1.00 1.00 1.00 1.00 1.00	1.00						1.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 25, 040 0 0 2. 00 0 2. 00 0 0 0 0 0 0 0 0 0				40, 337	1, 145		
2. 00 MAINTENANCE & REPAIRS 6. 00 12, 052 0 3. 00 OPERATION OF PLANT 7. 00 7, 122 0 3. 00 0PERATION OF PLANT 7. 00 7, 122 0 0 4. 00 4. 00 4. 00 5. 00 HOUSEKEEPING 9. 00 34, 059 0 0 5. 00 DIETARY 10. 00 22, 327 0 6. 00 NURSING ADMINISTRATION 13. 00 11, 114 0 7. 00 8. 00 SOCI AL SERVI CE 17. 00 3, 814 0 9. 00 PERATING PROMERY 1. 00 9	1 00		5 00	25 040	0		1 00
3.00 OPERATION OF PLANT							
4. 00 LAUNDRY & LINEN SERVICE		1					
5. 00 HOUSEKEEPING 9. 00 34, 059 0 6. 00 DI ETARY 10. 00 22, 327 0 7. 00 NURSI NG ADMI NI STRATI ON 13. 00 11, 114 0 8. 00 SOCI AL SERVI CE 17. 00 3, 814 0 9. 00 PARAMED ED PRGM- (SPECI FY) 23. 00 1, 622 0 10. 00 ADULTS & PEDI ATRI CS 30. 00 64, 325 0 11. 00 I NTENSI VE CARE UNI T 31. 00 29, 928 0 12. 00 OPERATI NG ROOM 50. 00 89, 252 0 13. 00 DELI VERY ROOM & LABOR ROOM 50. 00 89, 252 0 14. 00 RADI OLOGY-DI AGNOSTI C 54. 00 38, 114 0 15. 00 CT SCAN 57. 00 12, 142 0 16. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 4, 233 0 17. 00 CARDI AC CATHETERI ZATI ON 59. 00 66. 528 0 17. 00 18. 00 LABORATORY 60. 00 29, 727 0 18. 00 19. 00 RESPI RATORY THERAPY 65. 00 16, 759 0 19. 00 20. 00 PHYSI CAL THERAPY 66. 00 33, 101 0 20. 00<		1					
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15. 00 CT SCAN 57. 00 12, 142 0 15. 00 16. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 58. 00 4, 233 0 16. 00 17. 00 CARDI AC CATHETERI ZATI ON 59. 00 6, 528 0 17. 00 18. 00 LABORATORY 60. 00 29, 727 0 18. 00 19. 00 RESPI RATORY THERAPY 65. 00 16, 759 0 19. 00 20. 00 PHYSI CAL THERAPY 66. 00 33, 101 0 20. 00 21. 00 OCCUPATI ONAL THERAPY 67. 00 2, 635 0 21. 00 22. 00 SPEECH PATHOLOGY 68. 00 3, 320 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 9, 416 0 23. 00 24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73. 00 19, 730 0 25. 00 26. 00 EMERGENCY 91. 00 46, 468 0 26. 00	13.00	DELIVERY ROOM & LABOR ROOM	52.00	23, 430	0		13.00
16. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 16. 00 17. 00 17. 00 17. 00 18. 00 1	14.00	RADI OLOGY-DI AGNOSTI C	54.00	38, 114	0		14. 00
(MRI) 17. 00 CARDI AC CATHETERI ZATI ON 59. 00 6, 528 0 18. 00 LABORATORY 60. 00 29, 727 0 18. 00 19. 00 RESPI RATORY THERAPY 65. 00 16, 759 0 20. 00 PHYSI CAL THERAPY 66. 00 33, 101 0 21. 00 OCCUPATI ONAL THERAPY 67. 00 2, 635 0 22. 00 SPEECH PATHOLOGY 68. 00 3, 320 0 23. 00 ELECTROCARDI OLOGY 69. 00 9, 416 0 24. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 9, 010 PATI ENTS 25. 00 DRUGS CHARGED TO PATI ENTS 73. 00 19, 730 0 26. 00 EMERGENCY 91. 00 46, 468 0	15.00	CT SCAN	57.00	12, 142	0		15. 00
17. 00 CARDÍ AC CATHETERI ZATI ON 59. 00 6, 528 0 17. 00 18. 00 LABORATORY 60. 00 29, 727 0 18. 00 19. 00 RESPI RATORY THERAPY 65. 00 16, 759 0 19. 00 20. 00 PHYSI CAL THERAPY 66. 00 33, 101 0 20. 00 21. 00 OCCUPATI ONAL THERAPY 67. 00 2, 635 0 21. 00 22. 00 SPECH PATHOLOGY 68. 00 3, 320 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 9, 416 0 23. 00 24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73. 00 19, 730 0 25. 00 26. 00 EMERGENCY 91. 00 46, 468 0 26. 00	16.00	MAGNETIC RESONANCE I MAGING	58. 00	4, 233	0		16. 00
18. 00 LABORATORY 60. 00 29, 727 0 19. 00 RESPI RATORY THERAPY 65. 00 16, 759 0 20. 00 PHYSI CAL THERAPY 66. 00 33, 101 0 21. 00 OCCUPATI ONAL THERAPY 67. 00 2, 635 0 22. 00 SPEECH PATHOLOGY 68. 00 3, 320 0 23. 00 ELECTROCARDI OLOGY 69. 00 9, 416 0 24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 00 9, 010 25. 00 DRUGS CHARGED TO PATI ENTS 73. 00 19, 730 0 26. 00 EMERGENCY 91. 00 46, 468 0		(MRI)					
18. 00 LABORATORY 60. 00 29, 727 0 19. 00 RESPI RATORY THERAPY 65. 00 16, 759 0 20. 00 PHYSI CAL THERAPY 66. 00 33, 101 0 21. 00 OCCUPATI ONAL THERAPY 67. 00 2, 635 0 22. 00 SPEECH PATHOLOGY 68. 00 3, 320 0 23. 00 ELECTROCARDI OLOGY 69. 00 9, 416 0 24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 00 9, 010 25. 00 DRUGS CHARGED TO PATI ENTS 73. 00 19, 730 0 26. 00 EMERGENCY 91. 00 46, 468 0	17.00	CARDIAC CATHETERIZATION	59.00	6, 528	0		17.00
19. 00 RESPIRATORY THERAPY 65. 00 16, 759 0 20. 00 PHYSI CAL THERAPY 66. 00 33, 101 0 20. 00 21. 00 OCCUPATI ONAL THERAPY 67. 00 2, 635 0 21. 00 SPEECH PATHOLOGY 68. 00 3, 320 0 22. 00 ELECTROCARDI OLOGY 69. 00 9, 416 0 23. 00 24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73. 00 19, 730 0 25. 00 DRUGS CHARGED TO PATI ENTS 73. 00 19, 730 0 25. 00 26. 00 EMERGENCY 91. 00 46, 468 0 26. 00	18.00	LABORATORY	60.00	29, 727	0		18. 00
20. 00 PHYSI CAL THERAPY 66. 00 33, 101 0 21. 00 OCCUPATI ONAL THERAPY 67. 00 2, 635 0 22. 00 SPEECH PATHOLOGY 68. 00 3, 320 0 23. 00 ELECTROCARDI OLOGY 69. 00 9, 416 0 24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 00 9, 010 25. 00 DRUGS CHARGED TO PATI ENTS 73. 00 19, 730 0 26. 00 EMERGENCY 91. 00 46, 468 0	19. 00				0		· · · · · · · · · · · · · · · · · · ·
21. 00 OCCUPATI ONAL THERAPY 67. 00 2, 635 0 21. 00 22. 00 SPEECH PATHOLOGY 68. 00 3, 320 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 9, 416 0 23. 00 24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73. 00 19, 730 0 25. 00 26. 00 EMERGENCY 91. 00 46, 468 0 26. 00		•					
22. 00 SPEECH PATHOLOGY 68. 00 3, 320 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 9, 416 0 23. 00 24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 25. 00 DRUGS CHARGED TO PATI ENTS 73. 00 19, 730 0 25. 00 26. 00 EMERGENCY 91. 00 46, 468 0 26. 00		I I			-		
23. 00 ELECTROCARDI OLOGY 69. 00 9, 416 0 23. 00		I I					
24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 00 9, 010 0 25. 00 DRUGS CHARGED TO PATI ENTS 73. 00 19, 730 0 25. 00 26. 00 EMERGENCY 91. 00 46, 468 0 26. 00							
PATI ENTS 25. 00 DRUGS CHARGED TO PATI ENTS 73. 00 19, 730 0 25. 00 26. 00 EMERGENCY 91. 00 46, 468 0 26. 00		I I					
25. 00 DRUGS CHARGED TO PATIENTS 73. 00 19, 730 0 25. 00 26. 00 EMERGENCY 91. 00 46, 468 0 26. 00	Z4. UU		/1.00	9, 010	Y		24.00
26.00 EMERGENCY 91.00 46,468 0 26.00	25 00		72 00	10 720			25 00
77. 00 MEDI CAL RECORDS & LI BRARY 10. 00 4, 22 1 0 0 27. 00 10. 00 27. 00 0 0 0 0 0 0 0 0 0		· ·					
101ALS 504, 408 U	27.00				j		27.00
		ITOTALS		204, 408	U		I

Health Financial Systems RECLASSIFICATIONS ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 Provider CCN: 15-0086

Peri od: Worksheet A-6 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

					5/23/2022 10: 25 am	
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
	H - CENTRAL SUPPLY					
1.00	ADMINISTRATIVE & GENERAL	5. 00	400	168	1.00	0
2.00	MAINTENANCE & REPAIRS	6. 00	11	5	2. 0	0
3.00	OPERATION OF PLANT	7. 00	73	31	3. 0	0
4.00	HOUSEKEEPI NG	9. 00	1, 984	834	4. 0	0
5.00	DI ETARY	10. 00	893	375	5. 0	0
6.00	NURSING ADMINISTRATION	13. 00	1, 104	464	6. 0	0
7.00	SOCI AL SERVI CE	17. 00	2	1	7. 0	0
8.00	ADULTS & PEDIATRICS	30.00	20, 478	8, 607	8.0	0
9.00	INTENSIVE CARE UNIT	31.00	14, 945	6, 281	9.00	0
10.00	OPERATING ROOM	50.00	129, 698	54, 512	10.00	0
11. 00	DELIVERY ROOM & LABOR ROOM	52.00	4, 204	1, 767	11.0	0
12.00	ANESTHESI OLOGY	53.00	4, 253	1, 787	12.0	0
13.00	RADI OLOGY-DI AGNOSTI C	54.00	11, 044	4, 642	13. 0	0
14.00	CT SCAN	57. 00	5, 577	2, 344	14. 0	0
15.00	MAGNETIC RESONANCE I MAGING	58. 00	2, 186	919	15. 0	0
	(MRI)					
16.00	CARDIAC CATHETERIZATION	59. 00	8, 688	3, 651	16. 0	
17. 00	LABORATORY	60.00	10, 019	4, 211	17. 0	
18. 00	RESPI RATORY THERAPY	65. 00	8, 827	3, 710	18.0	
19. 00	PHYSI CAL THERAPY	66. 00	779	327	19. 0	
20.00	OCCUPATI ONAL THERAPY	67. 00	242	102	20. 0	
21. 00	SPEECH PATHOLOGY	68. 00	19	8	21. 0	
22.00	ELECTROCARDI OLOGY	69. 00	597	251	22. 0	
23.00	ELECTROENCEPHALOGRAPHY	70. 00	10	4	23. 0	
24. 00	DRUGS CHARGED TO PATIENTS	73. 00	5, 698	2, 395	24. 0	
25. 00	CARDIAC REHABILITATION	76. 97	53	22	25. 0	
26. 00	EMERGENCY	<u>91.</u> 00	16, 806		26. 0	0
	TOTALS		248, 590	104, 482		
500.00	Grand Total: Increases		2, 221, 292	5, 256, 604	500. 0	0

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/23/2022 10: 25 am

		Decreases				5/23/2022 10	25 diii
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1. 00	A - DRUGS TO PHARMACY ADULTS & PEDIATRICS	30.00	O	4, 508	0		1. 00
2.00	INTENSIVE CARE UNIT	31.00	0	7, 859			2. 00
3.00	OPERATING ROOM	50.00	o	23, 528	-		3. 00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	O	3, 400	0		4. 00
5.00	ANESTHESI OLOGY	53. 00	0	24, 571	0		5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	4, 371	0		6. 00
7. 00 8. 00	CT SCAN MAGNETIC RESONANCE IMAGING	57. 00 58. 00	0	2, 525 1, 365			7. 00 8. 00
0.00	(MRI)	30.00		1, 303			0.00
9.00	CARDIAC CATHETERIZATION	59. 00	0	156	0		9. 00
10.00	LABORATORY	60. 00	0	847			10. 00
11. 00	RESPI RATORY THERAPY	65.00	0	6, 591			11. 00
12. 00 13. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	16	0		12. 00 13. 00
14. 00	ELECTROCARDI OLOGY	70.00	0	7	0		14. 00
15. 00	MEDICAL SUPPLIES CHARGED TO	71.00	ő	, 799	-		15. 00
	PATI ENTS						
16. 00	EMERGENCY	91.00	•	1 <u>9, 0</u> 46			16. 00
	TOTALS		O	99, 593			
1. 00	B - CAFETERI A DI ETARY	10.00	487, 223	379, 851	0		1. 00
1.00	TOTALS		487, 223	379, 851			1.00
	C - IMPLANTS		, ====	3:17001			
1.00	NURSING ADMINISTRATION	13. 00	0	198	0		1. 00
2.00	ADULTS & PEDIATRICS	30. 00	0	96, 832			2. 00
3.00	OPERATING ROOM	50.00	0	4, 101, 911			3. 00
4. 00 5. 00	CARDIAC CATHETERIZATION EMERGENCY	59. 00 91. 00	0	37, 669 17			4. 00 5. 00
5.00	TOTALS			4, 236, 627			3.00
	D - LABOR & DELIVERY ROOM		<u> </u>	1,200,027			
1.00	DELIVERY ROOM & LABOR ROOM	52.00	746, 882	350, 823	0		1. 00
2.00		0.00	0	0	0		2. 00
	TOTALS		746, 882	350, 823			
1. 00	E - RADI OLOGY ADMI N RADI OLOGY-DI AGNOSTI C	54.00	125, 790	84, 085	0		1. 00
2. 00	INDI GEGGT BI AGNOSTI G	0.00	0	04, 003	0	1	2. 00
	TOTALS		125, 790	84, 085			
	F - PHARMACY RESIDENCY PROGRA				_		
1. 00	DRUGS CHARGED TO PATIENTS		48, 339				1. 00
	G - GAI NSHARI NG		48, 339	1, 143			
1.00	ADMI NI STRATI VE & GENERAL	5. 00	564, 468	0	0		1. 00
2.00		0. 00	0	0	0		2. 00
3.00		0. 00	0	0	-		3. 00
4.00		0.00	0	0	0		4. 00
5. 00 6. 00		0. 00 0. 00	0	0	0		5. 00 6. 00
7. 00		0.00	Ö	0			7. 00
8.00		0.00	0	0	0		8. 00
9.00		0.00	0	0			9. 00
10.00		0.00	0	0			10. 00
11.00		0.00	0	0			11.00
12. 00 13. 00		0. 00 0. 00	0	0			12. 00 13. 00
14. 00		0.00	0	0			14. 00
15. 00		0.00	0	0			15. 00
16.00		0. 00	О	0	0		16. 00
17. 00		0. 00	0	0			17. 00
18.00		0.00	0	0			18. 00
19. 00 20. 00		0. 00 0. 00	0	0	0		19. 00 20. 00
21. 00		0.00	0	0			21. 00
22. 00		0.00	ő	0			22. 00
23.00		0. 00	o	0	0		23. 00
24. 00		0.00	0	0	0		24. 00
25. 00		0.00	0	0			25. 00
26. 00 27. 00		0. 00 0. 00	0	0	0		26. 00 27. 00
27.00	TOTALS — — — —		564, 468	— — — ö	 		27.00
	H - CENTRAL SUPPLY						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	248, 590	104, 482	0		1. 00
2 00	PATI ENTS	0. 00		^			2. 00
2.00	1	0.00	0	0	0	<u> </u>	1 2.00

Health Financial Systems RECLASSIFICATIONS ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10

Peri od: Worksheet A-6 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/23/2022 10:25 am Provider CCN: 15-0086

						5/23/2022 10:25 am
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7.00	8. 00	9. 00	10.00	
3.00		0.00	0	0	C	3.00
4.00		0.00	0	0	C	4.00
5.00		0.00	О	0	C	5.00
6.00		0.00	О	0	C	6.00
7.00		0.00	o	0	C	7.00
8.00		0.00	О	0	C	8.00
9.00		0.00	o	0	C	9.00
10.00		0.00	o	0	C	10.00
11.00		0.00	o	0	C	11.00
12.00		0.00	О	0	C	12.00
13.00		0.00	О	0	C	13.00
14.00		0.00	o	0	C	14.00
15.00		0.00	o	0	C	15. 00
16.00		0.00	o	0	C	16.00
17. 00		0.00	o	0	C	17. 00
18.00		0.00	o	0	C	18.00
19.00		0.00	o	0	C	19.00
20.00		0.00	o	0	C	20.00
21.00		0.00	o	0	C	21.00
22.00		0.00	o	0	C	22.00
23.00		0.00	o	0	C	23.00
24. 00		0.00	o	0	C	24.00
25. 00		0.00	0	0	C	25. 00
26. 00		0.00	0	0	i c	26.00
	TOTALS — — — — —	— — - : - ° +	248, 590	104, 482	 	1 25.55
500.00	Grand Total: Decreases		2, 221, 292	5, 256, 604		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0086

Peri od: Worksheet A-7 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021

5/23/2022 10: 25 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 949, 066 -1, 449, 066 -1, 449, 066 0 1.00 0 2.00 Land Improvements 18, 800 18,800 0 2.00 ő 3.00 7, 328, 967 -5, 313, 765 3.00 Buildings and Fixtures -5, 313, 765 0 0 4.00 Building Improvements 2, 040, 779 -1, 588, 776 -1, 588, 776 0 4.00 5.00 Fixed Equipment 0 5.00 2, 986, 362 0 6.00 Movable Equipment 3, 300, 396 3, 300, 396 0 6.00 0 7.00 HIT designated Assets 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 14, 305, 174 -5, 032, 411 -5, 032, 411 0 8.00 9.00 Reconciling Items 2, 869, 319 0 2, 869, 319 0 9.00 Total (line 8 minus line 9) 14, 305, 174 -7, 901, 730 -7, 901, 730 10.00 10.00 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 500,000 1.00 2.00 Land Improvements 18, 800 0 2.00 2, 015, 202 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 452,003 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 6, 286, 758 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 9, 272, 763 0 8.00 9.00 Reconciling Items 2, 869, 319 9.00 10.00 Total (line 8 minus line 9) 6, 403, 444 0 10.00

Heal th	Financial Systems	ST ELIZABETI	H DEARBORN		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0086	Peri od:	Worksheet A-7	
					From 01/01/2021	Part II	
					To 12/31/2021	Date/Time Pre 5/23/2022 10:	pared:
			CI	JMMARY OF CAP		3/23/2022 10.	
			30	JIVIIVIART OF CAP	TIAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	cost center bescription	Depi eci ati on	Lease	Tilterest		instructions)	
		9, 00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR				12.00	10.00	
1.00	CAP REL COSTS-BLDG & FLXT	387, 790	· ·	110 2	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	966, 136	ł		0 0	0	2.00
3. 00	Total (sum of lines 1-2)	1, 353, 926	ł		0 0	0	3. 00
0.00	Total (cam of fillos f 2)	SUMMARY 0			<u> </u>		0.00
		001111111111111111111111111111111111111					
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	387, 790				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	966, 136				2. 00
2 00	T-+-1 (1 ! 1 2)		1 252 027	I			1 2 00

387, 790 966, 136 1, 353, 926

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	ST ELIZABETI	H DEARBORN		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/23/2022 10:2	oared:
		COMI	PUTATION OF RAT	10S	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		2.00	0.00	1. 00	0.00	
1.00	CAP REL COSTS-BLDG & FIXT	2, 986, 005	0	2, 986, 00	5 0. 322019	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	6, 286, 758		6, 286, 75		0	2. 00
3.00	Total (sum of lines 1-2)	9, 272, 763		9, 272, 76			3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONOLILIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT	INTERS 0	0	· · · · · · · · · · · · · · · · · · ·	0 1, 213, 708	0	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	0	0		0 1, 213, 706		2. 00
3. 00	Total (sum of lines 1-2)	0	0		0 2, 940, 823		3. 00
3.00	Total (Suil of Titles 1-2)	0	SI.	I JMMARY OF CAPI		0	3.00
			00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1712		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11. 00	12.00	13. 00	instructions)	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	13.00	14. 00	15.00	
1. 00	CAP REL COSTS-BLDG & FIXT	-517	0		0 0	1, 213, 191	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	-317			0 0		
3.00	Total (sum of lines 1-2)	-517					
			,	'	-1	_, _, , 000	

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0086

					To 12/31/2021	Date/Time Prep 5/23/2022 10: 2	
				Expense Classification	on Worksheet A	372372022 10.2	25 aiii
				To/From Which the Amount i			
	Cost Center Description		Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00	I	1.00	2.00	3.00	4. 00	5. 00	1 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-51/	CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	o	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3.00	Investment income - other		0		0.00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
4.00	di scounts (chapter 8)		Ü		0.00	٩	4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
	expenses (chapter 8)						
6. 00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	o	7. 00
7.00	stations excluded) (chapter		· ·		0.00		,, 00
	21)						
8. 00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician	A-8-2	-1, 762, 464		0.00	Ö	10. 00
	adj ustment						
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	18, 125, 342			0	12. 00
12.00	transactions (chapter 10)	A-0-1	10, 123, 342			٩	12.00
13. 00	Laundry and linen service		0		0.00	О	13.00
14. 00	Cafeteria-employees and guests		-254, 184	DI ETARY	10.00	0	14.00
15. 00	Rental of quarters to employee		0		0.00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
10.00	supplies to other than		0		0.00	Ĭ	10.00
	patients						
17. 00	Sale of drugs to other than	В	-341, 126	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
10 00	patients Sale of medical records and	В	1 200	MEDICAL DECODDS & LIBRARY	16 00	0	18. 00
18. 00	abstracts	D	-1, 309	MEDICAL RECORDS & LIBRARY	16. 00	٩	16.00
19. 00	Nursing and allied health		0		0.00	o	19. 00
	education (tuition, fees,						
20.00	books, etc.)	, n	1 445	DISTABLE	10.00		20.00
20. 00 21. 00	Vending machines Income from imposition of	В	-1, 445 0	DI ETARY	10. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty		0		0.00	Ĭ	21.00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
20.00	therapy costs in excess of		· ·		00.00		20.00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25. 00
	physicians' compensation						
26.00	(chapter 21)		^	CAD DEL COSTO DIDO O FLAT	1 00	_	24 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00		26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00	_	28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30.00	therapy costs in excess of	M-0-3	0		67.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
21 00	instructions)	A C 2	_	CDEECH DATHOLOGY	(0.00		21 00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
22.22	Depreciation and Interest		66 7-	ADMINI CEDATIVE A SEVERY		_	22.62
33.00	LEASE REVENUE	В	-29, 751	ADMINISTRATIVE & GENERAL	5.00	<u>ا</u> ا	33. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0086

				To	0 12/31/2021	Date/Time Prep 5/23/2022 10:2	
				Expense Classification on		0, 20, 2022 10.	20 4
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
33. 01	OTHER REVENUE	В	-6, 487	LAUNDRY & LINEN SERVICE	8. 00	0	
33. 02 33. 03	OTHER REVENUE OTHER REVENUE	B B	-81, 777 -88, 444	MAINTENANCE & REPAIRS	6. 00 10. 00	0	33. 02 33. 03
33. 04	LEASED PERSONNEL	В		SOCI AL SERVI CE	17. 00	Ö	33. 04
33. 05	PREMIER PURCHASING GAINS	A		ADMINISTRATIVE & GENERAL	5.00	0	33. 05
33. 06 33. 07	PREMIER PURCHASING GAINS PREMIER PURCHASING GAINS	A A		MAINTENANCE & REPAIRS OPERATION OF PLANT	6. 00 7. 00	0	33. 06 33. 07
33. 08	PREMIER PURCHASING GAINS	Α		HOUSEKEEPI NG	9. 00	О	33. 08
33. 09 33. 10	PREMIER PURCHASING GAINS PREMIER PURCHASING GAINS	A A		DIETARY NURSING ADMINISTRATION	10. 00 13. 00	0	33. 09 33. 10
33. 11	PREMIER PURCHASING GAINS	Ä		ADULTS & PEDIATRICS	30. 00	o	33. 11
33. 12	PREMIER PURCHASING GAINS	A		INTENSIVE CARE UNIT	31.00	0	33. 12
33. 13 33. 14	PREMIER PURCHASING GAINS PREMIER PURCHASING GAINS	A A		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	50. 00 52. 00	0	33. 13 33. 14
33. 15	PREMIER PURCHASING GAINS	A		ANESTHESI OLOGY	53. 00	0	33. 15
33. 16 33. 17	PREMIER PURCHASING GAINS PREMIER PURCHASING GAINS	A A		RADI OLOGY-DI AGNOSTI C CT SCAN	54. 00 57. 00	0	33. 16 33. 17
33. 18	PREMIER PURCHASING GAINS	A		MAGNETIC RESONANCE IMAGING	58. 00	Ö	33. 18
33. 19	PREMIER PURCHASING GAINS	A	-1 806	(MRI) CARDIAC CATHETERIZATION	59. 00	0	33. 19
33. 20	PREMIER PURCHASING GAINS	Ä		LABORATORY	60.00	o	33. 20
33. 21	PREMIER PURCHASING GAINS	A		RESPIRATORY THERAPY	65.00	0	33. 21
33. 22 33. 23	PREMIER PURCHASING GAINS PREMIER PURCHASING GAINS	A A		PHYSICAL THERAPY OCCUPATIONAL THERAPY	66. 00 67. 00	0	33. 22 33. 23
33. 24	PREMIER PURCHASING GAINS	A	-4	SPEECH PATHOLOGY	68. 00	O	33. 24
33. 25 33. 26	PREMIER PURCHASING GAINS PREMIER PURCHASING GAINS	A A		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00	0	33. 25 33. 26
33. 27	PREMIER PURCHASING GAINS	A		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 27
33. 28	PREMIER PURCHASING GAINS	A		CARDIAC REHABILITATION	76. 97	0	33. 28
33. 29 33. 30	PREMIER PURCHASING GAINS LOBBYING	A A		EMERGENCY ADMINISTRATIVE & GENERAL	91. 00 5. 00	0	33. 29 33. 30
33. 31	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	O	33. 31
33. 32	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 32
	(3)		J				
33. 33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33. 33
33. 34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 34
33. 35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 35
33. 36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 36
33. 37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 37
33. 38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 38
33. 39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 39
33. 40	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 40
33. 41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 41
33. 42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 42
33. 43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 43
33. 44	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 44
33. 45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 45
33. 46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 46
33. 47	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 47
33. 48	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 48
33. 49	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 49
	(3)	1		I	ı	I	

Health Financial Systems		ST ELIZABETH	H DEARBORN	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES				Peri od: From 01/01/2021	Worksheet A-8		
				To 12/31/2021	Date/Time Pre 5/23/2022 10:	pared: 25 am	
			Expense Classification o	n Worksheet A			
			To/From Which the Amount is	to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.		
	1.00	2.00	3.00	4. 00	5. 00		
33.50 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 50	
(3)							
50.00 TOTAL (sum of lines 1 thru 49)		15, 346, 513				50. 00	
(Transfer to Worksheet A,							
column 6, line 200.)							

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).

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

 B. Amount Received if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

OFFICE COSTS

12/31/2021 Date/Time Prepared: 5/23/2022 10:25 am Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 1. 00 3.00 4.00 5.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 HOME OFFICE COST 825, 918 1.00 2. OO CAP REL COSTS-MVBLE EQUIP HOME OFFICE COST 0 2.00 760.979 2.00 5.00 ADMINISTRATIVE & GENERAL 0 3.00 HOME OFFICE COST 16, 538, 445 3.00 4.00 0.00 0 4.00 5.00 TOTALS (sum of lines 1-4). 18, 125, 342 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.

			Related Organization(s) and	or Home Office					
					l				
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1. 00	2. 00	3. 00	4. 00	5. 00					
B. INTERRELATIONSHIP TO RELAT	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	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- Corporation, partnership, or other organization has financial interest in provider.
- 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Heal th	Financial Syste	ems		ST E	ELIZABETH DE	EARBORN				In Lie	u of Form CMS	S-2552-10
		SERVICES FROM	RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN:	15-0086	Peri od	l: 01/01/2021	Worksheet A	-8-1
OFFICE	C0515									2/31/2021	Date/Time P 5/23/2022 1	
	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.										
	6. 00	7. 00										
	A. COSTS INCUR HOME OFFICE CO	RED AND ADJUSTN STS:	MENTS REC	QUIRED AS A RES	SULT OF TRAI	NSACTI ONS	WI TH	RELATED C	RGANI Z	ATIONS OR (CLAI MED	
1.00	825, 918	9										1. 00
2.00	760, 979	9										2. 00
3.00	16, 538, 445	0										3. 00
4.00	0	0										4. 00
5.00	18, 125, 342											5. 00
appropr	i ate. Posi ti ve	es 1-4 (and sub amounts increas	se cost a	ınd negative am	ounts decre	ease cost.	For i	related or	gani zat	ion or hom	ne office cos	t which
I		14/ 1 1 1 4		4 1/ 0 11				1 1 1 11			C 11.1	

has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s)
and/or Home Office

Type of Business
6.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00		6. 00
7.00		7. 00
8.00		8. 00 9. 00
9.00		9. 00
10.00		10.00
7. 00 8. 00 9. 00 10. 00		100.00

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

| Period: | Worksheet A-8-2 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0086

					-	To 12/31/2021	Date/Time Pre 5/23/2022 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	25 4111
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	'		Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	1, 565, 886			_		
2.00		RADI OLOGY-DI AGNOSTI C	4, 653			0	0	2. 00
3.00		ELECTROCARDI OLOGY	2, 475			0	0	3. 00
4.00		EMERGENCY	189, 450	189, 450	0	0	0	4. 00
5.00	0.00		0	0	C	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7. 00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	O	0	0	8. 00
9.00	0.00		0	0	O	0	0	9. 00
10.00	0. 00		0	C	C	0	0	10. 00
200.00			1, 762, 464				0	200. 00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2. 00	8. 00	9. 00	Education 12.00	12 13. 00	14.00	
1.00		ADULTS & PEDIATRICS	0.00					1. 00
2. 00		RADI OLOGY-DI AGNOSTI C	0		_	_		2. 00
3. 00		ELECTROCARDI OLOGY	0	1	_		0	3. 00
4. 00		EMERGENCY	0				0	4. 00
5. 00	0.00	EMERGENOT	0				Ö	5. 00
6. 00	0.00		0	ľ			0	6. 00
7. 00	0.00		0				l o	
8. 00	0.00		0	i o	o c	0	0	8. 00
9. 00	0.00		0	i o	o c	0	0	9. 00
10. 00	0.00		0		Ö	l o	Ō	10.00
200.00			0	C	O	0	O	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0		-	.,,		1. 00
2.00		RADI OLOGY-DI AGNOSTI C	0		-	1,000		2. 00
3.00		ELECTROCARDI OLOGY	0	C	1	2, 475		3. 00
4.00		EMERGENCY	0	C	O	189, 450	1	4. 00
5.00	0.00		0	0	O	0		5. 00
6.00	0.00		0	C	C	0	1	6. 00
7. 00	0.00		0	C	C	0	1	7. 00
8. 00	0.00		0	C	C	0	1	8. 00
9.00	0.00		0	C	C	0		9. 00
10.00	0.00		0	0	0	0		10.00
200.00			0	[C	C	1, 762, 464	-	200. 00

	Financial Systems	ST ELIZABETH		ou 45 000/ 15		u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part Date/Time Pre	nared:
			CADITAL DEL		12/31/2021	5/23/2022 10:	25 am
			CAPITAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost Allocation			BENEFITS DEPARTMENT		
		(from Wkst A			DEPARTMENT		
		col . 7)					
	GENERAL SERVI CE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
1.00	O0100 CAP REL COSTS-BLDG & FLXT	1, 213, 191	1, 213, 191				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 727, 115		1, 727, 115			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 457, 532	0	1	,		4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	26, 380, 275 4, 688, 082	189, 599 398, 317			26, 947, 938 5, 690, 888	5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	521, 129	147	209		540, 865	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	358, 208	6, 500	9, 254		378, 937	8. 00
9.00	00900 HOUSEKEEPI NG	1, 889, 642	4, 810			1, 960, 382	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	225, 939 867, 074	16, 332 11, 584			281, 616 918, 884	
12. 00		007,074	0	10, 470	23, 730	710, 004	ı
13.00	01300 NURSING ADMINISTRATION	1, 093, 992	9, 371	13, 340	40, 466	1, 157, 169	1
14.00	1 1	0	0	C	0	0	14.00
15. 00 16. 00	+ I	558, 795	0	C	20, 970	0 579, 765	15. 00 16. 00
17. 00		753, 412	4, 120	5, 865		790, 863	•
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	C	0	0	
19.00	I I	0	0	C	0	0	
20. 00 21. 00		0	0		0	0	20. 00 21. 00
22. 00	I I	Ö	0	ď	Ö	0	1
23. 00		175, 511	1, 196	1, 703	7, 693	186, 103	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	4 707 174	1/2 /02	221 (10	1/5 5/0	F 257 044	20.00
30. 00 31. 00	1	4, 797, 174 2, 803, 125	162, 692 30, 214			5, 357, 044 2, 973, 973	
32. 00	1	0	00,211	0,011	0	0	
33. 00	1 1	0	0	C	0	0	
34.00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0	C	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0			0	40. 00 41. 00
43. 00		524, 824	0	C	17, 396	542, 220	•
44. 00	1 1	0	0	C		0	
45. 00 46. 00	+ I	0	0	C		0	
40.00	ANCILLARY SERVICE COST CENTERS	١			<u> </u>		40.00
50.00		8, 888, 600	143, 767	204, 669	229, 785	9, 466, 821	ł
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 1, 029, 283	0 40, 144	0 57 150	0 34, 519	0 1, 161, 096	
	1 1	1, 976, 878	40, 144	57, 150 C		1, 977, 085	
		2, 612, 550	59, 445			2, 839, 054	
55. 00		0	0	C	0	0	
56. 00 57. 00	1 1	0 889, 572	0		30, 240	0 919, 812	
58. 00	1	373, 884	3, 279	4, 668		394, 145	•
59. 00		617, 192	4, 716			645, 889	
60.00	06000 LABORATORY	3, 844, 366	27, 438			3, 991, 047	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	C	0	0	
62. 00	1	0	0	C	О	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	
64. 00	l l	0	0	0	0	0	
65. 00 66. 00	1 1	1, 294, 506 2, 013, 536	4, 753 30, 884			1, 343, 947 2, 162, 557	
67. 00		306, 441	3, 242			325, 940	
68. 00	1 1	226, 381	1, 731	2, 465		239, 766	•
69. 00	1 1	489, 579	13, 315			539, 055	•
70. 00 71. 00	1 1	6, 773	0	C	297 0	7, 070 0	1
71.00	1 1	4, 236, 627	0		o	4, 236, 627	
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 618, 159	6, 055	8, 620	62, 221	5, 695, 055	73. 00
		0	0	C	0	0	ł
75. 00 76. 97	1 1 7	0 135, 122	0		0 4, 619	0 139, 741	
	1 1	133, 122	0	o c		139, 741	1
	OUTPATIENT SERVICE COST CENTERS		-				
88. 00 89. 00	+ I	0	0			0	
	09000 CLINIC	0	0	•		-	90.00
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Health Financial Systems ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0086 Peri od: Worksheet B From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/23/2022 10: 25 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 91. 00 09100 EMERGENCY 3, 168, 948 39, 540 56, 290 106, 861 3, 371, 639 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 000000 0 95.00 09500 AMBULANCE SERVICES 0 95.00 Ω 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 0 0 98.00 09900 CMHC 0 99.00 99 00 0 0 99. 10 09910 CORF 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 0 101.00 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 106. 00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 107. 00 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 o 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 I NTEREST 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 SUBTOTALS (SUM OF LINES 1 through 117) 1, 213, 191 1, 727, 115 87, 762, 993 118. 00 118.00 87, 763, 417 1, 457, 108 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 42, 249 0 424 42, 673 190. 00 191. 00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 11, 434 0 0 11, 434 192. 00 0 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 194. 00 07950 CMH 0 0 194 00 0 C 0 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 87, 817, 100 1, 213, 191 1, 727, 115 1, 457, 532 87, 817, 100 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021

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5/23/2022 10:25 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 26, 947, 938 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 2, 519, 464 8, 210, 352 6.00 00700 OPERATION OF PLANT 239, 451 782, 246 7.00 1, 930 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 167, 763 85, 352 8, 134 640, 186 8.00 2, 897, 456 00900 HOUSEKEEPI NG 867.898 9.00 63, 157 6.019 9 00 10.00 01000 DI ETARY 124,677 214, 453 20, 437 15, 380 77, 094 10.00 11.00 01100 CAFETERI A 406, 807 152, 101 14, 495 0 54, 679 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12 00 0 0 13.00 01300 NURSING ADMINISTRATION 512, 301 123, 043 11,726 0 44, 233 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY C 0 0 14.00 01500 PHARMACY 15.00 0 0 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 256, 673 0 0 16.00 17.00 01700 SOCIAL SERVICE 350, 130 54, 096 5, 155 3,553 19, 447 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18 00 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 0 0 0 02000 NURSING PROGRAM 20 00 0 C 0 0 Λ 20 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 C 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 82, 391 15, 709 1.497 5, 647 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 2, 371, 665 2, 136, 278 203, 583 139, 256 767, 968 30.00 03100 INTENSIVE CARE UNIT 31.00 396, 739 37, 808 39, 421 142, 624 31.00 1, 316, 634 03200 CORONARY CARE UNIT 32.00 \cap Λ 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 C 0 03400 SURGICAL INTENSIVE CARE UNIT o 34.00 0 0 0 34.00 0 04000 SUBPROVIDER - IPF 0 0 40.00 40.00 0 0 04100 SUBPROVIDER - IRF 0 41.00 0 0 0 41.00 43.00 04300 NURSERY 240,051 0 0 0 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 0 44.00 0 45 00 04500 NURSING FACILITY O 45 00 0 0 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 191, 148 1,887,780 179, 902 146, 310 678, 638 50.00 05100 RECOVERY ROOM 51.00 Λ 51.00 05200 DELIVERY ROOM & LABOR ROOM 189, 497 52.00 514,039 527, 127 50, 234 34, 399 52.00 05300 ANESTHESI OLOGY 53.00 875, 293 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 1, 256, 903 780, 557 31, 155 280, 602 54 00 74.386 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 C 0 05600 RADI OI SOTOPE 56.00 56.00 57.00 05700 CT SCAN 407, 218 10, 418 57.00 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 43, 052 174, 495 4 103 16.343 15, 477 58 00 58 00 59.00 05900 CARDIAC CATHETERIZATION 285, 947 61, 923 5, 901 2, 953 22, 261 59.00 60.00 06000 LABORATORY 1, 766, 912 360, 282 34, 334 118 129, 518 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 0 0 0 06500 RESPIRATORY THERAPY 65 00 594, 991 62, 406 5 947 22.434 65 00 66.00 06600 PHYSI CAL THERAPY 957, 405 405, 532 38, 646 31, 018 145, 784 66.00 67.00 06700 OCCUPATIONAL THERAPY 144, 300 42, 569 4,057 1, 938 15, 303 67.00 06800 SPEECH PATHOLOGY 8, 172 22, 732 68.00 106, 149 2, 166 340 68.00 69.00 06900 ELECTROCARDI OLOGY 238, 650 174, 833 16,661 1.921 62, 851 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 3, 130 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 1, 875, 635 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 521, 309 79, 509 7,577 0 28, 583 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 C 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 0 75.00 07697 CARDIAC REHABILITATION 76.97 61,866 C 0 0 0 76.97 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0 89.00 09000 CLI NI C 90.00 0 0 90.00 91.00 09100 EMERGENCY 1, 492, 689 519, 192 49, 478 141, 148 186, 644 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 95. 00 09500 AMBULANCE SERVICES 0 0 0 95.00

Provider CCN: 15-0086

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared:

			'	0 12/31/2021	5/23/2022 10:	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 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	-	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 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 I NTEREST 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)	26, 923, 984	8, 210, 352	782, 246	615, 671	2, 897, 456	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18, 892	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	5, 062	0	0	24, 515	-	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 CMH	0	0	1 0	0		194. 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)	26, 947, 938	8, 210, 352	782, 246	640, 186	2, 897, 456	202. 00

Provider CCN: 15-0086

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: | From 2002 10 Prepared: |

Cost Control Description					0 12/31/2021	Date/lime Pre 5/23/2022 10:	
BERSHED SHAMES COST CRIMENS 10.00 19.00 19.00 13.00 14.00 1.00	Cost Center Description	DI ETARY	CAFETERI A			CENTRAL	
CHILDRY SUPPLIES COST COULDED				PERSONNEL	ADMINISTRATION		
0.00 0.000 CAP REL COSTS - GLUC & FIX		10.00	11. 00	12.00	13.00		
2.00				1			4 00
4.00							
9.00							
6.00							
2,00 0.0000 DUISPERT IN SERVICE 8.8 0.0 0.0000 DUISPERT IN SERVICE 1.0 0.0							
9.00 000000							
10.00 10000 DETARY 733,657 1.546,966 1.00 1.20 1.							
11.00 0 1100 (AFETERIA 0 1.546,966 11.00 1.596,664 12.00 1.300 (MIRS) MG ASIM NISTRATION 0 48,192 0 1.896,664 12.00 1.816 (MIRS) MG ASIM NISTRATION 0 0 0 0 0 0 0 0 1.816 (MIRS) MG ASIM NISTRATION 0 0 0 0 0 0 0 0 0	9. 00 00900 HOUSEKEEPI NG						9. 00
12.00 01200 MAINTENANCE OF PERSONNEL 0 0 0 1,896,064 13 00 13 00 1300 01300 MAINTENANCE OF PERSONNEL 0 0 0 0 0 0 1,896,064 13 00 14 00 0 0 0 14 00 0 0 14 00 0 0 14 00 0 0 14 00 0 0 14 00 0 0 14 00 0 0 14 00 0 0 0 14 00 0 0 0 0 0 0 0 0 0	10. 00 01000 DI ETARY	733, 657					10. 00
13.00 0.1300 NURSH NO ADMINISTRATION 0 48,192 0 1,896,664 13.00 14.00 14.00 14.00 14.00 14.00 15.0		0	1, 546, 966	1			
14.00 01400 CFNTRAL SFRVICES & SUPPLY 0 0 0 0 15.00 15.00 15.00 15.00 01.00 01.00 01.00 01.00 15.00 15.00 15.00 01.00 01.00 01.00 01.00 15.00 1	i i	0	0	1			
15.00 01500 PHARMACY 0 0 0 0 0 15.00 17.00 01700 SOCIAL SERVICE (SPECIFY) 0 0 0 0 0 0 16.00 17.00 01800 OTHER CREARAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 17.00 17.00 01800 OTHER CREARAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 18.00 17.00 01700 OTHER CREARAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 0 18.00 17.00 01700 OTHER CREARAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 0 0		0	48, 192		1, 896, 664	0	
16.00 01600 MEDICAL, RECORDS & LIBRARY 0 0 0 0 0 0 16.00	l I	0	0				
17.00 1700 SOCIAL SERVICE (SPECIFY)	l I		0				
18 00 0 1850 OTHER CENERAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 19 00 19 00 19 00 19 00 19 00 19 00 19 00 19 00 19 00 19 00 19 00 10 0 0 0	· ·		33. 734		40.070		
19. 00 01900 MORPHYSIC IAN AMESTHETISTS 0 0 0 0 0 0 0 0 0		o	0		0		
21. 00 20100 BAT SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 0 0 0 22.00	1 1	O	0) (o	0	19. 00
22 00 02200 LAR SERVICES-OTHER PROM COSTS APPRVD 0 0 0 0 0 0 0 0 0	20. 00 02000 NURSI NG PROGRAM	0	0) (o	0	20. 00
23.00 0.2300 PARAMED ED PRICU-(SPECIFY) 0 9,638 0 0 0 23.00		0	0) (0		
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 0.300 ADULTS & PEDI ATRICS 30.00 0.310 ADULTS & PEDI ATRICS 30.00 0.300 ADULTS & PEDI ATRICS 30.00 0.		0	0)	0		
30.00 03000 ADULTS & PEDI ATRICS 303, 666 207, 226 0 427, 417 0 30.00 31.00 31.00 31.00 31.00 11.0		0	9, 638	3 () 0	0	23. 00
31 00 03100 INTENSI VE_CARE_UNIT		202 444	207 224		127 417	0	20.00
32.00 03.200 COROMARY CARE UNIT 0 0 0 0 0 0 0 3.2 .00							
33 00 03300 BURN INTERSIVE CARE UNIT 0 0 0 0 0 0 33 0.00 40 00 04000 SURGICAL INTERSIVE CARE UNIT 0 0 0 0 0 0 0 0 34 0.00 41 00 04100 SURGICAL INTERSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		33, 347	110, 642	1			
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 0			0		ol ol		
11.00 O4100 SUBPROVI DER - IRF		O	0		o		
43.00 04300 NURSERY 0 0 0 0 0 0 0 44.00 44.00 04400 SKI LLED NURSING FACILITY 0 0 0 0 0 0 0 0 44.00 45.00 04500 OKORO SKI LED NURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	40. 00 04000 SUBPROVI DER - 1 PF	o	0) (o	0	40.00
44. 00 04400 SALLED NURSING FACILITY	41. 00 04100 SUBPROVI DER - RF	0	0) (0	0	41.00
45. 00 04500 NURSI NC FACILITY		0	0) (0		
46. 00 04600 014FR LONG TERN CARE 0 0 0 0 0 0 0 0 0		0	0		0		
ANCILLARY SERVICE COST CENTERS		0	0		0		
50.00 05000 05000 05000 05000 05100 0 0 0 0 0 0 0 0 0		U U	0)) 0	0	46.00
51-00 05-100 RECOVERY ROOM 0 0 0 0 0 0 51-00		214 220	313 250		560 985	0	50.00
S2.00 05200 05200 05200 05200 05200 05200 053000 053		1	010, 200	1			
53.00 05.300 ADSTONE STHESI OLOGY	· ·	18, 676	77, 107		200, 352		
55. 00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 55. 00 05600 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0) (o	0	53. 00
56.00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 56.00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	130, 119) c	13, 357	0	54.00
57. 00 05700 CT SCAN 0 33,734 0 0 0 57.00		0	0) (0		
58.00 05800 ACARDITIC RESONANCE IMAGING (MRI) 0 14,458 0 0 0 58.00 59.00 05900 CARDIAC CATHIETERIZATION 180 19,277 0 26,714 0 59.00 60.01 06000 LABORATORY 0 0 0 0 0 0 60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 64.00 06400 INTRAVROUS THERAPY 0 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 48,192 0 0 0 0 66.00 06600 PHYSICAL THERAPY 0 101,203 0 0 0 0 67.00 06700 0CCUPATIONAL THERAPY 0 14,458 0 0 0 0 68.00 06800 SPECH PATHOLOGY 147 9,638 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 24,096 0 40,070 0 69.00 71.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 72.00 07200 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 72.00 07200 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76.97 07697 CARDIAC REHABILITATION 0 4,819 0 13,357 0 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 0 77.00 07000 ELECRECARDLUS CELLA COULS ITION 0 0 0 0 77.00 07000 ELECRECARDLUS CELLA COULS ITION 0 0 0 0 77.00 07000 ELECRECARDLUS CELLA COULS ITION 0 0 0 0 77.00 07000 ELECRECARDLUS CELLA COULS ITION 0 0 0 0 77.00 07000 ELECRECARDLUS CELLA COULS ITION 0 0 0 0 77.00 07000 ELECRECARDLUS CELLA COULS ITION 0 0 0 0 77.00 07000 ELECRECARDLUS CELLA COULS ITION 0 0 0 0 77.00 07000 ELECRECARDLUS CELLA COULS ITION 0 0 0 0 77.00 07000 ELECRECARGED CELLA COULS ITION 0 0 0 0 77.00 07000 ELECRECA		0	0		0		
59, 00 05900 CARDIAC CATHETERIZATION 180 19,277 0 26,714 0 59,00		0		1	0		
60. 00 66000 LABORATORY 0 139,757 0 0 0 60. 00 60. 00 60. 01 600		1			0 24 714		
60.01 6001 BLOOD LABORATORY 0 0 0 0 0 60.01 61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 48, 192 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 101, 203 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 144, 458 0 0 0 0 68.00 06800 PECEP PATHOLOGY 147 9, 638 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 147 9, 638 0 0 0 0 69.00 07000 ELECTROENCEPHALLOGRAPHY 0 24, 096 0 40, 070 0 69.00 70.00 07000 ELECTROENCEPHALLOGRAPHY 0 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 74.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 76.97 07697 CARDI AC REHABILITATION 0 4, 819 0 13, 357 0 76. 97 77.00 07000 CURDANIC ACCUPANT OF ACCU		1			20, 714		
61. 00			137, 737			_	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 48, 192 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 101, 203 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 114, 458 0 0 0 0 68. 00 06800 SPECCH PATHOLOGY 147 9, 638 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 24, 096 0 40, 070 0 69. 00 69. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LITATI ON 0 4, 819 0 13, 357 0 75. 00 76. 97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 0 77. 00 07700 ALDEORELI C STEM CELL ACOUI SITION 0 0 0 0 0 79. 00 09000 CLINI C 0 0 0 0 0 79. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 79. 00 09200 BMSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 70 OTHER REIMBURSABLE COST CENTERS			· ·			Ü	
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 48, 192 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 101, 203 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 114, 458 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 147 9, 638 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 24, 096 0 40, 070 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 72, 288 0 13, 357 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATION 0 0 0 0 0 77. 00 07000 AUGUSTE STEM CELL ACQUISITION 0 0 0 0 0 77. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 79. 00 09000 CLINIC O 0 0 0 79. 00 09000 CLINIC O 0 0 0 79. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 79. 00 07600 EMERGENCY 27,720 134,938 0 293,849 0 70 OTHER REIMBURSABLE COST CENTERS		o	0) (o	0	
65. 00 06500 RESPIRATORY THERAPY 0 48, 192 0 0 0 65. 00 66. 00 6600 PHYSI CAL THERAPY 0 101, 203 0 0 0 66. 00 67. 00 67. 00 06000 PHYSI CAL THERAPY 0 114, 458 0 0 0 0 67. 00 68. 00 0 0 0 0 0 0 0 0 0	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	O	0) (o	0	63.00
66. 00 06600 PHYSI CAL THERAPY 0 101, 203 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 14, 458 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 147 9, 638 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 24, 096 0 40,070 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 76. 97 07697 CARDIAC REHABILITATION 0 4, 819 0 13, 357 0 76. 97 77. 00 000 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90. 00 09000 CUINIC C 0 0 0 0 0 91. 00 09200 DREGENALTY ON BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 09200 DREGENALTY ON BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 09200 DREGENALTY ON BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 09200 DREGENALTY ON BEDS (NON-DISTINCT PART) 0 0 0 92. 00 09200 DREGENALTY ON BEDS (NON-DISTINCT PART) 0 0 92. 00 09200 DREGENALTY ON BEDS (NON-DISTINCT PART) 0 92. 00 09200 DREGENALTY ON BEDS (NON-DISTINCT PART) 0 94. 00 09200 DREGENCY 09200 DREGENCATION 09200 DREGENCATION 09200 DREGENCATION 09200 DREGENCATION		0	0	0	0	0	
67. 00 06700 OCCUPATI ONAL THERAPY 0 14, 458 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 147 9, 638 0 0 0 0 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0 24, 096 0 40, 070 0 68. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 24, 096 0 40, 070 0 69. 00 70. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0			0		
68. 00		0			0		
69. 00 06900 ELECTROCARDI OLOGY 0 24,096 0 40,070 0 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 72,288 0 13,357 0 73.00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 4,819 0 13,357 0 76.97 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 77. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 CLINI C 0 0 0 0 0 90. 00 09000 CLINI C 0 0 0 0 90. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 00THER REI MBURSABLE COST CENTERS		147		1			
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 1 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72. 00 73. 00 73. 00 073. 00 DRUGS CHARGED TO PATIENTS 0 0 72. 288 0 13, 357 0 73. 00 74. 00 74. 00 RENAL DIALYSIS 0 0 0 0 0 0 0 0 0 74. 00 75. 00 75. 00 75. 00 76. 97 077. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		1	40.070		
71. 00			24, 090 0		40,070		
72. 00			0				
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 72, 288 0 13, 357 0 73. 00 74. 00 0 0 0 0 0 0 0 0 0			0		ol ol		
74. 00			72, 288	s c	13, 357		
76. 97			0)	0		
77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0	75.00 07500 ASC (NON-DISTINCT PART)	0	0) (0	0	75. 00
SERVICE COST CENTERS	l l	1		1			
88. 00		0	0) (0	0	77. 00
89. 00			_		\	~	00.00
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0		0	0		j S		
91. 00 09100 EMERGENCY 27,720 134,938 0 293,849 0 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS			0				
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS		27 720	134 938		293 849		
OTHER REI MBURSABLE COST CENTERS	· ·	21,120	104, 730		275, 647		
				•			
	94. 00 09400 HOME PROGRAM DIALYSIS	0	0) (0	0	94. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Pre

Date/Time Prepared: 5/23/2022 10:25 am 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 95. 00 09500 AMBULANCE SERVICES 95. 00 0 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0 0 0 0 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 99.00 99. 00 09900 CMHC 0 0 99. 10 09910 CORF 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 00000 0 0 0 0 0 0 106. 00 0 0 107.00 107.00 10700 LIVER ACQUISITION 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 0 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113. 00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 115.00 0 0 116. 00 11600 HOSPI CE 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 598, 206 1, 546, 966 0 1, 896, 664 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 191. 00 19100 RESEARCH 0 0 0 0 191. 00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 Ω 0 193.00 194.00 07950 CMH 0 0 194. 00 135, 451 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201. 00 0 TOTAL (sum lines 118 through 201) 0 1, 896, 664 0 202. 00 202.00 733, 657 1, 546, 966

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared:
5/23/2022 10:25 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0086

				10	3 12/31/2021	5/23/2022 10:	
					OTHER GENERAL		
	Coot Conton Decemintion	DUADMACY	MEDICAL	COCLAL CEDVICE	SERVI CE	NONDHIVELCLAN	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
			LI BRARY			711123111211313	
		15. 00	16. 00	17. 00	18. 00	19. 00	
	GENERAL SERVICE COST CENTERS	1		ı		Г	
1.00	00100 CAP REL COSTS MURLE FOULD						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						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 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	026 120				15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	836, 438 0				17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	l o	0	0	0		18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	O	0	0	0	0	19. 00
20. 00	02000 NURSI NG PROGRAM	0	0	0	0		20.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	0	0		21. 00
22. 00 23. 00	02200 1 & R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	0	0	_	0	l	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					25.00
30.00	03000 ADULTS & PEDI ATRI CS	0	84, 838	140, 122	0	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	64, 562	1	0		31. 00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF		0	Ö	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43.00	04300 NURSERY	0	2, 909	i	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	1	0	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	_	0		45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		<u>, </u>			40.00
50.00	05000 OPERATI NG ROOM	0	217, 149	408, 213	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0	_	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	10, 638		0	1	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	11, 754 63, 099		0	1	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		03, 077		0	1	55.00
56. 00	05600 RADI 0I SOTOPE	O	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	30, 842		0		57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	9, 584		0	1	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	16, 564 23, 093		0	0	59. 00 60. 00
60. 00	06001 BL00D LABORATORY	0	23, 043	35, 646	0	0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					_	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 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	54, 894	0 84, 563	0	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	19, 403		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	l o	3, 431		0	Ö	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1, 957	1	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	7, 563	1	0	0	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	0	177 0		0	0	70. 00 71. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	0	44, 833	_	0		71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	O	60, 188		0	Ö	73. 00
74.00	07400 RENAL DI ALYSI S	0	0		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	_	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1, 210		0	0	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	ı oj	0	0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	Ol	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	O	0	Ō	89. 00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	107, 750	192, 515	0	0	91. 00 92. 00
72.00	101200 ODOEKVATION DEDO (NON-DISTINCI FARI)	<u> </u>		I		l	1 /2.00

Provider CCN: 15-0086

			T	o 12/31/2021	Date/Time Pre 5/23/2022 10:	
				OTHER GENERAL	372372022 10.	25 (111)
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN	
		RECORDS &			ANESTHETI STS	
	45.00	LI BRARY	17.00	10.00	10.00	
OTHER REIMBURSABLE COST CENTERS	15. 00	16. 00	17. 00	18. 00	19. 00	
94. 00 09400 HOME PROGRAM DIALYSIS					0	94. 00
95. 00 09500 AMBULANCE SERVI CES				0	1 0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED				0	1 0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD				0	1 0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		Č		0	0	98.00
99. 00 09900 CMHC		C		0	0	99.00
99. 10 09910 CORF	o o	Ċ		0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	l ol	C	ol o	0	. 0	100.00
101.00 10100 HOME HEALTH AGENCY	o	C	o o	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>		
105. 00 10500 KIDNEY ACQUISITION	0	C	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION	0	C	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	C	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	C	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	C	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	C	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	C	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE					I	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					I	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	C	0	0	_	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	836, 438	1, 297, 048	0	0	118. 00
NONREI MBURSABLE COST CENTERS				ام		100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	C		0		190. 00
191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0			0		191. 00 192. 00
193. 00 19300 NONPALD WORKERS	0			0		193. 00
194. 00 07950 MONFALD WORKERS				0		194. 00
200.00 Cross Foot Adjustments		C	Ί			200. 00
201.00 Negative Cost Centers	0	(0	n		201.00
202.00 TOTAL (sum lines 118 through 201)	l ő	836, 438	1, 297, 048	0		202.00
	١	555, 100	., 2,,,010	۱	Ü	

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0086

			To	12/31/2021	Date/Time Pre 5/23/2022 10:	
		I NTERNS &	RESI DENTS		3/23/2022 10.	25 4111
Cost Center Description	NURSI NG	SERVI CES-SALAR	SERVI CES_OTHER	PARAMED ED	Subtotal	
cost center beschiptron	PROGRAM	Y & FRI NGES	PRGM COSTS	PRGM	Subtotal	
CENTERAL CERVICE COCT CENTERS	20. 00	21. 00	22. 00	23. 00	24. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS						5. 00 6. 00
7. 00 00700 0PERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A		-				10. 00 11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY						14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY						15. 00 16. 00
17. 00 01700 SOCIAL SERVICE						17. 00
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)						18. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS 20. 00 02000 NURSI NG PROGRAM						19. 00 20. 00
21. 00 02100 L&R SERVICES-SALARY & FRINGES APPRVD		Ó				21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD			0			22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)				300, 985		23. 00
30. 00 O3000 ADULTS & PEDIATRICS		ol	0	ol	12, 139, 063	30. 00
31. 00 03100 NTENSI VE CARE UNIT		1	0	o	5, 485, 057	31.00
32. 00 03200 CORONARY CARE UNIT	C	0	0	0	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	(0	0	0	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF			0	0	0	34. 00 40. 00
41. 00 04100 SUBPROVI DER - RF		o	0	o	0	41. 00
43. 00 04300 NURSERY	(1	0	0	785, 180	43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY		1 -1	0	0	0	44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE		1	0	o	0	46. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM			0	0	18, 264, 416 0	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1	0	o	2, 810, 127	52.00
53. 00 05300 ANESTHESI OLOGY	(0	0	0	2, 882, 209	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	(0	0	0	5, 566, 153	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	(0	0	0	55. 00 56. 00
57. 00 05700 CT SCAN		o o	0	o	1, 450, 025	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0	0	0	686, 772	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY			0	0	1, 114, 265 6, 480, 909	59. 00 60. 00
60. 01 06000 EABORATORY			0	0	0, 480, 909	60. 00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			-		0	61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	(0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY			0	0	0	63. 00 64. 00
65. 00 06500 RESPIRATORY THERAPY		o o	0	o	2, 217, 374	65. 00
66. 00 06600 PHYSI CAL THERAPY	C	0	0	o	3, 891, 370	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	(0	0	557, 307 394, 029	67. 00 68. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY			0	0	1, 117, 343	
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	0	0	o	10, 683	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	(0	0	0	0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	(0	300, 985	6, 157, 095 8, 829, 303	72. 00 73. 00
74. 00 07400 RENAL DIALYSIS			o	0	0, 829, 303	74.00
75.00 07500 ASC (NON-DISTINCT PART)	C	0	0	o	0	75. 00
76. 97 O7697 CARDIAC REHABILITATION	(1	0	0	222, 831	76. 97
77. 00 O7700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS		<u> </u>	U	U _I	0	77. 00
88. 00 08800 RURAL HEALTH CLINIC	C	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	89. 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY			0	0	0 6, 517, 562	90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1		Ĭ	3, 317, 302	92. 00
		'	'	·		

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2021 Part I Provider CCN: 15-0086

			To	12/31/2021	Date/Time Prepared:
		I NITEDNO 0	RESI DENTS		5/23/2022 10: 25 am
		INTERNS &	KESI DEN 13		
Cost Center Description	NURSI NG	SEDVI CES_SALAD	SERVI CES-OTHER	PARAMED ED	Subtotal
cost center bescription	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM	Subtotal
	20.00	21.00	22.00	23. 00	24. 00
OTHER REIMBURSABLE COST CENTERS	20.00	21100	22.00	20.00	211.00
94. 00 09400 HOME PROGRAM DIALYSIS	O	0	0	o	0 94.00
95. 00 09500 AMBULANCE SERVICES	o	0	o	ol	0 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	O	0	0	o	0 96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	o	0 97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	o	0	О	o	0 98.00
99. 00 09900 CMHC	0	0	О	o	0 99.00
99. 10 09910 CORF	O	0	0	o	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	0	o	0 100. 00
101.00 10100 HOME HEALTH AGENCY	o	0	0	o	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 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 UTILIZATION REVIEW-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	300, 985	87, 579, 073 118. 00
NONREI MBURSABLE COST CENTERS				_1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	61, 565 190. 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	41, 011 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194. 00 07950 CMH	0	0	0	O	135, 451 194. 00
200.00 Cross Foot Adjustments	0	0	0	0	0 200.00
201.00 Negative Cost Centers	0	0		300 005	0 201.00
202.00 TOTAL (sum lines 118 through 201)	l O	0	0	300, 985	87, 817, 100 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 Worksheet B Part I Date/Time Prepared: 5/23/2022 10: 25 am Provider CCN: 15-0086 Peri od: From 01/01/2021 To 12/31/2021 Cost Center Description Total Intern & Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS

00100 CAP REL COSTS-BLDG & FIXT
00200 CAP REL COSTS-MVBLE EQUIP 1.00 1.00 2.00 2. 00

4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			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 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11.00	01100 CAFETERI A			11.00
12.00	01200 MAINTENANCE OF PERSONNEL			12. 00
13.00	01300 NURSING ADMINISTRATION			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
	01850 OTHER GENERAL SERVICE (SPECIFY)			18. 00
	01900 NONPHYSICIAN ANESTHETISTS			19. 00
	02000 NURSI NG PROGRAM			20. 00
	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD			21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		40 400 0/0	1 00 00
	03000 ADULTS & PEDI ATRI CS	0	12, 139, 063	30.00
	03100 I NTENSI VE CARE UNI T	0	5, 485, 057	31.00
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	32. 00 33. 00
	1 1	0	0	34.00
	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	40.00
	04100 SUBPROVI DER – TFI	0	0	41.00
	04300 NURSERY		785, 180	43.00
	04400 SKILLED NURSING FACILITY		703, 100	44. 00
	04500 NURSING FACILITY	o o	0	45. 00
	04600 OTHER LONG TERM CARE	o	0	46. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		10.00
50.00	05000 OPERATING ROOM	0	18, 264, 416	50. 00
	05100 RECOVERY ROOM	1 1		1
5 I. UU	JUS TUU RECUVERT RUUW	0	0	51.00
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0 2, 810, 127	51. 00 52. 00
52.00	1 1	0 0	2, 810, 127	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0 0		52. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0 0 0	2, 810, 127 2, 882, 209	52. 00 53. 00
52. 00 53. 00 54. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153	52. 00 53. 00 54. 00
52. 00 53. 00 54. 00 55. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153	52. 00 53. 00 54. 00 55. 00
52. 00 53. 00 54. 00 55. 00 56. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0 0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153 0 0	52. 00 53. 00 54. 00 55. 00 56. 00
52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN	0 0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153 0 0 1, 450, 025	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00
52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOISOTOPE 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0 0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153 0 0 1, 450, 025 686, 772	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00
52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOISOTOPE 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0 0 0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153 0 0 1, 450, 025 686, 772 1, 114, 265	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOISOTOPE 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0 0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00
52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0 0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00
52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00 63. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOSTOPE 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00 63. 00
52. 00 53. 00 54. 00 55. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00 63. 00 64. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06000 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909 0 0	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
52. 00 53. 00 54. 00 55. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0 0 0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153 0 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909 0 0 0 0 2, 217, 374	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00
52. 00 53. 00 54. 00 55. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 810, 127 2, 882, 209 5, 566, 153 0 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909 0 0 0 0 2, 217, 374 3, 891, 370	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
52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 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 06600 PHYSI CAL THERAPY		2, 810, 127 2, 882, 209 5, 566, 153 0 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909 0 0 0 2, 217, 374 3, 891, 370 557, 307	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00
52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OSTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 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 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY		2, 810, 127 2, 882, 209 5, 566, 153 0 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909 0 0 0 2, 217, 374 3, 891, 370 557, 307 394, 029	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
52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	05200 DELIVERY ROOM & LABOR 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 05600 RADI OLOGY-THERAPEUTI C 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINI 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 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		2, 810, 127 2, 882, 209 5, 566, 153 0 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909 0 0 2, 217, 374 3, 891, 370 557, 307 394, 029 1, 117, 343	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 69. 00
52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI 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 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 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		2, 810, 127 2, 882, 209 5, 566, 153 0 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909 0 0 0 2, 217, 374 3, 891, 370 557, 307 394, 029 1, 117, 343 10, 683	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 69. 00 70. 00
52. 00 53. 00 54. 00 55. 00 57. 00 58. 00 60. 00 60. 01 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00	05200 DELIVERY ROOM & LABOR 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 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 06100 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCACDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		2, 810, 127 2, 882, 209 5, 566, 153 0 1, 450, 025 686, 772 1, 114, 265 6, 480, 909 0 0 2, 217, 374 3, 891, 370 557, 307 394, 029 1, 117, 343 10, 683	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00
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In Lieu of Form CMS-2552-10 Health Financial Systems ST ELIZABETH DEARBORN

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0086 Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/23/2022 10: 25 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 0 0 0 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-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 105. 00 10500 KIDNEY ACQUISITION 0 0 105.00 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 0 108.00 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 ACQUISITION 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.) 115. 00 0 0 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 87, 579, 073 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 0 61, 565 191. 00 19100 RESEARCH 191. 00 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 41, 011 192. 00 193. 00 19300 NONPALD WORKERS 193. 00 194. 00 07950 CMH 194. 00 135, 451 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 87, 817, 100 202. 00

					lo	12/31/2021	Date/lime Pre 5/23/2022 10::	
				CAPI TAL REI	ATED COSTS			
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		cost center bescription	Assigned New	DEDO & TIXI	WVBLL LQOIT	Jubtotai	BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1. 00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS		1.00	2.00	ZN	4.00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	2. 00 4. 00
5. 00		ADMINISTRATIVE & GENERAL	o	189, 599		459, 515	0	5. 00
6.00	00600	MAINTENANCE & REPAIRS	2, 500	398, 317		967, 867	0	6. 00
7.00		OPERATION OF PLANT	0	147		356	0	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	7, 120	6, 500 4, 810		15, 754 18, 777	0	8. 00 9. 00
10.00		DI ETARY	0	16, 332		39, 583	0	10.00
11. 00	1	CAFETERIA	0	11, 584	16, 490	28, 074	0	11. 00
12. 00 13. 00		MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION	0	0 9, 371	13, 340	0 22, 711	0	12. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	o	9, 371	13, 340	22, 711	0	14. 00
15. 00		PHARMACY	o	0	0	o	0	15. 00
16.00		MEDICAL RECORDS & LIBRARY	0	0 4, 120	0 5, 865	0 9, 985	0	16.00
17. 00 18. 00		SOCIAL SERVICE OTHER GENERAL SERVICE (SPECIFY)	0	4, 120	0, 865	9, 985	0	17. 00 18. 00
19. 00		NONPHYSI CI AN ANESTHETI STS	O	0	O	ō	0	19. 00
20.00		NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	21. 00 22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	o o	1, 196	1, 703	2, 899	0	23. 00
		IENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	23, 300 302	162, 692 30, 214		417, 602 73, 530	0	30. 00 31. 00
32. 00		CORONARY CARE UNIT	0	0, 214	·	73, 330	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	o	0	33. 00
34.00		SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00 41. 00		SUBPROVI DER	0	0		0	0	40. 00 41. 00
43. 00		NURSERY	0	0	O	ō	0	43. 00
44. 00		SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45. 00 46. 00		NURSING FACILITY OTHER LONG TERM CARE	0	0		0	0	45. 00 46. 00
10. 00		LARY SERVICE COST CENTERS	<u> </u>		<u> </u>			10.00
50.00		OPERATI NG ROOM	4, 408	143, 767	204, 669	352, 844	0	50.00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	0 40, 144		0 97, 294	0	51. 00 52. 00
53. 00		ANESTHESI OLOGY	o o	0, 144	0	0	0	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	74, 391	59, 445	84, 626	218, 462	0	54. 00
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	0	0	0	0	0	55. 00 56. 00
57. 00		CT SCAN	0	0		o	0	•
58.00		MAGNETIC RESONANCE IMAGING (MRI)	O	3, 279		7, 947	0	
59.00		CARDI AC CATHETERI ZATI ON LABORATORY	0 58, 205	4, 716		11, 430	0	59.00
60. 00 60. 01	1	BLOOD LABORATORY	36, 203	27, 438 0	39, 061	124, 704 0	0	60. 00 60. 01
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY				o	-	61. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
63. 00 64. 00	1	INTRAVENOUS THERAPY	0	0		0	0	63. 00 64. 00
65. 00		RESPI RATORY THERAPY	2, 479	4, 753	6, 766	13, 998	0	65. 00
66.00		PHYSI CAL THERAPY	45, 338	30, 884		120, 189	0	66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	3, 242 1, 731		7, 857 4, 196	0	67. 00 68. 00
69.00		ELECTROCARDI OLOGY	o	13, 315		32, 270	0	69.00
70. 00		ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70. 00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	215, 447	6, 055	8, 620	230, 122	0	1
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00		ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97 77. 00		CARDIAC REHABILITATION ALLOGENEIC STEM CELL ACQUISITION		0		ol Ol	0	76. 97 77. 00
	OUTPA	TIENT SERVICE COST CENTERS						
	08800	RURAL HEALTH CLINIC	0	0		0	0	
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER CLINIC		0		0	0	•
		EMERGENCY		39, 540		95, 830	0	1
					·			

Health Financial Systems ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0086 Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/23/2022 10: 25 am CAPITAL RELATED COSTS BLDG & FIXT **EMPLOYEE** Cost Center Description Directly MVBLE EQUIP Subtotal Assigned New **BENEFITS** Capi tal DEPARTMENT Related Costs 0 1.00 2.00 2A 4.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0 0 0 0 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 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 0 99. 00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 99. 10 0 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 105, 00 0000000 0 0 0 0 οĺ 106.00 10600 HEART ACQUISITION 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 108. 00 0 0 109.00 109.00 10900 PANCREAS ACQUISITION 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 116. 00 11600 HOSPI CE 0 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117) 433, 490 1, 213, 191 1, 727, 115 3, 373, 796 0 118.00 118.00 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 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 0 193.00 19300 NONPALD WORKERS 0 0 193. 00 0 0 0

0

1, 213, 191

433, 490

0

1, 727, 115

0

o

0

3, 373, 796

0 194. 00

0 201. 00

0 202. 00

200. 00

194. 00 07950 CMH

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

200.00

201.00

202.00

Provider CCN: 15-0086

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part II
To 12/31/2021 Date/Time Prepared: 5/23/2022 10:25 am

		1		1		5/23/2022 10:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	January 2007	5. 00	6.00	7.00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			I			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	459, 515					5. 00
6.00	00600 MAINTENANCE & REPAIRS	42, 961	1, 010, 828	1			6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	4, 083 2, 861	238 10, 508	1	29, 172		7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	14, 799	7, 776	1		41, 388	9. 00
10.00	01000 DI ETARY	2, 126	26, 403	1		1, 101	10.00
11. 00	01100 CAFETERI A	6, 937	18, 726	1	0	781	11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	1		0	12.00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	8, 735	15, 149	70 0	0	632 0	13. 00 14. 00
15. 00	01500 PHARMACY	0	0	0	0	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 377	0	ő	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	5, 970	6, 660	31	162	278	17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18. 00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS 02000 NURSI NG PROGRAM	0	0	0	0	0 0	19.00
20. 00 21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	Ö	Ö	ő	0	ő	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	1, 405	1, 934	9	0	81	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	40, 440	263, 008	1		10, 970	30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT	22, 451	48, 845	226 0	1, 796	2, 037 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	o	0	ő	0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
43.00	04300 NURSERY	4, 093	0	0	0	0	43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	o	Ö	ő	0	o O	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	71, 479	232, 417	1		9, 694	50.00
51. 00	05100 RECOVERY ROOM	0 7/5	(4.000	1	-	0	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	8, 765 14, 925	64, 898	300	1, 567	2, 707 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	21, 432	96, 099	_	1, 420	4, 008	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	6, 944	5 200	0	475	0	57. 00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	2, 975 4, 876	5, 300 7, 624			221 318	58. 00 59. 00
60.00	06000 LABORATORY	30, 128	44, 357	1		1, 850	1
60. 01	06001 BLOOD LABORATORY	0	0	i		0	60. 01
61. 00							61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	10, 145	7, 683	· ·	0	320	65.00
66. 00	06600 PHYSI CAL THERAPY	16, 325	49, 928			2, 082	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 461	5, 241	1			
68. 00	06800 SPEECH PATHOLOGY	1, 810	2, 799			117	68. 00
69. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	4, 069	21, 525	1		898	69.00
70. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	53	0	0	0	0	70. 00 71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	31, 982	0	Ö	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	42, 992	9, 789	45	0	408	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 055	0	0	0	0	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	U	ı ₁ 0	0	0	77. 00
88. 00		O	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	Ö	o	0	89. 00
90.00	09000 CLI NI C	0	0	0	0	. 0	90.00
91.00	09100 EMERGENCY	25, 453	63, 921	296	6, 432	2, 666	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00		Ö	0				

Provider CCN: 15-0086

| Period: | Worksheet B | From 01/01/2021 | Part II | To | 12/31/2021 | Date/Time Prepared:

			To	o 12/31/2021	Date/Time Pre 5/23/2022 10:	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	25 4111
oost center bescription	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOUSEREEFFING	
	5. 00	6. 00	7. 00	8. 00	9. 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						1
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	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 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	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	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	459, 107	1, 010, 828	4, 677	28, 055	41, 388	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	322	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	86	0	0	1, 117	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194. 00 07950 CMH	0	0	0	0	0	194. 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)	459, 515	1, 010, 828	4, 677	29, 172	41, 388	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0086

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/23/2022 10: 25 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **PERSONNEL** SUPPLY 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 70,036 10 00 01100 CAFETERI A 11.00 54, 605 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 1,701 48, 998 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 0 0 15.00 15.00 C 0 0 01600 MEDICAL RECORDS & LIBRARY 16.00 0 0 16.00 17.00 01700 SOCIAL SERVICE 0 1.035 17.00 1, 191 0 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 0 0 0 0 18.00 C 0 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 19 00 C 0 0 20.00 02000 NURSING PROGRAM C 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 21.00 0 0 21.00 o 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 22.00 0 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 340 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 28, 989 7, 315 11, 042 0 30.00 31 00 03100 INTENSIVE CARE UNIT 3 207 3, 913 0 6, 901 0 31 00 03200 CORONARY CARE UNIT 0 32.00 0 C 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 04000 SUBPROVI DER - I PF 0 0 40.00 C 0 40.00 04100 SUBPROVIDER - IRF 0 41.00 0 0 0 41.00 0 04300 NURSERY 0 43.00 0 0 0 0 43.00 44 00 04400 SKILLED NURSING FACILITY Ω 0 0 44 00 0 04500 NURSING FACILITY 0 45.00 C 0 45.00 04600 OTHER LONG TERM CARE 0 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 20, 450 O 14, 493 50 00 11, 057 0 0 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 1.783 2,722 5, 176 0 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 4, 593 345 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 0 0 56.00 05700 CT SCAN 0 1, 191 0 57.00 57.00 0 0 οl 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 510 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 17 680 0 690 0 59.00 60 00 06000 LABORATORY 0 4, 933 0 0 0 60.00 0 0 06001 BLOOD LABORATORY 0 60.01 0 60.01 C 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0000 0 0 0 63.00 0 06400 INTRAVENOUS THERAPY 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 1,701 0 65.00 66.00 06600 PHYSI CAL THERAPY 3, 572 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 510 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 14 340 0 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0000000 851 1,035 0 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 C 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 552 345 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 74.00 C 0 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 75.00 07697 CARDIAC REHABILITATION 76. 97 0 0 170 345 0 76.97 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 0 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 C 90.00 09000 CLI NI C 0 0 0 90.00 91 00 09100 EMERGENCY 0 7 591 91 00 2 646 4.763 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00 ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0086

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/23/2022 10:25 am 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 95. 00 09500 AMBULANCE SERVICES 95. 00 0 0 0 0 0 0 0 0 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 99. 00 09900 CMHC 99.00 0 0 99. 10 09910 CORF 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 00000 0 0 0 0 0 0 106. 00 0 107.00 10700 LIVER ACQUISITION 0 107.00 0 108.00 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 0 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113. 00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 115.00 0 116. 00 11600 HOSPI CE 0 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 106 54, 605 0 48, 998 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 191. 00 19100 RESEARCH 0 0 0 0 191. 00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 Ω 0 193.00 194.00 07950 CMH 0 0 194. 00 12, 930 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201. 00 0 0 202.00 TOTAL (sum lines 118 through 201) 70,036 0 48, 998 0 202. 00 54,605

				'	0 12/31/2021	Date/lime Pre 5/23/2022 10:	
					OTHER GENERAL		
	Coot Conton Decemintion	DUADMACY	MEDICAL	COCLAL CEDVICE	SERVI CE	NONDHYCLCLAN	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
			LI BRARY			7.112.77.70	
		15. 00	16. 00	17. 00	18. 00	19. 00	
1 00	GENERAL SERVICE COST CENTERS	T T		Ī			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP			1			1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300 NURSING ADMINISTRATION						13.00
15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	o	4, 377	,			16.00
17. 00	01700 SOCIAL SERVICE	o	0				17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	1	- 1	_	18. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0	0	0	0	0	19. 00
20. 00 21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD		0		0		20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	o	Ö	1	I I		22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	O	0	0	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	T					
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 NTENSIVE CARE UNIT	0	444 338	1	l .		30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT		0		l l		32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	l o	0	1	-		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	O		34. 00
40.00	04000 SUBPROVIDER - I PF	0	0	1	-		40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	15	0	0		41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY		0	1	0		44.00
45. 00	04500 NURSING FACILITY	o	0	0	O		45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0		46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	1, 138	7, 966	ol		50. 00
51. 00	05100 RECOVERY ROOM		1, 130		l .		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	56	526	O		52.00
53. 00	05300 ANESTHESI OLOGY	0	61	1	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	330	1	0		54. 00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE		0	1	0		55. 00 56. 00
57. 00	05700 CT SCAN		161	1	o		57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	50	1	I I		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	87	1			59. 00
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	0	121	1			60.00
60. 01 61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	U	U	0	U		60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	0	o		62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	O		63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	· ·		64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	287 101	1	I I		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		18	1	l l		67.00
68. 00	06800 SPEECH PATHOLOGY	o	10	1	I I		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	40	227	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1	6			70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		234	1	- 1		71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		315		· ·		73. 00
74. 00		O	0	1	l .		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	- 1		75. 00
76. 97		0	6	36	l .		76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	ı U	0) 0	0		77. 00
88. 00		O	C	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	. 1		89. 00
90.00	09000 CLINIC	0	0	0	0		90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)		564	3, 757	0		91. 00 92. 00
72.00	15.225 (NON DISTINCT TAKE)	<u>ı </u>		1	ı İ		, ,

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time | Prepared:

			Т	o 12/31/2021	Date/Time Pre 5/23/2022 10:	
				OTHER GENERAL	072072022 10.	20 4111
				SERVI CE		
Cost Center Description	PHARMACY		SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN	
		RECORDS &			ANESTHETI STS	
	45.00	LI BRARY	17.00	10.00	10.00	
OTHER REIMBURSABLE COST CENTERS	15. 00	16. 00	17. 00	18. 00	19. 00	
94. 00 09400 HOME PROGRAM DIALYSIS	ام	0		0		94. 00
95. 00 09500 AMBULANCE SERVICES		0		0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0		, o		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o o	0		0		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	o o	0		0		98. 00
99. 00 09900 CMHC	o	0	C	0		99. 00
99. 10 09910 CORF	o	0	l c	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	l c	0		100.00
101.00 10100 HOME HEALTH AGENCY	o	0	C	0		101. 00
SPECIAL PURPOSE COST CENTERS						Ī
105.00 10500 KIDNEY ACQUISITION	0	0	C	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	C	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	C	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	C	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	C	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	C	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	C	0		115. 00
116. 00 11600 HOSPI CE	0	0	C	0		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	0	4, 377	25, 312	2 0	0	118. 00
NONREI MBURSABLE COST CENTERS						100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		191. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 193. 00 19300 NONPAID WORKERS	0	0				192.00
193.00 19300 NONFALD WORKERS	0	0				194. 00
200.00 Cross Foot Adjustments	١	U	1		_	200. 00
201.00 Negative Cost Centers		0		0		200.00
202.00 TOTAL (sum lines 118 through 201)		4, 377	25, 312	0		202. 00
202.00 TOTAL (Sum Times The thirdgin 201)	١	7, 377	1 25,512	٠١ ٠١	0	1202.00

					10	12/31/2021	Date/lime Pre 5/23/2022 10:	
				INTERNS &	RESI DENTS		7 07 207 2022 101	
		Cost Conton Decemintion	NUDCLNC	CEDVI CEC CALAD	CEDVI CEC OTHER	DADAMED ED	Culatatal	
		Cost Center Description	NURSI NG PROGRAM	Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	
			20. 00	21.00	22.00	23. 00	24. 00	
		AL SERVICE COST CENTERS						
1.00	1 1	CAP REL COSTS MARIE FOLL D						1.00
2. 00 4. 00	1 1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	1 1	ADMINISTRATIVE & GENERAL						5. 00
6.00	1 1	MAINTENANCE & REPAIRS						6. 00
7.00	1 1	OPERATION OF PLANT						7. 00
8.00	1 1	LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	1 1	HOUSEKEEPI NG						9.00
11. 00	1 1	DI ETARY CAFETERI A						10. 00 11. 00
12. 00	1 1	MAINTENANCE OF PERSONNEL						12. 00
13.00	01300	NURSING ADMINISTRATION						13. 00
14. 00	1 1	CENTRAL SERVICES & SUPPLY						14. 00
15.00	1 1	PHARMACY MEDICAL DECORDS & LIBRARY						15.00
16. 00 17. 00	1 1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE						16. 00 17. 00
18. 00	1 1	OTHER GENERAL SERVICE (SPECIFY)						18. 00
19. 00	1 1	NONPHYSICIAN ANESTHETISTS						19. 00
20. 00	1 1	NURSI NG PROGRAM	0					20. 00
21. 00	1 1	I &R SERVI CES-SALARY & FRINGES APPRVD		0				21. 00
22. 00 23. 00	1 1	I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY)			0	6, 668		22. 00 23. 00
23.00		ENT ROUTINE SERVICE COST CENTERS				0, 000		23.00
30.00		ADULTS & PEDI ATRI CS					790, 106	30. 00
31.00		INTENSIVE CARE UNIT					165, 229	31. 00
32. 00	1 1	CORONARY CARE UNIT					0	32.00
33. 00 34. 00		BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT					0	33. 00 34. 00
40.00	1 1	SUBPROVIDER - IPF					0	40.00
41. 00	1 1	SUBPROVI DER - I RF					0	41. 00
43.00	04300	NURSERY					4, 108	43. 00
44. 00	1 1	SKILLED NURSING FACILITY					0	44. 00
45. 00	1 1	NURSING FACILITY					0	45. 00
46. 00		OTHER LONG TERM CARE ARY SERVICE COST CENTERS					0	46. 00
50.00		OPERATI NG ROOM					729, 281	50. 00
51.00	1 1	RECOVERY ROOM					0	51. 00
52. 00		DELIVERY ROOM & LABOR ROOM					185, 794	
53. 00 54. 00	1 1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C					15, 339 349, 025	
55. 00	1 1	RADI OLOGY-THERAPEUTI C					349, 023	55. 00
56. 00	1 1	RADI OI SOTOPE					0	56. 00
57. 00		CT SCAN					9, 708	
58. 00		MAGNETIC RESONANCE I MAGING (MRI)					18, 068	
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY					26, 412 207, 003	
60. 01	1 1	BLOOD LABORATORY					207,003	60. 01
61. 00	1 1	PBP CLINICAL LAB SERVICES-PRGM ONLY					_	61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS					0	62. 00
63.00		BLOOD STORING, PROCESSING & TRANS.					0	63.00
64. 00 65. 00	1 1	I NTRAVENOUS THERAPY RESPI RATORY THERAPY					0 35, 820	64. 00 65. 00
66. 00	1 1	PHYSI CAL THERAPY					194, 423	1
67.00	1 1	OCCUPATIONAL THERAPY					16, 522	
68. 00	1 1	SPEECH PATHOLOGY					9, 372	
69.00	1 1	ELECTROCARDI OLOGY					61, 103	
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS					60 0	70. 00 71. 00
72.00	1 1	IMPL. DEV. CHARGED TO PATIENTS					32, 216	
73.00	07300	DRUGS CHARGED TO PATIENTS					287, 553	
74.00		RENAL DIALYSIS					0	
75.00		ASC (NON-DISTINCT PART)					1 (12	
76. 97 77. 00		CARDIAC REHABILITATION ALLOGENEIC STEM CELL ACQUISITION					1, 612 0	
, , . 00		TIENT SERVICE COST CENTERS					0	, , , . 00
88. 00		RURAL HEALTH CLINIC					0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER					0	89. 00
90.00		CLI NI C					213 010	90.00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)					213, 919	91. 00 92. 00
, 00	10.200	TITE OF SESS (NOW BIOTHOUT TAKE)		l	1	'		, , 00

Provider CCN: 15-0086

				o 12/31/2021	Date/Time Prepa	
		LNTEDNO	DECLIDENTS		5/23/2022 10: 2	5 am
		INTERNS &	RESI DENTS			
Cost Center Description	NURSI NG	SERVI CES-SALAR	CEDVI CEC OTHER	PARAMED ED	Subtotal	
cost center bescription	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	
	20. 00	21.00	22.00	23. 00	24. 00	
OTHER REIMBURSABLE COST CENTERS	20.00	21.00	22.00	23.00	24.00	
94. 00 09400 HOME PROGRAM DIALYSIS					0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED						96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD						97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS						98. 00
99. 00 09900 CMHC						99. 00
99. 10 09910 CORF						99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM						00.00
101.00 10100 HOME HEALTH AGENCY		•				01. 00
SPECIAL PURPOSE COST CENTERS		'		'		
105. 00 10500 KIDNEY ACQUISITION					0 1	05.00
106.00 10600 HEART ACQUISITION					0 1	06. 00
107.00 10700 LIVER ACQUISITION					0 1	07.00
108.00 10800 LUNG ACQUISITION					0 1	08.00
109.00 10900 PANCREAS ACQUISITION					0 1	09.00
110.00 11000 INTESTINAL ACQUISITION					0 1	10.00
111.00 11100 ISLET ACQUISITION					0 1	11.00
113.00 11300 INTEREST EXPENSE					1	13.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					1	14.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					0 1	15.00
116. 00 11600 H0SPI CE					0 1	16.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	C	0	3, 352, 673 1	18.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					322 1	90.00
191. 00 19100 RESEARCH						91. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES					1, 203 1	
193.00 19300 NONPALD WORKERS					0 1	93.00
194.00 07950 CMH					12, 930 1	94.00
200.00 Cross Foot Adjustments	0	0	C	6, 668	6, 668 2	
201.00 Negative Cost Centers	0	0	C	0		01.00
202.00 TOTAL (sum lines 118 through 201)	0	0	(6, 668	3, 373, 796 2	02.00

ST ELIZABETH DEARBORN

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0086

				10 12/31/2	2021 Date/lime F 5/23/2022 1	
	Cost Center Description	Intern &	Total	<u>'</u>		
		Residents Cost				
		& Post				
		Stepdown Adjustments				
		25. 00	26. 00			
	GENERAL SERVICE COST CENTERS					4.00
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 ADMINISTRATIVE & GENERAL					5. 00
6.00	00600 MAINTENANCE & REPAIRS					6. 00
7.00	00700 OPERATION OF PLANT					7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG					8.00
10.00	01000 DI ETARY					9. 00
11. 00	01100 CAFETERI A					11. 00
12.00	01200 MAINTENANCE OF PERSONNEL					12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON					13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00 15. 00
16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)					18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS					19. 00
20.00	02000 NURSI NG PROGRAM					20.00
21. 00 22. 00	02100 1 & R SERVI CES-SALARY & FRINGES APPRVD 02200 1 & R SERVI CES-OTHER PRGM COSTS APPRVD					21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)					23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		'			
30. 00	03000 ADULTS & PEDIATRICS	0	790, 106			30.00
31. 00	03100 INTENSIVE CARE UNIT	0	165, 229			31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	O	o			34. 00
40. 00	04000 SUBPROVI DER - I PF	0	o			40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0			41. 00
43.00	04300 NURSERY	0	4, 108			43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY		0			44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	o o	o			46. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	729, 281			50. 00
51. 00 52. 00	05100 RECOVERY ROOM	0	105 704			51. 00 52. 00
53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	185, 794 15, 339			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	349, 025			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0			55. 00
56. 00	05600 RADI OI SOTOPE	0	0			56. 00
57. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	9, 708			57.00
	05900 CARDI AC CATHETERI ZATI ON		18, 068 26, 412			58. 00 59. 00
60. 00	06000 LABORATORY	0	207, 003			60.00
60. 01	06001 BLOOD LABORATORY	0	o			60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_			61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		O O			63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY		35, 820			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	194, 423			66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	16, 522			67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY	0	9, 372			68. 00 69. 00
70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		61, 103 60			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	32, 216			72. 00
73.00	I I	0	287, 553			73. 00
74. 00 75. 00	07400 RENAL DIALYSIS	0	0			74. 00 75. 00
	07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION		1, 612			76. 97
77. 00	1 1		0			77. 00
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC	0	0			88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0			89. 00 90. 00
90.00	09100 EMERGENCY		213, 919			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,,,,			92. 00
	·		'			

In Lieu of Form CMS-2552-10 Health Financial Systems ST ELIZABETH DEARBORN ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0086 Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/23/2022 10: 25 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 0 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVICES 95.00 0 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-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 105. 00 10500 KIDNEY ACQUISITION 0 0 105.00 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 107. 00 108. 00 108.00 10800 LUNG ACQUISITION 0 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 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.) 115. 00 0 0 116. 00 11600 HOSPI CE 0 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 3, 352, 673 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 0 0 0 0 0 0 0 322 191. 00 19100 RESEARCH 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1, 203 192. 00 193. 00 19300 NONPALD WORKERS 193. 00 0 194. 00 07950 CMH 12, 930 194. 00 200.00 Cross Foot Adjustments 6,668 200.00

3, 373, 796

201.00

202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/23/2022 10:25 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 297, 131 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 297, 131 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 29, 918, 062 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 46 436 46, 436 2 219 916 -26, 947, 938 60 869 162 5 00 6.00 00600 MAINTENANCE & REPAIRS 97, 555 97, 555 768, 496 5, 690, 888 6.00 7.00 00700 OPERATION OF PLANT 36 36 397, 816 540, 865 7.00 00800 LAUNDRY & LINEN SERVICE 1,592 1, 592 102, 111 0 378, 937 8.00 8.00 0 00900 HOUSEKEEPI NG 1, 178 9 00 1, 212, 781 1, 960, 382 1.178 9 00 10.00 01000 DI ETARY 4,000 4,000 330, 365 0 281, 616 10.00 01100 CAFETERI A 0 11.00 2,837 2,837 487, 223 918, 884 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 2.295 2.295 830, 630 1, 157, 169 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 C 01500 PHARMACY 0 15.00 15.00 0 01600 MEDICAL RECORDS & LIBRARY 579, 765 430, 436 16,00 16,00 17 00 01700 SOCIAL SERVICE 1,009 1.009 563, 781 790, 863 17 00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 o 19.00 Ω 0 02000 NURSI NG PROGRAM 20.00 0 0 20.00 C 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 r 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 293 293 157, 906 186, 103 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 39, 846 39, 846 3, 398, 565 0 5, 357, 044 30.00 03100 INTENSIVE CARE UNIT 0 31.00 7,400 7,400 2,003,820 2, 973, 973 31.00 0 32.00 03200 CORONARY CARE UNIT 0 C 32.00 0 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 0 40.00 0 0 Ω 40.00 0 41 00 \cap Λ 41 00 0 0 43.00 04300 NURSERY 357, 092 542, 220 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 0 0 44.00 04500 NURSING FACILITY 45.00 45.00 0 0 04600 OTHER LONG TERM CARE 46.00 \cap 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 35, 211 35, 211 4, 716, 464 9, 466, 821 50.00 0 05100 RECOVERY ROOM 51 00 C 51 00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 9,832 9, 832 708, 552 0 1, 161, 096 52.00 53.00 05300 ANESTHESI OLOGY 4, 253 0 1, 977, 085 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 14, 559 14, 559 1, 692, 087 0 2, 839, 054 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 C 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 620, 735 0 919, 812 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 803 803 252, 758 0 0 0 394, 145 58.00 05900 CARDIAC CATHETERIZATION 1, 155 354, 444 59 00 1.155 645, 889 59 00 60.00 06000 LABORATORY 6,720 6,720 1, 645, 870 3, 991, 047 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 0 06500 RESPIRATORY THERAPY 778, 415 1, 343, 947 65.00 1.164 1, 164 65 00 66.00 06600 PHYSI CAL THERAPY 7,564 7, 564 1, 522, 473 2, 162, 557 66.00 325, 940 06700 OCCUPATIONAL THERAPY 794 794 238, 970 0 67.00 67.00 0 06800 SPEECH PATHOLOGY 239, 766 68.00 424 424 188.617 68.00 06900 ELECTROCARDI OLOGY 69.00 3, 261 3. 261 353, 182 539, 055 69 00 7, 070 07000 ELECTROENCEPHALOGRAPHY 6,087 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 4, 236, 627 72.00 72.00 \cap 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 483 1, 483 1, 277, 199 5, 695, 055 73.00 07400 RENAL DIALYSIS 74.00 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 C O 75.00 07697 CARDIAC REHABILITATION 94, 808 76.97 76.97 0 0 0 139, 741 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 C 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89 00 0 89.00 90.00 09000 CLI NI C 0 0 0 0 90.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0086

			To	12/31/2021	Date/Time Prepared: 5/23/2022 10:25 am
	CAPITAL REL	ATED COSTS			072072022 TO. 20 dill
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL
			DEPARTMENT		(ACCUM. COST)
			(GROSS		
	1.00	2.00	SALARI ES) 4. 00	5A	5. 00
91. 00 09100 EMERGENCY	9, 684	9, 684	2, 193, 514	5A 0	3, 371, 639 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT P		7, 00 1	2, 170, 011	ŏ	92.00
OTHER REIMBURSABLE COST CENTERS	, l		l.		
94.00 09400 HOME PROGRAM DIALYSIS	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 MEDI CAL EQUI P-SOLD	0	0	0	0	0 97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC	0	0	0	0	0 98.00 0 99.00
99. 10 09900 CMRC 99. 10 09910 CORF		0	0	0	0 99.00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM		0	0	0	0 100.00
101. 00 10100 HOME HEALTH AGENCY	Ö	0	Ö	o	0 101.00
SPECIAL PURPOSE COST CENTERS	,	-	- 1	- 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	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 111.00 11100 ISLET ACQUISITION	0	0	0	0	0 110. 00 0 111. 00
113. 00 11300 NTEREST EXPENSE		U	U	٥	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	ol	0 115. 00
116. 00 11600 HOSPI CE	Ó	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 throug	h 117) 297, 131	297, 131	29, 909, 366	-26, 947, 938	60, 815, 055 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANT	EEN O	0	8, 696	0	42, 673 190. 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	11, 434 192. 00
193. 00 19300 NONPALD WORKERS 194. 00 07950 CMH		0	0	U O	0 193. 00 0 194. 00
200.00 Cross Foot Adjustments		U	U	U U	200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst.	B, 1, 213, 191	1, 727, 115	1, 457, 532		26, 947, 938 202. 00
Part I)			, ,		
203.00 Unit cost multiplier (Wkst. B, P		5. 812638	0. 048717		0. 442719 203. 00
204.00 Cost to be allocated (per Wkst.	В,		0		459, 515 204. 00
Part II)	.		0.000000		0.007540.005.00
205.00 Unit cost multiplier (Wkst. B, P	art		0. 000000		0. 007549 205. 00
206.00 NAHE adjustment amount to be all	ocated				206, 00
(per Wkst. B-2)					200.00
207.00 NAHE unit cost multiplier (Wkst.	D,				207. 00
Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

Peri od: Worksheet B-1 From 01/01/2021 To 12/31/2021 Date/Ti me Prepared:

5/23/2022 10: 25 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY REPAI RS PLANT LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 6.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 153, 140 6.00 00700 OPERATION OF PLANT 7.00 153, 104 36 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1.592 1, 592 440, 962 8.00 9.00 00900 HOUSEKEEPI NG 1, 178 1, 178 150.334 9.00 01000 DI ETARY 4,000 4,000 10, 594 4,000 44, 940 10.00 10.00 01100 CAFETERI A 11.00 2,837 2, 837 \cap 2,837 Λ 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 2, 295 2, 295 2, 295 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 14.00 0 C 0 01500 PHARMACY 15.00 0 C 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 01700 SOCIAL SERVICE 17.00 1,009 1,009 2, 447 1,009 0 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18 00 C 18 00 0 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19.00 02000 NURSING PROGRAM 0 0 0 20.00 20.00 C 0 02100 | &R SERVICES-SALARY & FRINGES APPRVD 21.00 0 0 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD O 22 00 22 00 0 r 0 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) 293 293 293 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 39 846 39 846 95, 920 39 846 18 601 30 00 31.00 03100 INTENSIVE CARE UNIT 7,400 7, 400 27, 153 7, 400 2,058 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00 0 0 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34 00 C 0 34 00 0 40.00 04000 SUBPROVI DER - I PF C 0 0 0 40.00 04100 SUBPROVIDER - IRF 0 0 0 41.00 41.00 0 0 43.00 04300 NURSERY 0 0 0 43.00 04400 SKILLED NURSING FACILITY 0 Ω 44.00 0 44 00 45.00 04500 NURSING FACILITY 0 C 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 46.00 ANCILLARY SERVICE COST CENTERS 13, 122 50.00 50.00 05000 OPERATING ROOM 35, 211 35, 211 100, 780 35, 211 05100 RECOVERY ROOM 51.00 51.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 9,832 9,832 23, 694 9,832 1, 144 52.00 05300 ANESTHESI OLOGY 53.00 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 14.559 14, 559 21, 460 14, 559 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 0 0 56.00 05700 CT SCAN 57.00 0 C 7, 176 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 803 803 11, 257 803 Ω 58.00 59.00 05900 CARDIAC CATHETERIZATION 1.155 1, 155 2,034 1, 155 11 59.00 06000 LABORATORY 6,720 6, 720 81 6,720 60.00 0 60.00 60.01 06001 BLOOD LABORATORY 0 С 0 Ω 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS 63.00 0 C 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 1, 164 1, 164 1, 164 65.00 06600 PHYSI CAL THERAPY 66.00 7.564 21, 365 7.564 66.00 7.564 06700 OCCUPATI ONAL THERAPY 67.00 794 794 1, 335 794 0 67.00 68.00 06800 SPEECH PATHOLOGY 424 424 234 424 68.00 06900 ELECTROCARDI OLOGY 69.00 3, 261 1, 323 3, 261 69.00 3, 261 07000 ELECTROENCEPHALOGRAPHY 70.00 0 C C 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 C 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 483 1, 483 0 1, 483 0 73.00 74 00 07400 RENAL DIALYSIS 0 0 74 00 0 C 0 07500 ASC (NON-DISTINCT PART) 0 75.00 0 C 0 0 75.00 07697 CARDIAC REHABILITATION 0 0 0 0 76. 97 76.97 C 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0 90.00 C 09100 EMERGENCY 97, 223 91 00 9,684 9,684 9,684 1,698 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 COST ALLOCATION - STATISTICAL BASIS

Parts III and IV)

Provider CCN: 15-0086

Period: Worksheet B-1 From 01/01/2021

12/31/2021 Date/Time Prepared: 5/23/2022 10: 25 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY REPAI RS LINEN SERVICE (SQUARE FEET) (MEALS SERVED) PLANT (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 9. 00 10.00 6.00 7.00 8.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 95.00 09500 AMBULANCE SERVICES 00000 0 0 0 0 0 0 0 95.00 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98. 00 0 98.00 09900 CMHC 0 99.00 99.00 0 0 99. 10 09910 CORF 0 99. 10 Ω 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 0 0 106.00 0 107. 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 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 0 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115. 00 116.00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 153, 140 153, 104 424, 076 150, 334 36, 643 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN n 0 190, 00 0 0 0 191. 00 19100 RESEARCH 0 0 0 191. 00 C 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 16, 886 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00 C 0 194. 00 07950 CMH 0 O 8, 297 194. 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 733, 657 202. 00 202.00 Cost to be allocated (per Wkst. B, 8, 210, 352 782, 246 640, 186 2, 897, 456 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 53. 613373 5 109246 1 451794 19. 273458 16. 325256 203. 00 204.00 Cost to be allocated (per Wkst. B, 1,010,828 29, 172 41, 388 70, 036 204. 00 4,677 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 6.600679 0.030548 0.066155 0. 275307 1. 558433 205. 00 II)206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/23/2022 10:25 am Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL (FTES) ADMI NI STRATI ON SERVICES & (COSTED (NUMBER **SUPPLY** REQUIS.) HOUSED) (NURSING FTES) (COSTED REQUIS.) 11.00 12.00 13.00 14.00 15.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 321 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 10 142 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14 00 14 00 C 15.00 01500 PHARMACY 0 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 7 0 0 0 0 0 0 0 0 0 0 16.00 01700 SOCIAL SERVICE 17 00 17 00 0 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 19.00 02000 NURSING PROGRAM 20.00 0 0 20.00 0 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21 00 Ω 21.00 0 0 0 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 43 32 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 23 20 0 0 31.00 03200 CORONARY CARE UNIT 0 32.00 0 0 0 0 0 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 00000 33.00 0 0 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 34.00 04000 SUBPROVIDER - IPF 40.00 0 0 0 40.00 04100 SUBPROVIDER - IRF 41.00 0 0 41.00 43.00 04300 NURSERY 0 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 Ω 0 44.00 04500 NURSING FACILITY 0 0 45.00 45.00 0 04600 OTHER LONG TERM CARE 0 46.00 0 0 O 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 65 n 42 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 16 15 52.00 52.00 0 0 05300 ANESTHESI OLOGY 0 0 53.00 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 27 0 1 0 0 0 0 0 0 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 0 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 0 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 4 2 0 59.00 59.00 0 29 0 06000 LABORATORY 60.00 C 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 62.00 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 0 64.00 06500 RESPIRATORY THERAPY 10 65.00 65.00 0 66 00 06600 PHYSI CAL THERAPY 21 0 0 0 66 00 06700 OCCUPATIONAL THERAPY 0 67.00 3 0 0 67.00 06800 SPEECH PATHOLOGY 2 5 0 68.00 68.00 0 06900 ELECTROCARDI OLOGY 0 3 69.00 69.00 0 0 70 00 07000 ELECTROENCEPHALOGRAPHY Ω 70 00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS С 0 72.00 15 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 07400 RENAL DIALYSIS 0 Ω 74 00 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 07697 CARDIAC REHABILITATION 0 76.97 0 76.97 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 0 0 0 90.00 90 00 09000 CLI NI C 0 0 91.00 09100 EMERGENCY 28 22 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 Health Financial Systems ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/23/2022 10:25 am Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL ADMI NI STRATI ON SERVICES & (COSTED (FTES) (NUMBER SUPPLY REQUIS.) HOUSED) (NURSING FTES) (COSTED REQUIS.) 11.00 12.00 15.00 13.00 14.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 000000 0 94.00 09500 AMBULANCE SERVICES 0 0 95.00 95.00 C 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 97.00 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 09900 CMHC 0 99.00 99.00 0 0 0 99. 10 09910 CORF 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 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 106.00 0 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 Ω 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 0 0 0 110.00 11000 INTESTINAL ACQUISITION 0 110.00 Ω 0 111.00 11100 I SLET ACQUI SI TI ON 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.) 0 115.00 0 Ω O 0 116. 00 11600 HOSPI CE 0 C 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 142 0 118. 00 321 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 00 0 0 193. 00 19300 NONPALD WORKERS 0 193. 00 0 0 194.00 07950 CMH 0 0 194, 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 546, 966 1, 896, 664 0 202.00 0 0 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4, 819. 208723 0.000000 13, 356. 788732 0.000000 0.000000 203.00 Cost to be allocated (per Wkst. B, 204.00 54,605 48, 998 0 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 170. 109034 0.000000 345. 056338 0.000000 0.000000 205.00

206. 00

207.00

II)

(per Wkst. B-2)

Parts III and IV)

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

206.00

207.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/23/2022 10:25 am OTHER GENERAL SERVI CE MEDI CAL SOCIAL SERVICE NONPHYSI CI AN NURSI NG Cost Center Description (SPECIFY) RECORDS & (TIME SPENT) **ANESTHETISTS PROGRAM** (TIME SPENT) (ASSI GNED (ASSI GNED LI BRARY (ADJUSTED TIME) TIME) CHARGES) 17. 00 18.00 19.00 20.00 16, 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 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 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 230, 211, 366 16,00 17 00 01700 SOCIAL SERVICE 12, 700 17 00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 Ω 0 19.00 0 02000 NURSI NG PROGRAM 20.00 0 0 0 20.00 C οĺ 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 C 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 23, 351, 983 1, 372 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 17, 771, 042 996 0 31.00 0 32.00 03200 CORONARY CARE UNIT C 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 C 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 0 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 0 0 0 0 40.00 0 41 00 0 C 0 41 00 04300 NURSERY 0 43.00 800, 812 C 0 43.00 0 04400 SKILLED NURSING FACILITY 0 44.00 44.00 0 0 0 04500 NURSING FACILITY 0 45.00 45.00 0 0 04600 OTHER LONG TERM CARE 0 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 59, 748, 989 3, 997 0 50.00 0 05100 RECOVERY ROOM 0 51 00 0 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 2, 928, 137 264 0 0 0 0 0 0 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 3, 235, 463 177 0 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 17, 368, 227 949 0 54.00 0 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 C 0 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 8, 489, 523 470 0 57.00 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 2, 638, 123 148 0 0 58.00 0 05900 CARDIAC CATHETERIZATION 4, 559, 348 59 00 261 0 59 00 60.00 06000 LABORATORY 6, 356, 392 351 0 0 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62 00 0 C 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 06500 RESPIRATORY THERAPY 15, 109, 888 0 65.00 828 0 65 00 0 66.00 06600 PHYSI CAL THERAPY 5, 340, 683 292 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 944.327 52 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 538.687 29 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 2.081.685 114 0 69.00 07000 ELECTROENCEPHALOGRAPHY 48, 783 0 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 12, 340, 559 0 72.00 72.00 Γ 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 16, 567, 134 494 0 73.00 07400 RENAL DIALYSIS 74.00 74.00 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) Ω 0 75.00 07697 CARDIAC REHABILITATION 332, 985 0 76.97 76.97 18 0 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89 00 0 89.00 0 90.00 09000 CLI NI C 0 0 0 90.00 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/23/2022 10:25 am OTHER GENERAL SERVI CE NURSI NG Cost Center Description MEDI CAL SOCIAL SERVICE (SPECI FY) NONPHYSI CI AN (TIME SPENT) PROGRAM RECORDS & **ANESTHETISTS** LI BRARY (TIME SPENT) (ASSI GNED (ASSI GNED (ADJUSTED TIME) TIME) CHARGES) 17. 00 18.00 19. 00 20.00 16.00 91. 00 09100 EMERGENCY 29, 658, 596 1, 885 0 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0 000000 09500 AMBULANCE SERVICES 0 95.00 95 00 Ω 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00 09900 CMHC 99 00 0 99 00 Ω 0 99. 10 09910 CORF 0 0 Ω 99. 10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 0 106. 00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 I NTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116, 00 SUBTOTALS (SUM_OF_LINES_1 through 117) 118.00 230, 211, 366 12,700 0 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 0 191. 00 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 0 0 194. 00 194. 00 07950 CMH 0 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 202.00 1, 297, 048 0 202.00 Cost to be allocated (per Wkst. B, 836, 438 0 Part I) 203.00 0.003633 102. 129764 0.000000 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 204.00 Cost to be allocated (per Wkst. B, 4, 377 25, 312 0 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000019 1.993071 0.000000 0.000000 0.000000 205.00 II)0 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)

0.000000 207.00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/23/2022 10:25 am Provider CCN: 15-0086

					10 12/31/2021	5/23/2022 10: 25 am
		INTERNS &	RESI DENTS			
	Cost Center Description	SEDVICES_SALAD	SERVI CES-OTHER	PARAMED ED		
	cost center bescription	Y & FRI NGES	PRGM COSTS	PRGM		
		(ASSI GNED	(ASSI GNED	(ASSI GNED		
		TIME)	TIME)	TIME)		
	GENERAL SERVICE COST CENTERS	21. 00	22.00	23. 00		
1. 00	00100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 6. 00	00500 ADMI NI STRATI VE & GENERAL					5.00
7. 00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT					6. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
12. 00 13. 00	O1200 MAI NTENANCE OF PERSONNEL O1300 NURSI NG ADMI NI STRATI ON					12.00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY					16. 00
17. 00 18. 00	O1700 SOCIAL SERVICE O1850 OTHER GENERAL SERVICE (SPECIFY)					17. 00 18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS					19. 00
20. 00	02000 NURSI NG PROGRAM					20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0				21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		0			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS			100)	23. 00
30. 00	03000 ADULTS & PEDIATRICS	0	0			30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0			31.00
32. 00	03200 CORONARY CARE UNIT	0	0	•	D	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0				34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	0	Ö			41. 00
43.00	04300 NURSERY	0	0		O O	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0		0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS				기	40.00
50.00	05000 OPERATING ROOM	0	0	(D	50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	1		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	Ö			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(o l	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		O .	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0			59.00
60.00	06000 LABORATORY	0	Ö	•		60.00
60. 01	06001 BLOOD LABORATORY	0	0		D .	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					61. 00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			62.00
64. 00	06400 I NTRAVENOUS THERAPY	0				64. 00
65.00	06500 RESPIRATORY THERAPY	0	0			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(D .	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0		1		68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	Ö			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0)	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	100	0	73.00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0			74. 00 75. 00
76. 97	07697 CARDI AC REHABILITATION	0	Ö	1	o o	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0			77. 00
00.00	OUTPATIENT SERVICE COST CENTERS	-	- -		J	20.55
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	88. 00 89. 00
90.00	09000 CLINIC		0	1		90.00
91. 00	09100 EMERGENCY	0	0			91.00
		_				

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086

				1	o 12/31/2021 Date/IIMe P 5/23/2022 10	
		INTERNS &	RESI DENTS		0, 20, 2022	51 25 diii
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED		
		Y & FRINGES	PRGM COSTS	PRGM		
		(ASSI GNED	(ASSI GNED	(ASSI GNED		
		TIME)	TIME)	TIME)		
		21. 00	22. 00	23. 00		
	OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
	REIMBURSABLE COST CENTERS					
	HOME PROGRAM DIALYSIS	0	0	0		94. 00
	AMBULANCE SERVICES	0	0	0		95. 00
96. 00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96. 00
97. 00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97. 00
98. 00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98. 00
99.00 09900	CMHC	0	0	0		99. 00
99. 10 09910	CORF	O	0	0		99. 10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	O	0	0		100. 00
101. 00 10100	HOME HEALTH AGENCY	O	0	0		101. 00
SPECI	AL PURPOSE COST CENTERS					
105. 00 10500	KIDNEY ACQUISITION	0	0	0		105. 00
106.00 10600	HEART ACQUISITION	0	0	0		106. 00
107. 00 10700	LIVER ACQUISITION	0	0	0		107. 00
108. 00 10800	LUNG ACQUISITION	o	0	0		108. 00
109. 00 10900	PANCREAS ACQUISITION	o	0	0		109. 00
110.00 11000	INTESTINAL ACQUISITION	o	0	0		110.00
111. 00 11100	ISLET ACQUISITION	o	0	0		111. 00
113. 00 11300	INTEREST EXPENSE					113. 00
114. 00 11400	UTILIZATION REVIEW-SNF					114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	o	0	0		115. 00
116, 00 11600				0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	o	0	100		118. 00
NONRE	IMBURSABLE COST CENTERS		-			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
191. 00 19100	RESEARCH	O	0	0		191. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	o	0	0		192. 00
	NONPALD WORKERS	o	0	0		193. 00
194, 00 07950	СМН	o	0	0		194. 00
200.00	Cross Foot Adjustments					200. 00
201.00	Negative Cost Centers					201.00
202. 00	Cost to be allocated (per Wkst. B,	0	0	300, 985		202. 00
202.00	Part I)		J	000, 700		202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	3, 009. 850000		203. 00
204. 00	Cost to be allocated (per Wkst. B,	0	0	6, 668		204. 00
	Part II)		_	-,		
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	66. 680000		205. 00
	[1])					
206. 00	NAHE adjustment amount to be allocated			0		206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,			0.000000		207. 00
	Parts III and IV)					
•		·				

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre	pared:
			Title	e XVIII	Hospi tal	5/23/2022 10: PPS	25 am
	Cook Cooker Decorated as	T-+-1 C+			Costs	T-+-1 C+-	
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col. 26)					
	INDATIENT POLITIME CEDVICE COCT CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	12, 139, 063		12, 139, 06	3 0	12, 139, 063	30.00
31. 00	03100 INTENSIVE CARE UNIT	5, 485, 057		5, 485, 05		1	31. 00
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	34.00
40. 00	04000 SUBPROVI DER - I PF	0			0	0	40. 00
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	785, 180		785, 18	0	0 785, 180	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	765, 160		703, 10	0 0	765, 160	1
45. 00	04500 NURSING FACILITY	0		1	0	0	
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0			0 0	0	46. 00
50.00	05000 OPERATI NG ROOM	18, 264, 416		18, 264, 41	6 0	18, 264, 416	50.00
51.00	05100 RECOVERY ROOM	0 010 127			0		51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	2, 810, 127 2, 882, 209		2, 810, 12 2, 882, 20		2, 810, 127 2, 882, 209	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 566, 153		5, 566, 15		5, 566, 153	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0	0	
56. 00 57. 00	05600	1, 450, 025		1, 450, 02	U 5 0	0 1, 450, 025	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	686, 772		686, 77		686, 772	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 114, 265		1, 114, 26		1, 114, 265	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	6, 480, 909		6, 480, 90	9 0	6, 480, 909 0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	Ö	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62. 00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0			0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	2, 217, 374	0	2, 217, 37	4 0	2, 217, 374	
66. 00	06600 PHYSI CAL THERAPY	3, 891, 370	0	3, 891, 37	0 0	3, 891, 370	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	557, 307	0	557, 30		557, 307	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	394, 029 1, 117, 343	0	394, 02 1, 117, 34		394, 029 1, 117, 343	
70. 00	07000 ELECTROENCEPHALOGRAPHY	10, 683		10, 68		10, 683	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		/ 157 00	0 0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	6, 157, 095 8, 829, 303		6, 157, 09 8, 829, 30		6, 157, 095 8, 829, 303	
74. 00	07400 RENAL DIALYSIS	0			0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0		222.02	0	0 222, 831	
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	222, 831 0		222, 83	0 0		77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
90.00	09000 CLINIC	0			0 0		
91. 00	09100 EMERGENCY	6, 517, 562		6, 517, 56	2 0	6, 517, 562	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	1, 470, 420		1, 470, 42	0	1, 470, 420	92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0			0 0	0	94.00
95. 00	09500 AMBULANCE SERVICES	0		•	0	1	
	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0			0	0	
	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	1
99.00	09900 CMHC	0			0	0	99. 00
	09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM	0			0	0	99. 10 100. 00
	10100 HOME HEALTH AGENCY	0			0	l	101.00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0		1	0		105. 00 106. 00
100.00	10700 LIVER ACQUISITION	0		1	0		107. 00
108.00	10800 LUNG ACQUISITION	0			0	0	108. 00
	10900 PANCREAS ACQUISITION	0			0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0			0	l	110. 00 111. 00
113.00	11300 INTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF					_	114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE	0 0			0 0		115. 00 116. 00
	'		ı	1	1		

Health Fina	ancial Systems	ST ELIZABET	ST ELIZABETH DEARBORN			In Lieu of Form CMS-2552-10		
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/23/2022 10:		
			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		
200. 00 201. 00 202. 00	Subtotal (see instructions) Less Observation Beds Total (see instructions)	89, 049, 493 1, 470, 420 87, 579, 073		89, 049, 49 1, 470, 42 87, 579, 07	0	89, 049, 493 1, 470, 420 87, 579, 073	201. 00	

Heal th Financial Systems

ST ELIZABETH DEARBORN

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0086

Period:
From 01/01/2021
To 12/31/2021

Date/Time Prepared:
5/23/2022 10: 25 am

The Count of Counting Prescription			T. 11	V0.41.1		5/23/2022 10:	25 am
Cast Center Description				e XVIII	Hospi tal	PPS	
1.00 1.00	Cost Center Description	Inpatient		Total (col. 6	Cost or Other	TFFRA	
DEATH THE REBUTIME SERVICE COST CENTERS 2,0 MO, 140 2,0 MO, 140 3,0 MO, 3,1 MO	2001 201101 20001 pt. 0.1	i inputi ont	output ont				
INVALLED SOUTH SOUTH SERVICE COST CENTERS 20,890,746 30,00 300,000 300,000 31,00				·			
30.00 30.000 ADULTS & PUBLISHER IS 20, PV, 746 17, 771, 642 31, 00 33.00	LANDATI ENT. DOUTLAND OFFICE COOT OFFITEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
31.00 033000 030000 030000 03000 03000 03000 03000 03000 03000 03000 030000 030000 0300000 0300000 0300000 0300000 0300000 0300000 0300000 0300000 03000000 03000000 0300000000		20, 000, 747		20,000,74/			20.00
32 0.0 3300 GOSCO CORPONARY CARE UNIT 0 0 33. 00 330							1
33.00 3300 BURN INTERSIVE CARE UNIT 0 0 33.00 40.00 3000 SURRINGHAL LINES WE CARE UNIT 0 0 0 34.00 40.00 3000 SURRINGHAL LINES 0 0 0 0 34.00 40.00 3000 SURRINGHAL LINES 0 0 0 0 0 40.00 3000 SURRINGHAL LINES 0 0 0 0 44.00 44.00 44.00 44.00 44.00 44.00 44.00 0 0 0 44.00 0 0 0 0 0 44.00 0 0 0 0 0 44.00 0 0 0 0 0 44.00 0 0 0 0 44.00 0 0 0 0 44.00 0 0 0 0 44.00 0 0 0 0 44.00 0 0 0 0 44.00 0 0 0 0 44.00 0 0 0 0 44.00 0 0 0 44.00 0 0 0 0 44.00 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 0 44.00 0 0 44.00 0 0 0 44.00 0 0 44.00 0 0 44.00 0		17, 771, 042		17,771,042)		
34.00		o o			ó		•
40.00 000000 SURPHOVIDER - IPF		0					•
43.00 04.00 MURSENF 10.00 0	40. 00 04000 SUBPROVI DER - 1 PF	0					40. 00
44.00 0.0400 SMILLED NURSING FACILITY		0					•
45.00 04500 URSING FACILITY 0 0 0 0 0 0 0 0 0		1		800, 812	2		•
46.00 04.000 OTHER LONG TERM CARE 0 04.00 04.00 05.00 05.0000 05.000 05.000 05.000 05.000 05.000 05.000 05.0		i					
MICHILLARY SERVICE COST CENTRES		١					
50.00 GEOODI GERATITIK GROWN 20,755,309 38,993,600 59,748,969 0,305666 0,000000 0,00000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,00000000		0			/		40.00
51.00 51.00 51.00 51.00 51.00 51.00 51.00 50.00 51.00 51.00 53.00		20, 755, 309	38, 993, 680	59, 748, 989	0. 305686	0. 000000	50.00
53.00 05.00 AMESTHESI OLDOY 754, 979 2, 480, 534 3, 287, 946 0, 890, 981 8, 0.000000 5.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1	0	(1
54.00 0.9400 RADI GLOY-HERAPITIC 4.080.273 13.287.984 17.368.227 0.320479 0.000000 54.00 0.000000 55.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 721, 691	206, 446	2, 928, 137	0. 959698	0. 000000	52.00
55.00 05500 MADI LOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0							
6.0 00		1	13, 287, 954	17, 368, 227			
57.00 05700 CT SCAM 2,170,248 6,319,275 8,489,523 0,170802 0,000000 55.00 59.00 05900 MARINETT C RESONANCE I MAGINO (MRI) 207,782 2,439,41 2,638,142 2,638,231 2,638,142 0,2032 2,729,040 55.00 59.0		0	0	(
58.00 0.6500 MAGNETIC RESONANCE I IMAGING (WRI) 207, 782 2, 430, 341 2, 638, 123 0, 24439 0, 000000 59.00 0.000000 0.00000 0.00000		2 170 248	6 319 275	8 489 523			
59.00 05000 CARDIAC CATHETEIZATION 2,988,765 1,600,583 4,559,348 0,24459 0,000000 60.00 60.01 60.001 LBORATORY 0 0 0 0 0 0 0 0 0							
60.00	` '						
6.1 0.0 66100 PBP CLINI CAL LAB SERVI CESPROM ONLY 0 0 0 0 0 0 0 0 0							
0.0000000 0.0000000 0.0000000 0.0000000 0.00000 0.00000 0.00000 0.0000000 0.0000000 0.0000000 0.00000000		0	0	(60. 01
63.00 06.300 06.000 STORI NO, PROCESSING & TRANS. 0 0 0 0 0.000000 0.000000 63.00		0	0	(
64.00 06-600 NTRAVENOUS THERAPY 13, 811, 696 1, 298, 192 15, 109, 888 0. 166750 0. 000000 65.00 06-600 RESPIRATORY THERAPY 690, 137 4, 650, 546 5, 340, 683 0. 728628 0. 000000 66.00 06-600 07-600 0		0	0	(1
65.00 06500 RESPIRATORY THERAPY 13, 811, 696 1, 298, 192 15, 109, 888 0.146,750 0.000000 65.00		0	0	(
66.00		13 911 606	1 200 102	15 100 999			
67. 00 06700 06700 06700 06700 06700 07. 00 07. 00 07. 00 07. 00 07. 00 08. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00 09. 00. 000000 07. 00 09. 00 09. 00 09. 00 09. 00 09. 00. 000000 07. 00 09. 00 07. 00 0							•
68. 00 06800 SPECCH PATHOLOGY 141,038 397,649 538,687 0.731462 0.000000 68. 00 06900 06900 ELECTROCRORADIOLOGY 6.37,001 1,444,668 2.081,685 0.536749 0.000000 57. 00 70. 00							
70. 00 070000 07000 070000 070000 070000 070000 070000 0700000 070000 070000 070000 070000 070000 070000 07000000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 07000000 07000000 07000000 07000000 0700000000							•
17.00		637, 001	1, 444, 684	2, 081, 685			69. 00
12.00 07200 IMPL DEV. CHARGED TO PATIENTS 3,331,344 9,009,215 12,340,559 0.498932 0.000000 73.00 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 9,049,661 7,517,473 16,567,134 0.532941 0.000000 73.00 73.00 75.00 07500 0.000000 0.000000 73.00 0.000000 0.000000 73.00 0.000000 0.000000 73.00 0.000000 0.000000 73.00 0.000000 0.000000 73.00 0.000000 0.000000 73.00 0.000000 0.000000 73.00 0.000000 0.000000 73.00 0.000000 0.000000 73.00 0.000000 0.000000 75.00 0.000000 0.000000 75.00 0.000000 0.000000 75.00 0.000000 0.000000 75.00 0.000000 0.000000 75.00 0.000000 0.000000 75.00 0.00000		723	48, 060	1			
13.00 07300 DRIGS CHARGED TO PATIENTS 9,049,661 7,517,473 16,567,134 0.532941 0.000000 74.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.97		0	0 000 015	1			
74.00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0							1
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0		9,049,001	7, 517, 475	10, 307, 132			1
76. 97 07697 CARDI AC REHABILITATION 9 332, 976 332, 985 0.669192 0.000000 76. 97 77. 00 00T700 ALLOGENEIC STEM CELL ACQUI SITION 0 0 0 0.000000 0.000000 77. 00 00T70700 ALLOGENEIC STEM CELL ACQUI SITION 0 0 0 0 0.000000 0.000000 77. 00 00T70700 ALLOGENEIC STEM CELL ACQUI SITION 0 0 0 0 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000		Ö	0				1
DUTPATI ENT SERVICE COST CENTERS		9	332, 976	332, 985			
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	(0.000000	0. 000000	77. 00
89, 00 09900 FEDERALLY QUALIFIED HEALTH CENTER				ı			
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0			0				
91.00 09100 EMERGENCY 8, 787, 473 20, 871, 123 29, 658, 596 0. 219753 0. 000000 91. 00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 439, 679 2, 021, 558 2, 461, 237 0. 597431 0. 000000 92. 00 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0. 000000 0. 000000 94. 00 95. 00 09500 OMBULANCE SERVICES 0 0 0 0 0 0. 000000 0. 000000 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0. 000000 0. 000000 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0. 000000 0. 000000 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0. 000000 0. 000000 97. 00 99. 00 09900 OMHC 0 0 0 0 0 0. 000000 0. 000000 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0. 000000 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0. 000000 99. 10 100. 00 10000 Lar SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0. 000000 99. 10 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0. 000000 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0. 000000 107. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0. 000000 109. 00 111. 00 11100 INTERSTI NAL ACQUI SI TI ON 0 0 0 0 0. 000000 110. 00 111. 00 11100 INTERSTI NAL ACQUI SI TI ON 0 0 0 0 0. 000000 110. 00 111. 00 11100 INTERST EXPENSE 0 0 0 0 0 0. 000000 110. 00 111. 00 11400 UTI LI ZATI ON REVIEW-SNF 0 0 0 0 0 0. 000000000000000000000	l i	0	0			0 000000	•
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 439, 679 2,021,558 2,461,237 0.597431 0.000000 92.00		8 787 473	20 871 123	29 658 596			
OTHER REIMBURSABLE COST CENTERS O O O. 000000 O. 000000 94.00 95. 00 095001 AMBULANCE SERVI CES 0 0 0 0.000000 0.000000 94.00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0.000000 0.000000 0.000000 95.00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0.000000 0.000000 97.00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.000000 0.000000 97.00 99. 00 09900 CMHC 0 0 0 0.000000 0.000000 98.00 99. 10 09910 CORF 0 0 0 0 0 99.00 99. 10 100. 01 1000 I SR SERVI CES-NOT APPRVD PRGM 0 0 0 0 99.00 99. 10 100. 01 1000 I HOME HEALTH AGENCY 0 0 0 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
95. 00 09500 AMBULANCE SERVICES 0 0 0 0.000000 0.000000 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0.000000 0.000000 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0.000000 0.000000 97. 00 98. 00 0980 OTHER REI MBURSABLE COST CENTERS 0 0 0 0.000000 0.000000 98. 00 99. 00 99. 00 0990 CMHC 0 0 0 0 0 0 0 0 0		,	, , , , , , , , , , , , , , , , , , , ,				
96. 00			0	(•
97. 00			0				
98. 00		0	0	(
99. 00		0	0	(
99. 10		0	0		0.000000	0.000000	
100. 00 10000 1&R SERVICES-NOT APPRVD PRGM		0	0		ó		
101. 00		o	0				•
105. 00	101.00 10100 HOME HEALTH AGENCY	0	0	(
106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 109. 00 110. 00 11000 INTERSTI NAL ACQUI SI TI ON 0 0 0 0 111. 00 11000 INTERSTI NAL ACQUI SI TI ON 0 0 0 0 111. 00 1100 INTERST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 116. 00 116. 00 11600 HOSPI CE 0 0 0 0 0 116. 00					_		
107. 00 10700 LIVER ACQUISITION 0 0 107. 00 108. 00 10800 LUNG ACQUISITION 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110. 00 INTESTINAL ACQUISITION 0 0 0 110. 00 111. 00 ISLET ACQUISITION 0 0 0 111. 00 113. 00 INTEREST EXPENSE 113. 00 114.00 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 116. 00 11600 HOSPICE 0 0 0 116. 00							
108. 00 10800 LUNG ACQUISITION 0 0 0 0 109. 00			0				
109. 00 10900 PANCREAS ACQUISITION 0 0 0 110. 00 110.		0	0				
110. 00 11000 INTESTINAL ACQUISITION	1	0	0				
111. 00	1	Ö	0				
113. 00			0				
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115. 00 116. 00 11600 HOSPICE 0 0 0 116. 00	113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE 0 0 0 116. 00							
	T15. UU 11500 AMBULATURY SURGICAL CENTER (D. P.)	0	0				
200. 00		114 043 063	116 167 102	230 211 24	(
	200. 00 Jubitotal (300 Histi deti olis)	117, 043, 703	110, 107, 403	250, 211, 300	1	<u> </u>	1200.00

Health Financial Systems ST			DEARBORN		In Lieu of Form CMS-2552-1			
COMPUTATION OF RATIO	OF COSTS TO CHARGES		Provi der CO		Peri od:	Worksheet C		
					From 01/01/2021	Part I		
					To 12/31/2021	Date/Time Pre		
-						5/23/2022 10:	25 am	
			Title	XVIII	Hospi tal	PPS		
			Charges					
Cost Cen	iter Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA		
				+ col. 7)	Ratio	I npati ent		
						Ratio		
		6.00	7. 00	8. 00	9. 00	10.00		
201.00 Less 0bs	ervation Beds						201.00	
202.00 Total (s	ee instructions)	114, 043, 963	116, 167, 403	230, 211, 36	6		202. 00	

In Lieu of Form CMS-2552-10
Worksheet C
01/2021 Part I
01/2021 Date/Time Prepared: 5/23/2022 10:25 am Provider CCN: 15-0086 Peri od: From 01/01/2021 To 12/31/2021

		Title XVIII	Hospi tal	PPS PPS
Cost Center Description	PPS Inpatient	,	1100pt tui	
·	Ratio			
LABORT FAIT POUTLAGE OFFICE OF CONT. OFFITTED	11.00			
30. 00 03000 ADULTS & PEDI ATRI CS	T			30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34. 00
40. 00 04000 SUBPROVI DER - PF				40.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY				41. 00 43. 00
44. 00 04400 SKI LLED NURSI NG FACILITY				44. 00
45. 00 04500 NURSI NG FACILITY				45. 00
46. 00 04600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 305686			50.00
51. 00 05100 RECOVERY ROOM	0.000000			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 959698 0. 890818			52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 320479			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 170802			57. 00
58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)	0. 260326			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0. 244391 1. 019589			59. 00 60. 00
60. 00 06000 LABORATORY	0. 000000			60. 00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 146750			65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0. 728628 0. 590163			66.00
68. 00 06800 SPEECH PATHOLOGY	0. 731462			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 536749			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 218990			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 498932			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS	0. 532941			73.00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)	0. 000000 0. 000000			74. 00 75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 669192			76. 97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89. 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0. 000000 0. 219753			90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 597431			92. 00
OTHER REIMBURSABLE COST CENTERS	0.077101			72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000			96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0.000000			97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 99. 00 09900 CMHC	0. 000000			98.00
99. 10 09910 CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100.00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KI DNEY ACQUI SI TI ON				105. 00
106. 00 10600 HEART ACQUISITION				106.00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION				107. 00 108. 00
109. 00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON				110. 00
111. 00 11100 SLET ACQUI SI TI ON				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.)				115.00
116.00 11600 HOSPICE 200.00 Subtotal (see instructions)				116. 00 200. 00
201.00 Subtotal (see Instructions) 201.00 Less Observation Beds				200. 00
202.00 Total (see instructions)				202. 00
				1

COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2021 To 12/31/2021		
			Ti tl	e XIX	Hospi tal	5/23/2022 10: Cost	25 am
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
		(from Wkst. B, Part I, col.	Adj .		Di sal I owance		
		26) 1. 00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		2.00				
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	12, 139, 063 5, 485, 057		12, 139, 06 5, 485, 05			
32. 00	03200 CORONARY CARE UNIT	0			0	0	32. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0			0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0			0	0	40. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	785, 180		785, 18	0 0	0 785, 180	
44. 00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0 0		•	0 0	-	
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	18, 264, 416 0		18, 264, 41	6 0		1
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 810, 127		2, 810, 12	7 0	2, 810, 127	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	2, 882, 209 5, 566, 153		2, 882, 20 5, 566, 15		2, 882, 209 5, 566, 153	•
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0	0	55. 00
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	1, 450, 025		1, 450, 02	0	0 1, 450, 025	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	686, 772		686, 77	2 0	686, 772	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 114, 265 6, 480, 909		1, 114, 26 6, 480, 90		1, 114, 265 6, 480, 909	
60. 01	06001 BLOOD LABORATORY	0, 400, 707		0, 400, 70	o o	0, 400, 707	1
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	ő				ő	1
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 217, 374	0	2, 217, 37	0	0 2, 217, 374	
66. 00	06600 PHYSI CAL THERAPY	3, 891, 370	0	3, 891, 37		3, 891, 370	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	557, 307	0	557, 30		557, 307	1
69. 00	06900 ELECTROCARDI OLOGY	394, 029 1, 117, 343		394, 02 1, 117, 34		394, 029 1, 117, 343	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 683		10, 68	3 0	10, 683 0	1
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 157, 095		6, 157, 09	5 0	6, 157, 095	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	8, 829, 303 0		8, 829, 30	3 0	8, 829, 303	1
75. 00	07500 ASC (NON-DISTINCT PART)	0			0 0	0	1
	07697 CARDI AC REHABI LI TATI ON	222, 831		222, 83	0 0	222, 831	1
77.00	07700 ALLOGENEI C STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0			J ₁ 0	0	77. 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		1	0 0	0	
90.00	09000 CLI NI C	0			0	o o	90. 00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 517, 562 1, 470, 420		6, 517, 56 1, 470, 42		6, 517, 562 1, 470, 420	1
72.00	OTHER REIMBURSABLE COST CENTERS	1,470,420		1,470,42	J	1, 470, 420	72.00
94. 00 95. 00		0		•	0 0	0	
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		1	0	0	96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0			0	0	
99. 00	09900 CMHC	Ö				0	99. 00
	09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM	0			0	0	99. 10 100. 00
	10100 HOME HEALTH AGENCY	0					101. 00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	T 0			ol	0	105. 00
106.00	10600 HEART ACQUISITION	0			O	0	106. 00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0 0		•	0		107. 00 108. 00
109.00	10900 PANCREAS ACQUISITION	0			0	0	109. 00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0					110. 00 111. 00
113.00	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D.P.)	0				0	114. 00 115. 00
	11600 HOSPI CE	0		1			116. 00
	<u> </u>						

Health Financial Systems	ST ELI ZABETI	ST ELIZABETH DEARBORN			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2021 Fo 12/31/2021	Worksheet C Part I Date/Time Pre 5/23/2022 10:			
		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			
200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	89, 049, 493 1, 470, 420 87, 579, 073		89, 049, 493 1, 470, 420 87, 579, 073)	89, 049, 493 1, 470, 420 87, 579, 073	201. 00		

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0086

		T' 11	V1.V		5/23/2022 10:	25 am
		Charges	e XIX	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
Social Social Person	i inputi ont	output on	+ col . 7)	Ratio	Inpati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20, 890, 746		20, 890, 746			20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 NTENSI VE CARE UNI T						30. 00 31. 00
31. 00 03100 INTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	17, 771, 042		17, 771, 042			32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0					33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0			ń		34. 00
40. 00 04000 SUBPROVI DER - I PF	o					40. 00
41. 00 04100 SUBPROVI DER - I RF	O					41.00
43. 00 04300 NURSERY	800, 812		800, 812	2		43. 00
44.00 04400 SKILLED NURSING FACILITY	0		(44. 00
45. 00 04500 NURSI NG FACI LITY	0		(45. 00
46. 00 O4600 OTHER LONG TERM CARE	0		[)		46. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 0PERATING ROOM	20 755 200	20, 002, 400	E0 740 000	0.205404	0.000000	50.00
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM	20, 755, 309	38, 993, 680	59, 748, 989	0. 305686 0. 000000	0. 000000 0. 000000	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 721, 691	206, 446	2, 928, 137		0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	754, 929	2, 480, 534	3, 235, 463		0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 080, 273	13, 287, 954			0. 000000	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0. 000000	0.000000	55. 00
56. 00 05600 RADI 01 SOTOPE	0	0	(0. 000000	0. 000000	56. 00
57.00 05700 CT SCAN	2, 170, 248	6, 319, 275	8, 489, 523		0.000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	207, 782	2, 430, 341	2, 638, 123		0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 958, 765	1, 600, 583			0. 000000	59. 00
60. 00 06000 LABORATORY	3, 627, 352	2, 729, 040			0.000000	60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY	0	0	(0. 000000 0. 000000	0.000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0. 000000	0. 000000 0. 000000	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0.000000	0. 000000	63.00
64. 00 06400 NTRAVENOUS THERAPY	0	0		0. 000000	0. 000000	64.00
65. 00 06500 RESPIRATORY THERAPY	13, 811, 696	1, 298, 192	15, 109, 888		0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	690, 137	4, 650, 546			0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	416, 253	528, 074	944, 327	0. 590163	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	141, 038	397, 649	538, 687	0. 731462	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	637, 001	1, 444, 684			0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	723	48, 060	1		0. 000000	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0 000 015	12 240 550		0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	3, 331, 344	9, 009, 215			0. 000000 0. 000000	72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	9, 049, 661	7, 517, 473	16, 567, 134	0. 000000	0. 000000	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0		0. 000000	0. 000000	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	9	332, 976	332, 985		0. 000000	76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	0	1		0. 000000	77. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	(0. 000000	0. 000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0. 000000		
90. 00 09000 CLI NI C	0	0	(0. 000000	0. 000000	
91. 00 09100 EMERGENCY	8, 787, 473	20, 871, 123			0.000000	
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	439, 679	2, 021, 558	2, 461, 237	0. 597431	0. 000000	92. 00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0		0. 000000	0. 000000	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0			0. 000000	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	o o	0			0. 000000	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0.000000	0. 000000	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0.000000	98. 00
99. 00 09900 CMHC	o	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	اء					
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	(105.00
106.00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION	0	0				106. 00 107. 00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION		0		(107.00
109. 00 10900 PANCREAS ACQUISITION	0	0				109.00
110. 00 11000 NTESTI NAL ACQUISITION		0		<u> </u>		110.00
111. 00 11100 SLET ACQUI SI TI ON	l ol	0) l		111.00
113. 00 11300 I NTEREST EXPENSE	1					113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0)		115. 00
116. 00 11600 HOSPI CE	0	0	(116.00
200.00 Subtotal (see instructions)	114, 043, 963	116, 167, 403	230, 211, 366	p		200. 00

Health Financial Systems	ST ELI ZABETH	ST ELIZABETH DEARBORN			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C			
				From 01/01/2021 To 12/31/2021	Part Date/Time Pre	epared.		
					5/23/2022 10:			
		Titl	e XIX	Hospi tal	Cost			
		Charges						
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA			
			+ col. 7)	Ratio	I npati ent			
					Ratio			
	6.00	7.00	8.00	9. 00	10.00			
201.00 Less Observation Beds						201. 00		
202.00 Total (see instructions)	114, 043, 963	116, 167, 403	230, 211, 36	6		202. 00		

In Lieu of Form CMS-2552-10
Worksheet C
D1/2021 Part I
B1/2021 Date/Time Prepared:
5/23/2022 10:25 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0086 Peri od: From 01/01/2021 To 12/31/2021

		Title XIX	Hospi tal	5/23/2022 10: 25 a	am_
Cost Center Description	PPS Inpatient	THE XIX	позрі саі	0031	
	Ratio				
INDATIENT DOUTINE CEDVICE COCT CENTEDO	11. 00				
30.00 O3000 ADULTS & PEDIATRICS				30	. 00
31. 00 03100 NTENSI VE CARE UNI T					. 00
32. 00 03200 CORONARY CARE UNIT				32.	. 00
33.00 03300 BURN INTENSIVE CARE UNIT					. 00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT					. 00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF					. 00 . 00
43. 00 04300 NURSERY					. 00
44.00 04400 SKILLED NURSING FACILITY					. 00
45.00 04500 NURSING FACILITY					. 00
46. 00 04600 OTHER LONG TERM CARE				46.	. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	0. 000000			FO	00
51. 00 05100 RECOVERY ROOM	0. 000000			l	. 00 . 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.	. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000				. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0. 000000				. 00
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN	0. 000000 0. 000000				. 00 . 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			l l	. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			l l	. 00
60. 00 06000 LABORATORY	0. 000000				. 00
60. 01 06001 BLOOD LABORATORY	0.000000				. 01 . 00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000 0. 000000				. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				. 00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0. 000000 0. 000000				. 00 . 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.	. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			l l	. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000			l	. 00
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000 0. 000000			l	. 00 . 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				. 97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77.	. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000 0. 000000			l	. 00 . 00
90. 00 09000 CLINIC	0. 000000				. 00
91. 00 09100 EMERGENCY	0. 000000			l l	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.	. 00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS 95.00 09500 AMBULANCE SERVICES	0. 000000 0. 000000			l l	. 00 . 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98.	. 00
99. 00 09900 CMHC					. 00
99. 10 09910 CORF 100. 00 10000 L&R SERVICES-NOT APPRVD PRGM				99. 100.	. 10
101.00 10100 HOME HEALTH AGENCY				100.	
SPECIAL PURPOSE COST CENTERS				101.	. 00
105.00 10500 KIDNEY ACQUISITION				105.	. 00
106. 00 10600 HEART ACQUI SI TI ON				106.	
107. 00 10700 LI VER ACQUI SI TI ON				107.	
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION				108. 109.	
110. 00 11000 NTESTI NAL ACQUI SI TI ON				1109.	
111. 00 11100 I SLET ACQUI SI TI ON				111.	
113. 00 11300 I NTEREST EXPENSE				113.	
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114.	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115.	
116.00 11600 HOSPICE 200.00 Subtotal (see instructions)				116. 200.	
201.00 Less Observation Beds				200.	
202.00 Total (see instructions)				202.	
	,				

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	ST ELIZABETI COSTS	Provi der C		In Lie Period: From 01/01/2021 To 12/31/2021	worksheet D Part I Date/Time Pre 5/23/2022 10:	pared:
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
· ·	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost		· ·	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2, 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	790, 106	0	790, 10	6 12, 730	62. 07	30.00
31. 00 INTENSIVE CARE UNIT	165, 229		165, 22			
32. 00 CORONARY CARE UNIT	0		100,22	0 0		
33. 00 BURN INTENSIVE CARE UNIT	0			0	0.00	
34. 00 SURGICAL INTENSIVE CARE UNIT	0			0	0.00	1
40. 00 SUBPROVI DER - I PF	0	0		0	0.00	
41. 00 SUBPROVI DER - I RF	0			0 0	0.00	
43. 00 NURSERY	4, 108	·	4, 10	٥	8.04	1
44.00 SKILLED NURSING FACILITY	4, 106		4, 10	0 0	0.00	
45. 00 NURSING FACILITY	0			0		45. 00
	050 443		050 44	15 (02		1
200. 00 Total (lines 30 through 199)	959, 443		959, 44	3 15, 693		200. 00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	/ 00	6) 7. 00	-			
INDATIENT POUTINE CERVICE COCT CENTERS	6. 00	7.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 ADULTS & PEDI ATRI CS	4, 594	285, 150				30.00
	727					
31. 00 INTENSIVE CARE UNIT		48, 993	1			31.00
32. 00 CORONARY CARE UNIT	0	0	<u>'</u>			32.00
33. 00 BURN INTENSIVE CARE UNIT	0	0)			33. 00
34. 00 SURGICAL INTENSIVE CARE UNIT	0	0)			34. 00
40. 00 SUBPROVI DER - I PF	0	0)			40. 00
41. 00 SUBPROVI DER - I RF	0	0)			41. 00
43. 00 NURSERY	0	0	1			43. 00
44.00 SKILLED NURSING FACILITY	0	0	1			44. 00
45.00 NURSING FACILITY	0	0	1			45. 00
200.00 Total (lines 30 through 199)	5, 321	334, 143	s			200. 00

Health Financial Systems	ST ELIZABETI	H DEARBORN		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0086	Peri od:	Worksheet D	
				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre 5/23/2022 10:	pared: 25 am
		Title	: XVIII	Hospi tal	PPS	20 4
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	729, 281	59, 748, 989	0. 01220	3, 977, 556	48, 550	50.00
51. 00 05100 RECOVERY ROOM	0		0. 00000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	185, 794	_	0. 06345		20, 997	52.00
53. 00 05300 ANESTHESI OLOGY	15, 339					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	349, 025					54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	00	0	55. 00
56. 00 05600 RADI 01 SOTOPE	0	0	0. 00000	00	0	56. 00
57. 00 05700 CT SCAN	9, 708	8, 489, 523	0. 00114		885	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	18, 068		0. 00684		552	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	26, 412					1
60. 00 06000 LABORATORY	207, 003	6, 356, 392	0. 03256			60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	00	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	35, 820	15 100 000	0.00000		1	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	194, 423					
67. 00 06700 OCCUPATI ONAL THERAPY	16, 522		0. 01749			1
68. 00 06800 SPEECH PATHOLOGY	9, 372		0. 01739			
69. 00 06900 ELECTROCARDI OLOGY	61, 103					
70. 00 07000 ELECTROENCEPHALOGRAPHY	60		0. 00123			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32, 216	12, 340, 559	0. 00261		4, 425	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	287, 553	16, 567, 134	0. 01735	2, 458, 879	42, 679	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0.00000	0 0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	0 0	0	75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 612	1	0. 00484		-	76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0. 00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS			0.0000	20	1 0	00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0. 00000 0. 00000			88. 00
90. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		-	89. 00 90. 00
91. 00 09100 EMERGENCY	213, 919	29, 658, 596			-	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	95, 707		0. 03888			1
OTHER REIMBURSABLE COST CENTERS	75, 767	2,401,237	0.03000	143, 270	3,030	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES		1				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	О	0. 00000	00 0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	Ō	0.00000		0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 00000		0	98. 00
200.00 Total (lines 50 through 199)	2, 488, 937	190, 748, 766		22, 577, 194	279, 751	200. 00

Health Financial Systems	ST ELIZABETI	H DEARBORN		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	ΓS Provider CO	CN: 15-0086 F	Peri od:	Worksheet D	
				rom 01/01/2021 o 12/31/2021	Part III Date/Time Pre	nared:
				0 12, 01, 2021	5/23/2022 10:	25 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medical	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments 1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	I IA	1.00	ZA	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	o o	Ö		-	Ö	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0		0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	(0	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	(0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	(0	0	41. 00
43. 00 04300 NURSERY	0	0	(0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	(0		44. 00
45.00 04500 NURSING FACILITY	0	0	(0		45. 00
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see instructions)	1 through 3, minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	12, 730	0.00	4, 594	30.00
31.00 03100 INTENSIVE CARE UNIT		0	2, 452	0.00	727	31. 00
32.00 03200 CORONARY CARE UNIT		0	(0.00	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0	(0.00	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	(0.00	0	34. 00
40. 00 04000 SUBPROVI DER - I PF	0	0	(0.00	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	(0	
43. 00 04300 NURSERY		0			0	
44. 00 04400 SKILLED NURSING FACILITY		0	(0	44. 00
45. 00 04500 NURSI NG FACILITY		0		0.00	0	45. 00
200. 00 Total (lines 30 through 199)	1	0	15, 693	3	5, 321	200. 00
Cost Center Description	Inpatient Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	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 INTENSI VE CARE UNIT	0					34.00
40. 00 04000 SUBPROVI DER - PF	0					40.00
41. 00 04100 SUBPROVI DER - RF	0					41.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0					44. 00 45. 00
200.00 Total (lines 30 through 199)	0					200. 00
200.00 10tal (111163 30 till bugli 177)	ı	I				1200.00

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 Systems
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 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-0086 THROUGH COSTS

					10 12/31/2021	5/23/2022 10:	
			Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments			0.00	
	ANCILLARY CERVICE COCT CENTERS	1. 00	2A	2.00	3A	3. 00	
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			J	0 0	0	E0 00
50. 00 51. 00	05100 RECOVERY ROOM	0		1	0 0	1	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0 0		52.00
53. 00	05300 ANESTHESI OLOGY	0					53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0			0 0	ő	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	Č		0 0	1	55. 00
56. 00	05600 RADI OI SOTOPE	0	l c		o c	o o	56. 00
57. 00	05700 CT SCAN	0	l c		o c	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		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	C		0 0	1	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	1	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	C		0 0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0)	0 0	1	65. 00
66.00	06600 PHYSI CAL THERAPY	0	C	2	0 0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0		2	0 0	1	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		(0 0	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY	0				0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	-	70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0		71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0					73. 00
74. 00	07400 RENAL DIALYSIS	0	7		0 0	1	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	Ĭ		0 0	1	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	Č		o c	1	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	ĺ		o c		77. 00
	OUTPATIENT SERVICE COST CENTERS	•		'			
88. 00	08800 RURAL HEALTH CLINIC	0	C)	0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0	89. 00
90.00	09000 CLI NI C	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			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	C		0 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	_	_		_	_	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C	2	0 0	1	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	1	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	1	98. 00
200.00	Total (lines 50 through 199)	1	1	'I	U _I	y 300, 985	200.00

Health Financial Systems	ST ELIZABETH D	EARBORN	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF INDATIENT (OUTDATIENT	T ANCILL ADV CEDVICE OTHER DACC	D	D!!	Waskahaat D

Period: From 01/01/2021 To 12/31/2021 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Part IV THROUGH COSTS Date/Time Prepared: 5/23/2022 10: 25 am Title XVIII Hospi tal Total Charges Cost Center Description All Other Total Cost Total Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 4) col s. 2, 3, 8) 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 59, 748, 989 0.000000 50.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 2, 928, 137 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 3, 235, 463 0.000000 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 17, 368, 227 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OI SOTOPE 00000 0 0.000000 56 00 0 56 00 0 8, 489, 523 57.00 05700 CT SCAN 0 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 2, 638, 123 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 4, 559, 348 0.000000 59.00 06000 LABORATORY 60 00 6, 356, 392 0.000000 60 00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 0.000000 63 00 64.00 06400 I NTRAVENOUS THERAPY 0 0.000000 64.00 06500 RESPIRATORY THERAPY 15, 109, 888 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 5, 340, 683 0.000000 66.00 66, 00 06700 OCCUPATIONAL THERAPY 0 944, 327 67.00 0.000000 67 00 68.00 06800 SPEECH PATHOLOGY 538, 687 0.000000 68.00 06900 ELECTROCARDI OLOGY 2, 081, 685 0.000000 69.00 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 48, 783 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 Ω 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 12, 340, 559 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 300, 985 300, 985 16, 567, 134 0.018168 73.00 07400 RENAL DIALYSIS 74.00 0 0.000000 74.00 C 75.00 07500 ASC (NON-DISTINCT PART) C 0 0.000000 75.00 76.97 07697 CARDIAC REHABILITATION 0 0 0.000000 76.97 332, 985 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0.000000 88.00 0 0 o 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 89.00 09000 CLINIC 0 90.00 0 0.000000 90.00 0 0 0 91.00 09100 EMERGENCY Ω 29, 658, 596 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 461, 237 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS 0 \cap 0 0.000000 94 00 95.00 09500 AMBULANCE SERVICES 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 97.00 0 Ω

 \cap

190, 748, 766

300, 985

300, 985

0.000000

98.00

200.00

98.00

200.00

09850 OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 ST ELIZABETH DEARBORN Provider CCN: 15-0086 THROUGH COSTS

						5/23/2022 10:	<u>25 am</u>
			Title	2 XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	5551 5511151 25551 Pt 1511	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
			chai ges		chai ges	Pass-IIII ougii	
		(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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	3, 977, 556	0	8, 652, 343	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0	o o	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	330, 922	0	5, 214	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	253, 878		536, 879	o o	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 658, 389		3, 200, 623	0	54.00
	1	1		i		1	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	_	0	0	55.00
56. 00	05600 RADI OI SOTOPE	0. 000000	0	1	0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	773, 260	0	1, 502, 137	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	80, 622	0	495, 086	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 078, 703	0	1, 307, 181	0	59. 00
60.00	06000 LABORATORY	0. 000000	1, 889, 992	0	920, 224	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000		1	. 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	62.00
63. 00		0. 000000	0		0	0	63.00
	06300 BLOOD STORING, PROCESSING & TRANS.	1	0		0	-	1
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	4, 787, 803		169, 462	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	319, 559	1	5, 955	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	192, 613		3, 834	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	73, 256	0	561	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	244, 523	0	316, 805	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	9, 752	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 694, 933	0	2, 683, 948	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 018168	2, 458, 879			38, 077	73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	_	0	Ö	75. 00
76. 97		1	0		140 070	0	76. 97
	07697 CARDI AC REHABI LI TATI ON	0.000000		1	140, 879		1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	T T		1		Г	
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	_	0	0	88. 00
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	2, 617, 016	0	3, 225, 201	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	145, 290	0	337, 786	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0	0	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	3. 333300	· ·		Ü		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		^	0	•
97.00	09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	_	0		
	1 1		-	_	0		•
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0	1	0 700 701	0	98. 00
200.00	Total (lines 50 through 199)	1	22, 577, 194	44, 673	25, 609, 701	38, 077	J∠UU. UU

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0086	Period: From 01/01/2021	Worksheet D Part V	
					To 12/31/2021	Date/Time Pre 5/23/2022 10:	pared: 25 am
			Title	: XVIII	Hospi tal	PPS	20 4
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
	ANOLUL ADV. CEDVI OF COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	0.205(0/	0 (52 242	I		2 (44 000	F0 00
50.00	05000 OPERATING ROOM	0. 305686	8, 652, 343		0 0		
51.00	05100 RECOVERY ROOM	0.000000	_		0 0	0	51.00
52.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0. 959698	5, 214		-	-,	52. 00 53. 00
53.00		0. 890818 0. 320479	536, 879		0 0	478, 261	
54. 00	05400 RADI OLOGY -DI AGNOSTI C	1	3, 200, 623				
55. 00	O5500 RADI OLOGY - THERAPEUTI C	0.000000	0		0 0	0	55. 00
56. 00 57. 00	05600	0.000000	1 500 107		0 0	1	56.00
58.00		0. 170802	1, 502, 137		0 0	256, 568	57. 00 58. 00
59.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 260326	495, 086		0 0	128, 884	1
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0. 244391 1. 019589	1, 307, 181 920, 224		0 0	319, 463 938, 250	59.00
60. 00 60. 01	06001 BLOOD LABORATORY	0. 000000	920, 224		0 0	938, 250	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	U		0 0	U	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	ľ	64. 00
65. 00	06500 RESPIRATORY THERAPY	1	_		0 0	1	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 146750 0. 728628	169, 462 5, 955		0 0	24, 869 4, 339	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 728028	3, 834		0 0	2, 263	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 390163	5, 634 561		0 0		1
69. 00	06900 ELECTROCARDI OLOGY	0. 731462	316, 805		0 0	170, 045	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 330749	9, 752	l .	0 0	2, 136	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 218990	9, 732 0		0 0	2, 130	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 498932	2, 683, 948		0 0	1, 339, 108	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 532941	2, 095, 831		0 3, 114	1, 116, 954	73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000	2,075,051		0 0	1, 110, 734	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0		75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 669192	140, 879			-	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	140, 077				
77.00	OUTPATIENT SERVICE COST CENTERS	0.00000			<u> </u>	<u> </u>	77.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00	09100 EMERGENCY	0. 219753	3, 225, 201		0 0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 597431	337, 786	1	0 0		
	OTHER REIMBURSABLE COST CENTERS		2217122	l .			
94.00	09400 HOME PROGRAM DIALYSIS	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	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	98. 00
200.00	1 1		25, 609, 701		0 3, 114	9, 462, 013	200. 00
201.00					0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		25, 609, 701	l	0 3, 114	9, 462, 013	202. 00

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0086 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/23/2022 10: 25 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 000000000000000000000000000000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 59 00 60.00 06000 LABORATORY 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 1,660 74.00 07400 RENAL DIALYSIS C 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 07697 CARDIAC REHABILITATION 76. 97 0 76. 97 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 Λ 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 00000 95.00

0

0

1,660

1, 660

96.00

97.00

98.00

200.00

201 00

202.00

96.00

97.00

200.00

201.00

202.00

09600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

09700 DURABLE MEDICAL EQUIP-SOLD

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Only Charges

	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der CO		Period: From 01/01/2021	Worksheet D Part V	2332 10
					To 12/31/2021	Date/Time Pre 5/23/2022 10:	pared: 25 am
			Ti tl	e XIX	Hospi tal	Cost	
	·			Charges		Costs	
	Cost Center Description	Cost to Charge	PS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins			
		1 00		(see inst.)	(see inst.)		
	ANOLLI ADV. CEDVI OF COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
EO 00	ANCILLARY SERVICE COST CENTERS	0.2054.04	O	212 72		0	FO 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0. 305686 0. 000000	0	,	0 0	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 959698	0			0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 939698	0	13, 16		0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 320479	0	99, 57		0	54.00
			0			0	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0. 000000 0. 000000	-		0 0	0	55.00
56.00	05700 CT SCAN		0	68, 70		0	56. 00 57. 00
58.00		0. 170802	0	10, 82		0	58.00
59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0. 260326	0	•		0	59.00
60.00	06000 LABORATORY	0. 244391 1. 019589	0	15, 88 62, 97		0	60.00
60. 00	06000 LABORATORY 06001 BLOOD LABORATORY	0. 000000	0	02, 97	0 0	0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	U		0 0	U	60. 01 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 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 146750	0	25, 15		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 728628	0	17, 69		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 726026	0	13, 56		0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 731462	0	18, 16		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 536749	0	16, 39		0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 218990	0	72		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 498932	0		0 0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 532941	0		0 0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
76. 97	07697 CARDI AC REHABILITATION	0. 669192	0	62	۷۱ ۲۱	0	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
,,,,,,	OUTPATIENT SERVICE COST CENTERS	0.00000	<u> </u>		<u> </u>		77.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00	09100 EMERGENCY	0. 219753	0	637, 18		0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 597431	0		0 0	0	
	OTHER REIMBURSABLE COST CENTERS		-,		-1		
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			0 0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000	o		o		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	o		0 0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	O		0 0	0	97. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	o		0 0	0	98. 00
200.00			o	1, 315, 55	9 0	0	200. 00
201.00					0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	1, 315, 55	9 0	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2021 | Part V | To 12/31/2021 | Date/Time Prepared: 5/23/2022 10: 25 am Health Financial Systems ST ELIZABET APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0086

					5/23/2022 10: 2	25 am_
		Title XI	X Hosp	oi tal	Cost	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	95, 600	0				50. 00
	95, 600					
51. 00 05100 RECOVERY ROOM	-1	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 108	0				52. 00
53. 00 05300 ANESTHESI OLOGY	11, 723	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	31, 911	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	О				55.00
56. 00 05600 RADI 0I SOTOPE	l ol	o				56.00
57. 00 05700 CT SCAN	11, 734	o				57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 818	o				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 882	0				59. 00
		0				60.00
	64, 210	-				
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	О				63.00
64.00 06400 INTRAVENOUS THERAPY	l ol	o				64.00
65. 00 06500 RESPIRATORY THERAPY	3, 692	o				65.00
66. 00 06600 PHYSI CAL THERAPY	12, 895	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	8, 005	0				67. 00
	1	0				
68. 00 06800 SPEECH PATHOLOGY	13, 284	٩				68. 00
69. 00 06900 ELECTROCARDI OLOGY	8, 800	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	158	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
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74. 00 07400 RENAL DI ALYSI S	0	О				74.00
75.00 07500 ASC (NON-DISTINCT PART)	l ol	o				75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	420	o				76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>				77.00
						88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	_	_				89. 00
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	140, 023	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0				94.00
95. 00 09500 AMBULANCE SERVICES	l ol					95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
	0					
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	1 9	0				98. 00
200.00 Subtotal (see instructions)	411, 263	0			•	200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	411, 263	0				202. 00

Health Financial Systems	ST ELIZABETH DEARBORN	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST	Provid	er CCN: 15-0086	Peri od:	Worksheet D-1	
			From 01/01/2021		
			To 12/31/2021	Date/Time Prepared:	
				5/23/2022 10:25 am	
		Title XVIII	Hospi tal	PPS	

		Title XVIII	Hospi tal	5/23/2022 10: PPS	25 am	
	Cost Center Description		•	1. 00		
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	I NPATI ENT DAYS			10 700		
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			12, 730 12, 730	1. 00 2. 00	
3. 00	Private room days (excluding swing-bed and observation bed day		ivate room days	12, 730	3.00	
0.00	do not complete this line.	ys). It you have only pr	rvate room days,	ŭ	0.00	
4.00	Semi-private room days (excluding swing-bed and observation be			11, 188	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private room	r 31 of the cost	0	5. 00		
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember	or the cost	O	0.00	
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00	
	reporting period					
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00	
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	4, 594	9. 00	
	newborn days) (see instructions)		g	.,		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00	
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00	
11.00	December 31 of the cost reporting period (if calendar year, en		dolli days) arter	U	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00	
	through December 31 of the cost reporting period			_		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00	
14. 00	Medically necessary private room days applicable to the Progra		0	14. 00		
15. 00	Total nursery days (title V or XIX only)	(0	15. 00	
16. 00	Nursery days (title V or XIX only)	0	16. 00			
47.00	SWING BED ADJUSTMENT		6.11	0.00	1 4 7 00	
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost	0. 00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00	
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to services	0. 00	19. 00			
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.00	
20.00	reporting period	arter becomber 31 or t	110 0031	0.00	20.00	
21. 00	Total general inpatient routine service cost (see instructions			12, 139, 063		
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00	
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	a period (line 6	0	23. 00	
23.00	x line 18)	31 of the cost reporting	g perrou (Trile o	O	23.00	
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00	
05.00	7 x line 19)				05.00	
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	si or the cost reporting	period (iine 8	0	25. 00	
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		12, 139, 063	27. 00	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		, 1			
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	28. 00 29. 00	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00	
31. 00	General inpatient routine service cost/charge ratio (line 27	+ line 28)		0. 000000	31.00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 22) (:+	±:>	0.00		
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin	tions)	0. 00 0. 00	34. 00 35. 00		
36. 00	Private room cost differential adjustment (line 3 x line 35)		0.00	36.00		
37. 00	General inpatient routine service cost net of swing-bed cost a	fferential (line	12, 139, 063	37. 00		
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see			953. 58	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	*		4, 380, 747	39.00	
40. 00	Medically necessary private room cost applicable to the Progra			0	40. 00	
41. 00	1.00 Total Program general inpatient routine service cost (line 39 + line 40) 4,380,747 4					

	Financial Systems	ST ELIZABETH		J. 1E 0007		eu of Form CMS-2	
COMPUI	ATION OF INPATIENT OPERATING COST		Provi der CCI		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre 5/23/2022 10:	pared:
			Title		Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per iem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	MUDCEDY (+: +1 a V & VI V and v)	1.00	2.00	3.00	4. 00 0 0	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		U	0.0	0 0] 0	J 42. UC
43. 00	INTENSIVE CARE UNIT	5, 485, 057	2, 452	2, 236. 9	7 727	1, 626, 277	43.00
44. 00	CORONARY CARE UNIT	0	0	0.0			
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0. 0 0. 0			
47. 00	OTHER SPECIAL CARE (SPECIFY)	J J	o _l	0. 0	0		47. 00
	Cost Center Description		<u>'</u>			1.00	
48. 00	Program inpatient ancillary service cost (Wk					8, 686, 753	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	s)		14, 693, 777	49.00
50. 00	Pass through costs applicable to Program inp		•			334, 143	50.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (fro	m Wkst. D, s	um of Parts II	324, 424	51.00
52.00	Total Program excludable cost (sum of lines					658, 567	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phys	ıcıan anesth	etist, and	14, 035, 210	53.00
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)			F/ '	50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (II	ne 56 minus	line 53)	0 0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket						
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the ma	rket basket		0.00	60.0
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the lesse	r of 50% of		0	61. 0
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62. 00							
63. 00							
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the co	st reporting	period (See	0	65. 0
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 65)(title XVII	l only). For	0	66. 0
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin					0	
68. 00	(line 12 x line 19)					0	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient			·	. tring porrou	0	
50	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID O	NLÝ			
70.00	Skilled nursing facility/other nursing facil						70.0
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		me /u ÷ IIne 2)			71.00
73. 00	Medically necessary private room cost applic		(line 14 x lin	e 35)			73.00
74. 00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)				74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)		costs (from Wo	rksheet B, P	art II, column		75.00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	•					76. 0
	Inpatient routine service cost (line 74 minu						78.00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79.00
80.00	Total Program routine service costs for comp		ost limitation	(line 78 min	us line 79)		80.0
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 0
83. 00	Reasonable inpatient routine service costs (83. 00
84. 00	Program inpatient ancillary services (see in						84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
JU. UU	PART IV - COMPUTATION OF OBSERVATION BED PAS		ough 65)				1 00.00
							1 07 0
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per					1, 542 953. 58	

Health Financial Systems	ST ELIZABETH DEARBORN			In Lieu of Form CMS-2552		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021		
				To 12/31/2021	Date/Time Prep 5/23/2022 10:2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	790, 106	12, 139, 063	0. 06508	8 1, 470, 420	95, 707	90.00
91.00 Nursing Program cost	0	12, 139, 063	0.00000	0 1, 470, 420	0	91.00
92.00 Allied health cost	0	12, 139, 063	0.00000	0 1, 470, 420	0	92.00
93.00 All other Medical Education	O	12, 139, 063	0.00000	0 1, 470, 420	0	93. 00

Health Financial Systems ST ELIZABET	H DEARBORN		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0086	Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
				5/23/2022 10:	
Cook Cooker Books at the	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
		To charges	Charges	(col. 1 x col.	
			ŭ	2)	
LNDATI ENT. DOUTINE OFFINA OF COOT OFFITEDO		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDI ATRI CS		1	12 524 240		30.00
31. 00 03100 NTENSI VE CARE UNIT			13, 536, 269 5, 600, 332		31.00
32. 00 03200 CORONARY CARE UNIT			0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34.00 O3400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
40. 00 04000 SUBPROVI DER - 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					1 43.00
50. 00 05000 OPERATI NG ROOM		0. 30568	3, 977, 556	1, 215, 883	50.00
51.00 05100 RECOVERY ROOM		0.00000		0	51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 95969		317, 585	
53. 00 05300 ANESTHESI OLOGY		0. 89081			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 32047 0. 00000		531, 479 0	54. 00 55. 00
56. 00 05600 RADI OI SOTOPE		0.00000		0	56.00
57. 00 05700 CT SCAN		0. 17080			1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 26032	80, 622	20, 988	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 24439		263, 625	
60. 00 06000 LABORATORY		1. 01958		1, 927, 015	1
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	60. 01 61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		ő	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 14675			
66. 00 06600 PHYSI CAL THERAPY		0. 72862		232, 840	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 59016		113, 673	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 7314 <i>6</i> 0. 53674		53, 584 131, 247	
70. 00 O7000 ELECTROENCEPHALOGRAPHY		0. 21899		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 49893	1, 694, 933		
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 53294		1, 310, 437	
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STINCT PART)		0.00000		0	74. 00 75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 00000 0. 66919		0	76. 97
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON		0.00000		ő	77. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	1
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY		0. 00000 0. 21975		0 575, 097	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 59743			91.00
OTHER REIMBURSABLE COST CENTERS		0.07710	110,270	00,001	72.00
94. 00 09400 HOME PROGRAM DIALYSIS		0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES					95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.00000		0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.00000		0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.00000	22, 577, 194	0 8, 686, 753	98.00
201.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		22, 377, 194	0,000,755	201.00
202.00 Net charges (line 200 minus line 201)	3.2 (3.)		22, 577, 194		202.00
		•	•	•	

Health Financial Systems ST ELIZABET	H DEARBORN		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	
	T' 11	V1.V		5/23/2022 10:	25 am
Cost Center Description	litl	e XIX Ratio of Cos	Hospi tal	Cost	
Cost Center Description		To Charges	t Inpatient Program	Inpatient Program Costs	
		10 onar ges	Charges	(col. 1 x col.	
			ŭ	2)	
LANDATI ENT. DOUTINE OFFICE OF COST. OFFITEDO		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDI ATRI CS		ı	454, 196	I	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT			680, 503		30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT			000, 309		32.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
40. 00 04000 SUBPROVI DER - 1 PF			0		40. 00
41. 00 04100 SUBPROVI DER -			0		41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			0		43. 00
50. 00 05000 OPERATI NG ROOM		0. 30568	6 248, 340	75, 914	50.00
51. 00 05100 RECOVERY ROOM		0. 00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 95969		65, 549	52.00
53. 00 05300 ANESTHESI OLOGY		0. 89081	8 5, 022	4, 474	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 32047		30, 315	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	55. 00
56. 00 05600 RADI OI SOTOPE		0.00000		0	56.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)		0. 17080			57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 26032 0. 24439		14, 107	59.00
60. 00 06000 LABORATORY		1. 01958		77, 936	60.00
60. 01 06001 BLOOD LABORATORY		0. 00000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 14675		108, 208	65. 00 66. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		0. 72862 0. 59016		6, 319 3, 408	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 73146			68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 53674		7, 822	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 21899	0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 49893		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS		0. 53294		44, 837	73.00
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART)		0. 00000 0. 00000		0	74. 00 75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 66919		i .	76. 97
77. 00 O7700 ALLOGENEI C STEM CELL ACQUI SI TI ON		0. 00000		l	77. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000		l	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY		0.00000		0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 21975 0. 59743		61, 680 0	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS		0.37743	1 0		72.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 00000		0	96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.00000		0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only char	cas (lino 61)		1, 720, 018	509, 875	200.00
202.00 Net charges (line 200 minus line 201)	ges (TITIE OT)		1, 720, 018		201.00
		1	., ,,20,010	ı	,_02.00

Health Financial Systems	ST ELIZABETH DEARBORN	In Lieu of Form CMS-2552-1			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0086	From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Ti me Prepared: 5/23/2022 10: 25 am		

PART A - I INPATIENT HOSPITAL SERVICES UNDER I PPS 1.00			T' 11 \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	11 11	5/23/2022 10:	25 am
Next A - IMPATIBN HOSPITAL SERVICES UNDER IPPS 0 1.0			Title XVIII	Hospi tal	PPS	
DBG Amounts Other than Outlier Payments 0 1.00					1. 00	
DRS amounts other than outlier payments for discharges occurring prior to October 1 (see 7,880,952 1.01						
Instructions 1.02		,	na prior to October 1 (200		•
Instructions 1.03	1.01		ing piror to october 1 (.	366	7,000,752	1.01
DRC for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1 (see instructions) 1 (a) (a) (b) (b) (a) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	1. 02		ng on or after October	1 (see	2, 803, 530	1. 02
1 (see instructions) 1.04 Decirating payment for Model 4 BPCI for discharges occurring on or after	1 03		or discharges occurring a	orior to October	0	1 03
October 1 (see Instructions) 2.00 2.00 2.01 2.00 2.01 2.00 2.01 2.00 2.01 2.00 2.01 2.00 2.01	1.03		or discharges occurring	orror to october	·	1.03
2.00 Outlier payments for discharges, (see instructions)	1.04	1 1 3 1 3	or discharges occurring	on or after	0	1. 04
2.01 Outlier resconciliation amount 0 2.01	2 00	,				2.00
2.02 Outlier payment for discharges cocurring prior to October 1 (see Instructions) 344, 646 2.03 2.04 Outlier payments for discharges occurring on or after October 1 (see Instructions) 209, 602 2.04 Outlier payments for discharges occurring on or after October 1 (see Instructions) 209, 602 2.04 Outlier payments for discharges occurring on or after October 1 (see Instructions) 209, 602 2.04 Outlier payments for discharges occurring on or after October 1 (see Instructions) 209, 602 2.04 Outlier payments for discharges occurring on or after October 1 (see Instructions) 50.07 4.00 Outlier payments delivered by the payment of the payme		, ,			0	
201 201 Control of Standard Stand			ons)		0	
Managed Care Simulated Payments 0 3 0.00	2.03	Outlier payments for discharges occurring prior to October 1	(see instructions)		344, 646	2. 03
Bed days available divided by number of days in the cost reporting period (see instructions) 56.78 4.00		, , ,	1 (see instructions)			
Indirect Medical Education Adjustment		, ,				ł
FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs. In accordance with 42 CFR 413, 79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.79(c), 413.79(c)(2)(1v), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost under § 5506 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) awarded FTE count for residents in dental and podiatric programs.	4. 00		rting period (see instru	ctions)	56. 78	4. 00
or before 12/31/1996. (see Instructions) 1. 00 First count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 1. 01 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost report straddles July 1, 2011 then see instructions) 1. 02 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost report straddles July 1, 2011 then see instructions) 1. 03 Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002). 1. 04 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 1. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 1. 03 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 1. 04 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 1. 05 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 1. 06 The count for residents in dental and podiatric programs. 1. 07 The count for residents in the current year from your records 1. 08 The count for residents in dental and podiatric programs. 1. 01 The count for residents in the penultimate year if that year ended on or after September 30, 1997. 1. 03 The count for residents in the penultimate year if that year ended on or after September 30, 1997. 1. 05 The count for all oweble FTE (see instructions) 1. 04 The count for penultimate year if that year ended on or after S	5 00		t recent cost reporting	port od onding on	0.00]] 5 00
new programs in accordance with 42 CFR 413.79(e) 0.00 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the co. 00 7.00 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the co. 00 7.01 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the co. 00 7.01 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the co. 00 7.01 ACA \$5503 reduction amount to increase in the the hospital was earlied for the first and first	5.00		r recent cost reporting	berroa enaring on	0.00	3.00
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(1) 0.00 7.00 7.01 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(8)(2) if the cost report straddle sully 1, 2011 then see instructions. 0.00 40 street (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50099 (August 1, 2002). 0.00 8.00 8.01 The amount of Increase if the hospital was awarded FIE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions. 0.00 8.01 8.02 Interport straddles July 1, 2011, see Instructions. 0.00 1.00 1.00 9.00 Instructions) 0.00 8.02 0.00 9.00 10.00 FIE count for Interport in Instructions. 0.00 1.	6.00		ne criteria for an add-o	n to the cap for	0.00	6. 00
ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f(1)(i)(i)(B)(2) if the cost report straddles July 1, 2011 then see instructions.	7 00		undon 42 CED \$412 10E(f)	(1) (; , ,) (D) (1)	0.00	7 00
cost report straddles July 1, 2011 then see instructions. 8. 00 All ustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affil lated programs in accordance with 42 CFR 413, 75(b), 413, 79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 Inc amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost under \$ 5506 of ACA. (see Instructions) 8. 02 Under \$ 5506 of ACA. (see Instructions) 8. 03 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 instructions) 9. 00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 11.00 instructions) 10. 00 FTE count for residents in dental and podiatric programs. 10. 00 Current year allowable FTE (see instructions) 11. 00 FTE count for residents in dental and podiatric programs. 11. 00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable provides enter zero. 15. 00 Sum of Iines 12 through 14 divided by 3. 16. 00 Algustment for residents in initial years of the program 0.00 17.00 Algustment for residents in initial years of the program 0.00 17.00 Algustment for residents in initial years of the program 0.00 17.00 Algustment for residents in initial years of the program 0.00 17.00 Algustment for residents in initial years of the program 0.00 17.00 Algustment for residents in initial years of the program of hospital closure 0						ł
Agl Justment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	7.01		42 CIR 9412. 105(1)(1)(1)	7)(b)(2) II the	0.00	7.01
affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1. 2002).	8.00		thic and osteopathic pro	grams for	0.00	8.00
8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions. 1. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.					·	
Report straddles July 1, 2011, see instructions.				-		
Section Sect	8. 01		ots under § 5503 of the A	ACA. If the cost	0. 00	8. 01
under \$ 5506 of ACA. (see instructions)	8 02		nts from a closed teachi	na hosnital	0.00	8 02
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 13.00 14.00	0.02	·	ora from a crosca teachin	ig nospi tai	0.00	0.02
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.	9.00		es (8, 8,01 and 8,02) (see	0. 00	9. 00
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 13.00 10.00 10.00 12.00 10.00 10.00 10.00 12.00 10.00 1	10.00	l	ont was from value sages	do	0.00	10 00
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00			ent year from your record	JS .		ı
13.00 Total allowable FTE count for the prior year. 0.00 13.00 13.00 14.00 14.10						ı
14.00		l ,				
Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 17.00 Adjustment for residents in initial years of the program 0.00 17.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00		' '	ar ended on or after Sep	tember 30, 1997,		l
16.00 Adj ustment for residents in initial years of the program 0.00 16.00 17.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.01 IME payment adj ustment (see instructions) 0.000000 21.00 22.01 IME payment adj ustment - Managed Care (see instructions) 0.22.01 Indirect Medical Education Adj ustment for the Add-on for § 422 of the MMA 0.000000 23.00 (f)(1)(iv)(C). 0.000000 23.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 0.000000 27.00 28.01 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.		otherwise enter zero.	•		 -	
17. 00						ł
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instructions			ower of line 23 or line	24 (see		1
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28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 34.00 Sum of lines 30 and 31 35.00 Allowable disproportionate share percentage (see instructions) 36.00 Sum of lines 30 and 31 37.00 Allowable disproportionate share percentage (see instructions) 38.00 Sum of lines 30 and 31 39.00 Allowable disproportionate share percentage (see instructions)	26.00				0.000000	26. 00
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29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 39.01 29.0)			•
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32.00 Sum of lines 30 and 31 20.38 32.00 33.00 Allowable disproportionate share percentage (see instructions) 6.28 33.00			atront days (see mistruc	11 0113)		1
33.00 Allowable disproportionate share percentage (see instructions) 6.28 33.00						
)			1
	34. 00	Disproportionate share adjustment (see instructions)			164, 607	34.00

_CUL	Financial Systems ST ELIZABETH D ATION OF REIMBURSEMENT SETTLEMENT		Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2021 To 12/31/2021	Part A Date/Time Pre	pared
		Title XVIII	Hospi tal	5/23/2022 10: 2 PPS	25 an
			Prior to 10/1	On/After 10/1	
	Uncompensated Care Adjustment		1. 00	2. 00	
00	Total uncompensated care amount (see instructions)		0	0	35. (
01	Factor 3 (see instructions)		0. 000000000	0. 000000000	
02	Hospital uncompensated care payment (If line 34 is zero, enter instructions)	r zero on this line) (see	973, 876	807, 283	35.
03	Pro rata share of the hospital uncompensated care payment amou	unt (see instructions)	728, 406	203, 480	35.
00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		931, 886		36.
00	Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges (see instructions)	scharges (lines 40 throug	jh 46) 0		40.
00	Total ESRD Medicare discharges (see instructions)		0		41.
01	Total ESRD Medicare covered and paid discharges (see instructi	ons)	0		41.
00	Divide line 41 by line 40 (if less than 10%, you do not qualit	fy for adjustment)	0.00		42.
00	Total Medicare ESRD inpatient days (see instructions)	41 7	0		43.
00	Ratio of average length of stay to one week (line 43 divided ldays)	by Title 41 divided by 7	0. 000000		44.
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)	0		46.
00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, sr	mall rural bacaitals	12, 135, 223 0		47. 48.
00	only. (see instructions)	nari rurar nospitars			40.
				Amount	
00	Total payment for inpatient operating costs (see instructions)			1. 00 12, 135, 223	49.
00	Payment for inpatient program capital (from Wkst. L, Pt. I and			866, 041	50
00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51
00	Direct graduate medical education payment (from Wkst. E-4, lim	ne 49 see instructions).		0	52
00	Nursing and Allied Health Managed Care payment			0	
00 01	Special add-on payments for new technologies Islet isolation add-on payment			308, 708 0	54 54
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	9)		0	55
00	Cost of physicians' services in a teaching hospital (see intru			Ö	56
00	Routine service other pass through costs (from Wkst. D, Pt. II		rough 35).	0	57
00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 11 line 200)		44, 673	
00	Total (sum of amounts on lines 49 through 58) Primary payer payments			13, 354, 645 16, 118	
00	Total amount payable for program beneficiaries (line 59 minus	line 60)		13, 338, 527	
00	Deductibles billed to program beneficiaries			1, 246, 828	
00	Coinsurance billed to program beneficiaries			102, 767	
00	Allowable bad debts (see instructions)			126, 989	
00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	cuctions)		82, 543 121, 443	
00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			12, 071, 475	
00	Credits received from manufacturers for replaced devices for a		e instructions)	0	
00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instructions	5)	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	sation) adjustment (occ. i	notruptions)	0	
50 87	Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration	ration) adjustment (see i	nstructions)	0	70. 70.
88	SCH or MDH volume decrease adjustment (contractor use only)			0	70
89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70
90	HSP bonus payment HVBP adjustment amount (see instructions)			0	ı
91	HSP bonus payment HRR adjustment amount (see instructions)			0	
92	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 5, 845	
73	payment adjustment amount (see Histiactions)				
94	HRR adjustment amount (see instructions)		I	-77, 966	/0.

Health Financial Systems	ST ELIZABETH D	FARBORN		In lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CC	CN: 15-0086	Peri od: From 01/01/2021	Worksheet E	pared:
		Title	XVIII	Hospi tal	PPS	
		•	FFY	(yyyy)	Amount	
				0	1. 00	

			-	To 12/31/2021	Date/Time Prep 5/23/2022 10:2	
		Title	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	2	021	638, 165	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in	a column O	2	022	897, 222	70. 97
70. 77	the corresponding federal year for the period ending on or aff		2	022	071, 222	10. 71
70. 98	Low Volume Payment-3	,			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			13, 534, 741	71.00
71. 01	Sequestration adjustment (see instructions)				0	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs				12 (20 02)	71. 03
72. 00 72. 01	Interim payments Interim payments-PARHM				13, 630, 836	72. 00 72. 01
73. 00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)				O	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			-96, 095	74. 00
	73)					
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			643, 389	75.00
	CMS Pub. 15-2, chapter 1, §115.2					
00 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	x€ 2.02			0	90. 00
90.00	plus 2.04 (see instructions)	01 2.03			U	90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92. 00
93.00	Capital outlier reconciliation adjustment amount (see instruc-				0	93.00
94.00	The rate used to calculate the time value of money (see instru	uctions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)				0	95.00
96. 00	Time value of money for capital related expenses (see instruc-	tions)		D	0	96. 00
				Prior to 10/1 1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	0	102. 00
100.00	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	102 00
	HRR adjustment factor (see instructions)			0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr		istment	<u> </u>	U	104.00
200.00	Is this the first year of the current 5-year demonstration per					200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	. ou unuo.	2131			200.00
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	e 49)				201. 00
	Medicare discharges (see instructions)					202. 00
203. 00	Case-mix adjustment factor (see instructions)	6: 1	6.11			203. 00
	Computation of Demonstration Target Amount Limitation (N/A in	Tirst year	or the current	t 5-year demonst	ration	
						204. 00
204 00	peri od)					
	Medicare target amount					
205.00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204)					205. 00 206. 00
205.00	Medicare target amount					205. 00
205. 00 206. 00 207. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see insti	,				205. 00 206. 00 207. 00
205. 00 206. 00 207. 00 208. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see insti	,				205. 00 206. 00 207. 00 208. 00
205. 00 206. 00 207. 00 208. 00 209. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see insti Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	,				205. 00 206. 00 207. 00 208. 00 209. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instrumedicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	,				205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	,				205. 00 206. 00 207. 00 208. 00 209. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	line 59)				205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	line 59)				205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	line 59) 211)	nbursement)			205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	line 59) 211)	nbursement)			205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0086

					20/11/1		5/23/2022 10:	25 am
		W/S E Dart A	Amounts (from	Pre/Post	Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3. 00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	(0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	7, 680, 952	0	7, 680, 952	2	7, 680, 952	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 803, 530	0		2, 803, 530	2, 803, 530	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	C	0	0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	O	1. 04
2.00	October 1 Outlier payments for	2. 00						2. 00
2. 01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	344, 646	0	344, 646	هٔ ا	344, 646	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see	2. 04	209, 602	0		209, 602	209, 602	2. 03
3. 00	instructions) Operating outlier reconciliation	2. 01	0	0	(0	0	3. 00
4.00	Managed care simulated payments	3. 00	0	0	(0	0	4. 00
	Indirect Medical Education Adju				i			
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0.000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see instructions)	22. 00	0	0	(o	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	(0	О	6. 01
7. 00	Indirect Medical Education Adju IME payment adjustment factor	ustment for the	e Add-on for Se 0.000000	ction 422 of t 0.000000		0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see instructions)	28. 00	0	0	(0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	О	0	(0	o	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	(0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	(0	0	9. 01
10 00	Disproportionate Share Adjustme		0.015=	0.0455	0.01	2 2 2 2 2		10 00
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0628	0. 0628	0. 0628	0. 0628		10. 00
11. 00	Di sproporti onate share adjustment (see instructions)	34. 00	164, 607	0	·		·	
11. 01	Uncompensated care payments Additional payment for high per		931, 886 RD beneficiary		·			
12. 00	Total ESRD additional payment	46. 00	0	0	"	0	이	12. 00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	12, 135, 223 0	0	8, 874, 59 <u>5</u>	3, 260, 628 0 0	12, 135, 223 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	12, 135, 223	0	8, 874, 595	3, 260, 628	12, 135, 223	15. 00
16. 00	<pre>instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,</pre>	50. 00	866, 041	0	633, 999	232, 042	866, 041	16. 00

						rom 01/01/2021 o 12/31/2021	Part A Exhibi Date/Time Pre 5/23/2022 10:	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	54.00	308, 708	0	185, 094	123, 614	308, 708	17. 00
	new technologies							
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68.00	0	0	C	0	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	0	0	C	0	0	18. 00
	adjustment amount (see							
	instructions)							
19. 00	SUBTOTAL			0	9, 693, 688	3, 616, 284	13, 309, 972	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	785, 812	0	580, 381	205, 431	785, 812	ł
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	0	0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	80, 229	0	53, 618	26, 611	80, 229	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	0	0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0.0000	0.0000	0. 0000		22. 00
	percentage (see instructions)							
23. 00	Indirect medical education	6. 00	0	0	0	0	0	23. 00
	adjustment (see instructions)							
24. 00	Allowable disproportionate	10. 00	0. 0000	0. 0000	0.0000	0. 0000		24. 00
	share percentage (see							
	instructions)		_	_	_	_	_	
25. 00	Di sproporti onate share	11. 00	0	0	C	0	0	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	866, 041	0	633, 999	232, 042	866, 041	26. 00
	payments (see instructions)	W /O F D . A						
		W/S E, Part A						
		line	Part A)	0.00	2.00	4.00	F 00	
07.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	1.00	2. 00	3.00	4. 00	5. 00	07.00
27. 00	Low volume adjustment factor	70.0/			0. 065833			27. 00
28. 00	Low volume adjustment	70. 96			638, 165	1	638, 165	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)	70.07				007 000	007 000	
29. 00	Low volume adjustment	70. 97				897, 222	897, 222	29. 00
	(transfer amount to Wkst. E,							
100.00	Pt. A, line)		V					100 00
100.00	Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.	I	l l		I	1		l

Health Financial Systems ST ELIZABETH DEARBORN
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provide In Lieu of Form CMS-2552-10 Worksheet E
Part A Exhi bi t 5
Date/Time Prepared:
5/23/2022 10: 25 am Provider CCN: 15-0086 Peri od: From 01/01/2021 To 12/31/2021 Title XVIII Hospital PPS
Wkst F Pt Amt from Period to Period on Total (cols 2)

		Wkst. E, Pt.	Amt. from	Period to	Peri od on	Total (cols. 2	
		A, line	Wkst. E, Pt. A)	10/01	after 10/01	and 3)	
		0	1.00	2. 00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1. 00					1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	7, 680, 952	7, 680, 952		7, 680, 952	1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1. 02	2, 803, 530		2, 803, 530	2, 803, 530	1. 02
1.02	di scharges occurring on or after October 1	1.02	2,003,330		2, 003, 330	2, 003, 330	1.02
1.03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
	for Model 4 BPCI occurring prior to October						
1. 04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
1.04	for Model 4 BPCI occurring on or after	1.04			O	Ĭ	1.04
	October 1						
2.00	Outlier payments for discharges (see	2. 00					2. 00
2. 01	instructions) Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
2.01	BPCI	2.02		0	0	٥	2.01
2.02	Outlier payments for discharges occurring	2. 03	344, 646	344, 646		344, 646	2. 02
0.00	prior to October 1 (see instructions)	0.04	202 (22		202 (22	000 (00	0.00
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	209, 602		209, 602	209, 602	2. 03
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	3. 00
4.00	Managed care simulated payments	3. 00	0	0	0	0	4. 00
	Indirect Medical Education Adjustment	-					
5. 00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6. 00	(see instructions) IME payment adjustment (see instructions)	22.00	0	0	0	0	6, 00
6. 01	IME payment adjustment for managed care (see	22. 01	ő	0	0	Ö	6. 01
	instructions)						
7.00	Indirect Medical Education Adjustment for the				0.00000	1	7.00
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
0.00	care (see instructions)	00.00			•		0.00
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0	0	0	0	9. 00 9. 01
7.01	lines 6.01 and 8.01)	27.01		0	0	٥	9.01
	Disproportionate Share Adjustment						
10. 00	1 1 1 9	33. 00	0. 0628	0. 0628	0. 0628		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	164, 607	120, 591	44, 016	164, 607	11. 00
11.00	instructions)	34.00	104, 007	120, 371	44, 010	104, 007	11.00
11. 01	Uncompensated care payments	36. 00	931, 886	728, 406	203, 480	931, 886	11. 01
40.00	Additional payment for high percentage of ESF						40.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	12, 135, 223	8, 874, 595	3, 260, 628	12, 135, 223	13. 00
14.00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14. 00
	and MDH, small rural hospitals only.) (see						
15 00	instructions) Total payment for inpatient operating costs	49. 00	12 125 222	0 07/ 505	3 260 628	12 125 222	15 00
13.00	(see instructions)	47.00	12, 135, 223	8, 874, 595	3, 260, 628	12, 135, 223	15.00
16.00	Payment for inpatient program capital (from	50. 00	866, 041	633, 999	232, 042	866, 041	16. 00
	Wkst. L, Pt. I, if applicable)						
17.00	Special add-on payments for new technologies	54. 00	308, 708	185, 094	123, 614	308, 708	
17. 01 17. 02	Net organ acquisition cost Credits received from manufacturers for	68. 00	0	0	0	0	17. 01 17. 02
02	replaced devices for applicable MS-DRGs	55. 55			O		102
18. 00	, ,	93. 00	0	0	0	0	18. 00
10 00	amount (see instructions) SUBTOTAL			9, 693, 688	3, 616, 284	13, 309, 972	10 00
17.00	JOODIGIAL	l	l l	7, 073, 000	3, 010, 204	13, 307, 7/2	1 7. 00

Health Financial Systems	ST ELIZABETH D	In Lieu of Form CMS-2552-		
HOSPITAL ACQUIRED CONDITION (HAC	REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0086		Worksheet E Part A Exhi bit 5 Date/Time Prepared: 5/23/2022 10: 25 am

HOST THE HOLD TREE SOLD THON (INO) RESCOTT ON GREECE	TON EXILIBITION	Trovider ex		From 01/01/2021 To 12/31/2021	Part A Exhibi Date/Time Pre 5/23/2022 10:	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	785, 812	580, 38	1 205, 431	785, 812	20. 00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00 Capital DRG outlier payments	2.00	80, 229	53, 61	26, 611	80, 229	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.000	0.0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	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	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	866, 041	633, 99	9 232, 042	866, 041	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	638, 165	638, 16	5	638, 165	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	897, 222		897, 222	897, 222	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	5, 845	5, 84	5 0	5, 845	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-77, 966	-64, 50	2 -13, 464	-77, 966	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
					(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			0	0	32. 00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

			10 12/31/2021	5/23/2022 10:	
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			1, 660	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		9, 423, 936	2. 00
3.00	OPPS payments		5, 921, 404	3. 00	
4.00	Outlier payment (see instructions)		37, 036	4. 00	
4. 01	Outlier reconciliation amount (see instructions)	i ana)		0. 000	4. 01 5. 00
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	i ons)		0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		38, 077	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			1, 660	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			3 114	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0, 111	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)	•		3, 114	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa			0	15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services on	a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			3, 114	18. 00
19.00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	e 11) (see	1, 454	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	e 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			1, 660	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	*		5, 996, 517	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	04.76		0	25. 00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	•		1, 051, 806 4, 946, 371	26. 00 27. 00
27.00	instructions)	us the sum of filles 22	and 23] (See	4, 740, 371	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			4, 946, 371	30. 00
31. 00	Primary payer payments			2, 183	31.00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)		4, 944, 188	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	3)		0	33. 00
34. 00	Allowable bad debts (see instructions)			89, 160	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			57, 954	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		81, 291	
37. 00	Subtotal (see instructions)			5, 002, 142	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			4	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruct	i ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			5, 002, 138	40.00
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 02 40. 03
41. 00	Interim payments			5, 143, 590	41. 00
41. 01	Interim payments-PARHM			2, 1.12, 212	41. 01
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43. 00	Balance due provider/program (see instructions)			-141, 452	43.00
43. 01	Balance due provider/program-PARHM (see instructions)	a with CMC Dub 1E 2 a	hantan 1	0	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordanc §115.2	e with CMS PUD. 15-2, C	партег Т,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93. 00 94. 00
74. UU	Total (sum of lines 91 and 93)			0	74. UU

Health Financial Systems ST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0086

				10 12/31/2021	5/23/2022 10: 2	
		Ti tl e	e XVIII	Hospi tal	PPS	
		I npati er	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		13, 443, 33	6	5, 029, 690	1. 00
2.00	Interim payments payable on individual bills, either			o	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	12/01/2021	187, 50	0 12/01/2021	113, 900	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER	12/01/2021		0 12/01/2021	113, 900	3. 01
3. 02			1	0		3. 02
3. 04			1	0		3. 03
3. 05			1	Ö	l ol	3. 05
0.00	Provider to Program			<u> </u>	J	0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				o	o	3. 51
3.52				o	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		187, 50	0	113, 900	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		13, 630, 83	6	5, 143, 590	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after		1			5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		1			
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				o	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52			1	0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
4 00	5. 50-5. 98)					4 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			o	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		96. 09	5	141, 452	6. 02
7.00	Total Medicare program liability (see instructions)		13, 534, 74		5, 002, 138	7. 00
	The second of th		10,001,71	Contractor	NPR Date	7.30
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems ST ELIZABETH D)FARBORN	Inlie	u of Form CMS-	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0086	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Pre 5/23/2022 10:	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.				1. 00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus f	or cost		2. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4. 00
F 00	reporting periods beginning on or after 10/01/2013, line 32)				F 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HII technology	WKST. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	, , , , , , , , , , , , , , , , , , , ,	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00

Health Financial Systems	ST ELIZABETH DEARBORN	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0086	Peri od: Worksheet E-3 From 01/01/2021 Part VII To 12/31/2021 Date/Time Prepared:

PART VII - CALCULATION OF REINBURSEWENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			-	To 12/31/2021	Date/Time Pre 5/23/2022 10:	pared:
Inpatient Outpatient Outp			Title XIX	Hospi tal		25 am
PART VII - CALCULATION OF RETIDBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			THE WAY			
PART VI - CALCILIATION OF RETIMEURSEMENT - ALL OTHER HEALTH SERVICES COMPUTATION OF NOT COSTO COMPUTED SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES 1,00 1,00 1,23 2,00 2,00 Medical and other services 3,00 0,30 0,		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XIX		2.00	
Medical and other services 411,263 2.00 3.00 3.00 0.00 3.00 3.00 0.00 3.0						
Medical and other services 411,263 2.00 3.00 3.00 0.00 3.00 3.00 0.00 3.0	1.00			0		1.00
3.00 Organ acquisition (certified transplant centers only) 0 411, 263 4.00 5.00 Inpatient primary payer payments 0 0 411, 263 4.00 5.00 Inpatient primary payer payments 0 0 6.00 6.00 Ostototal (Line 4 Less sum of Lines 5 and 6) 0 411, 263 7.00 COUNTAIN OF LESSER OF COST OR CHARGES COUNTAIN OF LESSER OF COST OR CHARGES COUNTAIN OF LESSER OF COST OR CHARGES 0 1.20, 018 1.315, 559 9.00 0 0 0 0 0 0 0 0 0	2.00				411, 263	2. 00
5.00	3.00	Organ acquisition (certified transplant centers only)		0		3. 00
0.00 0.00	4.00	Subtotal (sum of lines 1, 2 and 3)		0	411, 263	4. 00
Subtotal (line 4 less sum of lines 5 and 6)	5.00	Inpatient primary payer payments		0		5. 00
COMPUTATION OF LESSER OF COST OR CHARGES	6.00	Outpatient primary payer payments			0	6. 00
Reasonable Charges 8.00 8.00 Ancillary service charges 1,720,018 1,315,559 9,00 10.00 Incentive from target amount computation 1,00 10.00 Incentive from target amount computation 1,00 11.00 1,20,018 1,315,559 10.00 11.00 10.00 1	7.00			0	411, 263	7. 00
Routine service charges						
9.00 Ancillary service charges 1,720,018 1,315,559 9,00						
10.00 Organ acquisition charges, net of revenue 0 10.0				0		
11.00 Incentive from target amount computation 1.720, 018 1.315,559 12.00 COSTOMARY CHARGES 1.310, 04 1.315,559 12.00 COSTOMARY CHARGES 1.310, 04 1.31		, ,			1, 315, 559	
12.00 Total reasonable charges (sum of lines 8 through 11)				0		
CUSTOMARY CHARGES 0				4 700 040	4 045 550	
13.00 Amount actually collected from patients liable for payment for services on a charge 0 0 13.00	12.00			1, 720, 018	1, 315, 559	12.00
basis	12 00		comul acc on a change			12 00
14.00 Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413. 13(e) 0.000000 0.000000 15.00 15.00 16.00 Total customary charges (see instructions) 1.720,018 1.720,018 1.720,018 17.00 18.00 18.0	13.00	1	services on a charge	0	Ü	13.00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 15. 00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16. 00 Total customary charges (see instructions) 17. 00 Excess of customary charges (see instructions) 18. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1.720,018 904,296 17.00 line 4) (see instructions) 18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19. 00 Interns and Residents (see instructions) 19. 00 Interns and Residents (see instructions) 19. 00 Cost of physicians' services in a teaching hospital (see instructions) 10. 00 Cost of physicians' services (enter the lesser of line 4 or line 16) 10. 00 ROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 10. 00 Outlier payments 10. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0	1/ 00		navment for services on	0	0	14 00
15.00	14.00				O	14.00
16. 00 Total customary charges (see instructions) 1,720,018 1,315,559 16. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1,720,018 1,315,559 16. 00 10.	15. 00		2 011 3110. 10(0)	0. 000000	0.000000	15. 00
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1,720,018 904,296 17.00 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 0 0 18.00 19.00 Interns and Residents (see instructions) 0 0 0 20.00 19.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20.00 19.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 0 0 23.00 19.00 Other than outlier payments 0 0 25.00 19.00 Other than outlier payments 0 0 25.00 19.00 Other than outlier payments 0 25.00 19.00 Other and Ancillary service other pass through costs 0 25.00 19.00 Other and Ancillary service other pass through costs 0 25.00 19.00 Other and Ancillary service other pass through costs 0 25.00 19.00 Other and Ancillary service other pass through costs 0 25.00 19.00 Other and Ancillary service other pass through costs 0 25.00 19.00 Other and ancillary service other pass through costs 0 25.00 19.00 Other and ancillary service other pass through costs 0 2						
Iine 4 (see instructions)	17. 00		y if line 16 exceeds			
16) (see instructions)		line 4) (see instructions)	,			
19.00 Interns and Resi dents (see instructions) 0 0 19.00 20.00	18.00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds line	0	0	18. 00
20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 411,263 21.00		16) (see instructions)				
21.00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				0	0	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					-	
22.00 Other than outlier payments 0 0 0 22.00	21. 00			_	411, 263	21. 00
23. 00 Outlier payments			completed for PPS provide			
24. 00 25. 00 25. 00 26. 00 Routine and Ancillary service other pass through costs 27. 00 28. 00 29. 00 29. 00 29. 00 20.		1 3		1	-	
25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Coinsurance 31.00 Allowable bad debts (see instructions) 32.00 Utilization review 33.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Bal ance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub 15-2, 0 25.00 26.00 0 26.00 0 27.00 0 27.00 0 28.00 0 2411,263 0 25.00 0 30.00 0				1	0	
26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Deductibles 32. 00 Deductibles 33. 00 Coinsurance 30. 01 32. 00 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 411, 263 42. 00 Bal ance due provider/program (line 40 minus line 41) 41. 263 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,				-		
27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 0 411, 263 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	
28. 00 Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 29. 00 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Therefore a subtotal (line 36 ± line 37) Subtotal (line 36 ± line 37) Total amount payable to the provider (sum of lines 38 and 39) Logical Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, Utilized and 27, Computation of lines 21 and 27) Late of Line 30, 411, 263 Late of Line 31, 411, 263 Late					-	
Titles V or XIX (sum of lines 21 and 27)				-	-	
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 0 411, 263 31.00 32.00 Deductibles 0 0 0 32.00 33.00 Oinsurance 0 0 0 34.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 35.00 35.00 Utilization review 0 35.00 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 411, 263 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 0 411, 263 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 410.00 Total amount payable to the provider (sum of lines 38 and 39) 0 411, 263 40.00 410.00 Interim payments 0 410.00 410.00 Balance due provider/program (line 40 minus line 41) 0 411, 263 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				-	-	
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 32.00 Coinsurance 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	27.00			<u> </u>	411, 203	27.00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coi nsurance 31.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	30.00			0	0	30 00
32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 411, 263 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 0 411, 263 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 0 37.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 411, 263 40.00 41.00 Interim payments 0 0 411, 263 42.00 42.00 Balance due provider/program (line 40 minus line 41) 0 411, 263 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00		, ,		-	-	
33.00 Coinsurance 0 0 33.00 34.00 34.00 35.00 Utilization review 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 411,263 36.00 37.00 37.00 Subtotal (line 36 ± line 37) 0 50.00 0 5				0		
35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 411, 263 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 0 411, 263 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 11erim payments 0 411, 263 42.00 Balance due provider/program (line 40 minus line 41) 0 411, 263 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0	0	
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	34.00	Allowable bad debts (see instructions)		0	0	34. 00
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 0 411, 263 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 411, 263 40.00 41.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 411, 263 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	35.00	Utilization review		0		35. 00
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 411, 263 38.00 39.00 411, 263 40.00 411, 263 42.00 411, 263 42.00 411, 263 42.00 411, 263 42.00	36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	411, 263	36. 00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 411, 263 40.00 411, 263 42.00 43.00	37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 411, 263 40.00 411, 263 40.00 411, 263 42.00 43.00	38. 00	Subtotal (line 36 ± line 37)		0	411, 263	38. 00
41.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 411, 263 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0		
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 411, 263 42.00		, ,		0	411, 263	
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00						
		, , ,				
cnapter , §115.2	43. 00	,	ce with CMS Pub 15-2,	0	0	43. 00
		Cliapter 1, 9115.2		1		I

lealth Financial Systems ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10
BALANCE SHEET (If you are nonproprietary and do not maintain Provider CCN: 15-0086 Period: Worksheet G

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

Provi der CCN: 15-0086 | Peri od: | From 01/01/2021 | To 12/31/2021 |

21 | 21 | 21 | Date/Time Prepared: | 5/23/2022 10: 25 am

On y)					5/23/2022 10:	25 am
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	65, 199, 743	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	16, 323, 839	0	0	0	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	2, 445, 841	0	0	0	7. 00
8.00	Prepai d expenses	0	0	0	0	8. 00
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	83, 969, 423	0	0	0	11. 00
	FIXED ASSETS					
12.00	Land	500, 000	0	0	0	12. 00
13.00	Land improvements	18, 800	0	0	0	13. 00
14.00	Accumul ated depreciation	-4, 178	0	0	0	14. 00
15.00	Bui I di ngs	2, 467, 205	0	0	0	15. 00
16.00	Accumul ated depreciation	-432, 472	0	0	0	16. 00
17.00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumul ated depreciation	0	0	0	0	18. 00
19.00	Fi xed equipment	0	0	0	0	19. 00
20.00	Accumul ated depreciation	0	0	0	0	20. 00
21.00	Automobiles and trucks	0	0	o	0	21. 00
22.00	Accumul ated depreciation	0	0	0	0	22. 00
23.00	Major movable equipment	3, 376, 681	0	0	0	23. 00
24.00	Accumulated depreciation	-1, 277, 156	i	o	ol	24. 00
25. 00	Mi nor equi pment depreci abl e	40, 757		0	o	25. 00
26. 00	Accumulated depreciation	0	o	0	0	1
27. 00	HIT designated Assets	0	o	0	0	1
28. 00	Accumul ated depreciation	0	o	0	0	1
29. 00	Mi nor equi pment-nondepreci abl e	0	Ō	0	Ö	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	4, 689, 637		0		1
00.00	OTHER ASSETS	1,007,007		<u> </u>		00.00
31. 00	Investments	0	0	0	0	31. 00
32.00	Deposits on Leases	0		0	o	1
33. 00	Due from owners/officers	-74, 560, 101		0	Ö	
34. 00	Other assets	569, 480	1	0	o	
35. 00	Total other assets (sum of lines 31-34)	-73, 990, 621		Ö	o o	1
36. 00	Total assets (sum of lines 11, 30, and 35)	14, 668, 439	1	Ö	Ö	1
30.00	CURRENT LIABILITIES	14, 000, 437		<u> </u>		30.00
37. 00	Accounts payable	1, 347, 543	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	2, 005, 268		Ö	Ö	1
39. 00	Payroll taxes payable	2,000,200	Ŏ	0	o o	
40. 00	Notes and Loans payable (short term)		١	0	Ö	
41. 00	Deferred income		0	0	Ö	
42. 00	Accel erated payments			J	l o	42. 00
43. 00	Due to other funds		0	0	o	
44. 00	Other current liabilities	2, 895, 942	1	0	Ö	
45. 00	Total current liabilities (sum of lines 37 thru 44)	6, 248, 753	1	-1		
45.00	LONG TERM LIABILITIES	0, 240, 733	<u> </u>	<u> </u>		43.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	l o	1	Ö		
48. 00	Unsecured Loans	0	1	Ö		
49. 00	Other long term liabilities	313, 458	_	0	Ö	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	313, 458		0	Ö	1
51. 00	Total liabilities (sum of lines 45 and 50)	6, 562, 211		0		
31.00	CAPITAL ACCOUNTS	0, 302, 211	<u> </u>	<u> </u>	0	31.00
52. 00	General fund balance	8, 106, 228				52. 00
53. 00	Specific purpose fund	0, 100, 220	0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - restricted			0		55.00
				0		56.00
56. 00 57. 00	Governing body created - endowment fund balance			۷	0	1
57.00	Plant fund balance - invested in plant					
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	8, 106, 228	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	14, 668, 439	1	0		
00.00	[59]	14, 000, 439	ا	۷	ا	00.00
	1~~/	I	1	ı		I

| Period: | Worksheet G-1 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES ST ELIZABETH DEARBORN

Provider CCN: 15-0086

					То	12/31/2021	Date/Time Prep 5/23/2022 10:2	oared: 25 am
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		2, 206, 914			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8, 562, 299					2.00
3.00	Total (sum of line 1 and line 2)	_	10, 769, 213			0	_	3. 00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00					0		0	5. 00
6. 00 7. 00					0		0	6. 00 7. 00
8. 00					0		0	8. 00
9. 00					0		0	9. 00
10. 00	Total additions (sum of line 4-9)		0			0	Ĭ	10. 00
11. 00	Subtotal (line 3 plus line 10)		10, 769, 213			0		11. 00
12.00	OTHER	2, 662, 985			0		0	12.00
13.00		0			0		0	13.00
14.00		0			0		0	14.00
15. 00		0			0		0	15.00
16. 00		0			0		0	16. 00
17. 00	T	0	0 //0 005		0		0	17. 00
18.00	Total deductions (sum of lines 12-17)		2, 662, 985			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		8, 106, 228			U		19. 00
	paneer (Trite Trimings Trite 10)	Endowment Fund	PI ant	Fund				
	I 	6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
4.00	Additions (credit adjustments) (specify)		0		U			4. 00
5.00	Additions (credit adjustments) (specify)		0					5. 00
6.00			0					6. 00
7. 00			0					7. 00
8.00			0					8.00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12.00	OTHER		0					12.00
13.00			0					13. 00 14. 00
14. 00 15. 00			0					15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 12-17)	o	Ĭ		0			18. 00
19. 00	Fund balance at end of period per balance				O		ļ	19. 00
	sheet (line 11 minus line 18)							

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0086

			То	12/31/2021	Date/Time Prep 5/23/2022 10:2	
	Cost Center Description	I npati en	t	Outpati ent	Total	20 4
		1, 00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	21, 691,	558		21, 691, 558	1. 00
2.00	SUBPROVI DER - I PF		0		0	2. 00
3. 00	SUBPROVI DER - I RF		Ō		0	3. 00
4. 00	SUBPROVI DER				-	4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		0		0	7. 00
8.00	NURSING FACILITY		0		0	8. 00
9. 00	OTHER LONG TERM CARE		0		0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	21, 691,	558		21, 691, 558	
	Intensive Care Type Inpatient Hospital Services	, , , , ,			, , , , , , , , , , , , , , , , , , , ,	
11. 00	INTENSIVE CARE UNIT	17, 771,	042		17, 771, 042	11. 00
12.00	CORONARY CARE UNIT		0		0	12.00
13.00	BURN INTENSIVE CARE UNIT		0		0	13.00
14.00	SURGI CAL INTENSIVE CARE UNIT		0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of I	nes 17, 771,	042		17, 771, 042	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	39, 462,	600		39, 462, 600	17.00
18.00	Ancillary services	65, 354,	211	93, 274, 722	158, 628, 933	18.00
19.00	Outpati ent servi ces	9, 227,	152	22, 892, 681	32, 119, 833	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22.00	HOME HEALTH AGENCY			0	0	22.00
23.00	AMBULANCE SERVICES		0	0	0	23.00
24.00	CMHC			0	0	24.00
24. 10	CORF		0	0	0	24. 10
25.00	AMBULATORY SURGICAL CENTER (D. P.)		0	0	0	25.00
26.00	HOSPI CE		0	0	0	26.00
27.00	A&G AND OP RTN	1, 807,	880	2, 601, 106	4, 408, 194	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 115,851,	051	118, 768, 509	234, 619, 560	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			72, 470, 587		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)			0		36.00
37.00	DEDUCT (SPECIFY)		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
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		72, 470, 587		43.00
	to Wkst. G-3, line 4)	[

	Financial Systems	ST ELIZABETH DEARBORN		u of Form CMS-2	
TATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0086	Peri od: From 01/01/2021	Worksheet G-3	
			To 12/31/2021	Date/Time Pre	nareo
			10 12/31/2021	5/23/2022 10:	
				1. 00	
. 00	Total patient revenues (from Wkst. G-2, Part			234, 619, 560	
. 00	Less contractual allowances and discounts on	patients' accounts		154, 653, 626	
. 00	Net patient revenues (line 1 minus line 2)			79, 965, 934	
. 00	Less total operating expenses (from Wkst. G-			72, 470, 587	
. 00	Net income from service to patients (line 3	minus line 4)		7, 495, 347	5.
	OTHER INCOME				
00	Contributions, donations, bequests, etc			100	
00	Income from investments			0	
00	Revenues from telephone and other miscellane	ous communication services		0	
00	Revenue from television and radio service			0	
0. 00	Purchase di scounts			0	
1. 00	Rebates and refunds of expenses			0	
	Parking lot receipts			0	
3. 00	Revenue from Laundry and Linen service			0	13
1. 00	Revenue from meals sold to employees and gue	sts		254, 184	14
5. 00	Revenue from rental of living quarters			0	15
. 00	Revenue from sale of medical and surgical su	pplies to other than patients		0	16
. 00	Revenue from sale of drugs to other than pat	ients		344, 128	17
. 00	Revenue from sale of medical records and abs	tracts		1, 309	18
. 00	Tuition (fees, sale of textbooks, uniforms,	etc.)		0	19
. 00	Revenue from gifts, flowers, coffee shops, a	nd canteen		57, 746	20
. 00	Rental of vending machines			1, 445	21
	Rental of hospital space			29, 751	
	Governmental appropriations			0	
	OTHER REVENUE			378, 289	
	COVI D-19 PHE Fundi ng			0	1
	Total other income (sum of lines 6-24)			1, 066, 952	
	Total (line 5 plus line 25)			8, 562, 299	
	OTHER EXPENSES (SPECIFY)			0, 302, 277	
	Total other expenses (sum of line 27 and sub	scrints)		0	
	Net income (or loss) for the period (line 26			8, 562, 299	

0, 12002	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0086	Peri od:	Worksheet L	
			From 01/01/2021 To 12/31/2021	Parts I-III Date/Time Pre	pared:
		T: +1 o W/III	Hooni tol	5/23/2022 10:	25 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			785, 812	 1.00
1. 00	Model 4 BPCI Capital DRG other than outlier			785, 812	
2. 00	Capital DRG outlier payments			80, 229	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 0°
3.00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructions)	38. 98	
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)	the cum of lines 1 and 1 O	L columno 1 and	0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)	the sum of lines I and I.O	i, corumns i and	0	6.00
7. 00	Percentage of SSI recipient patient days to Medicare Part	A patient days (Worksheet E	E, part A line	0.00	7.00
	30) (see instructions)		•		
8. 00	Percentage of Medicaid patient days to total days (see ins	tructions)		0.00	
9.00	Sum of lines 7 and 8	>		0.00	
10. 00 11. 00	Allowable disproportionate share percentage (see instructi Disproportionate share adjustment (see instructions)	ons)		0.00	
12. 00	Total prospective capital payments (see instructions)			866, 041	
	Total prospective supriture paymonts (see this tractions)			3337 511	12.00
				1. 00	
4 00	PART II - PAYMENT UNDER REASONABLE COST				1 4 00
1. 00 2. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)		0	
3. 00	Total inpatient program capital cost (see Instructions	•)			
4.00	Capital cost payment factor (see instructions)			0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
					1 1 0
1. 00	Program inpatient capital costs (see instructions)			0] 1.00
2.00	Program inpatient capital costs for extraordinary circumst	ances (see instructions)		0	2. 0
2. 00 3. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2)	ances (see instructions)		0	2. 00 3. 00
2. 00 3. 00 4. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	ances (see instructions)		0 0 0.00	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	,		0 0 0.00 0	2. 0 3. 0 4. 0 5. 0
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	instructions)	(line 6)	0 0.00 0.00	2. 0 3. 0 4. 0 5. 0 6. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	instructions)	(line 6)	0 0 0.00 0	2. 0 3. 0 4. 0 5. 0 6. 0 7. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin	e instructions) wary circumstances (line 2 >	(line 6)	0 0.00 0 0.00 0.00	2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level t	e instructions) wary circumstances (line 2 x plicable) o capital payments (line 8	less line 9)	0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level ove	e instructions) wary circumstances (line 2 x plicable) o capital payments (line 8	less line 9)	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level t	e instructions) Pary circumstances (line 2 p Oplicable) O capital payments (line 8 Or capital payment (from pri	less line 9) or year	0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en	e instructions) ary circumstances (line 2 > uplicable) o capital payments (line 8 ar capital payment (from pri payments (line 10 plus line) ter the amount on this line	less line 9) or year ne 11)	0 0.00 0.00 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 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	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level ove	e instructions) ary circumstances (line 2 > uplicable) o capital payments (line 8 ar capital payment (from pri payments (line 10 plus line) ter the amount on this line	less line 9) or year ne 11)	0 0.00 0.00 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 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	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level ove (if line 12 is negative, enter the amount on this line)	e instructions) Hary circumstances (line 2) pplicable) O capital payments (line 8 Her capital payment (from pri payments (line 10 plus line Her the amount on this line Her capital payment for the 1	less line 9) or year ne 11)	0 0.00 0 0.00 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Program inpatient capital costs for extraordinary circumst Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level ove	e instructions) hary circumstances (line 2) plicable) o capital payments (line 8 er capital payment (from pri payments (line 10 plus line ter the amount on this line er capital payment for the fi	less line 9) or year ne 11)	0 0.00 0.00 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00