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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0149 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/30/2023 8: 21 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2023 8: 21 am use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [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] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(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 DEACONESS WOMENS HOSPITAL (15-0149) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 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	SI GNATURE STATEMENT	
1	Christina Ryan			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	Christina Ryan			2
3	Signatory Title	CEO			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-39, 763	11, 243	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-39, 763	11, 243	0	0	200. 00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

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.

Health Financial Systems DEACONESS WOMENS HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0149 Peri od: Worksheet S-2 From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/30/2023 8: 21 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 4199 GATEWAY BLVD 1.00 PO Box: 1.00 State: IN Zip Code: 47630-8940 County: WARRICK 2.00 City: NEWBURGH 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 DEACONESS WOMENS 150149 21780 05/03/2001 N 3.00 HOSPI TAL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 6 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Υ 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22.03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. 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.

58.00

Health Financial Systems DEACONESS WOMENS HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0149 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 8: 21 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IMF Direct GME IME Direct GME 2. 00 3. 00 4.00 5.00 1 00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 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 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions)

Teaching Hospitals that Claim Residents in Nonprovider Settings

Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

Health Financial Systems	DEACONE	SS WOMENS HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provi der CC		riod: com 01/01/2022 12/31/2022	Worksheet S-2 Part I Date/Time Prep 5/30/2023 8:2	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Yea			This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ry trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 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)			0.00	0.00		65. 00
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident B the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted		Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0. 000000	67. 00

Heal th	Financial Systems DEACONESS WOMENS	HOSPI TAL		ı	n Lie	u of Form	n CMS-2	2552-10
	· · · · · · · · · · · · · · · · · · ·	Provi der CC	N: 15-0149	Period: From 01/01/		Workshee Part I		
				To 12/31/		Date/Tir	me Pre	pared:
						5/30/202	23 8: 2	ı am
	D: LOWE : A	-D 400/F 40/	270 (4	10 0000)		1. 0	0	
68. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 For a cost reporting period beginning prior to October 1, 2022,				ur	N		68. 00
	MAC to apply the new DGME formula in accordance with the FY 202							
	(August 10, 2022)?							
					1. 00	2.00	3. 00	
70. 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or do	es it conta	in an IPF s	ubprovi der?	N			70. 00
74 00	Enter "Y" for yes or "N" for no.							74 00
71.00	If line 70 is yes: Column 1: Did the facility have an approved recent cost report filed on or before November 15, 2004? Enter						0	71. 00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train							
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter Column 3: If column 2 is Y, indicate which program year began of							
	(see instructions)		·					
75. 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or	does it co	ntain an IR	F	N			75. 00
77, 00	subprovi der? Enter "Y" for yes and "N" for no.	CME took!		. 464			0	77, 00
76. 00	If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2						U	76. 00
	no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co							
	indicate which program year began during this cost reporting pe							
						1.0	0	
	Long Term Care Hospital PPS					1.00	0	
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes ar			. 10 5		N		80.00
81. 00	Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no.	iii or the c	ost reporti	ng perioa? E	nter	N		81. 00
05.00	TEFRA Provi ders	·50.40 5 .	"""	"11"				
86.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE Did this facility establish a new Other subprovider (excluded upper subprovider)				no.	N		85. 00 86. 00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	•						
87.00	Is this hospital an extended neoplastic disease care hospital of 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified u	inder sectio	1		N		87. 00
				Approved		Number		
				Permane Adjustm		Appro Permar		
				(Y/N)		Adj ustm		
88. 00	Column 1: Is this hospital approved for a permanent adjustment	to the TEFR	A target	1.00		2. 0		88. 00
	amount per discharge? Enter "Y" for yes or "N" for no. If yes,	complete co	ol. 2 and li	ne				
	89. (see instructions) Column 2: Enter the number of approved permanent adjustments.							
				ne Effective	Date			
			NO.			Permar Adjusti		
						Amount		
			1. 00	2.00)	Di scha 3. 0		
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line			00				89. 00
	on which the per discharge permanent adjustment approval was be Column 2: Enter the effective date (i.e., the cost reporting pe							
	beginning date) for the permanent adjustment to the TEFRA targe							
	per discharge. Column 3: Enter the amount of the approved permanent adjustment	to the						
	TEFRA target amount per discharge.			V		XIX	,	
				1. 00	1	2.0		
00.00	Title V and XIX Services		IIVII C					00.00
90. 00	Does this facility have title V and/or XIX inpatient hospital syes or "N" for no in the applicable column.	services? En	iter "Y" for	N		Y		90. 00
91. 00	1.00 s this hospital reimbursed for title V and/or XIX through the cost report either in N							91. 00
92. 00	full or in part? Enter "Y" for yes or "N" for no in the applica Are title XIX NF patients occupying title XVIII SNF beds (dual					N		92. 00
	instructions) Enter "Y" for yes or "N" for no in the applicable	e column.		B 1				
93. 00	Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.	title v and	I ALA? ENTER	N		N		93. 00
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and	I "N" for no	in the	N		N		94. 00
95. 00	applicable column. If line 94 is "Y", enter the reduction percentage in the applic	able column	l.	0.00		0.0	0	95. 00
96. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes or			N		N		96. 00
97. 00	applicable column. If line 96 is "Y", enter the reduction percentage in the applic	able column	l.	0. 00		0.00	0	97. 00
				•				

116. 00

117. 00

118. 00

Ν

"N" for no.

116.00 Is this facility classified as a referral center? Enter "Y" for yes or

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00 s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems DEACONESS	WOMENS HOSPITAL		In Lie	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CO		eri od:	Worksheet S	
			rom 01/01/2022 o 12/31/2022	Part I Date/Time F	repared:
		Premi ums	Losses	5/30/2023 8 Insurance	
		1. 00	2. 00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:		370, 822	2 16, 011		0 118. 01
			1. 00	2.00	
118.02 Are mal practice premiums and paid losses reported in a Administrative and General? If yes, submit supporting			N		118. 02
and amounts contained therein.	scriedure ir string co	ost centers			
119. 00 DO NOT USE THIS LINE	Hal d Hammi and more		N.	N.	119.00
120.00 Is this a SCH or EACH that qualifies for the Outpatient §3121 and applicable amendments? (see instructions) Ent			N	N	120. 00
"N" for no. Is this a rural hospital with < 100 beds th	at qualifies for th	he Outpatient			
Hold Harmless provision in ACA §3121 and applicable ame Enter in column 2, "Y" for yes or "N" for no.	ndments? (see insti	ructions)			
121.00 Did this facility incur and report costs for high cost	implantable devices	s charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no.	c dofined in \$1002	(w) (2) of the	N		122 00
122.00 Does the cost report contain healthcare related taxes a Act?Enter "Y" for yes or "N" for no in column 1. If col			IN		122. 00
the Worksheet A line number where these taxes are inclu				.,	100.00
123.00 Did the facility and/or its subproviders (if applicable services, e.g., legal, accounting, tax preparation, boo			Y	Y	123. 00
management/consulting services, from an unrelated organ	1 3 1 3				
for yes or "N" for no. If column 1 is "Y", were the majority of the expenses,	i a greater than	50% of total			
professional services expenses, for services purchased					
located in a CBSA outside of the main hospital CBSA? In	column 2, enter "	Y" for yes or			
"N" for no. Certified Transplant Center Information					
125.00 Does this facility operate a Medicare-certified transpl		"Y" for yes	N		125. 00
and "N" for no. If yes, enter certification date(s) (mm 126.00 If this is a Medicare-certified kidney transplant progr		ification date			126. 00
in column 1 and termination date, if applicable, in col	umn 2.				120.00
127.00 f this is a Medicare-certified heart transplant progra in column 1 and termination date, if applicable, in col		fication date			127. 00
128.00 f this is a Medicare-certified liver transplant progra		fication date			128. 00
in column 1 and termination date, if applicable, in col					100.00
129.00 f this is a Medicare-certified lung transplant program in column 1 and termination date, if applicable, in col	, enter the certifi umn 2.	ication date			129. 00
130.00 If this is a Medicare-certified pancreas transplant pro	gram, enter the ce	rti fi cati on			130. 00
date in column 1 and termination date, if applicable, i 131.00 f this is a Medicare-certified intestinal transplant p		certification			131. 00
date in column 1 and termination date, if applicable, i	n column 2.				
132.00 f this is a Medicare-certified islet transplant progra in column 1 and termination date, if applicable, in col		fication date			132. 00
133. 00 Removed and reserved	uiiii Z.				133. 00
134.00 If this is a hospital-based organ procurement organizat		he OPO number			134. 00
in column 1 and termination date, if applicable, in col All Providers	ullil1 2.				
140.00 Are there any related organization or home office costs			Y	HB0778	140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1 are claimed, enter in column 2 the home office chain nu					
1.00	2. 00		3. 00		
If this facility is part of a chain organization, enter home office and enter the home office contractor name a		•	me and address	of the	
141. 00 Name: DEACONESS HEALTH SYSTEM Contractor's Nam			's Number: 0800	11	141. 00
142.00 Street: 600 MARY ST PO Box:	LNI	7: 01-	4774	0	142.00
143.00 Ci ty: EVANSVI LLE State:	I N	Zi p Code:	4771		143. 00
				1. 00	
144.00 Are provider based physicians' costs included in Worksh	eet A?			Y	144. 00
			1. 00	2. 00	
145.00 If costs for renal services are claimed on Wkst. A, lin					145. 00
inpatient services only? Enter "Y" for yes or "N" for no, does the dialysis facility include Medicare utiliza					
period? Enter "Y" for yes or "N" for no in column 2.					
146.00 Has the cost allocation methodology changed from the pr Enter "Y" for yes or "N" for no in column 1. (See CMS P			N		146. 00
yes, enter the approval date (mm/dd/yyyy) in column 2.	ub. 13-2, спартег 4	-0, 34020 <i>)</i> II			

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			HOSPITAL Provi der CC	N: 15-0149	Peri		u of Form CMS Worksheet S-	
					From	01/01/2022	Part I	
					То	12/31/2022	Date/Time Pr 5/30/2023 8:	
							373072023 0.	21 (1111
							1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for yes	or "N" for	no.			N	147. 0
148.00 Was there a change in the order of							N	148. 0
149.00 Was there a change to the simplifi	ed cost finding method	od? Ente	r "Y" for ye	s or "N"	for no.		N	149. 0
			Part A	Part		Title V	Title XIX	
<u> </u>			1.00	2.00		3.00	4.00	
Does this facility contain a provi								
or charges? Enter "Y" for yes or '	N for no for each c	omponent	N Part A	and Part	B. (See	N 42 CFR 9413	N N	155. 0
56. 00 Subprovi der – TPF			N	N		N	N	156. 0
57. 00 Subprovi der - IRF			N I	N		N	N N	157. 0
58. 00 SUBPROVI DER								158. 0
59. 00 SNF			N	N		N	N	159. 0
160.00 HOME HEALTH AGENCY			N	N	1	N	N	160. 0
61. 00 CMHC				N		N	N	161. 0
							1.00	
Multicampus						2021		4.5.0
165.00 Is this hospital part of a Multica	ampus hospital that h	as one o	or more campu	ses in di	fferent	CBSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	Name		County	State	Zip Co	de CBSA	FTE/Campus	
	0		1. 00	2.00	3.00		5. 00	\dashv
166.00 f line 165 is yes, for each	<u> </u>			1 2.00	0.00	11.00		0 166. 0
campus enter the name in column								
O, county in column 1, state in								
column 2, zip code in column 3,								
CBSA in column 4, FTE/Campus in								
column 5 (see instructions)								
							1.00	-
Health Information Technology (HI	() incentive in the A	meri can	Recovery and	l Reinvest	ment Ac	·†	1.00	
67.00 Is this provider a meaningful user						, .	Υ	167. 0
168.00 If this provider is a CAH (line 10						ter the	-	168. 0
reasonable cost incurred for the H	HT assets (see instr	uctions)	•					
168.01 If this provider is a CAH and is m	not a meaningful user					ardshi p		168. 0
					nc)			
exception under §413.70(a)(6)(ii)	P Enter "Y" for yes o							
169.00 f this provider is a meaningful ເ	P Enter "Y" for yes o user (line 167 is "Y")					, enter the	9.9	79 169. U
	P Enter "Y" for yes o user (line 167 is "Y")							79 169. 0
169.00 f this provider is a meaningful ເ	P Enter "Y" for yes o user (line 167 is "Y")					Begi nni ng	Endi ng	79 169. 0
169.00 If this provider is a meaningful transition factor. (see instruction	P Enter "Y" for yes on user (line 167 is "Y") ons)) and is	not a CAH (line 105				
transition factor. (see instruction) 170.00 Enter in columns 1 and 2 the EHR I	P Enter "Y" for yes on user (line 167 is "Y") ons)) and is	not a CAH (line 105		Begi nni ng	Endi ng	
169.00 If this provider is a meaningful transition factor. (see instruction	P Enter "Y" for yes on user (line 167 is "Y") ons)) and is	not a CAH (line 105		Begi nni ng	Endi ng	
169.00 If this provider is a meaningful of transition factor. (see instruction factor.) 170.00 Enter in columns 1 and 2 the EHR is period respectively (mm/dd/yyyy)	P Enter "Y" for yes on user (line 167 is "Y") ons) Deginning date and end) and is	e for the re	line 105		Begi nni ng 1. 00	Endi ng 2. 00	170. 0
171.00 If line 167 is "Y", does this provider is a meaningful of transition factor. (see instruction factor. (see instruction factor.) 170.00 Enter in columns 1 and 2 the EHR is period respectively (mm/dd/yyyy)	P Enter "Y" for yes or user (line 167 is "Y") ons) Deginning date and encoder the control of th) and is	e for the re	porting	is "N")	Begi nni ng 1. 00	Endi ng 2. 00	
69.00 If this provider is a meaningful of transition factor. (see instruction factor.) 70.00 Enter in columns 1 and 2 the EHR is period respectively (mm/dd/yyyy)	P Enter "Y" for yes on user (line 167 is "Y") ons) Deginning date and end Additional order of the control of) and is ding dat or indiv	e for the re	porting led in . 6? Ente	is "N")	Begi nni ng 1. 00	Endi ng 2. 00	170. 0

Heal th	Financial Systems DEACONESS WOME	ENS HOSPITAL		In Li∈	eu of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0149	Peri od:	Worksheet S-2	
				From 01/01/2022 To 12/31/2022		epared:
				Y/N	5/30/2023 8: 2 Date	21 am
				1.00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	sponses. Ent	er all dates in t	the	
	COMPLETED BY ALL HOSPITALS					
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	, boginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in c					1.00
			Y/N 1.00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare P	rogram? If	N N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in colum					
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includin	a management	Y			3. 00
	contracts, with individuals or entities (e.g., chain home of	offices, drug				
	or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Dublic	Υ	A		4. 00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C" f		ľ	A		4.00
	or "R" for Reviewed. Submit complete copy or enter date ava	ilable in				
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	erent from	Y			5. 00
	those on the filed financial statements? If yes, submit rec) ((t)		
				1. 00	Legal Oper. 2.00	
	Approved Educational Activities				=: 55	
6. 00	Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	2: If yes, is	the provide	r N		6. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in	structions.		N		7. 00
8. 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.	ed and/or renew	ed during the	e N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved	graduate medic	al education	N		9. 00
10.00	program in the current cost report? If yes, see instruction		ha aurrant	N		10.00
10. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.	n renewed in t	ne current	IN		10.00
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
	To a constant of the constant				1.00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions		Y	12. 00
	If line 12 is yes, did the provider's bad debt collection p			ost reporting	N N	13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura	unco amounte we	ivod2 lf voc	500	N N	14. 00
14.00	instructions.	ince amounts wa	iiveurii yes	, see	IN IN	14.00
15 00	Bed Complement Did total beds available change from the prior cost reporti	ng pori ad2 LE	voc. coo !	tructions	NI NI	15 00
15.00	bid total beds available change from the pirol cost reporti		t A		N N	15. 00
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3. 00	4.00	
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Υ	05/15/2023	Υ	05/15/2023	17. 00
	either column 1 or 3 is yes, enter the paid-through date					
10.00	in columns 2 and 4. (see instructions)	.,				40.00
18. 00	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
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
17.00	Report data for corrections of other PS&R Report	. 4		14		17.00
	information? If yes, see instructions.					I

	Financial Systems DEACONESS WOMEN				u of Form CMS-		
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	JN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/30/2023 8:2	pared:	
		Descri	pti on	Y/N	Y/N		
		()	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	noport data for other. Beserve the other day astiments.	Y/N	Date	Y/N	Date		
		1. 00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 0	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	T CHILDRENS H	OSPI TALS)		1.00		
	Capital Related Cost		,				
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 0	
23. 00	Have changes occurred in the Medicare depreciation expense d reporting period? If yes, see instructions.	iue to apprais	ais made dui	ring the cost		23. 0	
24. 00	Were new leases and/or amendments to existing leases entered If yes, see instructions	eporting period?		24. 0			
25. 00	Have there been new capitalized leases entered into during t	he cost repor	ting periodí	? If yes, see		25. 0	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	cost roper+:	na nori oda l	If yes soo		26. 0	
20.00	instructions.	cost reporti	ng periou? I	i yes, see		20.0	
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? It	f yes, submit		27. 0	
28. 00	<u>Interest Expense</u> Were new loans, mortgage agreements or letters of credit ent	ered into dur	ing the cost	t reporting		28. 0	
29. 00							
30. 00							
31. 00	instructions.						
32. 00	<u>Purchased Services</u> Have changes or new agreements occurred in patient care services? If yes, see instruc		d through co	ontractual		32.0	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.		g to competi	tive bidding? If		33. C	
	Provi der-Based Physi ci ans	· · · · · · · · · · · · · · · · · · ·				١	
34. 00	Were services furnished at the provider facility under an ar If yes, see instructions.	rangement wit	h provider-t	based physicians?		34.0	
35. 00	If line 34 is yes, were there new agreements or amended exis physicians during the cost reporting period? If yes, see ins		ts with the	provi der-based		35. C	
				Y/N	Date		
	Homo Offi co Costs			1. 00	2. 00		
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36. 0	
	If line 36 is yes, has a home office cost statement been pre	pared by the	home office			37. 0	
88. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home offi	ce different	from that of	f Y	09/30/2022	38. 0	
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other	of the home o	ffi ce.			39.0	
10. 00	see instructions. If line 36 is yes, did the provider render services to the h	ome office?	If yes, see	N		40.0	
	instructions.						
		1.	00	2.	00	1	
	Cost Report Preparer Contact Information						
1.00	held by the cost report preparer in columns 1, 2, and 3,	ANI ELLE		METZGER-CUNDI F	F	41. C	
	respectively. Enter the employer/company name of the cost report D	EACONESS HOSP			42. 0		
12. 00							

Health Financial Systems DEACONESS WO	MENS HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0149	Peri od: From 01/01/2022		
		To 12/31/2022	Date/Time Pre 5/30/2023 8:2	
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	REIMBURSEMENT ANALYST			41.00
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cost				43.00
report preparer in columns 1 and 2, respectively.				

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | Part | | Part

					1	0 12/31/2022	5/30/2023 8:2	
							I/P Days / 0/P	ı dili
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	'	Li ne No.			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		50	18, 250	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			50	18, 250	0. 00	0	7. 00
0.00	beds) (see instructions)	04.00	ŀ	0.4	0.7/0	0.00		0.00
8.00	INTENSIVE CARE UNIT	31. 00	ŀ	24	8, 760	0. 00	0	8. 00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43. 00	ŀ				o	12. 00 13. 00
14. 00		43.00	ŀ	74	27 010	0.00	0	14. 00
15. 00	Total (see instructions) CAH visits		ŀ	/4	27, 010	0. 00	0	15. 00
16. 00	SUBPROVIDER - IPF		ŀ				U	16. 00
17. 00	SUBPROVIDER - IPF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY		ŀ					19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE		ŀ					21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		ŀ					23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC		İ					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			74				27. 00
28. 00	Observation Bed Days		İ				0	28. 00
29.00	Ambul ance Tri ps							29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			o	0			32.00
32. 01	Total ancillary labor & delivery room			ĺ				32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 15-0149

0

0

34.00

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/30/2023 8:21 am Full Time Equivalents I/P Days / O/P Visits / Trips Component Title XVIII Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 8, 226 1.00 126 550 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) 39 8, 837 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 0 4.00 0 0 Hospital Adults & Peds. Swing Bed SNF 5.00 C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 126 550 8, 226 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 1,761 9.386 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 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 462 5, 303 13.00 Total (see instructions) 575.92 14.00 126 2,773 22, 915 0.00 14.00 15.00 CAH visits 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19 00 SKILLED NURSING FACILITY 19 00 20.00 NURSING FACILITY 20.00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23 00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 0 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 575.92 27.00 Observation Bed Days 1, 922 28.00 48 28.00 29 00 Ambul ance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 0 Labor & delivery days (see instructions) 0 32.00 32.00 160 390 32. 01 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 33.01 33.01

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part

				10	0 12/31/2022	5/30/2023 8:2	
		Full Time		Di sch	arges	7 07 007 2020 012	
		Equi val ents			_		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA			1			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	50	269	3, 628	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)			15	1, 249		2.00
3.00	HMO IPF Subprovider			13	1, 247		3.00
4. 00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				ď		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
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	0	50	269	3, 628	14. 00
15.00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						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 29. 00	Observation Bed Days						28. 00 29. 00
30. 00	Ambulance Trips Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Histruction)						31.00
31.00	Labor & delivery days (see instructions)						31.00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. U1	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			Ö			33. 01
	Temporary Expansion COVID-19 PHE Acute Care				ļ		34. 00
		' '			'		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0149

Peri od: Worksheet S-3 From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/30/2023 8:21 am Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col (from Wkst. Salaries in col. 5) A-6)3) col. 4 2.00 5.00 6. 00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 200. 00 52, 561, 403 -459, 372 52, 102, 031 1, 197, 908. 96 43. 49 1.00 Total salaries (see instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0.00 0.00 3.00 4.00 Physician-Part A -125,000 7, 820. 60 186.87 1, 336, 430 1, 461, 430 4.00 Administrative 4.01 Physicians - Part A - Teaching 0.00 0.00 4.01 Physician and Non 7, 763, 230 7, 763, 230 48, 052. 10 161. 56 5.00 5.00 Physician-Part B Non-physician-Part B for 6.00 O 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces 7.00 Interns & residents (in an 21.00 0 0.00 0.00 7.00 approved program) 7.01 Contracted interns and 0.00 0.00 7.01 residents (in an approved programs) Home office and/or related 8.00 0 0.00 0.00 8.00 organization personnel 9.00 44.00 0.00 0.00 9.00 4, 925, 569 5, 507, 289 10.00 Excluded area salaries (see 581, 720 103, 888. 38 53.01 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 0 0 0.00 0.00 11.00 0 0.00 12.00 Contract labor: Top level 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 1, 776, 111 1, 776, 111 8, 511. 30 208. 68 13.00 A - Administrative Home office and/or related 14.00 0.00 0.00 14.00 organization salaries and wage-related costs 78, 440. 00 37.59 14.01 Home office salaries 2, 948, 806 2, 948, 806 14.01 14.02 Related organization salaries 0.00 0.00 14.02 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative Home office and Contract 0 0.00 0.00 16.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 Teachi ng 16. 02 Home office contract C 0.00 0.00 16.02 Physicians <u>Part A - Teaching</u> WAGE-RELATED COSTS 10, 258, 016 10, 258, 016 17.00 Wage-related costs (core) (see 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 19.00 Excluded areas 1, 514, 785 1, 514, 785 19.00 Non-physician anesthetist Part 20.00 20.00 21.00 Non-physician anesthetist Part 21.00 22.00 Physician Part A -22.00 183, 116 183, 116 Administrative 22.01 Physician Part A - Teaching 22 01 23.00 Physician Part B 855, 218 855, 218 23.00 24.00 Wage-related costs (RHC/FQHC) 24.00 Interns & residents (in an 25.00 0 C 0 25.00 approved program) 25.50 Home office wage-related 849, 973 C 849, 973 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) Home office: Physician Part A 0 25, 52 25. 52 - Administrative wage-related (core)

					T	12/31/2022		
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	5/30/2023 8: 2 Average Hourly	ı am
		Number		on of Salaries			Wage (col. 4 ÷	
		Number	Reported	(from Wkst.	(col. 2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col . 4	(01. 3)	
		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)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	381, 561	12, 563	· ·	·		26.00
27. 00	Administrative & General	5. 00	7, 327, 761	-782, 485	6, 545, 276	·	1	
28. 00	Administrative & General under		188, 519	0	188, 519	537. 04	351. 03	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	448, 376	-4, 148	444, 228	·		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32.00	Housekeepi ng	9. 00	1, 026, 409	-8, 801	1, 017, 608	·		
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	0	236, 696	236, 696	9, 402. 10	25. 17	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	1, 168, 259	-616, 586	551, 673	31, 770. 94		36.00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00		37.00
38. 00	Nursing Administration	13. 00	0	0	0	0.00	0. 00	38.00
39. 00	Central Services and Supply	14. 00	145, 595	-7, 066	138, 529	5, 785. 39	23. 94	39.00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	458, 755	-1, 373	457, 382	19, 188. 18	23. 84	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	490, 354	-5, 888	484, 466	14, 516. 79	33. 37	42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43.00

					11	0 12/31/2022	5/30/2023 8: 2	
		N/ 1 1 1 A	Λ .	D 1 1 C 11	A 11 1 1	D 1 1 11		
		Worksheet A		Recl assi fi cati	,		Average Hourly	
		Line Number	Reported	on of Salaries		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		44, 986, 692	-459, 372	44, 527, 320	1, 150, 393. 90	38. 71	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 925, 569	581, 720	5, 507, 289	103, 888. 38	53. 01	2.00
	instructions)							
3.00	Subtotal salaries (line 1		40, 061, 123	-1, 041, 092	39, 020, 031	1, 046, 505. 52	37. 29	3.00
	minus line 2)							
4.00	Subtotal other wages & related		4, 724, 917	0	4, 724, 917	86, 951. 30	54. 34	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		11, 291, 105	0	11, 291, 105	0.00	28. 94	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		56, 077, 145	-1, 041, 092	55, 036, 053	1, 133, 456. 82	48. 56	6. 00
7.00	Total overhead cost (see		11, 635, 589	-1, 177, 088	10, 458, 501	314, 673. 31	33. 24	7. 00
	instructions)							

Health Financial Systems	DEACONESS WOMENS HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0149	Peri od: Worksheet S-3
		From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared:

	10 12/31/2022	5/30/2023 8:2	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 161, 637	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)	6, 336, 260	8. 02
8. 03	Heal th Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	287, 677	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	39, 460	
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1, 010, 383	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	169, 123	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion) TAXES		l
17. 00	FICA-Employers Portion Only	3, 563, 576	17. 00
18. 00	Medicare Taxes - Employers Portion Only	3, 303, 370	18.00
19. 00	Unemployment Insurance		19.00
20. 00	State or Federal Unemployment Taxes	80, 336	20.00
20.00	OTHER	00, 330	20.00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	57, 678	21. 00
21.00	instructions))	37,070	21.00
22. 00	Day Care Cost and Allowances	32, 556	22. 00
23. 00	Tuition Reimbursement	72, 450	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	12, 811, 136	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	DEACONESS WOMENS HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/30/2023 8:21 am
Cost Center Description		Contract Labor	Benefit Cost

			5/30/2023 8: 2	1 am
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	12, 811, 136	1.00
2.00	Hospi tal	0	12, 811, 136	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18. 00	Other	0	0	18. 00

10321	· · · · · · · · · · · · · · · · · · ·	<u>SPITAL</u> Tovider CCN: 15-014		eri od:	u of Form CMS-2 Worksheet S-10	
			F	rom 01/01/2022		
				o 12/31/2022	Date/Time Prep 5/30/2023 8: 2	
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line 202 co	ol umn	8)	0. 438971	1.0
. 00	Medicaid (see instructions for each line) Net revenue from Medicaid				17, 478, 619	2.0
. 00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental	l payments from Me	edi cai	d?	N	4.0
. 00	If line 4 is no, then enter DSH and/or supplemental payments from	m Medicaid			6, 381, 317	
. 00	Medi cai d charges				62, 479, 500	
7. 00 8. 00	Medicaid cost (line 1 times line 6)	ino 7 minus sum ot	Flino	c 2 and E. if	27, 426, 689	
. 00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)	ine / minus sum oi	rine	s z anu s; ii	3, 566, 753	8.0
	Children's Health Insurance Program (CHIP) (see instructions for	each line)				
. 00	Net revenue from stand-alone CHIP				0	9.0
0. 00	Stand-alone CHIP charges				0	
1.00	Stand-alone CHIP cost (line 1 times line 10)		0 : 6		0	11.0
2. 00	Difference between net revenue and costs for stand-alone CHIP (lienter zero)	ine ii minus iine	9; 11	< zero tnen	0	12.0
	Other state or local government indigent care program (see instru	uctions for each I	i ne)			
3. 00	Net revenue from state or local indigent care program (Not include				0	13.0
4. 00	Charges for patients covered under state or local indigent care p	program (Not inclι	uded i	n lines 6 or	0	14.0
	10)					45.0
5. 00 6. 00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indice	aont cara program	(Li no	1E minus Lino	0	
0.00	13; if < zero then enter zero)	gent care program	(TITIE	15 IIII IIUS TTIIE	U	10.0
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/local i	ndi ge	nt care program	is (see	
7. 00	Private grants, donations, or endowment income restricted to fund	ding charity care			0	17.0
8. 00	Government grants, appropriations or transfers for support of hos	•			0	18. 0
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)	indigent care proq	grams	(sum of lines	3, 566, 753	19.0
	, o, -12 and -19	Uni nsu	ıred	Insured	Total (col. 1	
		pati er		pati ents	+ col . 2)	
	Uncompanyed days (ass instructions for each line)	1.00	0	2. 00	3. 00	
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil	Lity 68	82, 390	173, 929	856, 319	20.00
.0. 00	(see instructions)		02, 070	170,727	000, 017	20.0
1. 00	Cost of patients approved for charity care and uninsured discoun-	ts (see 2º	99, 549	173, 929	473, 478	21.0
	instructions)	55				00.0
22. 00	Payments received from patients for amounts previously written of charity care	rr as	0	0	0	22. 00
23. 00	Cost of charity care (line 21 minus line 22)	20	99, 549	173, 929	473, 478	23. 0
		<u>'</u>				
	T				1.00	
4. 00	Does the amount on line 20 column 2, include charges for patient		ngth o	f stay limit	N	24. 0
5. 00	imposed on patients covered by Medicaid or other indigent care pulfine 24 is yes, enter the charges for patient days beyond the		ogram'	s length of	0	25. 0
6. 00	stay limit Total bad debt expense for the entire hospital complex (see insti	ructions)			2, 352, 540	26. 0
7. 00	Medicare reimbursable bad debts for the entire hospital complex)		25, 737	ı
	Medicare allowable bad debts for the entire hospital complex (see	,	,		39, 594	
7.01	Non-Medicare bad debt expense (see instructions)	•			2, 312, 946	ı
	Inon-medicale bad debt expense (see instructions)					
27. 01 28. 00 29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expen	nse (see instructi	ions)		1, 029, 173	
28. 00 29. 00 30. 00	· · · ·	•	i ons)		1, 029, 173 1, 502, 651 5, 069, 404	30. 0

Health Financial Systems	DEACONESS WOMEN	S HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC		Peri od:	Worksheet A	
				From 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
					5/30/2023 8: 2	
Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Reclassified	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +- col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT		0	(5, 152, 736	5, 152, 736	1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	(2, 870, 568	2, 870, 568	2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	381, 561	11, 760, 255	12, 141, 816	12, 563	12, 154, 379	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	7, 327, 761	19, 147, 817	26, 475, 578		20, 328, 399	5. 00
7. 00 00700 OPERATION OF PLANT	448, 376	1, 729, 882	2, 178, 258		2, 062, 580	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	0	1 210 212	2 244 (2)		982, 419	8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	1, 026, 409	1, 318, 213	2, 344, 622	2 -1, 007, 268 368, 585	1, 337, 354 368, 585	9. 00 10. 00
11. 00 01100 CAFETERI A	1, 168, 259	671, 380	1, 839, 639		859, 070	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 100, 237	071,300	1,037,03	700, 307	037,070	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	145, 595	73, 627	219, 222	-19, 934	199, 288	14. 00
15. 00 01500 PHARMACY	0	4, 262, 424	4, 262, 424		1, 349, 527	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	458, 755	50, 839	509, 594	0	509, 594	16. 00
17. 00 01700 SOCIAL SERVICE	490, 354	11, 879	502, 233	-203	502, 030	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	9, 913, 699	1, 032, 116			6, 219, 084	30.00
31. 00 03100 I NTENSI VE CARE UNIT	8, 728, 302	1, 821, 440			10, 136, 398	31.00
43. 00 04300 NURSERY	1, 069, 538	145, 129	1, 214, 667	-102, 162	1, 112, 505	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 0PERATING ROOM	4, 573, 258	9, 772, 605	14, 345, 863	-9, 181, 065	5, 164, 798	50. 00
51. 00 05100 RECOVERY ROOM	654, 835	11, 200			657, 194	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	054, 055	11, 200	(4, 111, 901	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 492, 312	1, 296, 497	3, 788, 809		2, 950, 274	54.00
57. 00 05700 CT SCAN	0	0	(107, 371	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	(108, 603	108, 603	58. 00
60. 00 06000 LABORATORY	0	3, 367, 476	3, 367, 476		3, 310, 351	60. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	(38, 491	38, 491	63. 00
65. 00 06500 RESPI RATORY THERAPY	1, 537, 563	675, 087	2, 212, 650		1, 910, 203	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	2, 959, 203	2, 959, 203		2, 769, 587	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0		-, ,	3, 749, 203	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		678, 641 2, 820, 314	678, 641 2, 820, 314	72.00
77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON	o	0			2, 020, 314	77. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u>~</u> _		,		77.00
90. 00 09000 CLI NI C	5, 256, 147	974, 269	6, 230, 416	-196, 333	6, 034, 083	90.00
91. 00 09100 EMERGENCY	1, 963, 110	741, 928	2, 705, 038	5, 500, 535	8, 205, 573	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	(0	0	102. 00
SPECIAL PURPOSE COST CENTERS	47 (05 004	(4 000 0//	400 450 400		400 7/4 400	440.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	47, 635, 834	61, 823, 266	109, 459, 100	-697, 997	108, 761, 103	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	٥	0	(572, 713	572, 713	100 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	4, 127, 290	646, 422	4, 773, 712		4, 895, 332	
194. 00 07950 OTHER DEPARTMENTS	7, 127, 270 N	040, 422 N	7,773,712) 121, 020		194. 00
194. 01 07951 WOMEN' S RESOURCES	350, 205	182, 205	532, 410	1 1	526, 042	
194. 02 07952 MARKETI NG	254, 081	465, 366	719, 447		733, 034	
194. 03 07953 REPRODUCTI VE MEDICI NE	0	710	710		3, 123	194. 03
194.04 07954 CENTER FOR HEALING ARTS	193, 993	134, 572	328, 565		322, 597	194. 04
200.00 TOTAL (SUM OF LINES 118 through 199)	52, 561, 403	63, 252, 541	115, 813, 944	o	115, 813, 944	

| Period: | Worksheet A | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/30/2023 8: 21 am |

			5/30/2023 8: 2	<u>1 am</u>
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT	52, 271	5, 205, 007		1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	0	2, 870, 568		2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	3, 700, 325	15, 854, 704		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-1, 180, 758	19, 147, 641		5. 00
7.00 O0700 OPERATION OF PLANT	1, 456, 777	3, 519, 357		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	982, 419		8. 00
9. 00 00900 HOUSEKEEPI NG	0	1, 337, 354		9. 00
10. 00 01000 DI ETARY	0	368, 585		10.00
11. 00 01100 CAFETERI A	-284, 708	574, 362		11. 00
13.00 01300 NURSING ADMINISTRATION	0	0		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	344, 429	543, 717		14.00
15. 00 01500 PHARMACY	862, 639	2, 212, 166		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	33, 736	543, 330		16. 00
17. 00 01700 SOCI AL SERVI CE	-121	501, 909		17. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	6, 219, 084		30.00
31.00 03100 INTENSIVE CARE UNIT	-3, 605, 281	6, 531, 117		31.00
43. 00 04300 NURSERY	0	1, 112, 505		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	-68, 139	5, 096, 659		50. 00
51.00 05100 RECOVERY ROOM	0	657, 194		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	4, 111, 901		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-26, 939	2, 923, 335		54. 00
57. 00 05700 CT SCAN	0	107, 371		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	108, 603		58. 00
60. 00 06000 LABORATORY	-12,000	3, 298, 351		60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	38, 491		63.00
65. 00 06500 RESPIRATORY THERAPY	o	1, 910, 203		65. 00
66. 00 06600 PHYSI CAL THERAPY	-1, 221, 959	1, 547, 628		66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	, , ,	3, 749, 203		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	678, 641		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	2, 820, 314		73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	o	0		77. 00
OUTPATIENT SERVICE COST CENTERS	-1			
90. 00 09000 CLI NI C	-4, 029, 281	2, 004, 802		90.00
91. 00 09100 EMERGENCY	-5, 593, 540	2, 612, 033		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,0,0,010	2,0.2,000		92.00
OTHER REIMBURSABLE COST CENTERS				72.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-9, 572, 549	99, 188, 554		118. 00
NONREI MBURSABLE COST CENTERS	7, 372, 347	77, 100, 334		1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-189, 806	382, 907		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	-107, 000	4, 895, 332		192. 00
194. 00 07950 OTHER DEPARTMENTS	0	4, 075, 552		194. 00
194. 01 07950 OTHER DEPARTMENTS 194. 01 07951 WOMEN' S RESOURCES	-54, 333	471, 709		194. 00
194. 01 07951 WOMEN S RESOURCES 194. 02 07952 MARKETI NG	-54, 333 0	733, 034		194. 01
194. 02 07952 MARKETTING 194. 03 07953 REPRODUCTI VE MEDI CI NE	ol Ol	3, 123		194. 02
194. 04 07954 CENTER FOR HEALING ARTS	-150, 341	172, 256		194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	-150, 341 -9, 967, 029			200. 00
200.00 TOTAL (SOW OF LINES THE HITOUGH 199)	-7, 701, 029	105, 846, 915		₁ 200.00

In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2022 To 12/31/2022

Date/Time Prepared: 5/30/2023 8:21 am

					5/30/2023 8:2	21 am
	0+ 0+	Increases	C-1	0+1		
	Cost Center 2.00	Li ne # 3.00	Sal ary	Other 5 00		
	A - LEASEHOLD I MPROVEMENTS	3.00	4. 00	5. 00		
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	605, 944		1.00
2.00	CAL REE COSTS-BEDG & TTAT	0.00	0	003, 744		2. 00
3.00		0.00	0	0		3. 00
4. 00		0.00	0	0		4. 00
5. 00		0.00	o	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	0	0		11.00
12. 00		0.00	0	0		12. 00
12.00			— — — 0	605, 944		12.00
	B - EQUIPMENT DEPRECIATION		<u> </u>	003, 744		1
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 616, 286		1.00
2.00	CAL REE COSTS-WIVEEL EQUIT	0.00	0	1, 010, 200		2. 00
3.00		0.00	0	0		3. 00
4. 00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00		0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12.00
13. 00		0.00	0	0		13. 00
14. 00			0	0		
		0.00		0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17. 00		0.00	0	~		17. 00
18.00		0.00	0	0		18.00
19. 00		0.00	0	0		19. 00
	C - INTEREST EXPENSE		U	1, 616, 286		-
1 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	234, 569		1 00
1. 00 2. 00	REPRODUCTIVE MEDICINE	194. 03	0	2, 413		1. 00 2. 00
	REPRODUCTIVE MEDICINE		i			3. 00
3. 00		0.00	o	0		3.00
	D - EQUIPMENT LEASES		υ	236, 982		1
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	846, 820		1.00
2. 00	CAP REL CUSTS-WVBLE EQUIP	0.00	0	040, 620		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
			0	0		1
7.00		0.00	ı	0		7.00
8. 00 9. 00		0.00	0	0		8.00
		0.00		0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13. 00		0.00		00		13. 00
	E - BUILDING LEASES		0	846, 820		1
1 00	CAP REL COSTS-BLDG & FLXT	1 00	٥	4 20E E12		1 00
1.00	CAF REL CUSIS-BLUG & FIXI	1.00	0	4, 395, 512		1.00
2.00		0. 00 0. 00	0	0		2.00
3.00			0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00 7. 00
7. 00		0.00	— — — 0	00		/.00
	F - DRUGS/IV SOLUTIONS		U	4, 395, 512		1
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2, 820, 314		1. 00
2.00	DRUGS CHARGED TO PATTENTS	0.00	0			2. 00
∠. 00		— — - 0.00	— — —	0		2.00
	G - IMPLANTABLE DEVICES		U	2, 820, 314		1
1 00	IMPL. DEV. CHARGED TO	72.00	ol	678, 641		1 00
1. 00	PATIENTS	/2.00	٩	078, 041		1. 00
2.00	FATIENTS	0.00	^	0		2. 00
2.00	<u> </u>		0	678, 641		2.00
	P	ı I	Ч	070, 041		I

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: Provider CCN: 15-0149

					To 12/31/2022 Date/Time Prepared: 5/30/2023 8:21 am
		Increases			07 007 2020 G. ZT diii
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00	
	H - PROPERTY INSURANCE	3.00	4.00	3.00	
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	57, 962	1.00
2. 00		0.00	0	0	2.00
	I - DIETARY		U	57, 962	
1.00	DI ETARY	10.00	236, 696	0	1.00
2.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	367, 782	0	2.00
3. 00	CANTEEN	0.00	0	0	3.00
4.00	DI ETARY	10.00	Ö	131, 889	4.00
5.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	204, 931	5. 00
6. 00	CANTEEN	0. 00	0	0	6. 00
0.00	0 — — — —		604, 478	336, 820	0.00
	J - PROPERTY TAXES				
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	151, 280 114, 931	1. 00 2. 00
3. 00	CAI REE COSTS-WVBEE EQUIT	0.00	o	0	3.00
	0			266, 211	
1 00	K - LABOR & DELIVERY DELIVERY ROOM & LABOR ROOM	52. 00	2 025 225	0	1.00
1. 00 2. 00	DELIVERY ROOM & LABOR ROOM DELIVERY ROOM & LABOR ROOM	52.00	3, 925, 235 0	0 186, 666	1. 00 2. 00
3.00		0.00	ŏ	0	3.00
4.00		0.00	0	0	4.00
	M - EMERGENCY DEPARTMENT		3, 925, 235	186, 666	
1.00	EMERGENCY	91.00	912, 277	0	1.00
2.00	- Lucas Charles	0.00	0	0	2.00
3. 00 4. 00	EMERGENCY	91. 00 0. 00	0	59, 723	3. 00 4. 00
1. 00	0 — — — —		912, 277	59, 723	1. 66
	N - INCENTIVE COMPENSATION			_	
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	12, 563 137, 973	0	1. 00 2. 00
3.00	HOUSEKEEPI NG	9. 00	583	Ö	3.00
4.00	CAFETERI A	11.00	5, 201	0	4.00
5. 00 6. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	11, 842 21, 999	0	5. 00 6. 00
7. 00	OPERATING ROOM	50.00	14, 312	0	7.00
8. 00	RECOVERY ROOM	51.00	466	0	8.00
9. 00 10. 00	RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	54. 00 65. 00	4, 857 1, 283	0	9. 00 10. 00
11. 00	CLINIC	90.00	326, 430	0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192. 00	365, 610	0	12. 00
13.00	WOMEN'S RESOURCES	194. 01	140 14, 262	0	13.00
14. 00 15. 00	MARKETING	194. 02 0. 00	14, 262	0	14. 00 15. 00
	0		917, 521	o	
1 00	O - PHYSICIAN PART A	F 00	10 500		1.00
1. 00 2. 00	ADMINISTRATIVE & GENERAL OPERATING ROOM	5. 00 50. 00	18, 500 125, 000	0	1. 00 2. 00
3. 00		0.00	0	0	3.00
	O DI CARLLETY		143, 500	0	
1. 00	P - DISABILITY ADMINISTRATIVE & GENERAL	5. 00	ol	21, 437	1.00
2. 00	OPERATION OF PLANT	7. 00	ő	4, 148	2.00
3.00	HOUSEKEEPI NG	9.00	o	9, 384	3.00
4. 00 5. 00	CAFETERIA CENTRAL SERVICES & SUPPLY	11. 00 14. 00	0 0	17, 309 7, 066	4. 00 5. 00
6. 00	MEDICAL RECORDS & LIBRARY	16. 00	ő	1, 373	6.00
7.00	SOCI AL SERVI CE	17. 00	o	5, 888	7. 00
8. 00 9. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	163, 167 92, 868	8. 00 9. 00
10. 00	NURSERY	43. 00	0	9, 907	10.00
11. 00	OPERATING ROOM	50.00	O	35, 797	11.00
12.00	RECOVERY ROOM	51. 00 54. 00	0	710	12.00
13. 00 14. 00	RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	54. 00 65. 00	0	33, 680 10, 039	13. 00 14. 00
15.00	CLINIC	90.00	ő	21, 558	15. 00
16.00	EMERGENCY	91.00	o	2, 467	16.00
17. 00 18. 00	PHYSICIANS' PRIVATE OFFICES WOMEN'S RESOURCES	192. 00 194. 01	0	19, 280 2, 658	17. 00 18. 00
19. 00	CENTER FOR HEALING ARTS	194.01	0	636	19.00
20. 00		0. 00	O	O	20. 00

	Financial Systems		DEACONESS WOM				u of Form CMS-2	2552-10
RECLAS	SI FI CATI ONS			Provider CCN:	15-0149	Peri od: From 01/01/2022	Worksheet A-6	
						To 12/31/2022	Date/Time Prep	pared:
		Increases					5/30/2023 8: 21	ı aııı
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
21. 00 22. 00		0. 00 0. 00	0	0				21. 00 22. 00
23. 00		0.00	0	0				23. 00
24. 00		0.00	o	0				24. 00
25.00		0.00	0	0				25. 00
26. 00		0.00	0	0				26. 00
27. 00		0.00	0	0				27. 00
28. 00 29. 00		0. 00 0. 00	0	0				28. 00 29. 00
30.00		0.00	0	0				30.00
31. 00		0.00	o	Ö				31. 00
32.00		0. 00	O	0				32.00
33. 00		0.00	0	0				33. 00
34. 00		0.00	0	0				34. 00
35. 00 36. 00		0. 00 0. 00	0	0				35. 00 36. 00
37. 00		0.00	0	0				37. 00
38. 00		0.00	Ö	0				38. 00
	0			459, 372				
	Q - LAUNDRY							
1.00	LAUNDRY & LINEN SERVICE	8.00	0	982, 419				1.00
2. 00			0	0 982, 419				2. 00
	R - MEDICAL SUPPLIES		U _I	902, 419				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	4, 427, 844				1. 00
	PATI ENTS							
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	183, 648				2. 00
3. 00 4. 00		0. 00 0. 00	0	0				3. 00 4. 00
5.00		0.00	0	0				5. 00
6. 00		0.00	o	0				6. 00
7.00		0.00	0	0				7. 00
8.00		0. 00	0	0				8. 00
9.00		0.00	0	0				9. 00
10. 00 11. 00		0. 00 0. 00	0	0				10. 00 11. 00
11.00			— — ŏ	4, 611, 492				11.00
	S - ANESTHESIA PART A			.,				
1.00	EMERGENCY	91. 00	0	4, 528, 902				1.00
2.00		0.00	0	0				2. 00
	O T - RADI OLOGY		0	4, 528, 902				
1.00	CT SCAN	57.00	88, 412	0				1. 00
2. 00	MAGNETIC RESONANCE I MAGING	58. 00	89, 426	0				2. 00
	(MRI)							
3.00		0.00	0	0				3. 00
4.00	CT SCAN	57. 00	0	18, 959 10, 177				4.00
5. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	0	19, 177				5. 00
6.00		0.00	o	О				6. 00
	0		177, 838	38, 136				
	U - BLOOD BANK	1	1					
1. 00	BLOOD STORING, PROCESSING, &	63. 00	0	38, 491				1. 00
2.00	TRANS.	0. 00		0				2. 00
2.00			— — — 0	38, 491				2.00
500.00	Grand Total: Increases		6, 680, 849	22, 766, 693				500. 00
	·		·	•				

RECLASSI FI CATIONS

Provider CCN: 15-0149

From 01/01/2022 To 12/31/2022

Peri od:

Worksheet A-6
Date/Time Prepared:

5/30/2023 8: 21 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - LEASEHOLD IMPROVEMENTS 1.00 0.00 1.00 0 2.00 ADMINISTRATIVE & GENERAL 5.00 258, 836 0 2.00 0 OPERATION OF PLANT 7.00 93. 169 0 3.00 3.00 0 4.00 CAFETERI A 11.00 0 13,057 4.00 PHARMACY 0 0 5.00 15.00 6, 420 5.00 0 0 6.00 SOCIAL SERVICE 17.00 203 6.00 0 0 30.00 7.00 ADULTS & PEDIATRICS 233 7.00 8.00 OPERATING ROOM 50.00 0 4,712 0 8.00 22, 790 9.00 RADI OLOGY-DI AGNOSTI C 54.00 0 0 9.00 PHYSICAL THERAPY 66 00 0 85 355 0 10 00 10 00 11.00 CLINIC 90.00 0 120, 628 0 11.00 12.00 WOMEN'S RESOURCES 194.01 541 12.00 0 ō 605, 944 B - EQUIPMENT DEPRECIATION 1.00 0.00 0 9 1.00 2.00 ADMINISTRATIVE & GENERAL 5.00 o 625, 580 0 2.00 OPERATION OF PLANT 3.00 7.00 0 19,807 0 3.00 0 0 HOUSEKEEPI NG 4 00 9.00 25, 047 4 00 5.00 CAFETERI A 11.00 0 31, 415 0 5.00 CENTRAL SERVICES & SUPPLY o 19, 934 0 6.00 14.00 6.00 0 ADULTS & PEDIATRICS 0 185, 701 7.00 30.00 7.00 8.00 INTENSIVE CARE UNIT 31.00 0 170, 511 0 8.00 9.00 43.00 14, 903 0 NURSERY 9.00 OPERATING ROOM 50.00 o 111, 544 0 10.00 10.00 RECOVERY ROOM 0 0 11.00 51.00 9.114 11 00 12.00 RADI OLOGY-DI AGNOSTI C 54.00 0 159, 178 0 12.00 LABORATORY o 0 13.00 60.00 18, 615 13.00 0 RESPIRATORY THERAPY 0 65.00 88.579 14.00 14.00 15.00 PHYSICAL THERAPY 66.00 0 18 971 15 00 16.00 CLINIC 90.00 0 18, 636 0 16.00 EMERGENCY 17.00 91.00 0 367 0 17.00 PHYSICIANS' PRIVATE OFFICES 0 18.00 192.00 0 92.416 18.00 19.00 CENTER FOR HEALING ARTS 194.04 0 5, 968 0 19.00 1, 616, 286 C - INTEREST EXPENSE 1.00 0.00 0 0 11 1.00 2.00 0.00 0 0 0 2.00 0 3.00 ADMINISTRATIVE & GENERAL 5.00 236, 982 0 3.00 236, 982 D - EQUIPMENT LEASES 1.00 0.00 0 10 1.00 ADMINISTRATIVE & GENERAL 179, 889 2.00 5.00 0 0 2.00 3.00 OPERATION OF PLANT 7.00 ol 2, 702 0 3.00 9.00 0 4.00 HOUSEKEEPI NG 0 385 4.00 5.00 PHARMACY 15.00 o 86, 163 0 5.00 6.00 ADULTS & PEDIATRICS 30.00 0 433 0 6.00 INTENSIVE CARE UNIT 31.00 0 0 7.00 13, 787 7.00 8.00 OPERATING ROOM 50.00 0 193, 180 0 8.00 9.00 RADI OLOGY-DI AGNOSTI C 54.00 0 108, 871 0 9.00 0 RESPIRATORY THERAPY 0 10 00 65 00 52 711 10 00 0 0 11.00 CLINIC 90.00 202, 057 11.00 12.00 WOMEN'S RESOURCES 194.01 0 5, 967 0 12.00 MARKETI NG_ 13.00 0 0 13.00 194.02 675 846, 820 BUILDING LEASES 1.00 0.00 0 10 1.00 2.00 ADMINISTRATIVE & GENERAL 5.00 0 3, 944, 319 0 2.00 0 3 00 INTENSIVE CARE UNIT 31.00 62,052 0 3 00 4.00 RADI OLOGY-DI AGNOSTI C 54.00 0 123, 332 0 4.00 5.00 PHYSICAL THERAPY 0 0 66.00 85, 290 5.00 o 172, 445 0 6.00 ICLI NI C 90.00 6.00 PHYSICIANS' PRIVATE OFFICES 0 8, 074 7.00 192.00 0 7.00 ō 4, 395, 512 F - DRUGS/IV SOLUTIONS 1.00 0. 00 0 0 1.00 2, 820, 314 2.00 PHARMACY 15.00 0 0 2.00 2, 820, 314 G - IMPLANTABLE DEVICES 1.00 0.00 0 1.00 0 MEDICAL SUPPLIES CHARGED TO 0 2.00 71.00 678, 641 0 2.00 PATI ENTS 678, 641

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0149

					То	12/31/2022 Date/Time Pr 5/30/2023 8:	
	Cost Center	Decreases Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
1. 00	H - PROPERTY INSURANCE	0.00	O	0	12		1.00
2. 00	ADMINISTRATIVE & GENERAL	5.00	0_	5 <u>7, 9</u> 62	0		2. 00
	O I - DIETARY		0	57, 962			
1.00	DI EI/IKI	0.00	0	0	0		1.00
2. 00 3. 00	CAFETERI A	0. 00 11. 00	0 604, 478	0	0		2. 00 3. 00
4.00	John Event M	0.00	0	Ö	Ö		4. 00
5. 00 6. 00	CAFETERI A	0. 00 11. 00	0	0 336, 820	0		5. 00 6. 00
0.00	0		604, 478	336, 820			
1. 00	J - PROPERTY TAXES	0.00	O	0	13		1.00
2.00		0.00	ő	0	13		2. 00
3. 00	ADMI NI STRATI VE & GENERAL			26 <u>6, 2</u> 11 266, 211	0		3. 00
	K - LABOR & DELIVERY		•				
1. 00 2. 00		0. 00 0. 00	0	0	0		1. 00 2. 00
3.00	ADULTS & PEDIATRICS	30.00	3, 925, 235	Ö	0		3. 00
4. 00	ADULTS & PEDIATRICS	30.00	0 3, 925, 235	18 <u>6, 6</u> 66 186, 666	0		4. 00
	M - EMERGENCY DEPARTMENT		3, 423, 233	180, 000			
1. 00 2. 00	OPERATING ROOM	0. 00 50. 00	0 912, 277	0	0		1. 00 2. 00
3. 00	CI EKATTING KOOM	0.00	0	0	Ö		3. 00
4. 00	OPERATING ROOM	50.00	000912, 277	5 <u>9, 7</u> 23 59, 723	0		4. 00
	N - INCENTIVE COMPENSATION						
1. 00 2. 00		0. 00 0. 00	0	0	0		1. 00 2. 00
3. 00		0.00	ő	Ö	Ö		3. 00
4. 00 5. 00		0. 00 0. 00	0	0	0		4. 00 5. 00
6. 00		0.00	o	0	0		6. 00
7.00		0.00	0	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0	0		8. 00 9. 00
10.00		0.00	o	0	O		10.00
11. 00 12. 00		0. 00 0. 00	0	0	0		11. 00 12. 00
13.00		0.00	0	0	0		13. 00
14. 00 15. 00	ADMINISTRATIVE & GENERAL	0. 00 5. 00	917, 521	0	0		14. 00 15. 00
	0 — — — — —		917, 521				
1. 00	O - PHYSICIAN PART A	0.00	0	0	0		1.00
2.00		0.00	0	0	0		2. 00
3. 00	PHYSICIANS' PRIVATE OFFICES 0	192.00	14 <u>3, 5</u> 00 143, 500	$ \frac{0}{0}$	0		3. 00
1 00	P - DISABILITY	0.00	ما	٥	ما		1 00
1. 00 2. 00		0. 00 0. 00	0	0 0	0		1. 00 2. 00
3.00		0.00	0	0	0		3. 00
4. 00 5. 00		0. 00 0. 00	0	0 0	0		4. 00 5. 00
6.00		0.00	0	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0	0		7. 00 8. 00
9.00		0.00	0	0	0		9. 00
10. 00 11. 00		0. 00 0. 00	0	0	0		10. 00 11. 00
12. 00		0.00	ő	Ö	Ö		12. 00
13.00		0.00	0	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0	0		14. 00 15. 00
16.00		0.00	0	0	o		16.00
17. 00 18. 00		0. 00 0. 00	0	0 0	0		17. 00 18. 00
19. 00	ADMINISTRATIVE & OFFICE	0.00	0	0	0		19. 00
20. 00 21. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	21, 437 4, 148	0	0		20. 00 21. 00
22. 00	HOUSEKEEPI NG	9. 00	9, 384	0	0		22. 00

Peri od: From 01/01/2022 To 12/31/2022

Date/Time Prepared: 5/30/2023 8:21 am

						5/30/2023 8: .	zı am
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
23. 00	CAFETERI A	11. 00	17, 309	0	0		23. 00
24. 00	CENTRAL SERVICES & SUPPLY	14. 00	7, 066	0	0		24. 00
25. 00	MEDICAL RECORDS & LIBRARY	16. 00	1, 373	0	0		25. 00
26. 00	SOCI AL SERVI CE	17. 00	5, 888	0	0		26. 00
27. 00	ADULTS & PEDIATRICS	30. 00	163, 167	0	0		27. 00
28. 00	INTENSIVE CARE UNIT	31.00	92, 868	0	0		28. 00
29. 00	NURSERY	43. 00	9, 907	0	0		29. 00
30.00	OPERATING ROOM	50. 00	35, 797	0	0		30. 00
31. 00	RECOVERY ROOM	51. 00	710	0	0		31. 00
32.00	RADI OLOGY-DI AGNOSTI C	54.00	33, 680	0	0		32. 00
33.00	RESPIRATORY THERAPY	65. 00	10, 039	0	0		33. 00
34.00	CLINIC	90.00	21, 558	0	0		34. 00
35. 00	EMERGENCY	91.00	2, 467	0	0		35. 00
36. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	19, 280	0	0		36. 00
37. 00	WOMEN'S RESOURCES	194. 01	2, 658	0	0		37. 00
38. 00	CENTER FOR HEALING ARTS	194.04	636	0	0		38. 00
	0		459, 372	0]
	Q - LAUNDRY						
1.00		0.00	0	0	0		1.00
2.00	HOUSEKEEPI NG	9.00	0	982, 419	0		2. 00
	0		0	982, 419			
	R - MEDICAL SUPPLIES						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	440, 305	0		3. 00
4.00	INTENSIVE CARE UNIT	31.00	0	188, 993	0		4. 00
5.00	NURSERY	43.00	0	87, 259	0		5. 00
6.00	OPERATING ROOM	50.00	0	3, 510, 039	0		6. 00
7.00	RECOVERY ROOM	51.00	0	193	0		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	213, 247	0		8. 00
9.00	LABORATORY	60.00	o	19	0		9. 00
10.00	RESPIRATORY THERAPY	65.00	o	162, 440	0		10.00
11.00	CLINIC	90.00	o	8, 997	0		11. 00
	0 — — — — —			4, 611, 492			1
	S - ANESTHESIA PART A				·		1
1.00		0.00	0	0	0		1. 00
2.00	OPERATING ROOM	50.00	0	4, 528, 902	0		2. 00
	0			4, 528, 902			
	T - RADI OLOGY						
1.00		0.00	0	0	0		1. 00
2.00		0.00	o	0	0		2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	177, 838	0	0		3. 00
4.00		0.00	0	0	0		4. 00
5.00		0.00	О	0	0		5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	38, 136	0		6. 00
	0 — — — — —		177, 838	38, 136			1
	U - BLOOD BANK						
1.00		0.00	0	0	0		1.00
2.00	LABORATORY	60.00	ol	38, 491	0		2. 00
	0			38, 491	— — †		
500.00	Grand Total: Decreases		7, 140, 221	22, 307, 321			500.00
		'			1		,

In Lieu of Form CMS-2552-10
Period: Worksheet A-7
From 01/01/2022 Part I

				Т	o 12/31/2022	Date/Time Prep 5/30/2023 8:2	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	6, 375, 314	164, 934	0	164, 934	33, 164	4. 00
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	21, 273, 126	995, 182	0	995, 182	1, 212, 956	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	27, 648, 440	1, 160, 116	0	1, 160, 116	1, 246, 120	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	27, 648, 440	1, 160, 116	0	1, 160, 116	1, 246, 120	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
		/ 00	Assets				
	DADT I ANALYCIC OF CHANCEC IN CADITAL ACCET	6.00	7. 00				
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES	0				1 00
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	(507 004	0				3. 00
4. 00 5. 00	Building Improvements	6, 507, 084	0				4. 00 5. 00
	Fixed Equipment	21 055 252	0				
6. 00 7. 00	Movable Equipment HIT designated Assets	21, 055, 352	0				6. 00 7. 00
7. 00 8. 00		27 5/2 42/	0				7. 00 8. 00
9. 00	Subtotal (sum of lines 1-7) Reconciling Items	27, 562, 436	0				9. 00
10.00	Total (line 8 minus line 9)	27, 562, 436	0				9. 00 10. 00
10.00	Tiotal (Time o milius Time 9)	27, 302, 430	U				10.00

Provider CCN: 15-0149	Heal th	Financial Systems	DEACONESS WOME	NS HOSPITAL		In Lieu of Form CMS-2552-10		
To 12/31/2022 Date/Time Prepared: 5/30/2023 8:21 am	RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 15-0149			
SUMMARY OF CAPITAL								narod:
Depreciation Lease Interest Insurance (see instructions) Insurance (see instruction						10 12/31/2022	5/30/2023 8: 2	1 am
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				Sl	JMMARY OF CAP	I TAL		
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2		Cost Center Description	Depreciation	Lease	Interest			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00						12. 00	13. 00	
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 0 0 0		PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	ind 2			
Summary OF CAPITAL Cost Center Description Other Total (1) (sum of cols. 9 through 14) Other instructions) 14.00 15.00 CAP REL COSTS-BLDG & FIXT O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O O CAP REL COSTS-MVBLE EQUIP O CAP REL COSTS-MVBLE EQUIP	1.00	CAP REL COSTS-BLDG & FLXT	0	0)	0 0	0	1.00
Cost Center Description Other Capital -Relate of cols. 9 through 14) instructions) 14.00 15.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FIXT 0 0 0 1.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 2.00	2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
Cost Center Description	3.00	Total (sum of lines 1-2)	0	0)	0 0	0	3. 00
Capital - Relate of cols. 9 through 14)			SUMMARY O	F CAPITAL				
Capital - Relate of cols. 9 through 14)								
d Costs (see instructions) 14.00 15.00		Cost Center Description	0ther	Total (1) (sum				
instructions 14.00 15.00			Capi tal -Rel ate	of cols. 9				
14.00 15.00			d Costs (see	through 14)				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			instructions)					
1.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 2.00			14.00	15. 00				
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 2.00		PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	ind 2			
	1.00	CAP REL COSTS-BLDG & FIXT	0	0	1			1. 00
3.00 Total (sum of lines 1-2) 0 0 3.00	2.00	CAP REL COSTS-MVBLE EQUIP	o	0)			2. 00
	3.00	Total (sum of lines 1-2)	o	0				3. 00

Health Financial Systems	DEACONESS WOM	ENS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part III Date/Time Pre 5/30/2023 8:2	pared:
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col . 2)	•		
	1. 00	2.00	3, 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FLXT	6, 507, 085		-,,		0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	21, 055, 352		,			2. 00
3.00 Total (sum of lines 1-2)	27, 562, 437		27, 562, 43			3. 00
	ALLOCA'	TION OF OTHER (CAPITAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE					4 005 540	4 00
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 605, 944		1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		1, 616, 286		2. 00 3. 00
3.00 Total (Suiii of Titles 1-2)	0	<u> </u>	JMMARY OF CAPI	2, 222, 230	5, 242, 332	3.00
		30	DIVINIART OF CAPT	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1	154.00		5 005 007	
1. 00 CAP REL COSTS-BLDG & FLXT	52, 271		,		5, 205, 007	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	234, 569				_,,	2.00
3.00 Total (sum of lines 1-2)	286, 840	57, 962	266, 21	1 0	8, 075, 575	3. 00

| Period: | Worksheet A-8 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0149

Page Page					T	01/01/2022	Date/Time Prep	
Cost Center Description							373072023 8.2	ı allı
1.00					To/From Which the Amount is	to be Adjusted		
1.00								
1.00								
1.00 Investment Income - CAP REL B 52,27 CAP REL COSTS-BLOG & FIXI 1.00 11 1.00 12 0.00		Cost Center Description						
Investment income - CAP REL OCAP REL COSTS-INVBLE EQUIP 2.00 0 2.00	1. 00	II						1. 00
3. 00 Investment Ticome - other (chapter 2) 0 0.00	2.00		1	0	CAP REL COSTS-MVBLE FOULP	2.00	0	2. 00
Chapter 2)	2 00			0		0.00	0	2 00
discounts (chapter 8)		(chapter 2)		0				
Beyoneses (Chapter 8)	4. 00			0		0.00	0	4. 00
Sential of provider space by 0 0.00 0.6.00 0.00 0.6.00 0.0	5.00		В	-2, 621	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
Telephone services (pay stations excluded) (chapter 21) Sations excluded) (chapter 22) Sations excluded) (chapter 23) Sations excluded) (chapter 24) Sation	6.00	Rental of provider space by		0		0. 00	0	6. 00
8. 00 Television and radio service (Chapter 21) 9.00 Parking Lot (chapter 21) 10. 00 Parking L	7.00			0		0.00	O	7. 00
Television and radio service (Chapter 21) 0 0.00 0								
Parking of (chapter 21) A-8-2 -13,347,160 0.00	8.00	Television and radio service		0		0. 00	0	8. 00
adjustment 10		Parking Lot (chapter 21)		0		0. 00	0	9. 00
11.00 Sale of Scrap, waste, etc. (Chapter 23) 12.00 Related organization A-8-1 10,635,205 0 12.00 12.00 13.00 13.00 13.00 14.00 13.00 14.00 14.00 16.00 16.00 15.00 15.00 Rental of quarter's to employee and guests B	10. 00		A-8-2	-13, 347, 160			0	10. 00
12.00 Related organization transactions (chapter 10) 13.00 Laundry and I linen service 0 13.00 13.00 15.00	11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
13.00 Laundry and I linen service 0 0.00 0.13.00 15.00 1	12. 00	Related organization	A-8-1	10, 635, 205			0	12. 00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 17.00 0 18.00 0 19.00 0	13. 00			0		0. 00	0	13. 00
and others			1	-249, 602	CAFETERI A			
Supplies to other than		and others		0				
17. 00 Sale of drugs to other than patients 0 0 0 0 0 0 0 0 17. 00	16.00			0		0.00	O	16.00
Bat lents S O No.	17. 00	1.		0		0. 00	0	17. 00
abstracts	10 00	pati ents		0		0.00	0	10 00
education (tuition, fees, books, etc.) 20.00 Vending machines B		abstracts		0				
20.00 Vending machines B	19. 00			0		0.00	O	19.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments and sorrowings he repay costs in excess of I ill mitation (chapter 14) A-8-3 OPHYSICAL THERAPY 65.00 24.00	20. 00		В	-1. 173	CAFETERI A	11. 00	0	20. 00
Charges (chapter 21)		Income from imposition of		0			O	
overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT 1.00 0.26.00 costs-BLDG & FIXT 0.00 0.00 0.27.00 costs-BLDG & FIXT 0.00 0.00 0.27.00 costs-BLDG & FIXT 0.00 0.00 0.29.00 0.00 0.00 0.29.00 0.00 0		charges (chapter 21)						
Page Medicare overpayments Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00	22. 00			0		0. 00	0	22. 00
therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Unitiation (chapter 14) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	22 00	repay Medicare overpayments		0	DESDI DATADV THEDADV	65.00		22 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0.26.00 0.00 0.27.00 0.00 0.27.00 0.00 0.29.00 0.00	23.00	therapy costs in excess of	A-0-3	0	RESTINATORY ITTERAFT	03.00		23.00
1 imitation (chapter 14) Utilization review -	24. 00		A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
25.00 Utilization review - physicians' compensation (chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0.26.00 0.00 0.27.00 0								
Chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 0 26.00	25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAP REL COSTS-MVBLE EQUIP 0 CAP REL COSTS-MVBLE EQUIP 2. 00 0 *** Cost Center Deleted *** 19. 00 0 27. 00 28. 00 0 *** Cost Center Deleted *** 67. 00 30. 00 30. 00 30. 00 30. 99 *** Cost Center Deleted *** 68. 00 31. 00 32. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 0 *** Cost Center Deleted *** 67. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 0 *** Cost Center Deleted *** 68. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		(chapter 21)						
COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest O **** Cost Center Deleted *** O **** Cost Center Deleted *** O ADULTS & PEDIATRICS O **** Cost Center Deleted ***	26. 00			0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 0 **** Cost Center Deleted **** 67.00 30.00	27. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 O *** Cost Center Deleted *** O ADULTS & PEDIATRICS 30.00		Non-physician Anesthetist		0	*** Cost Center Deleted ***			
limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30. 00 30. 99 **** Cost Center Deleted *** 68. 00 31. 00 0 0 0 0 32. 00			A-8-3	0	*** Cost Center Deleted ***		O I	
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest O ADULTS & PEDIATRICS 30. 00 30. 99 31. 00 31. 00 31. 00 32. 00 30. 99 31. 00 32. 00								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 0 *** Cost Center Deleted *** 68.00 31.00 32.00	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest		pathology costs in excess of limitation (chapter 14)						
	32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
	33. 00		В	-33, 933	CAFETERI A	11. 00	0	33. 00

					o 12/31/2022	Date/Time Pre 5/30/2023 8: 2	
				Expense Classification on	Worksheet A	0,00,2020 0.2	
				To/From Which the Amount is			
					Š		
					T		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
34. 00	CLASS REVENUE	В	•	ADMINISTRATIVE & GENERAL	5. 00	0	
35. 00	LOBBYI NG	В		ADMINISTRATIVE & GENERAL	5. 00		35. 00
36.00	II	Α	•	ADMINISTRATIVE & GENERAL	5. 00		36. 00
37. 00		A	•	ADMINISTRATIVE & GENERAL	5. 00		37. 00
38. 00	PHYSICIAN RECRUITMENT	A	•	ADMINISTRATIVE & GENERAL	5. 00		38. 00
39. 00	HENDERSON MGMT FEES	В		ADMINISTRATIVE & GENERAL	5. 00		39. 00
40.00	HAF	A	-5, 986, 597	ADMINISTRATIVE & GENERAL	5. 00	0	40. 00
41.00	PHYSICIAN BILLING	A	-293, 591	ADMINISTRATIVE & GENERAL	5. 00	0	41.00
41. 01	VENDING REVENUE	В		GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	41. 01
41. 02	COFFEE SHOP REVENUE	В	-22, 622	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190. 00	0	41. 02
41. 03	CAFETERI A REVENUE	В		GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	41. 03
41. 04	CENTER FOR HEALING ARTS REVENUE	В	-150, 341	CENTER FOR HEALING ARTS	194. 04	0	41. 04
41. 05	WOMEN' S RESOURCES REVENUE	В	13	WOMEN'S RESOURCES	194. 01	0	41. 05
41.06	LACTATION SERVICES REVENUE	В	-54, 346	WOMEN'S RESOURCES	194. 01	0	41. 06
50.00	TOTAL (sum of lines 1 thru 49)		-9, 967, 029				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

From 01/01/2022 To 12/21/2022

Dato/Time Propared

				10 12/31/2022	5/30/2023 8:2	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	T Call
			,	Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:			_		
1.00			FACILITY RENT	4, 238, 476		1.00
2.00			VARI OUS	3, 600, 259	-100, 066	2.00
3.00	5. 00		VARI OUS	6, 597, 379	1, 138, 121	3.00
4.00	7. 00	OPERATION OF PLANT	VARI OUS	2, 875, 487	1, 418, 710	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	VARI OUS	344, 429	0	4. 01
4.02	15. 00	PHARMACY	VARI OUS	2, 215, 805	1, 353, 166	4. 02
4.03			VARI OUS	33, 736	0	4. 03
4.04	30.00	ADULTS & PEDIATRICS	VARI OUS	2, 245	2, 245	4.04
4.05	31.00	INTENSIVE CARE UNIT	VARI OUS	12, 501	12, 501	4. 05
4.06	54.00	RADI OLOGY-DI AGNOSTI C	VARI OUS	13, 538	13, 538	4.06
4.07	60.00	LABORATORY	VARI OUS	4, 936	4, 936	4. 07
4.08	66. 00	PHYSI CAL THERAPY	VARI OUS	742	742	4. 08
4.09	90.00	CLINIC	VARI OUS	3, 370	3, 370	4.09
4.10	66. 00	PHYSI CAL THERAPY	THERAPY SERVICES	1, 512, 104	2, 734, 063	4. 10
5.00	TOTALS (sum of lines 1-4).			21, 455, 007	10, 819, 802	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	
				1	
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	ED ORGANIZATION(S) AND/OR HO	ME 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	THE WOMENS HOSP	50.00	DEACONESS HOSPI	50.00	6. 00
7.00	Α	DEACONESS HOSPI	51.00	PROGRESSIVE HEA	49. 00	7. 00
8.00			0.00		0.00	8. 00
9.00			0.00		0.00	9. 00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider. B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Heal th I	Financial Syste	ems		D	EACONESS	WOMENS	HOSPI TAL			In Lie	eu of Form CMS-	-2552-10
		SERVICES FROM	RELATED	ORGANI ZAT	IONS AND	HOME	Provi der	CCN:	15-0149	Peri od:	Worksheet A-8	8-1
OFFICE	COSTS									From 01/01/2022 To 12/31/2022		enared:
										10 12/31/2022	5/30/2023 8:	
		Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REC	QUI RED AS	A RESULT	OF TRAI	NSACTI ONS	WI TH	RELATED C	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	0	10										1.00
2.00	3, 700, 325	0										2. 00
3.00	5, 459, 258	0										3.00
4.00	1, 456, 777	0										4.00
4. 01	344, 429	0										4. 01
4. 02	862, 639	0										4. 02
4. 03	33, 736	0										4. 03
4.04	0	0										4. 04
4. 05	0	0										4. 05
4.06	0	0										4. 06
4. 07	0	o o										4. 07
4. 08	0	٥										4. 08
4. 09	0	١										4. 09
4. 10	-1, 221, 959	o o										4. 10

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 par

5.00

nas no	t been posted to worksheet A,	cordinas i and/or 2, the amount arrowable should be indicated in cordinar 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HOSPI TAL	6.00
7.00	THERAPY SERVICE	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

5.00

10, 635, 205

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Propaga | Provider CCN: 15-0149

						lo 12/31/2022	2 Date/lime Pre 5/30/2023 8:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	T CIII
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
1.00	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	4 00
1. 00		AGGREGATE-ADMINISTRATIVE & GENERAL	20, 400	0	20, 400	211, 500	84	1. 00
2.00		AGGREGATE-SOCIAL SERVICE	1, 375		1, 375			2. 00
3. 00	31. 00	AGGREGATE-INTENSIVE CARE	3, 662, 471	3, 582, 471	80, 000	237, 100	492	3. 00
4.00	50.00	AGGREGATE-OPERATING ROOM	125, 000	0	125, 000	246, 400	480	4. 00
5. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	52, 038	4, 038	48, 000	271, 900	192	5. 00
6. 00	60. 00	AGGREGATE-LABORATORY	12, 000	12, 000	0	260, 300	0	6. 00
7.00	90. 00	AGGREGATE-CLI NI C	4, 051, 985	3, 951, 985	100, 000	237, 100	180	7. 00
8.00		AGGREGATE-EMERGENCY	7, 162, 497	4, 281, 231	2, 881, 266	211, 500	14, 953	8. 00
9.00	0. 00		0	0	0	0	0	
10.00	0. 00				0	1	0	
200.00		0 1 0 1 (5)	15, 087, 766				16, 392	200. 00
	Wkst. A Line #		Unadjusted RCE Limit		Cost of	Provi der	Physician Cost	
		I denti fi er	LIMIT	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
				Limit	Education	12	Trisui ance	
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14. 00	
1. 00	5. 00	AGGREGATE-ADMINISTRATIVE & GENERAL	8, 541	427	0	0	0	1. 00
2. 00	17. 00	AGGREGATE-SOCIAL SERVICE	1, 254	63	0	0	0	2. 00
3. 00		AGGREGATE-INTENSIVE CARE	56, 083		0			3. 00
		UNI T						
4.00	50. 00	AGGREGATE-OPERATING ROOM	56, 861	2, 843	0	0	0	4. 00
5. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	25, 099	1, 255	0	0	0	5. 00
6. 00	60.00	AGGREGATE - LABORATORY	0	0	0	0	0	6. 00
7. 00		AGGREGATE-CLI NI C	20, 518	1, 026	0	1	88, 584	7. 00
8. 00		AGGREGATE - EMERGENCY	1, 520, 461	76, 023	0	Ö	120, 555	
9.00	0.00		0	0	0	0	0	i e
10.00	0. 00		0	0	0	0	0	10. 00
200.00			1, 688, 817		0		259, 840	200. 00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18.00		
1. 00		AGGREGATE-ADMINISTRATIVE &	0		11, 859			1. 00
		GENERAL	_	,,,,,,	,	,		
2.00		AGGREGATE-SOCIAL SERVICE	0	., 20.	121			2. 00
3.00	31. 00	AGGREGATE-INTENSIVE CARE	1, 107	57, 190	22, 810	3, 605, 281		3. 00
		UNIT		-, o,,				
4.00		AGGREGATE OPERATING ROOM	0		68, 139			4. 00
5. 00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	0	25, 099	22, 901	26, 939		5. 00
6. 00	60. 00	AGGREGATE-LABORATORY	0	0	0	12,000		6. 00
7. 00		AGGREGATE-CLI NI C	2, 186	22, 704	77, 296			7. 00
8.00		AGGREGATE-EMERGENCY	48, 496		1, 312, 309			8. 00
9.00	0. 00	l .	0	0	0	0		9. 00
10. 00	0. 00		0		0	0		10. 00
200. 00			51, 789	1, 740, 606	1, 515, 435	13, 347, 160		200. 00

	ALLOCATION - GENERAL SERVICE COSTS	DEACONESS WOWL	Provi der Co	CN: 15-0149	Peri od:	Worksheet B	2332-10
					From 01/01/2022 To 12/31/2022	Part I Date/Time Pre 5/30/2023 8:2	pared: 1 am
			CAPI TAL REI	LATED COSTS		7 07 007 2020 0. 2	
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFI TS		
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	5, 205, 007	5, 205, 007				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	2, 870, 568	00.040	2, 870, 56			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	15, 854, 704	90, 013		0 15, 944, 717	22 757 000	4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	19, 147, 641 3, 519, 357	653, 336 161, 686			22, 757, 999 3, 844, 259	
8.00	00800 LAUNDRY & LINEN SERVICE	982, 419	101, 000	1	0 130, 903	982, 419	1
9. 00	00900 HOUSEKEEPI NG	1, 337, 354	27, 511			1, 708, 295	
10. 00	01000 DI ETARY	368, 585	49, 233			498, 301	
11. 00	01100 CAFETERI A	574, 362	114, 735			876, 682	
13.00	01300 NURSING ADMINISTRATION	o	0		o	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	543, 717	32, 794		2 42, 717	642, 460	14. 00
15. 00	01500 PHARMACY	2, 212, 166	37, 822			2, 350, 405	
16.00	01600 MEDI CAL RECORDS & LI BRARY	543, 330			0 141, 039	705, 245	
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	501, 909	4, 944		0 149, 390	656, 243	17. 00
30. 00	03000 ADULTS & PEDIATRICS	6, 219, 084	1, 047, 663	125, 78	4 1, 799, 946	9, 192, 477	30.00
31. 00	03100 I NTENSI VE CARE UNI T	6, 531, 117	399, 270			9, 814, 802	
43. 00	04300 NURSERY	1, 112, 505	82, 745			1, 539, 367	1
	ANCILLARY SERVICE COST CENTERS	.,				.,,	
50.00	05000 OPERATI NG ROOM	5, 096, 659	609, 343	348, 64	4 1, 160, 824	7, 215, 470	50.00
51.00	05100 RECOVERY ROOM	657, 194	0			869, 666	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	4, 111, 901	550, 391			5, 963, 823	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 923, 335	237, 711			4, 178, 243	1
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	107, 371 108, 603	0		0 27, 263 0 27, 575	134, 634 136, 178	
60.00	06000 LABORATORY	3, 298, 351	6, 973	l .		3, 327, 018	1
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	38, 491	0, 779	21,07		38, 491	
65. 00	06500 RESPIRATORY THERAPY	1, 910, 203	13, 185	164, 66	3 471, 424	2, 559, 475	
66.00	06600 PHYSI CAL THERAPY	1, 547, 628	154, 164			1, 723, 901	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 749, 203	0		o o	3, 749, 203	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	678, 641	0	•	0 0	678, 641	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 820, 314	0	1	0 0	2, 820, 314	
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	0	0		0 0	0	77. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2, 004, 802	316, 779	257, 20	2 1, 714, 801	4, 293, 584	00 00
91.00	09100 EMERGENCY	2, 612, 033				3, 604, 241	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,012,000	77,070	0, 71	, 000, 070	0, 00 1, 2 11	
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	99, 188, 554	4, 710, 569	2, 736, 52	2 14, 246, 483	96, 861, 836	118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	382, 907	76, 490	11, 64	6 113, 410	584, 453	190 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	4, 895, 332	176, 265			6, 514, 541	
	07950 OTHER DEPARTMENTS	0	0	1	0 0		194. 00
	07951 WOMEN' S RESOURCES	471, 709	203, 100	6, 95	4 107, 213	788, 976	1
194. 02	07952 MARKETI NG	733, 034	0	78	7 82, 747	816, 568	194. 02
	07953 REPRODUCTI VE MEDICINE	3, 123	0		0 0		194. 03
	07954 CENTER FOR HEALING ARTS	172, 256	38, 583	6, 95	59, 624	277, 418	
200.00			^				200.00
201.00		105 044 045	0 E 20E 007		0 15 044 717		201.00
202.00	TOTAL (Sum Titles 118 through 201)	105, 846, 915	5, 205, 007	2, 870, 56	8 15, 944, 717	105, 846, 915	J∠U∠. UU

Provider CCN: 15-0149

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2022	Part
To 12/31/2022	Date/Time Prepared:
5/30/2023 8:21 am	

			'	0 12/01/2022	5/30/2023 8: 2	1 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
'	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1					4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	22, 757, 999					5. 00
7. 00 00700 OPERATION OF PLANT	1, 052, 939	4, 897, 198				7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	269, 084	1, 077, 170	1			8. 00
9. 00 00900 HOUSEKEEPI NG	467, 900	31, 332				9.00
10. 00 01000 DI ETARY	136, 484	56, 071	•		716, 294	10.00
11. 00 01100 CAFETERI A	240, 122	130, 671		59, 282	709, 892	11.00
13. 00 01130 NURSI NG ADMI NI STRATI ON	240, 122	130, 671		39, 202	709, 692	13.00
	1	-	1	14 044		1
14. 00 01400 CENTRAL SERVICES & SUPPLY	175, 969	37, 348			0	14.00
15. 00 01500 PHARMACY	643, 774	43, 076	1	19, 542	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	193, 166	23, 776		.0,,0,	0	16.00
17. 00 01700 SOCI AL SERVI CE	179, 744	5, 631	0	2, 555	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 517, 810	1, 193, 173			0	30. 00
31.00 03100 INTENSIVE CARE UNIT	2, 688, 292	454, 725			0	31.00
43. 00 04300 NURSERY	421, 631	94, 237	72, 412	42, 753	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 976, 310	693, 975			0	50. 00
51.00 05100 RECOVERY ROOM	238, 201	0	47, 420		0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	1, 633, 485	626, 835			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 144, 417	270, 727	1	122, 822	0	54.00
57.00 05700 CT SCAN	36, 876	0	1	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	37, 299	0) 0	0	0	58. 00
60. 00 06000 LABORATORY	911, 267	7, 941	0	3, 603	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	10, 543	0	0	0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	701, 038	15, 016	0	6, 813	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	472, 175	175, 575	0	79, 654	0	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 026, 903	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	185, 879	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	772, 481	0	0	0	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 176, 008	360, 777	' 0	163, 676	0	90.00
91. 00 09100 EMERGENCY	987, 198	113, 200	176, 281	51, 356	6, 402	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1					92.00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>			'		
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS		-	-	-1		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	20, 296, 995	4, 334, 086	1, 251, 503	1, 952, 057	716, 294	118.00
NONREI MBURSABLE COST CENTERS	20/2/0///0	1,001,000	1,201,000	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7.10/27.	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	160, 081	87, 114	. 0	39, 522	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 784, 326	200, 747				192. 00
194. 00 07950 OTHER DEPARTMENTS	0	200, 7.17		0		194. 00
194. 01 07951 WOMEN' S RESOURCES	216, 100	231, 309	1	104, 939		194. 01
194. 02 07952 MARKETI NG	223, 657	231, 307		104, 757		194. 02
194. 03 07953 REPRODUCTI VE MEDI CI NE	855	0				194. 02
194. 04 07954 CENTER FOR HEALING ARTS	75, 985	43, 942	ή	19, 935		194. 03
200.00 Cross Foot Adjustments	73, 703	43, 742		17, 733	U	200. 00
201.00 Negative Cost Centers	0	^			Δ.	201.00
202.00 TOTAL (sum lines 118 through 201)	22, 757, 999	4, 897, 198	1, 251, 503	2, 207, 527	716, 294	
202.00 TOTAL (Suil TITIES TTO LTITUUGH 201)	22, 131, 999	4, 077, 198	η 1, 201, 303	2, 201, 321	/10, 294	1202. UU

Provider CCN: 15-0149

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2022	Part
To 12/31/2022	Date/Time Prepared:
5/30/2023 8:21 am	

				7 12/31/2022	5/30/2023 8: 2	1 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
·		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 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	2, 016, 649					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	2,010,049	0				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	12, 883	0	885, 604			14. 00
1 1	12, 883	U	· ·	2 074 (0)		
15. 00 01500 PHARMACY	40.000	0	17, 899	3, 074, 696	075 040	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	42, 330		8	0	975, 312	16.00
17. 00 01700 SOCIAL SERVICE	32, 207	0	2	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	369, 006		30, 819	142	56, 263	30. 00
31.00 03100 INTENSIVE CARE UNIT	366, 705	1	46, 651	191, 132	120, 094	31. 00
43. 00 04300 NURSERY	81, 439	0	2, 914	2, 268	28, 598	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	227, 753	0	113, 327	0	164, 933	50. 00
51.00 O5100 RECOVERY ROOM	0	0	0	0	18, 728	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	242, 936	0	0	0	47, 982	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	160, 577	o	4, 418	9, 044	137, 018	54.00
57. 00 05700 CT SCAN	0	0	0	0	2, 705	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	2, 737	58. 00
60. 00 06000 LABORATORY	0	0	3	0	106, 725	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	1, 234	63. 00
65. 00 06500 RESPI RATORY THERAPY	84, 200	Ö	16, 726	155, 905	31, 586	65. 00
66. 00 06600 PHYSI CAL THERAPY	04, 200	0	3, 205	33	29, 891	66. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5, 205 546, 420	33	29, 691 44, 444	71.00
	•	U	·	U	· ·	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	93, 870	0 (00 014	7, 245	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	2, 693, 914	66, 597	73. 00
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	100 511		0.007	0.000	00.010	
90. 00 09000 CLI NI C	132, 511	0	2, 387	2, 398	38, 912	90.00
91. 00 09100 EMERGENCY	67, 636	0	0	U	69, 620	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS		_	_	_1		
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 820, 183	0	878, 649	3, 054, 836	975, 312	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 902		0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	128, 370	0	6, 292	19, 145		192. 00
194.00 07950 OTHER DEPARTMENTS	0	0	0	0	0	194. 00
194. 01 07951 WOMEN' S RESOURCES	31, 287	0	229	0		194. 01
194. 02 07952 MARKETI NG	17, 024	o	49	o	0	194. 02
194. 03 07953 REPRODUCTI VE MEDICINE	0	ol	0	715	0	194. 03
194.04 07954 CENTER FOR HEALING ARTS	12, 883	ol	385	o	0	194. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	ol	0	ol	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 016, 649	Ö	885, 604	3, 074, 696	975, 312	
1 1 (22 23. 23. 23.)	, - , ,	۱	,,	/9		

COST CENTED PRINCIPLE COST CENTER COST	Health Financial Systems	DEACONESS WOME	NS HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description	COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO	CN: 15-0149	Peri od:		
Cost Center Description					From 01/01/2022	Part I	
COST CENTER DESCRIPTION					10 12/31/2022	5/30/2023 8:2	pareu: 1 am
SEMERAL SERVICE COST CENTERS 17.00 24.00 25.00 26.00	Cost Center Description	SOCIAL SERVICE	Subtotal	Intern &	Total	37 307 2023 0. 2	i diii
SEMBRIL SERVICE COST CENTERS 17,00 24,00 25,00 26,00	2001 201101 20001 pti oii	0001712 021111 02					
Adjustments Adjustments							
GENERAL SERVICE COST CENTERS							
1,00		17. 00	24.00		26.00		
2.00	GENERAL SERVICE COST CENTERS						
4.00	1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
5.00 00500 ADM IN STRATIVE & GENERAL	2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
1.00	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
8. 00	5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
9,00 000900 0015EKEEPI NG	7.00 00700 OPERATION OF PLANT						7. 00
10.00 01000 015ARY 11.00 13.00 13.00 01300 AURSINS ADMINISTRATION 13.00 13.00 13.00 01300 AURSINS ADMINISTRATION 13.00 13.00 01500 CENTRAL SERVI CES & SUPPLY 14.00 14.0	8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
11.00 01100 CAFETERIA	9. 00 00900 HOUSEKEEPI NG						9. 00
13. 00 13.00 JURISHIN & ADMINISTRATION 14. 00 10.00 CENTRAL SERVICES & SUPPLY 16. 00 10.00 10.00 CENTRAL SERVICES & SUPPLY 15. 00 10. 00 10.00 MEDICAL RECORDS & LI BRARY 17. 00 10.00 MEDICAL RECORDS & LI BRARY 17. 00 10.00 10.00 MEDICAL RECORDS & LI BRARY 17. 00 10.00 10.00 MEDICAL RECORDS & LI BRARY 17. 00 10.	10. 00 01000 DI ETARY						10.00
14. 00	11. 00 01100 CAFETERI A						11. 00
15. 00 01500 PERAMACY	13.00 01300 NURSING ADMINISTRATION						13. 00
16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 1700 2010 SOCIAL SERVICE 876, 382 17.00 1700 2010 SOCIAL SERVICE COST CENTERS 17.00 17	14.00 01400 CENTRAL SERVICES & SUPPLY						14. 00
17. 00 01700 SOCI AL SERVICE 876, 382	15. 00 01500 PHARMACY						15. 00
IMPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.	16.00 01600 MEDICAL RECORDS & LIBRARY						16. 00
30.00 03000 ADULTS & PEDIATRICS 314, 603 14, 327, 692 0 14, 327, 692 30.00 30	17. 00 01700 SOCIAL SERVICE	876, 382					17. 00
31.00 03100 INTENSIVE CARE UNIT 358, 966 14, 551, 750 0 14, 551, 750 31.00	INPATIENT ROUTINE SERVICE COST CENTERS						
43.00 04300 NURSERY 202, 813 2, 488, 432 0 2, 488, 432 43.00	30. 00 03000 ADULTS & PEDIATRICS	314, 603			0 14, 327, 692		30. 00
ANCILLARY SERVICE COST CENTERS	31.00 03100 INTENSIVE CARE UNIT	358, 966	14, 551, 750		0 14, 551, 750		31. 00
50.00		202, 813	2, 488, 432		0 2, 488, 432		43. 00
51.00 05100 RECOVERY ROOM 0 1, 174, 015 0 1, 174, 015 51.00	ANCILLARY SERVICE COST CENTERS						
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 8,920,935 0 8,920,935 52.00		0					
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 6, 027, 266 0 6, 027, 266 54. 00		1					1
57. 00 05700 CT SCAN 0 174, 215 0 174, 215 57. 00 68.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 176, 214 0 176, 214 58. 00 69.00 06.000 LABDRATORY 0 4, 356, 557 0 4, 356, 557 60. 00 63. 00 06.000 LABDRATORY 0 4, 356, 557 0 4, 356, 557 60. 00 65. 00 06.000 STORI NG , PROCESSI NG , & TRANS. 0 50, 268 0 50, 268 63. 00 66.00 06.000 PHYSI CAL THERAPY 0 3, 570, 759 0 3, 570, 759 65. 00 66.00 06.000 PHYSI CAL THERAPY 0 2, 484, 434 0 2, 484, 434 66. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 5, 366, 970 0 5, 366, 970 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 6, 353, 306 0 65, 635 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 6, 353, 306 0 65, 635 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 6, 353, 306 0 6, 353, 306 73. 00 0700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 0	· ·	-					•
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	•	1		i e			1
60. 00 6000 LABORATORY 0 4, 356, 557 0 4, 356, 557 60. 00 63. 00 6300 BLOOD STORING, PROCESSING, & TRANS. 0 50, 268 0 50, 268 63. 00 66. 00 06500 RESPIRATORY THERAPY 0 3, 570, 759 0 3, 570, 759 65. 00 66. 00 06600 PHYSICAL THERAPY 0 2, 484, 434 0 2, 484, 434 66. 00 71. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 5, 366, 970 0 5, 366, 970 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 965, 635 0 965, 635 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 6, 353, 306 0 6, 353, 306 77. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 6, 353, 306 0 6, 353, 306 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 6, 353, 306 0 6, 353, 306 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 6, 353, 306 0 6, 353, 306 73. 00 07400 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 50, 268 0 50, 268 63. 00 65. 00 06500 RESPIRATORY THERAPY 0 3, 570, 759 0 3, 570, 759 65. 00 66. 00 06600 PHYSICAL THERAPY 0 2, 484, 434 0 2, 484, 434 466. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 5, 366, 970 0 5, 366, 970 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 965, 635 0 965, 635 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 6, 353, 306 0 6, 353, 306 73. 00 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77. 00 07700 ALLOGENEIC COST CENTERS 0 6, 170, 253 90. 00 90. 00 09000 CLIN C 0 0, 6, 170, 253 0 6, 170, 253 90. 00 91. 00 09100 BMERGENCY 0 5, 075, 934 0 5, 075, 934 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 5, 075, 934 0 5, 075, 934 91. 00 97. 00 0700 OFFICE REI MBURSABLE COST CENTERS 0 0 0 0 0 18. 00 SUBTOTALS (SUM OF LINES 1 through 117) 876, 382 93, 358, 969 0 93, 358, 969 118. 00 192. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 8, 744, 495 192. 00 194. 00 07950 OTHER DEPARTMENTS 0 0 0 0 8, 744, 495 192. 00 194. 01 07951 WOMEN'S RESOURCES 0 1, 372, 840 0 1, 372, 840 194. 01 194. 02 07952 MARKETING 0 1, 057, 298 0 1, 057, 298 194. 02 194. 03 07953 REPRODUCTIVE MEDICINE 0 4, 693 0 4, 693 194. 03 194. 04 07954 CENTER FOR HEALING ARTS 0 430, 548 194. 04 190. 00 Negative Cost Centers 0 0 0 0 0 0 100. 00 0 0 0 0 0 0 101. 00 Negative Cost Centers 0 0 0 0 0 101. 00 Negative Cost Centers 0 0 0 0 0 102. 00 00 0 0 0 0 0 103. 00 00 0 0 0 0 0 0 104. 01 07951 WOMEN'S RESOURCES 0 1, 372, 840 0 1, 372, 840 194. 03 194. 04 07954 CENTER FOR HEALING ARTS 0 4, 693 0 4, 693 194. 04 194. 04 07954 CENTER FOR HEALING ARTS		-					1
65.00 66500 RESPI RATORY THERAPY 0 3,570,759 0 3,570,759 66.00 66.00 06600 PHYSI CAL THERAPY 0 2,484,434 0 2,484,434 66.00 710.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 5,366,970 0 5,366,970 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 965,635 0 965,635 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 6,353,306 0 6,353,306 73.00 77.00 07700 ALLOGENEIC HISCT ACQUISITION 0 0 0 0 00 07700 ALLOGENEIC HISCT ACQUISITION 0 0 0 0 90.00 09100 CLINIC 0 6,170,253 0 6,170,253 90.00 91.00 09100 DEBERGENCY 0 5,075,934 0 5,075,934 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 102.00 OSEPO O	· · · · · · · · · · · · · · · · · · ·	1					
66. 00 06600 PHYSI CAL THERAPY 0 2, 484, 434 0 2, 484, 434 66. 00 71. 00 7700 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 5, 366, 970 0 5, 366, 970 71. 00 72. 00 70720 IMPL DEV. CHARGED TO PATIENTS 0 965, 635 0 965, 635 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 6, 353, 306 0 6, 353, 306 73. 00 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0		1					1
71. 00	· · · · · · · · · · · · · · · · · · ·	-					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 965, 635 0 965, 635 72. 00 73. 00 73. 00 73.00 DRUGS CHARGED TO PATIENTS 0 6, 353, 306 0 6, 353, 306 0 73. 00 77. 00		1					1
73. 00		-					ł
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 0 0		1					1
OUTPATIENT SERVICE COST CENTERS O O9000 CLI NI C O O O O O O O O O		1					1
90. 00		U U	0		0 0		//.00
91. 00			4 170 252		0 4 170 252		00 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0		1					
OTHER REI MBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O		٩	5, 075, 934				1
102. 00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O SPECIAL PURPOSE COST CENTERS	,				<u> </u>		72.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 876, 382 93, 358, 969 0 93, 358, 969 118.00			0				102 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 876, 382 93, 358, 969 0 93, 358, 969 118. 00		<u> </u>			<u> </u>		102.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 878, 072 0 878, 072 190. 00 192. 0		876 382	93 358 969		03 358 969		118 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 878, 072 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 8, 744, 495 0 8, 744, 495 192. 00 194. 00 0 0 0 0 0 194. 00 194. 01 194. 01 194. 02 195. 07952 MARKETI NG 0 1, 372, 840 194. 02 194. 03 195. 07953 REPRODUCTI VE MEDI CI NE 0 4, 693 194. 04 194. 03 194. 04 194. 04 194. 04 194. 05		070, 302	73, 330, 707		0 73, 330, 707		1110.00
192. 00 1920			878 072		0 878 072		190 00
194. 00 07950 OTHER DEPARTMENTS 0 0 0 0 194. 00 194. 01 07951 WOMEN'S RESOURCES 0 1, 372, 840 0 1, 372, 840 194. 01 194. 02 07952 MARKETI NG 0 1, 057, 298 0 1, 057, 298 194. 02 194. 03 07953 REPRODUCTI VE MEDI CI NE 0 4, 693 0 4, 693 194. 03 194. 04 07954 CENTER FOR HEALI NG ARTS 0 430, 548 0 430, 548 194. 04 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00		1					1
194. 01 07951 WOMEN'S RESOURCES 0 1, 372, 840 0 1, 372, 840 194. 01 194. 02 07952 MARKETI NG 0 1, 057, 298 0 1, 057, 298 194. 02 194. 03 07953 REPRODUCTI VE MEDI CI NE 0 4, 693 0 4, 693 194. 03 194. 04 07954 CENTER FOR HEALING ARTS 0 430, 548 0 430, 548 194. 04 200. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00			0, 744, 470 N		0 0, 744, 475		
194. 02 07952 MARKETING 0 1,057,298 0 1,057,298 194. 02 194. 03 07953 REPRODUCTIVE MEDICINE 0 4,693 0 4,693 194. 03 194. 04 07954 CENTER FOR HEALING ARTS 0 430,548 0 430,548 194. 04 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 201. 00			1 372 840		0 1 372 840		
194. 03 07953 REPRODUCTI VE MEDI CI NE 0 4, 693 0 4, 693 194. 03 194. 04 07954 CENTER FOR HEALING ARTS 0 430, 548 0 430, 548 194. 04 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00	· ·						1
194. 04 07954 CENTER FOR HEALING ARTS 0 430, 548 0 430, 548 194. 04 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 201. 00				ı			
200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0				i e			
201. 00 Negative Cost Centers 0 0 0 201. 00	•	١	730, 340 N		0 730, 340		
			0		ol ol		1
		876, 382	105, 846, 915				
	(11 (11 11 11 11 11 11 11 11 11 11 11 11			1			

| Period: | Worksheet B | From 01/01/2022 | Part II | To | 12/31/2022 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0149

				To	12/31/2022	Date/Time Pre	
			CAPLTAL REL	ATED COSTS		5/30/2023 8: 2	ı am
			0711 7 771E 17EE	21125 00010			
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFITS	
		Capi tal Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS				'		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	90, 013		90, 013	90, 013	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	653, 336		1, 592, 050	11, 395	5. 00
7.00	00700 OPERATION OF PLANT	0	161, 686 0		187, 919	773 0	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	27, 511	-	57, 150	1, 772	8. 00 9. 00
10.00	01000 DI ETARY		49, 233		56, 728	412	10. 00
11. 00	01100 CAFETERI A		114, 735	1	132, 206	960	
13. 00	01300 NURSI NG ADMI NI STRATI ON		0		0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	l ol	32, 794		56, 026	241	14. 00
15. 00	01500 PHARMACY	0	37, 822		138, 239	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	o	20, 876	0	20, 876	796	16. 00
17.00	01700 SOCIAL SERVICE	0	4, 944	0	4, 944	843	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	1, 047, 663		1, 173, 447	10, 162	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	399, 270		614, 055	15, 063	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	82, 745	17, 368	100, 113	1, 845	43. 00
50. 00	05000 OPERATING ROOM		609, 343	348, 644	957, 987	6, 554	50. 00
51. 00	05100 RECOVERY ROOM		007, 549	10, 622	10, 622	1, 140	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		550, 391		641, 533	6, 834	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	237, 711	312, 391	550, 102	3, 979	54.00
57.00	05700 CT SCAN	o	0	0	О	154	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	156	58. 00
60. 00	06000 LABORATORY	0	6, 973		28, 667	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	-1	0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	13, 185		177, 848	2, 662	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	154, 164		176, 273	0	66. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0	I - 1	ol Ol	0	72.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0		0	0	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	٩		<u> </u>	<u> </u>	0	77.00
90.00	09000 CLI NI C	0	316, 779	257, 202	573, 981	9, 682	90. 00
91.00	09100 EMERGENCY	o	99, 395	6, 917	106, 312	5, 002	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	l ol	4, 710, 569	2, 736, 522	7, 447, 091	80, 425	118 00
110.00	NONREI MBURSABLE COST CENTERS	ı o	4, 710, 309	2, 730, 322	7, 447, 071	60, 423	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76, 490	11, 646	88, 136	640	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES		176, 265		283, 969		192. 00
	07950 OTHER DEPARTMENTS	o	0	0	o	0	194. 00
	07951 WOMEN' S RESOURCES	0	203, 100	6, 954	210, 054		194. 01
	07952 MARKETI NG	0	0	787	787		194. 02
	07953 REPRODUCTI VE MEDI CI NE	0	0	0	0		194. 03
	07954 CENTER FOR HEALING ARTS	0	38, 583	6, 955	45, 538		194. 04
200.00			0		0		200. 00 201. 00
201. 00 202. 00		o	5, 205, 007	2, 870, 568	8, 075, 575	90, 013	
202.00	TOTAL (Sum Times The thirough 201)	١	5, 205, 007	2, 370, 300	0, 0/0, 0/0	70, 013	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0149

			11	o 12/31/2022	Date/lime Pre 5/30/2023 8:2	oared: 1 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	ı aiii
oust content beson per on	& GENERAL	PLANT	LINEN SERVICE	HOUSEREEL THO	DILIMIN	
	5. 00	7. 00	8. 00	9. 00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	1, 603, 445					5. 00
7.00 00700 OPERATION OF PLANT	74, 187	262, 879				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	18, 959	0	18, 959			8. 00
9. 00 00900 HOUSEKEEPI NG	32, 967	1, 682	0	93, 571		9. 00
10. 00 01000 DI ETARY	9, 616	3, 010		l	70, 844	10.00
11. 00 01100 CAFETERI A	16, 918	7, 014	0	2, 513	70, 211	11. 00
13. 00 01300 NURSING ADMINISTRATION	0	0	0	o	0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	12, 398	2, 005	0	718	0	14. 00
15. 00 01500 PHARMACY	45, 358	2, 312	0	828	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	13, 610	1, 276	0	l .	0	16. 00
17. 00 01700 SOCIAL SERVICE	12, 664	302	0	108	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	127001	002		.00		
30. 00 03000 ADULTS & PEDIATRICS	177, 396	64, 050	1, 699	22, 947	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	189, 399	24, 409			0	31. 00
43. 00 04300 NURSERY	29, 707	5, 059			0	43.00
ANCILLARY SERVICE COST CENTERS	,		,	, - ,		
50. 00 05000 OPERATING ROOM	139, 244	37, 252	6, 321	13, 345	0	50. 00
51.00 05100 RECOVERY ROOM	16, 783	0	719	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	115, 090	33, 648	1, 841	12, 054	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	80, 632	14, 532	0	5, 206	0	54.00
57. 00 05700 CT SCAN	2, 598	0	0		0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 628	0	0	o	0	58. 00
60. 00 06000 LABORATORY	64, 205	426	0	153	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	743	0		l .	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	49, 393	806	0	289	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	33, 268	9, 425	0	3, 376	0	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	72, 352	0	0	l ' '	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 096	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	54, 426	0	0	- 1	0	73. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	_			-1		
90. 00 09000 CLI NI C	82, 858	19, 366	0	6, 938	0	90. 00
91. 00 09100 EMERGENCY	69, 555	6, 077	2, 672	2, 177	633	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			, ,	'		92. 00
OTHER REIMBURSABLE COST CENTERS	'			,		
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS				'		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 430, 050	232, 651	18, 959	82, 743	70, 844	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 279	4, 676	0	1, 675	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	125, 718	10, 776	0	3, 860	0	192. 00
194.00 07950 OTHER DEPARTMENTS	0	0	0	0	0	194. 00
194. 01 07951 WOMEN' S RESOURCES	15, 226	12, 417	0	4, 448	0	194. 01
194. 02 07952 MARKETI NG	15, 758	0	0	O	0	194. 02
194. 03 07953 REPRODUCTIVE MEDICINE	60	0	0	0	0	194. 03
194.04 07954 CENTER FOR HEALING ARTS	5, 354	2, 359	0	845	0	194. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 603, 445	262, 879	18, 959	93, 571	70, 844	202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0149

				10	12/31/2022	Date/lime Pre 5/30/2023 8:2	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	i aiii
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13.00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 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	229, 822					11.00
13. 00	01300 NURSING ADMINISTRATION		0				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 468	1	72, 856			14. 00
15. 00	01500 PHARMACY		0	1, 472	188, 209		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 824	1	1	0	41, 840	1
17. 00	01700 SOCIAL SERVICE	3, 670	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	40.050		0.505	al		
30.00	03000 ADULTS & PEDI ATRI CS	42, 052	1	2, 535	9	2, 417	30.00
31.00	03100 I NTENSI VE CARE UNI T	41, 791		3, 838	11, 700	5, 159	1
43. 00	04300 NURSERY	9, 281	0	240	139	1, 228	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	25 055	ol ol	0.222	O	7.000	
50.00	05000 OPERATING ROOM	25, 955 0	-	9, 323	0	7, 028 804	50. 00 51. 00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	27, 686	1	0	0	2, 061	51.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		1	-	554	5, 886	
57. 00	05700 CT SCAN	18, 300	_	363	0		1
58. 00				-	0	116 118	•
60.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY		0	0	0	4, 585	58. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.			0	0	4, 565	63.00
65. 00	06500 RESPIRATORY THERAPY	9, 596		1, 376	9, 543	1, 357	65.00
66. 00	06600 PHYSI CAL THERAPY	9, 390		·	9, 043		66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			264 44, 953	0	1, 284 1, 909	71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS				0	311	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS			7, 722 0	164, 899	2, 861	73.00
77. 00	07700 ALLOGENEI CHSCT ACQUISITION			0	104, 699	2, 801	
77.00	OUTPATIENT SERVICE COST CENTERS	C	y O	U	<u> </u>	U	77.00
90. 00	09000 CLINIC	15, 101	0	196	147	1, 672	90.00
91. 00	09100 EMERGENCY	7, 708	1	0	0	2, 991	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,700	Ĭ		Ĭ	2, ,,,	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPI OI D TREATMENT PROGRAM	C	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS			<u>, </u>	-,		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	207, 432	. 0	72, 283	186, 993	41, 840	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	787	0	0	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	14, 629	0	518	1, 172	0	192. 00
	07950 OTHER DEPARTMENTS	C	0	0	0		194. 00
194.01	07951 WOMEN'S RESOURCES	3, 566	0	19	0		194. 01
	07952 MARKETI NG	1, 940	1	4	0		194. 02
	07953 REPRODUCTIVE MEDICINE	C	0	0	44		194. 03
	07954 CENTER FOR HEALING ARTS	1, 468	0	32	0	0	194. 04
200.00	,						200. 00
201.00		C	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	229, 822	! 이	72, 856	188, 209	41, 840	202. 00

Heal th	Financial Systems	DEACONESS WOME	NS_HOSPITAL		In Lie	eu of Form CMS	<u> 2552-10</u>
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der Co		eri od:	Worksheet B	
					rom 01/01/2022 o 12/31/2022		nared:
				'	0 12/31/2022	5/30/2023 8: 2	11 am
	Cost Center Description	SOCIAL SERVICE	Subtotal	Intern &	Total		
				Residents Cost			
				& Post			
				Stepdown			
		17. 00	24. 00	Adjustments 25.00	26. 00		
	GENERAL SERVICE COST CENTERS	17.00	24.00	25.00	20.00		
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 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
13.00	01300 NURSING ADMINISTRATION						13. 00
	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE	22, 531					17. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.000	4 504 000		1 504 000		00.00
30.00	03000 ADULTS & PEDI ATRI CS	8, 088	1, 504, 802				30.00
	03100 I NTENSI VE CARE UNI T	9, 229	927, 996		1	1	31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	5, 214	155, 736	C	155, 736		43. 00
50. 00	05000 OPERATING ROOM	O	1, 203, 009	C	1, 203, 009		50.00
51. 00	05100 RECOVERY ROOM		30, 068				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		840, 747				52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	679, 554		1		54.00
57. 00	05700 CT SCAN	0	2, 868		1	1	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2, 902	C	2, 902		58. 00
60.00	06000 LABORATORY	0	98, 036	[c	98, 036		60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	796	C	796		63. 00
65.00	06500 RESPI RATORY THERAPY	0	252, 870	C	252, 870		65. 00
	06600 PHYSI CAL THERAPY	0	223, 892		/		66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	119, 214		, =		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	21, 129		•		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	222, 186				73. 00
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	0	0	C	0		77. 00
00.00	OUTPATIENT SERVICE COST CENTERS	0	709, 941		709, 941		1 00 00
	09000 CLI NI C 09100 EMERGENCY		203, 127				90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	٩	203, 127				91.00
72.00	OTHER REIMBURSABLE COST CENTERS						92.00
102 00	10200 OPLOID TREATMENT PROGRAM	0	0	С	0		102. 00
102.00	SPECIAL PURPOSE COST CENTERS	9					1.02.00
118.00		22, 531	7, 198, 873	C	7, 198, 873		118. 00
	NONREI MBURSABLE COST CENTERS	<u> </u>					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	107, 193	C	107, 193		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	448, 181	C	448, 181		192. 00
	07950 OTHER DEPARTMENTS	0	0		_	l .	194. 00
	07951 WOMEN' S RESOURCES	0	246, 335		,		194. 01
	07952 MARKETI NG	0	18, 956			i e	194. 02
	07953 REPRODUCTI VE MEDI CI NE	0	104				194. 03
	07954 CENTER FOR HEALING ARTS	0	55, 933		55, 933	i e	194. 04
200.00			0				200. 00
201.00		0	0 075 575				201. 00
202. 00	TOTAL (sum lines 118 through 201)	22, 531	8, 075, 575	[c	8, 075, 575	1	202. 00

Heal th	Fi nan	cial Systems	DEACONESS WOME	ENS HOSPITAL		In Li€	eu of Form CMS-	2552-10
COST A	LLOCAT	ION - STATISTICAL BASIS		Provi der CC	CN: 15-0149 P	eri od:	Worksheet B-1	
						rom 01/01/2022	D 1 (T' D	
					1	o 12/31/2022	Date/Time Pre 5/30/2023 8:2	
			CAPITAL REL	LATED COSTS			37 307 2023 0. 2	1 aiii
			ON TIME REE	21120 00010				
		Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
				(DOLLAR VALUE)	BENEFITS		& GENERAL	
			,		DEPARTMENT		(ACCUM. COST)	
					(GROSS		,	
					SALARI ES)			
			1.00	2.00	4. 00	5A	5. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FLXT	123, 167					1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP		2, 463, 108				2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	2, 130		51, 707, 907			4. 00
5.00		ADMINISTRATIVE & GENERAL	15, 460		6, 545, 276			5. 00
7.00	1	OPERATION OF PLANT	3, 826		444, 228		3, 844, 259	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	-1	0	_	982, 419	
9. 00		HOUSEKEEPI NG	651	25, 432	1, 017, 608		1, 708, 295	9. 00
	1	DIETARY	1, 165		236, 696		498, 301	
11. 00		CAFETERI A	2, 715	14, 991	551, 673	0	876, 682	1
		NURSING ADMINISTRATION	0	0	0	0	0	13. 00
		CENTRAL SERVICES & SUPPLY	776		138, 529	0	642, 460	1
	1	PHARMACY	895		0	0	2, 350, 405	1
		MEDICAL RECORDS & LIBRARY	494		457, 382			1
17. 00		SOCIAL SERVICE	117	0	484, 466	0	656, 243	17. 00
00.00		ENT ROUTINE SERVICE COST CENTERS	04.704	107.000	F 007 400		0.400.477	
30.00	1	ADULTS & PEDIATRICS	24, 791	107, 930	5, 837, 139			30.00
		INTENSIVE CARE UNIT	9, 448		8, 657, 433			1
43. 00		NURSERY	1, 958	14, 903	1, 059, 631	0	1, 539, 367	43. 00
FO 00		_ARY SERVICE COST CENTERS OPERATING ROOM	14 410	200 15/	2.7/4.40/		7 015 470	
		RECOVERY ROOM	14, 419		3, 764, 496			•
51.00		DELIVERY ROOM & LABOR ROOM	12 024	.,	654, 591			•
52. 00 54. 00		RADI OLOGY-DI AGNOSTI C	13, 024 5, 625		3, 925, 235 2, 285, 651		5, 963, 823 4, 178, 243	•
		CT SCAN	5,025	200, 049	88, 412		134, 634	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0		89, 426		136, 178	1
	1	LABORATORY	165	18, 615	09, 420		3, 327, 018	1
63.00		BLOOD STORING, PROCESSING, & TRANS.	100	10, 015	0	0	38, 491	1
		RESPIRATORY THERAPY	312	141, 290	1, 528, 807	0	2, 559, 475	1
		PHYSI CAL THERAPY	3, 648		1, 526, 607	0	1, 723, 901	1
		MEDICAL SUPPLIES CHARGED TO PATIENTS	3,040	10, 7/1	0	0	3, 749, 203	
		IMPL. DEV. CHARGED TO PATIENTS	0		0	0	678, 641	1
		DRUGS CHARGED TO PATIENTS	0		0	0	2, 820, 314	1
		ALLOGENEIC HSCT ACQUISITION	0		0	0		1
77.00		TIENT SERVICE COST CENTERS		<u>ا</u>				77.00
90.00	09000	CLINIC	7, 496	220, 694	5, 561, 019	0	4, 293, 584	90.00
		EMERGENCY	2, 352		2, 872, 920	0		1
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER	REIMBURSABLE COST CENTERS		,				1
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECI A	AL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111, 467	2, 348, 089	46, 200, 618	-22, 757, 999	74, 103, 837	118. 00
		MBURSABLE COST CENTERS				T		
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 810					1
		PHYSICIANS' PRIVATE OFFICES	4, 171	92, 416	4, 330, 120		-, ,	
		OTHER DEPARTMENTS	0	0	0	, and the second		194. 00
		WOMEN'S RESOURCES	4, 806		347, 687		1 700, 770	
		MARKETI NG	0	675	268, 343	0	816, 568	
		REPRODUCTI VE MEDI CI NE	0	0	0	0		194. 03
	1	CENTER FOR HEALING ARTS	913	5, 968	193, 357	0	277, 418	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201. 00
202.00		Cost to be allocated (per Wkst. B,	5, 205, 007	2, 870, 568	15, 944, 717		22, 757, 999	202. 00
202 00		Part I)	42 250752	1 1/5/25	0 2002/1		0 272000	202 00
203.00		Unit cost multiplier (Wkst. B, Part I)	42. 259753	1. 165425			0. 273899	•
204.00		Cost to be allocated (per Wkst. B,			90, 013		1, 603, 445	204.00
205 00		Part II) Unit cost multiplier (Wkst. B, Part			0 001741		0. 019298	205 00
205.00		II)			0. 001741		0.019298	200.00
206.00		NAHE adjustment amount to be allocated						206. 00
200.00		(per Wkst. B-2)						
207.00		NAHE unit cost multiplier (Wkst. D,						207. 00
		Parts III and IV)						

		cial Systems	DEACONESS WOME				u of Form CMS-:	
COST A	LLOCAT	TION - STATISTICAL BASIS		Provi der Co	CN: 15-0149 F	Peri od:	Worksheet B-1	
						rom 01/01/2022	5	
						To 12/31/2022		
		C+ C+ Di-+i	ODEDATION OF	I ALINDOV 0	HOUSEKEEDING	DIETADY	5/30/2023 8: 2	ı am
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	CAFETERI A	
			PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(FTES)	
			(SQUARE FEET)	(GROSS				
				REVENUE)				
	I		7. 00	8. 00	9. 00	10.00	11. 00	
		AL SERVICE COST CENTERS			ı	, ,		
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00		ADMINISTRATIVE & GENERAL						5. 00
7.00	00700	OPERATION OF PLANT	101, 751					7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	0	107, 772, 428				8. 00
9.00	00900	HOUSEKEEPI NG	651	0	101, 100			9. 00
10.00	01000	DI ETARY	1, 165	0	1, 165	25, 845		10.00
11.00	01100	CAFETERI A	2, 715	0	2, 715		4, 383	11. 00
13.00	1	NURSING ADMINISTRATION	0	0	, (0	1
14. 00		CENTRAL SERVICES & SUPPLY	776	0	776		28	1
15. 00		PHARMACY	895	0	895		0	1
16. 00	1	MEDICAL RECORDS & LIBRARY	494	0	494		92	
17. 00		SOCIAL SERVICE	117	0	117		70	
17.00			117	0	11.	v U	70	17.00
00.00		ENT ROUTINE SERVICE COST CENTERS	04.704	0 /50 500	0.4.70	ıl al	000	
30. 00		ADULTS & PEDIATRICS	24, 791	9, 652, 500			802	
31. 00		INTENSIVE CARE UNIT	9, 448	26, 187, 102			797	
43. 00		NURSERY	1, 958	6, 235, 989	1, 958	0	177	43. 00
		LARY SERVICE COST CENTERS				, ,		
50.00		OPERATING ROOM	14, 419	35, 969, 325			495	
51.00	05100	RECOVERY ROOM	0	4, 083, 740	(0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13, 024	10, 462, 804	13, 024	1 0	528	52.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	5, 625	0	5, 625	sl ol	349	54.00
57.00		CT SCAN	l	0	. (0	57.00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	1
60.00		LABORATORY	165	0	165		0	1
63. 00		BLOOD STORING, PROCESSING, & TRANS.	0	0	100		0	1
65. 00		RESPIRATORY THERAPY	312	0	312	1 1	183	
		PHYSI CAL THERAPY	3, 648	0	3, 648			
66. 00	1		3, 048	0			0	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(-	0	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	
73. 00		DRUGS CHARGED TO PATIENTS	0	0	(0	
77. 00		ALLOGENEIC HSCT ACQUISITION	0	0	(0	0	77. 00
		TIENT SERVICE COST CENTERS						
90.00		CLI NI C	7, 496	0	7, 496		288	90.00
91.00	09100	EMERGENCY	2, 352	15, 180, 968	2, 352	231	147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER	REIMBURSABLE COST CENTERS			•			1
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	(0	0	102. 00
		AL PURPOSE COST CENTERS	-1			·		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90, 051	107, 772, 428	89, 400	25, 845	3 956	118. 00
		MBURSABLE COST CENTERS	,0,00.	10777727120	077.100	20,0.0	0,700	1.10.00
190 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 810	0	1, 810	ol	15	190. 00
		PHYSICIANS' PRIVATE OFFICES	4, 171	0				192. 00
	1	OTHER DEPARTMENTS	4, 171	0	4, 17,			194. 00
			4 004	0	4 00			
	1	WOMEN'S RESOURCES	4, 806	0	4, 806			194. 01
		MARKETI NG	0	0		0		194. 02
		REPRODUCTIVE MEDICINE	0	0	(이		194. 03
	1	CENTER FOR HEALING ARTS	913	0	913	3 0	28	194. 04
200.00)	Cross Foot Adjustments						200. 00
201.00)	Negative Cost Centers						201. 00
202.00)	Cost to be allocated (per Wkst. B,	4, 897, 198	1, 251, 503	2, 207, 527	716, 294	2, 016, 649	202. 00
		Part I)						
203.00)	Unit cost multiplier (Wkst. B, Part I)	48. 129237	0. 011612	21. 835084	27. 714993	460. 107004	203.00
204.00)	Cost to be allocated (per Wkst. B,	262, 879	18, 959	93, 57	70, 844	229, 822	204.00
		Part II)		•			•	
205.00)	Unit cost multiplier (Wkst. B, Part	2. 583552	0. 000176	0. 925529	2. 741110	52. 434862	205. 00
		11)						
206.00		NAHE adjustment amount to be allocated						206. 00
		(per Wkst. B-2)						
207. 00		NAHE unit cost multiplier (Wkst. D,						207. 00
		Parts III and IV)						
	1	,	ı I		1	1		

Health Finar	ncial Systems	DEACONESS WOME	NS_HOSPITAL		In Lie	u of Form CMS-2	<u> 2552-1</u> 1
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CC		eriod: rom 01/01/2022 o 12/31/2022	Worksheet B-1 Date/Time Pre 5/30/2023 8:2	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NURS.	CENTRAL SERVICES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	RECORDS &	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		HRS.)	REQUIS.)		CHARGES)	57.1.0)	
		13. 00	14. 00	15. 00	16.00	17. 00	
GENER	AL SERVICE COST CENTERS		•				
2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	0 0	6, 402, 545 129, 404	3, 052, 625			1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00
	MEDICAL RECORDS & LIBRARY	0	58	0	212, 676, 876		16.00
	SOCIAL SERVICE	0	14	0	U	22, 915	17. 00
	I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	222, 811	141	12, 268, 484	8, 226	30.00
1	INTENSIVE CARE UNIT	0	337, 269				
	NURSERY		21, 066	2, 252			
	LARY SERVICE COST CENTERS	٩.	2.7000	2,202	0,200,707	0,000	1 .0.00
	OPERATING ROOM	0	819, 301	0	35, 969, 326	0	50.00
	RECOVERY ROOM	0	O	0	4, 083, 740	0	51.00
4	DELIVERY ROOM & LABOR ROOM	0	0	0	,	0	
	RADI OLOGY-DI AGNOSTI C	0	31, 942	8, 979		0	
	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	589, 947 596, 715	0	
	LABORATORY	0	22	0	23, 272, 003	0	
-	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	269, 078	0	
	RESPI RATORY THERAPY	0	120, 921	154, 786		0	65. 00
	PHYSI CAL THERAPY	0	23, 171	33		0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 950, 389	0	9, 691, 295	0	1
	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	678, 641 0	0 2, 674, 575	1, 579, 787 14, 521, 832	0	
	ALLOGENEIC HSCT ACQUISITION	0	0	2, 674, 575	14, 321, 632	0	
	TIENT SERVICE COST CENTERS	<u> </u>		0	J		1 / / . 00
	CLINIC	0	17, 258	2, 381	8, 485, 052	0	90.00
	EMERGENCY	0	0	0	15, 180, 968	0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	REIMBURSABLE COST CENTERS		ام	0	0	0	100.00
	OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0	U	0	102. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	6, 352, 267	3, 032, 907	212, 676, 876	22, 915	1118.00
	I MBURSABLE COST CENTERS		.,,,	.,,,	, 2, 2, 3, 0		1
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	PHYSICIANS' PRIVATE OFFICES	0	45, 488	19, 008			192. 00
	OTHER DEPARTMENTS	0	0	0	0		194.00
194. 01 07951	WOMEN'S RESOURCES	0	1, 654 355	0	0		194. 0 ²
4	REPRODUCTIVE MEDICINE	0	333	710	0		194. 02
	CENTER FOR HEALING ARTS	0	2, 781	0	0		194. 04
200. 00	Cross Foot Adjustments]					200. 00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	885, 604	3, 074, 696		876, 382	
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0.000000	0. 138321 72, 856	1. 007230 188, 209			
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	0. 011379	0. 061655	0. 000197	0. 983242	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
		i I			i l		1

Health Financial Systems	DEACONESS WOM	ENS HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	CN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/30/2023 8:2	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	

Title Will Hospital PPS Costs Cost Center Description Total Cost From West. B, Part I, col. 260 1.00 2.00 3.00 4.00 5.00						5/30/2023 8: 2	1 am
Note Cost Center Description			Title	XVIII	Hospi tal		
INPATI ENT ROUTI NE SERVI CE COST CENTERS Adj Di sal I owance Di sal I owanc					Costs		
NAME NAME	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
NATI ENT ROUTI NE SERVI CE COST CENTERS 14, 327, 692 14, 327, 692 30, 00 30 30 30 30 30 30		(from Wkst. B,	Adj .		Di sal I owance		
INPATI ENT ROUTINE SERVICE COST CENTERS 1,00 2,00 3,00 4,00 5,00		Part I, col.					
NPATI ENT ROUTINE SERVICE COST CENTERS 14, 327, 692 14, 327, 692 0 14, 327, 692 30. 00 30. 00 30. 00 30. 00 30. 00 1NTENSI VE CARE UNIT 14, 551, 750 14, 551, 750 22, 810 14, 574, 560 31. 00 30. 00 30. 00 1NTENSI VE CARE UNIT 14, 551, 750 2, 488, 432 0 2, 488, 432 43. 00 2, 488, 432 0 2, 488, 432 43. 00 20. 00 2							
30. 00 03000 ADULTS & PEDIATRICS 14, 327, 692 14, 327, 692 0 14, 327, 692 30. 00 31. 00 03100 INTENSIVE CARE UNIT 14, 551, 750 14, 551, 750 22, 810 14, 574, 560 31. 00 43.00 ADULTS & PEDIATRIC S 2, 488, 432 2, 488, 432 0 2, 484, 434 0 2,		1.00	2.00	3.00	4. 00	5. 00	
31.00 03100 NTENSIVE CARE UNIT 14,551,750 24,88,432 0 2,488,434 0 2,488,434							
43.00 04300 NURSERY 2, 488, 432 2, 488, 432 0 2, 488, 432 43.00 2, 00 0 0 0 0 0 0 0 0 0		14, 327, 692		14, 327, 692	. 0	14, 327, 692	30. 00
ANCILLARY SERVICE COST CENTERS		14, 551, 750		14, 551, 750	22, 810	14, 574, 560	31. 00
50. 00 05000 OPERATING ROOM 11, 124, 334 11, 124, 334 68, 139 11, 192, 473 50. 00 5100 RECOVERY ROOM 1, 174, 015 1, 174, 015 0 1, 174, 015 51. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 8, 920, 935 8, 920, 935 0 8, 920, 935 52. 00 65. 00 05400 RADIOLOGY-DIAGNOSTIC 6, 027, 266 6, 027, 266 22, 901 6, 050, 167 54. 00 57. 00 05700 CT SCAN 174, 215 174, 215 0 174, 215 57. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 176, 214 176, 214 0 176, 214 58. 00 63. 00 06000 LABORATORY 4, 356, 557 4, 356, 557 0 4, 356, 557 0 06000 LABORATORY 3, 570, 759 0 3, 570, 75		2, 488, 432		2, 488, 432	. 0	2, 488, 432	43. 00
51. 00							
52. 00		11, 124, 334		11, 124, 334	68, 139	11, 192, 473	50.00
54. 00	51.00 05100 RECOVERY ROOM	1, 174, 015		1, 174, 015	0	1, 174, 015	51.00
57. 00 05700 CT SCAN 174, 215 174, 215 174, 215 0 174, 215 57. 00 5800 MAGNETI C RESONANCE IMAGING (MRI) 176, 214 176, 214 0 176, 214 0 176, 214 58. 00 60. 00 6000 LABORATORY 4, 356, 557 4, 356, 557 0 4, 356, 557 0 4, 356, 557 0 4, 356, 557 0 60. 00 60. 00 6000 BLOOD STORING, PROCESSING, & TRANS. 50, 268 50, 268 0 50, 268 63. 00 65. 00 6500 RESPIRATORY THERAPY 3, 570, 759 0 3, 570, 759 0 3, 570, 759 65. 00 66. 00 6600 PHYSICAL THERAPY 2, 484, 434 0 2, 484, 434 0 2, 484, 434 0 2, 484, 434 0 2, 484, 434 0 2, 484, 434 0 2, 484, 434 0 0 2,	52.00 05200 DELIVERY ROOM & LABOR ROOM	8, 920, 935		8, 920, 935	0	8, 920, 935	52.00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 176, 214 176, 214 0 176, 214 58. 00 60. 00 06000 LABORATORY 4, 356, 557 4, 356, 557 0 4, 356, 557 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 50, 268 50, 268 0 50, 268 63. 00 65. 00 06500 RESPI RATORY THERAPY 3, 570, 759 0 0 5, 366, 970	54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 027, 266		6, 027, 266	22, 901	6, 050, 167	54. 00
60. 00	57. 00 05700 CT SCAN	174, 215		174, 215	0	174, 215	57. 00
63. 00	58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	176, 214		176, 214	. 0	176, 214	58. 00
65. 00	60. 00 06000 LABORATORY	4, 356, 557		4, 356, 557	0	4, 356, 557	60.00
66. 00 06600 PHYSI CAL THERAPY 2, 484, 434 0 2, 484, 434 0 2, 484, 434 66. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 5, 366, 970 5, 366, 970 0 5, 366, 970 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 965, 635 965, 635 0 965, 635 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 6, 353, 306 6, 353, 306 0 6, 353, 306 73. 00 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0000 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0, 170, 253 77, 296 6, 247, 549 90. 00 91. 00 09100 EMERGENCY 5, 075, 934 5, 075, 934 1, 312, 309 6, 388, 243 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 2, 713, 614 2, 713, 614 22, 713, 614 102. 00 THER REIMBURSABLE COST CENTERS 102. 00 TOOO OUTPATIENT PROGRAM 0 0 0 0 200. 00 Subtotal (see instructions) 96, 072, 583 0, 96, 072, 583 1, 503, 455 97, 576, 038 200. 00 201. 00 Less Observation Beds 2, 713, 614 2, 713, 614 201. 00	63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	50, 268		50, 268	0	50, 268	63.00
71. 00	65. 00 06500 RESPIRATORY THERAPY	3, 570, 759	0	3, 570, 759	0	3, 570, 759	65. 00
72. 00	66. 00 06600 PHYSI CAL THERAPY	2, 484, 434	0	2, 484, 434	. 0	2, 484, 434	66.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 6, 353, 306 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 366, 970		5, 366, 970	0	5, 366, 970	71.00
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 77. 00 00 0 0 77. 00 00 0 0 0 0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	965, 635		965, 635	0	965, 635	72.00
OUTPATI ENT SERVI CE COST CENTERS O O O O O O O O O	73.00 07300 DRUGS CHARGED TO PATIENTS	6, 353, 306		6, 353, 306	0	6, 353, 306	73. 00
90. 00 09000 CLINI C 6, 170, 253 6, 170, 253 77, 296 6, 247, 549 90. 00 91. 00 9100 EMERGENCY 5, 075, 934 5, 075, 934 1, 312, 309 6, 388, 243 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 2, 713, 614 2, 713, 614 2, 713, 614 2, 713, 614 201. 00 0910 ID TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0	77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		C	0	0	77. 00
91. 00 09100 EMERGENCY 5, 075, 934 5, 075, 934 1, 312, 309 6, 388, 243 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 2, 713, 614 2, 713, 614 2, 713, 614 22, 713, 614 92. 00 000	OUTPATIENT SERVICE COST CENTERS						
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 2,713,614 2,713,614 92. 00 0THER REI MBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 0 0 0 0 0 0 0 0 0	90. 00 09000 CLI NI C	6, 170, 253		6, 170, 253	77, 296	6, 247, 549	90.00
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 0 102.00 0 102.00 0 0 102.00 0	91. 00 09100 EMERGENCY	5, 075, 934		5, 075, 934	1, 312, 309	6, 388, 243	91.00
102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 200.00 Subtotal (see instructions) 96,072,583 0 96,072,583 1,503,455 97,576,038 200.00 201.00 Less Observation Beds 2,713,614 2,713,614 2,713,614 2,713,614	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 713, 614		2, 713, 614		2, 713, 614	92.00
200.00 Subtotal (see instructions) 96,072,583 0 96,072,583 1,503,455 97,576,038 200.00 201.00 Less Observation Beds 2,713,614 201.00	OTHER REIMBURSABLE COST CENTERS						
201.00 Less Observation Beds 2,713,614 2,713,614 2,713,614 201.00	102.00 10200 OPI OI D TREATMENT PROGRAM	0		C		0	102. 00
	200.00 Subtotal (see instructions)	96, 072, 583	0	96, 072, 583	1, 503, 455	97, 576, 038	200. 00
202.00 Total (see instructions) 93,358,969 0 93,358,969 1,503,455 94,862,424 202.00	201.00 Less Observation Beds	2, 713, 614		2, 713, 614		2, 713, 614	201. 00
	202.00 Total (see instructions)	93, 358, 969	0	93, 358, 969	1, 503, 455	94, 862, 424	202. 00

Health Financial Systems	DEACONESS WOMENS HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Worksheet C
		From 01/01/2022	

					o 12/31/2022	Date/Time Pre 5/30/2023 8:2	
			Title	XVIII	Hospi tal	PPS	
			Charges	<u> </u>	· ·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9, 652, 500		9, 652, 500)		30. 00
31.00	03100 INTENSIVE CARE UNIT	26, 187, 102		26, 187, 102	2		31. 00
43.00	04300 NURSERY	6, 235, 989		6, 235, 989			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	11, 544, 743	24, 424, 583			0.000000	
51. 00	05100 RECOVERY ROOM	283, 279	3, 800, 461	4, 083, 740		0.000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	10, 462, 804	0	10, 462, 804		0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 265, 965	26, 611, 534	29, 877, 499		0. 000000	
57. 00	05700 CT SCAN	126, 401	463, 546	589, 947		0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	249, 861	346, 854	·		0. 000000	
60.00	06000 LABORATORY	11, 717, 809	11, 554, 194			0. 000000	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	230, 634	38, 444	269, 078		0. 000000	
65. 00	06500 RESPI RATORY THERAPY	6, 877, 801	9, 598			0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	501, 053	6, 016, 803			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 066, 712	7, 624, 583			0. 000000	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	75, 361	1, 504, 426			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	9, 227, 975	5, 293, 857	14, 521, 832		0. 000000	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0. 000000	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	299, 441	8, 185, 611	8, 485, 052		0. 000000	1
91. 00	09100 EMERGENCY	3, 247, 836	11, 933, 132			0. 000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 377, 151	1, 238, 833	2, 615, 984	1. 037321	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	10200 OPI OI D TREATMENT PROGRAM	0	0	()		102. 00
200.00		103, 630, 417	109, 046, 459	212, 676, 876			200. 00
201.00	l l						201. 00
202.00	Total (see instructions)	103, 630, 417	109, 046, 459	212, 676, 876) 		202. 00

Health Financial Systems	DEACONESS WOMEN	IS HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/30/2023 8:2	pared:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30 00 03000 ADULTS & PEDLATRICS					7 20 00

		II LIE XVIII	HOSPI Lai	PP3
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 311167			50. 00
51.00 05100 RECOVERY ROOM	0. 287485			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 852633			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 202499			54.00
57.00 05700 CT SCAN	0. 295306			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 295307			58. 00
60. 00 06000 LABORATORY	0. 187202			60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 186816			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 518448			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 381174			66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 553793			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 611244			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 437500			73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS	·			
90. 00 09000 CLI NI C	0. 736301			90.00
91. 00 09100 EMERGENCY	0. 420806			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 037321			92. 00
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPIOID TREATMENT PROGRAM				102. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	DEACONESS WOMENS HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/30/2023 8:21 am

			Т	o 12/31/2022	Date/Time Pre 5/30/2023 8:2	
		Ti tl	e XIX	Hospi tal	PPS	
·				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00 03000 ADULTS & PEDI ATRI CS	14, 327, 692		14, 327, 692		14, 327, 692	
31.00 03100 INTENSIVE CARE UNIT	14, 551, 750		14, 551, 750		14, 574, 560	1
43. 00 04300 NURSERY	2, 488, 432		2, 488, 432	0	2, 488, 432	43. 00
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	11, 124, 334		11, 124, 334		11, 192, 473	
51.00 05100 RECOVERY ROOM	1, 174, 015		1, 174, 015		1, 174, 015	
52.00 05200 DELIVERY ROOM & LABOR ROOM	8, 920, 935		8, 920, 935		8, 920, 935	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 027, 266		6, 027, 266		6, 050, 167	
57.00 05700 CT SCAN	174, 215		174, 215		174, 215	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	176, 214		176, 214		176, 214	
60. 00 06000 LABORATORY	4, 356, 557		4, 356, 557		4, 356, 557	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	50, 268		50, 268		50, 268	
65. 00 06500 RESPI RATORY THERAPY	3, 570, 759	0	3, 570, 759		3, 570, 759	
66. 00 06600 PHYSI CAL THERAPY	2, 484, 434	0	2, 484, 434		2, 484, 434	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 366, 970		5, 366, 970		5, 366, 970	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	965, 635		965, 635		965, 635	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 353, 306		6, 353, 306	0	6, 353, 306	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		C	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	6, 170, 253		6, 170, 253			
91. 00 09100 EMERGENCY	5, 075, 934		5, 075, 934		6, 388, 243	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 713, 614		2, 713, 614		2, 713, 614	92. 00
OTHER REIMBURSABLE COST CENTERS	1					
102.00 10200 OPI OI D TREATMENT PROGRAM	0		C			102. 00
200.00 Subtotal (see instructions)	96, 072, 583	0	96, 072, 583			
201.00 Less Observation Beds	2, 713, 614	_	2, 713, 614		2, 713, 614	
202.00 Total (see instructions)	93, 358, 969	0	93, 358, 969	1, 503, 455	94, 862, 424	202.00

Health Financial Systems	DEACONESS WOMENS HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Worksheet C
		From 01/01/2022	

					From 01/01/2022 Fo 12/31/2022	Part Date/Time Pre	
						5/30/2023 8: 2	21 am
		_		e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpati ent		Cost or Other	TEFRA	
				+ col . 7)	Ratio	Inpatient Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	6.00	9.00	10.00	
30. 00	03000 ADULTS & PEDI ATRI CS	9, 652, 500		9, 652, 500			30.00
31. 00	03100 I NTENSI VE CARE UNI T	26, 187, 102		26, 187, 10	1		31.00
	04300 NURSERY	6, 235, 989		6, 235, 98	1		43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	0,200,707		0, 200, 70	<u> </u>		10.00
50.00	05000 OPERATING ROOM	11, 544, 743	24, 424, 583	35, 969, 32	0. 309273	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	283, 279	3, 800, 461	4, 083, 740	1	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 462, 804	0	10, 462, 80	0. 852633	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 265, 965	26, 611, 534	29, 877, 49	0. 201733	0.000000	54. 00
57.00	05700 CT SCAN	126, 401	463, 546	589, 94	0. 295306	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	249, 861	346, 854	596, 71	0. 295307	0.000000	58. 00
60.00	06000 LABORATORY	11, 717, 809	11, 554, 194	23, 272, 00		0.000000	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	230, 634	38, 444	269, 07		0. 000000	
65.00	06500 RESPI RATORY THERAPY	6, 877, 801	9, 598			0.000000	
66.00	06600 PHYSI CAL THERAPY	501, 053	6, 016, 803	6, 517, 85	1	0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 066, 712	7, 624, 583	9, 691, 29		0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	75, 361	1, 504, 426	· · ·		0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	9, 227, 975	5, 293, 857	14, 521, 83		0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0.000000	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS				.1		
	09000 CLI NI C	299, 441	8, 185, 611	8, 485, 05		0. 000000	
	09100 EMERGENCY	3, 247, 836	11, 933, 132			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 377, 151	1, 238, 833	2, 615, 98	1. 037321	0. 000000	92. 00
400.00	OTHER REIMBURSABLE COST CENTERS		0				100.00
	10200 OPIOID TREATMENT PROGRAM	100 (20 417	100 047 450	212 (7/ 07	,		102. 00
200.00		103, 630, 417	109, 046, 459	212, 676, 87			200. 00
201.00		100 (00 117	400 047 450	040 (7/ 07	,		201. 00
202.00	Total (see instructions)	103, 630, 417	109, 046, 459	212, 676, 87	b		202. 00

Health Financial Systems	DEACONESS WOMENS	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/30/2023 8:2	pared:
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30. 00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 311167				50. 00
51.00 05100 RECOVERY ROOM	0. 287485				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 852633				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 202499				54.00
57. 00 05700 CT SCAN	0. 295306				57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 295307				58. 00
60. 00 06000 LABORATORY	0. 187202				60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 186816				63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 518448				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 381174				66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 553793				71. 00
TO BE STORE LINE BELL SUMBORD TO DATIFUTO	0 (44044				1

0. 611244

0. 437500

0.000000

0. 736301

72.00

73.00

77.00

90.00

72.00 07200 IMPL. DEV. CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

73.00 O7300 DRUGS CHARGED TO PATIENTS
77.00 O7700 ALLOGENEIC HSCT ACQUISITION

09000 CLI NI C

90.00

Health Financial Systems	DEACONESS WOMENS	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE C REDUCTIONS FOR MEDICALD ONLY	OST TO CHARGE RATIOS NET OF	Provider CCN: 15-0149	From 01/01/2022	Worksheet C Part II Date/Time Prepared:

				10) 12/31/2022	5/30/2023 8:2	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	11, 124, 334			0	0	
	05100 RECOVERY ROOM	1, 174, 015			0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	8, 920, 935			0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	6, 027, 266		5, 347, 712	0	0	54.00
	05700 CT SCAN	174, 215			0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	176, 214			0	0	58. 00
	06000 LABORATORY	4, 356, 557			0	0	60.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	50, 268			0	0	63. 00
	06500 RESPI RATORY THERAPY	3, 570, 759			0	0	65. 00
	06600 PHYSI CAL THERAPY	2, 484, 434			0	0	66. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 366, 970			0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	965, 635		944, 506	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	6, 353, 306	222, 186	6, 131, 120	0	0	73. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	_					
	09000 CLI NI C	6, 170, 253			0	0	
	09100 EMERGENCY	5, 075, 934			0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 713, 614	285, 005	2, 428, 609	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	10200 OPIOID TREATMENT PROGRAM	0	0	0	0		102. 00
200.00	,	64, 704, 709			0		200. 00
201.00	1 1	2, 713, 614			0		201. 00
202.00	Total (line 200 minus line 201)	61, 991, 095	4, 610, 339	57, 380, 756	0	0	202. 00

Health Financial Systems	DEACONESS WOMENS	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST	TO CHARGE RATIOS NET OF	Provider CCN: 15-0149	From 01/01/2022	Worksheet C Part II Date/Time Prepared:

					12,01,2022	5/30/2023 8:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Total Charges				
		Capital and		Cost to Charge			
		Operating Cost					
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						4
	05000 OPERATING ROOM	11, 124, 334					50.00
	05100 RECOVERY ROOM	1, 174, 015	4, 083, 740				51. 00
	05200 DELIVERY ROOM & LABOR ROOM	8, 920, 935	10, 462, 804	•			52. 00
	05400 RADI OLOGY-DI AGNOSTI C	6, 027, 266	29, 877, 499	•			54. 00
	05700 CT SCAN	174, 215	589, 947	•			57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	176, 214	596, 715	•			58. 00
	06000 LABORATORY	4, 356, 557	23, 272, 003	•			60. 00
	06300 BLOOD STORING, PROCESSING, & TRANS.	50, 268	269, 078				63. 00
	06500 RESPI RATORY THERAPY	3, 570, 759	6, 887, 399				65. 00
	06600 PHYSI CAL THERAPY	2, 484, 434	6, 517, 856	0. 381174	Į.		66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 366, 970	9, 691, 295	0. 553793	3		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	965, 635	1, 579, 787	0. 611244	Į.		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	6, 353, 306	14, 521, 832	0. 437500			73. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 000000)		77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	6, 170, 253	8, 485, 052				90. 00
	09100 EMERGENCY	5, 075, 934	15, 180, 968				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 713, 614	2, 615, 984	1. 037321			92. 00
	OTHER REIMBURSABLE COST CENTERS						
102. 00	10200 OPI OI D TREATMENT PROGRAM	0	0	0. 000000)		102. 00
200.00	Subtotal (sum of lines 50 thru 199)	64, 704, 709	170, 601, 285				200. 00
201.00	Less Observation Beds	2, 713, 614	0				201.00
202.00	Total (line 200 minus line 201)	61, 991, 095	170, 601, 285				202. 00

Health Financial Systems	DEACONESS WOME	NS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2022 To 12/31/2022		pared: 1 am
		Title	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 & PEDIATRICS	1, 504, 802	0	1, 504, 80	2 10, 148	148. 29	30.00
31.00 INTENSIVE CARE UNIT	927, 996		927, 99	6 9, 386	98. 87	31. 00
43. 00 NURSERY	155, 736		155, 73	6 5, 303	29. 37	43.00
200.00 Total (lines 30 through 199)	2, 588, 534		2, 588, 53	4 24, 837		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	126	18, 685				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
43. 00 NURSERY	O	0				43.00
200.00 Total (lines 30 through 199)	126	18, 685				200. 00

Health Financial Systems	DEACONESS WOME	ENS HOSPITAL		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider Co		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part II	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	(from Wkst. B, Part II, col.	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Program	Capital Costs (column 3 x column 4)	
	26) 1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	1, 203, 009			•	25, 389	50.00
51.00 05100 RECOVERY ROOM	30, 068	4, 083, 740	0. 00736	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	840, 747	10, 462, 804	0. 08035	20, 097	1, 615	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	679, 554	29, 877, 499	0. 02274	12, 175	277	54. 00
57.00 05700 CT SCAN	2, 868	589, 947	0. 00486	6, 217	30	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 902	596, 715	0.00486			58. 00
60. 00 06000 LABORATORY	98, 036	23, 272, 003	0.00421	381, 974	1, 609	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	796	269, 078	0.00295	19, 521	58	63.00
65. 00 06500 RESPI RATORY THERAPY	252, 870	6, 887, 399	0. 03671	5, 426	199	65. 00
66. 00 06600 PHYSI CAL THERAPY	223, 892	6, 517, 856	0. 03435	4, 350	149	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	119, 214	9, 691, 295	0. 01230	179, 004	2, 202	71. 00

21, 129

222, 186

709, 941

203, 127

285, 005

4, 895, 344

1, 579, 787

14, 521, 832

8, 485, 052

15, 180, 968

2, 615, 984 170, 601, 285

0.013375

0. 015300

0.000000

0.083670

0.013380

0. 108948

152, 817

3, 021

4, 879

14, 871

12, 414

1, 579, 390

2, 338

40

0 77.00

408

199

1, 352 92. 00

35, 882 200. 00

72.00

73.00

90.00

91.00

72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS

07700 ALLOGENEIC HSCT ACQUISITION

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

OUTPATIENT SERVICE COST CENTERS

73. 00 07300 DRUGS CHARGED TO PATIENTS

90. 00 09000 CLINIC

200.00

91. 00 09100 EMERGENCY

Health Financial Systems	DEACONESS WOME	ENS HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	S Provider C		Period: From 01/01/2022 To 12/31/2022		pared: 1 am
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
· ·	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	Ŭ	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	o	C	ol	ol o	0	31. 00
43. 00 04300 NURSERY	0	Ċ		0	0	43.00
200.00 Total (lines 30 through 199)	o	Ċ		o o	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
, , , , , , , , , , , , , , , , , , ,	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		'		
		minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			*	<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	0	C	10, 14	8 0.00	126	30.00
31.00 03100 INTENSIVE CARE UNIT		C	9, 38	6 0.00	0	31. 00
43. 00 04300 NURSERY		C	5, 30	0.00	0	1
200.00 Total (lines 30 through 199)		C	24, 83	7	126	200. 00
Cost Center Description	I npati ent			<u>'</u>		
· ·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	ol					31.00
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	o					200. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-1					

Health Financial Systems	DEACONESS WOME	NS HOSPITAL		In Lie	eu of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider C	CN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prep 5/30/2023 8:2	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Contor Doscription	Non Physician	Nurci na	Nurcina	Allied Health	Allied Health	

					5/30/2023 8: 2	1 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	(0	0	50. 00
51.00 05100 RECOVERY ROOM	0	0	(0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
57. 00 05700 CT SCAN	0	0	(0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(0	0	58. 00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
63.00 O6300 BLOOD STORING, PROCESSING, & TRANS.	0	0	(0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(0	0	90.00
91. 00 09100 EMERGENCY	0	0	(0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(D	0	92. 00
200.00 Total (lines 50 through 199)	0	0	(0	0	200. 00

	5	DE A CONECC WOM	THE HOODI TAI			6.5. 046.4	0550 40
	Financial Systems	DEACONESS WOME				u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider Co		Peri od:	Worksheet D	
THROUG	SH COSTS				From 01/01/2022 To 12/31/2022		narod:
					10 12/31/2022	5/30/2023 8: 2	1 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(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 OPERATI NG ROOM	0	0		0 35, 969, 326		50.00
51.00	05100 RECOVERY ROOM	0	0		0 4, 083, 740	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 10, 462, 804	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 29, 877, 499	0.000000	54.00
57.00	05700 CT SCAN	0	0		0 589, 947	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 596, 715	0.000000	58. 00
60.00	06000 LABORATORY	0	0		0 23, 272, 003	0.000000	60. 00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 269, 078	0.000000	63. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0 6, 887, 399	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 6, 517, 856	0.000000	66. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 9, 691, 295	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 579, 787	0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 14, 521, 832	0. 000000	73. 00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		ol o	0. 000000	
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>				<u> </u>	1
90.00	09000 CLI NI C	0	0		0 8, 485, 052	0.000000	90.00
91. 00	09100 EMERGENCY	0	0		0 15, 180, 968	l e	
92 00	00200 ORSERVATION REDS (NON-DISTINCT DART)		1		0 2 615 094		

0 0 0

0 0 0

8, 485, 052 15, 180, 968 2, 615, 984 170, 601, 285

0 0 0

0.000000

92. 00 200. 00

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50 through 199)

Health Financial Systems	DEACONESS WOMENS				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der Co		Peri od: From 01/01/2022	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2022		narod:
				10 12/31/2022	5/30/2023 8: 2	1 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	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 OPERATING ROOM	0. 000000	759, 140		0 3, 284, 445	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 445	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	20, 097		0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	12, 175		0 1, 275, 387	0	54.00
57. 00 05700 CT SCAN	0. 000000	6, 217		0 6, 153	0	57. 00
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 000000	3, 484		0 0	0	58. 00
60. 00 06000 LABORATORY	0. 000000	381, 974		0 638, 322	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	19, 521		0 0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	5, 426		0 242	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	4, 350		0 49, 794	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	179, 004		0 794, 261	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 021		0 211, 790	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	152, 817		0 309, 287	0	73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS				<u>'</u>		1
90. 00 09000 CLI NI C	0. 000000	4, 879		0 51, 682	0	90.00
91. 00 09100 EMERGENCY	0. 000000	14, 871		0 47, 205	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	12, 414		0 5, 673	0	92.00
200.00 Total (lines 50 through 199)		1, 579, 390		0 6, 674, 686	0	200. 00

Health Financial Systems	DEACONESS WOME	ENS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see		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.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			T			
50. 00 05000 OPERATI NG ROOM	0. 309273			0	1, 015, 790	
51. 00 05100 RECOVERY ROOM	0. 287485	l .		0	128	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 852633	l .		0	0	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 201733			0	257, 288	
57. 00 05700 CT SCAN	0. 295306	6, 153		0	1, 817	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 295307	0		0	0	58. 00
60. 00 06000 LABORATORY	0. 187202	638, 322		0	119, 495	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 186816			0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 518448			0	125	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 381174			0	18, 980	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 553793			0	439, 856	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 611244			0	129, 455	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 437500		ı	0	135, 313	
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	0.707404	F4 (00	ı		07.500	00.00
90. 00 09000 CLI NI C	0. 727191	51, 682		0 0	37, 583	
91. 00 09100 EMERGENCY	0. 334362			0	15, 784	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 037321	5, 673		0	5, 885	
200.00 Subtotal (see instructions)		6, 674, 686		0	2, 177, 499	
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)		6, 674, 686		0 0	2, 177, 499	202 00
202.00 Net charges (Title 200 - Title 201)	Į.	0,074,080	I	U _I U	2, 177, 499	J202. 00

Health Financial Systems	DEACONESS WOMENS	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HE	ALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/30/2023 8:21 am
		Title XVIII	Hospi tal	PPS
	Costs	:		

				lo	12/31/2022	Date/lime Pro 5/30/2023 8::	
		Title	XVIII	H	Hospi tal	PPS	
	Cos	sts					
Cost Center Description	Cost	Cost					
	Rei mbursed	Reimbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
		Ded. & Coins.					
	(see inst.)	(see inst.)					
	6. 00	7. 00					
ANCILLARY SERVICE COST CENTERS		·	T				_
50. 00 05000 OPERATI NG ROOM	0	0					50.00
51. 00 05100 RECOVERY ROOM	0	0					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0					52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0					54. 00
57. 00 05700 CT SCAN	0	0					57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0					58. 00
60. 00 06000 LABORATORY	0	0					60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0					63. 00
65. 00 06500 RESPI RATORY THERAPY	0	0					65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0					66. 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					73. 00
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	0	0					77. 00
OUTPATIENT SERVICE COST CENTERS	1		1				
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
200.00 Subtotal (see instructions)	0	0					200.00
201.00 Less PBP Clinic Lab. Services-Program	0						201. 00
Only Charges		_					202.00
202.00 Net Charges (line 200 - line 201)	0	0					202. 00

Provider CCN: 15-0149	Health Financial Systems	DEACONESS WOME	ENS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
To 12/31/2022 Date/Time Prepared: 5/30/2023 8: 21 am	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C				
Title XIX							narad.
Capital Related Cost (from Wkst. B, Part II, col. 26) 1.00 2.00 3.00 4.00 5.00					10 12/31/2022		
Related Cost (from Wkst. B, Part II, col. 26) 30.00 INPATIENT ROUTINE SERVICE COST CENTERS 1,504,802 0 1,504,802 10,148 148.29 30.00 43.00 1NTENSI VE CARE UNIT 927,996 155,736 155,736 5,303 29.37 43.00 200.00 Total (lines 30 through 199) Cost Center Description Inpatient Program Capital Cost (col. 5 x col. 6) Cost Center Description Cost			Ti tI	e XIX	Hospi tal		
(from Wkst. B, Part II, col. 26) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS	Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
Part II, col. 26)		Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
1.00 2.00 3.00 4.00 5.00		(from Wkst. B,		Related Cost			
1.00 2.00 3.00 4.00 5.00		Part II, col.		(col. 1 - col			
INPATIENT ROUTINE SERVICE COST CENTERS 1,504,802 0 1,504,802 10,148 148.29 30.00 31.00 INTENSIVE CARE UNIT 927,996 927,996 9,386 98.87 31.00 43.00 NURSERY 155,736 155,736 5,303 29.37 43.00 200.00 Total (lines 30 through 199) 2,588,534 2,588,534 24,837 200.00 Cost Center Description Inpatient Program days Capital Cost (col. 5 x col. 6) Cost Center Description Cost Center Description Cost Center Description Capital Cost (col. 5 x col. 6)		26)					
30. 00 ADULTS & PEDIATRICS 1, 504, 802 0 1, 504, 802 927, 996 927, 996 927, 996 9386 98. 87 31. 00 1NTENSI VE CARE UNIT 927, 996 155, 736 5, 303 29. 37 43. 00 200. 00 Total (lines 30 through 199) 2, 588, 534 24, 837 200. 00 Cost Center Description 1 Inpatient Program Capital Cost (col. 5 x col. 6)		1.00	2.00	3.00	4. 00	5. 00	
31. 00 INTENSI VE CARE UNIT 927, 996 927, 996 155, 736 155, 736 5, 303 29. 37 43. 00 200. 00 Total (lines 30 through 199) 2, 588, 534 24, 837 200. 00 Cost Center Description Inpatient Program Capital Cost (col. 5 x col. 6)	INPATIENT ROUTINE SERVICE COST CENTERS						
43. 00 NURSERY 155, 736 200. 00 Total (lines 30 through 199) 2, 588, 534 155, 736 2, 588, 534 24, 837 200. 00 Cost Center Description Inpatient Program days Capital Cost (col. 5 x col. 6)	30. 00 ADULTS & PEDI ATRI CS	1, 504, 802	0	1, 504, 80	2 10, 148	148. 29	30. 00
200.00 Total (lines 30 through 199) 2,588,534 2,588,534 24,837 200.00 Cost Center Description Inpatient Program days Capital Cost (col. 5 x col. 6) 6)	31.00 INTENSIVE CARE UNIT	927, 996		927, 99	6 9, 386	98. 87	31. 00
Cost Center Description Inpatient Program days Capital Cost (col. 5 x col. 6)	43. 00 NURSERY	155, 736		155, 73	6 5, 303	29. 37	43.00
Program days Capital Cost (col. 5 x col. 6)	200.00 Total (lines 30 through 199)	2, 588, 534		2, 588, 53	4 24, 837		200. 00
Capital Cost (col. 5 x col. 6)	Cost Center Description	I npati ent	I npati ent				
(coi . 5 x col . 6)		Program days	Program				
6)							
6.00 7.00							
0.00 7.00		6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDI ATRI CS 550 81, 560 30. 00	30. 00 ADULTS & PEDI ATRI CS	550					30. 00
31. 00 INTENSI VE CARE UNIT 1, 761 174, 110 31. 00	31.00 INTENSIVE CARE UNIT	1, 761	174, 110)			31. 00
43. 00 NURSERY 462 13, 569 43. 00	43. 00 NURSERY	462	13, 569				43.00
200.00 Total (lines 30 through 199) 2,773 269,239 200.00	200.00 Total (lines 30 through 199)	2,773	269, 239				200. 00

	554 664 566 111011	-110 110001 -11			6.5. 010.6	
Health Financial Systems	DEACONESS WOMI				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od: From 01/01/2022	Worksheet D Part II	
				To 12/31/2022		nared:
				10 12/01/2022	5/30/2023 8: 2	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_					
50. 00 05000 OPERATING ROOM	1, 203, 009	35, 969, 326	l .		12, 445	
51.00 05100 RECOVERY ROOM	30, 068		l .			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	840, 747	10, 462, 804	0. 08035	6 382, 696	30, 752	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	679, 554	29, 877, 499	0. 02274	5 244, 184	5, 554	54.00
57.00 05700 CT SCAN	2, 868	589, 947	0. 00486	1 12, 301	60	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 902	596, 715	0. 00486	3 7, 528	37	58. 00
60. 00 06000 LABORATORY	98, 036	23, 272, 003	0. 00421	3 898, 471	3, 785	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	796	269, 078	0.00295	81, 130	240	63. 00
65. 00 06500 RESPIRATORY THERAPY	252, 870	6, 887, 399	0. 03671	5 937, 362	34, 415	65. 00
66. 00 06600 PHYSI CAL THERAPY	223, 892	6, 517, 856	0. 03435	1 57, 341	1, 970	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	119, 214	9, 691, 295	0. 01230	1 74, 506	916	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	21, 129	1, 579, 787	0. 01337	5 17, 257	231	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	222, 186	14, 521, 832	0. 01530	0 511, 645	7, 828	73. 00
	1 _			_1	_	l

709, 941 203, 127

285, 005 4, 895, 344 8, 485, 052 15, 180, 968 2, 615, 984 170, 601, 285 0.000000

0.083670

0.013380

0. 108948

0 77.00

27

635

6, 931 92. 00

106, 240 200. 00

90.00

91.00

319

47, 489 63, 618 3, 764, 228

07700 ALLOGENEIC HSCT ACQUISITION
OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (lines 50 through 199)

77. 00

90. 00 09000 CLINIC

91. 00 | 09100 | EMERGENCY

Health Financial Systems	DEACONESS WOME	ENS HOSPITAL		In Li∈	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST			Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 8:2	pared: 1 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	<u> </u>		
30. 00 03000 ADULTS & PEDIATRICS	0	C)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31. 00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	Ö		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
p	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				*		
30. 00 03000 ADULTS & PEDIATRICS	0	0	10, 14	8 0.00	550	30.00
31.00 03100 INTENSIVE CARE UNIT		O	9, 38	6 0.00	1, 761	31. 00
43. 00 04300 NURSERY		0	5, 30	0.00	462	
200.00 Total (lines 30 through 199)		O	24, 83	7	2, 773	200. 00
Cost Center Description	I npati ent			*	· · · · · · · · · · · · · · · · · · ·	
·	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
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	0					200. 00
· · · · · · · · · · · · · · · · · · ·	-1					

Health Financial Systems	DEACONESS WOMEN	S HOSPITAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ATTHROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CC	CN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/30/2023 8:21 am
		Ti tl	e XIX	Hospi tal	PPS
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health

					10 12/31/2022	5/30/2023 8: 2	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0		0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0		0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
60. 00	06000 LABORATORY	0	0		0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS				_		
90.00	09000 CLI NI C	0	0		0	0	90. 00
91. 00	09100 EMERGENCY	0	0		0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92. 00
200.00	Total (lines 50 through 199)	0	0)	0 0	0	200. 00

Hoal th	Financial Systems	DEACONESS WOMI	ENS HOSDITAL		In Lie	eu of Form CMS-2	2552 10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI CH COSTS				Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV	pared:
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(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	0		0 35, 969, 326		
51.00	05100 RECOVERY ROOM	0	0		0 4, 083, 740	0.000000	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 10, 462, 804	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 29, 877, 499	0.000000	54.00
57.00	05700 CT SCAN	0	0		0 589, 947	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 596, 715	0.000000	58. 00
60.00	06000 LABORATORY	0	0		0 23, 272, 003	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	l o		0 269, 078	0.000000	63. 00
65.00	06500 RESPIRATORY THERAPY	0	l o		0 6, 887, 399	0.000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0			0 6, 517, 856	0.000000	66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l		0 9, 691, 295		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	l		0 1, 579, 787	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	l		0 14, 521, 832	0.000000	73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			o o	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS			'			1
90.00	09000 CLI NI C	0	0		0 8, 485, 052	0.000000	90.00
	09100 EMERGENCY	0	l o		0 15, 180, 968		
	00200 ORSEDVATION REDS (NON-DISTINCT DAPT)		1		0 2 615 084		

0 0 0

0 0 0

8, 485, 052 15, 180, 968 2, 615, 984 170, 601, 285

0 0 0

0.000000

92. 00 200. 00

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50 through 199)

	DEAGONEGO WOMENO	HOODITAL			C.F. OHC	0550 40
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	DEACONESS WOMENS	Provi der CO	N: 15_01/0	Period:	eu of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	WICE OHIEK FASS	Frovider CC	JN. 13-0149	From 01/01/2022		
1111100011 00313				To 12/31/2022		pared:
					5/30/2023 8: 2	1 am
	1		e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col. 7)		Costs (col.	8	Costs (col. 9	
	9.00	10. 00	x col. 10) 11.00	12.00	x col . 12) 13.00	
ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATI NG ROOM	0.000000	372, 096		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	56, 285			0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	382, 696			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	244, 184		0 0	0	54.00
57. 00 05700 CT SCAN	0. 000000	12, 301		0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	7, 528		0 0	l o	58.00
60. 00 06000 LABORATORY	0. 000000	898, 471		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	81, 130		o o	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	937, 362		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	57, 341		0 0	0	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	74, 506		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	17, 257		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	511, 645		0 0	0	73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	319		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	47, 489		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	63, 618		0	0	92. 00
200.00 Total (lines 50 through 199)		3, 764, 228		0 0	0	200. 00

| Period: | Worksheet D | From 01/01/2022 | Part V | To | 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0149

			Т	o 12/31/2022	Date/Time Pre 5/30/2023 8:2	
		Ti tl	e XIX	Hospi tal	PPS	
		<u> </u>	Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS			_		_	
50. 00 05000 OPERATING ROOM	0. 309273	0	0	301, 027	0	00.00
51. 00 05100 RECOVERY ROOM	0. 287485	0		27, 757	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 852633	0		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 201733	0		323, 197	0	54.00
57. 00 05700 CT SCAN	0. 295306	0		3, 142	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 295307	0		14, 932	0	58. 00
60. 00 06000 LABORATORY	0. 187202	0		333, 745	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 186816	0		2, 312	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 518448	0		58	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 381174	0		0	0	66.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 553793	0		43, 390	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 611244	0		5, 356	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 437500	0		29, 465		73.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	77. 00
90.00 OUTPATIENT SERVICE COST CENTERS	0, 727191	0		0.022	0	90.00
91. 00 09100 EMERGENCY	0. 72/191	0		9, 832 228, 053	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 037321	0		38, 071	0	
200.00 Subtotal (see instructions)	1.03/321	0		1, 360, 337		200.00
201. 00 Less PBP Clinic Lab. Services-Program		Ü		1, 300, 337	0	200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		0	C	1, 360, 337	0	202. 00
202.00 Net charges (Title 200 - Title 201)	1 1	Ü	1	1, 300, 337	0	1202.00

Health Financial Systems	DEACONESS WOMENS	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared:

					To 12/31/2022	Date/Time Pre 5/30/2023 8:2	
			Ti tl	e XIX	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	93, 100				50. 00
	05100 RECOVERY ROOM	0	7, 980				51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0)			52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	65, 200				54. 00
57. 00	05700 CT SCAN	0	928				57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4, 410				58. 00
60.00	06000 LABORATORY	0	62, 478	1			60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	432	1			63. 00
65.00	06500 RESPI RATORY THERAPY	0	30				65. 00
66.00	06600 PHYSI CAL THERAPY	0	0				66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24, 029				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 274				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12, 891				73. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0)			77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	7, 150)			90. 00
91. 00	09100 EMERGENCY	0	76, 252				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	39, 492				92. 00
200.00	Subtotal (see instructions)	0	397, 646	,			200. 00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	397, 646	,			202. 00

Health Financial Systems	DEACONESS WOMENS HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0149	Peri od: From 01/01/2022	Worksheet D-1	
			Date/Time Prep 5/30/2023 8:2	
	Title XVIII	Hospi tal	PPS	

			10 12,01,2022	5/30/2023 8: 2	1 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			10, 148	1.00
2.00	Inpatient days (including private room days, excluding swing-b			10, 148	2.00
3.00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pr	ivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		8, 226	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	5 () !!			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	126	9. 00
10.00	newborn days) (see instructions)				10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		Dolli days)	0	10. 00
11. 00	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, er		Juli days) arter	١	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		a room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Therdaing private	e room days)	١	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including private	e room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			,	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)	in (exertaining swring bea	udys)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
10.00	SWING BED ADJUSTMENT			J	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
.,. 00	reporting period	oo tiii oogii boooiiiboi o'i o			.,, 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	s through December 31 of	the cost	0.00	19. 00
	reporting period	G			
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			14, 327, 692	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost 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	or the cost reporting	period (iine 8	0	25. 00
24 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
26. 00 27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 24)		14, 327, 692	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Title 21 illitius Title 20)		14, 327, 092	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	l and observation had ch	argos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed ch	ai ges)	0	
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	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	ous line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	(10113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	14, 327, 692	
57.00	27 minus line 36)	private room cost ur		1 7, 521, 672	57.00
	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			1, 411. 87	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			177, 896	
40. 00	Medically necessary private room cost applicable to the Progra	,		0	40. 00
	Total Program general inpatient routine service cost (line 39	•		177, 896	
	, J. J. J. L.	,	1	, 270	

Accordance Acc		Financial Systems	DEACONESS WOME				u of Form CMS-2	2552-10
Cost Center Description	COMPU	TATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0149	From 01/01/2022	Date/Time Pre	pared:
NUMSERY (FITTE V & XIX entry)		Cost Center Description		Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
Intensive Care Type Impatient Rospital Unit 5.	12.00	MUDCEDV (+; +Lo V & VIV only)	_					42.00
4.1.00	42.00				η <u> </u>	00 0	0	42.00
1.00 1.00	44. 00 45. 00 46. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		9, 386	1, 552.	80 0	0	43. 00 44. 00 45. 00 46. 00 47. 00
Program language and calcular Therapy acquist from costs (Worksheet D-6, Part III, line 10, column 1)							1. 00	
50.00 Plass through costs applicable to Program inpatient routine services (from West. D., sum of Parts I and I 18.685 St. D. Plass through costs applicable to Program inpatient and I larry services (from West. D., sum of Parts II 35.885 St. D.	48. 01	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines	on cost (Worksh	eet D-6, Part		, column 1)	0	48. 01
51.00 pass through costs applicable to Program inpatient ancillary services (From Wisst. D. sum of Parts II and IV) 52.00 Total Program excludable cost (sum of Fines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 einus line 52) 54.00 Parameta Advantage (contractor use only) 55.00 Target amount per discharge 55.00 Adjustment amount per discharge 60.00 S5 55.01 Perment adjustment amount per discharge (contractor use only) 60.01 Target amount fine 54 x sum of Fines 55, 55.01, and 55.02) 61.02 Perment adjustment amount per discharge (contractor use only) 61.03 Perment adjustment in the state of the state	50. 00	Pass through costs applicable to Program inp	patient routine	services (from	n Wkst. D, su	m of Parts I and	18, 685	50.00
Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) S3. medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COUNTINATION	51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	rom Wkst. D,	sum of Parts II	35, 882	51.00
54.00 Program discharges 0.00 54.55.01 Target amount per discharge 0.00 55.50.01 Target amount per discharge 0.00 55.50.01 Adjustment amount per discharge 0.00 55.50.02 Adjustment amount per discharge (contractor use only) 0.00 55.50.02 Adjustment amount per discharge (contractor use only) 0.00 55.50.02 Adjustment amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00 55.50.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00 56.50.00 Target amount (see instructions) 0.50.50 0.00 56.50.00 Target amount (see instructions) 0.50.50 0.00 0		Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ıding capital re	elated, non-phy	ysician anest	hetist, and		1
55.00 Target amount per discharge 0.00 55.01 Permanent adjustment amount per discharge 0.00 55.01 Permanent adjustment amount per discharge (contractor use only) 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 50.00 0.00 50.00 0.00 50.00 0.00 50.00 0.00 50.00 0.00 50.00 50.00 0.00 0.00	54 00						0	54.00
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89.00 Observation bed cost (line 87 x line 88) (see instructions) 2,713,614 89.	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 411. 87	88. 00

Health Financial Systems	DEACONESS WO	MENS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Period: From 01/01/2022	Worksheet D-1	
				To 12/31/2022	Date/Time Pre 5/30/2023 8:2	
		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			<u> </u>		
90.00 Capital -related cost	1, 504, 80	2 14, 327, 692	0. 10502	8 2, 713, 614	285, 005	90. 00
91.00 Nursing Program cost		0 14, 327, 692	0.00000	0 2, 713, 614	0	91.00
92.00 Allied health cost		0 14, 327, 692	0.00000	0 2, 713, 614	0	92. 00
93.00 All other Medical Education		0 14, 327, 692	0.00000	0 2, 713, 614	0	93. 00

Health Financial Systems	DEACONESS WOMENS HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/30/2023 8:2	pared:
	Title XIX	Hospi tal	PPS	
Cost Center Description				

				5/30/2023 8: 2	1 am
		Title XIX	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s. excludina newborn)		10, 148	1.00
2.00	Inpatient days (including private room days, excluding swing-			10, 148	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	vate room days,	0	3. 00
	do not complete this line.		-		
4.00	Semi-private room days (excluding swing-bed and observation be			8, 226	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	0	5. 00
	reporting period	d> -£t Db	24 -6 -1		/ 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 OF the Cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
7.00	reporting period	daye, eag becombe.	0. 0. 1 0001	ا	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	550	9. 00
40.00	newborn days) (see instructions)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		nom davel after	o	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		Join days) arter	١	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	3 .	,		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			5, 303 462	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			402	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
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	s through December 31 of	the cost	0. 001	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	ne cost	0. 00	20. 00
20.00	reporting period	diter becomber 31 of t	10 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		14, 327, 692	21.00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ng period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	21 of the cost reporti	ag ported (line	0	24. 00
24.00	7 x line 19)	31 of the cost reporti	ig perrou (Trile	ا ا	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	О	25. 00
	x line 20)	9			
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)		14, 327, 692	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		<u>, </u>		00.00
28. 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	29. 00 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)	F 11116 20)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin		,	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	14, 327, 692	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTUENEO.			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 111 07	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 411. 87	38. 00 39. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		776, 529 0	40.00
	Total Program general inpatient routine service cost (line 39			776, 529	
	,	- · · - /	ı	, 02/	

	Financial Systems FATION OF INPATIENT OPERATING COST	DEACONESS WOMEN	Provi der Co	N: 15_0140	In Lie Period:	u of Form CMS-2 Worksheet D-1	
JOIVIPU I	ATTOM OF THEATTENT OPERATING COST				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 8:2	pared:
	Coot Contar Decement on	Total	_	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl		col . 2)	÷	Program Cost (col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1. 00 2, 488, 432	2. 00 5, 303	3. 00 469. 2	4. 00 25 462	5. 00 216, 794	42.00
12.00	Intensive Care Type Inpatient Hospital Unit		3, 303	407.2	-5 +02	210, 774	72.00
43. 00 44. 00	INTENSIVE CARE UNIT	14, 574, 560	9, 386	1, 552. 8	1, 761	2, 734, 481	
45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00
46. 00							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	·					1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Verogram inpatient cellular therapy acquisition)			III line 10	column 1)	1, 566, 614 0	1
49. 00	1 3 .				cordiiii 1)	5, 294, 418	1
	PASS THROUGH COST ADJUSTMENTS					0.000	
50. 00	Pass through costs applicable to Program in	npatient routine s	ervices (from	WKSt. D, sun	n of Parts I and	269, 239	50.00
51. 00	Pass through costs applicable to Program in and IV)	npatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	106, 240	51.00
52. 00	Total Program excludable cost (sum of lines	s 50 and 51)				375, 479	52.00
53. 00	Total Program inpatient operating cost excl		ated, non-phy	sician anesth	netist, and	4, 918, 939	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	9 52)					
	Program di scharges					0	
55. 00 55. 01	Target amount per discharge						55. 00
55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	r use only)					55. 0 55. 0
56. 00	Target amount (line 54 x sum of lines 55, !	55.01, and 55.02)				0	56.0
57. 00	Difference between adjusted inpatient opera	ating cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	rtina period	endi na 1996.	0 0. 00	58. 0 59. 0
	updated and compounded by the market baske	t)	·	0.			
60. 00	Expected costs (lesser of line 53 ÷ line 54 market basket)	4, or line 55 from	prior year c	ost report, ι	ipdated by the	0.00	60.0
51. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the lo 53) are less than expected costs (lines 54 enter zero. (see instructions)	esser of 50% of th	e amount by w	hich operatir	ng costs (line	0	61.00
62. 00	Relief payment (see instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	yment (see instruc	tions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine co	osts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	osts after Decembe	r 31 of the c	ost reportino	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rouse						66. 00
	CAH, see instructions	•	·	, ,	37.		
67. 00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	December 31 o	f the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	cember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER					0	69. 00
70. 00	Skilled nursing facility/other nursing faci	lity/ICF/IID rout	ine service c	ost (line 37)			70.00
71.00	Adjusted general inpatient routine service		ne 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 x li	ne 35)			72. 0
74. 00	Total Program general inpatient routine ser	rvice costs (line	72 + line 73)	ŕ			74.0
75. 00	Capital-related cost allocated to inpatien 26, line 45)	t routine service	costs (from W	orksheet B, F	Part II, column		75. 0
76. 00	Per diem capital-related costs (line 75 ÷ 1	ine 2)					76. 0
77. 00	Program capital -related costs (line 9 x line)						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce	•	ovi der record	s)			78. 0
30. 00				*	nus line 79)		80.0
31.00	Inpatient routine service cost per diem lin						81. 0
32. 00 33. 00	Inpatient routine service cost limitation Reasonable inpatient routine service costs	•					82. 0
34. 00	Program inpatient ancillary services (see i	•	,				84. 0
85.00	Utilization review - physician compensation	n (see instruction					85. 0
36. 00	Total Program inpatient operating costs (SEPART IV - COMPUTATION OF OBSERVATION BED PA		ough 85)				86. 0
	Total observation bed days (see instruction					1, 922	87. 0
37. 00		,				1, /22	

Health Financial Systems	DEACONESS WO	OMENS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CO		Peri od: From 01/01/2022	Worksheet D-1	
					To 12/31/2022	Date/Time Pre 5/30/2023 8:2	
			Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Ro	outine Cost	column 1 ÷	Total	Observati on	
		(fr	om line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	1, 504, 8	02	14, 327, 692	0. 10502	8 2, 713, 614	285, 005	90.00
91.00 Nursing Program cost		o	14, 327, 692	0. 00000	0 2, 713, 614	0	91.00
92.00 Allied health cost		O	14, 327, 692	0.00000	0 2, 713, 614	0	92.00
93.00 All other Medical Education		ol	14, 327, 692	0.00000	0 2, 713, 614	0	93.00

Health Fina	ncial Systems DEACONESS WOMENS	HOSPI TAI		In lie	eu of Form CMS-2	2552-10
	NCILLARY SERVICE COST APPORTIONMENT	Provider Co	CN: 15-0149	Peri od:	Worksheet D-3	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 8:2	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
LNDA	TIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
	ADULTS & PEDIATRICS			139, 698		30.00
	INTENSIVE CARE UNIT			137, 070		31.00
43. 00 0430						43. 00
	LLARY SERVI CE COST CENTERS					10.00
	OPERATING ROOM		0. 31116	57 759, 140	236, 219	50.00
51.00 0510	RECOVERY ROOM		0. 28748		0	51.00
52.00 0520	DELIVERY ROOM & LABOR ROOM		0. 85263	33 20, 097	17, 135	52. 00
54. 00 0540	RADI OLOGY-DI AGNOSTI C		0. 2024	99 12, 175	2, 465	54.00
	CT SCAN		0. 29530			
	MAGNETIC RESONANCE IMAGING (MRI)		0. 29530			
	LABORATORY		0. 18720			
	BLOOD STORING, PROCESSING, & TRANS.		0. 1868			
	RESPI RATORY THERAPY		0. 5184			
	PHYSI CAL THERAPY		0. 3811			
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 55379			
	IMPL. DEV. CHARGED TO PATIENTS		0. 61124			
	DRUGS CHARGED TO PATIENTS ALLOGENEIC HSCT ACQUISITION		0. 43750 0. 00000		66, 857 0	1
	ATIENT SERVICE COST CENTERS		0.00000	0	0	77.00
	CLINIC		0. 73630	01 4, 879	3, 592	90.00
	EMERGENCY		0. 42080	· ·		
	OBSERVATION BEDS (NON-DISTINCT PART)		1. 03732			
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1.0070.	1, 579, 390		
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)	(/)		1, 579, 390	1	202. 00
"			•	•	•	•

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0149	Peri od:	Worksheet D-3	1
THE THE PROPERTY OF THE STATE O	11.01.401		From 01/01/2022		
			To 12/31/2022		
	T: ±1	- VIV	11! 4-1	5/30/2023 8: 2	'i am
Cost Contar Deceription	11 11	e XIX Ratio of Cos	Hospi tal t Inpati ent	PPS Inpatient	
Cost Center Description		To Charges		Program Costs	
		10 charges		(col. 1 x col.	
			orial ges	2)	
		1, 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		•			
30. 00 03000 ADULTS & PEDIATRICS			390, 690		30.00
31.00 03100 INTENSIVE CARE UNIT			2, 011, 181		31.00
43. 00 04300 NURSERY			235, 520		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 31116			
51.00 O5100 RECOVERY ROOM		0. 28748			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 85263			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20249			
57. 00 05700 CT SCAN		0. 29530			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 29530			
50. 00 06000 LABORATORY		0. 18720			
53. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 18681			
65. 00 06500 RESPIRATORY THERAPY		0. 51844			
66. 00 06600 PHYSI CAL THERAPY		0. 38117			
71. 00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 55379			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 61124			
73.00 07300 DROGS CHARGED TO PATTENTS 77.00 07700 ALLOGENEIC HSCT ACQUISITION		0. 43750 0. 00000			
OUTPATIENT SERVICE COST CENTERS		0.00000	0		177.00
90. 00 09000 CLI NI C		0. 73630	01 319	235	90.00
91. 00 09100 CETNIC		0. 42080			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 03732			
200.00 Total (sum of lines 50 through 94 and 96 through 9	8)	1.03732	3, 764, 228		
201.00 Less PBP Clinic Laboratory Services-Program only c			3, 704, 220		201.00
Net charges (line 200 minus line 201)	900 (11110 01)		3, 764, 228	l	202. 00

1.01 DRC amounts other than outlier payments for discharges occurring prior to October 1 (see instructions) 1.02 DRC amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 DRC for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRC for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 october 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges (see instructions) 2.02 Outlier payments for discharges for Model 4 BPCI (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.05 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.01 FIE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see instructions) 5.01 FIE cap adjustment for qualifying hospitals under \$131 of the CAA 2021 (see instructions) 6.02 FIE cap adjustment for qualifying hospitals under \$131 of the CAA 2021 (see instructions) 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 \$503 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. 7.02 Adjustment (Increase or decrease) to the FIE count for allopathic programs in accordance with 44 2FR 413.79(e) 7.01 ACA \$503 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 7.02 Adj	am
PART A - IMPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments for discharges occurring prior to October 1 (see 288,955 instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 114,527 instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 october 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 october 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 october 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI (see instructions) Outlier payments for discharges. (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier p	
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 114,527 instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 114,527 instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior of October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior of October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instructions) DRG for federal specific operating perior to October 1 (see instru	
1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 october 1 (see instructions) 2.00 Dutlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges (see instructions) 2.02 Unitier payments for discharges for Model 4 BPCI (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (s	1. 00 1. 01
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11.00 FTE count for residents in dental and podiatric programs. 12.00 Current year allowable FTE (see instructions) 13.00 Total allowable FTE count for the prior year. 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 1	9. 00
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14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 1	
	13. 00 14. 00
15.00 Sum of lines 12 through 14 divided by 3. 0.00 1	15. 00
16.00 Adjustment for residents in initial years of the program (see instructions) 17.00 Adjustment for residents displaced by program or hospital closure 0.00 1	
	18. 00
	19.00
	20. 00 21. 00
22.00 IME payment adjustment (see instructions) 0 2	22. 00
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	22. 01 23. 00
(f)(1)(i v)(C).	24. 00
instructions)	25. 00
	26. 00 27. 00
28.00 IME add-on adjustment amount (see instructions) 0 2	28. 00
	28. 01 29. 00
	29. 00 29. 01
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 6.54 3	30. 00
	31.00
	32. 00 33. 00
34.00 Disproportionate share adjustment (see instructions) 13,305 3	34. 00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/30/2023 8:2	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompensated Care Payment Adjustment		1. 00	2. 00	
5. 00	Total uncompensated care amount (see instructions)		0	0	35.00
5. 01 5. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is ze	ro, enter zero on this line	0. 000000000 322, 745	0. 000000000 323, 995	35. 01 35. 02
5. 03 6. 00)	241, 396 323, 061	81, 665	35. 03 36. 00
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throu			
0.00	Total Medicare discharges (see instructions)		0		40.00
1. 00 1. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instr	uctions)	0		41. 00 41. 01
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qu		0.00		42.00
3. 00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
4. 00	Ratio of average length of stay to one week (line 43 divid days)	ed by line 41 divided by 7	0. 000000		44.00
5. 00	Average weekly cost for dialysis treatments (see instructi	•	0.00		45.00
5.00	Total additional payment (line 45 times line 44 times line	41. 01)	779, 848		46. 00 47. 00
7. 00 8. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH	, small rural hospitals	779, 848		48. 00
	only. (see instructions)			Amount	
9. 00	Total payment for inpatient operating costs (see instruction	one)		1. 00 779, 848	49. 00
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I			34, 664	50.00
1. 00	Exception payment for inpatient program capital (Wkst. L,			0	51.0
2. 00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	52.0
3. 00	Nursing and Allied Health Managed Care payment			0	53.0
4. 00	Special add-on payments for new technologies			0	54.0
4. 01 5. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin	۵ (49)		0	54. 0 55. 0
5. 01	Cellular therapy acquisition cost (see instructions)	e 07)		0	55.0
6. 00	Cost of physicians' services in a teaching hospital (see i	ntructions)		0	56. 0
7. 00	Routine service other pass through costs (from Wkst. D, Pt	. III, column 9, lines 30 t	hrough 35).	0	57.0
8. 00	Ancillary service other pass through costs from Wkst. D, P	t. IV, col. 11 line 200)		0	58. 0
9. 00	Total (sum of amounts on lines 49 through 58)			814, 512	
0. 00 1. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 mi	nus line 60)		0 814, 512	60. 00 61. 00
2. 00	Deductibles billed to program beneficiaries	nus Trile 00)		68, 392	1
3. 00	Coinsurance billed to program beneficiaries			0	63.0
4. 00	Allowable bad debts (see instructions)			21, 627	64.0
5. 00	Adjusted reimbursable bad debts (see instructions)			14, 058	
	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		20, 071	
7. 00 8. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	or applicable to MS DDCs (s	oo instructions)	760, 178 0	
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 9		′	0	69.0
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	5). (. c co., - c		0	70. 0
0. 50	Rural Community Hospital Demonstration Project (§410A Demo	nstration) adjustment (see	instructions)	0	70. 50
0. 75	N95 respirator payment adjustment amount (see instructions			0	70. 7
0. 87	Demonstration payment adjustment amount before sequestration			0	70.8
0. 88 0. 89	SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i	•		0	70. 8 70. 8
0. 69	HSP bonus payment HVBP adjustment amount (see instructions			0	70. 8
0. 91	HSP bonus payment HRR adjustment amount (see instructions)	,		0	
0. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92
				0	70. 9
0. 93	HVBP payment adjustment amount (see instructions)			O l	70. 9

Heal th	Financial Systems DEACONESS WOMENS	HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/30/2023 8:2	
		Titl∈	e XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98	Low Volume Payment-3	ŕ			0	70. 98
70. 99	HAC adjustment amount (see instructions)		İ		0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			760, 178	71. 00
71. 01	Sequestration adjustment (see instructions)				9, 578	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM or CHART pass-throughs					71. 03
72.00	Interim payments				790, 363	72. 00
72. 01	Interim payments-PARHM or CHART					72. 01
73.00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM or CHART (for contractor use only)				73. 01
	1=		1			

Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and

Protested amounts (nonallowable cost report items) in accordance with

Balance due provider/program-PARHM or CHART (see instructions)

90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)

92.00 Operating outlier reconciliation adjustment amount (see instructions)

93.00 Capital outlier reconciliation adjustment amount (see instructions)

CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

Capital outlier from Wkst. Ĺ, Pt. I, line 2

74.00

74. 01

75.00

90.00

91.00

93.00 0

470, 000

0

0

0 92.00

95.00 Capital outrier reconcilitation adjustment amount (see instructions)			93.00
94.00 The rate used to calculate the time value of money (see instructions)		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 instructions)		0	96. 00
	Prior to 10/1		
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0.000000000	0.000000000	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104. 00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00 Medicare discharges (see instructions)			202. 00
203.00 Case-mix adjustment factor (see instructions)			203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the curr	ent 5-year demonst	ration	
peri od)			
204.00 Medi care target amount			204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
Adjustment to Medicare Part A Inpatient Reimbursement			
207.00 Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)			209. 00
210.00 Reserved for future use			210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
Comparision of PPS versus Cost Reimbursement			
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213.00 Low-volume adjustment (see instructions)			213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
(line 212 minus line 213) (see instructions)			

74.00

74. 01

75.00

91.00

73)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2022 | Part A Exhibit 4 | To 12/31/2022 | Date/Time Prepared: | 5/30/2023 8:21 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0149

						0 12/31/2022	5/30/2023 8: 2	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
1.00	DRG amounts other than outlier	1.00	1. 00	2. 00	3.00	4. 00	5. 00 0	1. 00
1.00	payments	1.00	U	0	0	O	U	1.00
1. 01	DRG amounts other than outlier	1. 01	328, 955	0	328, 955		328, 955	1. 01
	payments for discharges		020, 700	· ·	020, 700		020, 700	
	occurring prior to October 1							
1.02	DRG amounts other than outlier	1. 02	114, 527	0		114, 527	114, 527	1. 02
	payments for discharges							
	occurring on or after October							
	1							
1. 03	DRG for Federal specific	1. 03	0	0	0		0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to October 1							
1.04	DRG for Federal specific	1. 04	0	0		0	0	1. 04
1. 04	operating payment for Model 4	1.04	U	U		U	U	1.04
	BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2. 00
	discharges (see instructions)							
2.01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
	discharges for Model 4 BPCI							
2.02	Outlier payments for	2. 03	0	0	0		0	2. 02
	discharges occurring prior to							
	October 1 (see instructions)		_	_			_	
2.03	Outlier payments for	2. 04	0	0		0	0	2. 03
	discharges occurring on or							
	after October 1 (see							
3.00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
3.00	reconciliation	2.01	U	Ü	U	U	U	3.00
4.00	Managed care simulated	3. 00	160, 702	0	160, 702	0	160, 702	4. 00
1. 00	payments	0.00	100, 702	O	100, 702	J	100, 702	1. 00
	Indirect Medical Education Adj	ustment	l					
5.00	Amount from Worksheet E, Part	21.00	0. 000000	0.000000	0.000000	0.000000		5. 00
	A, line 21 (see instructions)							
6.00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
	instructions)							
6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see							
	instructions) Indirect Medical Education Adj	ustmant for the	Add on for Co.	otion 100 of t	ha MMA			
7. 00	IME payment adjustment factor	27.00	0. 000000	0. 000000		0. 000000		7. 00
7.00	(see instructions)	27.00	0.000000	0.000000	0.00000	0.000000		7.00
8.00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
	instructions)							
8. 01	IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
	for managed care (see							
	instructions)							
9.00	Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
0.01	lines 6 and 8)	20.01		_	_	_	_ ا	0.01
9. 01	Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
	care (sum of lines 6.01 and 8.01)							
	Disproportionate Share Adjustm	ent						
10. 00	Allowable disproportionate	33.00	0. 1200	0. 1200	0. 1200	0. 1200		10. 00
	share percentage (see		3200	3200	3200	3200		
	instructions)							
11. 00	Di sproporti onate share	34.00	13, 305	0	9, 869	3, 436	13, 305	11. 00
	adjustment (see instructions)							
11. 01	Uncompensated care payments	36.00	323, 061	0	241, 396	81, 665	323, 061	11. 01
	Additional payment for high pe		D beneficiary					
12. 00	Total ESRD additional payment	46. 00	0	0	0	0	0	12. 00
10.00	(see instructions)	47.00	770 040	_	F00 000	100 (00	770 0:0	12.00
13.00	Subtotal (see instructions)	47.00	779, 848	0	580, 220	199, 628	779, 848	
14. 00	Hospital specific payments	48. 00	٥	0		U	ا	14. 00
	(completed by SCH and MDH, small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	779, 848	0	580, 220	199, 628	779, 848	15, 00
	operating costs (see		, , , , 540	O	000, 220	1,,,020	, , , , 540	. 5. 55
	instructions)							
16. 00	Payment for inpatient program	50.00	34, 664	0	25, 768	8, 896	34, 664	16. 00
	capital (from Wkst. L, Pt. I,							
	if applicable)							

12/31/2022 Date/Time Prepared: 5/30/2023 8:21 am Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 On/After 10/01 Part A) line Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 605, 988 208, 524 814, 512 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 20.00 1.00 34, 664 8, 896 34, 664 20.00 25, 768 Model 4 BPCI Capital DRG other 20.01 1 01 0 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 0 0 0 21.00 Model 4 BPCI Capital DRG 21.01 2.01 0 21.01 outlier payments Indirect medical education 22 00 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 C 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 25.00 C 0 adjustment (see instructions) 26.00 Total prospective capital 12.00 25, 768 8,896 34,664 26.00 34,664 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2.00 3.00 4.00 5. 00 0 1.00 27.00 Low volume adjustment factor 0.000000 0.000000 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) Low volume adjustment 29.00 29.00 70.97 0 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00

adjustments to Wkst. E, Pt. A.

 Heal th Financial
 Systems
 DEACONESS
 WOMEN

 HOSPITAL
 ACQUIRED
 CONDITION
 (HAC)
 REDUCTION
 CALCULATION
 EXHIBIT
 5
 In Lieu of Form CMS-2552-10 Provider CCN: 15-0149 Peri od: Worksheet E From 01/01/2022 Part A Exhi bit 5 To 12/31/2022 Date/Time Prepared:

West F. Pt. A. From From Period to Period an Total (cals. Period to Period an Period an Total (cals. Period to Period an Peri					T	o 12/31/2022	Date/Time Prep 5/30/2023 8:2	
A. Inc. Wist E. Pt. 10/01 after 10/01 and 3				Title	XVIII	Hospi tal		
DRG amounts other than outlier payments 0								
1.00 SRG amounts other than outilier payments for 1.00 32.955 328.955 328.955 328.955 328.955 328.955 1.00 328.955			A, line		10/01	after 10/01	and 3)	
1.00 DRG amounts other than out lier payments for 1.01 328, 955 328, 955 1.01 328, 955 1			0		2 00	3 00	4 00	
1.01 DRS amounts other than out lier payments for 1.01 3.28, 955 328, 955 3.29, 955 1.01 discharges occurring prior to October 1 1.02 114, 527 114, 527 1.02 1.02 discharges occurring on or after of to October 1 DRS for Federal specific operating payment 1.03 0 0 0 0 0 0 0 1.03 0 0 0 0 0 0 0 0 0	1 00	DRG amounts other than outlier payments		1.00	2.00	3.00	4.00	1 00
1.02				328, 955	328, 955		328, 955	1. 01
discharges occurring on or after october 1 0.00 0 0 0 0 0 0 1.03					·		·	
1.03 Dist For Federal specific operating payment 1.03 0 0 0 0 0 1.03	1.02		1. 02	114, 527		114, 527	114, 527	1. 02
For Model 4 BPCI occurring prior to October 1 1.04	4 00		4 00		0			4 00
1.04 00	1.03	for Model 4 RPCL occurring prior to October	1.03	0	Ü		0	1. 03
For Model 4 BPCI occurring on or after		1						
October 1	1.04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
2.00								
Instructions 1								
2.01 OutFler payments for discharges for Model 4 2.02 0 0 0 0 0 0 2.01	2.00		2.00					2.00
BPCI 2.02	2 01	1	2 02	0	0	0	0	2 01
Description	2.01		2.02		J	0	Ü	2.01
2.03 OutFlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Operating outFlier reconciliation 4.00 Managed care simulated payments 5.00 Indirect Medical Education Adjustment 5.00 Mount from Worksheet E, Part A, Line 21	2.02	Outlier payments for discharges occurring	2.03	0	0		0	2. 02
or after October 1 (see instructions) 0				_		_	_	
3.00 Operating outlier reconciliation 2.01 0 0 0 0 3.00	2. 03		2.04	0		0	0	2. 03
4.00 Managed care simulated payments 3.00 160,702 0 0 0 4.00	3 00		2 01	0	0	0	0	3 00
Indirect Medical Education Adjustment 21.00				160, 702	Ü	0		4. 00
(see instructions) 6.00 IME payment adjustment (see instructions) 6.01 IME payment adjustment for managed care (see 22.01 0 0 0 0 0 0 0 6.01 6.01 IME payment adjustment for managed care (see 22.01 0 0 0 0 0 0 0 0 6.01 7.00 IME payment adjustment factor (see 27.00 0.000000 0.000000 0.000000 0.000000 8.00 IME payment adjustment factor (see 27.00 0.000000 0.000000 0.000000 0.000000 8.01 IME payment adjustment add on for managed 28.01 0 0 0 0 0 0 8.01 8.01 IME payment (sum of lines 6 and 8) 29.00 0 0 0 0 0 0 0 0 9.01 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 0 0 0 0 0 9.01 Total IME payment for managed care (sum of 29.01 0 0 0 0 0 0 0 0 9.01 Total IME payment for managed care (sum of 29.01 0 0 0 0 0 0 0 0 9.01 Total IME payment for managed care (sum of 29.01 0 0 0 0 0 0 0 0 0							-	
100 1 1 1 1 1 1 1 1	5.00	Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 000000	0. 000000		5. 00
INE payment adjustment for managed care (see 22.01 0 0 0 0 0 0 0 0 0				_	_	_	_	
Instructions Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						0		
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA IME payment adjustment factor (see	6.01		22.01	0	U	U	U	6.01
17.00 IME payment adjustment factor (see 27.00 0.00000 0.0000000 0.0000000 0.0000000 0.00000000			e Add-on for Se	ection 422 of t	he MMA			
8.00	7.00	,				0.000000		7. 00
IME payment adjustment add on for managed 28.01 0 0 0 0 0 0 0 8.01								
Care (See Instructions)		1		0	0	0		
9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 0 0 0 0 0 0	8.01		28.01	0	Ü	Ü	0	8.01
Total IME payment for managed care (sum of lines 6.01 and 8.01)	9 00	1 '	29 00	0	0	0	0	9 00
Ii nes 6. 01 and 8. 01)				i o	0	0		9. 01
10.00 Allowable disproportionate share percentage (see instructions) 11.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 13,305 9,869 3,436 13,305 11.00 11.00 Instructions) 11.01 Uncompensated care payments 36.00 323,061 241,396 81,665 323,061 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 12.00 13.00 Subtotal (see instructions) 47.00 779,848 580,220 199,628 779,848 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00								
11.00 Disproportionate share adjustment (see 34.00 13,305 9,869 3,436 13,305 11.00 instructions)								
11. 00 Disproportionate share adjustment (see 34.00 13,305 9,869 3,436 13,305 11.00 11. 01 Uncompensated care payments 36.00 323,061 241,396 81,665 323,061 12. 00 Additional payment for high percentage of ESRD beneficiary discharges	10. 00		33.00	0. 1200	0. 1200	0. 1200		10. 00
11. 01 Uncompensated care payments 36. 00 323, 061 241, 396 81, 665 323, 061 11. 01 Additional payment for high percentage of ESRD beneficiary discharges 12. 00 Total ESRD additional payment (see 46. 00 0 0 0 0 12. 00 13. 00 14. 00 15. 00 1	11 00		34 00	13 305	0 840	3 136	13 305	11 00
11. 01 Uncompensated care payments 36. 00 323, 061 241, 396 81, 665 323, 061 11. 01	11.00	1 ' '	34.00	13, 303	7, 007	3, 430	13, 303	11.00
12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 147.00 Total ESRD additional payment (see instructions) 15.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 18.00 Total ESRD additional payment (see instructions) 46.00 Total ESRD additional payments for payments (completed by SCH 48.00 Total 779, 848	11. 01				241, 396	81, 665	323, 061	11. 01
13.00 Subtotal (see instructions) 47.00 779,848 580,220 199,628 779,848 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 47.00 779,848 580,220 199,628 779,848 15.00 0 0 0 0 0 0 0 0 0				di scharges				
13.00 Subtotal (see instructions) 47.00 779,848 580,220 199,628 779,848 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 48.00 0 0 0 0 14.00 15.00 Total payment for inpatient operating costs (see instructions) 49.00 779,848 580,220 199,628 779,848 15.00 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 50.00 34,664 25,768 8,896 34,664 16.00 17.01 Net organ acquisition cost 54.00 0 0 0 0 0 17.01 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 68.00 0 0 0 0 0 0 17.02 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 0 0 0 0 18.00	12. 00		46. 00	0	0	0	0	12. 00
14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 17.00 17.01 Net organ acquisition cost 0 0 0 0 0 0 17.00 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions)	12 00		47.00	770 040	500 220	100 620	770 040	12 00
and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 17.00 17.01 Net organ acquisition cost 0 0 0 0 0 17.00 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions)						177, 020		
instructions) Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 15.00 779,848 580,220 199,628 779,848 15.00 34,664 25,768 8,896 34,664 16.00 0 0 0 0 0 0 17.00 17.02 0 0 0 0 0 17.00 18.00 0 0 0 0 0 17.00 18.00 0 0 0 0 0 17.00	00		101 00		J	9		00
(see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 50.00 34,664 25,768 8,896 34,664 16.00 0 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions)								
16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 50.00 34,664 25,768 8,896 34,664 16.00 0 0 0 0 0 17.00 0 17.00 0 0 0 0 17.00 0 17.00 0 18.00	15. 00		49. 00	779, 848	580, 220	199, 628	779, 848	15. 00
Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 18.00 Met organ acquisition cost 0 0 0 0 0 17.00 17.00 17.00 17.00 17.00 0 0 0 18.00 18.00	1/ 00		FO 00	24 //4	25 7/0	0.007	24 (44	1/ 00
17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 54.00 0 0 0 0 0 17.00 17.00 17.00 0 0 0 0 0 18.00	16.00		50.00	34, 004	25, 708	8, 890	34, 004	16.00
17. 01 Net organ acquisition cost 17. 02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18. 00 Capital outlier reconciliation adjustment amount (see instructions) 17. 01 Net organ acquisition cost 17. 01 0 0 0 0 0 0 0 17. 02 0 18. 00	17. 00		54.00	0	0	0	ol	17. 00
17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 68.00 0 0 0 17.02								17. 01
18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 18.00 amount (see instructions)		Credits received from manufacturers for	68. 00	0	0	0	0	17. 02
amount (see instructions)	40	1 .	00					40 -
	18. 00		93. 00	0	0	0	0	18. 00
1 000, 700 200, 024 014, 312 17. 00	19 00	, ,			605 988	208 524	814 512	19 00
	17.00	1000.0.112	I	1	000, 700	200, 324	1 017, 512	17.00

Health Financial Systems	DEACONESS WOMENS	HOSPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (H	AC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0149		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2023 8:21 am

				Т	rom 01/01/2022 o 12/31/2022		pared:
				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	34, 664	25, 768	8, 896	34, 664	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	C	0	0	20. 01
21.00	Capital DRG outlier payments	2.00	0	C	0	0	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	С	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0	С	0	0	25. 00
26. 00	Total prospective capital payments (see linstructions)	12. 00	34, 664	25, 768	8, 896	34, 664	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt.				
		0	A) 1. 00	2.00	3. 00	4. 00	
27. 00		U	1.00	2.00	3.00	4.00	27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0			0	28.00
29. 00	Low volume adjustment on or after October 1	70. 97	0		ĺ	0	29.00
30. 00	HVBP payment adjustment (see instructions)	70. 93	0			0	30.00
30. 01	HVBP payment adjustment for HSP bonus	70. 90	0			0	30. 01
30. 01	payment (see instructions)	70.70			,	٥	30.01
31. 00	HRR adjustment (see instructions)	70. 94	0		0	0	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0		ol o	Ö	31. 01
01.01	instructions)	70.71				Ĭ	01.01
	,					(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		С	0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	DEACONESS WOMENS HOSPITAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CCN: 15-0149		Worksheet E Part B Date/Time Prepared: 5/30/2023 8:21 am

-		Ti +Lo VVIII	Hospi tal	5/30/2023 8: 2 PPS	1 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0	1 00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	ons)		2, 177, 499	1. 00 2. 00
3. 00	OPPS payments	5113)		1, 789, 220	3. 00
4. 00	Outlier payment (see instructions)			9, 133	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0. 000	5. 00
6. 00 7. 00	Line 2 times line 5			0 0. 00	6. 00 7. 00
8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13. line 200		0	9. 00
10.00	Organ acqui si ti ons	·		0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pay			0	15. 00
16. 00	Amounts that would have been realized from patients liable for p	payment for services or	i 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)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lir	ie 11) (see	0	19. 00
	instructions)			_	
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds lir	ie 18) (see	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			0	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			1, 798, 353	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 2	24 (for CAH, see instru	ıctions)	309, 404	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu	•	,	1, 488, 949	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 1, 488, 949	29. 00 30. 00
31. 00	Primary payer payments			1, 466, 949	31. 00
32. 00	Subtotal (line 30 minus line 31)			1, 488, 865	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			17.047	33.00
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			17, 967 11, 679	34. 00 35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		12, 598	
37. 00	Subtotal (see instructions)	,		1, 500, 544	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	PS&R OTHER ADJUSTMENTS			16	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	39. 75 39. 97
39. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruct	ions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	`	,	0	39. 99
40.00	Subtotal (see instructions)			1, 500, 560	40. 00
40. 01	Sequestration adjustment (see instructions)			18, 907	40. 01
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs			0	40. 02 40. 03
41. 00	Interim payments			1, 470, 410	41. 00
41. 01	Interim payments-PARHM or CHART			,	41. 01
42.00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)			44 0/0	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			11, 243	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2 o	chapter 1	10, 000	44. 00
00	§115. 2			10,000	00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 00	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	92. 00 93. 00
	Total (sum of lines 91 and 93)				94. 00
			!	!	

Health Financial Systems	DEACONESS WOMENS	HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0149	Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pr	epared:
				5/30/2023 8:	21 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(200. 00

| Period: | Worksheet E-1 | From 01/01/2022 | Part | | Date/Time Prepared: | 5/30/2023 8:21 am Health Financial Systems DEAC ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0149

					5/30/2023 8: 2	1 am
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		790, 36		1, 470, 410	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
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		(O	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05			(O	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				O	0	3. 51
3. 52				O	0	3. 52
3. 53				O	0	3. 53
3.54				O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(O	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		790, 36	2	1, 470, 410	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		790, 30.	3	1, 470, 410	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			O	0	5. 01
5. 02				O	0	5. 02
5.03				O	0	5. 03
E	Provider to Program TENTATIVE TO PROGRAM			1		E 50
5. 50 5. 51	IENTATIVE TO PROGRAW			0	0	5. 50 5. 51
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines))		5. 99
J. 77	5. 50-5. 98)		,			3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
5.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER			0	11, 243	6. 01
6. 02	SETTLEMENT TO PROGRAM	•	39, 76	3	0	6. 02
7.00	Total Medicare program liability (see instructions)		750, 600		1, 481, 653	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	0.05
8.00	Name of Contractor					8. 00

Heal th	Financial Systems DEACONESS WOMEN	S HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0149 Period: From 01/01/2022 To 12/31/2022 To 12/31/2022 To 3/30/20				epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				
	2.00 Medicare days (see instructions)				2. 00 3. 00
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days (see instructions)				4. 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 o	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		1		4
	Initial/interim HIT payment adjustment (see instructions)				30. 00
31. 00	, , , , , , , , , , , , , , , , , , , ,		,		31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32. 00

Heal th	Financial Systems DEACONESS WO	MENS HOSPITAL	In Lie	u of Form CMS-2	2552-10
			Worksheet E-5	·	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 8:21	
		Title XVIII		PPS	
				1. 00	
TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or	sum of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see i	nstructi ons)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see ins	tructions)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00	
6.00	Time value of money for operating expenses (see instructi	ons)		О	6.00
7.00	Time value of money for capital related expenses (see ins	tructions)		0	7.00

Heal th	Financial Systems DEACONESS WOM	ENS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	E SHEET (If you are nonproprietary and do not maintain	Provi der CO		Peri od:	Worksheet G	
	ype accounting records, complete the General Fund column			From 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
onl y)					5/30/2023 8: 2	
		General Fund	Specific	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1.00	
1.00	Cash on hand in banks	0	C		0	1. 00
2.00	Temporary investments	0	C	-		2. 00
3.00	Notes recei vabl e	0	(1	1	3. 00
4.00	Accounts receivable	35, 268, 264		1	0	4.00
5. 00 6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	1, 034, 142 -17, 962, 727				5. 00 6. 00
7. 00	Inventory	824, 182			0	7. 00
8. 00	Prepai d expenses	965, 448		o o	Ö	8. 00
9.00	Other current assets	116, 336		0	0	9. 00
10.00	Due from other funds	0	C	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	20, 245, 645	(0	0	11. 00
40.00	FI XED ASSETS					
12. 00 13. 00	Land	0				12. 00 13. 00
14. 00	Land improvements Accumulated depreciation			-		14. 00
15. 00	Buildings	0		0	Ö	15. 00
16. 00	Accumulated depreciation	i o		o o	o o	16. 00
17. 00	Leasehold improvements	6, 523, 075		0	0	17. 00
18. 00	Accumulated depreciation	-4, 124, 102	C	0	0	18. 00
19. 00	Fixed equipment	659, 478		,	0	19. 00
20.00	Accumulated depreciation	-659, 478		-	0	20.00
21. 00	Automobiles and trucks	0		1	0	21.00
22. 00 23. 00	Accumulated depreciation Major movable equipment	0		1	0	22. 00 23. 00
24. 00	Accumul ated depreciation	0			0	24. 00
25. 00	Mi nor equipment depreciable	20, 395, 875		o o	o o	25. 00
26. 00	Accumulated depreciation	-17, 308, 531	ď	0	0	26. 00
27.00	HIT designated Assets	0	C	0	0	27. 00
28. 00	Accumulated depreciation	0	C	1	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0				29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	5, 486, 317		0	0	30.00
31. 00	Investments	0		0	0	31.00
32. 00	Deposits on Leases	l ő			Ö	32. 00
33.00	Due from owners/officers	0	ď	0	0	33. 00
34.00	Other assets	34, 971, 085	C	0	0	34. 00
35.00	Total other assets (sum of lines 31-34)	34, 971, 085	C			35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	60, 703, 047		0	0	36. 00
27.00	CURRENT LIABILITIES Accounts payable	/ 227 FE2		0	0	27.00
37. 00 38. 00	Salaries, wages, and fees payable	6, 237, 552 6, 416, 799		-	0	37. 00 38. 00
39. 00	Payroll taxes payable	0,410,777			Ö	39. 00
40. 00	Notes and Loans payable (short term)	9, 273, 368		o o	o o	40. 00
41.00	Deferred income	0		0	0	41. 00
42.00	Accelerated payments	0				42. 00
43. 00	Due to other funds	0	C	-	0	43. 00
44. 00	Other current liabilities	1, 080, 286			0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	23, 008, 005		0	0	45. 00
46. 00	Mortgage payable	0		0	0	46. 00
47. 00	Notes payable	32, 216, 540		-		47. 00
48. 00	Unsecured Loans	0	d	o o	Ō	48. 00
49.00	Other long term liabilities	0	C	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	32, 216, 540			0	50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	55, 224, 545	(0	0	51.00
E0 00	CAPITAL ACCOUNTS	F 470 F00				E2 00
52. 00 53. 00	General fund balance	5, 478, 502				52. 00 53. 00
54. 00	Specific purpose fund Donor created - endowment fund balance - restricted			΄		54.00
55. 00	Donor created - endowment fund balance - restricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	5, 478, 502		0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	60, 703, 047		,	0	60. 00
	l~·/	I .	ı	I	ı	ı

Provider CCN: 15-0149

					To 12/31/2022	Date/Time Prep 5/30/2023 8:2	
		General	Fund	Special P	urpose Fund	Endowment Fund	ı aiii
				·			
		1.00	2.00	2.00	4.00	F 00	
1. 00	Fund balances at beginning of period	1.00	2. 00 12, 357, 417	3. 00	4. 00	5. 00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14, 094, 372				2. 00
3. 00	Total (sum of line 1 and line 2)		26, 451, 789		0		3. 00
4. 00	ROUNDING	0	20, 431, 709			o	4. 00
5.00	INCOMPT NO	0		l '	5		5. 00
6. 00							6. 00
7. 00))		7. 00
8.00))		8. 00
9.00		o o			Ď		9. 00
10. 00	Total additions (sum of line 4-9)		0		0		10.00
11. 00	Subtotal (line 3 plus line 10)		26, 451, 789		0		11. 00
12. 00	DI STRI BUTI ON TO MEMBERS	20, 973, 287	20/ 101/ 707		0	0	12. 00
13. 00	BY CYTTE OF THE MILE ME	0			0	l ol	13. 00
14. 00		o			0	0	14. 00
15. 00		o				0	15. 00
16.00		o			0	0	16.00
17. 00		o			O	0	17.00
18.00	Total deductions (sum of lines 12-17)		20, 973, 287		0		18.00
19.00	Fund balance at end of period per balance		5, 478, 502		0		19.00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00	_		
1. 00	Fund balances at beginning of period	0.00	7.00)		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)			,	3		2. 00
3.00	Total (sum of line 1 and line 2)	0		1			3. 00
4. 00	ROUNDI NG		0	·			4. 00
5. 00			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)	O			O		10.00
11. 00	Subtotal (line 3 plus line 10)	0			O		11.00
12.00	DISTRIBUTION TO MEMBERS		0				12.00
13. 00			0				13.00
14. 00			0				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)	0			0		18.00
19. 00	Fund balance at end of period per balance	0		·	O		19. 00
	sheet (line 11 minus line 18)	1		I	T		

Health Financial Systems

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0149

					5/30/2023 8: 2	1 am
	Cost Center Description	Inpatie	ent	Outpati ent	Total	
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	15, 88	8, 489		15, 888, 489	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY					7. 00
8. 00	NURSI NG FACILITY					8. 00
9.00	OTHER LONG TERM CARE	45.00			45 000 400	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)	15, 88	8, 489		15, 888, 489	10. 00
44.00	Intensive Care Type Inpatient Hospital Services	04.05	0 111		24.050.444	44 00
11.00	INTENSIVE CARE UNIT	34, 25	9, 414		34, 259, 414	11.00
12. 00 13. 00	CORONARY CARE UNIT					12. 00 13. 00
14. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT					14. 00
	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	i nes 34, 25	0 /1/		34, 259, 414	16. 00
10.00	111-15)	34, 23	9, 414		34, 239, 414	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	50, 14	7 903		50, 147, 903	17. 00
18. 00	Ancillary services	56, 63			153, 053, 347	
19. 00			4, 428		36, 518, 262	
20. 00	RURAL HEALTH CLINIC	., , , _	0	0.,0,0,00.	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21. 00
	HOME HEALTH AGENCY					22. 00
23. 00	AMBULANCE SERVICES					23. 00
24.00						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	NON-REI MBURSABLE		0	5, 324, 935	5, 324, 935	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst. 111,70	2, 729	133, 341, 718	245, 044, 447	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			115, 813, 944		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	T-t-1		0	0		35. 00
36. 00 37. 00	Total additions (sum of lines 30-35)		0	U		36. 00 37. 00
38. 00	DEDUCT (SPECIFY)		0			38.00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
	Total deductions (sum of lines 37-41)		U	0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		115, 813, 944		43. 00
10. 00	to Wkst. G-3, line 4)	(2. 357 61		110,010,744		.0.00
	1	1				

Heal th	Financial Systems DEACO	NESS WOMENS HOSPITAL	In Lie	u of Form CMS-2	2552-10	
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0149	Peri od:	Worksheet G-3		
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 8: 2		
	I=			1. 00		
1.00	Total patient revenues (from Wkst. G-2, Part I, col			245, 044, 447 116, 698, 213	1. 00 2. 00	
2.00						
3.00	Net patient revenues (line 1 minus line 2)			128, 346, 234 115, 813, 944	3. 00 4. 00	
	Loss total operating expenses (from Wkst. G-2, Part II, line 43)					
5. 00	Net income from service to patients (line 3 minus I OTHER INCOME	line 4)		12, 532, 290	5. 00	
6. 00	Contributions, donations, bequests, etc			-52, 271	6, 00	
7. 00	Income from investments			-52, 271	7. 00	
8. 00	Revenues from telephone and other miscellaneous com	mmunication services		0	8.00	
9. 00	Revenue from television and radio service	milan catron services		Ö		
10.00	Purchase di scounts			0	10.00	
11. 00	Rebates and refunds of expenses			0	11.00	
12. 00	Parking lot receipts			0	12.00	
13. 00	Revenue from Laundry and Linen service			0	13.00	
14. 00	Revenue from meals sold to employees and guests			474, 515	14. 00	
15.00	Revenue from rental of living quarters			0		
16.00	Revenue from sale of medical and surgical supplies	to other than patients		0	16. 00	
17.00	Revenue from sale of drugs to other than patients	·		0	17. 00	
18.00	Revenue from sale of medical records and abstracts			0	18. 00	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
20.00	Revenue from gifts, flowers, coffee shops, and can't	teen		272, 795	20. 00	
21. 00	Rental of vending machines			0	21. 00	
22. 00	Rental of hospital space			185, 907		
23. 00	Governmental appropriations			0		
24.00	OTHER INCOME			681, 136		
24. 50	COVI D-19 PHE Fundi ng			0	24. 50	
	Total other income (sum of lines 6-24)			1, 562, 082		
26. 00	Total (line 5 plus line 25)			14, 094, 372		
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00	
28. 00	Total other expenses (sum of line 27 and subscripts			0	28. 00	
29. 00	Net income (or loss) for the period (line 26 minus	line 28)	ļ	14, 094, 372	29. 00	

CALCIII	Financial Systems DEACONESS			u of Form CMS-2	2552-10
CALCUI	LATION OF CAPITAL PAYMENT	Provi der CCN: 15-0149	Peri od: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Pre 5/30/2023 8:2	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			34, 664	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments	0	2. 00		
2. 01	Model 4 BPCI Capital DRG outlier payments	0	2. 01		
3.00	Total inpatient days divided by number of days in the confidence of interns & residents (see instructions)	49. 32 0. 00	3. 00 4. 00		
4. 00 5. 00	Indirect medical education percentage (see instructions)			0.00	5. 00
6. 00	Indirect medical education adjustment (multiply line 5		columns 1 and	0.00	6. 00
0.00	1.01) (see instructions)	by the sam of fines f and f. of	, corumno i ana	o l	0.00
7.00	Percentage of SSI recipient patient days to Medicare Pa	rt A patient days (Worksheet E	, part A line	0.00	7. 00
	30) (see instructions)	, , , , , , , , , , , , , , , , , , , ,			
8.00	Percentage of Medicaid patient days to total days (see	instructions)		0.00	8. 00
9. 00	Sum of lines 7 and 8			0. 00	9. 00
10.00	Allowable disproportionate share percentage (see instru	ctions)		0.00	
11.00				24 444	11.00
12. 00	Total prospective capital payments (see instructions)			34, 664	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instruction			0	1. 00
2.00	Program inpatient ancillary capital cost (see instruction			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line :				
4.00	(: t-1t	2)		0	
	Capital cost payment factor (see instructions)	2)		0	4.00
	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)	2)			4.00
	Total inpatient program capital cost (line 3 x line 4)	2)		0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS	2)		1.00	4. 00 5. 00
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			1.00	4. 00 5. 00
1. 00 2. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circuit	mstances (see instructions)		1.00	4. 00 5. 00 1. 00 2. 00
1. 00 2. 00 3. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circulated program inpatient capital costs (line 1 minus line)	mstances (see instructions)		1.00	4. 00 5. 00 1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circulated program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions)	mstances (see instructions)		1.00 0 0 0 0 0 0.00	1. 00 2. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circu Net program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line	mstances (see instructions) 2)		0 0 1.00	1. 00 2. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circulor program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances (mstances (see instructions) 2) 4) see instructions)	(line 6)	1.00 0 0 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circu Net program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line	mstances (see instructions) 2) 4) see instructions)	(line 6)	0 0 1.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circulous program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances (Adjustment to capital minimum payment level for extraordinary	mstances (see instructions) 2) 4) see instructions) dinary circumstances (line 2 x	: line 6)	0 0 1.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circuments of the program inpatient capital costs (line 1 minus line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception) Capital minimum payment for extraordinary circumstances (line 5 plus line 7) Current year capital payments (from Part I, line 12, as current year comparison of capital minimum payment leve	mstances (see instructions) 2) 4) see instructions) dinary circumstances (line 2 x applicable) I to capital payments (line 8	less line 9)	0 0 1.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circuments (line 1 minus line 2 minus line 3 x line 2 minus line 3 x line 3 x line 3 minus line 3 x line 3 minus line 4 minus line 3 x line 4 minus line 4 minus line 5 minus line 5 minus line 7 minus line 7 minus line 7 minus line 7 minus line 7 minus line 7 minus line 7 minus line 7 minus line 7 minus line 1 minus line 1 minus payment level 6 minus line 1 minus payment level 6 minus line 1 minus payment level 6 minus line 1 minus payment level 6 minus line 1 minus payment level 6 minus line 1 minus payment level 6 minus line 1 minus payment level 6 minus line 1 minus payment level 6 minus line 1 minus payment level 6 minus line 1 minus payment level 6 minus line 1 minus line 1 minus payment level 6 minus line 1 minus	mstances (see instructions) 2) 4) see instructions) dinary circumstances (line 2 x applicable) I to capital payments (line 8 over capital payment (from pri	less line 9) or year	1.00 0 0 0 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00
5.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circuments (line 1 minus line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line appropriate percentage adjustment for extraordinary circumstances (adjustment to capital minimum payment level for extraordinary circumstances (adjustment to capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level (apital minimum payment level to capital minimum payment level (apital minimum payment level to capital minimum payment level to	mstances (see instructions) 2) 4) see instructions) dinary circumstances (line 2 x applicable) I to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus lir	less line 9) or year ne 11)	0 0 0 0 0 0 0 0.00 0 0.00 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 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	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circuments of the program inpatient capital costs (line 1 minus line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line approached adjustment for extraordinary circumstances (Adjustment to capital minimum payment level for extraordinary circumstances (adjustment to capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level (Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive,	mstances (see instructions) 2) 4) see instructions) dinary circumstances (line 2 x applicable) I to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus line enter the amount on this line	less line 9) or year ne 11)	0 0 0 0 0 0 0 0.000 0 0 0.000 0 0	4. 00 5. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 11. 00 12. 00 13. 00
5.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circuments of the program inpatient capital costs (line 1 minus line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception payment level for extraordinary circumstances (adjustment to capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level (worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level (carryover of accumulated capital minimum payment lev	mstances (see instructions) 2) 4) see instructions) dinary circumstances (line 2 x applicable) I to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus line enter the amount on this line	less line 9) or year ne 11)	0 0 0 1.00	4. 00 5. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 11. 00 12. 00 13. 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	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circuments of the program inpatient capital costs (line 1 minus line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception line payments (line 5 plus line 7) Current year capital minimum payment level (line 5 plus line 7) Current year comparison of capital minimum payment level (carryover of accumulated capital minimum payment level (worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line)	mstances (see instructions) 2) 4) see instructions) dinary circumstances (line 2 x applicable) I to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus line enter the amount on this line over capital payment for the f	less line 9) or year ne 11)	0 0 0 0 0 0 0 0.00 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 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	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (for extraordinary circuments) Net program inpatient capital costs (fine 1 minus line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions) Capital cost for comparison to payment level for extraory Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as current year comparison of capital minimum payment level worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capic current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line) current year allowable operating and capital payment (see the second of the second	mstances (see instructions) 2) 4) see instructions) dinary circumstances (line 2 x applicable) I to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus line enter the amount on this line over capital payment for the feee instructions)	less line 9) or year ne 11)	0 0 0 0 0 0 0 0.000 0 0 0.000 0 0	4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00