	BETH DEARE			u of Form CMS-2	552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b) payments made since the beginning of the cost reporting period				FORM APPROVED OMB NO. 0938-0 EXPIRES 09-30-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC AND SETTLEMENT SUMMARY	ATION Pro	ovider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prep 5/28/2024 1:58	
PART I - COST REPORT STATUS					
Provider 1. [X] Electronically prepared cost report			Date: 5/28/20	24 Time: 1:	58 pm
use only 2. [ ] Manually prepared cost report					
3.[ 0 ]If this is an amended report enter the r 4.[ F ]Medicare Utilization. Enter "F" for full	number of , "L" fo	times the provider re r low, or "N" for no.	esubmitted this co	ost report	
Contractor use only5. [1] Cost Report Status (1) As Submitted6. Date Received: 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended6. Date Received: 7. Contractor No. (7. Contractor No. 	port for the for the second	his Provider CCN 12.[		or Code: Jumn 1 is 4: En Nes reopened = C	
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI	STRATOR OF	R PROVIDER(S)			
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTL ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	LAW. FURT	HERMORE, IF SERVICES	IDENTIFIED IN TH	IIS REPORT WERE	
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR OF PRO	OVI DER(S)			
I HEREBY CERTIFY that I have read the above certificat electronically filed or manually submitted cost report Statement of Revenue and Expenses prepared by ST ELIZA beginning 01/01/2023 and ending 12/31/2023 and to the are true, correct, complete and prepared from the book applicable instructions, except as noted. I further ce regarding the provision of health care services, and t provided in compliance with such laws and regulations.	and submi ABETH DEAR best of my s and reco rtify that hat the se	tted cost report and 30RN (15-0086) for y knowledge and belie ords of the provider t I am familiar with	I the Balance Shee the cost reportin ef, this report and in accordance with the laws and regu	et and ng period nd statement th ulations	
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX 2	SIGN	ELECTRONIC		
1		I have read and agre statement. I certify signature on this ce binding equivalent o	e with the above that I intend my ertification be th	/ electronic ne legally	1
2 Signatory Printed Name					2

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	384, 044	-1, 274	0	364, 034	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	TOTAL	0	384, 044			364, 034	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.

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.

3 Signatory Title

4 Date

CF0

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi de	er CCN:	F	Period: From 01/01/ Fo 12/31/		Workshe Part I Date/Ti 5/28/20	me Pre	pare
	1.00	2.00		3.00		4	4.00	5720720	24 1.5	
	Hospital and Hospital Health Care Co	omplex Address:								
00	Street: 600 WILSON CREEK ROAD	P0 Box:								1.
00	City: LAWRENCEBURG	State: IN	Zip Code	e: 47025	5 Count	y: DEARBORN				2.
		Component Name	CCN	CBSA	Provi der	Date	Payme	nt Syst	em (P,	
			Number	Numbe	r Type	Certified	Т,	0, or	N)	
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer	nt Identification:								
00	Hospi tal	ST ELIZABETH DEARBORN	150086	17140	) 1	07/01/1966	N	Р	0	3.
00	Subprovider - IPF									4.
00	Subprovider - IRF									5.
0C	Subprovider - (Other)									6.
00	Swing Beds - SNF									7.
0C	Swing Beds - NF									8.
00	Hospital-Based SNF									9.
00	Hospital-Based NF									10.
00	Hospi tal -Based OLTC									11.
00	Hospital-Based HHA									12.
00	Separately Certified ASC									13.
	Hospi tal -Based Hospi ce									14.
00	Hospital -Based Health Clinic - RHC									15.
	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17.
10	Hospital -Based (CORF) I									17
00	Renal Dialysis									18
	Other									19.
			-11			From:		То	:	
						1.00		2.0	00	1
00	Cost Reporting Period (mm/dd/yyyy)					01/01/20	023	12/31/	/2023	20.
00	Type of Control (see instructions)					1				21.
										4
	Inpatient PPS Information				1.00	2.00		3.0	00	
00	Does this facility qualify and is it	currently receiving pa	vments for		Y	N				22.
00	di sproporti onate share hospi tal adju									22.
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo	or yes or "N" for no.								
01	Did this hospital receive interim UC	Ps, including supplement	tal UCPs, '	for	N	Y				22.
	this cost reporting period? Enter in	n column 1, "Y" for yes	or "N" for	no						
	for the portion of the cost reportin									
	1. Enter in column 2, "Y" for yes or			e						
	cost reporting period occurring on c	or after October 1. (see								
	instructions)									
02	Is this a newly merged hospital that				N	N				22.
	determined at cost report settlement			umn						
	1, "Y" for yes or "N" for no, for th									
	period prior to October 1. Enter in			10,						
	for the portion of the cost reportin Did this hospital receive a geograph	ic reclassification from	iouer I. m urban to		Ν	N		N		22
03	rural as a result of the OMB standar				IN IN	IN IN		IN		22
03		8								
03		olumn 1 "Y" for ves or	"N" for n	~ I						
03	adopted by CMS in FY2015? Enter in c									1
03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin	ng period prior to Octob	er 1. Ente							1
03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for	ng period prior to Octob no for the portion of t	er 1. Ente he cost							
03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin	ng period prior to Octob no for the portion of t er October 1. (see inst	er 1. Ente he cost ructions)	r						
03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft	ng period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	er 1. Ente he cost ructions) 99 beds (a:	r s						
03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	ng period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	er 1. Ente he cost ructions) 99 beds (a:	r s						
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	ng period prior to Octob no for the portion of t rer October 1. (see inst 100 but not more than 4 2.105)? Enter in column	er 1. Ente he cost ructions) 99 beds (a: 3, "Y" fo	r s r						22.
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alth Financial Systems ST SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	ELIZABETH DEA	Provider CC	CN: 15-0086	Period: From 01/	In Lieu		eet S-2	
					31/2023	Date/T	ime Pre 024 1:5	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	id ( ys Me	)ther di cai d days	
	1.00	2.00	3.00	4.00	5.00		6.00	
<ul> <li>.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in colum 4, Medicaid HMO paid and eligible but unpaid days i colum 5, and other Medicaid days in column 6.</li> <li>.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,</li> </ul>	n 0				7 1,	483 0	54	24. (
out-of-state Medicaid days in column 3, out-of-stat Medicaid eligible unpaid days in column 4, Medicaic HMO paid and eligible but unpaid days in column 5.								
					'Rural S .00		F Geogr 00	-
.00 Enter your standard geographic classification (not		at the beg	jinning of		1	۷.	20	26.0
<ul> <li>cost reporting period. Enter "1" for urban or "2" f</li> <li>00 Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban enter the effective date of the geographic reclassion of the state of</li></ul>	wage) status or "2" for r fication in	ural. If ap column 2.	plicable,		1			27.0
.00 If this is a sole community hospital (SCH), enter t effect in the cost reporting period.	ne number or	periods SC	H STATUS II	1	0			35.0
					nni ng: . 00	Endi 2.	ng: 00	-
. 00 Enter applicable beginning and ending dates of SCH		cript line	36 for num					36.
of periods in excess of one and enter subsequent da .00  If this is a Medicare dependent hospital (MDH), ent		r of period	ls MDH statu	ıs	О			37.
is in effect in the cost reporting period. .01 Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y"								37.
<ul> <li>instructions)</li> <li>.00 If line 37 is 1, enter the beginning and ending dat greater than 1, subscript this line for the number enter subsequent dates.</li> </ul>								38.
					//N . 00		/N 00	_
.00 Does this facility qualify for the inpatient hospit hospitals in accordance with 42 CFR §412.101(b)(2)( 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or ( or "N" for no. (see instructions)	(i), (ii), or t the mileage	(iii)? Ent requiremer	er in colum nts in	ıme ın	Y		<u> </u>	39.
.00 Is this hospital subject to the HAC program reducti "N" for no in column 1, for discharges prior to Oct no in column 2, for discharges on or after October	tober 1. Ente	r"Y" for y			N	I	N	40.
	1. (300 1131			I	V 1.00	XVIII 2.00		-
Prospective Payment System (PPS)-Capital						2.00	3.00	
<ul> <li>.00 Does this facility qualify and receive Capital paym with 42 CFR Section §412.320? (see instructions)</li> <li>.00 Is this facility eligible for additional payment experience</li> </ul>	ception for	extraordi na	ary circums <sup>.</sup>	ances	e N N	N N	N N	45.
pursuant to 42 CFR §412.348(f)? If yes, complete Wk Pt. III. .00  s this a new hospital under 42 CFR §412.300(b) PPS	6 capital? E	nter "Y for	yes or "N	for no.	N	N	N	47.
<ul> <li>.00 Is the facility electing full federal capital payme Teaching Hospitals</li> <li>.00 Is this a hospital involved in training residents i</li> </ul>	n approved G	ME programs	? For cost	reporting	N N	N	<u>N</u>	48. 56.
<ul> <li>periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to involved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column</li> <li>OO For cost reporting periods beginning prior to December is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II, ib beginning on or after December 27, 2020, under 42 (Debender 10, 2).</li> </ul>	per 27, 2020, column 1 is grams in the e CRs) MA dir 2. hoher 27, 2020 ch residents in column 1. s cost report ete Worksheet f applicable CFR 413.77(e	under 42 C "Y", or if prior year ect GME pay , if line 5 in approved If column ing period? E-4. If cc . For cost )(1)(iv) ar	ER 413.78(I this hospi or penultin ment reduc 66, column d GME progra 1 is "Y", o P Enter "Y" olumn 2 is " reporting p nd (v), rega	b)(2), see cal was nate year, cion? Enter l, is yes, mus trained id ' for yes of N", veriods ardless of	d or			57.
which month(s) of the cost report the residents wer for yes, enter "Y" for yes in column 1, do not comp .00 If line 56 is yes, did this facility elect cost rei	olete column	2, and comp	olete Works	neet E-4.				58.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	F	eriod: rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/28/2024 1:5	pared:
				V 1.00	XVIII XIX 0 2.00 3.00	1
59.00 Are costs claimed on line 100 of Worksheet A? If yes	s, compl	lete Wkst. D-2,	Pt. I.	N	2.00 3.00	59.00
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
50.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHI	see If column 1	N	N		60. 00
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	-
<ul> <li>51.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>51.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)</li> </ul>	N	2.00	0.00	0.00		61. 00
<ul> <li>1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)</li> <li>1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see</li> </ul>						61. 03
<ul> <li>instructions)</li> <li>Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).</li> <li>51.05 Enter the difference between the baseline primary</li> </ul>						61. 04
<ul> <li>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)</li> <li>1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)</li> </ul>						61. 00
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
<ul> <li>51.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>51.20 Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE</li> </ul>				0. 00		61. 10
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.						
ACA Provisions Affecting the Health Resources and Ser	rvi ces	Administration	(HRSA)		1.00	
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct)	traineo ctions)	d in this cost	reporting peri		0.00	62.00
2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	gram. (s	see instruction		your hospital	0.00	62.01
53.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	er Sett ettings	ings during this co	ost reporting p		N	63.

Health Financial Systems		LI ZABETH DEARBORN			u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CAI	RE COMPLEX IDENTIFICATION D	ATA Provider C		eriod: com 01/01/2023 p 12/31/2023	Date/Time Pre	pared:
			Unweighted		5/28/2024 1:5	
			FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te			
			1.00	2.00	3.00	
	ase Year FTE Residents in N after July 1, 2009 and befo		This base year	is your cost r	reporting	
64.00 Enter in column 1, if lin in the base year period, resident FTEs attributabl settings. Enter in colum resident FTEs that traine	e 63 is yes, or your facili the number of unweighted no e to rotations occurring in n 2 the number of unweighte d in your hospital. Enter i column 1 + column 2)). (see	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. OC	0. 000000	64.00
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
65.00 Enter in column 1, if li is yes, or your facility trained residents in the year period, the program associated with primary car program in which you trai residents. Enter in colum the program code. Enter i column 3, the number of unweighted primary care F residents attributable to rotations occurring in al non-provider settings. En column 4, the number of unweighted primary care resident FTEs that traine your hospital. Enter in co 5, the ratio of (column 3 divided by (column 3 + co 4)). (see instructions)	base name are e ned n 2, n TE I ter in d in olumn		0.00 Unwei ghted FTEs	0.00 Unweighted FTEs in	0.000000 Ratio (col. 1/ (col. 1 + col.	
			Nonprovider	Hospital	(col. l + col. 2))	
			Si te	nospitai	2))	
			1.00	2.00	3.00	+
Section 5504 of the ACA C	urrent Year FTE Residents i	n Nonprovider Setting				
beginning on or after Jul	y 1, 2010		-			
Enter in column 2 the num FTEs that trained in your	tions occurring in all non- ber of unweighted non-prima hospital. Enter in column umn 1 + column 2)). (see in	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
	Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col. 3/	·
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
	1.00	2.00	Si te	4.00	E 00	-
67.00 Enter in column 1, the pr	1.00	2.00	3.00	4.00	5.00 0.000000	67 00
name associated with each your primary care program which you trained residen Enter in column 2, the pr code. Enter in column 3, number of unweighted prim care FTE residents attrib to rotations occurring in non-provider settings. En column 4, the number of unweighted primary care resident FTEs that traine your hospital. Enter in c 5, the ratio of (column 3 + co 4)). (see instructions)	of s in ts. ogram the ary utable all ter in d in olumn					

Heal th	Financial Systems ST ELIZABETH DEARBORN		In	Lieu	of Form CMS-	2552-10
			Period:	W	orksheet S-2	
			rom 01/01/2 o 12/31/2		'art∣ ate/Time Pre	epared:
					/28/2024 1:5	
					1.00	-
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-4				1.00	
68.00	For a cost reporting period beginning prior to October 1, 2022, did you					68.00
	MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fi (August 10, 2022)?	nai Ruie, 87 FR	49065-49072	2		
				1.00	2.00 3.00	
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it con	tain an IPE sub	provi der?	N		70.00
70.00	Enter "Y" for yes or "N" for no.					/0.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teach				0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train resident					
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for					
	Column 3: If column 2 is Y, indicate which program year began during thi	s cost reportin	g period.			
	(see instructions) Inpatient Rehabilitation Facility PPS					-
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it	contain an IRF		N		75.00
74 00	subprovider? Enter "Y" for yes and "N" for no.		the meet			74 00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teach recent cost reporting period ending on or before November 15, 2004? Ente				0	76.00
	no. Column 2: Did this facility train residents in a new teaching progra	m in accordance	with 42			
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: I		1			
	indicate which program year began during this cost reporting period. (se	e finstructions)				
					1.00	
<u>00 00</u>	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for	<b>PO</b>			N	80.00
	Is this a LTCH co-located within another hospital for part or all of the		period? Ent	er	N	81.00
	"Y" for yes and "N" for no.					
9E 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Ent	or "V" for yor	or "N" for r		N	85.00
	Did this facility establish a new Other subprovider (excluded unit) unde			10.	IN	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 classified 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section			N	87.00
			Approved f	for	Number of	
			Permanen		Approved	
			Adjustmer (Y/N)		Permanent Adjustments	
			1.00		2.00	1
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TE		N		(	0 88.00
	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete 89. (see instructions)	col. 2 and line				
	Column 2: Enter the number of approved permanent adjustments.					
		Wkst. A Line	Effective [	Date	Approved	
		No.			Permanent Adjustment	
					Amount Per	
					Di scharge	
89 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00		3.00	89.00
07.00	on which the per discharge permanent adjustment approval was based.	0.0			· · · · · · · · · · · · · · · · · · ·	07.00
	Column 2: Enter the effective date (i.e., the cost reporting period					
	beginning date) for the permanent adjustment to the TEFRA target amount per discharge.					
	Column 3: Enter the amount of the approved permanent adjustment to the					
	TEFRA target amount per discharge.				<u> </u>	
			V 1.00		2.00	-
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? yes or "N" for no in the applicable column.	Enter "Y" for	N		Y	90.00
91.00	is this hospital reimbursed for title V and/or XIX through the cost repo	rt either in	N		Y	91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable colum	n.				
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certifica instructions) Enter "Y" for yes or "N" for no in the applicable column.	tion)? (see			Ν	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V a	nd XIX? Enter	N		Ν	93.00
	"Y" for yes or "N" for no in the applicable column.					
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for applicable column.	no in the	N		Ν	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable colu	mn.	0.00		0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for		N		Ν	96.00
97.00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable colu	mn.	0.00		0.00	97.00
			0.00	I	21.00	1

ealth Financial Systems ST ELIZABETI IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Period: From 01/01/2023	u of Form CMS Worksheet S- Part I	
			o 12/31/2023	Date/Time Pr 5/28/2024 1:	
			V	XI X	
8.00 Does title V or XIX follow Medicare (title XVIII) for the i	ntorno and roa	idente neet	1.00 Y	2.00 Y	98.
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in			
8.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.			Y	Y	98.
3.02 Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			Y	Y	98.
8. 03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.			N	N	98
B. 04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98
B. 05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in			Y	Y	98
<ul> <li>column 2 for title XIX.</li> <li>B. O6 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.</li> </ul>			Y	Y	98
Rural Providers					105
<ul> <li>5.00 Does this hospital qualify as a CAH?</li> <li>6.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)</li> </ul>	hod of payment	N N		105	
7.00 Column 1: If line 105 is Y, is this facility eligible for c training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do	structions) Rs in an	Ν		107	
approved medical education program in the CAH's excluded I Enter "Y" for yes or "N" for no in column 2. (see instruct 7.01 If this facility is a REH (line 3, column 4, is "12"), is i reimbursement for I&R training programs? Enter "Y" for yes	cost			107	
instructions) 18.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108
	Physi cal	Occupati onal	Speech	Respi ratory	
					_
9 001 f this bosnital qualifies as a CAH or a cost provider are	1.00	2.00	3.00	4.00	
19.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109
therapy services provided by outside supplier? Enter "Y"		2.00	3.00	4.00	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N al Demonstrati "Y" for yes or	2.00 N on project (§4	3.00 N 10A f yes,	4.00 N	
<ul> <li>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.</li> <li>0.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo</li> </ul>	N al Demonstrati "Y" for yes or	2.00 N on project (§4	3.00 N 10A f yes, gh 215, as	4.00 N 1.00 N	109
<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a</pre>	Al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in	2.00 N on project (§4 "N" for no. I i nes 200 throu Communi ty period? Enter enter the n col umn 2.	3.00 N 10A f yes,	4.00 N 1.00	109
<ul> <li>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.</li> <li>0.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.</li> <li>1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa</li> </ul>	Al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in	2.00 N on project (§4 "N" for no. I i nes 200 throu Communi ty period? Enter enter the n col umn 2.	3.00 N 10A f yes, gh 215, as	4.00 N 1.00 N	109
<ul> <li>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.</li> <li>0.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.</li> <li>1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.</li> </ul>	N al Demonstrati "Y" for yes or rksheet E-2, l the Frontier C ost reporting olumn 1 is Y, rticipating ir dditional beds	2.00 N on project (§4 "N" for no. I i nes 200 throu communi ty peri od? Enter enter the n col umn 2. s; and/or "C" 1.00	3.00 N 10A f yes, gh 215, as	4.00 N 1.00 N	109 1109 1110 1111
<ul> <li>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.</li> <li>0.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.</li> <li>1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.</li> <li>2.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began particidemonstration. In column 3, enter the date the hospital ce</li> </ul>	N al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the	2.00 N on project (§4 "N" for no. I i nes 200 throu communi ty period? Enter enter the n col umn 2. s; and/or "C"	3.00 N 10A f yes, gh 215, as 1.00 N	4.00 N 1.00 N 2.00	109 1109 1110 1111
<ul> <li>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.</li> <li>0.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.</li> <li>1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.</li> <li>2.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration.</li> <li>5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for yes on the provider?</li> </ul>	N al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no	2.00 N on project (§4 "N" for no. I i nes 200 throu communi ty peri od? Enter enter the n col umn 2. s; and/or "C" 1.00	3.00 N 10A f yes, gh 215, as 1.00 N	4.00 N 1.00 N 2.00	1109 1109 1110 1111 1111
<ul> <li>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.</li> <li>0.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.</li> <li>1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.</li> <li>2.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information</li> <li>5.00 Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide</li> </ul>	Al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating ir dditional beds I th Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes	2.00 N on project (§4 "N" for no. I i nes 200 throu communi ty peri od? Enter enter the n col umn 2. s; and/or "C" 1.00 N	3.00 N 10A f yes, gh 215, as 1.00 N	4.00 N 1.00 N 2.00	109
<ul> <li>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.</li> <li>0.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.</li> <li>1.00 If this facility qualifies as a CAH, did it participate in Heal th Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-heal th services.</li> <li>2.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Miscel aneous Cost Reporting Information</li> <li>5.00 Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.</li> </ul>	N al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on	2.00 N on project (§4 "N" for no. I i nes 200 throu communi ty peri od? Enter enter the n col umn 2. s; and/or "C" 1.00 N	3.00 N 10A f yes, gh 215, as 1.00 N	4.00 N 1.00 N 2.00	1109 1109 1110 1111 1111
<ul> <li>for yes or "N" for no for each therapy.</li> <li>10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.</li> <li>11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.</li> <li>12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration in fapplicable. Mi scell aneous Cost Reporting Information</li> <li>15.00 Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.</li> </ul>	N al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on for yes or rance? Enter	2.00 N on project (§4 "N" for no. I i nes 200 throu communi ty peri od? Enter enter the n col umn 2. s; and/or "C" 1.00 N N N	3.00 N 10A f yes, gh 215, as 1.00 N	4.00 N 1.00 N 2.00	1109 1109 1110 1111 1111 1112 0 1115

Ith Financial Systems         ST ELIZABETH DEAR           SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA         Pr		F	Period: From 01/01/2023 Fo 12/31/2023	Worksheet S Part I Date/Time P 5/28/2024 1	-2 repared
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
3.01 List amounts of malpractice premiums and paid losses:			2.00 0 270,80 <sup>2</sup>		60 118. (
			1.00	2.00	_
3.02 Are malpractice premiums and paid losses reported in a cost cente	r other 1	than the	1.00 N	2.00	118.
Administrative and General? If yes, submit supporting schedule I and amounts contained therein. 0.00D0 NOT USE THIS LINE					119.
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harm §3121 and applicable amendments? (see instructions) Enter in colu "N" for no. Is this a rural hospital with < 100 beds that qualifi Hold Harmless provision in ACA §3121 and applicable amendments? ( Enter in column 2, "Y" for yes or "N" for no.	mn 1, "Y' es for th	' for yes or ne Outpatient	N	N	120.
.00Did this facility incur and report costs for high cost implantabl patients? Enter "Y" for yes or "N" for no.	e devi ces	s charged to	Y		121.
2. 00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is " the Worksheet A line number where these taxes are included.		Y	5.00	122.	
8.00 Did the facility and/or its subproviders (if applicable) purchase services, e.g., legal, accounting, tax preparation, bookkeeping, management/consulting services, from an unrelated organization? I for yes or "N" for no.	payroll,	and/or	Y	N	123.
If column 1 is "Y", were the majority of the expenses, i.e., grea professional services expenses, for services purchased from unrel located in a CBSA outside of the main hospital CBSA? In column 2, "N" for no.	ated orga	ani zati ons			
Certified Transplant Center Information 5.00Does this facility operate a Medicare-certified transplant center	2 Enter '	'V" for ves	N		125.
and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy)	bel ow.	5			
b.00 If this is a Medicare-certified kidney transplant program, enter in column 1 and termination date, if applicable, in column 2.	the certi	fication date			126.
7.00 If this is a Medicare-certified heart transplant program, enter t in column 1 and termination date, if applicable, in column 2.					127. 128.
B. CO If this is a Medicare-certified liver transplant program, enter t in column 1 and termination date, if applicable, in column 2. D. CO If this is a Medicare-certified lung transplant program, enter the content of the					120.
in column 1 and termination date, if applicable, in column 2. 0.00  f this is a Medicare-certified pancreas transplant program, ente					130.
date in column 1 and termination date, if applicable, in column 2					
.00 If this is a Medicare-certified intestinal transplant program, en date in column 1 and termination date, if applicable, in column 2		certi fi cati on			131.
2.00 If this is a Medicare-certified islet transplant program, enter t in column 1 and termination date, if applicable, in column 2.	he certif	fication date			132.
B. 00 Removed and reserved I. 00 If this is a hospital-based organ procurement organization (0P0), in column 1 and termination date, if applicable, in column 2. All Providers	enter th	ne OPO number			133. 134.
0.00 Are there any related organization or home office costs as define chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, are claimed, enter in column 2 the home office chain number. (see	and home	office costs	Y	HB0843	140.
1.00         2.00           If this facility is part of a chain organization, enter on lines	141 thro	ugh 143 the na	3.00	of the	
home office and enter the home office contractor name and contrac		er.			
. 00 Name: ST. ELI ZABETH HEALTHCARE CONTractor's Name: CGS CORPORATE		Contracto	r's Number: 1510	01	141.
OOStreet: 1 MEDICAL VILLAGE DRIVE PO Box: OOCity: EDGEWOOD State: KY		Zip Code:	410	17	142. 143.
		[=: ]p =====:			
. 00 Are provider based physicians' costs included in Worksheet A?				1.00 Y	144.
00 If costs for renal services are claimed on Wkst. A, line 74, are inpatient services only? Enter "Y" for yes or "N" for no in colum no, does the dialysis facility include Medicare utilization for t	n 1. lf d	column 1 is	1.00 Y	2.00	145
period? Enter "Y" for yes or "N" for no in column 2. 0.00 Has the cost allocation methodology changed from the previously f Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2,	iled cost	t report?	N		146.

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	N: 15-0086	Peri od:	Worksheet S-	2
				From 01/01/2023 To 12/31/2023	3 Date/Time Pr	
					5/28/2024 1:	58 pm
					1.00	-
47.00Was there a change in the statisti	cal basis? Enter "Y" for	ves or "N" for	no.		N	147.00
48.00Was there a change in the order of					N	148.00
49.00Was there a change to the simplifi				or no.	N	149.00
	<u>x</u>	Part A	Part B	Title V	Title XIX	
		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 compon					
55.00 Hospi tal		N	N	N	N	155.0
56.00 Subprovider – IPF		N	N	N	N	156. 0
57.00 Subprovider – IRF		N	N	N	N	157.0
58. 00 SUBPROVI DER						158. C
59. 00 SNF		N	N	N	N	159. C
50.00 HOME HEALTH AGENCY		N	N	N	N	160. C
51.00 CMHC			N	N	N	161.0
51. 10 CORF			N	N	N	161.1
					1.00	_
					1.00	
Multicampus	mous beenited that has an		and in dif	formant CDCAo2	N	1/5 0
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus nospitai that has one	e or more campu	ises in ait	rerent CBSAS?	N	165. 0
Enter Froi yes of N Torno.	Name	County	State 2	Zip Code CBSA	FTE/Campus	
	0	1.00	2.00	3.00 4.00	5.00	-
66.00 If line 165 is yes, for each	5	1.00	2.00	0.00 1.00		0 166. 0
campus enter the name in column					0.0	
0, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	
Health Information Technology (HI	) incentive in the Americ	an Recovery and	d Reinvestm	ent Act	-	
67.00 Is this provider a meaningful user					Y	167.0
58.00 If this provider is a CAH (line 10			e 167 is "Y	"), enter the		168.0
reasonable cost incurred for the H						1100
58.01 If this provider is a CAH and is r						168. C
exception under §413.70(a)(6)(ii)? 59.00 If this provider is a meaningful u						9169.0
transition factor. (see instructio		IS HUL A CAH (		s wj, enter the	9.5	109.0
				Begi nni ng	Endi ng	
				1.00	2.00	-
		date for the re	portina		2.00	170.0
70.00 Enter in columns 1 and 2 the FHR b	eqinning date and ending (					
70.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and ending (					
	eginning date and ending o					
period respectively (mm/dd/yyyy)				1.00	2.00	-
period respectively (mm/dd/yyyy) 71.00 fline 167 is "Y", does this prov	ider have any days for in	di vi dual s enrol		N		0171.0
period respectively (mm/dd/yyyy)	ider have any days for in eported on Wkst. S-3, Pt.	dividuals enrol I, line 2, col	. 6? Enter	N		0171.0

OSPI T	Financial Systems ST ELIZABETH AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	DEARBORN Provider C	CN: 15-0086	Peri od:	u of Form CMS Worksheet S-	
				From 01/01/2023 To 12/31/2023	Part II Date/Time Pr 5/28/2024 1:	epared
				Y/N	Date	
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEN					
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ent	er all dates in t	he	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N		1.
	······································		Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other	ffices, drug er or its f the board	N			3.
	relationships? (see instructions)		Y/N	Туре	Date	-
			1.00	2. 00	3.00	
	Financial Data and Reports			2.00	0.00	
. 00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.
. 00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		Ν			5.
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for a nursing program? Column 2	2: If yes, is	s the provide	r N		6.
00 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing programs and/or allied health programs approved		ved during th	N e N		7.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved of	graduate medio	cal education	N		9.
). 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or		the current	N		10.
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		11.
	Teaching Program on Worksheet A? If yes, see instructions.				V /N	
					Y/N 1.00	
	Bad Debts				1.00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes,	see instruct	tions.		Y	12.
8. 00	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.	olicy change o	during this c	ost reporting	Ν	13.
. 00	If line 12 is yes, were patient deductibles and/or coinsurar instructions.	nce amounts wa	aived? If yes	, see	N	14.
5. 00	Bed Complement Did total beds available change from the prior cost reportin	na period? If	ves, see ins	tructions.	N	15.
			-t A	Par		101
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	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)	N		IN .		10.
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/30/2024	Y	04/30/2024	17.
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Ν		N		18.
9. 00	Report data for corrections of other PS&R Report	Ν		Ν		19.

Health Financial Systems

alth Financial Systems ST ELIZABE DSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE				eu of Form CMS-	2552 - I		
	ALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0086			Worksheet S-2 Part II Date/Time Pre	pared:		
	Descr	iption	Y/N	5/28/2024 1:5 Y/N	pm		
	Desci	0	1.00	3.00			
0.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		<u> </u>	N	N	20.00		
	Y/N	Date	Y/N	Date			
	1.00	2.00	3.00	4.00			
.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00		
				1.00			
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EX	CEPT CHILDRENS	HOSPI TALS)					
Capital Related Cost				1			
<ul> <li>2.00 Have assets been relifed for Medicare purposes? If yes, s</li> <li>3.00 Have changes occurred in the Medicare depreciation expension</li> </ul>			ng the cost		22. 0 23. 0		
Reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	red into during	this cost rep	oorting period?		24.0		
If yes, see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see							
b. 00 Were assets subject to Sec. 2314 of DEFRA acquired during							
<ul> <li>instructions.</li> <li>Has the provider's capitalization policy changed during t copy.</li> </ul>	he cost reporti	ng period?lf	yes, submit		27.00		
Interest Expense 3.00 Were new Loans, mortgage agreements or letters of credit	entered into du	ring the cost	reporting		28.0		
period? If yes, see instructions. 2.00 Did the provider have a funded depreciation account and/o	r bond funds (D	ebt Service Re	eserve Fund)		29.0		
treated as a funded depreciation account? If yes, see ins .00 Has existing debt been replaced prior to its scheduled ma		debt? If yes,	see		30. 0		
<ul> <li>instructions.</li> <li>Has debt been recalled before scheduled maturity without instructions.</li> </ul>	issuance of new	debt? If yes,	see		31.0		
Purchased Services 2.00 Have changes or new agreements occurred in patient care s	orvi cos furni ch	od through cor	stractual		32.0		
arrangements with suppliers of services? If yes, see inst 3.00 [If line 32 is yes, were the requirements of Sec. 2135.2 a	ructions.	0			33.0		
no, see instructions. Provider-Based Physicians		<u> </u>					
I. 00 Were services furnished at the provider facility under an If yes, see instructions.	arrangement wi	th provider-ba	ased physi ci ans?		34.0		
5.00 If line 34 is yes, were there new agreements or amended e physicians during the cost reporting period? If yes, see		nts with the p	orovi der-based		35. C		
			Y/N	Date			
			1.00	2.00			
Home Office Costs 0.00 Were home office costs claimed on the cost report?			Y		36.0		
7.00 If line 36 is yes, has a home office cost statement been If yes, see instructions.			Y		37.0		
8.00 If line 36 is yes, was the fiscal year end of the home o the provider? If yes, enter in column 2 the fiscal year e	nd of the home	offi ce.	N		38.0		
0.00 If line 36 is yes, did the provider render services to ot see instructions.		5			39.0		
0.00 If line 36 is yes, did the provider render services to th instructions.	e home office?	If yes, see	N		40.0		
	1	. 00	2.	00			
Cost Report Preparer Contact Information 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RON		HORNBERGER		41.0		
2.00 Enter the employer/company name of the cost report	ST. ELI ZABETH	HEALTHCARE			∥ 42.0		

Heal th	Financial Systems ST ELIZA	ветн	DEARBORN	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN: 15-0086		eriod:	Worksheet S-2	2
				T	rom 01/01/2023 o 12/31/2023		epared: 58 pm
		L					
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	F	REIMBURSEMENT MANAGER				41.00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cost	t					43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ST ELIZABETH	Provi der CO	N. 15_0086	Peri od:	u of Form CMS-2 Worksheet S-3	
00111	AE AND HOST THE HEALTH OAKE COMPLEX STATISTIC			N. 13 0000	From 01/01/2023	Part I	
					To 12/31/2023	Date/Time Pre 5/28/2024 1:5	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Line No. 1.00	2.00	Avai I abl e 3.00	4.00	5.00	
	PART I – STATISTICAL DATA	1.00	2.00	5.00	4.00	5.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	42	15, 33	0.00	0	1 1
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
00	HMO and other (see instructions)						2
00	HMO I PF Subprovi der						3
00	HMO I RF Subprovider						4
00	Hospital Adults & Peds. Swing Bed SNF					0	5
00	Hospital Adults & Peds. Swing Bed NF		10	15 01	0.00	-	6
00	Total Adults and Peds. (exclude observation beds) (see instructions)		42	15, 33	. 00	0	7
00	INTENSI VE CARE UNI T	31.00	8	2, 92	0.00	0	6
00	CORONARY CARE UNIT	32.00	0	2,72	0 0.00		
. 00	BURN I NTENSI VE CARE UNI T	33.00	0		0 0.00	0	10
. 00	SURGI CAL I NTENSI VE CARE UNI T	34.00	0		0 0.00		11
. 00	OTHER SPECIAL CARE (SPECIFY)	01100	0		0,00		12
. 00	NURSERY	43.00				0	13
. 00	Total (see instructions)		50	18, 25	0.00	0	14
. 00	CAH visits					0	15
. 10	REH hours and visits				0.00	0	15
. 00	SUBPROVIDER - IPF	40.00	0		0	0	16
. 00	SUBPROVIDER – IRF	41.00	0		0	0	17
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY	44.00	0		0	0	19
. 00	NURSING FACILITY	45.00	0		0	0	20
. 00	OTHER LONG TERM CARE	46.00	0		0		2
. 00	HOME HEALTH AGENCY	101.00				0	22
. 00	AMBULATORY SURGICAL CENTER (D. P. )	115.00	0		0		2:
. 00 . 10	HOSPICE HOSPICE (non-distinct part)	116. 00 30. 00	0		0		24
. 00	CMHC - CMHC	99. 00				0	25
. 10	CMHC - CORF	99. 00 99. 10				0	25
. 00	RURAL HEALTH CLINIC	88.00				0	20
. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	20
. 00	Total (sum of lines 14-26)	07.00	50			0	2
. 00	Observation Bed Days					0	28
. 00	Ambulance Trips						29
. 00	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31
2. 00	Labor & delivery days (see instructions)		11	4, 01	15		32
2. 01	Total ancillary labor & delivery room						32
	outpatient days (see instructions)						
8.00	LTCH non-covered days						33
3. 01	LTCH site neutral days and discharges						33
1.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0		0	0	34

OSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO		Period: From 01/01/2023	Worksheet S-3 Part I	
					To 12/31/2023		
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I – STATISTICAL DATA						
00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 217	969	10, 45	3		1.
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
00	HMO and other (see instructions)	4, 166	688				2
00	HMO IPF Subprovider	0	0				3
00	HMO IRF Subprovider	0	0				4
00	Hospital Adults & Peds. Swing Bed SNF	0	0		C		5
00	Hospital Adults & Peds. Swing Bed NF		0		C		6
00	Total Adults and Peds. (exclude observation	4, 217	969	10, 45	3		7
	beds) (see instructions)						
00	INTENSIVE CARE UNIT	594	292	1, 73	8		8
00	CORONARY CARE UNI T	0	0		D		9
. 00	BURN INTENSIVE CARE UNIT	0	0		D		10
. 00	SURGI CAL I NTENSI VE CARE UNI T	0	0		D		11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
3. 00	NURSERY		22	45	5		13
. 00	Total (see instructions)	4, 811	1, 283		-	424.24	
5.00	CAH visits	0	0	,	0		15
5. 10	REH hours and visits	0	0		2		15
5.00	SUBPROVIDER - IPF	0	0		0.00	0.00	
. 00	SUBPROVI DER – I RF	0	0		0.00		
. 00	SUBPROVI DER	Ű	0		0.00	0.00	18
9.00	SKILLED NURSING FACILITY	0	0		0.00	0.00	
0.00	NURSING FACILITY	0	0		0.00		
. 00	OTHER LONG TERM CARE		0		0.00	0.00	
. 00	HOME HEALTH AGENCY	0	0		0.00		
. 00	AMBULATORY SURGICAL CENTER (D. P. )	0	0		0.00	0.00	
. 00	HOSPICE	0	0		0.00		
. 10	HOSPICE (non-distinct part)	0	0		0.00	0.00	24
. 00	CMHC - CMHC	0	0		0.00	0.00	
. 10	CMHC - CORF	0	0		0.00		
0. 00	RURAL HEALTH CLINIC	0	0		0.00		
. 25		0	0		0.00		
	FEDERALLY QUALIFIED HEALTH CENTER	U	0				
. 00	Total (sum of lines 14-26)		15	0.77	0.00	424.24	
. 00	Observation Bed Days		15	2, 67	2		28
. 00	Ambul ance Trips	0					29
. 00	Employee discount days (see instruction)				D D		30
. 00	Employee discount days - IRF	_			D		31
2.00	Labor & delivery days (see instructions)	0	59	55	3		32
2. 01	Total ancillary labor & delivery room				U		32
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33
3. 01	LTCH site neutral days and discharges	0					33
1.00	Temporary Expansion COVID-19 PHE Acute Care	0	0		C		34

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ST ELIZABETH	Provider C	CN: 15-0086	Period:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/28/2024 1:55	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
00	PART I - STATISTICAL DATA	1	0	1 1	46 50	2 704	1.
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		U	1, 14	40 50	3, 794	1.
. 00	HMO and other (see instructions)			78	32 585		2.
. 00	HMO IPF Subprovider				0		3.
ł. 00	HMO IRF Subprovider				0		4.
. 00	Hospital Adults & Peds. Swing Bed SNF						5.
o. 00	Hospital Adults & Peds. Swing Bed NF						6.
. 00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						7. 8.
. 00	CORONARY CARE UNIT						9.
0.00	BURN INTENSIVE CARE UNIT						10
1.00	SURGI CAL INTENSI VE CARE UNI T						11
2. 00	OTHER SPECIAL CARE (SPECIFY)						12
3.00	NURSERY						13
ł. 00	Total (see instructions)	0.00	0	1, 1,	46 50	3, 794	14
5.00	CAH visits						15
5.10	REH hours and visits	0.00	0				15
5.00 7.00	SUBPROVI DER – I PF SUBPROVI DER – I RF	0.00	0		0 0	0	16
3.00	SUBPROVIDER - TRF	0.00	0		0 0	0	17   18
9.00	SKILLED NURSING FACILITY	0.00					19
). 00	NURSING FACILITY	0.00					20
. 00	OTHER LONG TERM CARE	0.00				0	21
2.00	HOME HEALTH AGENCY	0.00					22
8. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23
1.00	HOSPICE	0.00					24
1. 10	HOSPICE (non-distinct part)						24
5.00	CMHC - CMHC	0.00					25
5.10	CMHC - CORF	0.00					25
5.00	RURAL HEALTH CLINIC	0.00					26
5.25 7.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0. 00 0. 00					26 27
3.00	Observation Bed Days	0.00					27
9.00	Ambul ance Trips						20
). 00	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31
2.00	Labor & delivery days (see instructions)						32
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32
3. 00	LTCH non-covered days				0		33
3. 01	LTCH site neutral days and discharges				0		33
4.00	Temporary Expansion COVID-19 PHE Acute Care						34

	Financial Systems AL WAGE INDEX INFORMATION		ST ELIZABET	Provi der C	F	Period: From 01/01/2023 To 12/31/2023		
							5/28/2024 1:5	<u>8 pm</u>
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)			Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
00	Total salaries (see	200. 00	33, 995, 111	0	33, 995, 111	896, 951.00	37.90	1.
00	instructions) Non-physician anesthetist Part		C	0	C	0.00	0.00	2
0	A Non-physician anesthetist Part		C	0	C	0.00	0.00	3
00	B Physician-Part A -		C	0	C	0.00	0.00	4
1	Administrative Physicians – Part A – Teaching		C	0		0.00	0.00	4
0	Physician and Non Physician-Part B		C	-	-	0.00		
00	Non-physician-Part B for hospital-based RHC and FQHC		C	0	С	0.00	0. 00	6
0	services Interns & residents (in an	21.00	C	0	C	0.00	0.00	7
)1	approved program) Contracted interns and residents (in an approved		C	0	С	0.00	0.00	7
00	programs) Home office and/or related		C	0	C	0.00	0.00	8
0	organization personnel SNF	44.00	C	, o	-	0.00		
00	Excluded area salaries (see instructions)		21, 022	484	21, 506	901.00	23. 87	10
00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		698, 443	0	698, 443	6, 342. 00	110. 13	111
00	Care Contract Labor: Top Level management and other		C	0	C			
	management and administrative services							
00	Contract Labor: Physician-Part A - Administrative		62, 318					
00	Home office and/or related organization salaries and wage-related costs		C	0	C	0.00	0.00	14
	Home office salaries		5, 639, 284		5, 639, 284			
02 00	Related organization salaries Home office: Physician Part A		C C			0.00		
00	- Administrative Home office and Contract		C	0	C	0.00	0.00	16
01	Physicians Part A - Teaching Home office Physicians Part A		C	0	C	0.00	0.00	16
02	- Teaching Home office contract Physicians Part A - Teaching		C	0	С	0.00	0.00	16
00	WAGE-RELATED COSTS		7 524 204		7 524 204			1 1-
	Wage-related costs (core) (see instructions)		7, 524, 296	0	7, 524, 296			17
	Wage-related costs (other) (see instructions)							18
00 00	Excluded areas Non-physician anesthetist Part A		7, 365 C	0	7, 365 C	5 )		19 20
00	Non-physician anesthetist Part B		C	0	С	)		21
00	Physician Part A - Administrative		C	0	c			22
	Physician Part A - Teaching		C	0	C	)		22
	Physician Part B		C	0	0			23
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		C	0				24 25
50	approved program) Home office wage-related		1, 861, 875	0	1, 861, 875			25
51	(core) Related organization		C		C			25
	wage-related (core) Home office: Physician Part A		C		c			25
	- Administrative - wage-related (core)							

	Financial Systems		ST ELI ZABETH				u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part II Date/Time Pre 5/28/2024 1:5	pared:
		Wkst. A Line		Recl assi fi cati	Adj usted		Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
		1.00	2.00	A-6) 3.00	3)	<u>col. 4</u> 5, 00	6.00	
25.53	Home office: Physicians Part A	1.00	2.00	3.00		0.00	0.00	25.53
25. 53	- Teaching - wage-related		0	0		0		25. 53
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE	ES			<u> </u>			
26.00	Employee Benefits Department	4.00	0	0		0 0.00	0.00	26.00
27.00	Administrative & General	5.00	1, 931, 325	-681, 497	1, 249, 82	.8 0.00	0.00	27.00
28.00	Administrative & General under		60, 704	0	60, 70	4 557.00	108. 98	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	943, 867	25, 600	969, 46	0.00	0.00	29.00
30.00	Operation of Plant	7.00	491, 001	15, 740	506, 74	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	109, 526	6, 223	115, 74	.9 0.00	0.00	31.00
32.00	Housekeepi ng	9.00	1, 223, 321	45, 128	1, 268, 44	.9 0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	982, 804	-659, 877	322, 92	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	689, 328	689, 32			36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00		37.00
38.00	Nursing Administration	13.00	824, 031	16, 058	840, 08	. 00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0		0 0.00		39.00
40.00	Pharmacy	15.00	0	0		0 0.00		40.00
41.00	Medical Records & Medical Records Library	16.00	119, 285	6, 223		0.00		41.00
42.00	Social Service	17.00	354, 154	4, 537	358, 69			42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		ST ELI ZABETI	H DEARBORN		In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2023 To 12/31/2023			
		Worksheet A		Recl assi fi cati	, J		Average Hourly		
		Line Number	Reported	on of Salaries			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		34, 055, 815	0	34, 055, 81	5 897, 508. 00	37.94	1.00	
	instructions)								
2.00	Excluded area salaries (see		21, 022	484	21, 50	6 901.00	23. 87	2.00	
0.00	instructions)		04 004 700	10.1		00/ /07 00	07.04	0.00	
3.00	Subtotal salaries (line 1 minus line 2)		34, 034, 793	-484	34, 034, 30	9 896, 607. 00	37.96	3.00	
4.00	Subtotal other wages & related		6, 400, 045	0	6, 400, 04	5 115, 724. 00	55.30	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		9, 386, 171	0	9, 386, 17	1 0.00	27. 58	5.00	
( 00	(see inst.)		40.004.000	10.1	10 000 50	1 010 001 00	10.01	( 00	
6.00	Total (sum of lines 3 thru 5)		49, 821, 009						
7.00	Total overhead cost (see		7, 040, 018	-532, 537	6, 507, 48	1 557.00	11, 683. 09	7.00	
	instructions)								

Heal th	Financial Systems	ST ELIZABETH [	DEARBORN	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Pre 5/28/2024 1:55	
			-		Amount	o pii
					Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETI REMENT COST					
1.00	401K Employer Contributions				412, 671	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrib				0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)			-	
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla				0	6.00
7.00	Employee Managed Care Program Administration	1 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 Thir	2			0	
8.02	Health Insurance (Self Funded with a Third P	Party Administrato	nr)		4, 503, 576	
8.03	Health Insurance (Purchased)				0	
9.00	Prescription Drug Plan				0	
10.00	Dental, Hearing and Vision Plan				58, 192	
11.00	Life Insurance (If employee is owner or bene				13, 923	
12.00	Accident Insurance (If employee is owner or				0	
13.00	Disability Insurance (If employee is owner o				121, 355	
14.00	Long-Term Care Insurance (If employee is own	ner or beneficiary	·)			14.00
15.00	'Workers' Compensation Insurance				-5, 616	
16.00	Retirement Health Care Cost (Only current ye	ear, not the extra	iordi nary accrual require	ed by FASB 106.	0	16.00
	Noncumulative portion)					
17 00	TAXES FICA-Employers Portion Only				2 422 211	17 00
					2, 423, 211	
18.00 19.00	Medicare Taxes - Employers Portion Only Unemployment Insurance				-	18.00 19.00
					2,083	
20.00	State or Federal Unemployment Taxes OTHER				0	20.00
21 00	Executive Deferred Compensation (Other Than	Dati noment Coat D	langested on Lines 1 three	in t about (and	0	21.00
21.00	instructions))	Retirement Cost R	eported on times i throu	ign 4 above. (See	0	21.00
22.00	Day Care Cost and Allowances				0	22.00
22.00	Tui ti on Rei mbursement					22.00
	Total Wage Related cost (Sum of lines 1 -23)				7, 531, 662	
24.00	Part B - Other than Core Related Cost	·			7, 331, 002	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)					25.00
25.00	UTHEN WADE NEERIED COSIS (SECTIT)			1		20.00

Heal th	Financial Systems	ST ELIZABETH DEARBORN	In Lieu of Form CMS-2552-1				
HOSPIT	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0086	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Pre 5/28/2024 1:5	pared:		
	Cost Center Description		Contract Labor 1.00	Benefit Cost 2.00			
	PART V - Contract Labor and Benefit Cost		1.00	2.00			
	Hospital and Hospital-Based Component Identi	fication:					
1.00	Total facility's contract labor and benefit	cost	0	0	1.00		
2.00	Hospi tal		0	0	2.00		
3.00	SUBPROVIDER - IPF		0	0	3.00		
4.00	SUBPROVIDER - IRF		0	0	4.00		
5.00	Subprovider - (Other)		0	0	5.00		
6.00	Swing Beds - SNF		0	0	6.00		
7.00	Swing Beds - NF		0	0	1.00		
8.00	SKILLED NURSING FACILITY		0	0	8.00		
9.00	NURSING FACILITY		0	0	9.00		
10.00	OTHER LONG TERM CARE I				10.00		
11.00	Hospital-Based HHA		0	0			
12.00	AMBULATORY SURGICAL CENTER (D. P.) I		0	0			
13.00	Hospital-Based Hospice		0	0			
14.00	Hospital-Based Health Clinic RHC		0	0			
15.00	Hospital-Based Health Clinic FQHC		0	0	15.00		
16.00	Hospital-Based-CMHC		0	0	16.00		
16. 10	Hospital-Based-CMHC 10		0	0			
17.00	RENAL DIALYSIS I		0	0			
18.00	Other		0	0	18.00		

Heal th	Financial Systems	ST ELIZABETH DEARBORN In Li				u of Form CMS-2	2552-10
HOSPI 1	AL UNCOMPENSATED AND INDIGENT CARE DATA	Prov	/ider CCN: 15-	F	Period: From 01/01/2023 Fo 12/31/2023		pared:
						1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA						
	Uncompensated and Indigent Care Cost-to-Cha	rge Ratio					
1.00	Cost to charge ratio (see instructions)					0. 314129	1.0
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid					16, 421, 297	2.0
3.00	Did you receive DSH or supplemental payment					Y	3.00
4.00	If line 3 is yes, does line 2 include all D			Medi cai	d?	Ν	4.0
5.00	If line 4 is no, then enter DSH and/or supp	lemental payments from	Medi cai d			1	5.0
6.00	Medi cai d charges					53, 177, 229	6.0
7.00	Medicaid cost (line 1 times line 6)					16, 704, 510	7.0
8.00	Difference between net revenue and costs fo			)		283, 212	8.0
	Children's Health Insurance Program (CHIP)	(see instructions for ea	ach line)				
9.00	Net revenue from stand-alone CHIP					0	
	Stand-alone CHIP charges					0	1
11.00	Stand-alone CHIP cost (line 1 times line 10	))				0	11.0
12.00	Difference between net revenue and costs fo	r stand-alone CHIP (see	instructions	)		0	12.0
	Other state or local government indigent ca						
13.00	Net revenue from state or local indigent ca						13.0
14.00	Charges for patients covered under state or 10)	local indigent care pr	ogram (Not in	cl uded i	n lines 6 or	0	14.0
15.00	State or local indigent care program cost (	line 1 times line 14)				0	15.0
16.00	Difference between net revenue and costs fo	or state or local indige	nt care progr	am (see	instructions)	0	16.0
	Grants, donations and total unreimbursed com instructions for each line)	st for Medicaid, CHIP a	nd state/loca	∣ indige	ent care program	ns (see	
17.00	Private grants, donations, or endowment inc	ome restricted to fundi	ng charity ca	re		0	17.0
18.00	Government grants, appropriations or transf	ers for support of hosp	ital operatio	ns		0	18.0
19. 00	Total unreimbursed cost for Medicaid, CHIP 8, 12 and 16)	and state and local in	digent care p	rograms	(sum of lines	283, 212	19.0
			Uni ı	nsured	Insured	Total (col. 1	
				ients	patients	+ col. 2)	
			1	. 00	2.00	3.00	
	Uncompensated care cost (see instructions for	or each line)					

		patients	pati ents	+ col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	1, 664, 408	481, 456	2, 145, 864	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	522, 839	481, 456	1, 004, 295	21.00
22.00		0	0	0	22.00
23.00	Cost of charity care (see instructions)	522, 839	481, 456	1, 004, 295	23.00
				1.00	
24.00	N	24.00			
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent stay limit	care program's	s length of	0	25.00
25.01	Charges for insured patients' liability (see instructions)			0	25.01
26.00	Bad debt amount (see instructions)			5, 199, 718	26.00
27.00	Medicare reimbursable bad debts (see instructions)			154, 554	27.00
27.01	Medicare allowable bad debts (see instructions)			237, 775	27.01
28.00	Non-Medicare bad debt amount (see instructions)			4, 961, 943	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		1, 641, 911	29.00
	Cost of uncompensated care (line 23, col. 3, plus line 29)			2, 646, 206	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2, 929, 418	31.00

Health Financial Systems	ST ELIZABETH DEARBO	In Lieu of Form CMS-2552-1			
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Ριον		From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prep 5/28/2024 1:58	ared:

ovi der	CCN:	15-0086	Pe
			Fr

				1.00					
	PART II - HOSPITAL DATA			1.00					
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1				
00	Cost to charge ratio (see instructions)			0. 314129	1 1				
	Medicaid (see instructions for each line)			0. 514127	1 '				
00	Net revenue from Medicaid				2				
0	Did you receive DSH or supplemental payments from Medicaid?				3				
0	If line 3 is yes, does line 2 include all DSH and/or supplemental payment	s from Medicaid	2		4				
0	If line 4 is no, then enter DSH and/or supplemental payments from Medicai				5				
0	Medi cai d charges				6				
0	Medicaid cost (line 1 times line 6)				7				
0	Difference between net revenue and costs for Medicaid program (see instru	ictions)			8				
0	Children's Health Insurance Program (CHIP) (see instructions for each lin								
0	Net revenue from stand-al one CHIP	- /			19				
00	Stand-al one CHIP charges				10				
00	Stand-alone CHIP cost (line 1 times line 10)				11				
00	Difference between net revenue and costs for stand-alone CHIP (see instructions)								
	Other state or local government indigent care program (see instructions f				12				
00	Net revenue from state or local indigent care program (Not included on li				13				
00	Charges for patients covered under state or local indigent care program (		lines 6 or		14				
	10)								
00	State or local indigent care program cost (line 1 times line 14)				15				
00	Difference between net revenue and costs for state or local indigent care	nstructions)		16					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and stat	e/local indigen	t care program	ns (see					
	instructions for each line)	-							
00	Private grants, donations, or endowment income restricted to funding char	· ·							
00	in the grants, donations, of chaomient meene restricted to randing char	ity care			17				
	Government grants, appropriations or transfers for support of hospital op	2							
00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent	erations	sum of lines		18				
00	Government grants, appropriations or transfers for support of hospital op	erations care programs (			18				
00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent	erations care programs ( Uninsured	Insured	Total (col. 1	18				
00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent	erations care programs ( Uninsured patients	Insured patients	+ col. 2)	18				
00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16)	erations care programs ( Uninsured	Insured		18				
00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line)	erations care programs ( Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	17 18 19				
00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)	erations care programs ( Uninsured patients 1.00 1,664,408	l nsured pati ents 2.00 481, 456	+ col. 2) 3.00 2,145,864	18 19 20				
00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid, CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see	erations care programs ( Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	18 19 20				
00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid, CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions)	Uni nsured pati ents 1.00 1, 664, 408 522, 839	l nsured pati ents 2. 00 481, 456 481, 456	+ col. 2) 3.00 2,145,864 1,004,295	18 19 20 21				
00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid, CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	erations care programs ( Uninsured patients 1.00 1,664,408	l nsured pati ents 2.00 481, 456	+ col. 2) 3.00 2,145,864	18 19 20 21				
00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	Uni nsured pati ents 1.00 1,664,408 522,839 0	l nsured pati ents 2. 00 481, 456 481, 456 0	+ col . 2) 3.00 2,145,864 1,004,295 0	18 19 20 21 22				
00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid, CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	Uni nsured pati ents 1.00 1, 664, 408 522, 839	l nsured pati ents 2. 00 481, 456 481, 456	+ col. 2) 3.00 2,145,864 1,004,295	18 19 20 21 22				
00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	Uni nsured pati ents 1.00 1,664,408 522,839 0	l nsured pati ents 2. 00 481, 456 481, 456 0	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295	18 19 20 21 22				
00 00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)	erations care programs ( Uninsured patients 1.00 1,664,408 522,839 0 522,839	I nsured pati ents 2.00 481, 456 481, 456 0 481, 456	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295	18 19 20 21 22 23				
00 00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon	erations care programs ( Uninsured patients 1.00 1,664,408 522,839 0 522,839	I nsured pati ents 2.00 481, 456 481, 456 0 481, 456	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295	18 19 20 21 22				
00 00 00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid, CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program?	d a length of s	I nsured pati ents 2.00 481,456 481,456 0 481,456 :tay limit	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295 1.00 N	18 19 20 21 22 23 23 24				
00 00 00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon	d a length of s	I nsured pati ents 2.00 481,456 481,456 0 481,456 :tay limit	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295	18 19 20 21 22 23 23 24				
00 00 00 00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid, CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent	d a length of s	I nsured pati ents 2.00 481,456 481,456 0 481,456 :tay limit	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295 1.00 N	18 19 20 21 22 23 23 24 25				
00 00 00 00 00 00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid, CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit	d a length of s	I nsured pati ents 2.00 481,456 481,456 0 481,456 :tay limit	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295 1.00 N 0	18 19 20 21 22 23 23 24 25 25				
00 00 00 00 00 00 00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions)	d a length of s	I nsured pati ents 2.00 481,456 481,456 0 481,456 :tay limit	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295 1.00 N 0 0 0	18 19 20 21 22 23 24 25 25 26				
00 00 00 00 00 00 00 00 00 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)	d a length of s	I nsured pati ents 2.00 481,456 481,456 0 481,456 :tay limit	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295 1.00 N 0 5,199,718	18 19 20 21 22 23 23 24 25 25 26 27				
00 00 00 00 00 00 00 00 00 00 01 00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Medicare reimbursable bad debts (see instructions)	d a length of s	I nsured pati ents 2.00 481,456 481,456 0 481,456 :tay limit	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295 1.00 N 0 5,199,718 154,554	18 19 20 21 22 23 23 24 25 26 27 27 27				
00 00 00 00 00 00 00 00 00 00 01 00 01 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)	d a length of s	I nsured pati ents 2.00 481,456 481,456 0 481,456 :tay limit	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295 1.00 N 0 5,199,718 154,554 237,775	18 19 20 21 22 23 24 25 26 27 27 27 28				
00 00	Government grants, appropriations or transfers for support of hospital op Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	d a length of s	I nsured pati ents 2.00 481,456 481,456 0 481,456 :tay limit	+ col. 2) 3.00 2,145,864 1,004,295 0 1,004,295 1.00 N 0 5,199,718 154,554 237,775 4,961,943	18 19 20 21 22 23 24 25 26 27 27 28 29				

LOLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	F	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other		Reclassificati ons (See A-6)	5/28/2024 1:5 Reclassified Trial Balance (col. 3 +- col. 4)	
	L	1.00	2.00	3.00	4.00	5.00	
~~	GENERAL SERVICE COST CENTERS	1	(40.754	(10.75)		(10.754	1 1 00
. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		610, 754 1, 471, 581	610, 754 1, 471, 581		610, 754 1, 471, 581	1.00 2.00
. 00 . 00	00300 OTHER CAP REL COSTS		1, 471, 561	1, 471, 36		1, 471, 561	3.00
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	-126, 368	-126, 368	3 0	-126, 368	4.00
. 00	00500 ADMI NI STRATI VE & GENERAL	1, 931, 325	6, 822, 470	8, 753, 795		8, 072, 359	5.00
. 00	00600 MAINTENANCE & REPAIRS	943, 867	3, 796, 347	4, 740, 214		4, 765, 817	6.00
2.00 8.00	00700 OPERATION OF PLANT	491,001	126, 294	617, 295		633, 156	
9.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	109, 526 1, 223, 321	292, 200 887, 386			407, 949 2, 156, 070	
0.00	01000 DI ETARY	982, 804	801, 571	1, 784, 375		654, 347	1
1.00	01100 CAFETERI A	0	0	(		1, 159, 482	
2.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0 0	0	12.00
3.00	01300 NURSI NG ADMI NI STRATI ON	824, 031	452, 676	1, 276, 707	18, 040	1, 294, 747	13.00
4.00 5.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0		0	0	14.00 15.00
6.00	01600 MEDICAL RECORDS & LIBRARY	119, 285	48, 666	167, 951	6, 223	174, 174	16.00
7.00	01700 SOCIAL SERVICE	354, 154	399, 330			756, 322	
8.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		0	0	18.00
9.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0 0	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	(	0	0	20.00
1.00 2.00	02100 I & SERVI CES-SALARY & FRI NGES APPRVD 02200 I & SERVI CES-OTHER PRGM COSTS APPRVD	0	0			0	21.00 22.00
2.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0			0	23.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				, <u>_</u>		20100
0. 00	03000 ADULTS & PEDIATRICS	3, 688, 827	1, 637, 477	5, 326, 304		5, 731, 989	30.00
1.00	03100 I NTENSI VE CARE UNI T	2, 159, 564	802, 277	2, 961, 841	49, 204	3, 011, 045	
2.00 3.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			0	32.00 33.00
4.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0			0	34.00
0.00	04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
1. 00	04100 SUBPROVI DER – I RF	0	0	( ) (	0 0	0	41.00
3.00	04300 NURSERY	0	0	(	383, 205	383, 205	43.00
4.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0			0	44.00 45.00
6.00	04600 OTHER LONG TERM CARE	0	0			0	45.00
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	6, 085, 648	11, 328, 278	17, 413, 926	-5, 973, 020	11, 440, 906	
1.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 1, 599, 472	0 621, 668	2, 221, 140	0 -757, 744	0 1, 463, 396	
3.00	05300 ANESTHESI OLOGY	38, 044	1, 040, 554			1, 403, 390	
	05400 RADI OLOGY-DI AGNOSTI C	2, 320, 451	1, 072, 156			3, 042, 296	
5. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0 0	0	
6.00	05600 RADI OI SOTOPE	0	0	(	0	0	56.00
7.00 8.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	611, 368 272, 906	344, 796 71, 142	956, 164 344, 048		1, 095, 733 383, 562	57.00 58.00
9.00	05900 CARDIAC CATHETERIZATION	412, 255	420, 181	832, 436		615, 610	
0.00	06000 LABORATORY	1, 650, 181	2, 201, 307	3, 851, 488		3, 895, 192	60.00
0. 01	06001 BLOOD LABORATORY	0	0	0	0 0	0	60. 01
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	(	0	0	61.00
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	62.00
03.00 04.00	06400 I NTRAVENOUS THERAPY	0	0			0	63.00 64.00
5.00	06500 RESPIRATORY THERAPY	1, 153, 146	246, 001	1, 399, 147	33, 246	1, 432, 393	65.00
6.00	06600 PHYSI CAL THERAPY	1, 575, 226	513, 194	2, 088, 420		2, 128, 999	66.00
7.00	06700 OCCUPATI ONAL THERAPY	275, 151	76, 157	351, 308		356, 109	67.00
8.00		137, 836	40, 445	178, 281		182, 274	68.00
9.00 0.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	384, 014 5, 608	149, 343 19, 502	533, 357 25, 110		544, 880 25, 063	69.00 70.00
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	279, 121	120, 071	399, 192		23,003	71.00
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	6, 579, 846	6, 579, 846	72.00
3.00	07300 DRUGS CHARGED TO PATIENTS	1, 186, 879	3, 900, 860	5, 087, 739		5, 531, 713	
4.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	9, 339	3, 775	13, 114	163	13, 277	74.00
5.00 6.97	07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION	138, 762	0 65, 613	204, 375	1,024	0 205, 399	75.00 76.97
7.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(	) 0	203, 377	77.00
8.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS	1					0-
8.00	08800 RURAL HEALTH CLINIC	0	0		0	0	88.00
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00 90.00
0.00	09000 CLI NI C	( ))					

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-0086	Peri od:	Worksheet A	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/28/2024 1:5	
Cost Center Description	Sal ari es	Other	Total (col	1 Recl assi fi cati		
cost center bescription	Jararres	other	+ col. 2)	ons (See A-6)		
			+ COI. 2)	UII3 (See A-0)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4, 00	5.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	н	I				
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99.00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE		0		0 0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	33, 974, 089	41, 919, 927	75, 894, 01	-484	75, 893, 532	118.00
NONREI MBURSABLE COST CENTERS	I			1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21, 022	128, 244	149, 20		149, 750	
191.00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	14, 874	14, 8			192.00
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
194.00 07950 CMH	22.005.111		74 050 1	0 0		194.00
200.00   TOTAL (SUM OF LINES 118 through 199)	33, 995, 111	42, 063, 045	76, 058, 15	56 0	76, 058, 156	1200.00

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider CCN	: 15-0086	Period: From 01/01/2023	Worksheet A	
					To 12/31/2023	Date/Time Pi 5/28/2024 1:	
	Cost Center Description		Net Expenses		,	572072024 1.	<u>. 58 pii</u>
		(See A-8) F	or Allocation 7.00				
	GENERAL SERVICE COST CENTERS	0.00	7.00				
00	00100 CAP REL COSTS-BLDG & FIXT	1,005,440	1, 616, 194				1
00	00200 CAP REL COSTS-MVBLE EQUIP	2, 241, 082	3, 712, 663				2
00	00300 OTHER CAP REL COSTS	0	0				3
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	-126, 368				4
00	00500 ADMI NI STRATI VE & GENERAL	7,807,242	15, 879, 601				5
00 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	682, 265	5, 448, 082				6
00 00	00800 LAUNDRY & LINEN SERVICE	157, 986 2, 992	791, 142 410, 941				8
00 00	00900 HOUSEKEEPING	2, 992	2, 156, 070				9
00	01000 DI ETARY	-303, 251	351,096				10
00	01100 CAFETERI A	0	1, 159, 482				11
00	01200 MAINTENANCE OF PERSONNEL	0	0				12
00	01300 NURSING ADMINISTRATION	307, 816	1, 602, 563				13
00	01400 CENTRAL SERVICES & SUPPLY	0	0				14
	01500 PHARMACY	0	0				15
	01600 MEDI CAL RECORDS & LI BRARY	1, 741, 701	1, 915, 875				16
00	01700 SOCIAL SERVICE	14, 082	770, 404				17
	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0				18
	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0	0				19
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0				20
. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22
. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	o				23
	INPATIENT ROUTINE SERVICE COST CENTERS	•	· · · ·				
. 00	03000 ADULTS & PEDIATRICS	0	5, 731, 989				30
. 00	03100 I NTENSI VE CARE UNI T	0	3, 011, 045				31
	03200 CORONARY CARE UNI T	0	0				32
	03300 BURN INTENSIVE CARE UNIT	0	0				33
	03400 SURGI CAL INTENSI VE CARE UNI T	0	0				34
00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0				40
	04300 NURSERY	0	383, 205				41
. 00	04400 SKI LLED NURSI NG FACI LI TY	0	000,200				44
	04500 NURSING FACILITY	0	o				45
. 00	04600 OTHER LONG TERM CARE	0	o				46
	ANCILLARY SERVICE COST CENTERS						
. 00	05000 OPERATI NG ROOM	0	11, 440, 906				50
00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 -110,000	0 1, 353, 396				51
00	05300 ANESTHESI OLOGY	-110,000	1, 062, 921				52
00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 042, 296				54
00	05500 RADI OLOGY-THERAPEUTI C	0	0,012,270				55
	05600 RADI OI SOTOPE	0	o				56
. 00	05700 CT SCAN	0	1, 095, 733				57
00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	383, 562				58
00	05900 CARDI AC CATHETERI ZATI ON	0	615, 610				59
		0	3, 895, 192				60
. 01	06001 BLOOD LABORATORY	0	0				60
. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				61
00	06300 BLOOD STORING, PROCESSING & TRANS.		0				63
	06400 I NTRAVENOUS THERAPY	0	0				64
00	06500 RESPI RATORY THERAPY	0	1, 432, 393				65
	06600 PHYSI CAL THERAPY	0	2, 128, 999				66
. 00	06700 OCCUPATI ONAL THERAPY	0	356, 109				67
	06800 SPEECH PATHOLOGY	0	182, 274				68
	06900 ELECTROCARDI OLOGY	0	544, 880				69
	07000 ELECTROENCEPHALOGRAPHY	0	25, 063				70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0 E44 004	6, 579, 846				72
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	-564, 804	4, 966, 909 13, 277				73
	07500 ASC (NON-DI STI NCT PART)	0	13, 277				74
	07697 CARDIAC REHABILITATION	0	205, 399				76
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	203, 377				77
	07800 CAR T-CELL IMMUNOTHERAPY	0	0				78
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
	08800 RURAL HEALTH CLINIC	0	0				88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89
	09000 CLINIC	0	0				90
	09100 EMERGENCY	-448, 376	4, 288, 958				91

Health Financial Systems	ST ELI ZABETH	DEARBORN	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared:
			10 12/31/2023	5/28/2024 1:58 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) F	or Allocation		
	6.00	7.00		
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
99.00 09900 CMHC	0	0		99.00
99. 10 09910 CORF	0	0		99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		102.00
SPECIAL PURPOSE COST CENTERS	· · · · ·	· · · · ·		
105.00 10500 KIDNEY ACQUISITION	0	0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		106.00
107.00 10700 LIVER ACQUISITION	0	0		107.00
108.00 10800 LUNG ACQUISITION	0	0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111.00
113.00 11300 INTEREST EXPENSE	0	0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	О		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	o		115.00
116.00 11600 HOSPI CE	0	o		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	12, 534, 175	88, 427, 707		118.00
NONREI MBURSABLE COST CENTERS		i		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	149, 750		190.00
191. 00 19100 RESEARCH	0	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	14, 874		192.00
193. 00 19300 NONPALD WORKERS	0	o		193.00
194.0007950 CMH	0	о		194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	12, 534, 175	88, 592, 331		200.00
				•

## Health Financial Systems RECLASSIFICATIONS

# ST ELIZABETH DEARBORN Provider CCN: 15-0086 Period:

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

RECLAS	SIFICATIONS			Provider CCN	: 15-0086	Period: From 01/01/202 To 12/31/202		Prepared:
	Cost Center	I ncreases Li ne #	Salary	Other			372072024	
	2.00	3.00	4.00	5.00				
1 00	A - DRUGS TO PHARMACY	70.00		440.004				1 00
1.00 2.00	DRUGS CHARGED TO PATIENTS	73.00 0.00	0	410, 234 0				1.00 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 7.00		0.00 0.00	0	0				6.00 7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	Ö				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
	U B – CAFETERIA		0	410, 234				_
1.00	CAFETERI A	11.00	689, 328	470, 154				1.00
	0		689, 328	470, 154				
1 00	C - IMPLANTS	72.00		( 570 04(				1 00
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6, 579, 846				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00 6.00		0.00 0.00	0	0				5.00 6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
	0		0	6, 579, 846				_
1 00	D - LABOR & DELIVERY ROOM	30.00	272 220	104 000				1 00
1.00 2.00	ADULTS & PEDIATRICS NURSERY	43.00	272, 230 276, 549	104, 990 106, 656				1.00 2.00
2.00			548, 779	211, 646				2.00
	E - RADIOLOGY ADMIN							
1.00	CT SCAN	57.00	83, 642	22, 657				1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	24, 363	6, 599				2.00
	0		108,005	29, 256				
	F - GAI NSHARI NG							
1.00	ADMI NI STRATI VE & GENERAL	5.00	27, 151	0				1.00
2.00 3.00	MAINTENANCE & REPAIRS OPERATION OF PLANT	6.00 7.00	25, 593 15, 459	0				2.00 3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	6, 223	0				4.00
5.00	HOUSEKEEPI NG	9.00	44, 581	0				5.00
6.00	DI ETARY	10.00	29, 445	0				6.00
7.00 8.00	NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY	13.00 16.00	11, 450 6, 223	0				7.00 8.00
9.00	SOCI AL SERVI CE	17.00	4, 537	0				9.00
10.00	ADULTS & PEDIATRICS	30.00	85, 313	0				10.00
11.00	INTENSIVE CARE UNIT	31.00	34, 972	0				11.00
12.00	OPERATI NG ROOM ANESTHESI OLOGY	50.00	137, 042	0				12.00
13.00 14.00	RADI OLOGY - DI AGNOSTI C	53.00 54.00	2, 031 42, 526	0				13.00 14.00
15.00	CT SCAN	57.00	15, 596	0				15.00
16.00	MAGNETIC RESONANCE IMAGING	58.00	6, 220	0				16.00
17 00		E0.00	0 005	~				17 00
17.00 18.00	CARDI AC CATHETERI ZATI ON LABORATORY	59.00 60.00	9, 885 41, 647	0				17.00 18.00
19.00	RESPIRATORY THERAPY	65.00	25, 224	Ö				19.00
20.00	PHYSI CAL THERAPY	66.00	39, 787	0				20.00
21.00	OCCUPATIONAL THERAPY	67.00	4, 369	0				21.00
22.00 23.00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	68.00 69.00	3, 122 10, 515	0				22.00 23.00
24.00	DRUGS CHARGED TO PATIENTS	73.00	25, 376	0				24.00
25.00	EMERGENCY	91.00	54, 020	0				25.00
26.00	GIFT, FLOWER, COFFEE SHOP &	190.00	484	0				26.00
	<u>CANTEEN</u>	++	708, 791	— — — <u> </u>				
	U G - CENTRAL SUPPLY		108, 191	U				
1.00	ADMI NI STRATI VE & GENERAL	5.00	143	61				1.00
2.00	MAINTENANCE & REPAIRS	6.00	7	3				2.00
3.00	OPERATION OF PLANT	7.00	281	121				3.00
4.00 5.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	547	235 3				4.00 5.00
6.00	NURSING ADMINISTRATION	13.00	4, 608	1, 982				6.00
7.00	ADULTS & PEDIATRICS	30.00	24, 438	10, 513				7.00

## Health Financial Systems RECLASSIFICATIONS

### ST ELIZABETH DEARBORN

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

near th	TTHATCTAL SYSTEMS		JI LLIZADLII	I DLARDORN		III LIE		=2552=10
RECLASS	SI FI CATI ONS			Provider C	CCN: 15-0086	Period: From 01/01/2023	Worksheet A-	
						To 12/31/2023	Date/Time Pr 5/28/2024 1:	
		Increases						
	Cost Center	Line #	Salary	Other	]			
	2.00	3.00	4.00	5.00				
8.00	INTENSIVE CARE UNIT	31.00	16, 826	7, 238				8.00
9.00	OPERATING ROOM	50.00	156, 844	67, 471				9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	5, 234	2, 252				10.00
11.00	ANESTHESI OLOGY	53.00	1, 281	551				11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	10, 131	4, 358				12.00
13.00	CT SCAN	57.00	12, 643	5, 439				13.00
14.00	MAGNETIC RESONANCE IMAGING	58.00	2, 016	867				14.00
	(MRI)							
15.00	CARDI AC CATHETERI ZATI ON	59.00	4, 374	1, 882				15.00
16.00	LABORATORY	60.00	1, 438	619				16.00
17.00	RESPI RATORY THERAPY	65.00	5, 609	2, 413				17.00
18.00	PHYSICAL THERAPY	66.00	633	272				18.00
19.00	OCCUPATI ONAL THERAPY	67.00	302	130				19.00
20.00	SPEECH PATHOLOGY	68.00	609	262				20.00
	ELECTROCARDI OLOGY	69.00	707	304				21.00
22.00	DRUGS CHARGED TO PATIENTS	73.00	5, 848	2, 516				22.00
23.00	RENAL DIALYSIS	74.00	114	49				23.00
24.00	CARDIAC REHABILITATION	76. 97	716	308				24.00
25.00	EMERGENCY	91.00	23, 798	<u> </u>				25.00
	0		279, 153	120, 086				
500.00	Grand Total: Increases		2, 334, 056	7, 821, 222				500.00

### Health Financial Systems RECLASSIFICATIONS

#### ST ELIZABETH DEARBORN

In Lieu of Form CMS-2552-10

Provider CCN: 15-0086

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

						o 12/31/2023 Date/Time Pi 5/28/2024 1	
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00 A - DRUGS TO PHARMACY	7.00	8.00	9.00	10.00		
1.00	SOCIAL SERVICE	17.00	0	1, 699	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	Ö	10, 465			2.00
3.00	INTENSIVE CARE UNIT	31.00	0	4, 644	0		3.00
4.00	OPERATING ROOM	50.00	0	81, 495	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	4, 805	0		5.00
6.00	ANESTHESI OLOGY	53.00	0	19, 540			6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	266, 466			7.00
8.00 9.00	CT SCAN MAGNETIC RESONANCE IMAGING	57.00	0	174 551	0		8.00 9.00
9.00	(MRI)	58.00	0	221	0		9.00
10.00	ELECTROCARDI OLOGY	69.00	0	3	0		10.00
11.00	EMERGENCY	91.00	0	20, 392			11.00
	0 — — — — — —		o	410, 234			
	B – CAFETERIA	· · · · · ·					
1.00	<u>DIETARY</u>	<u>10.</u> 00	689, 328	470, 154			1.00
			689, 328	470, 154			_
1.00	C - IMPLANTS ADULTS & PEDIATRICS	30.00	0	81, 334	0		1.00
2.00	I NTENSI VE CARE UNI T	30.00	0	5, 188			2.00
3.00	OPERATING ROOM	50.00	0	6, 252, 882	0		3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 599	0		4.00
5.00	CT SCAN	57.00	0	234	0		5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	232, 967	0		6.00
7.00	PHYSI CAL THERAPY	66.00	0	113			7.00
8.00	EMERGENCY	91.00	<u>0</u>	3, 529			8.00
	D - LABOR & DELIVERY ROOM		U	6, 579, 846			_
1.00	DELIVERY ROOM & LABOR ROOM	52.00	548, 779	211, 646	0		1.00
2.00		0.00	0	0	0		2.00
	0		548, 779	211, 646			
	E - RADIOLOGY ADMIN						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	108, 005	29, 256			1.00
2.00	L		0	0			2.00
	F – GAI NSHARI NG	I	108, 005	29, 256			_
1.00	ADMI NI STRATI VE & GENERAL	5.00	708, 791	0	0		1.00
2.00	ADMINI STRATI VE & GENERAE	0.00	00,771	0			2.00
3.00		0.00	0	0			3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	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
9.00 10.00		0.00	0	0	0		10.00
11.00		0.00	o	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	-		14.00
15.00		0.00	0	0	-		15.00
16.00		0.00	0	0	0		16.00
17. 00 18. 00		0.00 0.00	0	0	0		17.00 18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	Ö	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00	<u> </u>		708, 791	0	0		26.00
	G - CENTRAL SUPPLY	I I	700, 771	0			-
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	279, 120	120, 072	0		1.00
	PATI ENTS						
2.00	ELECTROENCEPHALOGRAPHY	70.00	33	14	0		2.00
3.00		0.00	0	0	0		3.00
4.00 5.00		0.00 0.00	0	0	0		4.00
5.00 6.00		0.00	0	0			5.00 6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0			8.00
9.00		0.00	0	0	0		9.00

Heal th I	Financial Systems		ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-	-2552-10
RECLASS	I FI CATI ONS			Provider (	CCN: 15-0086	Peri od:	Worksheet A-	6
						From 01/01/2023 To 12/31/2023	Date/Time Pro 5/28/2024 1:	
		Decreases			-			
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	<u>.</u>		
	6. 00	7.00	8.00	9.00	10.00			
10.00		0.00	0	C		0		10.00
11.00		0.00	0	C	)	0		11.00
12.00		0.00	0	C	)	0		12.00
13.00		0.00	0	C	)	0		13.00
14.00		0.00	0	C		0		14.00
15.00		0.00	0	C		0		15.00
16.00		0.00	0	C		0		16.00
17.00		0.00	0	C		0		17.00
18.00		0.00	0	C		0		18.00
19.00		0.00	0	C		0		19.00
20.00		0.00	0	C		0		20.00
21.00		0.00	0	C		0		21.00
22.00		0.00	0	C		0		22.00
23.00		0.00	0	C		0		23.00
24.00		0.00	0	C		0		24.00
25.00		0.00	0	C		0		25.00
	<u> </u>		279, 153	120, 086		7		
500.00	Grand Total: Decreases		2, 334, 056	7, 821, 222				500.00
		•						

Heal th	Financial Systems	ST ELI ZABETH	I DEARBORN			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	Provider CCN: 15-0086		iod: m 01/01/2023 12/31/2023		
				Acqui si ti on	s			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	500, 000	0		0	0	0	1.00
2.00	Land Improvements	18, 800	14, 450		0	14, 450	0	2.00
3.00	Buildings and Fixtures	2, 621, 395	220, 769		0	220, 769	0	3.00
4.00	Building Improvements	530, 461	282, 582		0	282, 582	0	4.00
5.00	Fixed Equipment	0	13, 682		0	13, 682	0	5.00
6.00	Movable Equipment	8, 438, 403	1, 027, 215		0	1, 027, 215	98, 341	6.00
7.00	HIT designated Assets	74, 691	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12, 183, 750	1, 558, 698		0	1, 558, 698	98, 341	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	12, 183, 750	1, 558, 698		0	1, 558, 698	98, 341	10.00
		Endi ng Bal ance	Fully		-			
		J	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	500, 000	0					1.00
2.00	Land Improvements	33, 250	0					2.00
3.00	Buildings and Fixtures	2, 842, 164	0					3.00
4.00	Building Improvements	813, 043	0					4.00
5.00	Fixed Equipment	13, 682	0					5.00
6.00	Movable Equipment	9, 367, 277	0					6.00
7.00	HIT designated Assets	74, 691	0					7.00
8,00	Subtotal (sum of lines 1-7)	13, 644, 107	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	13, 644, 107	0					10.00
				1				

Heal th	Financial Systems	ST ELI ZABETH	H DEARBORN		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0086	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		pared:
						5/28/2024 1:5	
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	610, 754			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 471, 581			0 0	0	2.00
3.00	Total (sum of lines 1-2)	2,082,335			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	610, 754				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 471, 581				2.00
3.00	Total (sum of lines 1-2)	0	2, 082, 335				3.00

Health Financial Systems	ST ELI ZABETH	H DEARBORN		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2023 To 12/31/2023		
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	4, 202, 139 9, 441, 968 13, 644, 107	0	4, 202, 139 9, 441, 968 13, 644, 107 CAPI TAL	0. 692018	0	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT	NIERS 0	0		1, 644, 807	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	-	(	) 1, 644, 807 3, 712, 663 5, 357, 470	-	2.00 3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	NTERS -28, 613 0 -28, 613	0	0		1, 616, 194 3, 712, 663 5, 328, 857	1.00 2.00 3.00

Heal th	Fi nanci al	l Systems
AD JUST	MENTS TO	EXPENSES

	Financial Systems		ST ELI ZABETH			u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Date/Time Prep 5/28/2024 1:58	
				Expense Classification To/From Which the Amount i		572872024 1: 56	<u>s piii</u>
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
	COSTS-BLDG & FIXT (chapter 2)	D					
2.00 3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2) Investment income - other		00	CAP REL COSTS-MVBLE EQUIP	2.00 0.00	0	2.00 3.00
4.00	(chapter 2) Trade, quantity, and time		О		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
	expenses (chapter 8)		0			-	
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -558, 376		0.00	0 0	9. 00 10. 00
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	19, 430, 845			0	12.00
13.00	Laundry and linen service	_	0		0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others		-332, 247 l 0	DI ETARY	10. 00 0. 00	0 0	14. 00 15. 00
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17.00	Sale of drugs to other than patients	В	-858, 5351	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	В	-2171	MEDI CAL RECORDS & LI BRARY	16.00	0	18.00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. 00
20.00	Vending machines	В		DI ETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	01	RESPI RATORY THERAPY	65.00		23. 00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OI	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		Ol	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		O	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		O	NONPHYSI CI AN ANESTHETI STS	19.00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		O	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31. 00
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
33.00	Depreciation and Interest LEASE REVENUE	В	-34, 302	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Heal th	Financial Systems		ST ELI ZABETH	H DEARBORN	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0086	Period:	Worksheet A-8	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 1:5	
				Expense Classification of			
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	OTHER REVENUE	В	-5, 974	LAUNDRY & LINEN SERVICE	8.00	0	33.01
33. 02	OTHER REVENUE	В	-83, 709	MAINTENANCE & REPAIRS	6.00	0	33.02
33.03	OTHER REVENUE	В	-73, 110	DI ETARY	10.00	0	33.03
33.04	NET ASSETS RELEASED	В	-5, 797	SOCI AL SERVI CE	17.00	0	33.04
33.05	PROVIDER TAX	A	-4, 906, 825	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY)	A	0		0.00	0	33.06
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		12, 534, 175				50.00
	(Transfer to Worksheet A,						
		1					1

(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.
 (2) Additional adjustments may be made on Lines 22 thru 40 and subcorints thereof.

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

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

Heal th	Financial Systems	ST ELIZABE	TH DEARBORN	In Lie	u of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0086	Peri od:	Worksheet A-8-	-1
OFFICE	COSTS			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/28/2024 1:58	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (	DRGANI ZATI ONS OR	CLAI MED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE COST	1, 034, 053	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE COST	1, 413, 426	0	2.00
3.00		ADMINISTRATIVE & GENERAL	HOME OFFICE COST	12, 413, 226	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY	827, 656	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	335, 143	0	4.01
4.02	6.00	MAINTENANCE & REPAIRS	RELATED PARTY	765, 974	0	4.02
4.03	7.00	OPERATION OF PLANT	RELATED PARTY	157, 986	0	4.03
4.04	10.00	DI ETARY	RELATED PARTY	111, 071	0	4.04
4.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	307, 816	0	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	RELATED PARTY	1, 741, 918	0	4.06
4.07	17.00	SOCIAL SERVICE	RELATED PARTY	19, 879	0	4.07
4.08	73.00	DRUGS CHARGED TO PATIENTS	RELATED PARTY	293, 731	0	4.08
4.09	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	275, 403	266, 437	4.09
4.10	0.00			0	0	4.10
5.00	TOTALS (sum of lines 1-4).			19, 697, 282	266, 437	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
						1
	Symbol (1)	Name	Percentage of	Name	Percentage of	1
			Ownershi p		Ownershi p	1
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00 B	0. 00 ST. ELI ZABETH 100. 00	6.00
7.00 C	0.00 TRI STATE LAUND 33.13	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.

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

Health Financial Systems	ST ELIZABETH D	EARBORN	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZA	TIONS AND HOME	Provider CCN: 15-0086	Period: From 01/01/2023	Worksheet A-8-1
OFFICE COSIS				Date/Time Prepared:

							10 12/01/2020	5/28/2024	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6.00	7.00							
			IENTS REQUI RED	AS A RESULT OF	TRANSACTIONS W	ITH RELATED O	RGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO								
1.00	1, 034, 053								1.00
2.00	1, 413, 426								2.00
3.00	12, 413, 226								3.00
4.00	827,656	9							4.00
4.01	335, 143	0							4.01
4.02	765, 974	0							4.02
4.03	157, 986	0							4.03
4.04	111, 071	0							4.04
4.05	307, 816	0							4.05
4.06	1, 741, 918	0							4.06
4.07	19, 879	0							4.07
4.08	293, 731	0							4.08
4.09	8, 966	0							4.09
4.10	0	0							4.10
5.00	19, 430, 845								5.00

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

Related Organization(s) and/or Home Office		
T. C.D. I		
Type of Business		
6.00		
 B. INTERRELATIONSHIP TO RELAT	ED 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	HEALTHCARE	6.00
7.00	0 LAUNDRY 0 I	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00
(1) 11-		

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

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

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

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

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

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

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

Heal th	Financial Syste	ems	ST ELI ZABET	TH DEARBORN		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC				CN: 15-0086	Peri od:	Worksheet A-8	
						From 01/01/2023		
						To 12/31/2023		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	5/28/2024 1:5 Physi ci an/Prov	<u> </u>
	WKSL A LINE #	I denti fi er	Remuneration	Component	Component	KCE AIIIOUITI	ider Component	
		ruentirrei	Reliance at 1 of 1	component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		DELIVERY ROOM & LABOR ROOM	110,000	110,000		0 0	0	1.00
2.00		EMERGENCY	448, 376	448, 376		0 0	0	
3.00	0.00		0			0 0	0	
4.00	0.00		0				0	
5.00	0.00		0				0	
6.00	0.00		0	-		0 0	0	
7.00	0.00		0	0			0	
8.00	0.00		0	0			0	
9.00	0.00		0	0			0	
10.00	0.00		0	-			0	
200.00	0.00		558, 376	558, 376			0	
200100	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200100
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	1.00
2.00	91.00	EMERGENCY	0	0		0 0	0	2.00
3.00	0.00		0	0		0 0	0	3.00
4.00	0.00		0	0		0 0	0	4.00
5.00	0.00		0	0		0 0	0	5.00
6.00	0.00		0	0		0 0	0	6.00
7.00	0.00		0	0		0 0	0	7.00
8.00	0.00		0	0		0 0	0	8.00
9.00	0.00		0	0		0 0	0	9.00
10.00	0.00		0	0		0 0	0	
200.00			0	-		0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00		14	44.00	17.00	10.00		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		DELIVERY ROOM & LABOR ROOM	0			110,000		1.00
2.00		EMERGENCY	0			448, 376		2.00
3.00	0.00		0			0 0		3.00
4.00	0.00		0	-		0 0		4.00
5.00	0.00		0	-		0 0		5.00
6.00	0.00		0			0 0		6.00
7.00	0.00		0	Ŭ		0 0		7.00
8.00	0.00		0			0 0		8.00
9.00	0.00		0			0 0		9.00
10.00	0.00		0					10.00
200.00			0	0		558, 376		200.00

	n Financial Systems ALLOCATION - GENERAL SERVICE COSTS	ST ELI ZABETH	Provi der CO	F	eriod: rom 01/01/2023 o 12/31/2023	u of Form CMS-: Worksheet B Part I Date/Time Pre 5/28/2024 1:5	pared:
			CAPI TAL REL	ATED COSTS		572872024 1:5	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	1, 616, 194 3, 712, 663 -126, 368 15, 879, 601 5, 448, 082 791, 142 410, 941 2, 156, 070 351, 096 1, 159, 482 0	1, 616, 194 0 267, 859 517, 402 191 8, 444 6, 248 21, 215 15, 047 0	3, 712, 663 0 615, 315 1, 188, 561 439 19, 396 14, 352 48, 734 34, 565 0	-126, 368 0 0 0 0 0 0 0	16, 762, 775 7, 154, 045 791, 772 438, 781 2, 176, 670 421, 045 1, 209, 094 0	6.00 7.00 8.00 9.00 10.00 11.00
13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 602, 563 0 1, 915, 875 770, 404 0 0 0 0 0 0 0 0	12, 172 0 0 6, 545 0 0 0 0 0 0 0 0 0 0 0 0	27, 961 0 0 15, 034 0 0 0 0 0 0 0 0	0 0 0 0	1, 642, 696 0 1, 915, 875 791, 983 0 0 0 0 0 0 0 0 0 0 0	14.00 15.00 16.00 17.00 18.00 19.00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SUBGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	5, 731, 989 3, 011, 045 0 0 0 0 383, 205 0 0 0 0	211, 332 39, 247 0 0 0 0 0 2, 121 0 0 0 0 0	485, 463 90, 158 0 0 0 0 4, 873 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	6, 428, 784 3, 140, 450 0 0 0 0 390, 199 0 0 0 0 0 0	32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00
50.00		11, 440, 906	186, 749	428, 993	0	12, 056, 648	50.00
51.00 52.00 53.00 54.00 55.00 56.00 57.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OL SOTOPE 05700 CT SCAN	0 1, 353, 396 1, 062, 921 3, 042, 296 0 0 1, 095, 733	0 50, 025 0 77, 217 0 0 0	0 114, 915 0 177, 379 0 0 0 0	0 0 0 0 0 0	0 1, 518, 336 1, 062, 921 3, 296, 892 0 0 1, 095, 733	51.00 52.00 53.00 54.00 55.00 56.00 57.00
58.00 59.00 60.00 60.01 61.00 62.00 63.00 64.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 LINTRAVENOUS THERAPY	383, 562 615, 610 3, 895, 192 0 0 0 0	4, 259 6, 126 35, 641 0 0 0		0	397, 604 635, 808 4, 012, 706 0 0 0 0 0	59.00 60.01 61.00 62.00 63.00
64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00 76.97 77.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0 1, 432, 393 2, 128, 999 356, 109 182, 274 544, 880 25, 063 0 6, 579, 846 4, 966, 909 13, 277 0 205, 399 0	0 6, 174 40, 117 2, 249 17, 295 0 0 0 7, 865 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	92, 156 9, 674	0 0 0 0 0 0	0 1, 452, 749 2, 261, 272 369, 994 189, 689 601, 905 25, 063 0 6, 579, 846 4, 992, 842 13, 277 0 205, 399 0	65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00 76.97
78.00 88.00 89.00	07800 CAR T-CELL I MMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0		0	0	78.00

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/28/2024 1:5	pared:
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	<u>col.7)</u> 0	1.00	2.00	4.00	4A	
90.00         09000         CLI NI C           91.00         09100         EMERGENCY           92.00         OBSERVATI ON BEDS (NON-DI STI NCT PART)	0 4, 288, 958	0 51, 361		0 0	0 4, 458, 304 0	90.00 91.00 92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
94. 00 09500 AMBULANCE SERVICES 96. 00 09500 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0	94.00 95.00 96.00 97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 99.10 09910 CORF	0	0			0	97.00 98.00 99.00 99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	0			0	100. 00 101. 00
102.00 10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0 0	0	115.00
116. 0011600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	88, 427, 707	1, 597, 112	3, 668, 82	-	88, 491, 157	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	149, 750	10, 066	23, 12	.4 0	182, 940	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	14, 874	9, 016	20, 71		44, 602	
193. 00 19300 NONPALD WORKERS 194. 00 07950 CMH	0	0		0 0		193.00
200.00 Cross Foot Adjustments	0	0		0		194.00 200.00
201.00 Negative Cost Centers		Ω		0 -126, 368		
202.00 TOTAL (sum lines 118 through 201)	88, 592, 331	1, 616, 194	3, 712, 66			

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ST ELIZABETH	Provi der CCN	Fi	eriod: rom 01/01/2023	u of Form CMS-2 Worksheet B Part I	
				То	b 12/31/2023	Date/Time Prep 5/28/2024 1:58	pared: 8 pm
	Cost Center Description	ADMI NI STRATI VE N		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	REPAI RS 6.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	16, 762, 775					4.00 5.00
6.00	00600 MAINTENANCE & REPAIRS	1, 666, 599	8, 820, 644				6.00
7.00	00700 OPERATION OF PLANT	184, 450	2, 027	978, 249			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	102, 218	89, 631	9, 943	640, 573		8.00
9.00	00900 HOUSEKEEPING	507, 075	66, 322	7, 357	0	2, 757, 424	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	98, 086 281, 669	225, 203 159, 725	24, 982 17, 718	9, 280	71, 685 50, 842	10.00
12.00	01200 MAINTENANCE OF PERSONNEL	201,009	139, 723	17, 718	0	0 30, 842	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	382, 681	129, 210	14, 333	0	41, 129	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	446, 320	0	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	184, 500	69, 475	7, 707 0	0	22, 115	
18.00 19.00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18.00 19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	1 407 440	0.040.040	0.40, 050	104.00/	74.4 007	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 497, 643 731, 596	2, 243, 362 416, 626	248, 858 46, 216	134, 096 34, 503	714, 087 132, 617	30.00
31.00	03200 CORONARY CARE UNIT	/31, 370	410, 020	40, 210	34, 503	132, 017	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300 NURSERY	90, 900	22, 520	2, 498	0	7, 168	
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44.00 45.00
45.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	45.00
101.00	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 808, 701	1, 982, 407	219, 908	161, 651	631, 023	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	353, 710	531, 029	58, 907	28, 536	169, 033	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	247, 617 768, 041	819, 683	0 90, 927	43, 527	0 260, 914	53.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	/08,041	019,003	90, 927	43, 527	200, 914	55.00
56.00	05600 RADI OI SOTOPE	0	Ö	0	0	0	
57.00	05700 CT SCAN	255, 261	0	0	14, 222	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	92, 625	45, 210	5, 015	15, 432	14, 391	
59.00	05900 CARDI AC CATHETERI ZATI ON	148, 117	65, 027	7, 213	2, 692	20, 699	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	934, 796	378, 341	41, 969	112	120, 430 0	60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ő	Ö	o	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	О	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	338, 431	65, 534	7, 270	0	20, 860	1
66.00	06600 PHYSI CAL THERAPY	526, 784	425, 859	47, 241	29, 646	135, 556	
67.00 68.00	06700 OCCUPATIONAL THERAPY	86, 193	44, 703	4, 959 2, 648	1, 979 205	14, 229	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	44, 190 140, 219	23, 872 183, 597	2, 648 20, 366	205 1, 965	7, 599 58, 441	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	5, 839	0	20, 000	, , , , , , , , , , , , , , , , , , , ,	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ō	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 532, 834	О	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 163, 127	83, 494	9, 262	0	26, 577	73.00
74.00	07400 RENAL DI ALYSI S	3, 093	0	0	0	0	
75.00 76.97	07500 ASC (NON-DI STINCT PART) 07697 CARDI AC REHABI LI TATI ON	47 050	0	0	0	0	75.00
10.91	07700 ALLOGENEIC STEM CELL ACQUISITION	47,850	0	0	0	0	76.97
77 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	
77.00 78.00		. 9					
	OUTPATIENT SERVICE COST CENTERS			0	0	0	88.00
78.00 88.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	0	9	0	
78.00 88.00 89.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0 0	0	89.00
78.00 88.00 89.00 90.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0	0	89.00 90.00
78.00 88.00 89.00 90.00 91.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	0 0 1, 038, 602	0 0 545, 217	0 0 60, 481	0 0 134, 860	0	89.00 90.00 91.00
78.00 88.00 89.00 90.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0	0	89.00 90.00

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0086 P	eri od:	Worksheet B	
				rom 01/01/2023	Part I	
			T	o 12/31/2023		
Cost Center Description	ADMI NI STRATI VE		OPERATI ON OF	LAUNDRY &	5/28/2024 1:5 HOUSEKEEPI NG	8 pm
Cost center bescription	& GENERAL	REPAIRS	PLANT	LINEN SERVICE	HUUSEKEEPING	
	5.00	6.00	7.00	8. 00	9.00	
95.00 09500 AMBULANCE SERVICES	0.00	0.00	0	0.00	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	Ũ	100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0		100.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUISTITION	0	0	0	0		105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		108.00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		107.00
	0	0	0	0		
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110. 00 11000 INTESTINAL ACQUISITION 111. 00 11100 ISLET ACQUISITION	0	0	0	0		110.00
	0	0	0	0	0	111.00
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF			0			114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
116.00 11600 HOSPI CE	0	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	16, 709, 767	8, 618, 074	955, 778	612, 706	2, 692, 944	118.00
NONREI MBURSABLE COST CENTERS	40 (40	404 050	44.054		04.014	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	42, 618	106, 859	11, 854	0	34, 014	
191.00 19100 RESEARCH	0	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	10, 390	95, 711	10, 617	27, 867	30, 466	
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
194.00 07950 CMH	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments		_	-	_	_	200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	16, 762, 775	8, 820, 644	978, 249	640, 573	2, 757, 424	202.00

Health Financial Systems	ST ELI ZABETH	DEARBORN			n Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0086	Period: From 01/01		Worksheet B Part I	
				To 12/31	/2023	Date/Time Pre 5/28/2024 1:5	pared: 8 pm
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE PERSONNEL	OF NURSI I ADMI NI STR		CENTRAL SERVI CES &	
	- 10.00					SUPPLY	
GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	)	14.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT							2.00 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL							5.00
6.00 00600 MAINTENANCE & REPAIRS							6.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE							7.00 8.00
9.00 00900 HOUSEKEEPI NG							9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	850, 281 0	1, 719, 048					10.00
12. 00 01200 MAINTENANCE OF PERSONNEL	0	0		0			12.00
13. 00 01300 NURSING ADMINISTRATION	0	41, 548		0 2, 25	1, 597	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	0		0	0	0	14.00 15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	15, 580		0	0	0	
17.00 01700 SOCIAL SERVICE 18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	20, 774 0		0 4	4, 149	0	17.00 18.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	0	19.00
20. 00 02000 NURSING PROGRAM	0	0		0	0	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	0	0	21.00 22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	0	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS	352, 489	244, 094		0 51	5, 071	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	49, 861	114, 257			4, 894	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0		0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	0	33.00 34.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0	0	0	40.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0	0		0	0	0	41.00 43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0		0	0	0	43.00
45.00 04500 NURSING FACILITY	0	0		0	0	0	45.00
46. 00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	1	0	0	0	46.00
50. 00 05000 OPERATI NG ROOM	256, 291	373, 937			5, 815	0	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0 22, 866	0 83, 096		0 0 22	0 0, 745	0	51.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	5, 193		0 22	0, 743	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	84	155, 805		0	0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI 0I SOTOPE	0	0		0	0	0	
57.00 05700 CT SCAN	0	36, 354		0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0 604	15, 580 20, 774		0 2	0 9, 433	0	58.00 59.00
60. 00 06000 LABORATORY	101	129, 837		0	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0	0	0	60. 01 61. 00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0 62, 322		0	0	0	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	109, 063		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	15, 580 5, 193		0	0	0	67.00 68.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	25, 967		0 4	4, 149	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	67, 515		0	0	0	73.00
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0	0		0	0	0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 97 07697 CARDI AC REHABI LI TATI ON	0	0 10, 387		0 2	0 9, 433	0	75.00 76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	0		0	0	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATI ENT SERVICE COST CENTERS	0	0	1	0	0	0	78.00
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0		0	0	0	89.00 90.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0 27, 550	0 166, 192		0 36	0 7, 908	0 0	90.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)							92.00

Health Financial Systems	ST ELI ZABETH	DEARBORN		Inlie	u of Form CMS-25	552-10
COST ALLOCATION - GENERAL SERVICE COSTS	01 2212182111	Provi der CCN:	F	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I	ared:
Cost Center Description	DI ETARY			NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
OTHER REIMBURSABLE COST CENTERS				1		
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	C	0 0		94.00
95. 00 09500 AMBULANCE SERVI CES	0	0	C	0 0		95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0 0		96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0 0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0 0		98.00
99. 00 09900 CMHC	0	0	C	0 0		99.00
99. 10 09910 CORF	0	0	C	0 0		99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	C	0 0		00.00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0 0		01.00
102.00 10200 OPI OLD TREATMENT PROGRAM	0	0	C	0 0	0 1	02.00
SPECIAL PURPOSE COST CENTERS	· · · · · ·			-		
105.00 10500 KI DNEY ACQUI SI TI ON	0	0	C	0 0		05.00
106.00 10600 HEART ACQUI SI TI ON	0	0	C	0 0		06.00
107.00 10700 LI VER ACQUI SI TI ON	0	0	C	0 0		07.00
108.00 10800 LUNG ACQUISITION	0	0	C	0 0		08.00
109.00 10900 PANCREAS ACQUISITION	0	0	C	0 0		09.00
110.00 11000 INTESTINAL ACQUISITION	0	0	C	0 0		10.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	C	0 0		11.00
113.00 11300 INTEREST EXPENSE						13.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						14.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0 0		15.00
116. 00 11600 HOSPI CE	0	0	C	0 0		16.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	709, 846	1, 719, 048	C	2, 251, 597	0 1	18.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0 0		90.00
191. 00 19100 RESEARCH	0	0	C	0 0		91.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0 0		92.00
193.00 19300 NONPALD WORKERS	0	0	C	0 0		93.00
194. 00 07950 CMH	140, 435	0	C	0		94.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	C	0		01.00
202.00 TOTAL (sum lines 118 through 201)	850, 281	1, 719, 048	C	2, 251, 597	0 2	02.00

	Financial Systems	ST ELI ZABETH	DEARBORN Provider CO	CN: 15-0086 P	In Lie eriod:	u of Form CMS- Worksheet B	2552-10
CUST	ALLOCATION - GENERAL SERVICE COSTS			F	rom 01/01/2023		parad
						5/28/2024 1:5	
					OTHER GENERAL SERVI CE		
	Cost Center Description	PHARMACY		SOCIAL SERVICE		NONPHYSI CI AN	
			RECORDS & LI BRARY			ANESTHETI STS	
		15.00	16.00	17.00	18.00	19.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	[					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0					14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	2, 377, 775				16.00
17.00	01700 SOCIAL SERVICE	0	0	1, 140, 703	_		17.00
18.00 19.00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	18.00 19.00
	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0		21.00
22.00 23.00	02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY)	0	0	0	0		22.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0		23.00
30.00	03000 ADULTS & PEDIATRICS	0	238, 310			0	
31.00	03100 I NTENSI VE CARE UNI T	0	129, 548 0		0	0	
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	Ő	0	0	
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0	0 8, 099	-	-	0	
44.00	04400 SKILLED NURSING FACILITY	0	0	0		0	
45.00	04500 NURSING FACILITY	0	0	0	-	0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	46.00
50.00	05000 OPERATI NG ROOM	0	635, 819			0	
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	-	0	0	
52.00 53.00	05300 ANESTHESI OLOGY	0	32, 610 29, 220		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	284, 949			0	
55.00		0	0	0	0	0	
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	0	0 109, 213	0 52, 886	0	0	
58.00		0	31, 810			0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	44, 257			0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	66, 775 0	32, 328	0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65. 00		0	25, 187	-	0	0	
66.00	06600 PHYSI CAL THERAPY	0	68, 733	33, 370	0	0	66.00
67.00 68.00		0	10, 222			0	
68.00 69.00		0	5, 339 27, 749			0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	672	298	0	0	70.00
71.00		0	0		-	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	184, 367 137, 841			0	
		0	970			0	
	07500 ASC (NON-DI STI NCT PART)	0	0	-	-	0	
76.97 77.00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	0	7, 212	3, 426	0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	-	0	
	OUTPATIENT SERVICE COST CENTERS			1			
		0	0	0	0	0	88.00
	08800 RURAL HEALTH CLINIC			n	∩		
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0	0	89.00

Health Financial Systems	ST ELI ZABETH	I DEARBORN		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/28/2024 1:5	
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVIC	· · ·	NONPHYSI CI AN ANESTHETI STS	
	15.00	16.00	17.00	18.00	19.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	II					
94.00 09400 HOME PROGRAM DI ALYSI S	0	C	1	0 0	C	94.00
95. 00 09500 AMBULANCE SERVICES	0	C		0 0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	C		0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0	C C	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	C		0 0	0	
99. 00 09900 CMHC	0	0		0 0	C C	
99. 10 09910 CORF	0	0		0 0		
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0				-	100.00
101. 00 10100 HOME HEALTH AGENCY	0			0 0		101.00
102. 00 10200 OPI OLD TREATMENT PROGRAM	0	C		0 0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	C	1	0 0		102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	C		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		105.00
107. 00 10700 LI VER ACQUI SI TI ON	0			0 0		107.00
108. 00 10800 LUNG ACQUISITION	0			0 0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0					109.00
110. 00 11000   NTESTINAL ACQUISTION	0					1109.00
111. 00 11100 I SLET ACQUI SI TI ON	0					111.00
113. 00 11300 INTEREST EXPENSE	0	L.		0 0		113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115. 00/11500 AMBULATORY SURGICAL CENTER (D. P. )	0	c		0	0	115.00
116. 00 11600 HOSPI CE	0					116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 377, 775	1, 140, 70	3 0	0	118.00
NONREI MBURSABLE COST CENTERS	0	2,311,113	1, 140, 70	<u> </u>	0	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		1	0 0	0	190.00
190. 0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 0019100 RESEARCH	0					190.00
191. OU 19100 RESEARCH 192. OU 19200 PHYSI CLANS' PRI VATE OFFI CES	0					191.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 193. 00 19300 NONPALD WORKERS	0					192.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 CMH	0					193.00
200.00 Cross Foot Adjustments	0	Ĺ		0		200.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	_	~		0		200.00
	0	ן זרד דדר נ	1 140 70	3 0		
202.00  TOTAL (sum lines 118 through 201)	l O	2, 377, 775	1, 140, 70	0		202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ST ELI ZABET		CN: 15-0086 Pe	In Lieu eriod:	u of Form CMS-2 Worksheet B	2552-10
00017	LECONTON GENERAL SERVICE COSTS				om 01/01/2023	Part I Date/Time Pre	pared:
			I NTERNS &	RESI DENTS		5/28/2024 1:5	8 pm
	Cost Center Description	NURSI NG	SERVICES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	
	cost center bescription	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM		
	GENERAL SERVICE COST CENTERS	20.00	21.00	22.00	23.00	24.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERIA						11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00 13.00
13.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16.00 17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)						18.00
19.00 20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM						19.00 20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		C	D			21.00
22.00 23.00	02200 I & SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)			0	0		22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS						23.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT				0	12, 720, 481 5, 123, 436	30.00 31.00
32.00	03200 CORONARY CARE UNIT				0	5, 125, 450	32.00
33.00	03300 BURN INTENSIVE CARE UNIT			0	0	0	
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF				0	0	
41.00	04100 SUBPROVI DER – I RF			0	0	0	
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY				0	525, 257 0	43.00
45.00	04500 NURSING FACILITY			· · · · ·	Ō	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS			0 0	0	0	46.00
50.00	05000 OPERATING ROOM				0	20, 170, 430	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM				0	0 3, 034, 659	
53.00	05300 ANESTHESI OLOGY		o (	0	0	1, 359, 104	53.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C				0	5, 858, 922 0	
56.00	05600 RADI OI SOTOPE			0	0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)				0	1, 563, 669 633, 160	
59.00	05900 CARDI AC CATHETERI ZATI ON			0	0	996, 076	•
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY			0	0	5, 717, 395 0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			, 0	0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0	0	0	62.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY				0	0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY			0	0	1, 984, 569	•
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY				o	3, 637, 524 552, 775	1
68.00	06800 SPEECH PATHOLOGY		o (	0	0	281, 268	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY				0	1, 117, 766 31, 872	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0	0	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS				0	8, 386, 432 6, 547, 548	•
	07400 RENAL DI ALYSI S			o o	0	0, 547, 548 17, 787	
75.00 76.97	07500 ASC (NON-DI STI NCT PART) 07697 CARDI AC REHABI LI TATI ON				0	0 303, 707	
76.97 77.00	07700 ALLOGENEIC STEM CELL ACQUISITION				0	303,707	1
78.00	07800 CAR T-CELL IMMUNOTHERAPY			0 0	0	0	1
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC				ol	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	89.00
90. 00 91. 00	09000 CLINIC 09100 EMERGENCY				0	0 7, 416, 489	90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/28/2024 1:5	
		INTERNS &	RESI DENTS			
Cost Center Description	NURSI NG	SERVI CES-SALAR		ER PARAMED ED	Subtotal	
cost center bescription	PROGRAM	Y & FRINGES	PRGM COSTS		Subtotal	
	20.00	21.00	22.00	23.00	24.00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVI CES	0	0		0 0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99.00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I & R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
SPECIAL PURPOSE COST CENTERS						1
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0			0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 0	87, 980, 326	118.00
NONREI MBURSABLE COST CENTERS	1		L			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	219, 653	
193.00 19300 NONPAID WORKERS	0	0		0 0		193.00
194.00 07950 CMH	0	0		0 0	140, 435	
200.00 Cross Foot Adjustments	0	0		0 0		200.00
201.00 Negative Cost Centers	0	0		0	-126, 368	
202.00   TOTAL (sum lines 118 through 201)	0	0		0 0	88, 592, 331	202.00

Cost Center Description GENERAL SERVICE COST CENTERS 00 00100 CAP REL COSTS-BLDG & FIXT 00 00200 CAP REL COSTS-MVBLE EQUIP 00 00400 EMPLOYEE BENEFITS DEPARTMENT 00 00500 ADMINISTRATIVE & GENERAL 00 00500 ADMINISTRATIVE & GENERAL 00 00500 ADMINISTRATIVE & GENERAL 00 00500 ADMINISTRATIVE & GENERAL 00 00500 HOUSEKEEPING 00 00000 DIETARY 1.00 01100 CAFETERIA 2.00 01200 MINTENANCE OF PERSONNEL 3.00 01300 NURSING ADMINISTRATION	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26.00		5/28/2024 1:	1. 0 2. 0 4. 0 5. 0
.00         00100         CAP         REL         COSTS-BLDG         & FIXT           2.00         00200         CAP         REL         COSTS-MVBLE         EQUIP           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.00         00500         ADMINISTRATIVE         & GENERAL           5.00         00600         MAINTENANCE         & REPAIRS           7.00         00700         OPERATION         OF PLANT           8.00         00800         LAUNDRY         & LINEN         SERVICE           0.00         01000         DI ETARY         I.         OU         OO1000         DI ETARY           1.00         01100         CAFETERIA         2.00         01200         MAINTENANCE         OF PERSONNEL		20.00			2. 0 4. 0 5. 0
.00         00100         CAP         REL         COSTS-BLDG         & FIXT           2.00         00200         CAP         REL         COSTS-MVBLE         EQUIP           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.00         00500         ADMINISTRATIVE         & GENERAL           5.00         00600         MAINTENANCE         & REPAIRS           7.00         00700         OPERATION         OF PLANT           8.00         00800         LAUNDRY         & LINEN         SERVICE           0.00         01000         DI ETARY         I.         OU         OO1000         DI ETARY           1.00         01100         CAFETERIA         2.00         01200         MAINTENANCE         OF PERSONNEL					2. 0 4. 0 5. 0
4.00       01400       CENTRAL SERVICES & SUPPLY         5.00       01500       PHARMACY         6.00       01600       MEDICAL RECORDS & LIBRARY         7.00       01700       SOCIAL SERVICE         8.00       01850       OTHER GENERAL SERVICE (SPECIFY)         9.00       01900       NONPHYSICIAN ANESTHETISTS         00.00       02000       NURSING PROGRAM         11.00       02100       I&R SERVICES-SALARY & FRINGES APPRVD					6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 19.0 20.0 20.0
22.00 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS					21.0
30.00       03000       ADULTS & PEDIATRICS         31.00       03100       INTENSIVE CARE UNIT         32.00       03200       CORONARY CARE UNIT         33.00       03300       BURN INTENSIVE CARE UNIT         34.00       03400       SUBGICAL INTENSIVE CARE UNIT         60.00       04000       SUBPROVIDER - IPF         11.00       04100       SUBPROVIDER - IRF         13.00       04300       NURSERY         14.00       04400       SKILLED NURSING FACILITY         15.00       04500       NURSING FACILITY         16.00       04600       OTHER LONG TERM CARE		12, 720, 481 5, 123, 436 0 0 0 0 525, 257 0 0 0			30.0 31.0 32.0 33.0 40.0 41.0 43.0 44.0 45.0 46.0
ANCI LLARY SERVICE COST CENTERS					4
0.00         05000         OPERATI NG ROOM           1.00         05100         RECOVERY ROOM           2.00         05200         DELI VERY ROOM & LABOR ROOM           3.00         05300         ANESTHESI OLOGY           4.00         05400         RADI OLOGY-DI AGNOSTI C           5.00         05500         RADI OLOGY-THERAPEUTI C           6.00         05600         RADI OLOGY-THERAPEUTI C           6.00         05600         RADI OLOGY-THERAPEUTI C           6.00         05600         RADI OLOGY-THERAPEUTI C           7.00         05700         CT SCAN           8.00         05800         MAGNETI C           9.00         05900         CARDI AC CATHETERI ZATI ON           0.01         06001         LABORATORY           0.01         06010         DBOD CABORATORY           1.00         06100         PBP CLI NI CAL LAB SERVI CES-PRGM ONLY           2.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS           3.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.           4.00         06400         INTRAVENOUS THERAPY           5.00         06500         RESPI RATORY THERAPY           6.00         06600         PHYSI CAL THERAPY </td <td></td> <td><math display="block">\begin{array}{c} 20, 170, 430 \\ 0 \\ 3, 034, 659 \\ 1, 359, 104 \\ 5, 858, 922 \\ 0 \\ 0 \\ 1, 563, 669 \\ 633, 160 \\ 996, 076 \\ 5, 717, 395 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ </math></td> <td></td> <td></td> <td>50. 51. 52. 52. 54. 55. 56. 57. 58. 57. 58. 59. 60. 61. 62. 63. 64. 62. 63. 64. 64. 63. 64. 71. 71. 72. 73. 74. 75. 88.</td>		$\begin{array}{c} 20, 170, 430 \\ 0 \\ 3, 034, 659 \\ 1, 359, 104 \\ 5, 858, 922 \\ 0 \\ 0 \\ 1, 563, 669 \\ 633, 160 \\ 996, 076 \\ 5, 717, 395 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ $			50. 51. 52. 52. 54. 55. 56. 57. 58. 57. 58. 59. 60. 61. 62. 63. 64. 62. 63. 64. 64. 63. 64. 71. 71. 72. 73. 74. 75. 88.

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS	-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0086	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pr 5/28/2024 1:	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	25.00	26.00				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0				94.00
95. 00 09500 AMBULANCE SERVICES	0	0				95.00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
99. 00 09900 CMHC	0	0				99.00
99. 10 09910 CORF	0	0				99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0				102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	0				102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0				105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0				106.00
107. 00 10700 LIVER ACQUISITION	0	0				107.00
108. 00 10800 LUNG ACQUISITION	0	0				107.00
109. 00 10900 PANCREAS ACQUISITION	0	0				109.00
110. 00 11000   NTESTI NAL ACQUI SI TI ON	0	0				110,00
111. 00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113. 00 11300 I NTEREST EXPENSE	0	0				113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0				115.00
116. 00 11600 HOSPICE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	87, 980, 326				118.00
NONREI MBURSABLE COST CENTERS	U	07,900,320				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	378, 285				190.00
190.0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	376, 265				190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	219, 653				191.00
	0	219,053				
193. 00 19300 NONPALD WORKERS	0	140 405				193.00 194.00
194.00 07950 CMH	0	140, 435				
200.00 Cross Foot Adjustments	0	0				200.00
201.00 Negative Cost Centers	0	-126, 368				201.00
202.00  TOTAL (sum lines 118 through 201)	0	88, 592, 331				202.00

LOCAT	Financial Systems FION OF CAPITAL RELATED COSTS	ST ELI ZABETH	Provider CO	1	Period: From 01/01/2023	u of Form CMS-2 Worksheet B Part II	
					Го 12/31/2023	Date/Time Pre 5/28/2024 1:5	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
- F	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1
	00400 EMPLOYEE BENEFI TS DEPARTMENT	0	0	(	0 0	0	
	00500 ADMINI STRATI VE & GENERAL	0	267, 859	615, 31	5 883, 174	0	5
	00600 MAINTENANCE & REPAIRS	8, 590	517, 402	1, 188, 56		0	
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	19,071	191 8, 444	439 19, 390		0	
	00900 HOUSEKEEPI NG	8, 042	6, 248	14, 352		0	
	01000 DI ETARY	0	21, 215	48, 734		0	10
		0	15, 047	34, 56	5 49, 612	0	
	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	12, 172	27, 96	40, 133	0	
	01400 CENTRAL SERVICES & SUPPLY	0	0	27,70		0	
	01500 PHARMACY	0	0	(	0 0	0	
	01600 MEDICAL RECORDS & LIBRARY	0	0	15 02		0	
	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	0	6, 545	15, 034	4 21, 579	0	17
	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	19
	02000 NURSI NG PROGRAM	0	0	(	0 0	0	20
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	(	0	0	
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY)	0	0			0	
	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	<u> </u>	<u> </u>	0	20
	03000 ADULTS & PEDIATRICS	18, 494	211, 332	485, 463		0	
	03100 I NTENSI VE CARE UNI T	100	39, 247	90, 158	3 129, 505	0	31
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			0	
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	
	04000 SUBPROVIDER - IPF	0	0	(	0 0	0	
	04100 SUBPROVIDER - IRF	0	0	(		0	
	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	2, 121	4,873	3 6, 994 0 0	0	43
	04500 NURSING FACILITY	0	0		0	0	45
	04600 OTHER LONG TERM CARE	0	0	(	0 0	0	46
	ANCI LLARY SERVICE COST CENTERS	1(7.052	10( 740	420.00	702 705	0	
	05000 OPERATING ROOM 05100 RECOVERY ROOM	167, 053 0	186, 749 0	428, 993	3 782, 795 0 0	0	
	05200 DELIVERY ROOM & LABOR ROOM	100	50, 025	114, 91	165, 040	0	
	05300 ANESTHESI OLOGY	0	0	(	0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	77, 217	177, 379	254, 596	0	
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0			0	55 56
	05700 CT SCAN	4, 120	0		4, 120	0	57
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	4, 259			0	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 40, 602	6, 126 35, 641	14, 072 81, 873		0	59
	06000 BLOOD LABORATORY	40, 802	35, 641	01, 8/.	) 130, 110	0	
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	Ũ	61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(	0	0	
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	0			0	63
	06500 RESPI RATORY THERAPY	34, 058	6, 174	14, 182	2 54, 414	0	
00	06600 PHYSI CAL THERAPY	30, 324	40, 117	92, 150		0	
	06700 OCCUPATI ONAL THERAPY	0	4, 211	9, 67		0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	2, 249 17, 295	5, 160 39, 730		0	
	07000 ELECTROENCEPHALOGRAPHY	714	17,295	37,73	0 57,025 0 714	0	70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0 0	0	72
	07300 DRUGS CHARGED TO PATIENTS	224, 765	7, 865	18, 068	3 250, 698	0	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0			0	
	07697 CARDI AC REHABI LI TATI ON	0	0			0	
00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(		0	77
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(	0 0	0	78
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0			0	88
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	
	09000 CLINIC	0	0		0		90

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/28/2024 1:5	pared: 8 pm
Cost Center Description	Di rectl y	CAPITAL REL BLDG & FIXT	ATED COSTS	Subtotal	EMPLOYEE	
	Assigned New Capital Related Costs O	1.00	2.00	24	BENEFITS DEPARTMENT	
	-			2A	4.00	01.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	231	51, 361	117, 98	169, 577 0	0	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99, 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		0 0		102.00
SPECIAL PURPOSE COST CENTERS		0	1	0 0	0	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0		0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108. 00 10800 LUNG ACQUISITION	0	0		0 0		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0		108.00
	0	0		0 0		
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	556, 264	1, 597, 112	3, 668, 82	5, 822, 203	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 066	23, 12	33, 190	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	9, 016	20, 71	2 29, 728	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194. 00 07950 CMH	0	0		0 0		194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	n	201.00
202.00 TOTAL (sum lines 118 through 201)	556, 264	1, 616, 194	3, 712, 66	5, 885, 121		202.00
(	,20	., , . , .				

	Financial Systems TION OF CAPITAL RELATED COSTS	ST ELI ZABETH	Provi der CC		eriod: fom 01/01/2023	u of Form CMS-: Worksheet B Part II	2002
				To		Date/Time Pre 5/28/2024 1:5	pared
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.00	6.00	7.00	8. 00	9.00	
	GENERAL SERVICE COST CENTERS						
. 00 . 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
. 00	00500 ADMI NI STRATI VE & GENERAL	883, 174					5.0
. 00	00600 MAI NTENANCE & REPAI RS	87, 809	1, 802, 362				6.0
. 00	00700 OPERATION OF PLANT	9, 718	414	10, 762			7.0
. 00	00800 LAUNDRY & LINEN SERVICE	5, 386	18, 315	109	70, 721		8.
. 00	00900 HOUSEKEEPI NG	26, 716	13, 552	81	0	68, 991	
0.00	01000 DI ETARY 01100 CAFETERI A	5, 168	46, 017	275 195	1, 025	1,794	
1.00 2.00	01200 MAINTENANCE OF PERSONNEL	14, 840	32, 637 0	0	0	1, 272 0	
3.00	01300 NURSI NG ADMI NI STRATI ON	20, 162	26, 402	158	0	1,029	
4.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
5.00	01500 PHARMACY	0	0	0	0	0	15.
6. 00	01600 MEDI CAL RECORDS & LI BRARY	23, 515	0	0	0	0	
7.00	01700 SOCIAL SERVICE	9, 721	14, 196	85	0	553	
8.00 9.00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
5.00 D.00	02000 NURSI NG PROGRAM	0	0	0	0	0	
1.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	
2.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.
3.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
0.00	03000 ADULTS & PEDIATRICS	78, 907	458, 395	2, 739	14, 805	17, 868	
1.00 2.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	38, 546	85, 131 0	508 0	3, 809 0	3, 318 0	
3.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
4.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	
0. 00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.
1. 00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.
3.00	04300 NURSERY	4, 789	4, 602	27	0	179	
4.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	
5.00 6.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	
0.00	ANCI LLARY SERVICE COST CENTERS	0	Y		V	0	0.
0. OO	05000 OPERATI NG ROOM	147, 973	405, 074	2, 419	17, 845	15, 788	50.
1. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.
2.00	05200 DELIVERY ROOM & LABOR ROOM	18, 636	108, 508	648	3, 151	4, 229	
3.00	05300 ANESTHESI OLOGY	13,046	0	0	0	0	53.
4.00 5.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	40, 466	167, 490	1, 000	4, 805	6, 528 0	
6.00	05600 RADI OLOGI - MERAPEOTI C	0	0	0	0	0	
	05700 CT SCAN	13, 449	0	0	1, 570	0	1
B. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 880	9, 238	55	1, 704	360	1
9.00	05900 CARDI AC CATHETERI ZATI ON	7, 804	13, 287	79	297	518	
0.00	06000 LABORATORY	49, 252	77, 308	462	12	3, 013	
0.01	06001 BLOOD LABORATORY	0	0	0	0	0	
1.00 2.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61. 62.
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
4.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
5.00	06500 RESPI RATORY THERAPY	17, 831	13, 391	80	0	522	65.
5.00	06600 PHYSI CAL THERAPY	27, 755	87, 018	520	3, 273	3, 392	66.
7.00	06700 OCCUPATIONAL THERAPY	4, 541	9, 134	55	219	356	
8.00	06800 SPEECH PATHOLOGY	2, 328	4, 878	29	23	190	
9.00 0.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	7, 388 308	37, 515 0	224 0	217 0	1, 462 0	
1.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	308	0	0	0	0	
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	80, 761	0	0	0	0	
3.00	07300 DRUGS CHARGED TO PATIENTS	61, 282	17, 061	102	0	665	
. 00	07400 RENAL DIALYSIS	163	0	0	0	0	
6. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
. 97	07697 CARDI AC REHABI LI TATI ON	2, 521	0	0	0	0	
7.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
3. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.
	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	88.
2 00		0	0	0	0	0	
8.00 9.00	USYUU FEDERALLY UUALLELED HEALTH CENTER	0	-		0	0	
8.00 9.00 0.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	n	0	0			70
9. 00		0 54, 721	0 111, 407	0 665	14, 889	4, 342	
9.00 0.00	09000 CLI NI C	0 54, 721	Ű	-	Ű		

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0086 P	eri od:	Worksheet B	
				rom 01/01/2023	Part II	
			T	o 12/31/2023		
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATI ON OF	LAUNDRY &	5/28/2024 1:5 HOUSEKEEPI NG	8 pm
cost center bescription	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	HUUSEKEEFING	
	5.00	6.00	7.00	8.00	9.00	
95. 00 09500 AMBULANCE SERVICES	0.00	0.00	0	0.00	0	95.00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	0	0		106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
116. 00 11600 HOSPI CE	0	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	880, 382	1, 760, 970	10, 515	67, 644	67, 378	118.00
NONREI MBURSABLE COST CENTERS	0.045	04.005	100		054	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 245	21, 835	130	0		190.00
191.00 19100 RESEARCH	0	10 557	0	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 193.00 19300 NONPALD WORKERS	547	19, 557	117	3, 077		192.00 193.00
	0	0	0	0		
194.00 07950 CMH	0	0	0	0	0	194.00
200.00Cross Foot Adjustments201.00Negative Cost Centers		~	0		_	200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	002 174	0 1, 802, 362	0 10 740	0 70, 721	68, 991	
202.00   TOTAL (Sum TIMES THE INFOUGH 201)	883, 174	1, 802, 362	10, 762	10, 721	08, 991	202.00

	Financial Systems	ST ELI ZABETH				u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2023	Worksheet B Part II	
					o 12/31/2023	Date/Time Pre	pared:
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	5/28/2024 1:5 CENTRAL	8 pm
					ADMI NI STRATI ON	SERVICES &	
		10.00	11 00	12.00	12.00	SUPPLY	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	124, 228					9.00
11.00	01100 CAFETERI A	124, 220	98, 556				11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	2, 382		90, 266	0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0		0	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	893		0	0	1
17.00	01700 SOCIAL SERVICE	0	1, 191		1, 770	0	
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	
19.00 20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM	0	0		0	0	19.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	51, 499	13, 994	0	20, 649	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	7, 285	6, 551	0	10, 620	0	31.00
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	
43.00	04300 NURSERY	0	0	0	0	0	
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	
	ANCI LLARY SERVI CE COST CENTERS			1			
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	37, 445 0	21, 437 0		29, 498 0	0	
51.00	05200 DELIVERY ROOM & LABOR ROOM	3, 341	4, 764	-	8, 850	0	
53.00	05300 ANESTHESI OLOGY	0	298		0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	12	8, 933		0	0	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0	0	0	55.00 56.00
57.00	05700 CT SCAN	0	2,084		0	0	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	893		0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	88	1, 191		1, 180	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	15	7, 444	0	0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 3, 573		0	0	64.00 65.00
66. 00	06600 PHYSI CAL THERAPY	0	6, 253		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	893	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	298		0	0	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	1, 489 0		1, 770	0	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 871	0	0	0	
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)		0		0	0	74.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	596	0	1, 180	0	•
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	88.00
88 00	IO8800 RURAL HEALTH CLINIC		0	. 0	U U	0	1 00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0 0	0	0 0	0	90.00
89.00 90.00 91.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0 0 4, 025	0 0 9, 528	0 0 0	0 0 14, 749	-	•

ALLOCATION OF CAPITAL RELATED COSTS         Provider CN: 15-0086         Period: To 12/31/2023         Worksheet B Part II         Description           Cost Center Description         DIETARY         CAFETERIA         MAINTENANCE OF PERSONNEL         DNURSING DMINISTRATION         DESCRIPTION         DIETARY         CAFETERIA         MUNISTRATION SERVICES & SUPPLY         SERVICES & SUPPLY           0	Health Financial Systems	ST ELIZABETH			Inlie	u of Form CMS-	2552-10
Cost Center Description         DIETARY         CAFETERIA         MAINTENANCE OF PERSONNEL         NURSING ADMINISTRATION         OCCUPATION           94.00         09400         HOME PROCRAM DIALYSIS         0         0         0         14.00           95.00         09400         HOME RECORT CENTERS         0         0         0         0         94.00         0         0         0         0         94.00         0         0         0         0         94.00         0         0         0         0         0         0         0         0         0         0         94.00         0 <t< td=""><td></td><td>JI LLIZADLIII</td><td></td><td>CN: 15-0086</td><td></td><td></td><td>2332-10</td></t<>		JI LLIZADLIII		CN: 15-0086			2332-10
Cost Center Description         Di ETARY         CAFETERIA         MAI NTENANCE OF PERSONNEL         NURSI NG ADMI NI STRATI ON SERVI CES & SUPPLY           94.00         09400 HOME PROGRAM DI ALYSI S         0         0         10.00         12.00         13.00         14.00           94.00         09400 HOME PROGRAM DI ALYSI S         0         0         0         0         0         94.00           96.00         09500 AMBULANCE SERVI CES         0         0         0         0         94.00           97.00         09700 DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0         96.00           98.00         09500 OTHER REI MBURSABLE COST CENTERS         0         0         0         0         97.00           99.00         09900 CMHC         CORF         0         0         0         0         98.00           99.10         09710 CORF         0         0         0         0         0         99.00         99.00         99.00         99.00         99.00         99.00         99.00         99.00         99.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0					From 01/01/2023	Part II	
Cost Center Description         Di ETARY         CAFETERIA         MAI NETRANCE OF PERSONNEL         NURSI NG ADMI NI STRATI ON SERVICES & SUPPLY           94.00         09400 HOME PROGRAM DI ALYSI S         0         0         12.00         13.00         14.00           95.00         09500 AMBULANCE SERVICES         0         0         0         0         0         96.00         96.00         0         0         0         0         0         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         98.00         0         0         0         0         0         0         0         98.00         98.00         0         0         0         0         97.00         97.00         98.00         99.00         99.00         99.00         99.00         99.00         0 <td></td> <td></td> <td></td> <td></td> <td>To 12/31/2023</td> <td>Date/Time Pre</td> <td>pared:</td>					To 12/31/2023	Date/Time Pre	pared:
Image: PERSONNEL         ADMI NI STRATI ON SERVI CES & SUPPLY         SERVI CES & SUPPLY           94. 00         09400 HOME PROGRAM DI ALYSI S         0         0         13. 00         14. 00           94. 00         09400 HOME PROGRAM DI ALYSI S         0         0         0         0         0         94. 00           95. 00         09500 AMBULANCE SERVI CES         0         0         0         0         0         95. 00           96. 00         9600 DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0         96. 00           97. 00         09700 DURABLE MEDI CAL EQUI P-SOLD         0         0         0         97. 00           98. 00         0950 OTHER REI MBURSABLE COST CENTERS         0         0         0         0         98. 00           99. 00         09900 CMHC         0         0         0         0         0         0         99. 00           99. 10         0971 CORF         0 <td>Cost Center Description</td> <td>DIFTARY</td> <td></td> <td>MAINTENANCE</td> <td></td> <td></td> <td>8 pm</td>	Cost Center Description	DIFTARY		MAINTENANCE			8 pm
OTHER         REI MBURSABLE         COST         CENTERS           94.00         09400         HOME         PROGRAM         014.00         12.00         13.00         14.00           95.00         09500         AMBULANCE SERVICES         0         0         0         0         95.00           96.00         09600         DURABLE         MEDICAL         EQUIP -RENTED         0         0         0         96.00           97.00         09700         DURABLE         MEDICAL         EQUIP -SENTED         0         0         0         97.00           99.00         09850         OTHER         REI MBURSABLE         COST         CENTERS         0         0         0         97.00	cost center bescription	DILIANI					
DTHER RELMURSABLE COST CENTERS         10.00         11.00         12.00         13.00         14.00           94.00         09400 HOME PROGRAM DI ALYSI S         0         0         0         0         0         94.00           95.00         09500 AMBULANCE SERVI CES         0         0         0         0         0         0         94.00           96.00         09600 DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0         97.00           97.00         09700 DURABLE MEDI CAL EQUI P-SOLD         0         0         0         0         97.00           98.00         099500 CMHC         0         0         0         0         0         97.00           99.10         099500 CMHC         0         0         0         0         0         99.00           99.10         099500 CMHC         0         0         0         0         0         0         99.00         99.00           100.00         100000 I kas SERVI CES-NOT APPRVD PRGM         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0				TERSONNEE			
94.00         09400         00ME         PROGRAM DI ALYSI S         0		10.00	11.00	12.00	13.00		
95.00       09500       AMBULANCE SERVICES       0       0       0       0       0       0       0       0       95.00       96.00       0	OTHER REIMBURSABLE COST CENTERS	I					
96.00         09600         DURABLE MEDICAL EQUIP-RENTED         0	94.00 09400 HOME PROGRAM DI ALYSI S	0	0	I	0 0	0	94.00
97.00       09700       DURABLE MEDICAL EQUIP-SOLD       0       0       0       0       97.00         98.00       09850       OTHER REIMBURSABLE COST CENTERS       0       0       0       0       98.00         99.00       09900       CMRC       0       0       0       0       0       99.00         99.10       09910       CORF       0       0       0       0       0       99.00         90.01       100.02       LAR SERVICES-NOT APPRVD PRGM       0       0       0       0       0       0       100.00       0       101.00       0       0       101.00       0       101.00       0       0       0       0       0       0       101.00       0       101.00       0       101.00       0       101.00       0       101.00       0       101.00       0       101.00       0       101.00       0       101.00       0       0       0       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       100       100       101.00       101.00 </td <td>95. 00 09500 AMBULANCE SERVICES</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>95.00</td>	95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
98.00         09850         OTHER REIMBURSABLE COST CENTERS         0         0         0         0         0         0         98.00         99.00         09900         CMHC         0         0         0         0         0         0         99.00         09900         CMHC         0         0         0         0         99.10         09900         CMHC         0         0         0         0         0         99.10         09900         CMHC         0         0         0         0         0         99.10         09900         CMHC         0	96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
99.00         09900         CMHC         0         0         0         0         99.00         99.00         99.10         09910         CORF         0         0         0         0         0         0         0         99.10         0         99.10         0         99.10         0 <td>97.00 09700 DURABLE MEDICAL EQUIP-SOLD</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>97.00</td>	97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
99.10         09910         CORF         0 </td <td>98.00 09850 OTHER REIMBURSABLE COST CENTERS</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>98.00</td>	98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
100.00         100.00         1&R SERVI CES-NOT APPRVD PRGM         0	99.00 09900 CMHC	0	0		0 0	0	99.00
101.00         10100         HOME HEALTH AGENCY         0<	99. 10 09910 CORF	0	0		0 0	0	99.10
102.00         OPIOLD TREATMENT PROGRAM         0         0         0         0         0         0         102.00           SPECIAL PURPOSE COST CENTERS           105.00         10500         KI DNEY ACQUI SI TI ON         0<	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
SPECIAL PURPOSE COST CENTERS           105:00         105:00         KIDNEY ACQUI SI TI ON         0		0	0		0 0	-	
105.00         10500         KI DNEY         ACQUI SI TI ON         0		0	0		0 0	0	102.00
106.00         10600         HEART ACQUI SI TI ON         0         0         0         106.00           107.00         10700         LI VER ACQUI SI TI ON         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
107.00       107.00       LI VER ACQUI SI TI ON       0       0       0       0       107.00         108.00       LUNG ACQUI SI TI ON       0       0       0       0       0       108.00         109.00       PANCREAS ACQUI SI TI ON       0       0       0       0       0       0       109.00         110.00       INDOD INTESTI NAL ACQUI SI TI ON       0       0       0       0       0       0       109.00         111.00       ISLET ACQUI SI TI ON       0       0       0       0       0       0       0       110.00         113.00       INTEREST EXPENSE       0       0       0       0       0       111.00       111.00       111.00       1114.00       1114.00       1114.00       1114.00       1114.00       1116.00       11600       0       0       0       0       0       1118.00         116.00       11600       HBURSABLE COST CENTER (D. P. )       0       0       0       0       116.00       118.00         NORREI MBURSABLE COST CENTERS       0       0       0       0       0       0       0       190.00         191.00       19100       RESEARCH       0       0		0	0				
108.00         LUNG ACQUI SI TI ON         0         0         0         0         108.00           109.00         10900         PANCREAS ACQUI SI TI ON         0         110.00         1110.00         1111.00         1114.00         114.00         114.00         114.00         114.00         0         0         0         0         0         0         0         0         1114.00         114.00         114.00         115.00         115.00         116.00         115.00         0 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td></td></t<>		0	0		0 0		
109.00         PANCREAS         ACQUI SI TI ON         0         0         0         0         0         109.00           110.00         11000         INTESTI NAL         ACQUI SI TI ON         0         0         0         0         110.00           111.00         1SUET         ACQUI SI TI ON         0         0         0         0         0         110.00           111.00         ISLET         ACQUI SI TI ON         0         0         0         0         0         111.00           113.00         INTEREST         EXPENSE         113.00         111.00         111.00         111.00         111.00         113.00         113.00         114.00         114.00         114.00         114.00         114.00         115.00         MBULATORY SURGI CAL CENTER (D.P.)         0         0         0         0         115.00         116.00         116.00         116.00         116.00         0         0         0         118.00         118.00         118.00         118.00         118.00         0         0         0         0         118.00         118.00         1190.00         190.00         191.00         190.00         191.00         190.00         191.00         191.00         192.00		0	0		0 0		
110.00       INTESTINAL ACQUISITION       0       0       0       0       110.00         111.00       ISLET ACQUISITION       0       0       0       0       0       111.00         113.00       INTEREST EXPENSE       113.00       111.00       113.00       111.00       113.00         114.00       INTEREST EXPENSE       114.00       114.00       113.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       114.00       115.00       115.00       0       0       0       0       114.00       114.00       114.00       114.00       115.00       116.00       116.00       0       0       0       115.00       116.00       116.00       0       0       0       0       116.00       116.00       116.00       116.00       116.00       0       0       0       118.00       118.00       118.00       118.00       118.00       118.00       118.00       119.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       190.00       19		0	0		0 0		
111.00       1SLET ACQUISITION       0       0       0       0       111.00         113.00       11300       INTEREST EXPENSE       113.00       113.00       113.00       113.00         114.00       11400       UTILIZATION REVIEW-SNF       114.00       114.00       114.00         115.00       11500       AMBULATORY SURGICAL CENTER (D. P. )       0       0       0       0       115.00         116.00       100       HOSPICE       0       0       0       0       0       116.00         118.00       NONREI MBURSABLE COST CENTERS       0       0       0       0       118.00         119.00       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         191.00       19100       RESEARCH       0       0       0       0       191.00         192.00       19200       PHYSICIANS' PRIVATE OFFICES       0       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       193.00       193.00       193.00       194.00       0       0       0       194.00		0	0		0 0		
113.00       INTEREST EXPENSE       113.00       INTEREST EXPENSE       113.00         114.00       UTI LI ZATI ON REVI EW-SNF       114.00       114.00         115.00       11500       AMBULATORY SURGI CAL CENTER (D. P.)       0       0       0       0       115.00         116.00       11600       HOSPI CE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       103,710       98,556       0       90,266       118.00         119.00       IPONORE IMBURSABLE COST CENTERS       113.00       0       0       0       114.00         190.00       IPT, F, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00       191.00         191.00       19100       RESEARCH       0       0       0       0       191.00         192.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         194.00       07950       CMH       20, 518       0       0       0       193.00		0	0		0 0		1
114.00       UTI LI ZATI ON REVI EW-SNF       114.00         115.00       11500       AMBULATORY SURGI CAL CENTER (D. P.)       0       0       0       115.00         116.00       11600       HOSPI CE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       103,710       98,556       0       90,266       0       118.00         NONREL MBURSABLE COST CENTERS         190.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00       191.00       191.00       191.00       191.00       191.00       191.00       192.00       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         194.00       07950       CMH       20, 518       0       0       0       194.00		0	0		0 0	0	
115.00       11500       AMBULATORY SURGI CAL CENTER (D. P.)       0       0       0       0       115.00         116.00       11600       HOSPI CE       0       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       103,710       98,556       0       90,266       0       118.00         NONREL MBURSABLE COST CENTERS         190.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00       191.00       191.00       191.00       191.00       191.00       191.00       191.00       0       0       0       191.00         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       193.00         194.00       07950       CMH       20,518       0       0       0       194.00							
116.00         11600         HOSPI CE         0         0         0         0         0         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         103,710         98,556         0         90,266         0         118.00           NONREL MBURSABLE COST CENTERS           190.00         19000         GI FT. FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           191.00         19100         RESEARCH         0         0         0         0         191.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         0         0         0         0         192.00           193.00         19300         NONPAI D WORKERS         0         0         0         0         193.00           194.00         07950         CMH         20,518         0         0         0         194.00			_			_	
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         103,710         98,556         0         90,266         0         118.00           NONREI MBURSABLE COST CENTERS           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           191.00         19100         RESEARCH         0         0         0         0         191.00           192.00         19200         NONPAI D WORKERS         0         0         0         192.00           193.00         19300         NONPAI D WORKERS         0         0         0         193.00           194.00         07950         CMH         20,518         0         0         0         194.00		0	0		0 0		
NONREI MBURSABLE COST CENTERS           190. 00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         190. 00           191. 00         19100         RESEARCH         0         0         0         0         191. 00           192. 00         19200         PHYSI CI ANS' PRI VATE OFFICES         0         0         0         0         192. 00           193. 00         19300         NONPAI D WORKERS         0         0         0         0         193. 00           194. 00         07950         CMH         20, 518         0         0         0         194. 00		0	0		0 0		
190.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         191.00       19100       RESEARCH       0       0       0       0       191.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         194.00       07950       CMH       20, 518       0       0       0       194.00		103, 710	98, 556		0 90, 266	0	118.00
191.00       19100       RESEARCH       0       0       0       191.00         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         194.00       07950       CMH       20,518       0       0       0       194.00		0			0	0	100.00
192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         194.00       07950       CMH       20,518       0       0       0       194.00		0	0		0 0		1
193.00         19300         NONPAI D         WORKERS         0         0         0         193.00           194.00         07950         CMH         20,518         0         0         0         194.00		0	0		0 0		
194. 00 07950 CMH 20, 518 0 0 0 194. 00		0	0		0 0		
		20 E19	0				1
	200.00 Cross Foot Adjustments	20, 518	0		0	0	200.00
200.00         Cross Foot Adjustments         200.00		0	0		0	_	
201.00         Negative cost centers         0 </td <td></td> <td>124 220</td> <td>08 554</td> <td></td> <td></td> <td></td> <td>1</td>		124 220	08 554				1
		124, 220	70, 550	1	J 70, 200	0	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	ST ELI ZABETH	Provider C		eri od:	u of Form CMS- Worksheet B	2552-10
				F T	rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre	
					OTHER GENERAL	5/28/2024 1:5	pm
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	SERVI CE (SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
		15.00	LI BRARY 16.00	17.00	18.00	19.00	
	GENERAL SERVICE COST CENTERS	10100	10100		101.00		
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00							11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY	0					15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	24, 408				16.00
17.00	01700 SOCIAL SERVICE	0	0	49, 095	_		17.00
18.00 19.00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18.00 19.00
	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	2, 442	4, 463	0		30.00
31.00	03100 I NTENSI VE CARE UNI T	0	1, 328		0		31.00
32.00	03200 CORONARY CARE UNI T	0	0		0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0		34.00
40.00 41.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0	0	0		40.00
43.00	04300 NURSERY	0	83		0		43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0		44.00
45.00	04500 NURSI NG FACI LI TY	0	0		0		45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0		46.00
50.00	05000 OPERATI NG ROOM	0	6, 557	13, 265	0		50.00
51.00	05100 RECOVERY ROOM	0	0		0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	334	680	0		52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	299		0		53.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	2, 920 0		0		54.00 55.00
56.00	05600 RADI OI SOTOPE	Ő	0	0	0		56.00
57.00	05700 CT SCAN	0	1, 119	2, 276	0		57.00
58.00		0	326		0		58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	454 684		0		59.00 60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0		60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 258				64.00 65.00
66.00		0	704		0		66.00
67.00		0	105		0		67.00
68.00		0	55		0		68.00
69.00		0	284		0		69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	/	13			70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 889		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 413				73.00
	07400 RENAL DI ALYSI S	0	10		0		74.00
	07500 ASC (NON-DI STI NCT PART)	0	0		0		75.00
76.97 77.00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	0	74 0		0		76.97
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0		78.00
	OUTPATIENT SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·			1
00 00	08800 RURAL HEALTH CLINIC	0	0	0	0		88.00
		0	0	I 0	0		89.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0		90.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0086	Period: From 01/01/2023	Worksheet B Part II	
Cost Center Description				To 12/31/2023	Date/Time Pre 5/28/2024 1:5	
	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVI	OTHER GENERAL SERVI CE CE (SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
	15.00	16.00	17.00	18.00	19.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	I		1			1
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0		97.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0 0		98.00
99. 00 109900 CMHC	0	0		0 0		99.00
99. 10 09910 CORF	0	0		0 0		99.00
100.00 10000 I & SERVICES-NOT APPRVD PRGM	0	0		0 0		1
101.00/10100 HOME HEALTH AGENCY	0	0		0 0		100.00
102. 00 10200 OPI 0I D TREATMENT PROGRAM	0	0				
	U	0		0 0		102.00
SPECIAL PURPOSE COST CENTERS	0	0	1	0 0	1	105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0				105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	24, 408	49, 0	95 0	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
194.0007950 CMH	0	0		0 0		194.00
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	0	0		0 0	C	201.00
202.00 TOTAL (sum lines 118 through 201)	0	24, 408	49, 0	95 0	C	202.00

	Financial Systems	ST ELI ZABE	TH DEARBORN	01 45 000/ 5		u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	Fr	eriod: com 01/01/2023	Worksheet B Part II	
			_	Tc	12/31/2023	Date/Time Pre 5/28/2024 1:5	
			INTERNS &	RESI DENTS			
	Cost Center Description	NURSI NG		SERVI CES-OTHER	PARAMED ED	Subtotal	
		PROGRAM 20.00	Y & FRI NGES 21.00	PRGM COSTS 22.00	PRGM 23.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERI A						11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00							15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16.00 17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)						18.00
19.00 20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM		0				19.00 20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		C				21.00
22.00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD			0			22.00
23.00	02300 PARAMED ED PRGM-(SPECI FY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS				0		23.00
30.00	03000 ADULTS & PEDI ATRI CS					1, 381, 050	1
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T					289, 307 0	31.00 32.00
32.00	03300 BURN INTENSIVE CARE UNIT					0	•
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T					0	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF					0	40.00
43.00	04300 NURSERY					16, 841	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY					0	•
45.00 46.00	04500 OTHER LONG TERM CARE					0	•
50.00	ANCI LLARY SERVICE COST CENTERS					1 400 00(	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM					1, 480, 096 0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM					318, 181	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C					14, 252 492, 694	
	05500 RADI OLOGY-THERAPEUTI C					0	55.00
56.00	05600 RADI OI SOTOPE					0	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)					24, 618 32, 165	•
59.00	05900 CARDI AC CATHETERI ZATI ON					46, 019	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY					297, 697 0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					0	
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY					0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY					90, 595	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY					292, 948 29, 400	
68. 00	06800 SPEECH PATHOLOGY					15, 325	1
69.00	06900 ELECTROCARDI OLOGY					107, 951	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					1, 042 0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS					86, 497	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS					337, 971 192	•
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)					0	•
76.97	07697 CARDI AC REHABI LI TATI ON					4, 518	76.97
77.00 78.00	07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY					0	
	OUTPATIENT SERVICE COST CENTERS					0	1
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
89.00 90.00	09000 CLINIC					0	90.00
91.00	09100 EMERGENCY					393, 205	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00

Health Financial Systems	ST ELI ZABET	H DEARBORN		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	_	Provider C	CN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/28/2024 1:5	
		INTERNS &	RESI DENTS			
Cost Center Description	NURSI NG	SERVI CES-SALAR	SERVICES-OTH	ER PARAMED ED	Subtotal	
	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM		
	20.00	21.00	22.00	23.00	24.00	
OTHER REIMBURSABLE COST CENTERS			1			
94.00 09400 HOME PROGRAM DI ALYSI S					C	
95. 00 09500 AMBULANCE SERVICES					C	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED					C	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD					0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC					0	
					0	
99.10 09910 CORF					0	99.10
100.00 10000 I & SERVI CES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY						101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM						102.00
SPECIAL PURPOSE COST CENTERS					(	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON					(	105.00
106. 00 10600 HEART ACQUI SI TI ON						106.00
107.00 10700 LIVER ACQUISITION						107.00
108.00 10800 LUNG ACQUI SI TI ON					C	108.00
109. 00 10900 PANCREAS ACQUI SI TI ON						109.00
110.00 11000 INTESTINAL ACQUISITION					C	110.00
111.00 11100 I SLET ACQUI SI TI ON					C	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )						115.00
116. 00 11600 HOSPI CE					C	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	C	0 0		0 0	5, 752, 564	118.00
NONREI MBURSABLE COST CENTERS			1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
191. 00 19100 RESEARCH						191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES						192.00
193.00 19300 NONPAID WORKERS						193.00
194.0007950 CMH						194.00
200.00 Cross Foot Adjustments				0 0		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)				0 0	5, 885, 121	201.00
202.00  TOTAL (sum lines 118 through 201)	l C	ין ט	1	U U	ວ, ຮຽວ, 121	1202. UU

LOCA	Financial Systems TION OF CAPITAL RELATED COSTS	ST ELI ZABETH	Provider CCN:	15-0086	Period: From 01/01/2023 To 12/31/2023	u of Form CMS- Worksheet B Part II Date/Time Pre	eparec
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			5/28/2024 1:5	<u>58 pm</u>
		25.00	26.00				
00	GENERAL SERVICE COST CENTERS	1					
5.00 5.00 7.00 8.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD						1 2 4 5 6 7 8 9 10 11 13 13 14 15 14 15 14 15 16 17 18 20 21 22
3.00	02300 PARAMED ED PRGM-(SPECIFY)						23.
	INPATIENT ROUTINE SERVICE COST CENTERS						
). 00	03000 ADULTS & PEDI ATRI CS	0	1, 381, 050				30.
. 00	03100 I NTENSI VE CARE UNI T	0	289, 307				31.
2.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0				32.
I. 00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0				34.
0. 00	04000 SUBPROVIDER - IPF	0	0				40.
. 00	04100 SUBPROVIDER - IRF	0	0				41.
8.00	04300 NURSERY	0	16, 841				43.
1.00	04400 SKILLED NURSING FACILITY	0	0				44.
5.00	04500 NURSING FACILITY	0	0				45.
6.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0				46.
). 00	05000 OPERATING ROOM	0	1, 480, 096				50.
. 00	05100 RECOVERY ROOM	0	0				51.
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	318, 181				52.
	05300 ANESTHESI OLOGY	0	14, 252				53.
. 00	05400 RADI OLOGY-DI AGNOSTI C	0	492, 694				54.
5.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55.
	05600 RADI OI SOTOPE	0	0				56.
	05700 CT SCAN	0	24, 618				57
. 00 . 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	32, 165				58
. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	46, 019 297, 697				60
	06001 BLOOD LABORATORY	0	297,097				60
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	Ŭ	0				61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o				62
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	o				63
	06400 I NTRAVENOUS THERAPY	0	0				64
	06500 RESPI RATORY THERAPY	0	90, 595				65
. 00	06600 PHYSI CAL THERAPY	0	292, 948				66
		0	29, 400				67
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		15, 325 107, 951				68. 69.
	07000 ELECTROCARDIOLOGI	0	1, 042				70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	86, 497				72
	07300 DRUGS CHARGED TO PATIENTS	0	337, 971				73.
	07400 RENAL DI ALYSI S	0	192				74.
	07500 ASC (NON-DI STI NCT PART)	0	0				75.
	07697 CARDI AC REHABI LI TATI ON	0	4, 518				76.
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.
. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0				78.
00	OUTPATIENT SERVICE COST CENTERS	0	0				88.
	08800 FEDERALLY QUALIFIED HEALTH CENTER	0	0				88.
). 00	09000 CLINIC	0	ő				90.
	09100 EMERGENCY	0	393, 205				91.

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-2552-
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0086	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared 5/28/2024 1:58 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	25.00	26.00			
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0				92.
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DI ALYSI S	0	0			94.
95. 00 09500 AMBULANCE SERVICES	0	0			95.
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			96.
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0			97.0
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			98.
99. 00 09900 CMHC	0	0			99. (
99. 10 09910 CORF	0	0			99.
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0			100.
101.00 10100 HOME HEALTH AGENCY	0	0			101.0
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0			102.
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0			105.0
106.00 10600 HEART ACQUI SI TI ON	0	0			106.
107. 00 10700 LI VER ACQUI SI TI ON	0	0			107. (
108.00 10800 LUNG ACQUISITION	0	0			108.0
109.00 10900 PANCREAS ACQUISITION	0	0			109.0
110.00 11000 INTESTINAL ACQUISITION	0	0			110.0
111.00 11100 I SLET ACQUI SI TI ON	0	0			111.0
113.00 11300 INTEREST EXPENSE					113.0
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.0
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0			115.0
116. 00 11600 HOSPI CE	0	0			116.0
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 752, 564			118.0
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58, 251			190. (
191. 00 19100 RESEARCH	0	0			191. (
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	53, 788			192.
193.00 19300 NONPALD WORKERS	0	0			193. (
194.0007950 СМН	0	20, 518			194. (
200.00 Cross Foot Adjustments	0	0			200.
201.00 Negative Cost Centers	0	0			201.0
202.00 TOTAL (sum lines 118 through 201)	0	5, 885, 121	1		202.

	Financial Systems LLOCATION - STATISTICAL BASIS	ST ELIZABET	H DEARBORN Provider CO	CN: 15-0086 F	In Lie Period:	u of Form CMS-: Worksheet B-1	
				F	rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
		CAPITAL RE	LATED COSTS			5/28/2024 1:5	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
4 00	GENERAL SERVICE COST CENTERS	004 700	1				1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	304, 729	304, 729				1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	50, 504					5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	97, 555				7, 154, 045 791, 772	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	36				438, 781	
9.00	00900 HOUSEKEEPI NG	1, 178					
10.00	01000 DI ETARY	4,000				421,045	
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	2,837	2,837	689, 328		1, 209, 094	11.00 12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 295	2, 295	-	-	1, 642, 696	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	, c	0 0	0	
	01500 PHARMACY	0	0	105 506	-	0	
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 234	-	,		1, 915, 875 791, 983	
	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0			0	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0 0	0	
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	
21.00 22.00	02100 I & SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM COSTS APPRVD		0			0	
23.00	02300 PARAMED ED PRGM-(SPECI FY)	0	-			-	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00.04/	00.044	4 070 000		( 100 704	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	39,846					
32.00	03200 CORONARY CARE UNIT	0		2, 211, 302		0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	C	0 0	0	
34.00 40.00	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	0	0		0	0	
40.00	04100 SUBPROVIDER - IRF				-	0	
43.00	04300 NURSERY	400	400	276, 549	0	390, 199	
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	-	-		0	
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0			-	
	ANCILLARY SERVICE COST CENTERS		-				1
50.00	05000 OPERATING ROOM	35, 211	35, 211	6, 379, 534			
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	9, 432				-	
53.00	05300 ANESTHESI OLOGY	0	0	41, 356			
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 559	14, 559				
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		-	0	
57.00	05700 CT SCAN	0	0	723, 249	-	1, 095, 733	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	803				397, 604	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 155				635, 808	
60.00	06001 BLOOD LABORATORY	6, 720	6, 720 0	1, 693, 266		4, 012, 706 0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	•
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY		0			0	
65.00	06500 RESPI RATORY THERAPY	1, 164	1, 164	1, 183, 979	0	1, 452, 749	1
66.00	06600 PHYSI CAL THERAPY	7, 564				2, 261, 272	66.00
67.00	06700 OCCUPATIONAL THERAPY	794				369, 994	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	424 3, 261				189, 689 601, 905	1
	07000 ELECTROENCEPHALOGRAPHY	0,201	0,201	5, 575		25, 063	1
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	1, 483	0 1, 483	1, 218, 103	-	6, 579, 846 4, 992, 842	
73.00	07400 RENAL DIALYSIS	1, 483	1, 483	9, 453		4, 992, 842	1
75.00	07500 ASC (NON-DISTINCT PART)	0	0	C	0 0	0	75.00
76.97	07697 CARDIAC REHABILITATION	0	0	139, 478		205, 399	
77.00 78.00	07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY		0			0	
	OUTPATIENT SERVICE COST CENTERS		-			- -	
88.00	08800 RURAL HEALTH CLINIC						
09.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	1 0	u 0	0	0 0	1 0	89.00

	Financial Systems LOCATION - STATISTICAL BASIS	ST ELI ZABETH	Provider CC	CN: 15-0086	Period:	u of Form CMS-2 Worksheet B-1	
001 /12				F	From 01/01/2023		
				T	Γο 12/31/2023	Date/Time Pre 5/28/2024 1:5	
		CAPITAL REL	ATED COSTS			572072024 1.5	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
0.00	09000 CLI NI C	0	0	(			90. (
1.00	09100 EMERGENCY	9, 684	9, 684	3, 088, 795	5 0	4, 458, 304	91. (
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. (
	OTHER REIMBURSABLE COST CENTERS						1
4.00	09400 HOME PROGRAM DI ALYSI S	0	0	(	0 0	0	94. (
	09500 AMBULANCE SERVICES	0	0	(	0 0	0	95. (
5.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(	0 0	0	96. (
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97. (
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
	09900 CMHC	0	0		0 0	0	
	09910 CORF	0	0		0 0	0	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0		100. (
	10100 HOME HEALTH AGENCY	0	0		-		101. (
	10200 OPI OI D TREATMENT PROGRAM	0	0	(	0 0	0	102. (
	SPECIAL PURPOSE COST CENTERS						105
	10500 KIDNEY ACQUISITION	0	0		-	-	105. ( 106. (
	10600 HEART ACQUI SI TI ON	0	0		-		106.0
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0	0				107.0
	10900 PANCREAS ACQUISITION	0	0				108.0
	11000 INTESTINAL ACQUISITION	0	0				1109. (
	11100 I SLET ACQUI SI TI ON	0	0	(			1111. (
	11300 INTEREST EXPENSE	0	0		0	0	113. (
	11400 UTI LI ZATI ON REVI EW-SNF						114. (
	11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0	(	0	0	115. (
	11600 HOSPICE	0	0		-		116. (
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	301, 131	301, 131	33, 973, 605	-16, 762, 775		
	VONREI MBURSABLE COST CENTERS	0017101	001,101	00, , , 0, 000	10//02///0	11,720,002	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 898	1, 898	21, 506	5 0	182, 940	190. (
	19100 RESEARCH	0	0				191. (
2.00	19200 PHYSICIANS' PRIVATE OFFICES	1, 700	1, 700	(	0 0	44, 602	192. (
3. 00	19300 NONPALD WORKERS	0	0	(	0 0	0	193. (
94.00	07950 CMH	0	0	(	0 0	0	194. (
00.00	Cross Foot Adjustments						200. (
01.00	Negative Cost Centers						201. (
02.00	Cost to be allocated (per Wkst. B, Part I)	1, 616, 194	3, 712, 663	-126, 368	3	16, 762, 775	202. (
3.00	Unit cost multiplier (Wkst. B, Part I)	5. 303709	12. 183491	0. 000000	D	0. 232959	203.
94.00	Cost to be allocated (per Wkst. B,			(		883, 174	
05.00	Part II) Unit cost multiplier (Wkst. B, Part			0. 000000	ס	0. 012274	205.
6. 00	II) NAHE adjustment amount to be allocated						206.
07.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. (
,,	Parts III and IV)						207.

	Financial Systems	ST ELI ZABETI		21 45 000 /		u of Form CMS-2	2552-10
CUST A	LLOCATION - STATISTICAL BASIS		Provider C	F	veriod: from 01/01/2023 fo 12/31/2023	Worksheet B-1 Date/Time Pre	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	5/28/2024 1:58 DI ETARY (MEALS SERVED)	
		6.00	7.00	LAUNDRY) 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.00 6.00 7.00 8.00 9.00	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAIRS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	156, 670 36 1, 592 1, 178	156, 634 1, 592	569, 628	153, 864		2.00 4.00 5.00 6.00 7.00 8.00 9.00
7.00 10.00	01000 DI ETARY	4,000				50, 647	10.00
11.00	01100 CAFETERI A	2, 837	2, 837	C		0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	Ŭ Ŭ	0	12.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	2, 295 0	2, 295 0			0	13.00 14.00
15.00	01500 PHARMACY	0	0			0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	C	0	0	16.00
17.00	01700 SOCIAL SERVICE	1, 234	1, 234	C	1, 234	0	17.00
18.00 19.00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	18.00 19.00
20.00	02000 NURSI NG PROGRAM	0	0		0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	C	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	C	-	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	C	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	39, 846	39, 846	119, 245	39, 846	20, 996	30.00
31.00	03100 I NTENSI VE CARE UNI T	7,400	7,400	30, 682	7, 400	2, 970	31.00
32.00	03200 CORONARY CARE UNIT	0	0	C	-	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF	0	0		0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	C	0	0	41.00
43.00	04300 NURSERY	400	400	C	400	0	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0	0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE	0	0		-	0	46.00
	ANCI LLARY SERVI CE COST CENTERS	1					
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	35, 211	35, 211	143, 746		15, 266 0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9,432	9, 432	25, 376	U U	1, 362	
53.00	05300 ANESTHESI OLOGY	0	0	C		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 559	14, 559	38, 706	14, 559	5	54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		0	0	55.00 56.00
57.00	05700 CT SCAN	0	0	12, 647	-	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	803				0	
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 155				36	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	6, 720	6, 720	100	6, 720 0	6	60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 164	Ű		1, 164	0	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	7, 564				0	66.00
67.00	06700 OCCUPATIONAL THERAPY	794				0	67.00
68.00		424				0	68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	3, 261 0	3, 261	1, 747 C	3, 261 0	0	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	c	o o	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 483	1, 483		1, 483	0	73.00 74.00
74.00	07500 ASC (NON-DI STI NCT PART)	0	0		0	0	74.00 75.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0 O	0	76. 97
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C	-	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	78.00
88.00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	c	0	0	
90.00		0	0	0	0	0	90.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 684	9, 684	119, 924	9, 684	1, 641	91.00 92.00
,2.00		1	I	1			, 2. 00

Health Financ	cial Systems	ST ELI ZABETH	+ DEARBORN		In Lie	eu of Form CMS-:	2552-10
	ION - STATISTICAL BASIS		Provider C	CN: 15-0086	Peri od:	Worksheet B-1	
					From 01/01/2023		
					To 12/31/2023		
	Cast Castas Description					5/28/2024 1:5	8 pm
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
		REPAI RS	PLANT	LINEN SERVIC (POUNDS OF	E (SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)				
		6.00	7.00	LAUNDRY) 8.00	9.00	10.00	
OTHER	REIMBURSABLE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
94.00 09400	HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95.00 09500	AMBULANCE SERVICES	0	0		0 0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
	DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
99.00 09900		0	0		0 0	0	
99.10 09910		0	0		0 0	0	
	I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	-	100.00
	HOME HEALTH AGENCY	0	0		0 0		101.00
	OPIOID TREATMENT PROGRAM	0	0		0 0		102.00
	L PURPOSE COST CENTERS	0	0	1	0 0	0	102.00
	KIDNEY ACQUISITION	0	0		0 0	0	105.00
	HEART ACQUI SI TI ON	0	0		0 0		106.00
	LI VER ACQUI SI TI ON	0			0 0		107.00
	LUNG ACQUISITION	0			0 0		108.00
	PANCREAS ACQUISITION	0			0 0		109.00
	INTESTINAL ACQUISITION	0	0		0 0		110.00
	I SLET ACQUI SI TI ON	0	0		0 0		111.00
	INTEREST EXPENSE	0	0		0	0	113.00
	UTI LI ZATI ON REVI EW-SNF						114.00
	AMBULATORY SURGICAL CENTER (D. P. )	0	0		0	0	115.00
116. 00 11600		0	0		0 0		116.00
		152.072	152.02(	E44.0			•
	SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	153, 072	153, 036	544, 84	150, 266	42, 282	118.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 898	1, 898		0 1, 898	0	190.00
190.0019000		1,070	1,090		0 1, 090		190.00
		1 700	1 700	24.70	0 0		
	PHYSI CLANS' PRI VATE OFFI CES	1,700	1, 700	24, 78			192.00
	NONPAID WORKERS	0	0		0 0		193.00
194.0007950		0	0		0 0	8, 305	194.00
	Cross Foot Adjustments						200.00
	Negative Cost Centers	0.000 / / /	070 040	( 10 5	0 757 404	050.004	201.00
	Cost to be allocated (per Wkst. B,	8, 820, 644	978, 249	640, 57	2, 757, 424	850, 281	202.00
	Part I)	F( 20070F	( )45445	1 1045	17 001177	1/ 700070	202.00
	Unit cost multiplier (Wkst. B, Part I)	56. 300785	6. 245445				
	Cost to be allocated (per Wkst. B, Part [])	1, 802, 362	10, 762	70, 72	68, 991	124, 228	204.00
205.00	Unit cost multiplier (Wkst. B, Part	11. 504194	0. 068708	0. 12415	0. 448389	2. 452821	205. 00
	<pre>II) NAME adjustment amount to be allocated</pre>						206.00
	NAHE adjustment amount to be allocated (per Wkst. B-2)						200.00
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
	raits i i allu i V)	1	l	I	ļ	I	I

COST A	Financial Systems ALLOCATION - STATISTICAL BASIS	ST ELI ZABETH			Peri od:	u of Form CMS- Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	
	Cast Conton Deceninti en	CAFETERI A	MAINTENANCE OF		_	5/28/2024 1:5	
	Cost Center Description	(FTES)	PERSONNEL	NURSING ADMINISTRATIO	CENTRAL N SERVICES &	PHARMACY (COSTED	
			(NUMBER		SUPPLY	REQUIS.)	
			HOUSED)	(NURSING FTES	) (COSTED REQUIS.)		
		11.00	12.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS	I	Γ	1			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
5.00	00600 MAINTENANCE & REPAIRS						6.00
7.00 3.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00 9.00	00900 HOUSEKEEPING						9.0
0.00	01000 DI ETARY						10.0
1.00	01100 CAFETERI A	331					11.0
2.00 3.00	01200 MAINTENANCE OF PERSONNEL	0		15	0		12.0
4.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	8			3 0 0		14.0
5.00	01500 PHARMACY	0	C		0 0	0	15.0
6.00	01600 MEDICAL RECORDS & LIBRARY	3	C		0 0	0	16.0
7.00	01700 SOCIAL SERVICE	4	C		3 0	0	17.0
18.00 19.00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0				0	18.0
20.00		0			0 0	0	20.0
21.00	02100 I & R SERVICES-SALARY & FRINGES APPRVD	0	C		0 0	0	21.0
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	C		0 0	0	22.0
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	C		0 0	0	23.0
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	47	C	3	5 0	0	30.0
31.00	03100 I NTENSI VE CARE UNI T	22				0	31.0
32.00	03200 CORONARY CARE UNI T	0	C		0 0	0	32.0
33.00	03300 BURN INTENSIVE CARE UNIT	0	C		0 0	0	33.00
34.00 10.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0			0 0	0	34. 0 40. 0
1. 00	04100 SUBPROVIDER - IRF	0			0 0	0	40.00
13.00	04300 NURSERY	0	C		0 0	0	43.00
4.00	04400 SKILLED NURSING FACILITY	0	C		0 0	0	44.00
15.00 16.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0			0 0 0 0	0	45.00
+0. 00	ANCI LLARY SERVICE COST CENTERS	0		/	0 0	0	40.00
50.00	05000 OPERATI NG ROOM	72	C	5	0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	C		0 0	0	51.0
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	16		1		0	52.0 53.0
54.00		30			0 0	0	
55.00		0	C		0 0	0	55.00
	05600 RADI OI SOTOPE	0	C		0 0	0	56.0
	05700 CT SCAN	7	C		0 0	0	57.0
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	3			2 0	0	58.0 59.0
0.00		25			0 0	0	60.0
60. 01	06001 BLOOD LABORATORY	0	c		0 0	0	60.0
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.0
2.00 3.00		0			0 0	0	62.0 63.0
	06400 I NTRAVENOUS THERAPY	0			0 0	0	64.0
	06500 RESPI RATORY THERAPY	12	C		0 0	0	65.0
	06600 PHYSI CAL THERAPY	21	C		0 0	0	66.0
57.00 58.00	06700 OCCUPATI ONAL THERAPY	3			0 0	0	67.0 68.0
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	5			3 0	0	69.0
	07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.0
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	13				0	73.0
	07500 ASC (NON-DI STI NCT PART)	0			o 0	0	75.0
	07697 CARDI AC REHABI LI TATI ON	2	c		2 0	0	76.9
7.00	07700 ALLOGENEIC STEM CELL ACQUI SI TI ON	0	C		0 0	0	77.0
8.00		0	C		0 0	0	78.0
38, 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	C		0 0	0	88.0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
	09000 CLI NI C	0	C		0 0	0	1
	09100 EMERGENCY	32		2	5 0	0	91.0

Health Financial Systems	ST ELI ZABETH	H DEARBORN		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				From 01/01/2023	Data (Time Dres	
				To 12/31/2023	Date/Time Pre 5/28/2024 1:5	
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
	(FTES)	PERSONNEL	ADMI NI STRATI O		(COSTED	
		(NUMBER		SUPPLY	REQUIS.)	
		HOUSED)	(NURSING FTES	) (COSTED	,	
				REQUIS.)		
	11.00	12.00	13.00	14.00	15.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS			1			
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	
95. 00 09500 AMBULANCE SERVI CES	0	0		0 0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99.00 09900 CMHC	0	0		0 0	0	
99. 10 09910 CORF	0	0		0 0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	_	_			_	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 H0SPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	331	0	15	3 0	0	118.00
NONREI MBURSABLE COST CENTERS	0	0	1		0	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0 0 0		190.00 191.00
191. 00 19100 RESEARCH	0	0				
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS	0	0		0 0		192.00 193.00
193. 00 19300 NONPAT D WORKERS 194. 00 07950 CMH	0	0		0 0		193.00
200.00 Cross Foot Adjustments	0	0		0 0	0	200.00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	1, 719, 048	o	2, 251, 59	7 0	0	201.00
Part 1)	1, /19, 040	0	2,201,09	/	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	5, 193. 498489	0. 000000	14, 716. 32026	1 0. 000000	0. 000000	203 00
204.00 Cost to be allocated (per Wkst. B,	98, 556	0.000000				204.00
Part II)	,0,000	0	,0,20	0	0	201.00
205.00 Unit cost multiplier (Wkst. B, Part	297. 752266	0. 000000	589.97385	6 0.000000	0. 000000	205.00
	, 02200	2.00000		3.000000		
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)						

	Financial Systems LLOCATION - STATISTICAL BASIS	ST ELIZABET			Period:	u of Form CMS- Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 1:5	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (ADJUSTED CHARGES)	SOCI AL SERVI CE (TI ME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	NURSI NG PROGRAM (ASSI GNED TI ME)	
		16.00	17.00	18.00	19.00	20.00	
13.00 14.00 15.00 16.00 17.00 18.00 19.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 0000 DUECNAC	280, 077, 347 C	, , , , , , , , , , , , , ,		0 0 0 0		$\begin{array}{c} 1.00\\ 2.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 20.00\\ \end{array}$
21. 00 22. 00	02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS		-		0 0 0 0	C	20. 00 21. 00 22. 00 23. 00
30.00	03000 ADULTS & PEDIATRICS	28, 069, 458			0 0	C	
32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	15, 258, 912 C C C 953, 960 C C C C C C C	0 0 0 0 0 0 0 0 0 0 0 26 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		32.00         33.00         34.00         40.00         41.00         43.00         44.00         45.00
50.00	05000 OPERATI NG ROOM	74, 899, 805	2,069		0 0	C	50.00
51.00 52.00 53.00 54.00 55.00 56.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN	3, 840, 997 3, 441, 680 33, 562, 932 0 12, 863, 704	0 0 7 106 95 2 927 0 0 0 0			( c	51.00         52.00         53.00         54.00         55.00         55.00         56.00
58. 00 59. 00 60. 00 60. 01	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	3, 746, 814 5, 212, 868 7, 865, 156	104 3 144				58.00         59.00         60.00         60.01         61.00         62.00
66.00 67.00 68.00 69.00 70.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 966, 706 8, 095, 733 1, 203, 949 628, 854 3, 268, 486 79, 130	3 224 9 33 4 17 9 90		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		65.00         66.00         67.00         68.00         69.00         70.00
72.00 73.00 74.00 75.00 76.97 77.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	21, 715, 83 16, 235, 683 114, 237 0 849, 498 0 0	3 449 7 3 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		<ul> <li>72.00</li> <li>73.00</li> <li>74.00</li> <li>75.00</li> <li>76.97</li> <li>77.00</li> </ul>
88. 00 89. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	C C			0 0 0 0		) 88.00 89.00

Health Financial Syste		ST ELI ZABET				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0086			Period: From 01/01/2023	Worksheet B-1	
					To 12/31/2023	Date/Time Pre	epared:
						5/28/2024 1:5	
				OTHER GENERAL	-		
		MEDLOAL		SERVI CE			
Cost Center Description		MEDICAL RECORDS &	SOCI AL SERVI CE	(SPECIFY) (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
		LIBRARY	(TIME SPENT)	(ITME SPENT)	(ASSI GNED	(ASSI GNED	
		(ADJUSTED			TI ME)	TIME)	
		CHARGES)					
		16.00	17.00	18.00	19.00	20.00	
90.00 09000 CLINIC		0	0 0		0 0	0	
91.00 09100 EMERGENCY		35, 202, 947	973		0 0	0	
	ON BEDS (NON-DI STI NCT PART)						92.00
94.00 09400 HOME PROG	BLE COST CENTERS	0			0 0	0	94.00
95. 00 09500 AMBULANCE					0 0	0	
	EDICAL EQUIP-RENTED	0			0 0	0	
	EDI CAL EQUI P-SOLD	0	o o		0 0	0	
	MBURSABLE COST CENTERS	0	0		0 0	0	98.00
99. 00 09900 CMHC		0	0	)	0 0	0	99.00
99. 10 09910 CORF		0	0		0 0	0	
100.00 10000 I &R SERVI (		0	0		0 0		100.00
101.00 10100 HOME HEAL		0	0		0 0		101.00
102.00 10200 OPI OI D TR		0	0 0		0 0	0	102.00
SPECIAL PURPOSE 105.00 10500 KI DNEY ACC						0	105 00
105.00 10500 KIDNEY ACC 106.00 10600 HEART ACQ		0			0 0 0 0		105.00
107.00 10700 LIVER ACQ					0 0		107.00
108.00 10800 LUNG ACQU		0			0 0		107.00
109.00 10900 PANCREAS		0	o o		0 0		109.00
110.00 11000 I NTESTI NAI		0	0		0 0	0	110.00
111.00 11100 I SLET ACQ		0	0		0 0	0	111.00
113.00 11300 INTEREST I							113.00
114.00 11400 UTI LI ZATI (							114.00
	Y SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE					0		116.00
118.00 SUBTOTALS NONREI MBURSABLE	(SUM OF LINES 1 through 117)	280, 077, 347	7,657		0 0	0	118.00
	WER, COFFEE SHOP & CANTEEN	0			0 0	0	190.00
191. 00 19100 RESEARCH	ier, corree shor a chirteen	0			0 0		191.00
192.00 19200 PHYSI CI ANS	S' PRIVATE OFFICES	0	0		0 0		192.00
193.00 19300 NONPALD W	DRKERS	0	0 0		0 0	0	193.00
194.0007950CMH		0	0		0 0	0	194.00
	t Adjustments						200.00
	Cost Centers					_	201.00
	e allocated (per Wkst. B,	2, 377, 775	1, 140, 703		0 0	0	202.00
203.00 Part I) 203.00 Unit cost	multiplier (Wkst. B, Part I)	0. 008490	148. 975186	0. 00000	0.00000	0. 000000	203 00
	e allocated (per Wkst. B, Part r)	24, 408			0 0.000000		203.00
Part II)		21,400					
	multiplier (Wkst. B, Part	0. 000087	6. 411780	0.00000	0.00000	0. 000000	205.00
1)							
	stment amount to be allocated					0	206. 00
(per Wkst.						0,000000	207 00
207.00 NAHE unit Parts III	cost multiplier (Wkst. D, and LV)					0. 000000	207.00
		ļ	1	I	1	I	1

ST /	1 Financial Systems ALLOCATION - STATISTICAL BASIS	ST ELI ZABETH	Provider CC	CN: 15-0086	Peri od:	u of Form CMS Worksheet B-	
					From 01/01/2023 To 12/31/2023	Date/Time Pr	
		INTERNS &	RESIDENTS			5/28/2024 1:	58 pn
Cost Center Description		Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM			
		(ASSI GNED	(ASSI GNED	(ASSI GNED			
		TIME)	TIME)	TIME)			
		21.00	22.00	23.00			
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 1
00	00200 CAP REL COSTS-BEDG & FIXT						2
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4
00	00500 ADMI NI STRATI VE & GENERAL						5
00	00600 MAI NTENANCE & REPAI RS						6
00	00700 OPERATION OF PLANT						7
00	00800 LAUNDRY & LINEN SERVICE						8
00	00900 HOUSEKEEPING						9
00 00	01000 DI ETARY 01100 CAFETERI A						10
00	01200 MAINTENANCE OF PERSONNEL						12
00							13
00							14
	01500 PHARMACY						15
00							16
00							17
00							18
00							20
00		0					21
00			0				22
00					0		23
	INPATIENT ROUTINE SERVICE COST CENTERS	-					
00		0	0		0		30
00 00		0	0		0		31
00	03300 BURN I NTENSI VE CARE UNI T	0	0		0		33
00		0	0		0		34
00	04000 SUBPROVI DER – I PF	0	0		0		40
00		0	0		0		41
00		0	0		0		43
00 00		0	0		0		44
00		0	0		0		40
00	ANCI LLARY SERVICE COST CENTERS						
00	05000 OPERATING ROOM	0	0		0		50
00		0	0		0		51
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52
	05300 ANESTHESI OLOGY	0	0		0		53
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0		0		55
00		0	0		0		56
00		0	o		0		57
00		0	0		0		58
00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59
00		0	0		0		60
01 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		U		60
00		0	0		0		62
00		0	0		õ		63
00		0	0		0		64
00		0	0		0		65
00		0	0		0		66
00		0	0		0		67
			0		0		68
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		0		0		69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	n 0	0		õ		71
00		0	0		0		72
	07300 DRUGS CHARGED TO PATIENTS	0	0		0		73
00		0	0		0		74
	07500 ASC (NON-DI STI NCT PART)	0	0		0		75
	07697 CARDIAC REHABILITATION	0	0		0		76
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0		77
00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATI ENT SERVICE COST CENTERS	0	0		V		78
00	08800 RURAL HEALTH CLINIC	0	0		0		88
00		0	0		0		89
	09000 CLI NI C	0	0		0		90

lealth Financial Systems		ST ELI ZABETH				u of Form CMS-25	52-
COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 15-008		Period: From 01/01/2023	Worksheet B-1	
					To 12/31/2023	Date/Time Prepa 5/28/2024 1:58	
		INTERNS &	RESI DENTS				
Cost Center Descripti	on	SERVI CES-SALAR		PARAMED ED			
COST CENTER DESCRIPTION		Y & FRINGES	PRGM COSTS	PRGM			
		(ASSI GNED	(ASSI GNED	(ASSI GNED			
		TIME)	TIME)	TIME)			
		21.00	22.00	23.00			
91.00 09100 EMERGENCY		0	0		0	ç	91. (
92.00 09200 OBSERVATION BEDS (NOM	I-DISTINCT PART)					Ģ	92.0
OTHER REIMBURSABLE COST CEI							
94.00 09400 HOME PROGRAM DIALYSIS	5	0	0		0		94. (
95.00 09500 AMBULANCE SERVICES		0	0		0		95. (
96.00 09600 DURABLE MEDICAL EQUIF	P-RENTED	0	0		0	Q	96. (
97.00 09700 DURABLE MEDICAL EQUIF		0	0		0	Q	97. (
98.00 09850 OTHER REIMBURSABLE CO	OST CENTERS	0	0		0		98.
99. 00 09900 CMHC		0	0		0	Ģ	99.
99. 10 09910 CORF		0	0		0	(	99.
100.00 10000 I&R SERVICES-NOT APPF	RVD PRGM	0	0		0	10	00.
101.00 10100 HOME HEALTH AGENCY		0	0		0	10	01.0
02.00 10200 OPI OI D TREATMENT PROC	GRAM	0	0		0	10	02.
SPECIAL PURPOSE COST CENTER	RS						
105.00 10500 KIDNEY ACQUISITION		0	0		0	1(	05. (
106.00 10600 HEART ACQUI SI TI ON		0	0		0	10	06.
107.00 10700 LIVER ACQUISITION		0	0		0	10	07.
108.00 10800 LUNG ACQUISITION		O	0		0	10	08.
09.00 10900 PANCREAS ACQUISITION		o	0		0	10	09.
110.00 11000 INTESTINAL ACQUISITIC	DN	o	0		0	11	10.
111.00 11100 I SLET ACQUI SI TI ON		o	0		0	11	11.
113.00 11300 INTEREST EXPENSE						11	13. (
114.00 11400 UTILIZATION REVIEW-SM	IF					11	14.
115.00 11500 AMBULATORY SURGICAL (	ENTER (D. P.)	O	0		0	11	15.
116. 00 11600 HOSPI CE					0	11	16. (
118.00 SUBTOTALS (SUM OF LIN	IES 1 through 117)	0	0		0	1.	18. (
NONREI MBURSABLE COST CENTER	रऽ						
90.00 19000 GIFT, FLOWER, COFFEE	SHOP & CANTEEN	0	0		0	19	90. (
91. 00 19100 RESEARCH		0	0		0	19	91. (
92. 00 19200 PHYSI CI ANS' PRI VATE (	OFFI CES	0	0		0	19	92.
93.00 19300 NONPALD WORKERS		0	0		0	19	93.
94.0007950 CMH		0	0		0	19	94.
200.00 Cross Foot Adjustment	S					20	00.
201.00 Negative Cost Centers	5					20	01.
202.00 Cost to be allocated	(per Wkst. B,	0	0		0	20	02.
Part I)							
203.00 Unit cost multiplier		0. 000000	0. 000000	0.0000	00	20	03.
Cost to be allocated	(per Wkst. B,	0	0		0	20	04.
Part II)							
205.00 Unit cost multiplier	(Wkst. B, Part	0. 000000	0. 000000	0.0000	00	20	05.
)							
206.00 NAHE adjustment amour	nt to be allocated				0	20	06.
(per Wkst. B-2)							
207.00 NAHE unit cost multip	olier (Wkst. D,			0.0000	00	20	207. (
Parts III and IV)							

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	ST ELI ZABETI	H DEARBORN Provider C		In Lie Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet C Part I Date/Time Pre 5/28/2024 1:5	pared:
		1	Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	12, 720, 481		12, 720, 48	1 0	12, 720, 481	30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 123, 436		5, 123, 43		5, 123, 436	31.00
32.00	03200 CORONARY CARE UNI T	0			0 0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0			0 0	0	33.00
34.00 40.00	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	0				0	34.00 40.00
41.00	04100 SUBPROVI DER – I RF	0			0 0	0	41.00
43.00	04300 NURSERY	525, 257		525, 25	7 0	525, 257	43.00
44.00	04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0			0 0 0 0	0	45.00 46.00
40.00	ANCI LLARY SERVICE COST CENTERS	0	1		0 0	0	40.00
50.00	05000 OPERATING ROOM	20, 170, 430		20, 170, 43	0 0	20, 170, 430	50.00
51.00	05100 RECOVERY ROOM	0			0 0	0	51.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	3, 034, 659 1, 359, 104		3, 034, 65 1, 359, 10		3, 034, 659 1, 359, 104	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 858, 922		5, 858, 92		5, 858, 922	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0			0 0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 563, 669		1, 563, 66		1, 563, 669	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	633, 160 996, 076		633, 16 996, 07		633, 160 996, 076	
60.00	06000 LABORATORY	5, 717, 395		5, 717, 39		5, 717, 395	60.00
60. 01	06001 BLOOD LABORATORY	0			0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0			0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	1, 984, 569				1, 984, 569	
66.00	06600 PHYSI CAL THERAPY	3, 637, 524		3, 637, 52		3, 637, 524	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	552, 775		552, 77 281, 26		552, 775 281, 268	
69.00	06900 ELECTROCARDI OLOGY	1, 117, 766		1, 117, 76		1, 117, 766	
70.00	07000 ELECTROENCEPHALOGRAPHY	31, 872		31, 87	2 0	31, 872	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	8, 386, 432 6, 547, 548		8, 386, 43 6, 547, 54		8, 386, 432 6, 547, 548	
	07400 RENAL DI ALYSI S	17, 787		17, 78		17, 787	
	07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
	07697 CARDI AC REHABI LI TATI ON	303, 707		303, 70		303, 707	
77.00 78.00	07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0			0 0 0 0	0	77.00 78.00
70.00	OUTPATIENT SERVICE COST CENTERS				0 0	0	/0.00
88.00	08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	7, 416, 489		7, 416, 48	9 0	0 7, 416, 489	90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 589, 649		2, 589, 64		2, 589, 649	
	OTHER REIMBURSABLE COST CENTERS		1	1			
94.00 95.00	09400 HOME PROGRAM DI ALYSI S	0			0 0	0	94.00 95.00
95.00 96.00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED				0 0	0	95.00 96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	98.00
	09900 CMHC 09910 CORF	0			0	0	99.00 99.10
	10000 I &R SERVICES-NOT APPRVD PRGM				0	0	100.00
	10100 HOME HEALTH AGENCY	0			0		101.00
	10200 OPI OI D TREATMENT PROGRAM	0			0		102.00
105 00	SPECIAL PURPOSE COST CENTERS		1		0	0	105 00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0			0		105.00 106.00
	10700 LIVER ACQUISITION	0			0		107.00
	10800 LUNG ACQUISITION	0			0		108.00
	10900 PANCREAS ACQUISITION	0			0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION				0		110. 00 111. 00
	11300 I NTEREST EXPENSE					0	113.00
114.00	11400 UTI LI ZATI ON REVI EW-SNF						114.00

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2023 To 12/31/2023		pared:
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0	0	115.00
116. 00 11600 HOSPI CE	0			0	0	116.00
200.00 Subtotal (see instructions)	90, 569, 975	0	90, 569, 97	5 0	90, 569, 975	200.00
201.00 Less Observation Beds	2, 589, 649		2, 589, 64	9	2, 589, 649	201.00
202.00 Total (see instructions)	87, 980, 326	0	87, 980, 32	6 0	87, 980, 326	202.00

Liste XVIII         Hege/tail         Providence           Cool Cantor Boscription         Input init         Mulphi entiterit         Scient Charges         Cool Cantor Boscription         Trepstient           Notation         6.00         7.00         8.00         9.00         Scient Charges         Input init         Scient Charges         Input init         Scient Charges         Input init         Scient Charges         Input init         Input init         Scient Charges         Input init         Scient Charges         Input init         Input init         Scient Charges         Input init         Input init         Scient Charges         Input init         Input init<	Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	ST ELI ZABETH		CN: 15-0086	In Lie Period: From 01/01/2023 To 12/31/2023	wof Form CMS- Worksheet C Part I Date/Time Pre 5/28/2024 1:5	pared:
Cost Conter Description         Input ent 0.00         Output ent 0.00         Output ent 0.00         Output ent 0.00         Field of 0.00         Either 10.00           INPUT PAT BOUT NE SERVICE COST DENTERS         22,085,085         12,285,085         12,285,085         30.00 <t< td=""><td></td><td></td><td></td><td>e XVIII</td><td>Hospi tal</td><td>PPS</td><td></td></t<>				e XVIII	Hospi tal	PPS	
INVELTM         ROUTING SIGNACE COST CINTES         Z2, UBB, 997         Z2, UBB, 993         Z2, UBB, 993 <thz2, 993<="" th="" ubb,="">         Z2, UBB, 993         <thz2, td="" u<=""><td>Cost Center Description</td><td>I npati ent</td><td><u>v</u></td><td></td><td></td><td>Inpati ent</td><td></td></thz2,></thz2,>	Cost Center Description	I npati ent	<u>v</u>			Inpati ent	
30.00         40.00         40.000         40.000         40.0000         40.000         40.0000         40.000         40.0000         40.000         40.000         40.000         40.0000         40.000         40.000		6.00	7.00	8.00	9.00		
10.00         Dottol INTERNIVE CARE UNIT         15.258,912         15.258,912         31.00         32.00         42.00							
31.00         CONTRACT         CONTRACT         0         32.00         CONTRACT         32.00         CONTRACT         33.00         30.00         50.00							
31.00       03300       03000       03000       03000       03000       03000       03000       030000       0300000       0300000       0300000       0300000       03000000       03000000       03000000       03000000       03000000       03000000       03000000       030000000       030000000       0300000000       03000000000       0300000000000000000000000       0300000000000000000000000000000000000		15, 258, 912		15, 258, 9	2		
14.00         DORADO SURRELCAL INTENT VICATIONIT         0         0         44.00         0         44.00		0			0		
11.00         Delthol SuBPROVIDER - I RF         0 <th< td=""><td>34.00 03400 SURGICAL INTENSIVE CARE UNIT</td><td>0</td><td></td><td></td><td>0</td><td></td><td>34.00</td></th<>	34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0		34.00
41.00         00 4000         NURSERY         953,960         953,960         43.00           43.00         04000         NURSERF LED WESH GE ACLLETY         0         0         0         44.00           44.00         04000         NURSERF LED WESH GE ACLLETY         0         0         0         0         0         44.00           45.00         MARCLED WESH NG FACLLETY         0         0         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         51.00         0         0.000000         51.00         0         0.000000         51.00         0         0.000000         51.00         0         0.000000         51.00         0         0.000000         51.00         0.000000         51.00         0.000000         51.00         0.00000         51.00         0.000000         51.00         0.000000         51.00         0.000000         51.00         0.000000         51.00         0.000000         51.00         0.000000         51.00		0			0		
44. 00         0.4000         SKILLED. NURSING FACILITY         0         0         44. 00           46. 00         JOSCONESING FACILITY         0         0         0         45. 00         46.		953 960		953.96	0		
41. 00         04000         04000         04000         04000         0         45. 00           00         04000         04000         0         0         0         000000         0         0         000000         0         0         000000         0         0         000000         0		0		/////			
ACT LLARY SERVICE COST CENTERS	45.00 04500 NURSING FACILITY	0			0		•
50. 00         05000         0FERATING ROOM         20. 826, 474         54, 073, 331         74, 899, 805         0. 2000000         51. 00           52. 00         05200         0FELVICER ROOM         3, 606, 495         222, 502         3, 841, 480         0. 394896         0. 000000         52. 00           52. 00         05200         DELUICER ROOM         4, 992, 774         172, 744, 223         3, 841, 480         0. 394896         0. 000000         52. 00           51. 00         05700         05700         077, 417         222, 502         3, 841, 480         0. 394896         0. 000000         51. 00           50. 00         05700         007700         T174, 697, 820, 837         12, 863, 744         54. 073, 834, 748         54. 073, 834, 748         54. 073, 934, 744         54. 073, 934, 744         54. 073, 934, 744         54. 073, 934, 744         54. 074, 934, 934, 934, 934, 934, 934, 934, 93		0			0		46.00
51.00         05100         DECOVERY ROOM         3.000         0         0         0         0.000000         0.000000         51.00           53.00         05300         ANESTHESI LOGY         677,417         2.764,243         3.441,600         0.000000         53.00         0.000000         55.00         0.000000         50.00         0.000000         50.00         0.000000         50.00         0.000000         50.00         0.000000         60.0000000         60.00         0.000000		20 826 474	54 073 331	7/ 800 80	0 260200	0,00000	50.00
52.00         05200         DELU VERY ROOM & LABOR ROOM         3, 608,495         222,502         3, 840,995         0. 790071         0. 5000000         52,000           54.00         05400         RAD GLOCY - M ARMOSTIC         4,992,735         28,570,197         33,552,922         0. 174556         0. 000000         56,000         0. 000000         56,000         0. 000000         0. 000000         56,000         0. 000000         56,000         0. 000000         0. 000000         56,000         56,00         0. 000000         0. 000000         56,000         56,00         0. 000000         56,00         0. 000000         56,000         56,00         0. 000000         56,00         56,00         0. 000000         56,00         56,00         0. 000000         56,00         56,00         0. 000000         56,00							
54.00         05400         RADI OLOY-DEADNETIC         4,992,735         28,570,197         33,562,932         0.174565         0.000000         55.00           55.00         05500         05600         RADI OLOY-DEADNETIT         0         0         0.000000         55.00           56.00         05600         RADI OLOY-DEADNETIT         0         0         0.000000         55.00         0.000000         65.00         0.000000         65.00         0.000000         65.00         0.0000000         0.0000000         65.0		3, 608, 495	232, 502	3, 840, 99			
55. 00         00         00         0         0.0000000         0.0000000         55. 00           55. 00         05600         057. 00         05700         05700         00         0000000         55. 00           55. 00         05600         05700         05700         00         0000000         55. 00         0000000         55. 00           59. 00         05900         CARDIAC CATHETRE ZATION         1.447, 732         3.565, 136         5.712, 663. TS         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         0.000000         60. 00         60. 00         0.000000         60. 00         60. 00         60. 00         60. 00         60. 00         0.000000         0.000000         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
56. 00         05600         06401         05700         05700         05700         05700         05700         0570000         057000         0570000         057000         0570000         0570000         057000         0570000         0570000         0570000         0570000         0570000         0570000         0570000         0570000         0570000         0570000         0570000000         0570000000         05700000000         0570000000000         05700000000000000000000000000000000000		_	_				
57.00         05700 CT SCAN         3,042,667         9,820,837         12.868,704         0.121557         0.000000         57.00           59.00         05600 CARDA C CATHETERI XATI NN         1,647,732         3,566,136         5,724,68         0.1191860         0.000000         57.00           00.00         05000 CARDA C CATHETERI XATI NN         1,647,732         3,566,136         5,724,868         0.1191860         0.000000         66.00           00.00         05200 MHOLE BLOOD LABORATORY         0         0         0         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000         66.00		0					
59.00         05900 CARDIAC CATHETERIZATION         1, 647, 732         33, 566, 136         52, 22, 668         0.0100000         0500         0.000000         60.01           06.00         106001         BLODD LABORATORY         3, 828, 828         4, 033, 328, 828         7, 865, 156         0, 26000         0.000000         60.01           06.01         BLODD LABORATORY         3, 828, 828         4, 034, 328         7, 865, 156         0, 000000         0.000000         60.00           06.00         BLODD LABORATORY         0         0         0         0.000000         61.00           06.00         BLODD LABORATORY         0         0         0         0.000000         61.00           06.200         BLODD REP CLINICAL LAS SERVICES-PREB         0         0         0.000000         63.00           06.400         INTRAVENUIS THERAPY         757, 187         2, 005, 733         0.449314         0.000000         66.00           06.600         PHYSICAL THERAPY         240, 678         420, 176         3.288, 864         0.447271         0.000000         66.00           00         006000         DECITROCARDIOLOGY         208, 678         4.20, 176         3.286, 864         0.447271         0.000000         60.00         0.000000		3, 042, 867					
60.00         6000 LABORATORY         3, 828, 828         4, 036, 328         7, 865, 156         0, 724922         0, 000000         60.00           0.10         0610 PBP CLINICAL LAB SERVICES-PRGN 0NLY         0         0         0, 000000         60.00         0, 000000         60.00         0, 000000         60.00         60.00         60.00         0, 000000         60.00         66.00         60.00         67.00         60.00         60.00         60.00         60.00	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	360, 386	3, 386, 428	3, 746, 81	4 0. 168986	0. 000000	58.00
60.01         6001         6001         6001         6001         6001         60000         0.0000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000							
61.00         61000         PEP CLINICAL LAB SERVICES-PREM ONLY         0         0         0.0000000         0.0000000 <td></td> <td>3, 828, 828</td> <td>4, 036, 328</td> <td>7, 865, 15</td> <td></td> <td></td> <td></td>		3, 828, 828	4, 036, 328	7, 865, 15			
62:00         00         00:000000         0.0000000         0.		0	0				
64.00         06400         INTRAVENUIS THERAPY         0         0         0         0.000000         64.00         0.000000         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         66.00         67.00		0	C				
65:00         06500         PHSTCAL THERAPY         757, 187         2, 209, 570         0.068947         0.000000         65:00           66:00         06600         PHSTCAL THERAPY         840, 474         7, 255, 259         8, 695, 733         0.0449314         0.000000         66:00           66:00         06600         SPECH PATHOLOGY         208, 678         420, 176         628, 854         0.447271         0.000000         66:00         66:00           69:00         06900         ELECTROCARDIOLOGY         813, 378         2,455, 108         3,268, 486         0.41993         0.000000         67:00           00         07100         IELCTROCARDIOLACSY         813, 378         2,455, 108         3,268, 486         0.41993         0.000000         70:00         0.000000         70:00         0.000000         70:00         0.000000         70:00         0.000000         70:00         0.000000         72:00         72:00         72:00         72:00         72:00         72:00         73:00         0.16:67         11:657         11:4:237         0.000000         72:00         72:00         72:00         72:00         0.000000         72:00         72:00         72:00         72:00         72:00         0.0000000         72:00         72:00		0	C				
66. 00         066.00         PH/ST CAL THERAPY         B4.0., 474         7, 255, 298         8, 095, 733         0. 449314         0. 000000         66. 00           67. 00         67.00 <td></td> <td>0</td> <td>0 000 540</td> <td></td> <td></td> <td></td> <td></td>		0	0 000 540				
67. 00         06700         0CUPATIONAL THERAPY         449, 800         754, 149         1, 203, 949         0. 459135         0.000000         67. 00           69. 00         06600         LECTRPCARDIOLOGY         B13, 378         2, 455, 107         628, 854         0. 447271         0.0007000         67.00         70.00         70.00         70.00         0.000200         0.000200         70.00         70.00         70.00         0.0002000         70.00							
68. 00         068.00         568.00         578         420.176         6.28,854         0447271         0000000         66. 00           69.00         06900         CECTROENCEPHALOGRAPHY         5,652         73.478         79.130         0402780         0000000         70.00           71.00         OTION MEDICAL SUPPLIES CHARGED TO PATIENTS         0         0         0         0.0000000         0.0000000         70.00           73.00         OT300 INUES CHARGED TO PATIENTS         6.026,487         10,299,186         1.423,68,48         0386190         0.0000000         72.00           73.00         OT300 ONES CHARGED TO PATIENTS         6.026,487         10,299,186         11,657         114,237         0155703         0.000000         76.00000           76.00         OT400 RENAL DIALYSIS         TOAT         0         0         0.0000000         0.000000         76.00000         76.00           76.00         OT607 CARDIAC REHABILITATION         1.653         847,845         849,498         0.357513         0.000000         70.00000           77.00         OT760 CAR T-CELL IMMUNOTHERAPY         0         0         0         0.000000         0.000000         70.0000           89.00         08900 FEDERALLY CLL INCE <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>							
70.00       07000       [ClECROENCEPHALLOGRAPHY       5, 652       73, 478       79, 130       0.402780       0.000000       70.00         71.00       07100       MEDI CAL SURVEIES CHARGED TO PATIENTS       4, 809, 986       16, 905, 852       21, 715, 838       0.386190       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       6, 026, 487       10, 209, 196       16, 235, 683       0.403281       0.000000       73.00         74.00       07400       RENAL DIALYSIS       102, 588       11, 657       114, 237       0.155703       0.000000       76.00         75.00       07500       ASC (NON-DISTINCT PART)       0       0       0       0.000000       76.00         70       07700       ALLOGENEIC STEM CELL ACQUISITION       1, 653       847, 845       849, 948       0.357513       0.000000       76.00         80       07800       REARLI HCLNIC       0       0       0       0.000000       76.00       77.00         00       0700       RLIGENEALY       0.00177       0       0       0       0.000000       76.00         01700       ALLOGENEIC STEURALY       0.01171       78.57       4, 397, 032       5, 182, 602       0.0000000       0							
11.00       00       0100       MEDICAL       SUPPLIES       CHARGED TO PATIENTS       0       0       0.000000       0.000000       71.00         72.00       07200       DRUGS CHARGED TO PATIENTS       4,809,966       16,905,852       217,715,838       0.386190       0.000000       72.00         74.00       07400       RENAL DI ALYSIS       102,560       11.657       114,237       0.155703       0.000000       74.00         75.00       7500       07500       ASC (NON-DI STINCT PART)       0       0       0.000000       0.000000       75.00         77.00       7700       7700       ATARTIENT SERVICE COST CENTERS       0       0       0.000000       0.000000       76.00         0176.00       CROD CAR T-CELL IMMUNTHERAPY       0       0       0       0.000000       70.00       76.00       0       0.000000       0.000000       76.00       77.00							
72.00         072.00         IVPL.         Dev. CHARGED TO PATIENTS         4.809,986         16,955, 22         21,715,838         0.386190         0.000000         72.00           73.00         07300         DARGED TO PATIENTS         6.026,477         10.209,196,16,235,683         0.403281         0.000000         73.00           74.00         07400         REMAL DIALYSIS         102,580         11,657         114,237         0.155703         0.000000         76.00           75.00         07697         CARDIAC REHABILITATION         1         0.653         847,845         849,498         0.357513         0.000000         76.07           0700         ALLOGENEI C STEM CELL ACQUISITION         0         0         0         0.000000         0.000000         78.00           00         0700         RAUGENERALTH CLINIC         0         0         0         0.000000         78.00           00         08000         REDROIC CAST CENTERS         0         0         0         0.000000         78.00           92.00         090000         CLINIC TO TENTER         0         0         0.000000         79.00           93.00         080000         CLAST ST, ST, ST, ST, ST, ST, ST, ST, ST, S							
73.00         DRUGS CHARGED TO PATLENTS         6.026,487         10,209,196         16,235,683         0.402814         0.000000         73.00           74.00         OYA00 RENAL DIALYSIS         102,580         11,657         114,237         0.155703         0.000000         74.00           75.00         O7500 ASC (NON-DI STI NCT PART)         0         0         0         0.000000         75.00           77.00         O7700 ALLCECENT C STEM CELL ACQUISITION         0         0         0         0.000000         77.00           007800 CAR T-CELL IMMUNTHERAPY         0         0         0         0.000000         77.00           007800 FEDERALLY OLE COST CENTERS         0         0         0         0.000000         78.00           88.00         08900 RURAL HEALTH CENTER         0         0         0         0.000000         0.000000         90.00           90.00         09000 CLINIC         0         0         0         0         0.000000         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00		-	-				
75.00         07500         ASC (NON-DISTINCT PART)         0         0         0         0.000000         0.000000         75.00           77.00         07700         ALDGENEIC STEM CELL ACQUISITION         1,653         847,845         849,498         0.357513         0.000000         76.97           77.00         07700         ALLOGENEIC STEM CELL ACQUISITION         0         0         0.000000         0.000000         77.00           00T700         ALLOGENEIC STEM CELL ACQUISITION         0         0         0.000000         0.000000         77.00           00T700         ALLOGENEIC COST CENTERS         0         0         0.000000         0.000000         0.000000         0.000000         97.00           88.00         08900         GB000 CLINIC         0         0         0         0.000000         0.000000         97.00           91.00         091000         DERGENCY         8.911,409         26.291,538         35,202,947         0.210678         0.000000         97.00           92.00         OOFHER REIMBURSABLE COST CENTERS         0         0         0.000000         0.000000         94.00         95.00         96.00         0.000000         0.000000         94.00         95.00         96.00         96.00							
76       97       07697       CARDIAC REHABILITATION       1,653       847,845       849,498       0.357513       0.000000       76,90         77.00       07000       ALLOGENEIC STEM CELL ACQUISITION       0       0       0.000000       0.000000       77.90         80       07800       CART-CELL IMMUNTHERAPY       0       0       0       0.000000       77.90         80       07800       CART-CELL IMMUNTHERAPY       0       0       0       0.000000       0.000000       76.00         80       07800       RENOTE COST CENTERS       0       0       0       0       0.000000       0.000000       90.00         90.00       09100       EMERAILY QUALIFIED HEALTH CENTER       0       0       0       0.000000       90.00       90.00       0.000000       90.00       90.00       90.00       0.000000       90.000       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       92.00       0.90000       0.000000       0.000000       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00       91.00		102, 580	11, 657	114, 23			
77.00         O <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td> <td></td>		-	-				
78.00       07800       CAR       T-CELL       IMMUNOTHERAPY       0       0       0.000000       0.000000       0.000000       78.00         00       08500       RURAL HEALTH CLINIC       0       0       0       0       89.00       0       00000       0.000000       0.000000       90.00       90.00       90.00       0.000000       0.000000       90.00       90.00       90.00       90.00       0.000000       0.000000       90.00				1			
88.00         08800         RURAL HEALTH CLINIC         0         0         0         88.00         88.00         89.00         09000         Clinical Control         88.00         89.00         99.00         <							
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0				I			
90.00         09000         CLINIC         0         0         0         0.000000         0.000000         90.00         91.00         09100         DEMERGENCY         0.000000         90.00         26,291,538         35,202,947         0.210678         0.000000         92.00         09200         DESERVATION BEDS (NON-DISTINCT PART)         785,570         4,397,032         5,182,602         0.210678         0.000000         92.00         92.00           OTHER REIMBURSABLE COST CENTERS         0         0         0         0.000000         0.000000         0.000000         94.00         94.00         0.000000         0.000000         95.00         95.00         95.00         95.00         95.00         95.00         95.00         96.00         0         0.000000         0.000000         95.00         95.00         96.00         96.00         96.00         0         0.000000         0.000000         96.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         99.00         0.000000         0.000000         0.000000         99.00         99.00         99.00         0.000000         0.000000         99.00         99.00         0.000000         0.000000         100.00         100.00		0	C		0		
91.00         09100         EMERGENCY         8, 911, 409         26, 291, 538         35, 202, 947         0. 210678         0. 000000         91.00         92.00           09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         785, 570         4, 397, 032         5, 182, 602         0. 499681         0. 000000         94.00         0.9900         CMBRSABLE COST CENTES         94.00         09400         HOME PROGRAM DI ALYSIS         0         0         0. 000000         0. 000000         95.00         95.00         0.000000         0.000000         0.000000         95.00         95.00         0.000000         0.000000         0.000000         95.00         96.00         0.9700         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0.000000         0.000000         95.00         96.00         0.9850         0.000000         0.000000         96.00         97.00         97.00         0.000000         0.000000         97.00         99.00		0	C C		0 0.00000	0 00000	
OTHER         REI MBURSABLE         COST         CENTERS           94.00         09400         HOME         PROGRAM         DI ALYSIS         0         0         0.000000         0.000000         94.00           95.00         O9500         AMBULANCE SERVI CES         0         0         0.000000         0.000000         95.00           95.00         O9600         DURABLE         MEDI CAL         EQUI P-RENTED         0         0         0.000000         0.000000         96.00           97.00         09700         DURABLE         MEDI CAL         EQUI P-SOLD         0         0         0.000000         0.000000         96.00           98.00         09850         OTHER         REI MBURSABLE         COST CENTERS         0         0         0         0.000000         97.00         99.00		8, 911, 409	26, 291, 538	35, 202, 94			
94.00         O9400         HOME         PROGRAM         DI ALYSI S         O         O         O         O.000000         O.000000         94.00           95.00         O9500         AMBULANCE SERVI CES         O         O         O.000000         O.000000         O.000000         P5.00           96.00         OP600         DURABLE MEDI CAL EQUI P-RENTED         O         O         O.000000         O.000000         P5.00           97.00         OP700         DURABLE MEDI CAL EQUI P-SOLD         O         O         O.000000         O.000000         P6.00           98.00         O9850         OTHER REI MBURSABLE COST CENTERS         O         O         O         O.000000         O.000000         P8.00         P9.00         P9.00         P9.00         O9900         CMF         O         <		785, 570	4, 397, 032	5, 182, 60	0. 499681	0.00000	92.00
95.00       09500       AMBULANCE SERVICES       0       0       0.000000       0.000000       95.00         96.00       09600       DURABLE MEDICAL EQUIP-RENTED       0       0       0.000000       0.000000       96.00         97.00       09700       DURABLE MEDICAL EQUIP-SOLD       0       0       0.000000       0.000000       96.00         98.00       09850       OTHER REIMBURSABLE COST CENTERS       0       0       0       0.000000       97.00         99.00       09900       CMHC       0       0       0       0.000000       98.00         99.01       09910       CORF       0       0       0       99.10         100.00       10000       I & SERVI CES-NOT APPRVD PRGM       0       0       100.00         101.00       10100       HMEATHA GENCY       0       0       101.00       101.00         102.00       101 DT REATMENT PROGRAM       0       0       0       102.00       102.00         105.00       10500       KIDMEY ACQUI SI TI ON       0       0       0       105.00         106.00       10600       HEART ACQUI SI TI ON       0       0       0       107.00         107.00       <					0 000000	0.000000	04.00
96.00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0.000000         0.000000         96.00         97.00         09700         DURABLE MEDI CAL EQUI P-SOLD         0         0         0.000000         0.000000         97.00         97.00         09850         OTHER REI MBURSABLE COST CENTERS         0         0         0.000000         0.000000         97.00         98.00         99.00         99.00         99.00         99.00         0.000000         0.000000         98.00         99.00         99.00         99.00         0.000000         0.000000         98.00         99.00		0	C				
97.00       09700       DURABLE MEDICAL EQUIP-SOLD       0       0       0.000000       97.00         98.00       09850       0THER REIMBURSABLE COST CENTERS       0       0       0.000000       0.000000       98.00         99.00       09900       CMHC       0       0       0       0.000000       98.00         99.10       09910       CORF       0       0       0       99.10         100.00       18x       SERVICES-NOT APPRVD PRGM       0       0       0       100.00         101.00       10100       HOME HEALTH AGENCY       0       0       0       101.00         102.00       10101 DID TREATMENT PROGRAM       0       0       0       102.00         SPECIAL PURPOSE COST CENTERS       5       0       0       0       105.00         105.00       10500       KI DNEY ACQUI SI TI ON       0       0       106.00       106.00         106.00       10600       HEAR TA CQUI SI TI ON       0       0       0       107.00       107.00       107.00       107.00       106.00       106.00       106.00       106.00       106.00       106.00       106.00       106.00       109.00       109.00       109.00       1		0	0				
99.00       09900       CMHC       0       0       0       99.00         99.10       09910       CORF       0       0       0       0       99.10         100.00       18R SERVICES-NOT APPRVD PRGM       0       0       0       100.00       101.00       101.00       101.00       101.00       101.00       101.00       102.00		0	C				
99.10       09910       CORF       0       0       0       99.10         100.00       10000       I&R SERVICES-NOT APPRVD PRGM       0       0       0       100.00         101.00       10100       HOME HEALTH AGENCY       0       0       0       101.00         102.00       0PIOID TREATMENT PROGRAM       0       0       0       101.00         102.00       0PIOID TREATMENT PROGRAM       0       0       0       102.00         SPECIAL PURPOSE COST CENTERS         TOS.00       10500       KI DNEY ACQUI SI TI ON       0       0       0       105.00         106.00       10600       HEART ACQUI SI TI ON       0       0       0       106.00         107.00       10700       LI VER ACQUI SI TI ON       0       0       0       106.00         108.00       10800       LUNG ACQUI SI TI ON       0       0       0       108.00         109.00       PANCREAS ACQUI SI TI ON       0       0       0       109.00         109.00       PANCREAS ACQUI SI TI ON       0       0       0       109.00         101.00       INTESTI NAL ACQUI SI TI ON       0       0       0       110.00		0	C		0 0. 000000	0. 000000	
100.00       1&R SERVICES-NOT APPRVD PRGM       0       0       100.00         101.00       10100       HOME HEALTH AGENCY       0       0       0       101.00         102.00       10200       OPIOID TREATMENT PROGRAM       0       0       0       102.00         SPECIAL PURPOSE COST CENTERS         105.00       10500       KIDNEY ACQUISITION       0       0       105.00         106.00       10600       HEART ACQUISITION       0       0       106.00       106.00         107.00       10700       LIVER ACQUISITION       0       0       0       106.00         107.00       10700       LIVER ACQUISITION       0       0       0       106.00         108.00       10800       LUNG ACQUISITION       0       0       0       107.00         108.00       10800       LUNG ACQUISITION       0       0       0       109.00         109.00       PANCREAS ACQUISITION       0       0       0       109.00       109.00         101.00       INTESTINAL ACQUISITION       0       0       0       110.00       110.00         111.00       INTESTINAL ACQUISITION       0       0       0		0	C	0	0		
101.00       10100       HOME HEALTH AGENCY       0       0       0       101.00         102.00       10200       OPI OI D TREATMENT PROGRAM       0       0       0       102.00         SPECIAL PURPOSE COST CENTERS         105.00       10500       KI DNEY ACQUI SI TI ON       0       0       0       105.00         106.00       10600       HEART ACQUI SI TI ON       0       0       0       106.00         107.00       10700       LI VER ACQUI SI TI ON       0       0       0       106.00         108.00       10800       LUNG ACQUI SI TI ON       0       0       0       107.00         109.00       PANCREAS ACQUI SI TI ON       0       0       0       108.00       109.00         100.011000       INTERSTI NAL ACQUI SI TI ON       0       0       0       109.00       109.00         111.00       11000       INTERSTI NAL ACQUI SI TI ON       0       0       0       111.00         111.00       1SLET ACQUI SI TI ON       0       0       0       111.00       111.00         113.00       INTEREST EXPENSE       113.00       111.00       111.00       114.00       114.00       114.00       114.00		0			0		
102.00         10200         OPI OI D TREATMENT PROGRAM         0         0         102.00           SPECIAL PURPOSE COST CENTERS           105.00         10500         KI DNEY ACQUI SI TI ON         0         0         0         105.00         105.00         105.00         105.00         105.00         105.00         105.00         105.00         105.00         105.00         105.00         105.00         106.00         107.00         107.00         107.00         107.00         107.00         108.00         109.00         108.00         109.00         108.00         109.00         109.00         109.00         109.00         109.00         109.00         100.00         100.00         110.00         110.00         110.00         110.00         110.00         111.00         111.00         111.00         111.00         111.00         111.00         113.00         114.00 <t< td=""><td></td><td>0</td><td>C</td><td></td><td>0</td><td></td><td></td></t<>		0	C		0		
105.00       10500       KI DNEY ACQUI SI TI ON       0       0       0       105.00         106.00       10600       HEART ACQUI SI TI ON       0       0       0       106.00         107.00       10700       LI VER ACQUI SI TI ON       0       0       0       106.00         107.00       10700       LI VER ACQUI SI TI ON       0       0       0       107.00         108.00       10800       LUNG ACQUI SI TI ON       0       0       0       108.00         109.00       10900       PANCREAS ACQUI SI TI ON       0       0       0       109.00         100.01       INTESTI NAL ACQUI SI TI ON       0       0       0       110.00       110.00         111.00       ISLET ACQUI SI TI ON       0       0       0       111.00       111.00         113.00       INTEREST EXPENSE       113.00       111.00       111.00       114.00       111.00<		0	C		0		
106.00         10600         HEART ACQUI SI TI ON         0         0         106.00           107.00         10700         LI VER ACQUI SI TI ON         0         0         107.00           108.00         10800         LUNG ACQUI SI TI ON         0         0         108.00           109.00         PANCREAS ACQUI SI TI ON         0         0         0         108.00           109.00         PANCREAS ACQUI SI TI ON         0         0         0         109.00           110.00         INTESTI NAL ACQUI SI TI ON         0         0         0         110.00           111.00         ISLET ACQUI SI TI ON         0         0         0         111.00           113.00         INTEREST EXPENSE         113.00         113.00         114.00							105 55
107.00       107.00       LI VER ACQUI SI TI ON       0       0       107.00         108.00       10800       LUNG ACQUI SI TI ON       0       0       0       108.00         109.00       PANCREAS ACQUI SI TI ON       0       0       0       109.00       109.00         110.00       INTESTI NAL ACQUI SI TI ON       0       0       0       110.00       100.00       110.00       110.00       110.00       111.00       0       0       0       111.00       113.00       113.00       113.00       114.00       UTI LI ZATI ON REVI EW-SNF       114.00 </td <td></td> <td>0</td> <td>C</td> <td></td> <td>0</td> <td></td> <td>•</td>		0	C		0		•
108.00       LUNG ACQUI SI TI ON       0       0       0       108.00         109.00       10900       PANCREAS ACQUI SI TI ON       0       0       0       109.00         110.00       1000       INTESTI NAL ACQUI SI TI ON       0       0       0       110.00         111.00       11100       I SLET ACQUI SI TI ON       0       0       0       111.00         113.00       11300       INTEREST EXPENSE       113.00       114.00		0			0		
109.00         10900         PANCREAS         ACQUISITION         0         0         109.00           110.00         11000         INTESTINAL         ACQUISITION         0         0         110.00           111.00         11100         ISLET         ACQUISITION         0         0         111.00           113.00         11300         INTEREST         EXPENSE         113.00         114.00 <td></td> <td>0</td> <td>C</td> <td>b</td> <td>õ</td> <td></td> <td></td>		0	C	b	õ		
111.00       1 SLET ACQUI SI TI ON       0       0       111.00         113.00       1 SLET ACQUI SI TI ON       0       0       111.00         113.00       1 SLET ACQUI SI TI ON       0       0       113.00         114.00       11400       UTI LI ZATI ON REVIEW-SNF       114.00       114.00	109.00 10900 PANCREAS ACQUI SI TI ON	0	C	þ	0		109.00
113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00		0	C		0		
114.00 11400 UTILIZATION REVIEW-SNF 114.00		0	C	) 	U		
	115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	C	þ	0		115.00

Health Financial Systems	ST ELIZABETH DEARBORN			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/28/2024 1:5	epared: 58 pm
		Title	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
116. 00 11600 H0SPI CE	0	0		0		116.00
200.00 Subtotal (see instructions)	101, 797, 516	178, 279, 831	280, 077, 34	7		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	101, 797, 516	178, 279, 831	280, 077, 34	7		202.00

Heal th	Financial Systems	ST ELI ZABETH	DEARBORN	In Lie	u of Form CMS-2	2552-10
	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0086	Period: From 01/01/2023	Worksheet C Part I	
				To 12/31/2023	Date/Time Prep 5/28/2024 1:58	
		1	Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio				
		11.00				
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
32.00	03200 CORONARY CARE UNI T					32.00
33.00	03300 BURN INTENSIVE CARE UNIT					33.00
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF					34.00 40.00
41.00	04100 SUBPROVI DER – I RF					41.00
43.00	04300 NURSERY					43.00
44.00	04400 SKILLED NURSING FACILITY					44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE					45.00 46.00
101.00	ANCI LLARY SERVICE COST CENTERS					10.00
	05000 OPERATING ROOM	0. 269299				50.00
	05100 RECOVERY ROOM	0. 000000 0. 790071				51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0. 394896				52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 174565				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56.00	05600 RADI OI SOTOPE 05700 CT SCAN	0.000000				56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 121557 0. 168986				57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 191080				59.00
60.00	06000 LABORATORY	0. 726927				60.00
60.01	06001 BLOOD LABORATORY	0.000000				60.01
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000				61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000				64.00
65.00		0. 668947				65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0. 449314 0. 459135				66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0. 447271				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 341983				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 402780				70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000 0. 386190				71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 403281				73.00
74.00	07400 RENAL DIALYSIS	0. 155703				74.00
	07500 ASC (NON-DI STINCT PART)	0.000000				75.00
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 357513 0. 000000				76. 97 77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0.000000				78.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC					88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0. 000000				89.00 90.00
	09100 EMERGENCY	0. 210678				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 499681				92.00
04 00	OTHER REIMBURSABLE COST CENTERS	0.000000				04 00
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0.000000				94.00 95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97.00
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.00
	09900 CMHC 09910 CORF					99. 00 99. 10
	10000 I &R SERVICES-NOT APPRVD PRGM					100.00
101.00	10100 HOME HEALTH AGENCY					101.00
102.00	10200 OPI OLD TREATMENT PROGRAM					102.00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON					105.00
	10600 HEART ACQUI SI TI ON					106.00
	10700 LI VER ACQUI SI TI ON					107.00
	10800 LUNG ACQUISITION					108.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION				1	109.00 110.00
	11100 I SLET ACQUI SI TI ON				1	111.00
113.00	11300 INTEREST EXPENSE					113.00
	11400 UTI LI ZATI ON REVI EW-SNF				1	114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE				1	115.00 116.00
200.00						200.00
		1			I'	

Health Fin	ancial Systems	ST ELI ZABETH	DEARBORN	In Lieu of Form CMS-2552-1			
COMPUTATIC	N OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/28/2024 1:5		
			Title XVIII	Hospi tal	PPS		
	Cost Center Description	PPS Inpatient Ratio 11.00					
201.00 202.00	Less Observation Beds Total (see instructions)					201. 00 202. 00	

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	ST ELI ZABET	H DEARBORN Provider C		Peri od:	u of Form CMS-2 Worksheet C	2552-10
					From 01/01/2023 To 12/31/2023		pared:
			Titl	e XIX	Hospi tal	5/28/2024 1:5 Cost	8 pm
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
		(from Wkst. B,			Di sal I owance		
		Part I, col. 26)					
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30.00	03000 ADULTS & PEDIATRICS	12, 720, 481		12, 720, 48		12, 720, 481	30.00
31.00 32.00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	5, 123, 436		5, 123, 430	6 O	5, 123, 436 0	31.00 32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0				0	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0		(	0	0	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF					0	40.00
43.00	04300 NURSERY	525, 257		525, 25		525, 257	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY					0	44.00
46.00	04600 OTHER LONG TERM CARE	0				0	46.00
50.00	ANCILLARY SERVICE COST CENTERS	20, 170, 430	1	20, 170, 430	0 0	20, 170, 430	50.00
51.00	05100 RECOVERY ROOM	20, 170, 430				20, 170, 430	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,034,659		3, 034, 659		3, 034, 659	•
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	1, 359, 104 5, 858, 922		1, 359, 104 5, 858, 922		1, 359, 104 5, 858, 922	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0 1, 563, 669		1, 563, 669		0 1, 563, 669	56.00 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	633, 160		633, 160		633, 160	
59.00	05900 CARDI AC CATHETERI ZATI ON	996, 076		996, 076		996, 076	•
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	5, 717, 395		5, 717, 39		5, 717, 395 0	60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		(	0 0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0				0	64.00
65.00	06500 RESPIRATORY THERAPY	1, 984, 569				1, 984, 569	•
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 637, 524 552, 775		3, 637, 524 552, 77		3, 637, 524 552, 775	
68.00	06800 SPEECH PATHOLOGY	281, 268	0	281, 268	з о	281, 268	68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 117, 766 31, 872		1, 117, 760 31, 872		1, 117, 766 31, 872	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	01,072			0 0	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	8, 386, 432		8, 386, 432		8, 386, 432	•
	07400 RENAL DIALYSIS	6, 547, 548 17, 787		6, 547, 548 17, 78		6, 547, 548 17, 787	•
75.00	07500 ASC (NON-DISTINCT PART)	0		(	0 0	0	75.00
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	303, 707		303, 70	7 O	303, 707 0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		(	0 0	0	
88.00	OUTPATIENT SERVICE COST CENTERS	0			0 0	0	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0			0	0	89.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0 7, 416, 489		7, 416, 489		0 7, 416, 489	90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 589, 649		2, 589, 649		2, 589, 649	•
04 00	OTHER REIMBURSABLE COST CENTERS		1			0	04.00
94.00 95.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES				0 0 0	0	94.00 95.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0		(	0 0	0	96.00
97.00 98.00	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0				0	97.00 98.00
99.00	09900 СМНС	0		(		0	99.00
	09910 CORF 10000 I &R SERVICES-NOT APPRVD PRGM	0				0	99.10 100.00
	10000 FAR SERVICES-NOT APPROD PROM	0					100.00
102.00	10200 OPI OLD TREATMENT PROGRAM	0				0	102.00
105.00	SPECIAL PURPOSE COST CENTERS	0				0	105.00
106.00	10600 HEART ACQUI SI TI ON	0			D	0	106. 00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0					107. 00 108. 00
109.00	10900 PANCREAS ACQUISITION	0			Ď	0	109. 00
	11000 INTESTINAL ACQUISITION	0					110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0				0	111. 00 113. 00
	11400 UTILIZATION REVIEW-SNF						114.00

Health Financial Systems	ST ELI ZABETH	ST ELIZABETH DEARBORN			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2023 Fo 12/31/2023		pared: 8 pm	
		Titl	e XIX	Hospi tal	Cost		
				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		
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			D	0	115.00	
116. 00 11600 HOSPI CE	0			D	0	116.00	
200.00 Subtotal (see instructions)	90, 569, 975	0	90, 569, 97	5 0	90, 569, 975	200.00	
201.00 Less Observation Beds	2, 589, 649		2, 589, 64	9	2, 589, 649	201.00	
202.00  Total (see instructions)	87, 980, 326	0	87, 980, 32	6 0	87, 980, 326	202.00	

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	ST ELI ZABETH		F	In Lie Period: rom 01/01/2023 o 12/31/2023	Worksheet C Part I Date/Time Pre	pared:
		Ti tl	e XIX	Hospi tal	5/28/2024 1:5 Cost	
Cost Center Description	I npati ent	Charges Outpatient		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS	22, 886, 856		22, 886, 856			30.00
31. 00 03100 I NTENSI VE CARE UNI T	15, 258, 912		15, 258, 912			31.00
32. 00 03200 CORONARY CARE UNI T	0		0,200,712			32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		C	)		33.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0		C			34.00
40. 00 04000 SUBPROVIDER - IPF	0		C			40.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0 953, 960		953, 960			41.00 43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	953, 960		953, 960			43.00
45. 00 04500 NURSI NG FACILITY	0					45.00
46.00 04600 OTHER LONG TERM CARE	0		C			46.00
ANCI LLARY SERVICE COST CENTERS			I.			
50. 00 05000 OPERATI NG ROOM	20, 826, 474	54,073,331				
51.00 05100 RECOVERY ROOM	0		-	0.000000	0.00000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	3, 608, 495 677, 417	232, 502 2, 764, 263			0. 000000 0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 992, 735	28, 570, 197			0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0			0.000000	55.00
56. 00 05600 RADI 0I SOTOPE	0	C	0 0	0. 000000	0. 000000	56.00
57.00 05700 CT SCAN	3, 042, 867	9, 820, 837			0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	360, 386	3, 386, 428			0.00000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 647, 732	3, 565, 136			0.00000	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	3, 828, 828	4, 036, 328	7, 865, 156		0. 000000 0. 000000	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0			0. 000000	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	Ő		0. 000000	0. 000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C		0. 000000	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	C	u u	0. 000000	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	757, 187	2, 209, 519			0.00000	65.00
66.00 06600 PHYSI CAL THERAPY	840, 474	7, 255, 259			0.00000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	449, 800 208, 678	754, 149 420, 176			0. 000000 0. 000000	1
69. 00 06900 ELECTROCARDI OLOGY	813, 378	2, 455, 108			0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	5, 652	73, 478			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C		0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 809, 986	16, 905, 852			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 026, 487	10, 209, 196			0.00000	
74.00 07400 RENAL DIALYSIS	102, 580	11, 657			0.00000	
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 97 07697 CARDI AC REHABI LI TATI ON	0 1, 653	C 847, 845			0. 000000 0. 000000	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	047,043				
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	C				
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 RURAL HEALTH CLINIC	0	0	0		0.00000	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0		0. 000000	0.00000	89.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	8, 911, 409	26, 291, 538	35, 202, 947	0. 000000 0. 210678	0. 000000 0. 000000	90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	785, 570	4, 397, 032			0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	.,				
94.00 09400 HOME PROGRAM DI ALYSI S	0	C	C		0. 000000	94.00
95. 00 09500 AMBULANCE SERVICES	0	C	C	0. 000000	0.00000	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.00000	96.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 98.00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0. 000000 0. 000000	0. 000000 0. 000000	97.00 98.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC	0			0.000000	0.00000	98.00 99.00
99. 10 09910 CORF	0	0				99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	Ő				100.00
101.00 10100 HOME HEALTH AGENCY	0	C	0 0			101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	) C	)		102.00
SPECIAL PURPOSE COST CENTERS				0.000000	0,000000	105 00
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON				0. 000000	0. 000000	1
108. 00 10800 LUNG ACQUISITION	0	0		0.000000	0. 000000	
109. 00 10900 PANCREAS ACQUISITION	0	C		0. 000000	0. 000000	
110.00 11000 INTESTINAL ACQUISITION	0	C	0	0. 000000	0. 000000	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	C	C	0. 000000	0. 000000	
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	C	c			114. 00 115. 00
110.00 TISOU ANDULATONT SUNDICAL CENTER (D. P. )	<u> </u>	0	<u>'</u> 1 U	1		115.00

Health Financial Systems	ST ELIZABETH DEARBORN			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2023	Worksheet C Part I	
				To 12/31/2023		epared: 58 pm
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
116.00 11600 HOSPI CE	0	0	I	0		116.00
200.00 Subtotal (see instructions)	101, 797, 516	178, 279, 831	280, 077, 34	7		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	101, 797, 516	178, 279, 831	280, 077, 34	7		202.00

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	ST ELI ZABETH	DEARBORN Provider CCN: 15-0086	Peri od:	u of Form CMS-2552- Worksheet C
				From 01/01/2023 To 12/31/2023	Part I Date/Time Prepared 5/28/2024 1:58 pm
	Cost Center Description	PPS Inpatient	Title XIX	Hospi tal	Cost
		Ratio			
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	03000 ADULTS & PEDIATRICS				30.
31.00	03100 INTENSIVE CARE UNIT				31.
32.00	03200 CORONARY CARE UNI T				32.
	03300 BURN INTENSIVE CARE UNIT				33.
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF				34. 40.
40.00	04100 SUBPROVIDER - IRF				40.
43.00	04300 NURSERY				43.
44.00	04400 SKILLED NURSING FACILITY				44.
45.00	04500 NURSING FACILITY				45.
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS				46.
50.00	05000 OPERATING ROOM	0.000000			50.
51.00	05100 RECOVERY ROOM	0. 000000			51.
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.
53.00 54.00	05300 ANESTHESI OLOGY	0.000000			53. 54.
55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.
56.00	05600 RADI OI SOTOPE	0. 000000			56.
57.00	05700 CT SCAN	0. 000000			57.
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0.000000			59. 60.
60.00	06001 BLOOD LABORATORY	0. 000000			60.
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0.000000			64. 65.
66.00	06600 PHYSI CAL THERAPY	0. 000000			66.
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.
68.00	06800 SPEECH PATHOLOGY	0. 000000			68.
69.00		0. 000000			69.
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			70. 71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.
	07400 RENAL DIALYSIS	0. 000000			74.
	07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION	0.000000			75. 76.
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			70.
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.
	OUTPATIENT SERVICE COST CENTERS				
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			88. 89.
90.00	09000 CLINIC	0. 000000			90.
	09100 EMERGENCY	0. 000000			91.
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.
94.00	OTHER REIMBURSABLE COST CENTERS	0.000000			94.
	09500 AMBULANCE SERVICES	0. 000000			94. 95.
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97.
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98.
	09900 CMHC 09910 CORF				99. 99.
	10000 I &R SERVICES-NOT APPRVD PRGM				100.
101.00	10100 HOME HEALTH AGENCY				101.
102.00	10200 OPI OI D TREATMENT PROGRAM				102.
105 00	SPECIAL PURPOSE COST CENTERS	0.000000			105.
	10500 REART ACQUISITION	0. 000000			105.
	10700 LIVER ACQUISITION	0. 000000			107.
108.00	10800 LUNG ACQUISITION	0. 000000			108.
	10900 PANCREAS ACQUISITION	0. 000000			109.
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0.000000			110. 111.
	11300 INTEREST EXPENSE	0.000000			111.
	11400 UTI LI ZATI ON REVI EW-SNF				114.
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)				115.
	11600 HOSPICE				116.
200.00	Subtotal (see instructions)				200.

Health Fin	ancial Systems	ST ELI ZABETH	DEARBORN	In Lieu of Form CMS-2552-1			
COMPUTATIC	N OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/28/2024 1:5		
			Title XIX	Hospi tal	Cost		
	Cost Center Description	PPS Inpatient Ratio 11.00					
201.00 202.00	Less Observation Beds Total (see instructions)					201. 00 202. 00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS         Provider CCN: 15-0086         Period: From 01/01/2023 To 12/31/2024         Worksheet D patr 1 Date/Time Prepared: 52/2024 1:58 pm           Cost Center Description         Capital Related Cost (from KKS, B, Part II, col. 26)         Reduced Adjustment         Reduced Copital Related Cost (col. 1 - col. 20)         To 12/31/2024         So 0         So 0           1.00         2.00         3.00         4.00         5.00         So 0         So 0 </th <th>Health Financial Systems</th> <th>ST ELI ZABETH</th> <th>DEARBORN</th> <th></th> <th>In Lie</th> <th>u of Form CMS-:</th> <th>2552-10</th>	Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-:	2552-10
Cost Center Description         Capital Related Cost (from Wkst. B, Part II, col. 26)         Swing Bed Adjustment         Reduced Capital Related Cost (col. 1 - col. 2)         Total Patient Days         Part II 3 / col. 4)           100         INPATIENT ROUTINE SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           ADULTS & PEDIATRICS         1.381.050         0         1.381.050         0         1.381.050         1.381.050         0         0.00         0.00         3.00         4.00         5.00           32.00         CORONARY CARE UNIT         289.307         1.381.050         0         1.381.050         0         0         0.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         0         0.00         3.00 <t< td=""><td>APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI</td><td>TAL COSTS</td><td></td><td></td><td>From 01/01/2023 To 12/31/2023</td><td>Part I Date/Time Pre 5/28/2024 1:5</td><td>pared: 8 pm</td></t<>	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS			From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/28/2024 1:5	pared: 8 pm
Related Cost (from Wkst. B) 26)         Adjuštment (col. 1 - col. 20)         Days Related Cost (col. 1 - col. 2)         3 / col. 4)           30.00         INPATI ENT ROUTI NE SERVI CE COST CENTERS         2)         4.00         5.00           30.00         ADULTS & PEDI ATRICS         1.381.050         0         1.381.050         13.125         105.22         30.00           31.00         INPATI ENT ROUTI NE SERVI CE COST CENTERS         1.381.050         0         1.381.050         13.125         105.22         30.00           32.00         CORONARY CARE UNI T         0         0         0         0         0.00         32.00         32.00         33.00         44.00         5.00         32.00         32.00         33.00         44.00         5.00         0         0         0         0         0.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00         33.00         44.00         40.00         40.00         32.00         32.00         32.00         32.00         32.00         33.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         45.00         45.00         45.00         45.00         45.00         45.00							
Impart ENT ROUTINE SERVICE COST CENTERS         Impart H1, col. 20         Related Cost (col. 1 - col. 2)         Impart H1,	Cost Center Description						
Part II, col. 20         (col. 1 - col. 2)         2)         4           0         1.00         2.00         3.00         4.00         5.00           0         ADULTS & PEDIATRICS         1.381.050         0         1.31.25         105.22         30.00           1.00         INTENSIVE CARE UNIT         289.307         289.307         1.738         166.46         31.00           32.00         BURN INTENSIVE CARE UNIT         0         0         0         0.00         32.00           33.00         BURN INTENSIVE CARE UNIT         0         0         0         0.00         33.00           34.00         SURGICAL INTENSIVE CARE UNIT         0         0         0         0.00         33.00           34.00         SURGICAL INTENSIVE CARE UNIT         0         0         0         0.00         33.00           44.00         SURPROVIDER - IPF         0         0         0         0         0.00         44.00           5KILLED NURSING FACILITY         0         0         0         0         0         0.00         44.00           6.00         NORSING FACILITY         0         0         0         0         0.00         45.00           200.00 <td></td> <td></td> <td>Adjustment</td> <td></td> <td></td> <td>3 / col. 4)</td> <td></td>			Adjustment			3 / col. 4)	
26)         2)							
INPATIENT ROUTINE SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           30.00         ADULTS & PEDIATRICS         1.381,050         0         1.381,050         13,125         105.22         30.00           31.00         INTENSIVE CARE UNIT         289,307         1.738         166.46         31.00         0         0.00         32.00         34.00         32.00         32.00         34.00         32.00         32.00         32.00         32.00         34.00         32.00         32.00         32.00         32.00         32.00         32.00         32.00							
INPATLENT ROUTINE SERVICE COST CENTERS         Impatlent							
30.00       ADULTS & PEDIATRICS       1,381,050       13,125       105.22       30.00         31.00       INTENSIVE CARE UNIT       289,307       1,738       166.46       31.00         32.00       CORONARY CARE UNIT       0       0       0       0.00       32.00         33.00       BURN INTENSIVE CARE UNIT       0       0       0       0       0.00       32.00         34.00       SUBPROVIDER - IPF       0       0       0       0       0.00       33.00         41.00       SUBPROVIDER - IPF       0       0       0       0       0.00       40.00         43.00       NURSING FACILITY       16,841       16,841       455       37.01       43.00         44.00       SKILLED NURSING FACILITY       0       0       0       0       0.00       43.00         200.00       Total (Lines 30 through 199)       1,687,198       11,687,198       15,318       200.00         200.00       Total (Lines 30 through 199)       1,687,198       15,318       200.00       31.00         31.00       INTENSIVE CARE UNIT       0       0       0       31.00       31.00         31.00       INTENSIVE CARE UNIT       0       0		1.00	2.00	3.00	4.00	5.00	
31.00       INTENSIVE CARE UNIT       289,307       1,738       166.46       31.00         32.00       CORONARY CARE UNIT       0       0       0       0.00       32.00         33.00       BURN INTENSIVE CARE UNIT       0       0       0       0.00       32.00         34.00       SURGICAL INTENSIVE CARE UNIT       0       0       0       0.00       32.00         34.00       SURGICAL INTENSIVE CARE UNIT       0       0       0       0       0.00       33.00         40.00       SUBROVIDER - IPF       0       0       0       0       0.00       40.00         41.00       SUBROVIDER - IRF       16.841       455       37.01       43.00         44.00       SKILLED NURSING FACILITY       0       0       0       0.00       45.00         200.00       Total (LIED NURSING FACILITY       0       0       0.00       45.00       0.00       45.00         200.00       Total (LIED NURSING FACILITY       0       0       0.00       45.00       200.00       1.687.198       15.318       200.00         200.00       Total (LIED NURSING FACILITY       0       0       0       0.00       31.00       31.00 <tr< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr<>							
32.00       CORONARY CARE UNIT       0       0       0.00       32.00         33.00       BURN INTENSIVE CARE UNIT       0       0       0       0.00       33.00         40.00       SUBPROVIDER - IPF       0       0       0       0.00       34.00         40.00       SUBPROVIDER - IRF       0       0       0       0.00       40.00         41.00       SUBPROVIDER - IRF       0       0       0       0       0.00       40.00         43.00       NURSING FACILITY       0       0       0       0       0.00       40.00         44.00       SKILLED NURSING FACILITY       0       0       0       0.00       44.00         45.00       NURSING FACILITY       0       0       0       0.00       0.00       44.00         500.00       NURSING FACILITY       0       0       0       0.00       0.00       45.00         500.01       NURSING FACILITY       0       0       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00	30. 00 ADULTS & PEDIATRICS	1, 381, 050	0	1, 381, 05	0 13, 125	105.22	30.00
33.00       BURN INTENSIVE CARE UNIT       0       0       0.00       33.00         34.00       SURGICAL INTENSIVE CARE UNIT       0       0       0.00       33.00         40.00       SUBPROVIDER - IPF       0       0       0       0.00       34.00         41.00       SUBPROVIDER - IPF       0       0       0       0.00       40.00         43.00       NURSERY       16.841       455       37.01       43.00         44.00       SKILLED NURSING FACILITY       0       0       0       0.00       44.00         50.00       NURSING FACILITY       0       0       0       0.00       45.00         200.00       Total (lines 30 through 199)       1, 687, 198       1, 687, 198       15, 318       200.00         Cost Center Description       Inpatient       Program days       Capital Cost (cost _ cost	31.00 INTENSIVE CARE UNIT	289, 307		289, 30	7 1, 738	166.46	31.00
34.00       SURGI CAL INTENSIVE CARE UNIT       0       0       0       0.00       34.00         40.00       SUBPROVI DER - IPF       0       0       0       0.00       40.00         41.00       SUBPROVI DER - IRF       0       0       0       0.00       40.00         43.00       NURSERY       16,841       16,841       455       37.01       43.00         44.00       SKILLED NURSING FACILITY       0       0       0       0.00       45.00         200.00       Total (Lines 30 through 199)       1,687,198       1,687,198       15,318       200.00         200.00       Total (Lines 30 through 199)       1,687,198       1,687,198       15,318       200.00         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       ADULTS & PEDIATRICS       4,217       443,713       30.00         31.00       INTENSIVE CARE UNIT       0       0       33.00       31.00         31.00       BURN INTENSIVE CARE UNIT       0       0       33.00       33.00         32.00       SUBPROVIDER - IPF       0       0       44.00       44.00         44.00       SUBPROVIDER - IPF       0       0       44.00       44.00 <td>32.00 CORONARY CARE UNI T</td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td>0.00</td> <td>32.00</td>	32.00 CORONARY CARE UNI T	0			0 0	0.00	32.00
40.00       SUBPROVIDER - IPF       0       0       0       0       0.00       40.00         41.00       SUBPROVIDER - IRF       0       0       0       0       0.00       41.00         43.00       NURSERY       16,841       16,841       455       37.01       43.00         44.00       SKILLED NURSING FACILITY       0       0       0       0       0.00       44.00         50.01       NURSERY       16,841       16,841       455       37.01       43.00         44.00       SKILLED NURSING FACILITY       0       0       0       0       0.00       44.00         200.00       Total (lines 30 through 199)       1,687,198       1,687,198       15,318       200.00         200.00       Total (lines 200 through 199)       1,687,198       1,687,198       15,318       200.00         6.00       7.00       6.00       7.00       6.00       7.00       31.00       31.00       31.00       31.00       31.00       31.00       31.00       31.00       31.00       31.00       31.00       32.00       33.00       31.00       33.00       33.00       33.00       33.00       33.00       33.00       33.00       44.00	33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00
41.00       SUBPROVIDER - IRF       0       0       0       0.00       41.00         43.00       NURSERY       16,841       455       37.01       43.00         44.00       SKILLED NURSING FACILITY       0       0       0       0.00       44.00         44.00       SKILLED NURSING FACILITY       0       0       0       0.00       44.00         200.00       Total (lines 30 through 199)       1,687,198       1,687,198       15,318       200.00         200.00       Total (lines 30 through 199)       1,687,198       1,687,198       15,318       200.00         Cost Center Description       Inpatient Program Capital Cost (col . 5 x col . 6)       6       7.00       7.00       7.00         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       ADULTS & PEDIATRICS       4,217       443,713       30.00         31.00       INTENSI VE CARE UNIT       0       0       33.00       30.00         32.00       CORNARY CARE UNIT       0       0       33.00       30.00       33.00         34.00       SUBGICAL INTENSI VE CARE UNIT       0       0       44.00       43.00         44.00       SUBPROVIDER - IPF       0       0	34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
43.00       NURSERY       16,841       455       37.01       43.00         44.00       SKI LLED NURSING FACILITY       0       0       0       0.00       44.00         45.00       NURSING FACILITY       0       0       0       0.00       44.00         45.00       NURSING FACILITY       0       0       0       0.00       44.00         45.00       NURSING FACILITY       0       0       0       0.00       45.00         200.00       Total (lines 30 through 199)       1,687,198       11,687,198       15,318       200.00         Cost Center Description       Inpatient Program Capital Cost (col. 5 x col. 6)       1,687,198       15,318       200.00         NEMATION RESERVICE COST CENTERS         30.00       ADULTS & PEDIATRICS       4,217       443,713       31.00         31.00       INTENSIVE CARE UNIT       594       98,877       31.00       32.00         33.00       BURN INTENSIVE CARE UNIT       0       0       33.00       33.00       33.00       33.00       33.00       33.00       43.00       43.00         44.00       SUBPROVIDER - IPF       0       0       43.00       43.00       43.00       44.00	40.00 SUBPROVIDER - IPF	0	0		0 0	0.00	40.00
43.00       NURSERY       16,841       16,841       455       37.01       43.00         44.00       SKI LLED NURSING FACILITY       0       0       0       0.00       44.00         45.00       NURSING FACILITY       0       0       0       0.00       44.00         200.00       Total (lines 30 through 199)       1,687,198       1,687,198       15,318       200.00         Cost Center Description       Inpatient Program Capital Cost (col. 5 x col. 6)       1,687,198       15,318       200.00         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       ADULTS & PEDIATRICS       4,217       443,713       31.00         31.00       INTENSIVE CARE UNIT       594       98,877       31.00         32.00       CORONARY CARE UNIT       0       0       33.00         34.00       SURGICAL INTENSIVE CARE UNIT       0       0       33.00         34.00       SUBPROVIDER - IRF       0       0       43.00         44.00       SUBPROVIDER - IRF       0       0       43.00         44.00       SUBPROVIDER - IRF       0       0       43.00		0	0		0 0	0,00	41.00
44.00       SKILLED NURSING FACILITY       0       0       0       0.00       44.00         45.00       NURSING FACILITY       0       0       0       0       0.00       45.00         200.00       Total (lines 30 through 199)       1,687,198       1,687,198       15,318       200.00         Cost Center Description       Inpatient Program days       Inpatient Program Capital Cost (col. 5 x col. 6)       1,687,198       15,318       200.00         INPATIENT ROUTINE SERVICE COST CENTERS         0		16, 841		16.84	1 455		
45.00       NURSING FACILITY       0       0       0       0.00       45.00         200.00       Total (Lines 30 through 199)       1,687,198       1,687,198       15,318       200.00         Cost Center Description       Inpatient Program days       Program Capital Cost (col. 5 x col. 6)       10       10       10       10         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       ADULTS & PEDIATRICS       4,217       443,713       30.00         31.00       INTENSIVE CARE UNIT       594       98,877       31.00       32.00         32.00       SURGI CAL INTENSIVE CARE UNIT       0       0       33.00       32.00       33.00         34.00       SURGI CAL INTENSIVE CARE UNIT       0       0       44.00       44.00         41.00       SUBPROVIDER - IPF       0       0       44.00       44.00         44.00       SUBPROVIDER - IRF       0       0       44.00       44.00         45.00       NURSING FACILITY       0       0       44.00       44.00		0					
200.00         Total (lines 30 through 199)         1, 687, 198         1, 687, 198         15, 318         200.00           Cost Center Description         Inpatient Program days         Inpatient Capital Cost (col. 5 x col. 6)         Inpatient Program         20.00         20.00           INPATIENT ROUTINE SERVICE COST CENTERS         6.00         7.00         30.00         30.00         30.00         30.00         30.00         30.00         31.00         31.00         INTENSIVE CARE UNIT         594         98,877         31.00         31.00         31.00         31.00         31.00         32.00         32.00         32.00         32.00         32.00         32.00         33.00         34.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         45.00         0         0         0         45.00		0			0 0		
Cost Center Description       Inpatient Program days       Inpatient Program Capital Cost (col. 5 x col. 6)         30.00       ADULTS & PEDIATRICS       4,217         443,713       30.00         31.00       INTENSIVE CARE UNIT         32.00       CORONARY CARE UNIT         30.00       SURGI CAL INTENSIVE CARE UNIT         30.00       SURGI CAL INTENSIVE CARE UNIT         30.00       SURGI CAL INTENSIVE CARE UNIT         30.00       0         31.00       SURGI CAL INTENSIVE CARE UNIT         0       0         32.00       SURGI CAL INTENSIVE CARE UNIT         0       0         34.00       SURGI CAL INTENSIVE CARE UNIT         0       0         33.00       SUBPROVIDER - IPF         0       0         43.00       SUBPROVIDER - IRF         0       0         43.00       SURSERY         0       0         0       0         0       0         0       0         0       0         44.00       44.00		1 687 198		1 687 19	8 15 318		
Impartient routine service cost centers         Program days         Program Capital Cost (coi. 5 x coi. 6)         30.00           ADULTS & PEDIATRICS         4,217         443,713         30.00           31.00         INTENSI VE CARE UNIT         594         98,877         31.00           32.00         CORONARY CARE UNIT         0         0         32.00         30.00           34.00         SURGI CAL INTENSI VE CARE UNIT         0         0         33.00         34.00         34.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         44.00         45.0			Innatient	1,007,17	10,010		200.00
INPATI ENT ROUTINE SERVICE COST CENTERS         6.00         7.00           30.00         ADULTS & PEDI ATRICS         4,217         443,713         30.00           31.00         INTENSI VE CARE UNIT         594         98,877         31.00           32.00         CORONARY CARE UNIT         0         0         32.00           33.00         BURN INTENSI VE CARE UNIT         0         0         33.00           34.00         SURGI CAL INTENSI VE CARE UNIT         0         0         33.00           34.00         SUBGI CAL INTENSI VE CARE UNIT         0         0         0           41.00         SUBPROVI DER - I PF         0         0         0         41.00           43.00         NURSERY         0         0         0         43.00         43.00           44.00         SKI LLED NURSI NG FACI LI TY         0         0         43.00         44.00	obst center beschiption						
INPATI ENT ROUTI NE SERVI CE COST CENTERS         6.00         7.00           30.00         ADULTS & PEDI ATRI CS         4,217         443,713         30.00           31.00         INTENSI VE CARE UNI T         594         98,877         31.00           32.00         CORONARY CARE UNI T         0         0         32.00           33.00         BURN INTENSI VE CARE UNI T         0         0         33.00           34.00         SURGI CAL INTENSI VE CARE UNI T         0         0         34.00           40.00         SUBPROVI DER - I PF         0         0         40.00           43.00         NURSERY         0         0         0           44.00         SKI LLED NURSI NG FACI LI TY         0         0         43.00           45.00         NURSI NG FACI LI TY         0         0         44.00							
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         ADULTS & PEDIATRICS         4,217         443,713         30.00           31.00         INTENSIVE CARE UNIT         594         98,877         31.00           32.00         CORONARY CARE UNIT         0         0         32.00           33.00         BURN INTENSIVE CARE UNIT         0         0         33.00           34.00         SURGICAL INTENSIVE CARE UNIT         0         0         34.00           40.00         SUBPROVIDER - IPF         0         0         34.00           41.00         SUBPROVIDER - IRF         0         0         41.00           43.00         SKILLED NURSING FACILITY         0         0         43.00           45.00         NURSING FACILITY         0         0         43.00							
6.00         7.00           INPATI ENT ROUTINE SERVICE COST CENTERS         30.00           30.00         ADULTS & PEDIATRICS         4,217           31.00         INTENSI VE CARE UNIT         594           32.00         CORONARY CARE UNIT         0           33.00         BURN INTENSI VE CARE UNIT         0           34.00         SURGI CAL INTENSI VE CARE UNIT         0           34.00         SURGI CAL INTENSI VE CARE UNIT         0           40.00         SUBPROVI DER - I PF         0         0           43.00         NURSERY         0         0         43.00           44.00         SKI LLED NURSI NG FACI LI TY         0         0         43.00           45.00         NURSI NG FACI LI TY         0         0         44.00			•				
INPATI ENT ROUTINE SERVICE COST CENTERS           30.00         ADULTS & PEDIATRICS         4, 217         443, 713         30.00           31.00         INTENSIVE CARE UNIT         594         98, 877         31.00           32.00         CORONARY CARE UNIT         0         0         32.00           33.00         BURN INTENSIVE CARE UNIT         0         0         32.00           34.00         SURGICAL INTENSIVE CARE UNIT         0         0         33.00           44.00         SUBPROVIDER - IPF         0         0         34.00           41.00         SUBPROVIDER - IRF         0         0         41.00           43.00         NURSERY         0         0         43.00           44.00         SKILLED NURSING FACILITY         0         0         44.00           45.00         NURSING FACILITY         0         0         45.00		6.00					
30. 00       ADULTS & PEDIATRICS       4, 217       443, 713       30. 00         31. 00       INTENSI VE CARE UNIT       594       98, 877       31. 00         32. 00       CORONARY CARE UNIT       0       0       32. 00         33. 00       BURN INTENSIVE CARE UNIT       0       0       32. 00         34. 00       SURGI CAL INTENSIVE CARE UNIT       0       0       33. 00         40. 00       SUBPROVI DER - IPF       0       0       34. 00         41. 00       SUBPROVI DER - IRF       0       0       40. 00         43. 00       NURSERY       0       0       43. 00         44. 00       SKILLED NURSING FACILITY       0       0       44. 00         45. 00       NURSING FACILITY       0       0       45. 00	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
31.00       INTENSI VE CARE UNIT       594       98,877       31.00         32.00       CORONARY CARE UNIT       0       0       32.00         33.00       BURN INTENSIVE CARE UNIT       0       0       33.00         34.00       SUBGI CAL INTENSIVE CARE UNIT       0       0       34.00         40.00       SUBPROVI DER - IPF       0       0       40.00         41.00       SUBPROVI DER - IRF       0       0       41.00         43.00       NURSERY       0       0       43.00         44.00       SKI LLED NURSING FACILITY       0       0       44.00         45.00       NURSING FACILITY       0       0       45.00		4 217	443 713				30.00
32.00       CORONARY CARE UNIT       0       0       32.00         33.00       BURN INTENSIVE CARE UNIT       0       0       33.00         34.00       SUBGI CAL INTENSIVE CARE UNIT       0       0       34.00         40.00       SUBPROVIDER - IPF       0       0       40.00         41.00       SUBPROVIDER - IRF       0       0       41.00         43.00       NURSERY       0       0       43.00         44.00       SKILLED NURSING FACILITY       0       0       44.00         45.00       NURSING FACILITY       0       0       45.00							
33.00       BURN INTENSIVE CARE UNIT       0       0       33.00         34.00       SURGICAL INTENSIVE CARE UNIT       0       0       34.00         40.00       SUBPROVIDER - IPF       0       0       40.00         41.00       SUBPROVIDER - IRF       0       0       41.00         43.00       SKILLED NURSING FACILITY       0       0       43.00         44.00       SKILLED NURSING FACILITY       0       0       44.00							
34.00       SURGICAL INTENSIVE CARE UNIT       0       0       34.00         40.00       SUBPROVIDER - IPF       0       0       40.00         41.00       SUBPROVIDER - IRF       0       0       41.00         43.00       NURSERY       0       0       43.00         44.00       SKILLED NURSING FACILITY       0       0       44.00         45.00       NURSING FACILITY       0       0       45.00		0	0				
40.00       SUBPROVIDER - IPF       0       0       40.00         41.00       SUBPROVIDER - IRF       0       0       41.00         43.00       NURSERY       0       0       43.00         44.00       SKILLED NURSING FACILITY       0       0       44.00         45.00       NURSING FACILITY       0       0       45.00		0	0				
41.00       SUBPROVIDER - IRF       0       0       41.00         43.00       NURSERY       0       0       43.00         44.00       SKILLED NURSING FACILITY       0       0       44.00         45.00       NURSING FACILITY       0       0       45.00		0	0				
43.00     NURSERY     0     0     43.00       44.00     SKILLED NURSING FACILITY     0     0     44.00       45.00     NURSING FACILITY     0     0     45.00		0	0				
44.00         SKILLED NURSING FACILITY         0         0         44.00           45.00         NURSING FACILITY         0         0         45.00		0	0				
45.00 NURSING FACILITY 0 0 45.00		0	0				
		0	0				
200. 00 10 tai (11 nes 30 through 199) [ 4, 811] 542, 590] [200. 00		0	0				
	200.00/10tal (ITNES 30 Through 199)	4, 811	542, 590	1			200.00

APPORTI 0MMENT OF INPATLENT AUCILLARY SERVICE CAPITAL COSTS         Provider CX: 15-0086         Period: Provider CX: 15-0086         Period: Provider CX: 15-0086         Period: Provider CX: 15-0086         Description           Cost Center Description         Capital Relaced Cost (From INSt. C. 20)         Total Charges (Col. 1 + col. Port 1, col. Provider CX: 15-0086         Inpatient Provider CX: 15-0086         Inpatient Provider CX: 15-0086         Period: Provider CX: 15-0086           MeduLLARY SERVICE COST CENTERS         From INSt. C. 20)         Col. 1 + col. Port 1, col. Provider CX: 15-0086         Inpatient Provider CX: 15-0086         Provider CX: 15-0086         Provider CX: 15-0086           MeduLLARY SERVICE COST CENTERS         From INSt. C. 20)         Col. 1.00         Col. Provider CX: 15-0086         0.019761         3.880.116         76.675         50.00           50.00         Discool DEEXATING ROM         1.480.096         74.899.805         0.019761         3.880.116         76.675         50.00           50.00         Discool DEEXATING ROM         1.480.0976         74.899.805         0.019761         1.880.116         76.675         50.00           50.00         Discool PEXATING ROM         1.425.23         3.542.992         0.019761         1.986.597         27.867.50           50.00         Discool PEXATING ROM         2.4618         1.286.704         0.0009000	Health Financial Systems	ST ELI ZABETI	H DEARBORN		In Lie	u of Form CMS-:	2552-10
Cost Center Description         Capital (From Wist, B, Part II, col. 20)         Total Charges (From Wist, B, Part II, col. 2)         Inpatient (From Wist, B, Part II, col. 2)         Capital Costs (col um 4)         Capital Costs (col um 4)           4000         05000         0FEXPT         1, col. 2)         0         3, 00         4, 00         5, 00           50, 00         05000         0FEXPT         0, 00 <t< th=""><th>APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT/</th><th>AL COSTS</th><th>Provider C</th><th>CN: 15-0086</th><th>From 01/01/2023</th><th>Part II Date/Time Pre</th><th>pared: 8 pm</th></t<>	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT/	AL COSTS	Provider C	CN: 15-0086	From 01/01/2023	Part II Date/Time Pre	pared: 8 pm
Rel ated Cost (Prom Wist, E., e) 220         (Col un 3.x (Col un 4.)         (Col un 3.x (Col un 4.)           MCLLLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           0.00         05000 (PERATING ROM State)         1.400.096         74.899.805         0.019761         3.880.116         76.675         50.00           0.00         05200 (DELVLEW ROM & LABOR ROM State)         1.480.096         74.899.805         0.019761         3.880.116         76.675         50.00           0.00         05200 (DELVLEW ROM & LABOR ROM State)         1.480.096         74.899.805         0.0019761         3.881.16         51.00         51.00         52.00         0.000000         0         65.00         0.000000         0         52.00         0.0019761         3.881.51         3.841.60         0.001488         1.896.321         27.66         51.00         52.00         0         0.000000         0         65.00         0         0.000000         0         65.00         0         0.001981         1.004.400         1.922         57.00         0         0.001981         1.004.400         1.922         57.00         0         0.001981         1.002.400         1.922         57.00         0         0.0019814         1.004.400         1.922 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Image: Constraint of the second sec	Cost Center Description						
Part II., col. 20         8)         2)         -         -           MCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50. 00         05000 (PECATING ROOM         1.480,096         74,899,805         0.019761         3,880,116         76,675         50.00           50. 00         05200 (PECATING ROOM         318,181         3,840,977         0.0028238         350,271         29,016         52.00           50. 00         05400 (RADIOLOGY - ILAGNOSTIC         492,094         33,562,922         0.014680         1,898,221         27,867         54.00         0.000000         0         0         55.00           50. 00         05600 (RADIOISTICE - ILRAPEUTIC         0         0.000000         0         0         55.00           50. 00         05600 (SADIOST-IRAPEUTIC         492,094         33,562,922         0.000000         0         0         55.00           50. 00         05600 (SADIOST-IRAPEUTIC         0         0.000000         0         0         57.71         57.65         0.000800         0         0.000000         0         65.00           50.00         05900 (MARGIAC CATHETERIZATION         297.67         7,865.155         0         0.0000000 <td< td=""><td></td><td></td><td></td><td></td><td>5</td><td></td><td></td></td<>					5		
26)         20         3.00         4.00         5.00           NCI LLARY SERVICE COST CENTERS         0         0.00000         0.000000         0         5.00           51.00         05100 (PERATI IR ROM         1.480.096         74,899.805         0.0117761         3.880.116         76,675         5.00           52.00         05200 (PERATI IR ROM         1.480.096         74,899.805         0.0117761         3.880.116         76,675         55.00           53.00         05300 (AMESTHES) LLOCY         114,252         3.441.680         0.0014461         1.986.31         27,675         55.00           55.00         05500 (RADI CLOCY - HRAPEUTI C         0         0         0.000000         0         55.00           56.00         05500 (RADI CLOCY - HRAPEUTI C         0         0         0.000000         0         55.00           57.00         05700 (CT SCAN         24,618         12,863.704         0.0009000         0         55.00           59.00         05900 (CARDI AC CATHETER STATI ON         46,019         5.212.866         0.039378         2.707,90         0         0         0         0         0.000000         0         6.00         6.00         6.00         6.00         0         0.0000000				1 ·	. Charges	column 4)	
ANCI LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 [OFEANTING ROOM         1.480,096         74,899,805         0.017761         3.880,116         76,675         50.00           52.00         05200 [DELU FERV ROM & LABOR ROOM         318,181         3.840,997         0.0028283         350,271         29,016         52.00           53.00         05300 [DELU FERV ROM & LABOR ROOM         318,181         3.840,997         0.0028283         350,271         29,016         52.00           55.00         05600 [RADI LOCY - HERPETIC         0         0         0.000000         0         0.56.00           56.00         05600 [ARDI IOSOT-HERPETIC         0         0         0.000000         0         0.56.00           58.00         05800 [MAGRETIC RESONAUCE IMAGI NG (MRI )         32,165         3.746,814         0.008856         131,068         1,125         56.00           00         0.00000 [LABORATORY         2297,697         7.865,156         0         0.000000         0         0.60.01           00.010 [HOP LIN ICAL LAB SERVI CES-PRGIM ONLY         0         0         0.000000         0         0.60.01           0.010 [BOOD LABORATORY         297,697         7.865,156<			8)	2)			
ANCI LLARY SERVICE COST CENTERS         Image: Control of the co							
50:00         05000 OPEKATI NG ROOM         1,480,0%         74,899,805         0.019761         3,880,116         76,675         50.00           51:00         05100 RECOVERY ROOM         318,181         3,840,997         0.082838         350,271         29,016         52.00           50:00         05300 RADIOLOGY         14,252         3,441,680         0.04141         213,899         886         53.00           50:00         05500 RADIOLOGY-THERAPEUTIC         0         0.000000         0         65.00           56:00         05500 CT SCAN         24,418         12,863,704         0.001714         1,004,400         1,922         57.00           59:00         05900 CARDIA CATHERAPEUTIC         24,418         12,863,704         0.001714         1,004,400         1,922         57.00           59:00         05900 CARDIA CATHERAPENTORY         297,697         7,865,156         0.037850         2,028,863         7,722         60.0         66.00         66.		1.00	2.00	3.00	4.00	5.00	
51.00         651.00         FCOV         0         <		1 400 00/	74 000 005	0.0107	1 0 000 444	7/ /75	50.00
52.00         05200         DELIVERY ROM & LABOR ROM         318, 181         3, 480, 997         0.08238         350, 277         29, 016         52           53.00         D5300         RADILOCY         14, 252         3, 441, 660         0.004141         213, 899         866         53         00           56.00         D5600         RADILOCY-THERAPEUTIC         0         0.000000         0         55         00           57.00         D5700         CTSCAN         24, 618         12, 863, 704         0.000000         0         55         00           59.00         D5900         CARDILOCY-THERAPEUTIC         44, 618         12, 83, 704         0.001941         1, 044, 400         1, 925         57         00           59.00         D5900         CARDIL CACTHETERIZATION         44, 019         5, 212, 868         0.008828         650, 293         5, 741         59         00         0         0.000000         0         66, 01         0         0.000000         0         0         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00			/4, 899, 805				
53. 00       06300       ANESTHESI OLOGY       14, 252       3, 441, 680       0.00411       213, 899       886       53. 00         55. 00       05500       RAD IOLOGY-THERAPEUTIC       492, 694       33, 562, 932       0.014680       1, 998, 321       27, 867       54. 00         55. 00       05500       RAD IOLOGY-THERAPEUTIC       492, 694       33, 562, 932       0.014680       1, 998, 321       27, 867       54. 00       55. 00       0.000000       0       0       55. 00       0.000000       0       0       55. 00       0.00000       0       0       56. 00       0.000000       0       0       56. 00       57. 00       0.000000       0       0       0.000858       131, 068       1, 125       58. 00       0.000000       0       0       0.000000       0       0       0.000000       0       0       0.000000       0       0       0.000000       0       0       0.000000       0       0       0.000000       0       0       0.000000       0       0       0.000000       0       0       0.000000       0       0       0.000000       0       0       0.000000       0       0.000000       0       0.000000       0       0.000000       0		-	0				
54. 00         054.00         RADI OLGOY-DI AGNOSTI C         492, 694         33, 562, 922         0.014680         1, 898, 321         27, 867         84, 00           55.00         05500         RADI OLGOY-THERAPEUTI C         0         0         0.0000000         0         0         55.00           56.00         05700         05700         CT SCAN         24, 618         12, 863, 704         0.001914         1, 004, 400         1, 922         57.00           59.00         05900         CARDI AC CATHETERI ZATI ON         46, 019         5, 212, 868         0.008822         650, 293         5, 741         59.00           0.00         06000         LABORATORY         297, 697         7, 865, 156         0         0.337850         2, 028, 863         76, 792         60.01           0.00         06000         LABORATORY         0         0         0.000000         0         66.00           0.00         06000         ILABORATORY         29         0         0         0.000000         0         63.00           0.00         06000         ILADOR & PACKED RED BLODD CILLS         0         0         0.000000         0         68.00           0.000000         0         0.0000000         0							
55. 00         OSSOQ         RADIOLGGY-THERAPEUTIC         0         0         0.000000         0         0         55. 00           55. 00         OSSOQ         RADIOLGGY-THERAPEUTIC         0         0         0.000000         0         55. 00           57. 00         OSSOQ         RADIOLGGY-THERAPEUTIC         24. 618         12, 663, 774         0.001914         1, 004, 400         1, 922         57. 00           58. 00         OSSOQ         CARDIAC CATHETERIZATION         24, 618         12, 663, 774         0.001914         1, 004, 400         1, 922         57. 00           60. 00         06000         LABORATORY         297, 977         7, 865, 156         0.037850         2, 028, 863         76, 72         60         6         0         0         0         0         0         0         6         0         6         0         6         0							
56. 00         OS600         RADIOLISTOPE         0         0.000000         0         0         0         57.00           57.00         OS700         CTSON         24, 618         12, 863, 704         0.001914         1.044,400         1, 922         57.00           58.00         05900         CARDIAC CATHETERI ZATION         46, 019         52, 128, 86         0.00822         650, 293         5, 741         59. 00           00.00         IGBOO LABORATORY         277, 697         7, 865, 128, 86         0.003780         2, 028, 863         76, 792         60. 01           01.00         O6100 PPP CLIN RCL LAB SERVICES-PRGM ONLY         0         0         0.000000         0         62. 00           05.00         BLODD STOR INC, PROCESING & TRANS.         0         0         0.000000         0         64. 00           06400         INTEAVENUS THERAPY         90, 595         2, 966, 760         0.03373         37119         11, 944         65. 00           06500         RESPI RATORY THERAPY         292, 948         8, 095, 733         0.034185         376, 743         13, 622         66. 00           06700         OCCLPATIONAL THERAPY         294, 400         1, 203, 949         0.024420         178, 023         4, 347							
57. 00         DST00 CT SCAN         24, 618         12, 863, 704         0.001914         1, 004, 400         1, 922         57. 00           58. 00         OS900 MAGNETI C RESONANCE INAGING (NRI )         32, 165         3, 746, 814         0.008828         650, 293         5, 741         59. 00           00         00000 LABORATORY         297, 697         7, 865, 156         0.037850         2, 028, 863         76, 792         60. 01           01         00000 BLD00 LABORATORY         0         0         0.000000         0         0         60. 01           0.010         00000 WHOLE BLOOD CABORATORY         0         0         0.000000         0         61. 00           0.010         00000 WHOLE BLOOD CABORATORY         0         0         0.000000         0         62. 00           0.010         00001 UNTEQUEVENDUS THERAPY         0         0         0.000000         0         63. 00           0.05000 OCCUPATIONES THERAPY         292, 948         8, 057, 733         0.036185         376, 743         13, 632         66. 00           0.00000 OC CUCUPATIONAL THERAPY         292, 400         1, 203, 949         0.024420         178, 823         4, 347         67. 00           0.000000 OC CUCUPATIONAL THERAPY         292, 408							
58. 00         05800         MAGNUETI C RESONANCE I MAGI NG (MRI )         32, 165         3, 74, 814         0.008585         131,068         1,125         58. 00           60. 000         CADDI AC CATHETERI ZATI ON         46,019         5,212,868         0.00828         650, 293         5,741         69. 00           60. 01         D6001         LABORATORY         0         0         0.000000         0         60. 01           60. 01         D6001         ILADOA LABORATORY         0         0         0.000000         0         60. 01           60. 00         D6200         IHOLE BLODD A PACKED RED BLODD CELLS         0         0         0.000000         0         62. 00           64. 00         D6400         RESPI RATORY         0         0         0.000000         0         64. 00           65.00         D6500         RESPI RATORY         90. 595         2. 966, 706         0.03053         391, 119         11, 944         45. 00           66.00         D6500         RESPI RATONAL THERAPY         292, 948         895, 733         0.03185         376, 743         133, 522         628, 854         0.024370         78, 743         43, 47         70. 00           67.00         D6700         DELCHROARDIOLOGY		-	-				
59.00         OS900         CARDINAC CATHETERI ZATION         46, 019         5, 212, 868         0.008828         650, 293         5, 741         59.00           60.00         06000         LABORATORY         297, 697         7, 865, 156         0.037850         2, 028, 863         76, 792         60.00           61.00         06100         PBC LINICAL LAB SERVICES-PRGM ONLY         0         0         0.000000         0         60.00           62.00         062000         WHOLE BLOOD & PACKER BED BLOOD CELLS         0         0         0.000000         0         0         63.00         0.000000         0         0         63.00         0.000000         0         0         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         66.00         0.000000         0         0         64.00         66.00         66.00         150.713         0.036185         376, 743         13, 632         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         68.00         68.00         68.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
60.00         0c000         LABORATORY         297, 697         7, 865, 156         0.037850         2, 028, 863         76, 792         60.01           60.01         06001         BLODD LABORATORY         0         0.00000         0         60.01           61.00         06100         PBP CLINI CAL LAB SERVICES-PRGM ONLY         0         0.000000         0         62.00           62.00         06200         WHOLE         BLOOD & PACKED RED BLODD CELLS         0         0         0.000000         0         63.00           63.00         06300         RESPI RATORING, PROCESSING & TRANS.         0         0         0.000000         0         64.00           64.00         06400         INTRAVENOUS THERAPY         292, 948         8,095,733         0.036185         376,743         13,632         66.00           65.00         06600         PHYSI CAL THERAPY         292,400         11,233,949         0.024430         78,023         4,347         7.00           67.00         05000         CELCTROCARDI OLOGY         117,951         3,268,486         0.033028         2,184,878         8,702         72.00           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         361,497         21,1715,838         0.003							
60. 01         0.0001         BLOOD         LABORATORY         0         0.00000         0         60. 01           61. 00         06100         PBP CLINICAL LAB SERVICES-PRGM ONLY         0         0.000000         0         61. 00           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0         0         0.000000         0         0         62. 00           63. 00         06300         BLOOD STORING, PROCESSING & TRANS.         0         0         0.000000         0         63. 00           64. 00         CACOO INTRAVENUS THERAPY         90, 595         2, 966, 706         0.030537         391, 119         11, 944         65. 00           66. 00         06500         RESPI RATORY THERAPY         292, 948         8, 905, 733         0.036185         376, 743         13, 632         66. 00           67. 00         06700         OCLPARTINALITHERAPY         294, 400         1, 203, 949         0.024420         178, 023         4, 347         67. 00           68. 00         06800 SPEECH PATHOLOGY         15, 325         628, 854         0.033028         284, 716         9, 404         69. 00           71. 00         07000         ELECTROENCEPHALOGRAPHY         1, 042         79, 130         0.13168							
61.00         06100         PBP CLI NI CAL LAB SERVICES-PRCM ONLY         61.00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0         0.000000         0         62.00           63.00         06300         BLOOD STORI NO, PROCESSI NG & TRANS.         0         0.000000         0         63.00           64.00         06400         INTRAVENOUS THERAPY         0         0.000000         0         64.00           65.00         06500 RESPI RATORY THERAPY         90.595         2.966,706         0.030537         391,119         11.944         65.00           66.00         06000 OCUPATI ONAL THERAPY         292.948         8.095,733         0.034185         376,743         13.632         66.00           67.00         06000 SPEECH PATHOLOGY         15.325         628,854         0.024320         98,058         2.390         68.00           00         00000 ELECTROCARDI OLOGY         107.951         3.268,486         0.033028         284,716         9.404         69.00           0100         07000 IEECTROCARDI OLOGY         107.951         3.268,486         0.030281         1.948,478         8.702         72.00           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         337,971         16.235,							
62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0         0.000000         0         62.00           63.00         06300 BLOOD STORING, PROCESSING & TRANS.         0         0.000000         0         63.00           64.00         06400 INTRAVENUS THERAPY         90.595         2.966.706         0.30537         391,119         11.944         65.00           66.00         0600         PHYSI CAL THERAPY         292,948         8.095,733         0.36185         376,743         13.632         64.00           67.00         06700         OCCUPATI ONAL THERAPY         292,940         1.203,949         0.024420         178,023         4.347         67.00           68.00         06800         SPECH PATHOLOGY         15.325         628,854         0.024370         98,058         2.390         68.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATI ENTS         0         0.000000         0         0         71.00           73.00         07300         RUGS CHARGED TO PATI ENTS         337,971         16.235,683         0.029812         1.48,878         8.702         72.00           75.00         07500         ASC (NON-DI STI NCT PART)         0         0.0000000         0         0		0		0.0000	0	0	
63.00         06300         BLOOD STORING, PROCESSING & TRANS.         0         0         0.000000         0         63.00           64.00         06400         INTRAVENOUS THERAPY         0         0         0.000000         0         64.00           65.00         06500         RESPI RATORY THERAPY         90,595         2,966,706         0.030537         391,119         11,944         65.00           66.00         06600         PHYSI CAL THERAPY         292,948         8,095,733         0.036185         376,743         13,632         66.00           67.00         06600         SPEECH PATHOLOGY         15,325         628,854         0.024370         98,058         2,390         68.00           69.00         06900         ELECTROCARDI OLOGY         107,951         3,268,486         0.033028         284,716         9,404         69.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         86.497         21,715,838         0.003983         2,184,878         8,702         72.00           74.00         07400         RENAL DI ALVSIS         192         114,237         0.001681         19,851         33         74.00           75.00         07500         ACK (NN-DI STI NCT PART) <td< td=""><td></td><td></td><td></td><td>0.0000</td><td></td><td></td><td></td></td<>				0.0000			
64.00         06400         INTRAVENOUS THERAPY         0         0         0.000000         0         0         64.00           65.00         06500         RESPI RATORY THERAPY         90,595         2,966,706         0.030537         391,119         11,944         65.00           66.00         06600         PHYSI CAL THERAPY         292,948         8,095,733         0.036185         376,743         13,632         64.00           67.00         06700         0CCUPATI ONAL THERAPY         294,400         1,203,949         0.024420         178,023         4,347         67.00           68.00         06800         PELECTROCARDI OLOGY         15,325         628,854         0.023028         284,716         9,404         69.00           70.00         OTOO         ELECTROCARDI OLOGY         107,951         3,268,486         0.033028         2.84,716         9,404         69.00           71.00         0100         MEDI CALSUPPLIES CHARGED TO PATI ENTS         0         0         0.000000         0         0         71.00           72.00         07300         RENGS CARAGED TO PATI ENTS         337,971         16,235,683         0.020817         1,908,498         39,729         73.00           74.00         07400							
65.00       06500       RESPI RATORY THERAPY       90,595       2,966,706       0.030537       391,119       11,944       65.00         66.00       06600       PHYSI CAL THERAPY       292,948       8,095,733       0.036185       376,743       13,632       66.00         67.00       06700       0CCUPATIONAL THERAPY       29,400       1,203,949       0.024420       178,023       4,347       67.00         68.00       06800       SPEECH PATHOLOGY       15,325       628,854       0.024320       98,058       2,390       68.00         69.00       06900       ELECTROCARDIOLOGY       107,951       3,268,486       0.033028       284,716       9,404       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0.000000       0       71.00         72.00       07300       DRUS CHARGED TO PATI ENTS       337,971       16,235,683       0.020817       1,908,498       39,729       73.00         74.00       07400       RNAL DI ALYSI S       192       114,237       0.01681       19,851       33       74.00         75.00       ASC (MON-DI STINCT PART)       0       0       0.000000       0       75.00         7050		0	, o				
66.00       06600       PHYSI CAL THERAPY       292,948       8,095,733       0.036185       376,743       13,632       66.00         67.00       0CCUPATI IONAL THERAPY       29,400       1,203,949       0.024420       178,023       4,347       67.00         68.00       06600       SPEECTROCARDI OLOGY       15,325       628,854       0.024370       98,058       2.900       68.00         69.00       06900       ELECTROCARDI OLOGY       107,951       3,268,486       0.033028       284,716       9,404       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       1,042       79,130       0.013168       942       12       70.00         71.00       07100       ELECTROENCEPHALOGRAPHY       1,042       79,130       0.003983       2,184,878       8,702       72.00         73.00       DRUGS CHARGED TO PATIENTS       337,971       16,235,683       0.020817       1,908,498       39,727       73.00         75.00       O7500       ASC (NON-DI STI NCT PART)       0       0       0.000000       0       0       75.00         76.97       CARDI AC REHABI LI TATI ON       4,518       849,498       0.005318       4113       2       76.97         700 <td></td> <td></td> <td>, s</td> <td></td> <td></td> <td></td> <td></td>			, s				
67.00         06700         0CCUPATIONAL THERAPY         29,400         1,203,949         0.02420         178,023         4,347         67.00           68.00         06800         SPECH PATHOLOGY         15,325         628,854         0.024370         98,058         2,390         68.00           06900         ELECTROCARDIOLOGY         107,951         3,268,486         0.033028         284,716         9,404         96.00           70.00         ELECTROENCEPHALGGRAPHY         1,042         79,130         0.013168         942         12         70.00           71.00         07200         IMPL AKGED TO PATIENTS         86,497         21,715,838         0.003983         2,184,878         8,702         72.00           73.00         O7300         DRUGS CHARGED TO PATIENTS         337,971         16,235,683         0.020817         1,908,498         39,729         73.00           74.00         O7500 ASC (NON-DISTINCT PART)         0         0         0.000000         0         0         75.00           76.97         CARDIA C REHABILTATION         4,518         849,498         0.005318         4133         2         76.97           76.00         ALLOGENEI C STEM CELL ACQUISITION         0         0         0.000000							
68.00         06800         SPEECH         PATHOLOGY         15,325         628,854         0.024370         98,058         2,390         68.00           69.00         06900         ELECTROCARDIOLOGY         107,951         3,268,486         0.033028         284,716         9,404         69.00           70.00         O7000         ELECTROCARDIOLOGY         107,951         3,268,486         0.033028         284,716         9,404         69.00           71.00         O7100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0         0.03168         942         12         70.00           73.00         O7200         IMPL. DEV. CHARGED TO PATIENTS         364,977         21,715,838         0.03983         2,184,878         8,702         72.00           75.00         O7500         RUGS CHARGED TO PATIENTS         337,971         16,235,683         0.020817         1,908,498         39,729         73.00           75.00         O7500         ASC (NON-DISTINCT PART)         0         0         0.000000         0         75.00           76.97         ORADIAC REHABILITATION         4,518         849,498         0.05318         413         2         76.97           78.00         O7800 CAR         CARDIAC REHABILITATION							
69.00       06900       ELECTROCARDI OLOGY       107,951       3,268,486       0.033028       284,716       9,404       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       1,042       79,130       0.013168       942       12       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0.000000       0       71.00         72.00       07200       IRWIL. DEV. CHARGED TO PATI ENTS       86,497       21,715,838       0.003983       2,184,878       8,702       72.00         73.00       07300       RENAL DI ALYSI S       192       114,237       0.001681       19,8498       39,729       73.00         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0.000000       0       75.00         76.97       07697       CARDI AC REHABI LI TATI ON       4,518       849,498       0.005318       413       2       76.97         76.00       07000 LART -CELL ACQUI SI TI ON       0       0       0.000000       0       0       0       0.000000       0       0       0       0.000000       0       0       0       0.000000       0       0       0       0.000000       0       0							
70.00       07000       ELECTROENCEPHALOGRAPHY       1,042       79,130       0.013168       942       12       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0.000000       0       0       71.00         72.00       07200       IMPL       DEV. CHARGED TO PATI ENTS       86,497       21,715,838       0.003983       2,184,878       8,702       72.00         73.00       07400       RENAL DIALYSIS       192       114,237       0.01681       19,851       333       74.00         75.00       07507       CARDI AC REHABILI TATI ON       4,518       849,498       0.005318       413       2       76.97         77.00       0700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0.000000       0       73.00         78.00       08800       RURAL HEALTH CLINIC       0       0       0.000000       0       70.00         78.00       08900       FEDERALLY QUALI FIED HEALTH CENTER       0       0       0.000000       0       88.00         89.00       08900       FEDERALLY QUALI FIED HEALTH CENTER       0       0       0.000000       0       90.00         91.00       9100       EN							
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0.000000       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       86,497       21,715,838       0.03983       2,184,878       8,702       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       337,971       16,235,683       0.002817       1,908,498       39,729       73.00         74.00       07400       RENAL DI ALYSIS       192       114,237       0.01681       19,851       33       74.00         75.00       07607       CARDI AC REHABI LI TATI ON       4,518       849,498       0.005318       413       2       76.97         77.00       0700       ALLOGENEI C STEM CELL ACOUI SI TI ON       0       0       0.000000       0       78.00         078.00       07800       CRR T-CELL IMMUNOTHERAPY       0       0       0.000000       0       78.00         0800       FEDERALLY QUALI FIED HEALTH CENTER       0       0       0.000000       0       0       89.00         09100       EMERGENCY       393,205       35,202,947       0.011170       2,575,645       28,770       91.00         92.00       DESERVATI ON BEDS (NON-DI STINCT PART) <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       86,497       21,715,838       0.003983       2,184,878       8,702       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       337,971       16,235,683       0.020817       1,908,498       39,729       73.00         74.00       RENAL DI ALYSI S       192       114,237       0.001681       19,851       33       74.00         75.00       07500       ASC (NON-DISTINCT PART)       0       0       0.000000       0       75.00         76.97       CARDI AC REHABILITATION       4,518       849,498       0.005318       413       2       76.97         77.00       07600       CARDI AC REHABILITATION       4,518       849,498       0.005318       413       2       76.97         77.00       07600       CART - CELL IMMUNOTHERAPY       0       0       0.000000       0       78.00         0800       RURAL HEALTH CLINIC       0       0       0.000000       0       88.00         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0.000000       0       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00			/ / / / / / / / /				
73.00       07300       DRUGS CHARGED TO PATIENTS       337,971       16,235,683       0.020817       1,908,498       39,729       73.00         74.00       07400       RENAL DI ALYSIS       192       114,237       0.01681       19,851       33       74.00         75.00       ASC (NON-DI STINCT PART)       0       0       0.000000       0       0       75.00         76.97       OR697       CARDIAC REHABILITATION       4,518       849,498       0.005318       413       2       76.97         77.00       0700       ALLOGENEI C STEM CELL ACQUISITION       0       0       0.000000       0       75.00         0800       08800       RURAL HEALTH CLINIC       0       0       0.000000       0       88.00         99.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0.000000       0       88.00         91.00       09100       CLINIC       0       0       0.000000       0       90       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00		-	21 715 838				
74.00       07400       RENAL DI ALYSI S       192       114, 237       0.001681       19, 851       33       74.00         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0.000000       0       0       75.00         76.97       O7697       CARDI AC REHABI LI TATI ON       4, 518       849, 498       0.005318       413       2       76.97         77.00       O700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0.000000       0       77.00         07800       CAR T-CELL IMMUNOTHERAPY       0       0       0.000000       0       78.00         01000       DESRVICE COST CENTERS       0       0       0.000000       0       88.00         88.00       08900       RURAL HEALTH CLINIC       0       0       0.000000       0       88.00         90.00       O9000       CLINIC       0       0       0.000000       0       99.00       99.00         91.00       DMERGENCY       393,205       35,202,947       0.011170       2,575,645       28,770       91.00         92.00       OSERVATI ON BEDS (NON-DI STI NCT PART)       281,156       5,182,602       0.054250       293,457       15,920       9							
75.00       07500       ASC (NON-DI STINCT PART)       0       0       0.000000       0       0       75.00         76.97       07697       CARDI AC REHABI LI TATI ON       4, 518       849, 498       0.005318       413       2       76.97         77.00       0700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0.000000       0       0       77.00         78.00       07800       CAR T-CELL IMUNOTHERAPY       0       0       0.000000       0       0       78.00         000       08800       RURAL HEALTH CLINI C       0       0       0.000000       0       88.00         89.00       08800       RURAL HEALTH CLINI C       0       0       0.000000       0       88.00         99.00       FEDERALLY QUALI FIED HEALTH CENTER       0       0       0.000000       0       88.00         99.00       09000       CLINI C       0       0       0.000000       0       99.00         91.00       09100       EMERGENCY       393, 205       35, 202, 947       0.011170       2, 575, 645       28, 770       91.00         92.00       OBSERVATION BEDS (NON-DI STINCT PART)       281, 156       5, 182, 602       0.054250       2							
76. 97       07697       CARDI AC REHABI LI TATI ON       4, 518       849, 498       0.005318       413       2       76. 97         77. 00       07700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0.000000       0       0       77. 00         78. 00       07800       CAR T-CELL IMMUNOTHERAPY       0       0       0.000000       0       0       78. 00         0UTPATI ENT SERVICE COST CENTERS       0       0       0.000000       0       0       88. 00         88. 00       08800       RURAL HEALTH CLINIC       0       0       0.000000       0       88. 00         90. 00       09000       FEDERALLY QUALI FIED HEALTH CENTER       0       0       0.000000       0       90. 00         91. 00       09100       EMERGENCY       393, 205       35, 202, 947       0.011170       2, 575, 645       28, 770       91. 00         92. 00       OP200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       281, 156       5, 182, 602       0.054250       293, 457       15, 920       92. 00         94. 00       09400       HME PROGRAM DI ALYSI S       0       0       0.000000       0       95. 00         96. 00       09400       DURABLE MEDI CAL EQ							
77.00       0700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0.000000       0       77.00         78.00       07800       CAR T-CELL IMMUNOTHERAPY       0       0       0.000000       0       78.00         0UTPATI ENT SERVICE COST CENTERS       0       0       0.000000       0       0       88.00         88.00       08800       RURAL HEALTH CLINIC       0       0       0.000000       0       89.00         90.00       09000       CLINIC       0       0       0.000000       0       89.00         90.00       09000       CLINIC       0       0       0.000000       0       90.00         91.00       09100       EMERGENCY       393,205       35,202,947       0.011170       2,575,645       28,770       91.00         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       281,156       5,182,602       0.054250       293,457       15,920       92.00         94.00       09400       HOME PROGRAM DI ALYSIS       0       0       0.000000       0       94.00       95.00         96.00       09500       AMBULANCE SERVI CES       9       95.00       0       0.000000       0       96.00       96.00		-	-				
78.00         07800         CAR T-CELL IMMUNOTHERAPY         0         0         0.000000         0         0         78.00           OUTPATIENT SERVICE COST CENTERS         0         0         0.000000         0         0         88.00         08800         RURAL HEALTH CLINIC         0         0         0.000000         0         88.00         89.00         09000         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0.000000         0         0         90.00         90.00         90.00         0         0         90.00         90.00         90.00         90.00         90.00         90.00         0         0         0         90.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
OUTPATI ENT SERVICE COST CENTERS           88.00         08800 RURAL HEALTH CLINIC         0         0         0.000000         0         0         88.00           89.00         08900 FEDERALLY QUALI FIED HEALTH CENTER         0         0         0.000000         0         0         89.00           90.00         09000 CLINIC         0         0         0.000000         0         0         90.00           91.00         09100 EMERGENCY         393,205         35,202,947         0.011170         2,575,645         28,770         91.00           92.00         09200 OBSERVATI ON BEDS (NON-DI STINCT PART)         281,156         5,182,602         0.054250         293,457         15,920         92.00           0THER REI MBURSABLE COST CENTERS         0         0         0.000000         0         94.00         94.00         09400 HOME PROGRAM DI ALYSI S         0         0         0.000000         0         94.00         95.00         95.00         95.00         95.00         95.00         95.00         96.00         0.000000         0         0         95.00           96.00         09400 DURABLE MEDI CAL EQUI P-RENTED         0         0         0.000000         0         95.00           97.00         09700 DURABLE ME							
88.00         08800         RURAL HEALTH CLINIC         0         0         0.000000         0         0         88.00           89.00         08900         FEDERALLY QUALI FIED HEALTH CENTER         0         0         0.000000         0         0         89.00           90.00         09000         CLINIC         0         0         0.000000         0         0         90.00           91.00         09100         EMERGENCY         393,205         35,202,947         0.011170         2,575,645         28,770         91.00           92.00         OBSERVATI ON BEDS (NON-DI STINCT PART)         281,156         5,182,602         0.054250         293,457         15,920         92.00           0THER REIMBURSABLE COST CENTERS         0         0         0.000000         0         94.00         9400         HME PROGRAM DI ALYSIS         95.00         95.00         94.00         95.00         0         0.000000         0         94.00         95.00         9500 AMBULANCE SERVI CES         95.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00		-	-	1		-	
90.00         09000         CLINIC         0         0.00         0.00000         0         0         90.00         90.00         91.00         91.00         91.00         393,205         35,202,947         0.011170         2,575,645         28,770         91.00         92.00         09200         DBSERVATION BEDS (NON-DISTINCT PART)         281,156         5,182,602         0.054250         293,457         15,920         92.00         94.00         94.00         94.00         94.00         94.00         94.00         95.00         0.000000         0         0         94.00         95.00         95.00         96.00         0.000000         0         94.00         95.00         95.00         96.00         0.000000         0         96.00         96.00         96.00         0.000000         0         96.00		0	C	0.0000	0 00	0	88.00
91.00         09100         EMERGENCY         393,205         35,202,947         0.011170         2,575,645         28,770         91.00           92.00         D9200         DBSERVATI ON BEDS (NON-DI STI NCT PART)         281,156         5,182,602         0.054250         293,457         15,920         92.00           01HER         REI MBURSABLE COST CENTERS         0         0         0.000000         0         94.00         95.00           96.00         09500         AMBULANCE SERVI CES         0         0         0.000000         0         95.00           96.00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0.000000         0         96.00         96.00         97.00         97.00         97.00         97.00         98.00         0         0.000000         0         96.00         98.00         98.00         0         0.000000         0         98.00         98.00         98.00         0         0.000000         0         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         9	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	c	0. 00000	0 0	0	89.00
92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         281,156         5,182,602         0.054250         293,457         15,920         92.00           OTHER REI MBURSABLE COST CENTERS         0         0         0.000000         0         94.00         94.00         95.00         0         0.000000         0         94.00         95.00         95.00         96.00         0.000000         0         95.00         95.00         96.00         0.000000         0         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         96.00         97.00         97.00         97.00         97.00         97.00         0         0         0         97.00         98.00         98.00         0         0         0         0         98.00         98.00         98.00         0         0         0         0         98.00	90. 00 09000 CLINIC	0	0	0. 00000	0 0	0	90.00
OTHER         REI MBURSABLE         COST         CENTERS           94. 00         09400         HOME         PROGRAM         DI ALYSI S         0         0         0.000000         0         94. 00           95. 00         09500         AMBULANCE         SERVI CES         95. 00         95. 00         95. 00         96. 00         0         0.000000         0         0         96. 00         96. 00         96. 00         96. 00         0         0.000000         0         0         96. 00         96. 00         97. 00         97. 00         09700         DURABLE         MEDI CAL         EQUI P-SOLD         0         0.000000         0         0         97. 00         97. 00         98. 00         09850         OTHER         REI MBURSABLE         COST         CENTERS         0         0         0.000000         0         0         98. 00	91. 00 09100 EMERGENCY	393, 205	35, 202, 947	0. 01117	2, 575, 645	28, 770	91.00
94. 00         09400         HOME PROGRAM DI ALYSI S         0         0         0.000000         0         94. 00         95. 00         95. 00         95. 00         96. 00         0.000000         0         0         95. 00         95. 00         95. 00         96. 00         0.000000         0         0         96. 00         96. 00         96. 00         96. 00         0.000000         0         0         96. 00         97. 00         97. 00         09700         DURABLE MEDI CAL EQUI P-RENTED         0         0         0.000000         0         97. 00         97. 00         98. 00         09850         0THER REI MBURSABLE COST CENTERS         0         0         0.000000         0         0         98. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	281, 156	5, 182, 602	0. 05425	293, 457	15, 920	92.00
94. 00         09400         HOME PROGRAM DI ALYSI S         0         0         0.000000         0         94. 00         95. 00         95. 00         95. 00         96. 00         0.000000         0         0         95. 00         95. 00         95. 00         96. 00         0.000000         0         0         96. 00         96. 00         96. 00         96. 00         0.000000         0         0         96. 00         97. 00         97. 00         09700         DURABLE MEDI CAL EQUI P-RENTED         0         0         0.000000         0         97. 00         97. 00         98. 00         09850         0THER REI MBURSABLE COST CENTERS         0         0         0.000000         0         0         98. 00	OTHER REIMBURSABLE COST CENTERS						]
96.00         09600         DURABLE         MEDICAL         EQUIP-RENTED         0         0         0.000000         0         96.00         96.00         97.00         97.00         09700         DURABLE         MEDICAL         EQUIP-SOLD         0         0         0.000000         0         0         97.00         97.00         98.00         0         0.000000         0         0         98.00         98.00         0         0.000000         0         0         98.00         98.00         0         0.000000         0         0         98.00         0         0         0         0         0         0         0         98.00         0 <th< td=""><td>94.00 09400 HOME PROGRAM DI ALYSI S</td><td>0</td><td>C</td><td>0.0000</td><td>0 0</td><td>0</td><td>94.00</td></th<>	94.00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	0 0	0	94.00
97. 00         09700         DURABLE         MEDI CAL         EQUI P-SOLD         0         0         0.000000         0         97. 00         98. 00         0         0         0.000000         0         0         97. 00         98. 00         98. 00         0         0.000000         0         0         98. 00         98. 00         98. 00         0         0         0         98. 00         0         0         0         98. 00         0         0         0         0         98. 00         0         0         0         0         98. 00         0	95. 00 09500 AMBULANCE SERVI CES						95.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.000000 0 0 98. 00	96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.0000	0 0	0	96.00
		0	0	0.0000	0 0	0	
200.00           Total         (lines 50 through 199)         4, 346, 522         240, 977, 619         18, 469, 574         354, 909         200.00		-	, s				
	200.00   Total (lines 50 through 199)	4, 346, 522	240, 977, 619	2	18, 469, 574	354, 909	200.00

ST ELI ZABETH	I DEARBORN		In Lie	eu of Form CMS-:	2552-10
R PASS THROUGH COST	S Provider C	F	rom 01/01/2023	Date/Time Pre	pared: 8 pm
	Title	XVIII	Hospi tal	PPS	-
Nursing Program Post-Stepdown	Nursing Program		Allied Health	All Other Medical Education Cost	
	1 00	24	2.00	2.00	
IA	1.00	ZA	2.00	3.00	
0 0 0 0	0			0 0 0	31.00 32.00 33.00
				0 0 0	40. 00 41. 00
0 0 Swipg-Bed	0 0 Total Costs	( Total Patient	0 0 Per Diem (col		45.00 200.00
Adjustment Amount (see instructions)	(sum of cols. 1 through 3, minus col. 4)	Days	5 ÷ col. 6)	Program Days	
4.00	5.00	6.00	7.00	8.00	
0 0 0		1, 738 () () () () () () () () () () () () ()	3         0.00           0         0.00           0         0.00           0         0.00           0         0.00           0         0.00           0         0.00           0         0.00           0         0.00           0         0.00           0         0.00           0         0.00           0         0.00           0         0.00	594 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00 32.00 33.00 34.00 40.00 41.00 43.00 44.00
Inpatient Program Pass-Through Cost (col. 7 x <u>col. 8)</u> 9.00					
					20.00
					30.00 31.00 32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00
	R PASS THROUGH COST Nursi ng Program Post-Stepdown Adj ustments 1A 0 0 0 0 0 0 0 0 0 0 0 0 0	Nursi ng Program Adj ustments         Nursi ng Program           1A         1.00           1A         1.00           0         0 <td>R PASS THROUGH COSTS         Provi der CCN: 15-0086         F           Ittle         Title XVIII           Nursi ng Program Post-Stepdown Adj ustments         Nursi ng Program Program         Allied Heal th Post-Stepdown Adj ustments           1A         1.00         2A           0         0         0           1 through 3, instructions)         0</td> <td>R PASS THROUGH COSTS         Provider CCN: 15-0086         Period: From 01/01/2023 To 12/31/2023           Nursing Post-Stepdown Adjustments         Nursing Program         Nursing Program         Allied Health Post-Stepdown Adjustments         Allied Health Cost           1A         1.00         2A         2.00           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           1 sthrough 3, instru</td> <td>R PASS THROUGH COSTS         Provider CCN: 15-0086         Period: From 01/01/2023 To 12/31/2023         Worksheet D Part 111 Date/Time Pre 5/28/2024 1:5           Nursing Program Adjustments         Nursing Program Adjustment         Nursing Program P</td>	R PASS THROUGH COSTS         Provi der CCN: 15-0086         F           Ittle         Title XVIII           Nursi ng Program Post-Stepdown Adj ustments         Nursi ng Program Program         Allied Heal th Post-Stepdown Adj ustments           1A         1.00         2A           0         0         0           1 through 3, instructions)         0	R PASS THROUGH COSTS         Provider CCN: 15-0086         Period: From 01/01/2023 To 12/31/2023           Nursing Post-Stepdown Adjustments         Nursing Program         Nursing Program         Allied Health Post-Stepdown Adjustments         Allied Health Cost           1A         1.00         2A         2.00           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           0         0         0         0           1 sthrough 3, instru	R PASS THROUGH COSTS         Provider CCN: 15-0086         Period: From 01/01/2023 To 12/31/2023         Worksheet D Part 111 Date/Time Pre 5/28/2024 1:5           Nursing Program Adjustments         Nursing Program Adjustment         Nursing Program P

	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PAS	S Provider CO	CN: 15-0086	Peri From To	od: 01/01/2023 12/31/2023	Worksheet D Part IV Date/Time Pre 5/28/2024 1:55	pared: 8 pm
			Title	XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Po	lied Health st-Stepdown djustments	Allied Health	
		1.00	2A	2.00		3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0			0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	0	56.00
57.00	05700 CT SCAN	0	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0			0	0	0	73.00
75.00		0	0		0	0	0	75.00
76.97	07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION		0		0	0	0	76.97
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	-		0	0	0	78.00
70.00	OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	0	89.00
90.00	09000 CLINIC	0	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	0	92.00
	OTHER REIMBURSABLE COST CENTERS				-		0	1 00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0	0	0	94.00
95.00	09500 AMBULANCE SERVICES				-	Ū	J. J	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	0	97.00
98.00	09850 OTHER REI MBURSABLE COST CENTERS	0	-		0	0	0	98.00
	Total (lines 50 through 199)	0		1	0	0		200.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	ST ELIZABET		CN: 15-0086	Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	SERVICE OTHER PAS			From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre	pared:
		T: +1 -			5/28/2024 1:5 PPS	8 pm
Cost Center Description	All Other	Total Cost	XVIII Total	Hospi tal	Ratio of Cost	
cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		$(col. 5 \div col.$	
		4)	col s. 2, 3,	8)	7)	
			and 4)	0)	(see	
					instructions)	
	4,00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	C		0 74, 899, 805	0.00000	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 3, 840, 997	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	C	)	0 3, 441, 680	0.00000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C	)	0 33, 562, 932	0.00000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	)	0 0	0.00000	55.00
56. 00 05600 RADI 0I SOTOPE	0	c		0 0	0.000000	56.00
57.00 05700 CT SCAN	0	c c		0 12, 863, 704	0.000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	c c		0 3, 746, 814	0.000000	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	C C		0 5, 212, 868	0.000000	59.00
60. 00 06000 LABORATORY	0	c c		0 7, 865, 156	0.000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0.000000	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	(	-		-		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELI				0 0	0.000000	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0		0 0	0.000000	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 966, 706	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 8, 095, 733	0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 203, 949	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 628, 854	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 3, 268, 486	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 79, 130	0.000000	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	rs o	0		0 0	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	c c		0 21, 715, 838	0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C C	1	0 16, 235, 683	0.000000	
74.00 07400 RENAL DIALYSIS	0	c c	1	0 114, 237	0.000000	
75.00 07500 ASC (NON-DISTINCT PART)	0	c c		0 0	0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	c c		0 849, 498	0.00000	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	)	0 0	0.000000	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	C	)	0 0	0.000000	
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	0.00000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0. 000000	
90. 00 09000 CLINIC	0	C		0 0	0.000000	
91.00 09100 EMERGENCY	0	c c		0 35, 202, 947	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	Г) (	C		0 5, 182, 602	0.000000	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0. 000000	94.00
95.00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0. 000000	96.00
			1		0.000000	97.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	1 L		0 0	0.000000	77.00
97.0009700DURABLEMEDICALEQUIP-SOLD98.0009850OTHERREIMBURSABLECOSTCENTERS				0 0 0 0 240, 977, 619	0. 000000	

Health Financial Systems	ST ELI ZABETH	DEARBORN		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/28/2024 1:5	
			XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0. 000000	3, 880, 116		0 10, 040, 242	0	
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	350, 271		0 1, 952	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	213, 899		0 519, 736	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 898, 321		0 6, 545, 759	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	1,004,400		0 1, 840, 995	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	131, 068		0 560, 786	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	650, 293		0 795, 651	0	59.00
60. 00 06000 LABORATORY	0. 000000	2, 028, 863		0 944, 978	0	60.00
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	391, 119		0 411, 913	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	376, 743		0 17, 347	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	178, 023		0 3,749	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	98, 058		0 1, 393	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	284, 716		0 491, 493	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	942		0 16,666	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 184, 878		0 4, 206, 474	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 908, 498		0 1, 338, 185	0	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	19, 851		0 1, 330, 109	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0. 000000	19,001		0 0	0	75.00
76. 97   07697   CARDI AC REHABI LI TATI ON	0. 000000	413		0 246, 668	0	76.97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	413		0 240,000	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	78.00
88. 00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90. 00 09000 CLINIC		0		0 0	0	90.00
	0. 000000	0 E7E (4E			0	1
	0.000000	2, 575, 645		0 3, 414, 418		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS	0. 000000	293, 457		0 464, 072	0	92.00
	0.000000			0 0	0	04 00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0	
95. 00 09500 AMBULANCE SERVICES	0 00000	-		-	_	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	
200.00  Total (lines 50 through 199)		18, 469, 574	l	0 31, 862, 477	0	200. 00

	Financial Systems IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	ST ELIZABETH VACCINE COST	Provider C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 1:5	pared:
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)		5.00	
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVICE COST CENTERS	0.0/0000	10 040 040		0	2 702 027	
	05000 OPERATING ROOM	0. 269299	10, 040, 242		0 0		
	05100 RECOVERY ROOM	0.00000	0		0 0		
	05200 DELIVERY ROOM & LABOR ROOM	0. 790071	1, 952		0 0		
	05300 ANESTHESI OLOGY	0. 394896	519, 736		0 0	205, 242	
	05400 RADI OLOGY-DI AGNOSTI C	0. 174565	6, 545, 759		0 0		
	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	
	05700 CT SCAN	0. 121557	1, 840, 995		0 0	223, 786	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 168986	560, 786		0 0	94, 765	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 191080	795, 651		0 0	152, 033	59.00
60.00	06000 LABORATORY	0. 726927	944, 978		0 0	686, 930	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0		0 0	0	63.00
	06400 I NTRAVENOUS THERAPY	0.000000	0		0 0	0	64.00
	06500 RESPI RATORY THERAPY	0. 668947	411, 913		0 0	275, 548	65.00
	06600 PHYSI CAL THERAPY	0. 449314	17, 347		0 0	7, 794	
	06700 OCCUPATI ONAL THERAPY	0. 459135	3, 749		0 0	1, 721	
	06800 SPEECH PATHOLOGY	0. 447271	1, 393		0 0	623	
	06900 ELECTROCARDI OLOGY	0. 341983	491, 493		0 0	168, 082	
	07000 ELECTROENCEPHALOGRAPHY	0. 402780	16, 666		0 0	6, 713	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	.0,000		0 0	0,710	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 386190	4, 206, 474		0 0	1, 624, 498	
	07300 DRUGS CHARGED TO PATIENTS	0. 403281	1, 338, 185		52 1, 795	539, 665	
	07400 RENAL DIALYSIS	0. 155703	1, 330, 103	2.	0 0	0	
	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	1
	07697 CARDI AC REHABI LI TATI ON	0. 357513	246, 668		0 0	88, 187	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	240,000		0 0	00,107	
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0		
	OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	/0.00
	08800 RURAL HEALTH CLINIC						88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
		0,00000	0		0	0	
		0.000000	0 414 410		0 0		
	09100 EMERGENCY	0. 210678	3, 414, 418		0 0	719, 343	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 499681	464, 072		0 0	231, 888	92.00
	OTHER REIMBURSABLE COST CENTERS	0.000000		1	0		04.00
	09400 HOME PROGRAM DI ALYSI S	0.000000			0 0		94.00
	09500 AMBULANCE SERVICES	0. 000000	-		0	_	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0		0 0	0	
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	
200.00			31, 862, 477	25	52 1, 795	8, 874, 847	
201.00	5				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1	31, 862, 477	1 21	52 1, 795	8, 874, 847	1000 00

	inancial Systems DNMENT OF MEDICAL, OTHER HEALTH SERVICES AND	ST ELIZABETH VACCINE COST	Provider C	CN: 15-0086	Peri od:	u of Form CMS-255 Worksheet D	
					From 01/01/2023 To 12/31/2023	Part V Date/Time Prepa 5/28/2024 1:58	
			Title	× XVIII	Hospi tal	PPS	_p
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)				
		6.00	7.00	-			
A	NCILLARY SERVICE COST CENTERS	0.00	7.00	1			
	5000 OPERATING ROOM	0	0			5	50.00
51.00 0	5100 RECOVERY ROOM	0	0			5	51.0
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0	0			5	52.0
53.00 0	5300 ANESTHESI OLOGY	0	0			5	53.0
64.00 0	5400 RADI OLOGY-DI AGNOSTI C	0	0			5	54.0
5.00 0	5500 RADI OLOGY-THERAPEUTI C	0	0			5	55.0
	5600 RADI OI SOTOPE	0	0			5	56.0
	5700 CT SCAN	0	0				57.0
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.0
	5900 CARDI AC CATHETERI ZATI ON	0	0				59.0
	6000 LABORATORY	0	0				60.0
	6001 BLOOD LABORATORY	0	0				60.0
	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.0
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.0
	6300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.0
		0	0				64.0 65.0
	6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY	0	0				65. U 66. 0
	6700 OCCUPATIONAL THERAPY	0	0				67. 0
	6800 SPEECH PATHOLOGY	0	0				68. 0
	6900 ELECTROCARDI OLOGY	0	0				69. 0
	7000 ELECTROENCEPHALOGRAPHY	0	0				70.0
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.0
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1			72.0
	7300 DRUGS CHARGED TO PATIENTS	102	724			7	73. C
4.00 0	7400 RENAL DIALYSIS	0	0			7	74. C
5.00 0	7500 ASC (NON-DISTINCT PART)	0	0			7	75. C
	7697 CARDI AC REHABI LI TATI ON	0	0				76.9
	7700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.0
	7800 CAR T-CELL IMMUNOTHERAPY	0	0			7	78.0
	UTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC						88.0
1	8900 FEDERALLY QUALIFIED HEALTH CENTER	_	_				89.0
	9000 CLINIC	0	0				90.0
	9100 EMERGENCY	0	0	1			91.0
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1		9	92. 0
	THER REIMBURSABLE COST CENTERS	0					01 0
	9400 HOME PROGRAM DI ALYSI S 9500 AMBULANCE SERVI CES	0	0				94.0 95.0
	9500 DURABLE MEDICAL EQUIP-RENTED	0	0				95. U 96. O
	9700 DURABLE MEDICAL EQUIP-RENTED 9700 DURABLE MEDICAL EQUIP-SOLD	0	0	•			90.0 97.0
	9850 OTHER REIMBURSABLE COST CENTERS	0	0	•			97.0 98.0
200.00	Subtotal (see instructions)	102	724	•			90. 0 00. 0
201.00	Less PBP Clinic Lab. Services-Program	0	/24				00.00
	Only Charges					20	0
02.00	Net Charges (line 200 - line 201)	102	724			20	02.0

PORTIONM	ancial Systems IENT OF MEDICAL, OTHER HEALTH SERVICES AND	ST ELIZABETH VACCINE COST	Provider C		Period: From 01/01/2023 To 12/31/2023	u of Form CMS- Worksheet D Part V Date/Time Pre 5/28/2024 1:5	epared:
				e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Reimbursed	Reimbursed	(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 SERVICE COST CENTERS						
. 00 0500	DO OPERATING ROOM	0. 269299	0	197, 33	36 0	0	50.0
. 00 0510	DO RECOVERY ROOM	0. 000000	0		0 0	0	51.0
	DO DELIVERY ROOM & LABOR ROOM	0. 790071	0			0	
	DO ANESTHESI OLOGY	0. 394896	0	8,00		0	
			0				
	DO RADI OLOGY-DI AGNOSTI C	0. 174565	0			0	
	DO RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
. 00  0560	DO RADI OI SOTOPE	0. 000000	0		0 0	0	56.0
. 00 0570	DO CT SCAN	0. 121557	0	92, 79	92 0	0	57.0
. 00 0580	DO MAGNETIC RESONANCE IMAGING (MRI)	0. 168986	0	15, 35	58 0	0	58.0
	DO CARDI AC CATHETERI ZATI ON	0. 191080	0			0	59.0
	DO LABORATORY	0. 726927	0	81, 75		0	
			0	01,7	0 0	0	
	D1 BLOOD LABORATORY	0.000000	0			0	
	DO PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61. C
. 00  0620	DO WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.0
. 00 0630	DO BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.0
. 00 0640	DO INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.0
	DO RESPI RATORY THERAPY	0. 668947	0	13, 81	12 0	0	65.0
	DO PHYSI CAL THERAPY	0. 449314	0			0	
	DO OCCUPATI ONAL THERAPY	0. 459135	0			0	
	DO SPEECH PATHOLOGY	0. 447271	0			0	
		1					
		0. 341983	0			0	
	DO ELECTROENCEPHALOGRAPHY	0. 402780	0			0	
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.0
. 00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	0. 386190	0		0 0	0	72.0
. 00 0730	DO DRUGS CHARGED TO PATIENTS	0. 403281	0	11, 67	74 0	0	73.0
. 00 0740	DO RENAL DI ALYSI S	0. 155703	0		0 0	0	74.0
	DO ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.0
	97 CARDI AC REHABI LI TATI ON	0. 357513	0		0 0	0	
	DO ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	
		0.000000	0		0 0	0	
	DO CAR T-CELL IMMUNOTHERAPY	0.000000	0		0 0	0	/0.0
	PATIENT SERVICE COST CENTERS	1					
	DO RURAL HEALTH CLINIC						88. C
	DO FEDERALLY QUALIFIED HEALTH CENTER						89.0
. 00 0900	DO CLINIC	0. 000000	0		0 0	0	90.0
. 00 0910	DO EMERGENCY	0. 210678	0	596, 54	17 0	0	91.0
	DO OBSERVATION BEDS (NON-DISTINCT PART)	0. 499681	0		0 0	0	92.0
	ER REIMBURSABLE COST CENTERS			1			
	DO HOME PROGRAM DI ALYSI S	0.000000			0 0		94.0
	DO AMBULANCE SERVICES	0.000000	^		0		95.0
			0		-	^	
	DO DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0 0	0	
	DO DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	
	50 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	
0.00	Subtotal (see instructions)		0	1, 419, 31	13 0	0	200. 0
1.00	Less PBP Clinic Lab. Services-Program				0 0		201.0
	Only Charges						
	Net Charges (line 200 - line 201)	1	0	1, 419, 31	13 0	_	202. (

alth Financial Systems	ST ELI ZABETI				u of Form CMS-255
PORTIONMENT OF MEDICAL, OTHER HEALTH SERVI	CES AND VACCINE COST	Provider CC	JN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepar 5/28/2024 1:58 p
		Titl	e XIX	Hospi tal	Cost
	Cos				
Cost Center Description	Cost	Cost			
	Reimbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
		Ded. & Coins.			
	(see inst.) 6.00	(see inst.) 7.00			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00			
0. 00 05000 OPERATING ROOM	53, 142	0			50
00 05100 RECOVERY ROOM	0	0			5
2. 00 05200 DELIVERY ROOM & LABOR ROOM	5,967	0			5
3. 00 05300 ANESTHESI OLOGY	3, 160	0			5
I. 00 05400 RADI OLOGY-DI AGNOSTI C	30, 489	0			54
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0			5
5. 00 05600 RADI OLOGI - MERALEUTIC	0	0			50
7. 00 05700 CT SCAN	11, 280	0			5
3. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)					58
2. 00 05900 CARDI AC CATHETERI ZATI ON	28, 345				59
0. 00 06000 LABORATORY	59, 431	0			60
0. 01 06001 BLOOD LABORATORY	0,101	0			60
0 06100 PBP CLINICAL LAB SERVICES-PRGM	-	, o			6
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD (		0			63
3. 00 06300 BLOOD STORING, PROCESSING & TRAN		0			63
I. 00 06400 I NTRAVENOUS THERAPY	0	0			64
5. 00 06500 RESPI RATORY THERAPY	9, 239				6
5. 00 06600 PHYSI CAL THERAPY	9,463				60
7. 00 06700 OCCUPATIONAL THERAPY	720	0			6
3. 00 06800 SPEECH PATHOLOGY	12, 471	0			68
2. 00 06900 ELECTROCARDI OLOGY	6, 207	0			60
0. 00 07000 ELECTROENCEPHALOGRAPHY	1, 138	0			70
00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENTS 0	0			7
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1		72
3. 00 07300 DRUGS CHARGED TO PATIENTS	4, 708	0			73
I. 00 07400 RENAL DIALYSIS	0	0			74
5.00 07500 ASC (NON-DISTINCT PART)	0	0			7!
5. 97 07697 CARDI AC REHABI LI TATI ON	0	0			70
7.00 07700 ALLOGENEIC STEM CELL ACQUISITION	N 0				7
3.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0			78
OUTPATIENT SERVICE COST CENTERS					
3.00 08800 RURAL HEALTH CLINIC					88
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTE					89
0. 00 09000 CLINIC	0	0			90
. 00 09100 EMERGENCY	125, 679				9'
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT F	PART) 0	0			92
OTHER REIMBURSABLE COST CENTERS					
I. 00 09400 HOME PROGRAM DI ALYSI S	0	0			94
5. 00 09500 AMBULANCE SERVICES	0	_			9
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			90
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0			9
3. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			98
00.00 Subtotal (see instructions)	364, 034	0			200
01.00 Less PBP Clinic Lab. Services-Pr Only Charges	ogram 0				201
02.00 Net Charges (line 200 - line 201	1) 364,034	0			202
2.00 Inet that yes (The 200 - The 20	i) 304,034	I U			202

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/28/2024 1:58	pared:
	Cost Center Description	Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
1.00	Inpatient days (including private room days and swing-bed day			13, 125	
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room days	13, 125 0	
	do not complete this line.	5, 5, 5, 5,	rvate room days,		
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	10, 453 0	
5.00	reporting period	Join days) thi bagit beceinde	er st of the cost	0	5.0
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.0
7.00	Total swing-bed NF type inpatient days (including private roc	om days) through December	- 31 of the cost	0	7.0
3. 00	reporting period Total swing-bed NF type inpatient days (including private roc	m dava) after December (	1 of the east	0	8.0
5.00	reporting period (if calendar year, enter 0 on this line)	Jill days) al ter December .	ST OF THE COST	0	0.0
9.00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	4, 217	9.0
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private i	room days)	0	10.0
11.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		nor dovo) ofter	0	11. C
11.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11.0
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12.0
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13.0
14 00	after December 31 of the cost reporting period (if calendar y	year, enter 0 on this lin	ne)		14.0
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	"am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	16.0
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (	of the cost	0,00	17.0
	reporting period	C			
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18.0
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19. C
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of i	the cost	0.00	20.0
	reporting period				
21.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	12, 720, 481 0	
	5 x line 17)		51 (		
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ng period (line 6	0	23.0
24.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24.0
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.0
	x line 20)				
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 12, 720, 481	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00 29.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed ch	narges)	0	
80. 00	Semi -private room charges (excluding swing-bed charges)			0	30.0
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
35.00 36.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0. 00 0	1
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	12, 720, 481	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			969.18	1
39.00 10.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			4, 087, 032 0	1
	Total Program general inpatient routine service cost (line 39			4, 087, 032	1

	ATION OF INPATIENT OPERATING COST		Provider CCN: 15		od:	Worksheet D-1	1
				To	01/01/2023 12/31/2023		
			Title XVII	I F	ospi tal	PPS	
	Cost Center Description	Total Inpatient CostIn	patient Days <mark>Diem</mark>		ogram Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	0		0.00		1	42.00
43.00	INTENSIVE CARE UNIT	5, 123, 436	1, 738	2, 947. 89	594	1, 751, 047	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	C		
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	C		
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0.00	L		46.00
	Cost Center Description						
40.00	Program inpatient ancillary service cost (Wks	+ D 2 col 2	Line 200)			1.00	40.00
48.00 48.01	Program inpatient cellular therapy acquisition			line 10 colu	ımrı 1)	6, 441, 033	
49.00	Total Program inpatient costs (sum of lines 4					12, 279, 112	
	PASS THROUGH COST ADJUSTMENTS	¥	•				
50.00	Pass through costs applicable to Program inpa	atient routine se	rvices (from Wkst	t. D, sum of F	Parts I and	542, 590	50.00
51.00	<pre>III) Pass through costs applicable to Program inpa and IV)</pre>	atient ancillary	services (from Wk	kst. D, sum of	<sup>°</sup> Parts II	354, 909	51.00
52.00	Total Program excludable cost (sum of lines !	50 and 51)				897, 499	52.00
53.00	Total Program inpatient operating cost exclud	5 1	ted, non-physicia	an anesthetist	, and	11, 381, 613	3 53.00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)				<u> </u>	
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge						55.00
55.01	Permanent adjustment amount per discharge					0.00	
55. 02 56. 00	Adjustment amount per discharge (contractor u Target amount (line 54 x sum of lines 55, 55.					0.00	
57.00	Difference between adjusted inpatient operati		et amount (line 5	56 minus line	53)		
58.00	Bonus payment (see instructions)	5				0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from t	he cost reporting	g period endir	ng 1996,	0.00	59.00
60.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior vear cost r	eport update	d by the	0.00	60.00
	market basket)		p				
61.00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of the	amount by which	operating cos	sts (line	C	61.00
62.00	enter zero. (see instructions) Relief payment (see instructions)					C	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instruct	i ons)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Docomb	or 21 of the cost	t roporting p	vriad (Soo	0	64.00
04.00	instructions) (title XVIII only)	ts thi ough beceild		t reporting pe			04.00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	31 of the cost r	reporting peri	od (See	C	65.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 64	plus line 65)(ti	tle XVIII onl	y); for	C	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through D	ecember 31 of the	e cost reporti	ng period	C	67.00
68.00	(line 13 x line 20)	e costs after Dec	ember 31 of the c	cost reportino	g period	C	68.00
69. 00	Total title V or XIX swing-bed NF inpatient of PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID ONLY			С	69.00
70.00	Skilled nursing facility/other nursing facili	2		(line 37)			70.00
71.00 72.00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		e /U ÷ line 2)				71.00
73.00	Medically necessary private room cost application		line 14 x line 35	5)			73.00
74.00	Total Program general inpatient routine servi						74.00
75.00	Capital-related cost allocated to inpatient i	routine service c	osts (from Worksh	neet B, Part I	I, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
77.00	Program capital -related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minus	,					78.00
79.00 80.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			a 78 minus li	no 70)		79.00
80.00	Inpatient routine service costs for compa			ic io minus li	10 /7)		80.00
	Inpatient routine service cost limitation (li						82.00
83.00	Reasonable inpatient routine service costs (						83.00
84.00	Program inpatient ancillary services (see ins		<b>`</b>				84.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00 86.00
55.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		agii 00)			1	00.00
87.00	Total observation bed days (see instructions)	)				2, 672	
88.00	Adjusted general inpatient routine cost per o					969.18	88.00

Health Financial Systems	H DEARBORN		In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2023	Worksheet D-1	
				To 12/31/2023	Date/Time Pre 5/28/2024 1:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	1, 381, 050	12, 720, 481	0. 10856	9 2, 589, 649	281, 156	90.00
91.00 Nursing Program cost	0	12, 720, 481	0.00000	2, 589, 649	0	91.00
92.00 Allied health cost	0	12, 720, 481	0.00000	2, 589, 649	0	92.00
93.00 All other Medical Education	0	12, 720, 481	0.00000			93.00

PATIENT ANCILLARY	ST ELIZA SERVICE COST APPORTIONMENT	BETH DEARBORN Provider C	CN: 15-0086	Peri od:	u of Form CMS- Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	naro
				10 12/31/2023	5/28/2024 1:5	
		Title	e XVIII	Hospi tal	PPS	
Cost Ce	nter Description		Ratio of Cos		Inpatient	
			To Charges		Program Costs (col. 1 x col.	
				onal goo	2)	
			1.00	2.00	3.00	
	TINE SERVICE COST CENTERS		1	10,004,045		
. 00 03000 ADULTS . 00 03100 I NTENSI				13, 324, 045 5, 371, 249		30.
. 00 03200 CORONAF				5, 371, 249		31.
	TENSIVE CARE UNIT			0		33.
	L INTENSIVE CARE UNIT			0		34.
. 00 04000 SUBPROV				0		40.
. 00 04100 SUBPROV				0		41.
. 00 04300 NURSERY						43.
. 00 05000 OPERATI	VICE COST CENTERS		0. 2692	99 3, 880, 116	1, 044, 911	50.
. 00 05100 RECOVER			0.2092		1, 044, 911	
	Y ROOM & LABOR ROOM		0. 7900		276, 739	
. 00 05300 ANESTHE			0. 3948		84, 468	
. 00 05400 RADI OLO	GY-DI AGNOSTI C		0. 1745	65 1, 898, 321	331, 380	54
	GY-THERAPEUTI C		0.0000		0	
. 00 05600 RADI 01 S			0.0000		0	
. 00 05700 CT SCAN			0. 1215		122, 092	
	C RESONANCE I MAGI NG (MRI) CATHETERI ZATI ON		0. 1689 0. 1910		22, 149 124, 258	
. 00 05900 CARDI AC			0. 1910		1, 474, 835	
. 01 06001 BLOOD L			0.0000		0	
	NI CAL LAB SERVI CES-PRGM ONLY		0.0000		0	
.00 06200 WHOLE E	LOOD & PACKED RED BLOOD CELLS		0.0000	00 00	0	62
	TORING, PROCESSING & TRANS.		0.0000		0	
. 00 06400 I NTRAVE			0.0000		0	
. 00 06500 RESPI RA			0. 6689		261, 638	
. 00 06600 PHYSI CA . 00 06700 0CCUPAT	L THERAPY IONAL THERAPY		0. 4493 0. 4591		169, 276 81, 737	
. 00 06800 SPEECH			0. 4371		43, 858	
. 00 06900 ELECTRO			0. 3419		97, 368	
	ENCEPHALOGRAPHY		0. 4027		379	
. 00 07100 MEDI CAL	SUPPLIES CHARGED TO PATIENTS		0.0000	00 00	0	
	EV. CHARGED TO PATIENTS		0. 3861		843, 778	
	HARGED TO PATIENTS		0.4032		769, 661	
. 00 07400 RENAL E . 00 07500 ASC (NO	IALYSIS N-DISTINCT PART)		0. 1557		3, 091 0	
	REHABILITATION		0. 3575		148	
	EIC STEM CELL ACQUISITION		0.0000		0	
	ELL IMMUNOTHERAPY		0.0000		0	
OUTPATI ENT SE	RVICE COST CENTERS					
. 00 08800 RURAL H			0.0000		0	
	LY QUALIFIED HEALTH CENTER		0.0000		0	
. 00 09000 CLINIC . 00 09100 EMERGEN	CV.		0.0000		0	
	TION BEDS (NON-DISTINCT PART)		0.2106		542, 632 146, 635	
	SABLE COST CENTERS		0.4790	273,437	140, 035	72
	OGRAM DI ALYSI S		0.0000	0 00	0	94
. 00 09500 AMBULAN						95
	MEDI CAL EQUI P-RENTED		0.0000	00 00	0	
	MEDICAL EQUIP-SOLD		0.0000		0	
	EIMBURSABLE COST CENTERS		0.0000		0	
	sum of lines 50 through 94 and 96 through 9			18, 469, 574	6, 441, 033	
	P Clinic Laboratory Services-Program only c rges (line 200 minus line 201)	marges (IIne 61)		0 18, 469, 574		201 202

IPATIENT ANC	I LLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0086	Period: From 01/01/2023	Worksheet D-3	5
				To 12/31/2023	Date/Time Pre	
		Ti †I	e XIX	Hospi tal	5/28/2024 1:5 Cost	os pr
С	ost Center Description	1 11 11	Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00		2)	
	NT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
	DULTS & PEDIATRICS		1	220, 846		30
	NTENSI VE CARE UNI T			571, 428		31
1 1	ORONARY CARE UNIT			0		32
	URN INTENSIVE CARE UNIT			0		33
. 00 03400 S	URGICAL INTENSIVE CARE UNIT			0		34
). 00  04000  S	UBPROVIDER – IPF			0		40
	UBPROVIDER – IRF			0		41
3.00 04300 N				0		43
	RY SERVICE COST CENTERS		0.0(00	00 447 400	04 5/0	1 50
	PERATING ROOM ECOVERY ROOM		0.2692		31, 560	
	ELIVERY ROOM & LABOR ROOM		0.0000		0 71, 417	
	NESTHESI OLOGY		0. 7900		1, 642	
	ADI OLOGY-DI AGNOSTI C		0. 1745		11, 696	
	ADI OLOGY-THERAPEUTI C		0.0000		0	
	ADI OI SOTOPE		0.0000		0	
. 00 05700 C			0. 1215		5, 034	
	AGNETIC RESONANCE IMAGING (MRI)		0. 1689		1, 206	
0. 00 05900 C	ARDI AC CATHETERI ZATI ON		0. 1910	80 12, 359	2, 362	59
). 00  06000  L	ABORATORY		0. 7269	27 55, 181	40, 113	60
). 01  06001  B	LOOD LABORATORY		0.0000	00 0	0	60
1 1	BP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
1 1	HOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	
1 1	LOOD STORING, PROCESSING & TRANS.		0.0000		0	
1 1	NTRAVENOUS THERAPY		0.0000		0	
	ESPI RATORY THERAPY HYSI CAL THERAPY		0. 6689 0. 4493		11, 852 2, 697	
1 1	CCUPATIONAL THERAPY		0. 4493		2, 097	
	PEECH PATHOLOGY		0. 4472		1, 247	
	LECTROCARDI OLOGY		0.3419			
1 1	LECTROENCEPHALOGRAPHY		0. 4027		0	
.00 07100 M	EDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	00 0	0	71
	MPL. DEV. CHARGED TO PATIENTS		0. 3861	90 0	0	72
	RUGS CHARGED TO PATIENTS		0. 4032		16, 585	
	ENAL DI ALYSI S		0. 1557		0	
	SC (NON-DI STI NCT PART)		0.0000		0	
	ARDIAC REHABILITATION		0.3575		0	
	LLOGENEIC STEM CELL ACQUISITION AR T-CELL IMMUNOTHERAPY		0.0000			
	ENT SERVICE COST CENTERS		0.0000	00 0	0	///
	URAL HEALTH CLINIC		0.0000	00 0	0	88
	EDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
0.00 09000 C			0.0000		0	
	MERGENCY		0. 2106		32, 060	91
. 00 09200 0	BSERVATION BEDS (NON-DISTINCT PART)		0. 4996		0	
	EIMBURSABLE COST CENTERS					
	OME PROGRAM DI ALYSI S		0.0000	00 0	0	
	MBULANCE SERVICES					95
	URABLE MEDICAL EQUIP-RENTED		0.0000		0	
	URABLE MEDICAL EQUIP-SOLD		0.0000		0	
	THER RELIMBURSABLE COST CENTERS		0.0000		0 225 026	
	otal (sum of lines 50 through 94 and 96 through 98) ess PBP Clinic Laboratory Services-Program only charge	s (lino 61)		629, 248	235, 036	200
	et charges (line 200 minus line 201)	s (i në oi)		629, 248		201

	Financial Systems ST ELIZABETH DEA ATION OF REIMBURSEMENT SETTLEMENT P	rovider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/28/2024 1:5	pared:
		Title XVIII	Hospi tal	PPS	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring instructions)	g prior to October 1 (	see	7, 822, 206	1.01
1.02	DRG amounts other than outlier payments for discharges occurring	g on or after October	1 (see	2, 328, 991	1. 02
1.03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	di scharges occurri ng	prior to October	0	1.03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	di scharges occurri ng	on or after	0	1.04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)	je i			2.00
2.00	Outlier reconciliation amount			0	2. 01
2.02 2.03	Outlier payment for discharges for Model 4 BPCI (see instruction Outlier payments for discharges occurring prior to October 1 (see			0 43, 708	2.02 2.03
2.03	Outlier payments for discharges occurring provide october 1 (se			43, 700	
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporti	na pariod (soo instru	ctions)	0 53.68	3.00 4.00
4.00	Indirect Medical Education Adjustment	ng period (see mistru		55.00	4.00
5.00	FTE count for allopathic and osteopathic programs for the most r or before 12/31/1996. (see instructions)	recent cost reporting	period ending on	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA			0.00	
6.00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	criteria for an add-o	n to the cap for	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap- the CAA 2021 (see instructions)	d under §127 of	0.00	6. 26	
7.00	MMA Section 422 reduction amount to the IME cap as specified und			0.00	
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 cost report straddles July 1, 2011 then see instructions.	2 CFR §412.105(f)(1)(i	v)(B)(2) If the	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track track programs with a rural track for Medicare GME affiliated pr	0.00	7. 02		
8.00	and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(			0.00	8.00
8.01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots	0.00	8. 01		
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions)	s from a closed teachi	ng nospitai	0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots instructions)	s under §126 of the CA	A 2021 (see	0.00	8. 21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6. minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.23		7.01, plus or	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current		ds	0.00	10.00
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11. 00 12. 00
12.00	Total allowable FTE count for the prior year.				12.00
14.00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	tember 30, 1997,	0.00	14.00
15.00	Sum of Lines 12 through 14 divided by 3.				15.00
16.00	Adjustment for residents in initial years of the program (see in				16.00
17.00 18.00	Adjustment for residents displaced by program or hospital closur Adjusted rolling average FTE count	e		0.00	17.00 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
20. 00 21. 00	Prior year resident to bed ratio (see instructions)			0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0. 000000 0	
22.01	IME payment adjustment - Managed Care (see instructions)			0	
22.00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allocathic and established ME FTE resident		ED 412 105	0.00	23.00
23.00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$ .	t cap siots under 42 c	FK 412.105	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	
25.00	If the amount on line 24 is greater than -O-, then enter the low instructions)	wer of line 23 or line	24 (see	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
27.00 28.00	IME payments adjustment factor. (see instructions)			0.000000	27.00 28.00
28.00	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0	28.00
29.00	Total IME payment ( sum of lines 22 and 28)			0	29.00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29.01
30.00	Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruc	tions)	2.07	30.00
31.00	Percentage of Medicaid patient days (see instructions)			15.38	31.00
32.00 33.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			17.45 4.09	
	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			4.09	

CALCU	Financial Systems ST ELIZABETH ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0086	Period:	u of Form CMS-2 Worksheet E	
			From 01/01/2023 To 12/31/2023		pared:
				5/28/2024 1:5	8 pm
		Title XVIII	Hospital	PPS	
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Payment Adjustment				
5.00	Total uncompensated care amount (see instructions)			5, 938, 006, 757	35.0
5. 01	Factor 3 (see instructions)		0. 000078676		35.0
5.02	Hospital UCP, including supplemental UCP (see instructions)		540, 851	488, 440	35.0
5.03	Pro rata share of the hospital UCP, including supplemental		404, 527	122, 777	35.0
6. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		527, 304		36.0
0 00	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throu	° , ,		10 0
0.00	Total Medicare discharges (see instructions)		0		40. 0 41. 0
1.00	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instru	uctions)	0		41.0
2.00	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00		41.0
3.00	Total Medicare ESRD inpatient days (see instructions)	in right august mente	0.00		43.0
4.00	Ratio of average length of stay to one week (line 43 divide	ed by line 41 divided by 7	0. 000000		44.0
	days)		01000000		
5.00	Average weekly cost for dialysis treatments (see instructio	ons)	0.00		45. C
6.00	Total additional payment (line 45 times line 44 times line		0		46.0
7.00	Subtotal (see instructions)		10, 869, 217		47.0
8.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48.0
	only. (see instructions)				
				Amount 1.00	
9.00	Total payment for inpatient operating costs (see instructio	ons)		10, 869, 217	49. (
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I	and Pt. II, as applicable)		767, 119	50. (
1. 00	Exception payment for inpatient program capital (Wkst. L, P	Pt. III, see instructions)		0	51.0
2.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	52. (
3.00	Nursing and Allied Health Managed Care payment			0	53.0
1. 00	Special add-on payments for new technologies			42, 702	54.0
4.01	Islet isolation add-on payment			0	54.0
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	e 69)		0	55.0
5.01	Cellular therapy acquisition cost (see instructions)			0	55.0
6.00 7.00	Cost of physicians' services in a teaching hospital (see in	-	brough 2E)	0	56.0
7.00 3.00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt		nrougn 35).	0	57. 58.
9.00	Total (sum of amounts on lines 49 through 58)			11, 679, 038	
0. 00	Primary payer payments			0	60.0
1.00	Total amount payable for program beneficiaries (line 59 min	us line 60)		11, 679, 038	61.
2.00	Deductibles billed to program beneficiaries			1, 260, 052	62.0
3.00	Coinsurance billed to program beneficiaries			41, 200	
4.00	Allowable bad debts (see instructions)			118, 220	64. (
5.00	Adjusted reimbursable bad debts (see instructions)			76, 843	65.0
6.00	Allowable bad debts for dual eligible beneficiaries (see in	istructions)		24, 512	66.
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			10, 454, 629	67.0
	Credits received from manufacturers for replaced devices fo			0	68.
	Outlier payments reconciliation (sum of lines 93, 95 and 96	<ul> <li>). (For SCH see instruction</li> </ul>	s)	0	
				0	70.
9.00 0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		instructions)	0	70.
9.00 0.00 0.50	Rural Community Hospital Demonstration Project (§410A Demon				70.
9.00 0.00 0.50 0.75	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions)			0	
9.00 0.00 0.50 0.75 0.87	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestratio	n		0	
9.00 0.00 0.50 0.75 0.87 0.88	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only)	n			70.
9.00 0.00 0.50 0.75 0.87 0.88 0.88	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in	nn Instructions)		0 0	70.8 70.8
9.00 0.00 0.50 0.75 0.87 0.88 0.89 0.90	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)	nn Instructions)		0 0 0	70. 70. 70.
9.00 0.00 0.50 0.75 0.87 0.88 0.89 0.90 0.91	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	nn Instructions)		0 0 0	70. 8 70. 8 70. 9 70. 9
9.00         0.00         0.50         0.75         0.87         0.88         0.90         0.90         0.91         0.91	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	nn Instructions)		0 0 0 0	70. 8 70. 8 70. 9 70. 9
98.00         99.00         70.00         70.50         70.75         70.87         70.88         70.90         70.90         70.91         70.92         70.93         70.94	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	nn Instructions)		0 0 0	70. 9 70. 9

CALCULAT	inancial Systems ST ELIZABETH   FION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0086	Peri od:	u of Form CMS-2 Worksheet E	
				From 01/01/2023 To 12/31/2023	Part A Date/Time Pre	
		T: +1 -		11	5/28/2024 1:5	8 pm
	· · · · · · · · · · · · · · · · · · ·	Intre	XVIII	Hospi tal	PPS Amount	
				0	1.00	
	ow volume adjustment for federal fiscal year (yyyy) (Enter i	n column O	:	2023	192, 515	70.
	the corresponding federal year for the period prior to $10/1$ )					
	.ow volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70.
	.ow Volume Payment-3			0	0	70.
1	AC adjustment amount (see instructions)				0	1
	mount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			10, 645, 521	
	Sequestration adjustment (see instructions)				212, 910	
	Demonstration payment adjustment amount after sequestration Dequestration adjustment-PARHM pass-throughs				0	71.0
1	nterim payments				10, 048, 567	
1	nterim payments-PARHM					72.
	entative settlement (for contractor use only)				0	
	entative settlement-PARHM (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.0	12 72 and			384, 044	73.
		52, 72, and			304, 044	/ 4.
	alance due provider/program-PARHM (see instructions)					74.
	Protested amounts (nonallowable cost report items) in accorda	ance with			1, 458, 515	75.
	MS Pub. 15-2, chapter 1, §115.2 O BE COMPLETED BY CONTRACTOR (lines 90 through 96)				<u> </u>	
	perating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.
	lus 2.04 (see instructions)					
	apital outlier from Wkst. L, Pt. I, line 2				0	1
	perating outlier reconciliation adjustment amount (see instr capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instruction and the time value of money (see instruction)				0.00	
	ime value of money for operating expenses (see instructions)				0	95.
6.00 T	ime value of money for capital related expenses (see instruc	ctions)			0	96.
				1.00	0n/After 10/1 2.00	
H:	SP Bonus Payment Amount					
	ISP bonus amount (see instructions)			0	0	100.
	VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions)			0.000000000	0.000000000	101
	IVBP adjustment amount for HSP bonus payment (see instruction	ns)		0.0000000000000000000000000000000000000		101.
	RR Adjustment for HSP Bonus Payment					
	IRR adjustment factor (see instructions)			0.0000		
	IRR adjustment amount for HSP bonus payment (see instructions ural Community Hospital Demonstration Project (§410A Demonst		ctmont	0	0	104.
	s this the first year of the current 5-year demonstration pe					200.
	century Cures Act? Enter "Y" for yes or "N" for no.		10 2101			
С	ost Reimbursement				L	
C						201.
01.00 M	ledicare inpatient service costs (from Wkst. D-1, Pt. II, lir	ne 49)				202.
01.00 M 02.00 M	ledicare discharges (see instructions)	ne 49)				
C 01.00 M 02.00 M 03.00 C		-	of the currer	it 5-year demonst	tration	
01.00 M 02.00 M 03.00 C C(	ledicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A ir eriod)	-	of the currer	it 5-year demonst		
01.00 M 02.00 M 03.00 C 03.00 C 04.00 M	ledicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A ir eriod) ledicare target amount	-	of the currer	it 5-year demonst		
01.00 M 02.00 M 03.00 C 03.00 C 04.00 M 05.00 C	ledicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A ir eriod) ledicare target amount case-mix adjusted target amount (line 203 times line 204)	n first year	of the currer	it 5-year demonst		204. 205. 206.
01.00 M 02.00 M 03.00 C 03.00 C 04.00 M 05.00 C 06.00 M	ledicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A ir eriod) ledicare target amount	n first year	of the currer	it 5-year demonst		
01.00 M 02.00 M 03.00 C 04.00 M 05.00 C 06.00 M 05.00 R 06.00 P	ledicare discharges (see instructions) ase-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount ase-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	) tructions)	of the currer	it 5-year demonst		205. 206. 207.
C1. 00 M D2. 00 M D2. 00 M D3. 00 C P D4. 00 M D5. 00 C D6. 00 M A D7. 00 P D8. 00 M	ledicare discharges (see instructions) ase-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount ase-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst ledicare Part A inpatient service costs (from Wkst. E, Pt. A,	) tructions)	of the currer	it 5-year demonst		205. 206. 207. 208.
C1.00 M D2.00 M D2.00 C C1 D2.00 M D3.00 C C2 D4.00 M D5.00 C D6.00 M D7.00 P D8.00 M D9.00 A	ledicare discharges (see instructions) ase-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount ase-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement rogram reimbursement under the §410A Demonstration (see inst ledicare Part A inpatient service costs (from Wkst. E, Pt. A, djustment to Medicare IPPS payments (see instructions)	) tructions)	of the currer	it 5-year demonst		205. 206. 207. 208. 209.
C(0) C(0)	ledicare discharges (see instructions) ase-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount ase-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst ledicare Part A inpatient service costs (from Wkst. E, Pt. A,	tructions)	of the currer	it 5-year demonst		205. 206. 207. 208. 209. 210.
Cit. 00 M 22. 00 M 23. 00 C Cit 24. 00 M 25. 00 C 26. 00 M 27. 00 P 28. 00 M 28. 00 M 29. 00 A 10. 00 R 11. 00 T Cit Cit Cit Cit Cit Cit Cit Cit	ledicare discharges (see instructions) ase-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount ase-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst ledicare Part A inpatient service costs (from Wkst. E, Pt. A, djustment to Medicare IPPS payments (see instructions) teserved for future use total adjustment to Medicare IPPS payments (see instructions) comparision of PPS versus Cost Reimbursement	tructions) line 59)	of the currer	it 5-year demonst		205. 206. 207. 208. 209. 210. 211.
C1. 00 M C2. 00 M C2. 00 M C3. 00 C C4 C4 C4 C5. 00 C C6 C4 C4 C4 C4 C4 C4 C4 C4 C4 C4	ledicare discharges (see instructions) ase-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount ase-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst ledicare Part A inpatient service costs (from Wkst. E, Pt. A, adjustment to Medicare IPPS payments (see instructions) reserved for future use orbit adjustment to Medicare IPPS payments (see instructions) comparision of PPS versus Cost Reimbursement otal adjustment to Medicare Part A IPPS payments (from line	tructions) line 59)	of the currer	it 5-year demonst		205. 206. 207. 208. 209. 210. 211. 211.
C1.00 C2.00 C3.00 C4	ledicare discharges (see instructions) ase-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount ase-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst ledicare Part A inpatient service costs (from Wkst. E, Pt. A, djustment to Medicare IPPS payments (see instructions) teserved for future use total adjustment to Medicare IPPS payments (see instructions) comparision of PPS versus Cost Reimbursement	tructions) line 59)		it 5-year demonst		205. 206. 207. 208. 209. 210. 211.

	Financial Systems LUME CALCULATION EXHIBIT 4		ST ELI ZABETH	Provider C	F	eriod: rom 01/01/2023 o 12/31/2023	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Prep 5/28/2024 1:55	t 4 pare
		W/S E Doot A	Amounte (from	Title Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS	
		W/SE, Part A	Amounts (from E, Part A)	Entitlement		On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0	0	0	0	1.
01	payments DRG amounts other than outlier payments for discharges	1. 01	7, 822, 206	0	7, 822, 206		7, 822, 206	1
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 328, 991	0		2, 328, 991	2, 328, 991	1
)3	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1. 03	0	0	0		0	1
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1
00	Outlier payments for	2.00						2
)1	discharges (see instructions) Outlier payments for	2. 02	0	0	0	0	0	2
	discharges for Model 4 BPCI	2.02		0		0	0	
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	43, 708	0	43, 708		43, 708	2
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	43, 212	0		43, 212	43, 212	2
0	Operating outlier	2.01	0	0	0	0	0	3
~	reconciliation	2 00		0			0	
0	Managed care simulated payments Indirect Medical Education Adju	3.00 ustment	0	0	0	0	0	4
0	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5
00	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6
1	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	O	0	6
	Indirect Medical Education Adju							
0	IME payment adjustment factor (see instructions) IME adjustment (see	27.00 28.00	0. 000000	0. 000000			0	8
1	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	0	0	0	
00	instructions) Total IME payment (sum of	29.00	0	0	0	0	0	9
)1	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29.01	0	0	0	0	0	9
	8.01)	ant and						1
00	Disproportionate Share Adjustme Allowable disproportionate share percentage (see	33.00	0. 0409	0. 0409	0. 0409	0. 0409		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	103, 796	0	79, 982	23, 814	103, 796	11
01	Uncompensated care payments	36.00	527, 304	0	404, 527	122, 777	527, 304	11
00	Additional payment for high per Total ESRD additional payment (see instructions)	46.00	<u>D beneficiary</u> 0	di scharges 0	0	0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	10, 869, 217 0	0 0	8, 350, 423 0	2, 518, 794 0	10, 869, 217 0	
00	(see instructions) Total payment for inpatient operating costs (see	49.00	10, 869, 217	0	8, 350, 423	2, 518, 794	10, 869, 217	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	767, 119	0	586, 534	180, 585	767, 119	16

	Financial Systems		ST ELI ZABETH		NIL 1E 0004		eu of Form CMS-2	2002-1
LOW VC	DLUME CALCULATION EXHIBIT 4			Provider CC		Period: From 01/01/2023 To 12/31/2023		pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	42, 702	0	42, 70	2 0	42, 702	
7.01	Net organ aquisition cost							17.0
7.02	Credits received from	68.00	0	0		0 0	0	17.0
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	0	0		0 0	0	18. C
	adjustment amount (see							
	instructions)			0	0.070./5	0 0 00 070	11 (70 000	10 (
9.00	SUBTOTAL	W/S L, line	(Amounts from	0	8, 979, 65	9 2, 699, 379	11, 679, 038	19.0
		W/S L, TITTE	(Amounts from L)					
		0	1,00	2.00	3.00	4,00	5.00	
0.00	Capital DRG other than outlier	1.00	764, 813	0	585, 38	7 179, 426	764, 813	20.0
0. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0			0 0	0	
21.00	Capital DRG outlier payments	2.00	2, 306	0	1, 14	7 1, 159	2,306	21.0
1.01	Model 4 BPCI Capital DRG	2.01	0			0 0		
	outlier payments	2.01	0	0		0		1
22.00	Indirect medical education	5.00	0. 0000	0.0000	0.000	0.0000		22.0
	percentage (see instructions)							
23.00	Indirect medical education	6.00	0	0		0 0	0	23.0
	adjustment (see instructions)							
24.00	Allowable disproportionate share percentage (see	10.00	0. 0000	0.0000	0.000	0 0.0000		24. (
	instructions)							
25.00	Disproportionate share	11.00	0	0		0 0	0	25.0
	adjustment (see instructions)							
26. 00	Total prospective capital payments (see instructions)	12.00	767, 119	0	586, 53	4 180, 585	767, 119	26. (
			(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0. 02143			27.0
8. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 96			192, 51	5	192, 515	28.0
9.00	Pt. A, line) Low volume adjustment	70, 97				0	0	29.0
27.00	(transfer amount to Wkst. E,	10.97				0		29.0
	Pt. A, line)							
100.00	Transfer low volume		Y					100. 0
	adjustments to Wkst. E, Pt. A.							

	Financial Systems	ST ELI ZABETI				eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider C	1	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			Title	• XVIII	Hospi tal	5/28/2024 1:58 PPS	<u>8 pm</u>
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Peri od on after 10/01	Total (cols. 2 and 3)	
		0	A) 1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	1.00	2.00	3.00	4.00	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7, 822, 206	7, 822, 20	6	7, 822, 206	1
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2, 328, 991		2, 328, 991	2, 328, 991	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		o o	0	2. 01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	43, 708	43, 70	8	43, 708	2. 02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	43, 212		43, 212	43, 212	2.03
3.00 4.00	Operating outlier reconciliation Managed care simulated payments	2.01 3.00	0				
4.00	Indirect Medical Education Adjustment	5.00	0		<u>, 0</u>		4.00
5.00	Amount from Worksheet E, Part A, Line 21 (see instructions)	21.00	0. 000000	0.00000	0 0. 000000		5.00
6. 00 6. 01	IME payment adjustment for managed care (see	22. 00 22. 01	0			0	
0.01	Indirect Medical Education Adjustment for the		otion 422 of t	bo MMA			
7.00	IME payment adjustment factor (see	27.00	0. 000000		0 0. 000000		7.00
	instructions)	27100					
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0		OC	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 C	0	9. 01
	Disproportionate Share Adjustment		1	1			
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0409	0.040	9 0.0409		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	103, 796	79, 98	2 23, 814	103, 796	11.00
11.01	Uncompensated care payments Additional payment for high percentage of ESR	36.00	527, 304	404, 52	7 122, 777	527, 304	11.01
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	10, 869, 217	8, 350, 42	3 2, 518, 794	10, 869, 217	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0	0,000,12	0	0	
15.00	instructions) Total payment for inpatient operating costs	49.00	10, 869, 217	8, 350, 42	3 2, 518, 794	10, 869, 217	15.00
16.00	(see instructions) Payment for inpatient program capital (from	50.00	767, 119	586, 53	4 180, 585	767, 119	16.00
17.00	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	54.00	42, 702	42, 70	2 0	42, 702	
17. 01 17. 02	Net organ acquisition cost Credits received from manufacturers for replaced dowings for applicable MS_DBCs	68.00	0		o o	0	17.01 17.02
18.00	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		o o	0	18.00
			1	1	1	1 1	1

Health Financial Systems	ST ELI ZABETI	H DEARBORN		In Lie	u of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 01/01/2023 To 12/31/2023		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	764, 813	585, 38	37 179, 426	764, 813	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	2, 306	1, 14	1, 159	2, 306	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see	5.00	0. 0000	0.000	0. 0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.000	0. 0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	767, 119	586, 53	180, 585	767, 119	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70.96	192, 515	192, 5 <sup>-</sup>	15	192, 515	28.00
29.00 Low volume adjustment on or after October 1	70.97	0		0	0	
30.00 HVBP payment adjustment (see instructions)	70.93	23, 598		0 23, 598	23, 598	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	30. 01
31.00 HRR adjustment (see instructions)	70.94	-25, 221	-17,30	-7, 919	-25, 221	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70.99			0 0	0	32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

CALCUL	Financial Systems     ST ELIZABETH DEARE       ATION OF REIMBURSEMENT SETTLEMENT     Production	Dovider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023 Hospital	u of Form CMS-2 Worksheet E Part B Date/Time Pre 5/28/2024 1:5 PPS	pared:
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00 3.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruction OPPS or REH payments	s)		826 8, 874, 847 6, 689, 583	2.00
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)	20)		170, 285 0	4.01
5.00 6.00 7.00	Enter the hospital specific payment to cost ratio (see instructio Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	ns)		0. 000 0 0. 00	6.00
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH direct g Wkst. D, Pt. IV, col. 13, line 200	raduate medical educ	ation costs from	0 0	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0 826	
	Reasonabl e charges				
12.00 13.00 14.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13)	69)		2, 047 0 2, 047	13.00
	Customary charges			2,017	
15. 00 16. 00	Aggregate amount actually collected from patients liable for paym Amounts that would have been realized from patients liable for pa had such payment been made in accordance with 42 CFR §413.13(e)			0 0	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only i instructions)	fline 18 exceeds li	ne 11) (see	2, 047 1, 221	
20. 00 21. 00	Excess of reasonable cost over customary charges (complete only i instructions) Lesser of cost or charges (see instructions)	fline 11 exceeds li	ne 18) (see	0 826	
	Interns and residents (see instructions)			020	
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instruct Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	i ons)		0 6, 859, 868	
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 24 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus instructions)	-		1, 231, 044 5, 629, 650	1
28.00 28.50 29.00	Direct graduate medical education payments (from Wkst. E-4, line REH facility payment amount (see instructions) ESRD direct medical education costs (from Wkst. E-4, line 36)	50)		0	28.50
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			5, 629, 650	
	Primary payer payments			1, 418	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			5, 628, 232	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00 35.00	Allowable bad debts (see instructions)			119, 555	
36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instruct	ions)		77, 711 91, 460	
37.00	Subtotal (see instructions)			5, 705, 943	
38.00	MSP-LCC reconciliation amount from PS&R			-15	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39.00 39.50
39.75	N95 respirator payment adjustment amount (see instructions)			0	
39.97	Demonstration payment adjustment amount before sequestration			0	
39. 98 39. 99	Partial or full credits received from manufacturers for replaced RECOVERY OF ACCELERATED DEPRECIATION	devices (see instruc	tions)	0	
40.00	Subtotal (see instructions)			5, 705, 958	
40. 01	Sequestration adjustment (see instructions)			114, 119	
40.02	Demonstration payment adjustment amount after sequestration			0	
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			5, 593, 113	40.03 41.00
41.01	Interim payments-PARHM			., ,	41.01
42.00	Tentative settlement (for contractors use only)			0	
42.01 43.00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-1, 274	42.01 43.00
43.00	Balance due provider/program-PARHM (see instructions)			-1,2/4	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance §115.2 TO BE COMPLETED BY CONTRACTOR	with CMS Pub. 15-2,	chapter 1,	0	44.00
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00

Health Financial Systems	ST ELI ZABETH DEARBORN	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0086	Peri od:	Worksheet E Part B	
		From 01/01/2023 To 12/31/2023		pared: 8 pm
	Title XVIII	Hospi tal	PPS	
			1.00	
94.00 Total (sum of lines 91 and 93)			0	94.00
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

MALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	-	Period: From 01/01/2023 To 12/31/2023	Date/Time Prep 5/28/2024 1:58	pared
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		10, 048, 56		5, 593, 113	1. C
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			D	0	2.0
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. (
	Program to Provider					
. 01 . 02	ADJUSTMENTS TO PROVIDER			0	0	3. C 3. C
. 02 . 03				0	0	3.
. 03				0	0	3.
. 05				0	Ő	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52 53				0	0	3. 3.
. 53				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10, 048, 56	7	5, 593, 113	4.
~~	TO BE COMPLETED BY CONTRACTOR	1				-
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
01				0	0	5. 5.
03				0	0	5.
	Provider to Program			I.		
50	TENTATI VE TO PROGRAM			0	0	5.
51 52				0	0	5. 5.
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 5.
00	5.50-5.98) Determined net settlement amount (balance due) based on				Ū	6.
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		384, 04		0	6.
02	SETTLEMENT TO PROGRAM			0	1,274	6.
00	Total Medicare program liability (see instructions)		10, 432, 61	Contractor Number	5,591,839 NPR Date (Mo/Day/Yr)	7.
		0	)	1.00	2.00	

Heal th	Financial Systems ST ELIZA	BETH DEARBORN	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023		epared:
	·	Title XVIII	Hospi tal	PPS	
				1.00	_
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR	-			_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL				
1.00	Total hospital discharges as defined in AARA §4102 from	Wkst. S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col				6.00
7.00	CAH only - The reasonable cost incurred for the purchase line 168	e of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instruction	ons)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestra	ation (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions	6)			30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instruction	is)		32.00

		LIZABETH DEARBORN		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Pre 5/28/2024 1:58	pared:
		Title XIX	Hospi tal	Cost	o piii
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER	HEALTH SERVICES FOR TITLES V OR X	IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0	244 024	1.0
2.00 3.00	Medical and other services Organ acquisition (certified transplant programs on		0	364, 034	2.0 3.0
4.00	Subtotal (sum of lines 1, 2 and 3)	Ty)	0	364, 034	4.0
5.00	Inpatient primary payer payments		0	304, 034	5.0
5.00	Outpatient primary payer payments			0	6.0
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	364, 034	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
3.00	Routine service charges		0		8.0
9.00	Ancillary service charges		629, 248	1, 419, 313	9.0
10.00	Organ acquisition charges, net of revenue		0		10.0
11.00 12.00	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11	\ \	629, 248	1 410 212	11.0 12.0
12.00	CUSTOMARY CHARGES	)	027, 240	1, 419, 313	12.0
13.00	Amount actually collected from patients liable for	payment for services on a charge	0	0	13.0
	basi s		Ū	0	
14.00	Amounts that would have been realized from patients	liable for payment for services o	n 0	0	14.0
	a charge basis had such payment been made in accord	ance with 42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000	)	0. 000000	0.00000	
16.00	Total customary charges (see instructions)		629, 248	1, 419, 313	
17.00	Excess of customary charges over reasonable cost (c	omplete only it line 16 exceeds	629, 248	1, 055, 279	17. C
18.00	line 4) (see instructions) Excess of reasonable cost over customary charges (c	omplete only if line 4 exceeds lin	e 0	0	18.0
10.00	16) (see instructions)	omprete only in this 4 exceeds inh	0	0	10.0
19.00	Interns and Residents (see instructions)		0	0	19.0
20.00	Cost of physicians' services in a teaching hospital	(see instructions)	0	0	20. C
21.00	Cost of covered services (enter the lesser of line		0	364, 034	21.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 mu	st only be completed for PPS provi			
	Other than outlier payments		0	0	22.0
23.00	Outlier payments		0	0	23.0 24.0
	Program capital payments Capital exception payments (see instructions)		0		24.0
26.00	Routine and Ancillary service other pass through co	sts	0	0	26.0
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.0
28.00	Customary charges (title V or XIX PPS covered servi	ces only)	0	0	28.0
29.00	Titles V or XIX (sum of lines 21 and 27)		0	364, 034	29.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.0
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lin	es 5 and 6)	0	364, 034	
32.00	Deducti bl es		0	0	32.0
	Coinsurance		0	0	33.0
34.00 35.00	Allowable bad debts (see instructions) Utilization review		0	0	34.0 35.0
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of l	ines 32 and 33)	0	364, 034	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.0
38.00	Subtotal (line 36 $\pm$ line 37)		0	364, 034	38.0
39.00	Direct graduate medical education payments (from Wk	st. E-4)	0		39. (
40.00	Total amount payable to the provider (sum of lines	38 and 39)	0	364, 034	40. (
41.00	Interim payments		0	0	41.0
	Balance due provider/program (line 40 minus line 41	)	0	364, 034	42. (
12.00 13.00	Protested amounts (nonallowable cost report items)		-	0	43.0

Heal th	Financial Systems ST ELIZABETH I	DEARBORN	In Lie	u of Form CMS-2	552-10
OUTLIE	ER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0086	Period: From 01/01/2023	Worksheet E-5	
			To 12/31/2023	Date/Time Prep 5/28/2024 1:58	pared: 3 pm
		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 instr	ructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instruct			0	4.00
5.00	The rate used to calculate the time value of money (see instr			0.00	5.00
6.00	Time value of money for operating expenses (see instructions)			0	6,00
7.00	Time value of money for capital related expenses (see instruct			0	7.00

y)         CURREN 0           Cash of 0         Tempor           0         Cash of 0         Remove           0         Accour         Notes           0         Accour         Notes           0         Accour         Notes           0         Accour         Notes           0         Invent         Fixed           0         Due fr         Notes           0         Land i         Notes           0         Land i         Notes           0         Accum         Notes           0         Deposi         Notes           0         Deposi         Notes           0         Deferr         Notes           0         Deferr         Notes           0         Notes         Notes           0         Notes         Notes           0         Note	accounting records, complete the General Fund column  RENT ASSETS  h on hand in banks porary investments es receivable ounts receivable er receivable owances for uncollectible notes and accounts receivable entory paid expenses er current assets	General Fund 1.00 261,976,160 0 10,069,888 110,904 0 3,359,775	Speci fi c Purpose Fund 2.00	rom 01/01/2023 p 12/31/2023 Endowment Fund 3.00 0 0 0 0 0 0 0 0 0 0 0 0	Date/Time Prep 5/28/2024 1:58 Plant Fund 4.00 0 0	8 pm
0         Cash of Tempor           00         Tempor           00         Notes           00         Accour           00         Allows           00         Invent           00         Other           00         Other           00         Invent           00         Prepail           00         Due fri           00         Land           00         Land           00         Accum           00         Buildi           00         Accum           00         Acc	h on hand in banks porary investments es receivable ounts receivable er receivable owances for uncollectible notes and accounts receivable entory paid expenses er current assets	1.00 261,976,160 0 10,069,888 110,904 0	Purpose Fund 2.00 0 0 0 0 0 0	3. 00 0 0	4.00 0 0	
0         Cash of Tempor           00         Tempor           00         Notes           00         Accour           00         Allows           00         Invent           00         Other           00         Other           00         Invent           00         Prepail           00         Due fri           00         Land           00         Land           00         Accum           00         Buildi           00         Accum           00         Acc	h on hand in banks porary investments es receivable ounts receivable er receivable owances for uncollectible notes and accounts receivable entory paid expenses er current assets	261, 976, 160 0 10, 069, 888 110, 904 0	0 0 0 0	0	0	1 1
0         Cash of Tempor           00         Tempor           00         Notes           00         Accour           00         Allows           00         Invent           00         Other           00         Other           00         Invent           00         Prepail           00         Due fri           00         Land           00         Land           00         Accum           00         Buildi           00         Accum           00         Acc	h on hand in banks porary investments es receivable ounts receivable er receivable owances for uncollectible notes and accounts receivable entory paid expenses er current assets	0 0 10, 069, 888 110, 904 0	0 0 0	Ō	0	1 1
0         Tempor           0         Notes           0         Accour           0         Other           0         Allowa           0         Prepai           0         Due fr           0         FIXED           0         Land           0         Accourd           0         Buildi           00         Accumd           00         Land           00         Accumd           01         Minor           00         Accumd           00         Accumd           00         Total           00         Total           00         Accel e           00         Due fr           00         Accumd           00         Accel e           00         Due f	porary investments es receivable ounts receivable er receivable owances for uncollectible notes and accounts receivable entory paid expenses er current assets	0 0 10, 069, 888 110, 904 0	0 0 0	-		1 1.
0         Accour           0         Other           0         Other           0         Other           0         Prepai           0         Other           0         Prepai           0         Total           FIXED         O           00         Land           00         Land i           00         Accum           00         Buildi           00         Accum           00         Minor           00         Accum           00         Accum           00         Due fr	ounts receivable er receivable owances for uncollectible notes and accounts receivable entory paid expenses er current assets	110, 904 0	0	0		2.
0         Other           0         Allowa           0         Allowa           0         Invent           0         Prepaid           0         Other           00         Due fr           00         Due fr           00         Land           00         Land           00         Accum	er receivable owances for uncollectible notes and accounts receivable entory paid expenses er current assets	110, 904 0	Ŭ		0	
0         Allowa           0         Allowa           0         Invent           0         Other           00         Other           00         Total           FIXED         Land           00         Accum           00         Total           00         Accum           00         Accum           00         Accum <td>owances for uncollectible notes and accounts receivable entory paid expenses er current assets</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td></td>	owances for uncollectible notes and accounts receivable entory paid expenses er current assets	0		0	0	
0         Invent           0         Prepai           0         Other           00         Other           00         Other           00         Other           00         Other           00         Due fri           01         Total           01         EISE           00         Land           00         Accum           00         HIT de           00         Accum           00         HIT de           00         Accum           00         Total           00         Total           00         Total           00         Accum           00         Deposi           00         Deter           00         Deter           00         Deter           00         Other </td <td>entory paid expenses er current assets</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td>	entory paid expenses er current assets		0	0	0	
0         Prepai           0         Other           00         Due fr           00         Land           00         Land           00         Land           00         Land           00         Land           00         Land           00         Accum           00         Total           00         Total           00         Accol           00         Deferr           00         Accel           00         Duet for           00         Accel           00         Duet for           00         Accel           00         Duet for	paid expenses er current assets		0	0	0	
0         Other           00         Due fr           00         Total           FIXED         Land           00         Land i           00         Accum           00         Buildi           00         Accum           00         Buildi           00         Accum           00         Due for           00         Due for           00         Accu           00         Accu           00         Accu           00         Accu           00         Accu           00         Accu           00         Accu </td <td>er current assets</td> <td>0</td> <td>0</td> <td>0</td> <td>Ő</td> <td></td>	er current assets	0	0	0	Ő	
Total           FIXED           00         Land           00         Land           00         Land           00         Land           00         Accum           00         Lease           00         Lease           00         Accum           00         Accum           00         Accum           00         Accum           00         Accum           00         Accum           00         Major           00         Accum           00         Due for           00         Total           00         Other           00         Acceu           00         Accu           00         Total           00         Acceu           00         Notes           00         Defer           00         Acceu           00		0	0	0	0	9
FIXED           00         Land           00         Land i           00         Accum           00         Major           00         Accum           00         Minor           00         Total           00         Total           00         Other           00         Total           00         Notes           00         Defori           00         Notes           00         Defori           00         Notes           00         Unsect           00         Notes           00         Unsect           00         Unter           00         Unter           00         Unter	from other funds	0	0	0	0	10
00         Land           00         Land           00         Land           00         Accum           00         Accum           00         Accum           00         Accum           00         Fixed           00         Accum           00         Fixed           00         Accum           00         Accum           00         Accum           00         Accum           00         Accum           00         Accum           00         HIT de           00         Due fr           00         Total           00         Total           00         Notes           00         Deferr           00         Notes           00         Unsect           00         Notes           00         Unsect           00         Total	al current assets (sum of lines 1-10)	275, 516, 727	0	0	0	11
00         Land i           00         Accumu           00         Buil di           00         Accumu           00         Leasel           00         Accumu           00         Fixed           00         Accumu           00         Fixed           00         Accumu           00         Accumu           00         Major           00         Accumu           00         Minor           00         Total           00         Total           00         Total           00         Total           00         Notes           00         Deposi           00         Accouru           00         Total           00         Total           00         Notes           00         Deposi           00         Notes           00         Detern           00         Notes           00         Notes           00         Unsect           00         Notes           00         Total           00         To	ED_ASSETS	<b>500.000</b>				1 40
00         Accumu           00         Buildi           00         Accumu           00         Minor           00         Accumu           00         Minor           00         Accumu           00         Minor           00         Accumu           00         Minor           00         Total           00         Due fri           00         Due fri           00         Total           00         Notes           00         Deferri           00         Notes           00         Due fri           00         Notes           00         Notes           00         Notes           00         Uther           00         Notes           00         Notes           00         <	d d improvements	500, 000		0	0	
00         Buildi           00         Accum           00         Leaset           00         Accum           00         Major           00         Accum           00         Minor           00         Accum           00         Minor           00         Accum           00         Minor           00         Deposi           00         Due fr           00         Total           00         Total           00         Accour           00         Accour           00         Total           00         Accel           00         Due tr           00         Due tr           00         Due tr           00         Notes           00         Unsect           00         Notes           00         Unter           00         Total <td>umulated depreciation</td> <td>33, 250 -16, 862</td> <td></td> <td>0</td> <td>0</td> <td></td>	umulated depreciation	33, 250 -16, 862		0	0	
00         Accumu           00         Leasef           00         Accumu           00         Fi xed           00         Accumu           00         Accumu           00         Accumu           00         Accumu           00         Accumu           00         Major           00         Accumu           00         Minor           00         Accumu           00         Minor           00         Total           00         Deposi           00         Detori           00         Total           00         Notes           00         Deferr           00         Notes           00         Detosi           00         Notes           00         Detori           00         Notes           00         Unsect           00         Notes           00         Unsect           00         Total           00         Notes           00         Unsect           00         Total           00	•	3, 638, 529		0	0	
00         Leasef           00         Accumu           00         Fixed           00         Accumu           00         Accumu           00         Accumu           00         Accumu           00         Accumu           00         Accumu           00         Major           00         Accumu           00         Minor           00         Accumu           00         Minor           00         Total           00         Due fr           00         Other           00         Total           00         Total           00         Accourd           00         Notes           00         Deposi           00         Notes           00         Detern           00         Notes           00         Duet of           00         Notes           00         Unsect           00         Notes           00         Other           00         Total           00         Notes           00         U	umulated depreciation	-1, 517, 124	0	0	Ő	
00         Fixed           00         Accuma           00         Accuma           00         Accuma           00         Major           00         Accuma           00         Major           00         Accuma           00         Minor           00         Accuma           00         HIT data           00         Total           00         Account           00         Total           00         Total           00         Notes           00         Deport           00         Notes           00         Duet for           00         Notes           00         Unsect           00         Notes           00         Unsect           00         Total           00         Total           00         Unsect           00         U	sehold improvements	16, 678	0	0	0	
00         Accumu           00         Automo           00         Accumu           00         Major           00         Accumu           00         Major           00         Accumu           00         Minor           00         Accumu           00         HITde           00         Accumu           00         Minor           00         Total           00         Deposi           00         Due fri           00         Total           00         Total           00         Total           00         Accour           00	umulated depreciation	-6, 671	0	0	0	18
00     Automo       00     Accumu       00     Major       00     Accumu       00     Minor       00     Accumu       00     Accumu       00     Accumu       00     Accumu       00     Accumu       00     Accumu       00     Total       00     Total       00     Deposi       00     Other       00     Total       00     Total       00     Accourt       00     Accourt       00     Accourt       00     Accourt       00     Accourt       00     Accourt       00     Notes       00     Deferr       00     Total       00     Total       00     Total       00     Notes       00     Notes       00     Unsector       00     Total       00<	ed equipment	13, 682	0	0	0	19
00         Accumu           00         Maj or           00         Maj or           00         Accumu           00         Mi nor           00         OTAL           00         Total           00         Deposi           00         Deposi           00         Deter           00         Total           00         Total           00         Total           00         Total           00         Account           00         Notes           00         Deferr           00         Acceut           00         Total           00         Notes           00         Notes           00         Unker           00         Notes           00         Total           00         Total           00         Other           00         <	umulated depreciation	-2, 280	0	0	0	
00         Maj or           00         Accumu           00         Mi nor           00         Accumu           00         HI T du           00         Accumu           00         Accumu           00         Accumu           00         Accumu           00         Accumu           00         Accumu           00         Total           00         Deposi           00         Detosi           00         Total           00         Total           00         Accour           00         Notes           00         Deferi           00         Accel e           00         Other           00         Total           00         Deteri           00         Other           00         Total           00         Notes           00         Unsect           00         Total           00         Total           00         Total           00         Total           00         Total           00 <td< td=""><td>omobiles and trucks</td><td>25, 530</td><td></td><td>0</td><td>0</td><td></td></td<>	omobiles and trucks	25, 530		0	0	
00         Accumu           00         Minor           00         Accumu           00         HIT de           00         Accumu           00         HIT de           00         Accumu           00         HIT de           00         Accumu           00         Invest           00         Invest           00         Due fr           00         Other           00         Total           00         Total           00         Accour           00         Resource           00         Notes           00         Deferr           00         Accel e           00         Other           00         Total           00         Notes           00         Notes           00         Notes           00         Unsect           00         Total           00         Notes           00         Uther           00         Total           00         Total           00         Total           00	umulated depreciation	-25, 530	0	0	0	
00         Minor           00         Accuma           00         HIT de           00         Accuma           00         Minor           00         Total           01         OTHER           00         Deposi           00         Dother           00         Total           00         Total           00         Total           00         Total           00         Total           00         Accour           00         Accour           00         Accour           00         Notes           00         Deferr           00         Accel e           00         Due to           00         Other           00         Notes           00         Mortga           00         Notes           00         Unsect           00         Total	or movable equipment umulated depreciation	6, 853, 907 -3, 778, 591	0	0	0	
00         Accum           00         HI T de           00         Accum           00         Minor           01         OTHER           00         Due fr           00         Total           00         Deposi           00         Due fr           00         Other           00         Total           00         Total           00         Total           00         Accour           00         Sal ari           00         Notes           00         Deferr           00         Accel e           00         Due to           00         Other           00         Notes           00         Notes           00         Notes           00         Unsect           00         Other           00         Other<	or equipment depreciable	202, 680	-	0	0	
00         HIT de           00         Accum           00         Minor           00         Total           00         Deposi           00         Due fr           00         Other           00         Total           00         Total           00         Total           00         Total           00         Accour           00         Salari           00         Notes           00         Deferr           00         Accel e           00         Notes           00         Total           00         Notes           00         Other           00         Total	umulated depreciation	-100, 997	0	0	0	
00 Accume 01 January Accume 01 January Accume 00 January Accume 00 January Accume 00 January Accume 00 Accume 00 Accume 00 Accume 00 January Accume 00 Accume 00 January Accume 00 Accume 00 January Accume 00 J	designated Assets	0	0	0	Ő	
Total           0THER           00           01           01           02           03           04           05           06           07           07           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00	umulated depreciation	0	0	0	0	28
OTHER 00 Invest 00 Deposi 00 Due fri 00 Total 00 Total 00 Accour 00 Ac	or equipment-nondepreciable	0	0	0	0	29
00 Invest 00 Deposi 00 Due fr 00 Other 00 Total 00 Total 00 Accour 00 Salari 00 Payrol 00 Notes 00 Due to 00 Other 00 Total 100 Mortga 00 Notes 00 Unsect 00 Notes 00 Unsect 00 Other 00 Total 100 Mortga 00 Notes 00 Unsect 00 Other 00 Total 100 Mortga 00 Notes 00 Unsect 00 Other 00 Total 00 Total 00 Total	al fixed assets (sum of lines 12-29)	5, 836, 201	0	0	0	30
00 Deposi 00 Due fr 00 Other 00 Total 00 Total 00 CURREN 00 Accour 00 Salari 00 Payrol 00 Notes 00 Defer 00 Accela 00 Other 00 Total 00 Notes 00 Notes 00 Notes 00 Notes 00 Notes 00 Notes 00 Notes 00 Notes 00 Total 00 Total 00 Total 00 Total 00 Total 00 Total	ER ASSETS					1
00 Due fr 00 Other 00 Total 00 Total 00 CURREN 00 Accour 00 Salari 00 Payrol 00 Notes 00 Deferr 00 Accel 6 00 Due to 00 Other 00 Total 00 Mortga 00 Notes 00 Unsect 00 Other 00 Other 00 Other 00 Total 00 Total 00 Total 00 Total 00 Total 00 Total 00 Total 00 Total 00 Total 00 Total	estments osits on leases	0	0	0	0	
00 Other 00 Total 00 Total CURREN 00 Accour 00 Salari 00 Payrol 00 Notes 00 Defer 00 Accel 00 Due to 00 Total LONG T 00 Mortga 00 Notes 00 Unsecu 00 Other 00 Other 00 Other 00 Other 00 Other 00 Other 00 Total 00 Total 00 Total 00 Total 00 Total 00 Total 00 Total	from owners/officers	-259, 975, 761	0	0	0	
00 Total 00 Total CURREN 00 Accour 00 Salari 00 Payrol 00 Notes 00 Deferr 00 Accel e 00 Due to 00 Other 100 Mortga 00 Notes 00 Unsect 00 Other 00 Other 00 Other 00 Total 00 Total 00 Total 00 Total 00 Corel FA	er assets	1, 475, 468	Ŭ	0	0	
CURREN           00         Accour           00         Sal ari           00         Payrol           00         Notes           00         Deferr           00         Accel @           00         Due to           00         Other           00         Total           100         Mortga           00         Notes           00         Unsect           00         Other           00         Total           00         Total           00         Total           00         Total           00         Total	al other assets (sum of lines 31-34)	-258, 500, 293		0	0	
00         Accour           00         Sal ari           00         Payrol           00         Notes           00         Defern           00         Accel @           00         Due to           00         Other           00         Total           100         Mortga           00         Notes           00         Unsecu           00         Total           00         Total           00         Total           00         Total           00         Total           00         Total	al assets (sum of lines 11, 30, and 35)	22, 852, 635	0	0	0	36
00         Sal ari           00         Payrol           00         Notes           00         Deferr           00         Accel a           00         Due to           00         Other           00         Total           00         Notes           00         Mortga           00         Notes           00         Other           00         Other           00         Total           00         Total           00         Total           00         Total	RENT LIABILITIES					
00 Payrol 00 Notes 00 Deferr 00 Accel 6 00 Due to 00 Total LONG T 00 Mortga 00 Notes 00 Unsecu 00 Other 00 Other 00 Total 00 Total 00 Total 00 Total	ounts payable	848, 561	0	0	0	
00 Notes 00 Deferr 00 Accel e 00 Due to 00 Other 100 Mortga 00 Notes 00 Unsecu 00 Other 00 Other 00 Other 00 Other 00 Other 00 Dotal 00 Cotal 00 Other 00 Dotal 00 Other 00 Notes 00 Dotal 00 Other 00 Notes 00 Notes 00 Dotal 00 Other 00 Notes 00 Notes 00 Other 00 Notes 00 Other 00 Notes 00 Notes 00 Other 00 Notes 00 Other 00 Notes 00 Other 00 Notes 00 Other 00 Notes 00 Other 00 Notes 00 Other 00 Other	aries, wages, and fees payable	3, 601, 886		0	0	
00         Deferr           00         Accel e           00         Due tot           00         Other           00         Total           LONG T         Mortga           00         Notes           00         Unsect           00         Other           00         Unsect           00         Other           00         Total           00         Total           00         Total           00         Total	roll taxes payable es and loans payable (short term)	0	0	0	0	
00 Accel e 00 Due to 00 Other 00 Total LONG T 00 Mortgs 00 Notes 00 Unsect 00 Other 00 Total 00 Total 00 Total 00 Total	erred income		0	0	0	
00 Due to 00 Other 00 Total LONG T 00 Mortgs 00 Notes 00 Unsect 00 Other 00 Total 00 Total 00 Total	elerated payments	0	U U	0	0	42
00 Total LONG T 00 Mortga 00 Notes 00 Unsect 00 Other 00 Total 00 Total 00 CAPITA	to other funds	0	0	0	0	
LONG T 00 Mortga 00 Notes 00 Unsecu 00 Other 00 Total 00 Total CAPITA	er current liabilities	13, 525, 932	0	0	0	
00 Mortga 00 Notes 00 Unsecu 00 Other 00 Total 00 Total CAPITA	al current liabilities (sum of lines 37 thru 44)	17, 976, 379	0	0	0	45
00 Notes 00 Unsecu 00 Other 00 Total 00 Total CAPITA	G TERM LIABILITIES	T	1	T		4
00 Unsecu 00 Other 00 Total 00 Total CAPITA	tgage payable	0	0	0	0	
00 Other 00 Total 00 Total CAPITA	es payable	0	0	0	0	
00 Total 00 Total CAPI TA	er long term liabilities	1, 107, 515	-	0	0	
00 Total CAPI TA		1, 107, 515		0	0	
<b>CAPI TA</b>		19, 083, 894		0	Ő	
	al long term liabilities (sum of lines 46 thru 49)					
00 Genera			1 1			52
	al long term liabilities (sum of lines 46 thru 49) al liabilities (sum of lines 45 and 50)	3, 768, 741				53
	al long term liabilities (sum of lines 46 thru 49) al liabilities (sum of lines 45 and 50) TAL ACCOUNTS eral fund balance cific purpose fund	3, 768, 741	0			54
	al long term liabilities (sum of lines 46 thru 49) al liabilities (sum of lines 45 and 50) TAL ACCOUNTS eral fund balance cific purpose fund or created - endowment fund balance - restricted	3, 768, 741		0		
	al long term liabilities (sum of lines 46 thru 49) al liabilities (sum of lines 45 and 50) TAL ACCOUNTS eral fund balance cific purpose fund or created - endowment fund balance - restricted or created - endowment fund balance - unrestricted	3, 768, 741		0		55
	al long term liabilities (sum of lines 46 thru 49) al liabilities (sum of lines 45 and 50) TAL ACCOUNTS eral fund balance cific purpose fund or created - endowment fund balance - restricted or created - endowment fund balance - unrestricted erning body created - endowment fund balance	3, 768, 741		0 0 0		55 56
	al long term liabilities (sum of lines 46 thru 49) al liabilities (sum of lines 45 and 50) TAL ACCOUNTS eral fund balance cific purpose fund or created - endowment fund balance - restricted or created - endowment fund balance - unrestricted erning body created - endowment fund balance nt fund balance - invested in plant	3, 768, 741		0 0 0	0	55 56 57
	al long term liabilities (sum of lines 46 thru 49) al liabilities (sum of lines 45 and 50) TAL ACCOUNTS eral fund balance cific purpose fund or created - endowment fund balance - restricted or created - endowment fund balance - unrestricted erning body created - endowment fund balance nt fund balance - invested in plant nt fund balance - reserve for plant improvement,	3, 768, 741		0 0 0	0 0	55 56 57
00 Total	al long term liabilities (sum of lines 46 thru 49) al liabilities (sum of lines 45 and 50) TAL ACCOUNTS eral fund balance cific purpose fund or created - endowment fund balance - restricted or created - endowment fund balance - unrestricted erning body created - endowment fund balance nt fund balance - invested in plant	3, 768, 741	0	0 0 0		55 56 57 58

Heal th	Financial Systems	ST ELI ZABETH	DEARBORN			In Lie	eu of Form CMS	-2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0086	Perio From To		Worksheet G-	1 epared:
		General	Fund	Speci al	Purpo	se Fund	Endowment Fun	
			0.00					
1.00	Fund balances at beginning of period	1.00	2.00	3.00		4.00	5.00	1.00
2.00 3.00	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2)		2, 358, 455 2, 010, 738			C		2.00 3.00
4.00	HOME OFFICE	14, 860, 705			0			0 4.00
5.00	RELATED PARTY	4, 570, 140			0			5.00
6.00	ROUNDING	5			0			0 6.00
7.00 8.00		0			0			0 7.00 0 8.00
8.00 9.00		0			0			9.00
10.00	Total additions (sum of line 4-9)	0	19, 430, 850		U	C		10.00
11.00	Subtotal (line 3 plus line 10)		21, 441, 588			0		11.00
12.00	DEDUCTIONS	17, 672, 847	2.17 1.17 000		0			12.00
13.00		0			0			0 13.00
14.00		0			0			0 14.00
15.00		0			0			0 15.00
16.00		0			0			0 16.00
17.00		0			0			0 17.00
18.00	Total deductions (sum of lines 12-17)		17, 672, 847			C		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3, 768, 741			C		19.00
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
1.00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				~			2.00
3.00 4.00	Total (sum of line 1 and line 2) HOME OFFICE	0	0		0			3.00
4.00 5.00	RELATED PARTY		0					4.00 5.00
6.00	ROUNDING		0					6.00
7.00	Rounding		0					7.00
8.00			0					8.00
9.00			0					9.00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	DEDUCTIONS		0					12.00
13.00			0					13.00
14.00			0					14.00
15.00			0					15.00
16.00 17.00			0					16.00 17.00
17.00	Total deductions (sum of lines 12-17)	o	0		0			17.00
18.00	Fund balance at end of period per balance	0			0			19.00
17.00	sheet (line 11 minus line 18)				Ŭ			'. 00
	······································	· ·	1					

IAIEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	rovider (	CN: 15-0086	Period: From 01/01/202 To 12/31/202		epared
	Cost Center Description		Inpati ent	Outpatient	Total	
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					-
00	Hospi tal		23, 840, 8	16	23, 840, 816	5 1.0
00	SUBPROVIDER - IPF		20,010,0	0	20,010,010	
00	SUBPROVIDER - IRF			0		
00	SUBPROVI DER			-		4. (
00	Swing bed - SNF			0	(	
00	Swing bed - NF			0	(	6.0
00	SKILLED NURSING FACILITY			0	(	7.0
00	NURSING FACILITY			0	(	8.0
00	OTHER LONG TERM CARE			0	(	9.0
0. 00	Total general inpatient care services (sum of lines 1-9)		23, 840, 8	16	23, 840, 816	5 10.
	Intensive Care Type Inpatient Hospital Services			- F		
1.00	INTENSIVE CARE UNIT		15, 258, 9		15, 258, 912	
2.00	CORONARY CARE UNI T			0	(	
3.00	BURN INTENSIVE CARE UNIT			0		) 13.0
4.00	SURGI CAL I NTENSI VE CARE UNI T			0	(	) 14.0
5.00	OTHER SPECIAL CARE (SPECIFY)		45.050.0		15 050 044	15.0
5.00	Total intensive care type inpatient hospital services (sum of l	i nes	15, 258, 9	12	15, 258, 912	2 16.
7 00	11-15)		20,000,7	20	20,000,720	3 17.
7.00 3.00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services		39, 099, 72 53, 000, 80		39, 099, 728 200, 592, 070	
	Outpatient services		9, 696, 9			
	RURAL HEALTH CLINIC		7,070,7		0 40, 385, 54	
1.00	FEDERALLY QUALIFIED HEALTH CENTER				0 0	
	HOME HEALTH AGENCY			0	0 0	
3.00	AMBULANCE SERVICES			0	0 0	
4.00	СМНС				0 0	24.
4. 10	CORF			0	0 0	24.
5.00	AMBULATORY SURGICAL CENTER (D. P. )			0	0 0	25.0
5.00	HOSPI CE			0	0 0	26.0
7.00	OTHER-PYSICIAN CHARGES-OP ROUTINE		7, 780, 9	55 2, 325, 55	10, 106, 509	9 27.0
3.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	109, 578, 4	71 180, 605, 38	85 290, 183, 856	5 28.0
	G-3, line 1)					
	PART II - OPERATING EXPENSES		1	74 050 15		1 20
	Operating expenses (per Wkst. A, column 3, line 200) HOME OFFICE ALLOCATION		14, 860, 70	76, 058, 15	00	29.
1.00	RELATED PARTY ALLOCATION		4, 570, 14			30.
2.00	RELATED FARTT ALLOCATION		4, 570, 14	0		32.
3.00				0		33.
4.00				0		34.
5.00				0		35.
5.00	Total additions (sum of lines 30-35)			19, 430, 84	5	36.
7.00	DEDUCT (SPECIFY)			0	-	37.
3.00				0		38.
9.00				0		39.
). 00				0		40.
1.00				0		41.
2.00	Total deductions (sum of lines 37-41)				0	42.
3.00	Total operating expenses (sum of lines 29 and 36 minus line 42)		1	95, 489, 00	1	43.

Heal th	Financial Systems	ST ELIZABETH DEARBORN		u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-00		Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	nared
			10 12/31/2023	5/28/2024 1:5	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I			290, 183, 856	
2.00	Less contractual allowances and discounts on p	atients' accounts		193, 997, 696	
3.00	Net patient revenues (line 1 minus line 2)			96, 186, 160	
4.00	Less total operating expenses (from Wkst. G-2,			95, 489, 001	
5.00	Net income from service to patients (line 3 mi	nus line 4)		697, 159	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneou	s communication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guest	S		332, 247	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supp			0	16.00
	Revenue from sale of drugs to other than patie			858, 534	
	Revenue from sale of medical records and abstr			217	18.00
	Tuition (fees, sale of textbooks, uniforms, et			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and	canteen		173, 427	
21.00	Rental of vending machines			8, 965	
22.00	Rental of hospital space			34, 302	
23.00	Governmental appropriations OTHER-GRANTS			0	
				253, 604	
	COVID-19 PHE Funding Total other income (sum of lines 6-24)			0	
				1, 661, 296	
	Total (line 5 plus line 25) OTHER EXPENSES (SPECIFY)			2, 358, 455 0	26.00
	Total other expenses (sum of line 27 and subsc	ri ntc)		0	27.00
	Net income (or loss) for the period (line 26 m			2, 358, 455	
29.00	Iner income (or ross) for the period (fine 20 m	Thus The 20)	I	2, 358, 455	29.00

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0086	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre 5/28/2024 1:55	
		Title XVIII	Hospi tal	PPS	<u>o p</u>
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			764, 813	
. 01	Model 4 BPCI Capital DRG other than outlier			0	1
. 00	Capital DRG outlier payments			2, 306	
. 01	Model 4 BPCI Capital DRG outlier payments			0	
. 00	Total inpatient days divided by number of days in the cos	t reporting period (see inst	ructions)	34.92	
. 00	Number of interns & residents (see instructions)			0.00	
. 00	Indirect medical education percentage (see instructions)			0.00	
. 00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1.01	, columns 1 and	0	6.
00	1.01) (see instructions)	A pationt dava (Warkahaat [	nort A Line	0.00	
. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	A patrent days (worksheet e	., part A rine	0.00	7.
. 00	Percentage of Medicaid patient days to total days (see in:	structions)		0.00	8.
9.00 9.00	Sum of lines 7 and 8			0.00	
	Allowable disproportionate share percentage (see instruct	ions)		0.00	
	Disproportionate share adjustment (see instructions)			0.00	
	Total prospective capital payments (see instructions)			767, 119	
2100				, , , , , , , , , , , , , , , , , , , ,	
				1.00	
	PART II – PAYMENT UNDER REASONABLE COST				
. 00	Program inpatient routine capital cost (see instructions)			0	] 1.(
2.00	Program inpatient ancillary capital cost (see instruction	s)		0	2.0
. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.
. 00	Capital cost payment factor (see instructions)			0	4.
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
. 00	Program inpatient capital costs (see instructions)			0	
. 00	Program inpatient capital costs for extraordinary circums	tances (see instructions)		0	
. 00	Net program inpatient capital costs (line 1 minus line 2)			0	
. 00	Applicable exception percentage (see instructions)			0.00	
. 00	Capital cost for comparison to payments (line 3 x line 4)			0	
. 00	Percentage adjustment for extraordinary circumstances (see			0.00	
. 00	Adjustment to capital minimum payment level for extraordin	nary circumstances (line 2 >	(line 6)	0	
. 00	Capital minimum payment level (line 5 plus line 7)			0	
. 00 0. 00	Current year capital payments (from Part I, line 12, as a			0	
	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov			0	
1.00	Worksheet L, Part III, line 14)	er capitar payment (from pri	u year	0	'''.
2 00	Net comparison of capital minimum payment level to capita	l navments (line 10 nus lin	ie 11)	0	12.
	Current year exception payment (if line 12 is positive, e			0	
	Carryover of accumulated capital minimum payment level ov			0	
	Tour yover of accumulated capital minimum payment rever ov	ci capital payment for the r	showing period	0	14.
	(if line 12 is negative enter the amount on this line)				
4. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	instructions)		0	15.
4. 00 5. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see Current year operating and capital costs (see instruction:			0	