This report is required by law (42 USC 1395g: 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPLRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT	Provi der CCN: 15-0086	Peri od:	Worksheet S
CERTIFICATION AND SETTLEMENT SUMMARY		From 01/01/2022	
		To 12/31/2022	Date/Time Prepared:
			5/23/2023 8:05 am

				5/23	<u> 3/2023 8: 0</u>	<u> 15 am</u>
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepa	ared cost report		Date: 5/23/2023	Time: 8	: 05 am
use only	2. [] Manually prepared co	ost report				
	3. [0]If this is an amenda 4. [F]Medicare Utilization				report	
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended		11 For this Provider CCMI2	O.NPR Date: 1.Contractor's Vendor Co 2.[O]If line 5, column number of times r	1 is 4: I	

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST ELIZABETH DEARBORN (15-0086) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			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		0 249,	-116, °	727	0 368	, 680	1.00
2.00	SUBPROVIDER - IPF		0	0	0		0	2.00
3.00	SUBPROVI DER - I RF		0	0	0		0	3.00
5.00	SWING BED - SNF		0	0	0		0	5. 00
6.00	SWING BED - NF		0				0	6. 00
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		0 249,	-116,	727	0 368	, 680	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.

Hea<u>lth Financial Systems</u> ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0086 Peri od: From 01/01/2022 Worksheet S-2 01/01/2022 | Part I 12/31/2022 | Date/Time Prepared: 5/23/2023 8: 05 am 1.00 3.00 4. 00 2.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 600 WILSON CREEK ROAD 1.00 PO Box: LAWRENCEBURG State: IN Zi p Code: 47025 County: DEARBORN 2.00 2.00 Ci ty: CBSA Component Name CCN Provi der Payment System (P. Date Number Number Type Certi fi ed T, 0, or N) V XVIII XIX 2. 00 3.00 4. 00 5. 00 1.00 6.00 7. 00 8. 00 Hospital and Hospital-Based Component Identification: ST ELIZABETH DEARBORN 150086 17140 07/01/1966 Ν Р 0 3.00 Subprovi der - IPF 4.00 4.00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 7.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 8.00 Hospital -Based SNF 9.00 9.00 Hospi tal -Based NF 10 00 10.00 Hospi tal -Based OLTC 11.00 11.00 Hospi tal -Based HHA 12.00 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17. 00 Hospital -Based (CORF) I 17.10 17.10 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: To: 2. 00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20. 00 21.00 Type of Control (see instructions) 1 21.00 1.00 2.00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for N 22.00 γ disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22 01 ٧ N 22 01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν N 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no Ν Ν 22.03 N for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost

23.00

Ν

ves or "N" for no.

reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" fo

Which method is used to determine Medicaid days on lines 24 and/or 25

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Hea<u>lth Financial Systems</u> ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0086 Peri od: From 01/01/2022 Worksheet S-2 01/01/2022 | Part | 12/31/2022 | Date/Time Prepared: 5/23/2023 8:05 am In-State In-State Out-of Out-of Medi cai d Other Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 6. 00 5 00 1 00 2 00 3 00 4.00 24. 00 24.00 | If this provider is an IPPS hospital, enter the 382 237 16 1.589 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.
If this provider is an IRF, enter the in-state 0 0 0 0 25.00 0 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2. out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26, 00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 27 00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi na: 1.00 2.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36.00 36, 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37 00 37 00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37. 01 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and 38.00 38.00 enter subsequent dates Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 39. 00 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Ν 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 Ν Ν Ν with 42 CFR Section §412.320? (see instructions)
Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 47.00 Ν Ν Ν Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν 48.00 Ν Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see 56.00 Ν the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete "Y" that I is "Y", did "Y" to yes or "N" for no in column 2. for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00

59.00

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

Hea<u>lth Financial Systems</u> ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0086 Peri od: From 01/01/2022 Worksheet S-2 01/01/2022 | Part I 12/31/2022 | Date/Time Prepared: 5/23/2023 8:05 am NAHE 413.85 Worksheet A Pass-Through Qual i fi cati on Y/N Line # Criterion Code 3. 00 1.00 2.00 60 00 60.00 Are you claiming nursing and allied health education (NAHE) costs for Ν any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. 60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see 23 00 60 01 1 instructions) Y/N IME Direct GME I ME Direct GME 3.00 1 00 2 00 4 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 61.00 N 0.00section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports 61 01 61.01 ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the 61.04 61.04 current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unwei ghted Direct GME FTE FTE Count Count 1. 00 2.00 3. 00 4. 00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the <u>direct GME FTE unweighted count</u>. 1. 00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0. 0d 62. 00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) N 63.00 Unwei ghted Unwei ghted Ratio (col. 1, FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care 0 00 0 00 0.000000 64.00 resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

Hea<u>lth Financial Systems</u> ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0086 Peri od: From 01/01/2022 Worksheet S-2 | Part | | Date/Time Prepared: | 10000 8:05 am 12/31/2022 5/23/2023 8:05 am Ratio (col. 3 (col. 3 + col Program Name Program Code Unwei ghted Unweighted FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 4. 00 5.00 2.00 3.00 0.000000 65.00 65.00 Enter in column 1, if line 63 0 00 0 00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. FTĔs (col. 1 + col. FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010

Enter in column 1 the number of unweighted non-primary care resident 0.000000 66.00 0.00 0.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

Program Name

Program C Program Code Unwei ghted Unwei ghted Ratio (col. 3, FTEs FTEs in (col. 3 + colNonprovi der 4)) Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column (see instructions) 4)). 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your 68 00 N 68.00 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 70

(August 10, 2022)?						
	1.00	2. 00	3. 00			
Inpatient Psychiatric Facility PPS						
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider?	N			70. 00		
Enter "Y" for yes or "N" for no.	!	[ĺ			
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most	!	[0	71. 00		
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see	!	[
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching		[ĺ			
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.	!	[ĺ			
Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.		[ĺ			
(see instructions)						
Inpatient Rehabilitation Facility PPS						
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N	[ĺ	75. 00		
subprovi der? Enter "Y" for yes and "N" for no.		[ĺ			

Health Financial Systems ST ELIZABETH D	DEARBORN		In Lie	u of	Form CM	S-2552-	-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-008			Wor	ksheet :			
		То	12/31/2022	Dat	e/Time 3/2023	Prepare 8:05 an	ed:	
			_	1. 00		3. 00		
76.00 If line 75 is yes: Column 1: Did the facility have an approx recent cost reporting period ending on or before November 15 no. Column 2: Did this facility train residents in a new tea CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. indicate which program year began during this cost reporting	5, 2004? Enter "Y" fo aching program in acc . Column 3: If column	or yes or cordance n 2 is Y,	he most "N" for with 42	1.00	2.00	0	76.	00
Long Term Care Hospital PPS					1. 0	0		
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no. TEFRA Providers		porting	peri od? Ent	er	N N		80. 81.	
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ed unit) under 42 CFR	R Section		10.	N		85. 86.	00
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified under s	ection			N		87.	00
			Approved f Permanen Adjustmer (Y/N)	t	Number Appro Permar Adjustn 2.0	ved nent nents		
88.00 Column 1: Is this hospital approved for a permanent adjustme amount per discharge? Enter "Y" for yes or "N" for no. If yes 89. (see instructions) Column 2: Enter the number of approved permanent adjustments	es, complete col. 2 a					0	88.	00
	Wkst.	A Line No.	Effective [Date	Appro Permar Adjust Amount Discha	ment ment Per		
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A		0.00	2. 00		3. 0	0	89.	
on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA taper discharge. Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	s based. g period arget amount							
TEFRA Larget amount per discharge.			V		XΙ>			
Title V and XIX Services			1. 00		2. 0	0		—
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	ıl services? Enter "Y	" for	N		Υ		90.	00
91.00 Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl	icable column.		N		Υ		91.	
92.00 Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applications.		see			N		92.	00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.			N		N		93.	
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no in th	ie	N		N		94.	00
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes		ne	0. 00 N		O. O N	0	95. 96.	
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the app. 98.00 Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	nterns and residents		0. 00 Y		0. 0 Y	0	97. 98.	
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti			Y		Υ		98.	01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of	alculation of observa	ati on	Y		Υ		98.	02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for years to be a few title VIX.			N N		N		98.	03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in the column 2 for title XIV		V, and	N		N		98.	04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.			Y		Υ		98.	05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y		Y	_	98.	06
Rural Providers 105.00 Does this hospital qualify as a CAH?			N				105.	00
106.00 If this facility qualifies as a CAH, has it elected the all-		. '	N	- 1			106.	

Health Financial Systems ST ELIZABETH [of Form CMS-255	<u>2-10</u>
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN		n 01/01/2022 Pa 12/31/2022 Da	orksheet S-2 art I ate/Time Prepai /23/2023 8:05 a	
			V 1.00	XI X 2. 00	
107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded II Enter "Y" for yes or "N" for no in column 2. (see instructions)	nn 1. (see ins b you train I&R PF and/or IRF tions)	structions) Rs in an unit(s)?	N		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		edul e? See 42 Occupati onal	N Speech	Respi ratory	108. 00
	1. 00	2. 00	3. 00	4.00	
109.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	e N	N	N	N	109. 00
110.00 Did this hospital participate in the Rural Community Hospita	al Demonstrati	on project (§41	IOA	1. 00 N	110. 00
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Woi applicable.	"Y" for yes or	"N" for no. If	f yes,		113.
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this country "Y" for yes or "N" for no in column 1. If the response to contintegration prong of the FCHIP demo in which this CAH is particle all that apply: "A" for Ambulance services; "B" for action for tele-health services.	cost reporting poolumn 1 is Y, warticipating in	period? Enter enter the n column 2.	1. 00 N	2.00	111.00
		1.00	2. 00	3. 00	!
112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital comparticipation in the demonstration, if applicable.	reporting column 1 is pating in the	N			112. 00
participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information		N			113. 00
Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, I 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 provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) '93" percent (includes	N			0 115. 00
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116. 00
117.00 s this facility legally-required to carry malpractice insulary "Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence pole		Υ 2			117. 00 118. 00
if the policy is claim-made. Enter 2 if the policy is occurrence		Premi ums	Losses	Insurance	110.00
		PI ellii uiiis	LUSSES	Hisur arise	
and naid losses		1.00	2.00	3. 00	2110 01
118.01 List amounts of malpractice premiums and paid losses:		0	331,12		0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.			1. 00 N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies the control of the co	n column 1, "Y qualifies for t	Y" for yes or the Outpatient	N	N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	antabl e devi ce	es charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A Line number where these taxes are included.	1 is "Y", ente		Y	5. 00	122. 00
the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) pur services, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizati for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e.,	urchase profess eping, payroll, tion? In column , greater than	and/or n 1, enter "Y" n 50% of total	Y	N	123. 00
professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In column for no.					

Health Financial Systems ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0086 Peri od: From 01/01/2022 Worksheet S-2 Part I
Date/Time Prepared: 12/31/2022 5/23/2023 8: 05 am 1. 00 2. 00 Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N 125.00 and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the certification date 126, 00 in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, enter the certification date 127. 00 in column 1 and termination date, if applicable, in column 2. 128.00|If this is a Medicare-certified liver transplant program, enter the certification date 128. 00 in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certified lung transplant program, enter the certification date 129. 00 in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification 131. 00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified islet transplant program, enter the certification date 132. 00 in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133.00 134.00 If this is a hospital-based organ procurement organization (0PO), enter the OPO number 134.00 in column 1 and termination date, if applicable, in column 2 All Providers HB0843 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, 140.00 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number Contractor's Name: CGS 141. 00 Name: ELIZABETH HEALTHCARE Contractor's Number: 15101 141.00 CORPORATE 142.00 Street: 1 MEDICAL VILLAGE DRIVE PO Box: 142.00 143. 00 Ci ty: **EDGEWOOD** State: ΚY Zip Code: 41017 143.00 1. 00 144.00 Are provider based physicians' costs included in Worksheet A? Υ 144.00 1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 145 00 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If Ν 146, 00 enter the approval date (mm/dd/yyyy) in column 2 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 N 149. 00 Part A Part B Title XIX Title V 1.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413, 13) 155. 00 Hospi tal N Ν N 155.00 Ν 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν 157.00 Subprovi der - IRF Ν Ν Ν Ν 157. 00 158. 00 SUBPROVI DER 158. 00 159.00 SNF N N N N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν N 161.00 CMHC 161.00 Ν Ν Ν 161. 10 CORF Ν Ν Ν 161.10 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 3.00 0 1.00 2.00 4.00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

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3	ABETH DEARBORN		f Form CMS-2552	2-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT			orksheet S-2	
		From 01/01/2022 Pa To 12/31/2022 Da	art i ate/Time Prepar	od:
			/23/2023 8:05 a	
			/23/2023 0.03 a	1111
			1. 00	+
Usalith Information Taskerslam (IIIII) inconting in the	American December and Deligoneto		1.00	
Health Information Technology (HIT) incentive in the		ent Act		la / = 00
167.00 Is this provider a meaningful user under §1886(n)? Er	•		Υ	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a m		"), enter the		168. 00
reasonable cost incurred for the HIT assets (see instr				
168.01 If this provider is a CAH and is not a meaningful user	r, does this provider qualify f	or a hardship		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes of	or "N" for no. (see instruction	s)		
169.00 If this provider is a meaningful user (line 167 is "Y'	') and is not a CAH (line 105 i	s "N"), enter the	9.90	9169. 00
transition factor. (see instructions)	•	, .		
		Begi nni ng	Endi ng	
		1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and er	nding date for the reporting		2	170. 00
period respectively (mm/dd/yyyy)	laring date for the reporting			170.00
perrou respectivery (IIIII) du, yyyy)				
		1.00	2.00	+
474 001 6 1 4 4 7 1 11 11 11 1 1 1 1 1 1 1 1 1 1		1.00	2. 00	174 00
171.00 If line 167 is "Y", does this provider have any days f		N		171. 00
section 1876 Medicare cost plans reported on Wkst. S-3				
"Y" for yes and "N" for no in column 1. If column 1 is	s yes, enter the number of sect	i on		
1876 Medicare days in column 2. (see instructions)				

Health Financial Systems ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 15-0086 Peri od: From 01/01/2022 Worksheet S-2 Part II Date/Time Prepared: 12/31/2022 5/23/2023 8: 05 am Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost 1.00 1.00 Ν reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 2.00 1.00 3.00 Has the provider terminated participation in the Medicare Program? If 2 00 N 2 00 yes, enter in column 2 the date of termination and in column $\widetilde{\mathbf{3}}$, voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3 00 3 00 N contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar $% \left(1\right) =\left(1\right) \left(1\right$ relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in 4.00 Column 1: Α 4.00 column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5 00 N those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper 1.00 2 00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N 6.00 the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the 8.00 8.00 cost reporting period? If yes, see instructions. 9 00 Are costs claimed for Interns and Residents in an approved graduate medical education N 9 00 program in the current cost report? If yes, see instructions. 10.00 Was an approved Intern and Resident GME program initiated or renewed in the current Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 11.00 N Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 15.00 Part A Y/N Date Y/N Date 1. 00 2.00 3. 00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? 04/28/2023 04/28/2023 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Ν Ν 17.00 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) If line 16 or 17 is yes, were adjustments made to PS&R Ν 18.00 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. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems ST ELIZABETH AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCI	N: 15-0086	Peri		Worksheet	CMS-2552-1 S-2
	TE AND THE TELETH OWE RETAINED SEATENT QUESTION WITH	11001461 001	. 10 0000		01/01/2022 12/31/2022	Part II	Prepared
		Descri p	ti on		Y/N	Y/N	, c. cc am
		0			1. 00	3. 00	
. 00	If line 16 or 17 is yes, were adjustments made to PS&R				N	1	N :
	Report data for Other? Describe the other adjustments:	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	N N	2.00		N	1. 00	
	records? If yes, see instructions.						
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEDT CHILDDENS	AUSDI TVI SV			1.00	
	Capital Related Cost	DEL L'OHI EDICENS	103FF FALS)				
	Have assets been relifed for Medicare purposes? If yes, so	ee instructions					
00	Have changes occurred in the Medicare depreciation expense	e due to apprai	sals made d	luri ng	the cost		
	reporting period? If yes, see instructions.						
00	Were new leases and/or amendments to existing leases enter	red into during	τhis cost	repor	Ting period	a?	:
00	If yes, see instructions Have there been new capitalized leases entered into during	a the cost repo	rting perio	d? If	ves see		
50	instructions.	g the cost repo	. tring perio	u: II	yes, see] •
00	Were assets subject to Sec. 2314 of DEFRA acquired during	the cost report	ing period?	'lf y	es, see		
	instructions.						
00	Has the provider's capitalization policy changed during the	ne cost reporti	ng period?	If ye	es, submit		:
	copy. Interest Expense						
00	Were new Loans, mortgage agreements or Letters of credit of	entered into du	ring the co	st re	eporting		
	period? If yes, see instructions.		o .				
00	Did the provider have a funded depreciation account and/or		ebt Service	Rese	erve Fund)		
00	treated as a funded depreciation account? If yes, see ins		4-6-40-1-6				
00	Has existing debt been replaced prior to its scheduled mainstructions.	turity with new	aept? If y	es, s	see		;
00	Has debt been recalled before scheduled maturity without i	issuance of new	debt? If v	es, s	see		
	instructions.		,				
	Purchased Services						
00	Have changes or new agreements occurred in patient care so		ed through	contr	actual		;
00	arrangements with suppliers of services? If yes, see instill line 32 is yes, were the requirements of Sec. 2135.2 a		na to compe	ti ti v	e hiddina?	l f	
00	no, see instructions.	ppired pertain	ing to compe		c brading.		'
	Provi der-Based Physi ci ans						
1	Were services furnished at the provider facility under an						
		arrangement wi	th provider	-base	ed physicia	ns?	
00	If yes, see instructions.	· ·	·		. 3		
00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	xisting agreeme	·		. 3		
00	If yes, see instructions.	xisting agreeme	·		. 3		
00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in	xisting agreeme	·		ovi der-based	d	
00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the second	xisting agreeme	·		y/N 1.00	d Date	
00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the second of the cost were home office costs. Were home office costs claimed on the cost report?	xisting agreeme instructions.	nts with th	e pro	y/N 1.00	d Date	
00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the second of the costs Were home office costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been period.	xisting agreeme instructions.	nts with th	e pro	y/N 1.00	d Date	
00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the second of the cost were home office costs. Were home office costs claimed on the cost report?	xisting agreeme instructions.	home offic	e pro	y/N 1.00	d Date	
00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the second of the cost see in the second of the cost see in the second of the cost second of the	xisting agreeme instructions. prepared by the ffice different	home offic	e pro	Y/N 1.00 Y	d Date	
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00 00 00 00 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the second of the home of the cost statement been yet yes, see instructions. If line 36 is yes, was a home office cost statement been yet, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to oth see instructions.	xisting agreeme instructions. prepared by the ffice different and of the home her chain compo	home office from that office.	ee?	y/N 1.00 Y Y Y N	d Date	
00 00 00 00 00 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the second of the cost see in the second of the second of the second of the home of the provider? If yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end in the provider? If yes, did the provider render services to other in the provider of the see instructions. If line 36 is yes, did the provider render services to the see instructions.	xisting agreeme instructions. prepared by the ffice different and of the home her chain compo	home office from that office.	ee?	y/N 1.00 Y N	d Date	
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00 00 00 00 00 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the second of the cost see in the second of the second of the second of the home of the provider? If yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end in the provider? If yes, did the provider render services to other in the provider of the see instructions. If line 36 is yes, did the provider render services to the see instructions.	xisting agreeme instructions. prepared by the ffice different and of the home her chain compo	home office from that office. nents? If yes, se	ee?	y/N 1.00 Y Y N N N	d Date	
00 00 00 00 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the line 36 is yes, has a home office cost statement been yet, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end in the provider? If yes, enter in column 2 the fiscal year end in the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	xisting agreeme instructions. prepared by the ffice different nd of the home her chain compo e home office?	home office from that office. nents? If yes, se	e pro	y/N 1.00 Y Y N N N N 2.	Date 2.00	
00 00 00 00 00 00 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the line 36 is yes, has a home office cost statement been yet, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end in the provider? If yes, enter in column 2 the fiscal year end in the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	xisting agreeme instructions. prepared by the ffice different nd of the home her chain compo e home office?	home office from that office. nents? If yes, se	e pro	y/N 1.00 Y Y N N N	Date 2.00	
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00 00 00 00 00 00 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the line of the cost see in the line of the cost see instructions. If line 36 is yes, has a home office cost statement been put yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	prepared by the ffice different her chain compo e home office?	home office from that office. nents? If yes, se	ee? of es,	y/N 1.00 Y Y N N N N 2.	Date 2.00	
00 00 00 00 00 00 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in the line 36 is yes, has a home office cost statement been yet, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	xisting agreeme instructions. prepared by the ffice different nd of the home her chain compo e home office?	home office from that office. nents? If yes, se	ee? of es,	y/N 1.00 Y Y N N N N 2.	Date 2.00	

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0086			
			To 12/31/2022	Date/Time Pre 5/23/2023 8:0	
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	REIMBURSEMENT MANAGER		,	41.
	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.
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.
	report preparer in columns 1 and 2, respectively.				

Health Financial Systems	ST ELIZABETH D	EARBORN	In Lieu	of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE	COMPLEX STATISTICAL DATA	Provi der CCN: 15-0086	Peri od:	Worksheet S-3

Part I
Date/Time Prepared: From 01/01/2022 12/31/2022 5/23/2023 8:05 am I/P Days / 0/P Visits / Tri ps Bed Days Title V Component Worksheet A No. of Beds CAH Hours Avai I abl e Li ne No. 2. 00 1.00 3.00 4.00 5.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 30.00 42 15, 330 0. 00 0 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) 2.00 2.00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF 5.00 5.00 0 6 00 6 00 Total Adults and Peds. (exclude observation 0 7.00 7.00 42 15, 330 0.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 2 920 0.00 O 8 00 31.00 8 CORONARY CARE UNIT 0 9.00 32.00 0 0.00 9.00 BURN INTENSIVE CARE UNIT 10.00 33.00 0 0 0.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0.00 0 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 43.00 0 13.00 14.00 Total (see instructions) 50 18, 250 0.00 0 14.00 15.00 CAH visits 0 15.00 SUBPROVIDER - IPF 16.00 40.00 0 16.00 SUBPROVIDER - IRF 0 17.00 41.00 0 0 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 0 0 19.00 44.00 0 NURSING FACILITY 0 0 20.00 20.00 45.00 0 21.00 OTHER LONG TERM CARE 46.00 0 0 21.00 HOME HEALTH AGENCY 0 22 00 101.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 115.00 23.00 24 00 HOSPI CF 116.00 0 0 24.00 24. 10 HOSPICE (non-distinct part) 30.00 24. 10 CMHC - CMHC CMHC - CORF 25.00 99.00 0 25.00 25. 10 99. 10 0 25.10 26.00 RURAL HEALTH CLINIC 88.00 0 26.00 FEDERALLY QUALIFIED HEALTH CENTER 89.00 26. 25 26. 25 27.00 Total (sum of lines 14-26) 50 27.00 28.00 Observation Bed Days 0 28.00 Ambul ance Trips 29.00 29.00 30 00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 4,015 32.00 11 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 32. 01 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges

30.00

0

0

33.01

0 34.00

33.01

34.00 Temporary Expansion COVID-19 PHE Acute Care

Health Financial Systems ST ELIZ HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA ST ELIZABETH DEARBORN
AL DATA Provider CCN: 15-0086

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 01/01/2022 Part I

						To		12/31/2022	Da	ite/Time Prepa		
		1 /0 0	,	0 (D) (: : 1				- 11 6		<u>/23/2023 8: 05</u>	am	_
		1/P Days	/	0/P Visits	/	Irips	ŀ	Full Time E	-qui	valents		
	Component	Title XVIII	-	Title XIX	1 7	Total All	Tota	al Interns	Fm	ployees On		
	Component	THE AVITE		II LIC XIX		Patients		Resi dents	LIII	Payrol I		
		6. 00		7. 00		8. 00	<u> </u>	9. 00		10. 00		
	PART I - STATISTICAL DATA											
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 33	33	1	70	10, 4	16					1. 00
	8 exclude Swing Bed, Observation Bed and											
	Hospice days) (see instructions for col. 2											
	for the portion of LDP room available beds)				ļ							
2.00	HMO and other (see instructions)	3, 91	- 1	2, 0	- 1							2. 00
3.00	HMO IPF Subprovider		0		0							3. 00
4.00	HMO IRF Subprovider		0		0							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF		0		0		0					5. 00
6. 00	Hospi tal Adul ts & Peds. Swing Bed NF			_	0		0					6. 00
7. 00	Total Adults and Peds. (exclude observation	4, 33	33	1	70	10, 41	16					7. 00
0.00	beds) (see instructions)	-			7.1	1 0	20					0.00
8.00	INTENSIVE CARE UNIT	59	- 1		71	1, 82	- 1					8. 00
9.00	CORONARY CARE UNIT		0		0		0					9. 00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		0		0		0					10.00
12. 00	l e		۷		۷		۷					11. 00 12. 00
13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY		ł		0	E*	23					13. 00
14. 00	Total (see instructions)	4, 93	, 1	2	241	12, 75		0	. 00	418. 6		14. 00
15. 00	CAH visits	4, 73	0	2	0	12, 73	0	0.	. 00	410.0		15. 00
16. 00	SUBPROVI DER - I PF		0		0		0	0	. 00	0. 0		16. 00
17. 00	SUBPROVI DER - I RF		0		0		0		. 00	0. (17. 00
18. 00	SUBPROVI DER		\mathbb{I}		Ĭ		4	0.	. 00	0. (18. 00
19. 00	SKILLED NURSING FACILITY		o		0		o	0	. 00	0.0		19. 00
20. 00	NURSING FACILITY				0		ol		. 00	0. (20. 00
21. 00	OTHER LONG TERM CARE		İ		Ĭ		0		. 00	0. (21. 00
22. 00	HOME HEALTH AGENCY		o		o		o		. 00	0. (22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				1				. 00	0. 0		23. 00
24. 00	HOSPI CE		0		o		o		. 00	0. (00	24. 00
24. 10	HOSPICE (non-distinct part)		İ		Ì		o				Ì	24. 10
25.00	CMHC - CMHC		0		0		o	0.	. 00	0.0	00	25. 00
25. 10	CMHC - CORF		0		0		0	0.	. 00	0.0	00	25. 10
26.00	RURAL HEALTH CLINIC		0		0		0	0.	. 00	0.0	00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER		0		0		0	0.	. 00	0.0	00	26. 25
27.00	Total (sum of lines 14-26)							0.	. 00	418. 6	66	27. 00
28.00	Observation Bed Days			3	318	1, 73	38					28. 00
29. 00	Ambul ance Tri ps		0									29. 00
30.00	Employee discount days (see instruction)						0					30.00
31. 00	Employee discount days - IRF						0					31. 00
32.00	Labor & delivery days (see instructions)		0		42	6	13					32. 00
32. 01	Total ancillary labor & delivery room						0					32. 01
	outpatient days (see instructions)											
33. 00	LTCH non-covered days		0									33. 00
33. 01	LTCH site neutral days and discharges		0								- 1	33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	T	0		0		0		ļ			34. 00

Health Financial Systems ST ELIZ HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA ST ELIZABETH DEARBORN
AL DATA Provider CCN: 15-0086 Period: In Lieu of Form CMS-2552-10
Worksheet S-3

HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	CAL DATA	Provider	CCIN:			a: 01/01/2022 12/31/2022	Part	ksneet 3-3 t I e/Time Pre		ed:
									3/2023 8: 0		
		Full Time			Di sc	:harge:	s				
	Component	Equi val ents Nonpai d	Title V	Ті	tle XVIII	Ti	tle XIX	To	tal All		
	Component	Workers	TI LIC V	''	THE AVIII	"	tic xix		tients		
		11. 00	12. 00		13. 00		14. 00		15. 00		
	PART I - STATISTICAL DATA									Ι,	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	d		0	1,	091		60	3,	809	1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2										
	for the portion of LDP room available beds)										
2. 00	HMO and other (see instructions)					706	į	512			2. 00
3.00	HMO I PF Subprovi der							0			3. 00
4.00	HMO IRF Subprovider							0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF										5. 00
6.00	Hospital Adults & Peds. Swing Bed NF										6. 00
7. 00	Total Adults and Peds. (exclude observation										7. 00
0.00	beds) (see instructions)										0.00
8. 00 9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT										8. 00 9. 00
10. 00	BURN INTENSIVE CARE UNIT										10.00
11. 00	SURGICAL INTENSIVE CARE UNIT										11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)					ı					12. 00
13.00	NURSERY										13.00
14.00	Total (see instructions)	0.0	o	0	1,	091		60	3,	809	14.00
15. 00	CAH visits										15. 00
16. 00	SUBPROVIDER - I PF	0.0		0		0		0		0	16. 00
17. 00	SUBPROVI DER - I RF	0.0	0	0		0		0		0	17. 00
18.00	SUBPROVI DER					ŀ					18. 00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY	0.0				ŀ					19. 00 20. 00
21. 00	OTHER LONG TERM CARE	0.0								0	21. 00
22. 00	HOME HEALTH AGENCY	0.0				1				۷	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.0	-								23. 00
24.00	HOSPI CE	0.0	1			İ					24. 00
24. 10	HOSPICE (non-distinct part)										24. 10
25.00	CMHC - CMHC	0.0	0								25. 00
25. 10	CMHC - CORF	0.0									25. 10
26. 00	RURAL HEALTH CLINIC	0.0									26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.0									26. 25
27. 00 28. 00	Total (sum of lines 14-26) Observation Bed Days	0.0	٩								27. 00 28. 00
29. 00	Ambul ance Tri ps										29. 00
30.00	Employee discount days (see instruction)										30.00
	Employee discount days - IRF										31. 00
32.00	Labor & delivery days (see instructions)										32. 00
32. 01	Total ancillary labor & delivery room										32. 01
	outpatient days (see instructions)										
	LTCH non-covered days					0					33. 00
	LTCH site neutral days and discharges					0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	1	1			I		1		ı	34. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 Provider CCN: 15-0086 Period: From 01/01/2022 To 12/31/2022 Worksheet S-3 Part II Date/Time Prepared: 5/23/2023 8:05 am

Wkst. A Line Amount Reclassificat Adjusted Paid Hours Average Penarted ion of Salaries Pelated to Hourly Warge

		Wkst. A Line Number	Reported		Sal ari es col . 2 ± col . S	Salaries in	Average ourly Wage (col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col . 5)	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
1. 00	SALARIES Total salaries (see	200.0	0 31, 435, 75	1	31, 435, 75	1 870, 812. 00	36. 1	0 1.00
2. 00	instructions) Non-physician anesthetist Part		0 31, 435, 75			0.00		
3. 00	Non-physician anesthetist Part					0.00	0.0	3.00
4. 00	B Physician-Part A - Administrative)		0.00	0.0	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B	3)	-	0.00	1	
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services)		0.00	0.0	6. 00
7. 00	Interns & residents (in an	21.0	0			0.00	0.0	7. 00
7. 01	approved program) Contracted interns and residents (in an approved programs))		0.00	0.0	7. 01
8.00	Home office and/or related organization personnel					0.00	0.0	8.00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44.0	70, 947	0 7 4, 720	75, 667	0. 00 7 3, 053. 00	1	
11. 00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		829, 450		829, 450	7, 839. 00	105.8	1 11. 00
12. 00	Care Contract labor: Top level		027, 430			0.00		12.00
12.00	management and other management and administrative services			,		0.00	0.0	0 12.00
13. 00	Contract Labor: Physician-Part A - Administrative		119, 635	5	119, 635	689. 00	173. 6	13.00
14. 00	Home office and/or related organization salaries and wage-related costs					0.00	0.0	14. 00
14. 01 14. 02	Home office salaries Related organization salaries		(0.00	1	14. 01 10 14. 02
15. 00	Home office: Physician Part A - Administrative					0.00	0.0	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching					0.00		16. 00
16. 01	Home office Physicians Part A - Teaching					0.00	0.0	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS					0.00	0.0	16. 02
17. 00	Wage-related costs (core) (see instructions)		8, 041, 959	9	8, 041, 959	9		17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		25, 118	3	25, 118	3		19. 00 20. 00
21. 00	A Non-physician anesthetist Part							21. 00
22. 00	B Physician Part A - Administrative		(22. 00
22. 01	Physician Part A - Teaching				- I			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)))		23. 00 24. 00
25. 00	Interns & residents (in an approved program)							25. 00
25. 50	Home office wage-related (core)							25. 50
25. 51	Related organization							25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -)				25. 52
25. 53	wage-related (core) Home office: Physicians Part A - Teaching - wage-related (core)))		25. 53
	OVERHEAD COSTS - DIRECT SALARI		1					1
	Employee Benefits Department Administrative & General	4.0	l e		0 3 1, 341, 217			26. 00 1 27. 00

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

						10	12/31/2022				
						<u> </u>		5/23/2023 8	: 05 a	am	_
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	F	Paid Hours	Average			
		Number	Reported	ion of	Sal ari es	F	Related to	Hourly Wage			
				Sal ari es	(col.2 ± co	1. S	Salaries in	(col. 4 ÷			
				(from Wkst.	3)		col. 4	col. 5)			
				A-6)							
		1.00	2. 00	3. 00	4. 00		5. 00	6. 00			
28.00	Administrative & General under	r		0	0	0) 0	. 00	0.00	28	3. 00
	contract (see inst.)										
29. 00	Maintenance & Repairs	6. 0	0 918, 39	99 8, 8	342 92°	7, 241	29, 716	. 00	31. 20) 29). 00
30.00	Operation of Plant	7. 0	0 512, 89	5, 8	353 51	8, 747	18, 311	. 00	28. 33	3 30). 00
31.00	Laundry & Linen Service	8.0	0 102, 58	33 2, 2	272 10⋅	4, 855	6, 273	. 00	16. 72	2 31	. 00
32.00	Housekeepi ng	9. 0	0 1, 096, 46	19, 1	i79 1, 11!	5, 642	55, 491	. 00	20. 10	32	2. 00
33.00	Housekeeping under contract			0	0	0	0	. 00	0.00	33	3. 00
	(see instructions)										
34.00	Di etary	10. 0	0 867, 72	-507, 6	360	0, 095	17, 011	. 00	21. 17	7 34	. 00
35.00	Di etary under contract (see			0	0	0	0	. 00	0.00	35	. 00
	instructions)										
36.00	Cafeteri a	11. 0	0	0 520, 0)41 520	0, 041	25, 443	. 00	20. 44	4 36	o. 00
37.00	Maintenance of Personnel	12. 0	o	0	0	O	0	. 00	0.00	37	. 00
38.00	Nursing Administration	13. 0	0 864, 46	9, 6	647 87	4, 107	17, 222	. 00	50. 76	5 38	3. 00
39.00	Central Services and Supply	14. 0	o	o	o	C	o	. 00	0.00	39). 00
40.00	Pharmacy	15. 0	o	o	o	C	o	. 00	0.00	3 40). 00
41.00	Medical Records & Medical	16. 0	0 162, 95	50 1, 5	515 16	4, 465	8, 664	. 00	18. 98	3 41	. 00
	Records Library										
42.00	Social Service	17. 0	0 407, 57	75 2, 3	392 40'	9, 967	8, 231	. 00	49. 81	1 42	2. 00
43.00	Other General Service	18. 0	o	o	0	O) o	. 00	0.00	3 43	3. 00

Health Financial Systems	ST ELIZABETH DEARBORN				In Lieu	ı of Form CMS-2	552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der C		Peri od: From 01/01/2022	Worksheet S-3	
						Date/Time Pre 5/23/2023 8:0	
	Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
	Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			Salarios	(col 2 col	Salarios in	(col 4 ·	

							07 E07 E0E0 01 0	<u> </u>	_
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average		
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage		
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷		
				(from	3)	col. 4	col. 5)		
				Worksheet					
				A-6)					
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		31, 435, 75	51	0 31, 435,	751 870, 812	. 00 36	. 10	1.00
	instructions)								
2.00	Excluded area salaries (see		70, 94	47 4, 7	720 75, 6	3, 053	. 00 24	. 78	2.00
	instructions)								
3.00	Subtotal salaries (line 1		31, 364, 80	04 -4,7	720 31, 360, (867, 759	. 00 36	. 14	3.00
	minus line 2)								
4.00	Subtotal other wages & related	l	949, 08	35	0 949, (8, 528	. 00 111	. 29	4.00
	costs (see inst.)								
5.00	Subtotal wage-related costs		8, 041, 95	59	0 8, 041, 9	959 0	. 00 25	. 64	5.00
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		40, 355, 84	48 -4, 7	720 40, 351, ¹	28 876, 287	. 00 46	. 05	6.00
7.00	Total overhead cost (see		6, 544, 12	20 -207, 7	743 6, 336, 3	229, 062	. 00 27	. 66	7.00
	instructions)								

Heal th	Financial Systems ST ELIZABETH D)EARBORN	In Lieu	of Form CMS-2	2552-	10
HOSPI T	TAL WAGE RELATED COSTS	Provi der CCN: 15-0086	Peri od: From 01/01/2022	Worksheet S-3 Part IV		
				Date/Time Pre 5/23/2023 8:0		
				Amount	<u> </u>	
				Reported		_
				1. 00		
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETI REMENT COST					
1.00	401K Employer Contributions			440,	394	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution				0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				اءا	
5.00	401K/TSA Plan Administration fees				0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan				0	6. 00
7. 00	Employee Managed Care Program Administration Fees				0	7. 00
	HEALTH AND INSURANCE COST					
8.00	Health Insurance (Purchased or Self Funded)				0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administ				0	8. 0
8. 02	Health Insurance (Self Funded with a Third Party Administrat	tor)		5, 136,	572	8. 0
8. 03	Health Insurance (Purchased)				0	8. 0

4.00	dualitied betitied beliefft frail cost (see firstidetrons)	L	Οl	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7. 00
	HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)		0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	5, 136, 5	572	8. 02
8. 03	Health Insurance (Purchased)		0	8. 03
9.00	Prescription Drug Plan		0	9. 00
10.00	Dental, Hearing and Vision Plan	49, 5	527	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	12, 7	771	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	128, 9	63	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15. 00	'Workers' Compensation Insurance	17, 1	64	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.		0	16.00
	Noncumul ative portion)			
	TAXES			
17. 00	FICA-Employers Portion Only	2, 273, 2	216	17.00
18. 00	Medicare Taxes - Employers Portion Only		0	18.00
19. 00	Unemployment Insurance	8, 4	170	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
	OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see		0	21.00
	instructions))			
22. 00	Day Care Cost and Allowances		0	22. 00
	Tuition Reimbursement		0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	8, 067, 0)77	24.00
	Part B - Other than Core Related Cost			
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

Health Financial Systems
HOSPITAL CONTRACT LABOR AND BENEFIT COST ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 Provi der CCN: 15-0086

Peri od: | Worksheet S-3 | From 01/01/2022 | Part V | To | 12/31/2022 | Date/Time Prepared: | 5/23/2023 8:05 am | Labor | Labor | Labor | Labor | Date | Total | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Da Cost Center Description Labor 1. 00 2. 00

	PART V - Contract Labor and Benefit Cost							
	Hospital and Hospital-Based Component Identification:		١.					
1.00	Total facility's contract labor and benefit cost	0	0	1.00				
2.00	Hospi tal	0	0	2.00				
3.00	SUBPROVI DER - I PF	0	0	3.00				
4.00	SUBPROVI DER - I RF	0	0	4.00				
5.00	Subprovi der - (0ther)	o	0	5.00				
6.00	Swing Beds - SNF	o	0	6.00				
7.00	Swing Beds - NF	o	0	7.00				
8.00	SKILLED NURSING FACILITY	o	0	8. 00				
9.00	NURSING FACILITY	o	0	9. 00				
10.00	OTHER LONG TERM CARE I			10.00				
11.00	Hospi tal -Based HHA	o	0	11.00				
12.00	AMBULATORY SURGICAL CENTER (D. P.) I	o	0	12.00				
13.00	Hospi tal -Based Hospi ce	o	0	13.00				
14.00	Hospital-Based Health Clinic RHC	o	0	14.00				
15.00	Hospital-Based Health Clinic FOHC	o	0	15.00				
16.00	Hospi tal -Based-CMHC	ol	0	16.00				
16. 10	Hospi tal -Based-CMHC 10	ol	0	16. 10				
17.00	RENAL DIALYSIS I	ol	0	17.00				
18.00	Other	o	0	18.00				
	•	'						

	Financial Systems ST ELIZABETH DEAF TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCN	: 15-0086	Peri	od:	Wo	<u>f Form CMS-</u> orksheet S-		
				From To	01/01/202 12/31/202		ate/Time Pr	enar	ad∙
				10	12/ 31/ 202		/23/2023 8:		
						-	1. 00		
	Uncompensated and indigent care cost computation								
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 col	umn 8)		0. 36	832	1
00	Medicaid (see instructions for each line)						10.000	047	_
00 00	Net revenue from Medicaid						13, 822 N	267	2
00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemen	ntal navment	s from Med	li cai d	2		N N		4
00	If line 4 is no, then enter DSH and/or supplemental payments f			ii cai c				0	5
00	Medi cai d charges		<u> </u>				46, 493	-	6
00	Medicaid cost (line 1 times line 6)						17, 148		7
00	Difference between net revenue and costs for Medicaid program	(line 7 mir	nus sum of	lines	2 and 5;	if	3, 326	111	8
	< zero then enter zero)							_	
20	Children's Health Insurance Program (CHIP) (see instructions for	or each lin	e)						_
00	Net revenue from stand-alone CHIP Stand-alone CHIP charges							0	9 10
00	Stand-alone CHIP cost (line 1 times line 10)							0	11
00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9	e if	< zero the	en		0	12
	enter zero)	(,	,	20.0			Ŭ	
	Other state or local government indigent care program (see ins								
00	Net revenue from state or local indigent care program (Not inc							0	13
00	Charges for patients covered under state or local indigent car	re program (Not includ	led in	lines 6 d	or		0	14
00	[10]	1.43						0	10
00	State or local indigent care program cost (line 1 times line 1	14)						U	15
$\cap \cap$	Difference between net revenue and costs for state or local in		nrogram (line	15 minus I	i no		Λ	16
. 00	Difference between net revenue and costs for state or local in 13: if < zero then enter zero)		e program (line	15 minus I	i ne		0	16
. 00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	ndigent care						0	16
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	IP and stat	e/local in						
00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f	IP and stat	e/local in					0	17
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of	IP and statured in the stature of th	e/local in ity care perations	di gen	t care pro	gran	ms (see	0 0	17 18
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca	IP and statured in the stature of th	e/local in ity care perations	di gen	t care pro	gran		0 0	17 18
00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of	IP and statured in the stature of th	e/local in ity care perations	digen	t care pro	nes	ms (see	0 0 111	17 18
00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca	IP and statured in the stature of th	e/local in ity care perations care progr Uninsured patients	digen	t care pro sum of lin Insured patients	nes	3,326 tal (col. 1	0 0 111	17 18
00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16)	IP and statured in the stature of th	e/local in rity care perations care progr	digen	t care pro sum of lin	nes	3, 326 tal (col. 1	0 0 111	17 18
00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line)	IP and stat Funding char hospital op indigent	e/local in rity care perations care progr Uninsured patients 1.00	digen	sum of lin	nes	3,326 tal (col. 1 + col. 2) 3.00	0 0 1111	17 18 19
00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	IP and stat Funding char hospital op indigent	e/local in rity care perations care progr Uninsured patients 1.00	digen	sum of lin	nes	3,326 tal (col. 1 + col. 2) 3.00	0 0 1111	17 18 19
00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line)	IP and stat	e/local in rity care perations care progr Uninsured patients 1.00	digen	sum of lin	nes	3, 326 tal (col. 1 + col. 2) 3.00	0 0 1111	177 18 19 20
00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured disco	IP and stat Funding char hospital op al indigent acility punts (see	e/local in rity care perations care progr Uninsured patients 1.00	di gen	sum of lin	nes To , 942	3,326 tal (col. 1 + col. 2) 3.00 2,187 1,105	0 0 1111 606 996	177 188 199 200 211
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000000000000000000000000000000000000000	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured discoinstructions) Payments received from patients for amounts previously written charity care	IP and stat Funding char hospital op al indigent acility punts (see	e/local in ity care perations care progr Uninsured patients 1.00 1,713 632	di gen rams (3,664 2,054	sum of lin Insured patients 2.00 473 473	ogram To , 942 0	3,326 tal (col. 1 + col. 2) 3.00 2,187 1,105	0 0 1111 606 996	17 18 19 20 21 22
000000000000000000000000000000000000000	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured discounts received from patients for amounts previously written	IP and stat Funding char hospital op al indigent acility punts (see	e/local in ity care perations care progr Uninsured patients 1.00 1,713 632	di gen	sum of lin Insured patients 2.00 473 473	nes To , 942	3,326 tal (col. 1 + col. 2) 3.00 2,187 1,105	0 0 1111 606 996	17 18 19 20 21 22
00 00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured discoinstructions) Payments received from patients for amounts previously written charity care	IP and stat Funding char hospital op al indigent acility punts (see	e/local in ity care perations care progr Uninsured patients 1.00 1,713 632	di gen rams (3,664 2,054	sum of lin Insured patients 2.00 473 473	7 y 42 y 942	3,326 tal (col. 1 + col. 2) 3.00 2,187 1,105	0 0 1111 606 996	177 188 199 200 211
00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured discoinstructions) Payments received from patients for amounts previously written charity care	IP and state funding char hospital opal indigent acility punts (see a off as	e/local in hity care perations care progr Uninsured patients 1.00 1,713 632	di gen rams (3,664 0 2,054	sum of lin Insured patients 2.00 473 473	ogran nes To , 942 0 , 942	3,326 tal (col. 1 + col. 2) 3.00 2,187 1,105	0 0 1111 606 996	177 188 199 200 211 222 23
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00 00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured discoinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t	IP and stat Funding char hospital op al indigent acility bunts (see a off as	e/local in Tity care perations care progr Uninsured patients 1.00 1,713 632 rond a leng	di gen rams (3, 664 0 2, 054 gth of	sum of lin Insured patients 2.00 473 473 473	ogran To , 942 0 , 942 t	3, 326 tal (col. 1 + col. 2) 3.00 2, 187 1, 105	0 0 1111 606 996 0	177 188 199 200 211 222 233
00 00 00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured discoinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit	IP and state funding char hospital opal indigent acility bunts (see a off as ent days bey program? the indigent	e/local in rity care perations care progr Uninsured patients 1.00 1,713 632 cond a leng	di gen rams (3, 664 0 2, 054 gth of	sum of lin Insured patients 2.00 473 473 473	ogran To , 942 0 , 942 t	3,326 tal (col. 1 + col. 2) 3.00 2,187 1,105 1.00 N	0 0 1111 606 606 996 0	177 188 19 20 21 22 23 24 25
00 00 00 00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured discoinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in	IP and state funding char hospital op al indigent acility ounts (see a off as ent days beyen program? the indigent estructions)	e/local in rity care perations care progr Uninsured patients 1.00 1,713 632 cond a lenger care progr	di gen rams (3, 664 0 2, 054 gth of	sum of lin Insured patients 2.00 473 473 473	ogran To , 942 0 , 942 t	3, 326 tal (col. 1 + col. 2) 3.00 2, 187 1, 105 1, 105 1, 00 N	0 0 1111 606 996 0 996	177 188 19 20 21 22 23 24 25 26
000000000000000000000000000000000000000	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured discoinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complex	TP and state and igent care and igent care and igent care and indigent are indigent as a cility ounts (see an off as a cent days beyone program? The indigent astructions) ex (see inst	e/local in rity care perations care progr Uninsured patients 1.00 1,713 632 cond a leng care progr	di gen rams (3, 664 0 2, 054 gth of	sum of lin Insured patients 2.00 473 473 473	ogran To , 942 0 , 942 t	3, 326 tal (col. 1 + col. 2) 3.00 2, 187 1, 105 1.00 N 4, 201 77	0 0 0 1111 6066 996 0 996 0 500 273	177 188 199 200 211 222 233 244 255 266 277
00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured disco instructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complex (TP and state and igent care and igent care and igent care and indigent are indigent as a cility ounts (see an off as a cent days beyone program? The indigent astructions) ex (see inst	e/local in rity care perations care progr Uninsured patients 1.00 1,713 632 cond a leng care progr	di gen rams (3, 664 0 2, 054 gth of	sum of lin Insured patients 2.00 473 473 473	ogran To , 942 0 , 942 t	3, 326 tal (col. 1 + col. 2) 3. 00 2, 187 1, 105 1. 00 N 4, 201 77 118	0 0 0 1111 606 996 0 996 0 500 273 882	177 188 199 200 211 222 23 24 25 26 27 27
. 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured discoinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complex	IP and state funding char hospital op al indigent acility bunts (see a off as ent days beye program? The indigent enstructions) ex (see instructions) ex (see instructions)	e/local in ity care perations care progr Uninsured patients 1.00 1,713 632 /ond a leng care progr ructions)	digen rams (3,664 0 2,054 gth of	sum of lin Insured patients 2.00 473 473 473	ogran To , 942 0 , 942 t	3, 326 tal (col. 1 + col. 2) 3.00 2, 187 1, 105 1.00 N 4, 201 77 118 4, 082	0 0 0 1111	17 18 19 20 21 22
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line) Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa (see instructions) Cost of patients approved for charity care and uninsured disco instructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complex (Non-Medicare bad debt expense (see instructions)	IP and state funding char hospital op all indigent acility bunts (see a off as ent days beyen program? The indigent enstructions) ex (see instructions) ex (see instructions)	e/local in ity care perations care progr Uninsured patients 1.00 1,713 632 /ond a leng care progr ructions)	digen rams (3,664 0 2,054 gth of	sum of lin Insured patients 2.00 473 473 473	ogran To , 942 0 , 942 t	3, 326 tal (col. 1 + col. 2) 3. 00 2, 187 1, 105 1. 00 N 4, 201 77 118	0 0 0 1111 606 606 0 996 0 500 273 882 618 409	177 188 19 20 21 22 23 24 25 26 27 27 28

ılth Financial Systems CLASSIFICATION AND ADJUSTMENTS OF TRIAL BALAN	ST ELIZABETH D	Provider CC	N: 15-0096	<u> </u>	u of Form CMS-: Worksheet A	2552-1
LLASSIFICATION AND ADJUSTMENTS OF TRIAL BALAN	ICE OF EXPENSES	Provider CC	I	From 01/01/2022	Date/Time Pre	
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +-	
	1.00	2. 00	3. 00	4. 00	col . 4) 5. 00	
GENERAL SERVICE COST CENTERS		495, 53	33 495,	Eaal	0 495,	Easl
00 00100 CAP REL COSTS-BLDG & FLXT 00 00200 CAP REL COSTS-MVBLE EQUIP		495, 53 1, 307, 75			0 495,	
00 00300 OTHER CAP REL COSTS		., 00,, 70	0	0	0	0
00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 263, 63			0 1, 263,	
00 00500 ADMINISTRATIVE & GENERAL	1, 611, 070	5, 583, 02				
00 00600 MAI NTENANCE & REPAI RS 00 00700 OPERATION OF PLANT	918, 399 512, 894	4, 268, 95 119, 69			847 5, 196, 253 638,	
00 00800 LAUNDRY & LINEN SERVICE	102, 583	260, 12			272 364,	
00 00900 HOUSEKEEPI NG	1, 096, 463	737, 89			706 1, 854,	
00 01000 DI ETARY	867, 726	759, 33	35 1, 627,			
00 01100 CAFETERIA 00 01200 MAINTENANCE OF PERSONNEL	0		0	0 975,	121 975, 0	
00 01200 MAI NTENANCE OF PERSONNEL 00 01300 NURSI NG ADMI NI STRATI ON	864, 460	318, 38	0 31 1, 182,	841 11	389 1, 194,	0 1 230 1
00 01400 CENTRAL SERVICES & SUPPLY	0	310, 30	0	0	0	0 1
00 01500 PHARMACY	0		0	0	0	0 1
00 01600 MEDICAL RECORDS & LIBRARY	162, 950	63, 80			515 228,	
00 01700 SOCIAL SERVICE 00 01850 OTHER GENERAL SERVICE (SPECIFY)	407, 575	330, 82	738,	395 2,	392 740,	787 1 0 1
00 01900 NONPHYSICIAN ANESTHETISTS			0		0	0 1
00 02000 NURSI NG PROGRAM			o	Ö	Ö	0 2
00 02100 I &R SERVICES-SALARY & FRINGES APPRV			0	0	0	0 2
00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV			0	0	0	0 2
00 02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	50, 602	8, 08	30 58,	682 4,	901 63,	583 2 1
00 03000 ADULTS & PEDIATRICS	3, 672, 257	1, 449, 76	5, 122,	020 479,	129 5, 601,	」 149 3
00 03100 I NTENSI VE CARE UNI T	1, 982, 438	988, 88			590 3, 008,	
00 03200 CORONARY CARE UNIT	0		0	0	0	0 3
00 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	0 3
00 03400 SURGI CAL INTENSI VE CARE UNIT 00 04000 SUBPROVI DER - I PF	0		0		0	0 3
00 04100 SUBPROVI DER - I RF	Ö		o	o	o	0 4
00 04300 NURSERY	0		0	0 462,	998 462,	
00 04400 SKILLED NURSING FACILITY	0		0	0	0	0 4
00 04500 NURSI NG FACILITY 00 04600 OTHER LONG TERM CARE	0		0	0	0	0 4
ANCI LLARY SERVI CE COST CENTERS	<u> </u>		<u> </u>	- Ο _Ι	<u> </u>] 0 4
00 05000 OPERATING ROOM	5, 063, 704	9, 139, 99	93 14, 203,	697 -4, 901,	025 9, 302,	672 5
00 05100 RECOVERY ROOM	0		0	0	0	0 5
00 05200 DELIVERY ROOM & LABOR ROOM 00 05300 ANESTHESIOLOGY	1, 643, 708 2, 056	904, 40 1, 941, 32				
00 05400 RADI OLOGY-DI AGNOSTI C	1, 969, 844	1, 941, 32				
00 05500 RADI OLOGY-THERAPEUTI C	0	., .55, 76	0	0	0	0 5
00 05600 RADI OI SOTOPE	0		0	0	0	0 5
00 05700 CT SCAN	550, 639	272, 51				
00 05800 MAGNETI C RESONANCE I MAGING (MRI) 00 05900 CARDIAC CATHETERIZATION	216, 649 343, 497	92, 8 <i>6</i> 406, 12			236 348, 825 768,	
00 06000 LABORATORY	1, 526, 668	1, 995, 59			833 3, 545,	
01 06001 BLOOD LABORATORY	0		0	0	0	0 6
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0	0	0	0 6
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	-S 0		0	0	0	0 6
00 06300 BLOOD STORING, PROCESSING & TRANS. 00 06400 INTRAVENOUS THERAPY					0	0 6
00 06500 RESPIRATORY THERAPY	1, 065, 728	585, 74	1, 651,	473 17.	051 1, 668,	
00 06600 PHYSI CAL THERAPY	1, 638, 828	526, 19	98 2, 165,	026 16,	036 2, 181,	062 6
00 06700 OCCUPATI ONAL THERAPY	260, 174	69, 88			370 331,	
00 06800 SPEECH PATHOLOGY	159, 452	36, 63		•	984 197,	
00 06900 ELECTROCARDI OLOGY 00 07000 ELECTROENCEPHALOGRAPHY	344, 929 7, 043	126, 41 1, 32		346 5, 364	149 476, 55 8,	495 6 419 7
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		104, 69	ľ			0 7
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0 5, 175,		- 1
00 07300 DRUGS CHARGED TO PATIENTS	1, 116, 848	3, 403, 20	06 4, 520,	054 319,		
00 07400 RENAL DIALYSIS	0		0	0	0	0 7
00 07500 ASC (NON-DISTINCT PART)	l O		니	Ψ	υ	0 7
97 07697 CARDIAC REHABILITATION	139, 252	70, 68	35 209,	937	87 210,	024 7

88. 00

Health Financial Systems	ST ELIZABETH	DEARBORN		In Lieu	ı of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der (CCN: 15-0086	Peri od:	Worksheet A	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/23/2023 8:0	
Cost Center Description	Sal ari es	Other	Total (col	1 Reclassi fi cat	Reclassi fi ed	3 alli
oost denter bescription	our ur res	Other	+ col . 2)		Tri al Balance	
			' 5511 2)	A-6)	(col. 3 +-	
				,	col . 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS)	0	0	0	0 98.00
99. 00 09900 CMHC			0	0	0	0 99.00
99. 10 09910 CORF	(0	0	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM			0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	(0	0	0	0 101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	()	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 ACQUISITION)	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 ISLET ACQUISITION			0	0	0	0 111. 00
113. 00 11300 I NTEREST EXPENSE			0	0	0	0 113. 00
114.00 11400 UTILIZATION REVIEW-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)	31, 415, 406	40, 266,	207 71, 68°	1, 613	0 71, 681,	613 118. 00
NONREI MBURSABLE COST CENTERS	T		1		_1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	20, 345	47,	655 68	3, 000	0 68,	000 190. 00
191. 00 19100 RESEARCH			0	0	0	0 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		9,	275	9, 275	0 9,	275 192. 00
193. 00 19300 NONPALD WORKERS		2	O	O	U	0 193. 00
194. 00 07950 CMH	04 405 75	40.000	0 74 75	0	0	0 194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	31, 435, 751	40, 323,	137 71, 758	3, 888	0 71, 758,	888 200. 00

Health FinancialSystemsST ELIZABETHDEARBORNRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSESProvide

Provi der CCN: 15-0086

In Lieu of Form CMS-2552-10

Period: Worksheet A
From 01/01/2022
To 12/31/2022 Date/Time Prepared:
5/3/2023 8:05 am

				10 12/31/2022 Date/Time Pr 5/23/2023 8:	
	Cost Center Description		let Expenses	, , , , , , , , , , , , , , , , , , , ,	
		(See A-8)	For Allocation		
		6. 00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	770, 271	1, 265, 804		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	733, 553	1		2. 00
3.00	00300 OTHER CAP REL COSTS	0	1		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	12 550 5(2	1, 263, 630		4.00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	13, 550, 562 -85, 857			5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	03,037	638, 846		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	-16, 556			8. 00
9.00	00900 HOUSEKEEPI NG	0	1, 854, 064		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	-342, 989	321, 366 975, 121		10.00
12. 00	01200 MAINTENANCE OF PERSONNEL	Ö	773, 121		12. 00
13. 00	01300 NURSING ADMINISTRATION	0	1, 194, 230		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDI CAL RECORDS & LI BRARY	-161	228, 108		15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	-11, 376			17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		19. 00
20. 00 21. 00	02000 NURSI NG PROGRAM 02100 L&R SERVI CES-SALARY & FRI NGES APPRVD	0			20. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	Ö	Ö		22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	63, 583		_ 23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T 0	F (01 140		1 20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 NTENSIVE CARE UNIT		5, 601, 149 3, 008, 913		30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	Ö	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		34.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF		0		40. 00 41. 00
43. 00	04300 NURSERY	Ö	462, 998		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44. 00
45. 00	04500 NURSI NG FACI LI TY	0 0	0		45. 00
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS] 0	0		46. 00
50.00	05000 OPERATING ROOM	0	9, 302, 672		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	-100, 845	1, 506, 180 1, 927, 731		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	Ö	2, 804, 710		54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56. 00	05600 RADI OI SOTOPE	0	0 052 074		56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)		952, 876 348, 745		57. 00 58. 00
59. 00		Ö	768, 443		59. 00
60. 00	06000 LABORATORY	0			60. 00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	1, 668, 524		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		2, 181, 062 331, 430		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	197, 066		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	476, 495		69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 419		70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5, 175, 744		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-530, 824	1		73. 00
74. 00	07400 RENAL DIALYSIS	0	0		74. 00
75. 00 76. 97	O7500 ASC (NON-DISTINCT PART) O7697 CARDI AC REHABI LI TATI ON	0	210, 024		75. 00 76. 97
77. 00	· •		210,024		77. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0		89. 00 90. 00
91.00	09100 EMERGENCY	-400, 693	3, 950, 099		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,010	3, 122, 211		92. 00
0	OTHER REIMBURSABLE COST CENTERS				
94. 00 95. 00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0	0		94. 00 95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0			96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	o o		97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	o		98. 00

 Heal th Financial
 Systems
 ST ELIZABETH DEARBORN

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-0086

In Lieu of Form CMS-2552-10
Period:
From 01/01/2022
To 12/31/2022 Date/Time Prepared:

					То	12/31/2022	Date/Time Pr 5/23/2023 8:	
Cost Center Description	Adjustments	Net	t Expenses				3/23/2023 0.	
'	(See A-8)		For					
		AI	llocation					
	6. 00		7. 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 OPIOID TREATMENT PROGRAM		0		0				102. 00
SPECIAL PURPOSE COST CENTERS								4 , 1
105.00 10500 KIDNEY ACQUISITION		0		0				105. 00
106.00 10600 HEART ACQUISITION		0		0				106. 00
107.00 10700 LIVER ACQUISITION		0		0				107. 00
108. 00 10800 LUNG ACQUI SI TI ON		0		0				108. 00
109. 00 10900 PANCREAS ACQUI SI TI ON		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		0		0				113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF		0		0				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0		0				115. 00
116. 00 11600 HOSPI CE		0		0				116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 565, 08	85	85, 246, 6	98				_ 118. 00
NONREI MBURSABLE COST CENTERS								4 , 1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	68, 0	00				190. 00
191. 00 19100 RESEARCH		0		0				191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES		0	9, 2	75				192. 00
193.00 19300 NONPALD WORKERS		0		0				193. 00
194. 00 07950 CMH		0		0				194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	13, 565, 08	85	85, 323, 9	73				200. 00

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

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/23/2023 8: 05 am Provi der CCN: 15-0086 RECLASSI FI CATI ONS

					5/23/2023 8:	05 am
	Cost Center	Increases Line #	Salary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - DRUGS TO PHARMACY	0.00	1. 00	0.00		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	306, 417		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		0.00	0	0		5. 00
6. 00 7. 00		0.00	0	0		6. 00 7. 00
7. 00 8. 00		0.00	0	0		8.00
9.00		0.00	0	0		9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	Ö	o		11.00
12. 00		0.00	o	ō		12. 00
13.00		0.00	О	o		13.00
14.00		0. 00	0	0		14. 00
	0		0	306, 417		,
	B - CAFETERIA	T]
1. 00	CAFETERI A	11.00	520, 041	<u>455, 0</u> 80		1.00
	O LMDLANTC		520, 041	455, 080		, I
1. 00	C - IMPLANTS IMPL. DEV. CHARGED TO	72.00	ol	E 17E 744] 1 00
1.00	PATIENTS	72.00	U	5, 175, 744		1. 00
2. 00	TATIENTS	0.00	o	o		2. 00
3. 00		0.00	Ö	o		3.00
4. 00		0.00	ol	ol		4. 00
5. 00		0.00	o	ol		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00		0.00	•	0		10. 00
	D LABOR & DELLVERY BOOM		0	5, 175, 744		, I
1. 00	D - LABOR & DELIVERY ROOM ADULTS & PEDIATRICS	30.00	320, 194	175, 094		1.00
2.00	NURSERY	43. 00	299, 319	163, 679		2.00
2.00	0	 	619, 513	338, 773		2.00
	E - RADIOLOGY ADMIN		0177010	000/ / / 0		1 '
1.00	CT SCAN	57. 00	75, 321	37, 267		1.00
2.00	MAGNETIC RESONANCE IMAGING	58. 00	23, 200	11, 479		2. 00
	(MRI)					
	0		98, 521	48, 746		,
1 00	F - PHARMACY RESIDENCY PROGRA		4 720	101] 1 00
1. 00	PARAMED ED PRGM-(SPECIFY) 0	23. 00	$\frac{4,720}{4,720}$	<u>181</u> 181		1. 00
	G - GAI NSHARI NG		4, 720	101		ן '
1.00	ADMI NI STRATI VE & GENERAL	5.00	12, 773	0		1.00
2.00	MAINTENANCE & REPAIRS	6. 00	8, 829	ō		2. 00
3.00	OPERATION OF PLANT	7. 00	4, 776	o		3. 00
4.00	LAUNDRY & LINEN SERVICE	8. 00	2, 272	o		4. 00
5.00	HOUSEKEEPI NG	9. 00	17, 760	0		5. 00
6.00	DI ETARY	10. 00	12, 385	0		6. 00
7.00	NURSING ADMINISTRATION	13. 00	4, 925	0		7. 00
8. 00	SOCI AL SERVI CE	17. 00	2, 392	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	30,000	0		9.00
10.00	INTENSIVE CARE UNIT OPERATING ROOM	31.00	15, 600	0		10.00
11. 00 12. 00	DELIVERY ROOM & LABOR ROOM	50. 00 52. 00	46, 892 13, 041	0 0		11. 00 12. 00
12.00	ANESTHESI OLOGY	53.00	456	0		13.00
14. 00	RADI OLOGY-DI AGNOSTI C	54. 00	19, 038	0		14. 00
15. 00	CT SCAN	57. 00	5, 134	o		15. 00
16. 00	MAGNETIC RESONANCE IMAGING	58. 00	2, 579	o		16. 00
	(MRI)		, -			
17.00	CARDIAC CATHETERIZATION	59. 00	3, 029	0		17. 00
18.00	LABORATORY	60. 00	15, 249	o		18. 00
19. 00	RESPI RATORY THERAPY	65. 00	8, 080	0		19. 00
20. 00	PHYSI CAL THERAPY	66. 00	15, 507	0		20. 00
21. 00	OCCUPATIONAL THERAPY	67. 00	1, 145	0		21. 00
22. 00	SPEECH PATHOLOGY	68.00	957	0		22. 00
23. 00	ELECTROCARDI OLOGY	69.00	4, 165	0		23. 00
24. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	4, 614	U		24. 00
25. 00	DRUGS CHARGED TO PATIENTS	73. 00	9, 637	0		25. 00
26. 00	EMERGENCY	91. 00	20, 604	0		26.00
27. 00	MEDICAL RECORDS & LIBRARY	16. 00	1, 515	o		27. 00
27.00	0	10.00	283, 354	— — ŏ		27.00
			200,001	<u> </u>		1 '
	H - CENTRAL SUPPLY					
1. 00	H - CENTRAL SUPPLY ADMINI STRATI VE & GENERAL	5. 00	728	270] 1.00
2.00	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	6. 00	13	5		2. 00
	ADMINISTRATIVE & GENERAL					1. 00 2. 00 3. 00 4. 00

Health Financial Systems In Lieu of Form CMS-2552-10 ST ELIZABETH DEARBORN Provi der CCN: 15-0086 RECLASSI FI CATI ONS

						 5/23/2023 8: 05 ar	<u></u>
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
5.00	DI ETARY	10.00	2!	5	9		5. 00
6.00	NURSING ADMINISTRATION	13. 00	4, 72	2 1, 7	753		6.00
7.00	ADULTS & PEDIATRICS	30.00	21, 55	8,0	002		7. 00
8.00	INTENSIVE CARE UNIT	31.00	20, 01:	2 7,4	129		8. 00
9.00	OPERATING ROOM	50.00	149, 45	1 55, 4	181		9. 00
10.00	DELIVERY ROOM & LABOR ROOM	52. 00	7, 090	2, 6	32		10.00
11.00	ANESTHESI OLOGY	53. 00	2, 20	3 8	318		11.00
12.00	RADI OLOGY-DI AGNOSTI C	54. 00	6, 53	9 2,4	128		12.00
13.00	CT SCAN	57. 00	10, 48	1 3, 8	391		13.00
14.00	MAGNETIC RESONANCE IMAGING	58. 00	2, 542	2 9	944		14.00
	(MRI)						
15.00	CARDI AC CATHETERI ZATI ON	59. 00	16, 00	5, 9	941		15. 00
16.00	LABORATORY	60.00	5, 53	1 2, ()53		16. 00
17.00	RESPI RATORY THERAPY	65. 00	6, 54	2, 4	129		17. 00
18.00	PHYSI CAL THERAPY	66. 00	67	4 2	250		18. 00
19.00	OCCUPATI ONAL THERAPY	67. 00	16	1	61		19. 00
20.00	SPEECH PATHOLOGY	68. 00	20		7		20.00
21.00	ELECTROCARDI OLOGY	69. 00	718	3 2	266		21. 00
22.00	ELECTROENCEPHALOGRAPHY	70.00	40		15		22. 00
23.00	DRUGS CHARGED TO PATIENTS	73. 00	6, 29	5 2, 3	337		23. 00
24.00	CARDIAC REHABILITATION	76. 97	84	1	31		24. 00
25.00	EMERGENCY	91. 00	18, 10:	3 6, 7	20		25. 00
	0		282, 03	5 104, <i>6</i>	99		
500.00	Grand Total: Increases		1, 808, 18	6, 429, 6	40		500.00

RECLASSI FI CATI ONS

Provider CCN: 15-0086

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/23/2023 8:05 am

							5/23/2023 8:05 am
	Cost Center	Decreases Line #	Sal ary	Other	Wkst. A-7	1	
					Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1. 00	A - DRUGS TO PHARMACY NURSING ADMINISTRATION	13.00	0		11	0	1.00
2.00	ADULTS & PEDIATRICS	30. 00	0	7, 6		o	2. 00
3.00	INTENSIVE CARE UNIT	31.00	0	5, 4	42	O	3.00
4.00	OPERATING ROOM	50.00	0	52, 0		0	4. 00
5. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	5, 5		0	5. 00
6.00	ANESTHESI OLOGY	53.00	0	19, 1		0	6. 00
7. 00 8. 00	RADI OLOGY-DI AGNOSTI C CT SCAN	54. 00 57. 00	0	179, 5 1, 9		0	7. 00 8. 00
9. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	1, 9		0	9. 00
7. 00	(MRI)	00.00	0	1,0			7. 00
10.00	CARDÍ AC CATHETERI ZATI ON	59. 00	0	2	08	О	10.00
11. 00	PHYSICAL THERAPY	66. 00	0		1	O	11.00
12.00	CARDIAC CATHETERIZATION	59. 00	0		67	0	12. 00
13.00	CARDI AC REHABI LI TATI ON	76. 97	0		28	0	13.00
14. 00	EMERGENCY	91.00	— — <u>0</u>	33, 1 306, 4		0	14.00
	B - CAFETERIA		0	300, 4	17]		
1.00	DI ETARY	10.00	520, 041	455, 0	80	0	1.00
	0		520, 041	455, 0	80		
4 00	C - IMPLANTS	10.00			al .		
1. 00 2. 00	DI ETARY ADULTS & PEDI ATRI CS	10. 00 30. 00	0	68, 0	4	0	1. 00 2. 00
3. 00	INTENSIVE CARE UNIT	31. 00	0	00,0	91	0	3. 00
4. 00	OPERATING ROOM	50.00	0	5, 100, 7	84	Ö	4.00
5. 00	ANESTHESI OLOGY	53. 00	0	5, 100, 1	9	o	5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	2	52	0	6. 00
7.00	CT SCAN	57. 00	0		98	0	7. 00
8.00	CARDIAC CATHETERIZATION	59. 00	0	5, 7		0	8. 00
9.00	PHYSI CAL THERAPY	66.00	0		94	0	9.00
10. 00	EMERGENCY	91.00	$\frac{0}{0}$		30	0	10.00
	D - LABOR & DELIVERY ROOM			5, 175, 7	44		
1.00	DELIVERY ROOM & LABOR ROOM	52. 00	619, 513	338, 7	73	0	1.00
2.00		0.00	0		0	0	2. 00
	0		619, 513	338, 7	73		
1 00	E - RADI OLOGY ADMI N RADI OLOGY-DI AGNOSTI C	54.00	00 531	40.7	47	0	1 1 00
1. 00 2. 00	RADI OLOGY - DI AGNOSTI C	0.00	98, 521 0	48, 7	40	0	1. 00 2. 00
2.00	0 — — — — —		98, 521	48, 7	46 — —	— ⁴	2.00
	F - PHARMACY RESIDENCY PROGRA	AM	.,				
1.00	DRUGS CHARGED TO PATIENTS	73.00	4,720		81	0	1. 00
	G - GAI NSHARI NG		4, 720	1	81		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	283, 354		o	0	1.00
2.00		0.00	0		0	O	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 7. 00		0. 00 0. 00	0		0	0	6. 00 7. 00
8. 00		0.00	0		0	0	8. 00
9. 00		0. 00	0		o	o	9. 00
10.00		0.00	0	•	0	O	10. 00
11. 00		0.00	0		0	0	11.00
12.00		0.00	0		0	0	12. 00
13.00		0.00	0		0	0	13.00
14. 00 15. 00		0. 00 0. 00	0		0	0	14. 00 15. 00
16. 00		0.00	0		o	0	16. 00
17. 00		0.00	0		o	o	17. 00
18. 00		0.00	0		o	O	18. 00
19.00		0.00	0		0	O	19. 00
20.00		0.00	0		0	0	20. 00
21. 00		0.00	0		0	0	21. 00
22. 00 23. 00		0. 00 0. 00	0		0	0	22. 00 23. 00
24. 00		0.00	0		0	0	24. 00
25. 00		0.00	0		0	Ö	25. 00
26. 00		0.00	0		0	O	26. 00
27.00		0.00	0	L	0	o	27. 00
	0		283, 354		0		
1. 00	H - CENTRAL SUPPLY MEDICAL SUPPLIES CHARGED TO	71.00	282, 036	104, 6	99	0	1.00
2. 00	PATI ENTS	0.00				0	2. 00
2. 00 3. 00		0.00	0		0	0	3.00
4. 00		0. 00	0		Ö	o o	4. 00
5.00		0. 00	0		0	0	5. 00

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

Heal th Fi	nancial Systems		ST ELI ZABET	H DEARBORN		In Lie	u of Form CMS-	2552-10
RECLASSI F	FICATIONS			Provi der	CCN: 15-0086	Peri od: From 01/01/2022	Worksheet A-	5
						To 12/31/2022	Date/Time Pro 5/23/2023 8:0	
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.			
	6. 00	7. 00	8. 00	9. 00	10.00			
6. 00		0.00		0	0	0		6. 00
7. 00		0.00		0	0	0		7. 00
8. 00		0.00		0	0	0		8. 00
9. 00		0.00		0	0	0		9. 00
10. 00		0.00		0	0	0		10. 00
11. 00		0.00		0	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	0		14. 00
15. 00		0.00		0	0	0		15. 00
16.00		0.00		0	0	0		16.00
17. 00		0.00			0	0		17. 00
18. 00 19. 00		0.00				0		18. 00 19. 00
20. 00		0. 00 0. 00			0	0		20.00
21. 00		0.00			0	0		21. 00
21.00		0.00			0	0		22. 00
23. 00		0.00				0		23. 00
24. 00		0.00			0	0		24. 00
25. 00		0.00				0		25. 00
25.00		 	282, 03	6 104, 6	- — -	— ĕ		25.00
500. 00 Gr	rand Total: Decreases		1, 808, 18					500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10

Provider CCN: 15-0086 Period: Worksheet A-7
From 01/01/2022 Part I

							01/01/2022			
						To	12/31/2022			
								5/23/2023 8	: 05 a	<u>n</u>
					Acquisitions	;				
		Begi nni ng	P	urchases	Donati on		Total	Di sposal s ar		
		Bal ances						Retirements		
		1. 00		2. 00	3. 00		4. 00	5. 00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES								
1.00	Land	500,	000		0	0		0	0	1. 00
2.00	Land Improvements	18,	800		0	0		0	0	2. 00
3.00	Buildings and Fixtures	2, 015, 1	202	606, 1	93	0	606,	193	0	3. 00
4.00	Building Improvements	452, (003	78, 4	58	0	78,	458	0	4. 00
5.00	Fixed Equipment		0		0	0		0	0	5. 00
6.00	Movable Equipment	6, 286,	758	2, 221, 6	21	0	2, 221,	621 6	9, 976	6. 00
7.00	HIT designated Assets		O	74, 6	91	0	74,		0	7. 00
8.00	Subtotal (sum of lines 1-7)	9, 272,	763	2, 980, 9	63	0	2, 980,	963 6	9, 976	8. 00
9.00	Reconciling Items	2, 869,	319	-297, 4	99	0	-297,	499	0	9. 00
10.00	Total (line 8 minus line 9)	6, 403,	444	3, 278, 4	62	0	3, 278,	462 6	9, 976	10.00
		Endi ng		Fully						
		Bal ance	De	preci ated						
				Assets						
		6. 00		7. 00						
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	Γ BALANCES								
1.00	Land	500,	000		0					1. 00
2.00	Land Improvements	18,	800		0					2. 00
3.00	Buildings and Fixtures	2, 621,	395		0					3. 00
4.00	Building Improvements	530,	461		0					4. 00
5.00	Fixed Equipment		0		0					5. 00
6.00	Movable Equipment	8, 438,	403		0					6. 00
7.00	HIT designated Assets	74,	691		0					7. 00
8.00	Subtotal (sum of lines 1-7)	12, 183,	750		0					8. 00
9.00	Reconciling Items	2, 571,	820		0					9. 00
10.00	Total (line 8 minus line 9)	9, 611,	930		0					10. 00

Health Financial Systems		ST ELI ZABETI	H DEARBORN		In Lie	u of Form CMS-2	552-	10
RECONCILIATION OF CAPITAL (Provi der C	CN: 15-0086	Peri od: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part II Date/Time Pre 5/23/2023 8:0	pare	d:	
			SU	IMMARY OF CAP	I TAL			
Cost Center Des	scription	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00		
	TION OF AMOUNTS FROM WO			and 2				
1.00 CAP REL COSTS-BLDG &		495, 5	33	0	0	0	0	1.00
2.00 CAP REL COSTS-MVBLE	EQUI P	1, 307, 7	52	0	0	0	0	2.00
3.00 Total (sum of lines	1-2)	1, 803, 2	85	0	0	0	0	3. 00
		SUMMARY 0	F CAPITAL					
Cost Center Des	scription	Other	Total (1)]				
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
PART II - RECONCILIA	TION OF AMOUNTS FROM WO	RKSHEET A, COL	UMN 2, LINES 1	and 2				
1.00 CAP REL COSTS-BLDG &			0 495, 5	33				1.00
2.00 CAP REL COSTS-MVBLE	EQUI P		0 1, 307, 7	'52				2. 00
3.00 Total (sum of lines	1-2)		0 1, 803, 2	185				3. 00

Heal th	Financial Systems	ST ELIZABETH	H DEARBORN		In Lie	u of Form CMS-2	552-1	0
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	reriod: rom 01/01/2022 o 12/31/2022		pared	:
		COMF	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1. 00	2. 00	3. 00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS (
1.00	CAP REL COSTS-BLDG & FIXT	3, 670, 65	•	0 3, 670,			- 1	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8, 513, 09	1	0 8, 513, (•		- 1	2.00
3.00	Total (sum of lines 1-2)	12, 183, 74		0 12, 183,			0	<u>3</u> . 00
		ALLOCAT	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL		
	Cost Center Description	Taxes	Other Capi tal -Rel at ed 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 (CENTERS						_
1.00	CAP REL COSTS-BLDG & FIXT		0	0	0 1, 266,	226	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	0	0 2,041,	305	0	2.00
3.00	Total (sum of lines 1-2)		0	0	0 3, 307,	531	0	3.00
			SL	JMMARY OF CAPIT	ΓAL			
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)		
			(see	instructions)	Capi tal -Rel at			
			instructions)		ed Costs (see instructions)	9 through 14)		
		11. 00	12. 00	13. 00	14. 00	15. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS (CENTERS						_
1.00	CAP REL COSTS-BLDG & FIXT	-42	22	0	0	0 1, 265,	804	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	О	o	0 2, 041,	305	2.00
3.00	Total (sum of lines 1-2)	-42	22	o	o	0 3, 307,	109	3. 00
		•	•	,	'		,	

Provi der CCN: 15-0086

Health Financial Systems ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 Peri od: From 01/01/2022 ADJUSTMENTS TO EXPENSES Worksheet A-8 Date/Time Prepared: 12/31/2022 5/23/2023 8: 05 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code Amount Cost Center Li ne # Wkst. A-7 (2) Ref 2. 00 4.00 1.00 3.00 5.00 1.00 Investment income - CAP REL В -422 CAP REL COSTS-BLDG & FIXT 1. 00 11 1. 00 COSTS-BLDG & FLXT (chapter 2) Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 2.00 C COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 C (chapter 2) 4.00 4.00 Trade, quantity, and time 0.00 C di scounts (chapter 8) 5.00 Refunds and rebates of 0.00 C 5.00 expenses (chapter 8) Rental of provider space by suppliers (chapter 8) 6.00 0.00 С 6.00 7 00 Tel ephone services (pay 0.00 C 7 00 stations excluded) (chapter 8.00 Tel evi si on and radi o servi ce 0.00 0 8.00 (chapter 21) 9.00 9.00 Parking lot (chapter 21) 0.00 0 10.00 Provi der-based physician A-8-2 -503, 882 0 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 C 11.00 (chapter 23) 12.00 Related organization A-8-1 15, 376, 347 C 12.00 transactions (chapter 10) Laundry and linen service 13 00 0.00 13 00 C 14.00 Cafeteria-employees and guests В -266, 303 DI ETARY 10.00 0 14.00 15.00 Rental of quarters to employee 0.00 0 15.00 and others 16.00 Sale of medical and surgical 0.00 C 16.00 supplies to other than pati ents -518, 193DRUGS CHARGED TO PATIENTS 17.00 Sale of drugs to other than В 73.00 0 17.00 pati ents -161 MEDICAL RECORDS & LIBRARY 0 18 00 Sale of medical records and В 18 00 16 00 abstracts 19.00 Nursing and allied health C 19.00 0.00 education (tuition, fees, books, etc.) -9. 337DI ETARY 20.00 В 20.00 Vending machines 10.00 0 Income from imposition of interest, finance or penalty 21.00 0.00 21.00 charges (chapter 21) Interest expense on Medicare overpayments and borrowings to C 22 00 22 00 0.00 repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 23.00 A - 8 - 365, 00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review OUTILIZATION REVIEW-SNF 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 C 26.00 COSTS-BLDG & FLXT OCAP REL COSTS-MVBLE EQUIP 27.00 Depreciation - CAP REL 2.00 С 27.00 COSTS-MVBLE EQUIP 28.00 ONONPHYSICIAN ANESTHETISTS 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29.00 0.00 29.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 0 32.00 Depreciation and Interest

-35,422ADMINISTRATIVE & GENERAL

-305,569ADMINISTRATIVE & GENERAL

-4, 932 LAUNDRY & LINEN SERVICE

-85, 857 MAINTENANCE & REPAIRS

В

В

В

33.00

33.02

33.03

0

0 33.01

0

5.00

5.00

8.00

6.00

33.00

33.02

33.03

LEASE REVENUE

OTHER REVENUE

OTHER REVENUE

OTHER REVENUE

Health Financial Systems		ST ELIZABETH	DEARBORN	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provi der CCN: 15-0086	Peri od:	Worksheet A-8	3
				From 01/01/2022 To 12/31/2022		
			Expense Classification o			
			To/From Which the Amou	nt is to be		
			Adj usted			
Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	(2)				Ref.	
	1. 00	2. 00	3. 00	4.00	5. 00	
33. 04 OTHER REVENUE	В	-67, 34	9DI ETARY	10	. 00	0 33.04
33.05 LEASED PERSONNEL	В		6 SOCIAL SERVICE	17	. 00	0 33.05
33. 06 LOBBYING	Α		9 ADMINISTRATIVE & GENERAL	5	. 00	0 33.06
50.00 TOTAL (sum of lines 1 thru 49))	13, 565, 08!	5			50. 00
(Transfer to Worksheet A,						
column 6, line 200.)						

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

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

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

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

Heal th	Financial Systems	ST ELIZABET	TH DEARBORN	In Lie	u of Form CMS-	2552-1	0
	ENT OF COSTS OF SERVICES FROM	N RELATED ORGANIZATIONS AND	Provi der CCN: 15-0086	Peri od: From 01/01/2022	Worksheet A-	8-1	
HOME O	FFICE COSTS			To 12/31/2022			:
	Li ne No.	Cost Center	Expense Items	Amount of	Amount		
				Al I owabl e	Included in		
				Cost	Wks. A,		
					column 5		
	1. 00	2. 00	3. 00	4. 00	5. 00		
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT O	F TRANSACTIONS WITH RELATED	ORGANI ZATI ONS	OR CLAIMED		
	HOME OFFICE COSTS:						
1. 00	1.0	OCAP REL COSTS-BLDG & FLXT	HOME OFFICE COST	770, 6	593	0	1. 00
2.00	2. 0	OCAP REL COSTS-MVBLE EQUIP	HOME OFFICE COST	733, 5	553	0	2.00
3.00	5. 0	OADMINISTRATIVE & GENERAL	HOME OFFICE COST	13, 896, 3	356	0	3.00
4.00	8. 0	OLAUNDRY & LINEN SERVICE	LAUNDRY	224, 8	358 236,	482	4.00
4. 01	73. 0	ODRUGS CHARGED TO PATIENTS	PHARMACY RESIDENCY		0 12,	631	4. 01
5.00	TOTALS (sum of lines 1-4).			15, 625, 4	160 249,	113	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

			Related Organization(s) a Office	Related Organization(s) and/or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2.00	3.00	4. 00	5. 00			
 B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR H	HOME OFFICE:					

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

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

6.00	В	0. 00 ST. ELI ZABETH 100.	6.00
7.00	С	0.00 TRI STATE LAUND 33.	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

 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 provider.

	ENT OF COSTS OF FFICE COSTS	SERVICES FROM	M RELATED ORGANIZATIONS AND	Provi der CCN: 15-0086	Peri od: From 01/01/2022 To 12/31/2022	Worksheet	A-8-1
TIOME OF	110E 00010					Date/Time	Prepared:
						5/23/2023	8: 05 am
	Net	Wkst. A-7					
	Adjustments	Ref.					
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATE	D ORGANIZATIONS C	OR CLAIMED	
	HOME OFFICE CO	STS:					
1.00	770, 693	3	9				1.00
2.00	733, 553	8	9				2.00
3.00	13, 896, 356		o				3.00
4.00	-11, 624		o				4. 00
4.01	-12, 631		o				4. 01
5.00	15, 376, 347	,					5. 00

ST ELIZABETH DEARBORN

In Lieu of Form CMS-2552-10

15, 376, 347 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

pai t.	pai t.						
	Related Organization(s) and/or Home Office						
	Type of Business						
	6. 00						
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	HOME OFFICE	6.00					
7.00	LAUNDRY	7.00					
8.00		8.00					
8. 00 9. 00		9.00					
10. 00 100. 00		10.00					
100.00		100.00					

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

Health Financial Systems

Health Financial Systems

ST ELIZABETH DEARBORN

In Lieu of Form CMS-2552-10

PROVI DER BASED PHYSI CI AN ADJUSTMENT

Provi der CCN: 15-0086

Peri od:
From 01/01/2022
From 01/01/2022
Physical Research

FROVIDE	IN DASED FIIISIO	TAN ADJUSTNIENT		FIOVIDE	CCN. 13-0000	From 01/01/2022	WOLKSHEEL A-	0-2
						To 12/31/2022	2 Date/Time Pro	epared:
							5/23/2023 8:0	
	Wkst. A Line	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Pro	
	#	ldentifier	Remuneration	Component	Component		vi der	
							Component	
	1. 00	2.00	3. 00	4.00	5. 00	6. 00	Hours 7.00	
1. 00			2, 3	!		0	0	0 1.00
2.00		DELIVERY ROOM & LABOR ROOM	100, 84			0	0	0 2.00
3.00		EMERGENCY	400, 69			o	0	0 3.00
4. 00	0.00	1	400,0	75	,,,,	0	0	0 4.00
5. 00	0.00	I and the second		0		o	0	0 5.00
6.00	0.00	l .	1			0	0	0 6.00
7. 00	0.00	1				0		0 7.00
8. 00	0.00	1				0		0 8.00
9.00	0.00	1	1					0 9.00
10. 00	0.00					0		0 10.00
200.00	0.00	1	503, 88	82 503, 8	000	0	o o	0 200.00
200.00	Wkst. A Line	Cost Center/Physician	Unadj usted	5 Percent of	Cost of	Provi der	Physi ci an	0 200.00
	#	I denti fi er	RCE Li mi t	Unadjusted	Memberships &		Cost of	
	"	radittrioi	NOL LI III C	RCE Limit	Continuing	Share of col.	Mal practice	
					Education	12	Insurance	
	1. 00	2.00	8. 00	9.00	12. 00	13. 00	14. 00	
1. 00		ADMINISTRATIVE & GENERAL		0	0	0	0	0 1.00
2.00		DELIVERY ROOM & LABOR ROOM		O	o	o	O	0 2.00
3. 00		EMERGENCY		o	o	o	ol	0 3.00
4. 00	0. 00	1		o	o	Ö	ol	0 4.00
5. 00	0. 00	1		o	o	Ö	ol	0 5.00
6. 00	0. 00			ol	ol	o	ol	0 6.00
7. 00	0. 00			ol	ol	o	ol	0 7.00
8. 00	0. 00			ol	ol	o	ol	0 8.00
9. 00	0.00			o	o	o	O	0 9.00
10. 00	0.00			o	o	o	O	0 10.00
200.00				o	O	o	O	0 200.00
	Wkst. A Line	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
	#	Identifier	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL		0	0		344	1. 00
2.00		DELIVERY ROOM & LABOR ROOM		0	0	0 100,		2. 00
3. 00		EMERGENCY		0	0	0 400,	693	3. 00
4.00	0. 00	1		0	0	0	0	4. 00
5. 00	0. 00	1		0	0	0	0	5. 00
6.00	0. 00	1		0	0	0	0	6. 00
7. 00	0. 00			0	0	0	0	7. 00
8. 00	0. 00	l .		0	0	0	0	8. 00
9. 00	0. 00		1	0	0	0	0	9. 00
10. 00	0. 00	1		0	0	0	0	10. 00
200.00				0	0	0 503,	882	200. 00

ST ELIZABETH DEARBORN

| Peri od: | Worksheet B | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0086

				-	То	12/31/2022	Date/Time Pr 5/23/2023 8:		
			CAPITAL REI	LATED COSTS			97 207 2020 9.		
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	E	EMPLOYEE	Subtotal		
		for Cost Allocation				BENEFITS EPARTMENT			
		(from Wkst A				-I AIXTWENT			
		col. 7) 0	1. 00	2. 00		4. 00	4A		
	GENERAL SERVICE COST CENTERS					1. 00			
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FLXT	1, 265, 80 2, 041, 30		2,041,	305				1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 263, 63	1	0 2,041,	0	1, 263,	630		4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	20, 475, 07 5, 110, 34				53, 37,			5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	638, 84			241	20,		, 088	
8.00	00800 LAUNDRY & LI NEN SERVI CE	348, 42			654			, 900	l.
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 854, 06 321, 36			884 769	44, 14,		, 682 , 210	
11. 00	01100 CAFETERI A	975, 12			986	20,			11. 00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	1, 194, 23	0 30 9, 5	0 15	359	35,	0 136 1, 254	240	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 174, 23	0	0	0	33,	0	0	1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	220 10	0	0	0	,	0	710	
17. 00	01700 SOCIAL SERVICE	228, 10 729, 41		121 8,	258	16,	1	, 719 , 269	1
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)		0	0	0		0	0	
19. 00 20. 00	O1900 NONPHYSI CLAN ANESTHETI STS O2000 NURSI NG PROGRAM			0	0		0	0	19. 00 20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		0	0	0		O	0	21. 00
22. 00 23. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	63, 58	0 33 1, 2	0	961	2	0 224 68	0 , 984	00
	INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 601, 14 3, 008, 91			662 523	162, 81,			
32. 00	03200 CORONARY CARE UNIT	3,000,7	0	0	0	01,	0	, 203	1
33.00	03300 BURN INTENSIVE CARE UNIT		0	0	0		0	0	
34. 00 40. 00	03400 SURGI CAL INTENSI VE CARE UNIT 04000 SUBPROVI DER - I PF		0	0	0		0	0	
41. 00	04100 SUBPROVI DER - I RF		0	0	0		0	0	
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	462, 99	98 1, 6	560 2,	677	12,	032 479	, 367 0	1
45. 00	04500 NURSING FACILITY		0	0	o		Ö	0	
46. 00	O4600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS		0	0	0		0	7 0	46. 00
50. 00	05000 OPERATING ROOM	9, 302, 67	72 146, 1	121 235,	643	211,	444 9, 895	_ , 880	50.00
51.00	05100 RECOVERY ROOM	1 50/ 1/	0	0	0	41	0	0	
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 506, 18 1, 927, 73		0 63,	122	41,	979 1, 650 190 1, 927		
54.00	05400 RADI OLOGY - DI AGNOSTI C	2, 804, 71	60, 4	118 97,	434	76,	1		
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	952, 87	1	O	O	25,			57. 00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	348, 74 768, 44			374 730	9, 14,	1	, 298 , 539	58. 00 59. 00
60.00	06000 LABORATORY	3, 545, 09			972	62,			1
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0		0	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0		O	0	1
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	1, 668, 52	24 4, 8	330 7.	790	43,	427 1, 724	. 571	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 181, 06	31, 3	390 50,	621	66,	526 2, 329	, 599	66. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	331, 43 197, 06			314 838	10,			67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	476, 49	1		824	14,	1		69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 41	19	0	0		285 8	, 704 0	70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 175, 74	14	0	0				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 309, 01	6, 1	154 9,	925	45,	345 4, 370		73. 00
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)			0	0		0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	210, 02	1	O	O	5,	601 215	, 625	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS		0	0	0		0	7 0	77. 00
88. 00	08800 RURAL HEALTH CLINIC		0	0	0		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0		0	0	
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	3, 950, 09	99 40, 1	187 64,	808	115,	697 4, 170	0 791 ,	90. 00 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)							0	92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DIALYSIS	1	ol	0	o		O		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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST ELIZABETH DEARBORN Provi der CCN: 15-0086

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared:

			T	To 12/31/2022	2 Date/Time Pre		,
					5/23/2023 8: 0	<u>)5 am</u>	1
		CAPITAL REI	LATED COSTS				1
							ı
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal		,
	for Cost			BENEFI TS			ı
	Allocation			DEPARTMENT			ı
	(from Wkst A						ı
	col . 7)						1
	0	1. 00	2.00	4. 00	4A		_
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0	0	0	0	0 97.0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0	0	0	0	0 98.0	
99. 00 09900 CMHC		0	0	0	0	0 99.0	
99. 10 09910 CORF		0	0	0	0	0 99. 1	-
100.00 10000 I&R SERVICES-NOT APPRVD PRGM		0	0	0	0	0 100. 0	
101.00 10100 HOME HEALTH AGENCY		O	0	0	0	0 101.0	
102.00 10200 OPI OI D TREATMENT PROGRAM		0	0	0	0	_ 0 102.0	JO
SPECIAL PURPOSE COST CENTERS							I
105. 00 10500 KIDNEY ACQUISITION	T	0	0	0	0	0 105. 0	
106.00 10600 HEART ACQUISITION		o	0	o	0	0 106.0	
107.00 10700 LIVER ACQUISITION		o	o	o	0	0 107.0	
108.00 10800 LUNG ACQUISITION		o	o	o	0	0 108.0	
109.00 10900 PANCREAS ACQUISITION		o	o	o	o	0 109. 0	
110.00 11000 INTESTINAL ACQUISITION		o	o	o	0	0 110.0	00
111.00 11100 ISLET ACQUISITION		o	o	o	0	0 111.0	
113.00 11300 INTEREST EXPENSE						113. 0	JO
114.00 11400 UTILIZATION REVIEW-SNF						114. 0	00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		o	o	o	0	0 115.0	00
116. 00 11600 HOSPI CE		o	o	o	0	0 116.0	00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	85, 246, 69	1, 250, 8	373 2, 017, 2	226 1, 262,	812 85, 206,	_870 118. C	00
NONREI MBURSABLE COST CENTERS						1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	68, 00	7, 8	376 12, 7	702	818 89,	ື 396 190. ເ	
191. 00 19100 RESEARCH		ol	o	ol	o	0 191.0	00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	9, 27	75 7,0)55 11, 3	377	0 27,	707 192. 0	
193. 00 19300 NONPALD WORKERS		o	o	o	o	0 193. 0	00
194. 00 07950 CMH		o	ol	o	o	0 194. 0	00
200.00 Cross Foot Adjustments						0 200. 0	00
201.00 Negative Cost Centers			ol	ol	o	0 201. 0	
202.00 TOTAL (sum lines 118 through 201)	85, 323, 97	73 1, 265, 8	2, 041, 3	305 1, 263,	630 85, 323,	973 202. 0	

Provider CCN: 15-0086

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | 5/23/2023 8:05 am |

	Cost Center Description	ADMI NI STRATI V MA			LAUNDRY & HO	/23/2023 8: 0 DUSEKEEPI NG	<u>5 am</u>
		E & GENERAL 5. 00	REPAIRS 6. 00	7. 00	NEN SERVICE 8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	21, 076, 557					4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	2, 035, 677	8, 241, 00	77			6. 00
7. 00	00700 OPERATION OF PLANT	216, 544	1, 89		2		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	121, 347	83, 58		1		8. 00
9. 00	00900 HOUSEKEEPI NG	627, 133		1	1	_, _, , .	1
10.00	01000 DI ETARY	124, 401	210, 0			1	
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	336, 840	148, 9!		2 C	47, 9	982 11.00 0 12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	411, 460	120, 49		1	38, 8	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	.==, .	0			0 14.00
15. 00	01500 PHARMACY	0		0	o c		0 15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	77, 000		0	0		0 16.00
17. 00	01700 SOCIAL SERVICE	249, 080	64, 78	6, 90	11, 836	20, 8	1
18. 00 19. 00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0					0 18.00
20. 00	02000 NURSI NG PROGRAM	l ő		o o			0 20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	O		0			0 21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0		0	o c		0 22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	22, 630	15, 38	83 1, 640) <u> </u>	4,	956 23.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 032, 526	2, 092, 0	30 223, 07:	125, 194	673,	916 30.00
31. 00	03100 NTENSIVE CARE UNIT	1, 040, 015	388, 52				
32. 00	03200 CORONARY CARE UNIT	0	000, 0.	0 (o	1	0 32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		0	o c		0 33.00
34. 00	03400 SURGI CAL INTENSI VE CARE UNIT	0		0	O C		0 34.00
40. 00	04000 SUBPROVIDER - I PF	0		0			0 40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	157, 258	21, 00	0		6 -	0 41.00 765 43.00
44. 00	04400 SKILLED NURSING FACILITY	137, 230	21,00	0 2,23		0,	0 44.00
45. 00	04500 NURSING FACILITY	o		0	o c		0 45.00
46. 00	04600 OTHER LONG TERM CARE	0		0 (o c		0 46.00
F0 00	ANCILLARY SERVICE COST CENTERS	2 24/ 275	4 040 /	70 407 40	1 405 400	505	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	3, 246, 375	1, 848, 6		1 125, 189	595,	524 50.00 0 51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	541, 426	495, 20		-	159, !	
53. 00	05300 ANESTHESI OLOGY	632, 460	.,,,	0		,	0 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	996, 891	764, 38	81, 50	29, 262	246, 2	236 54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0			0 55.00
56.00	05600	221 054		0	10.041		0 56.00 0 57.00
57. 00 58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	321, 054 120, 493	42, 10	60 4, 49!	0 10, 861 5 15, 136		l l
59. 00	05900 CARDI AC CATHETERI ZATI ON	260, 979	60, 64	1	1	1	
60.00	06000 LABORATORY	1, 207, 286	352, 8°				
60. 01	06001 BLOOD LABORATORY	0		0	O C		0 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0					0 62.00
64. 00	06400 I NTRAVENOUS THERAPY	Ö		0			0 64.00
65. 00	06500 RESPI RATORY THERAPY	565, 751	61, 1°	13 6, 510	s c	19, 0	1
66. 00	06600 PHYSI CAL THERAPY	764, 232	397, 13				1
67. 00	06700 OCCUPATI ONAL THERAPY	114, 999	41, 68	1			
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	68, 272 172, 527	22, 20 171, 2		1		171 68.00 153 69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 855	171, 2	0 10, 230) 1, 431	33,	0 70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	o c		0 71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 697, 918		0	o c		0 72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 433, 736	77, 86	62 8, 30	2 C	25, (082 73.00
74. 00	07400 RENAL DIALYSIS	0		0			0 74.00
75. 00 76. 97	07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION	70, 736		-			0 75.00 0 76.97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	70, 730		-1			0 77.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0		0	o c		0 88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0			0 89.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	1 240 240	508, 43	0 38 54, 21	129, 485	163,	0 90.00 786 91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 368, 240	300, 4.	34, 214	129, 400	103,	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0		0 94.00
95. 00	09500 AMBULANCE SERVICES	0		0			0 95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0			0 96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD			U C			0 97.00
98. 00 99. 00	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC						0 98.00
	09910 CORF			-			0 99.10
	. ,			*	•	•	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

				10 12/31/2022	5/23/2023 8: 0	
Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
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 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	0 106. 00
107. 00 10700 LI VER ACQUI SI TI ON		0	0	0	0	0 107. 00
108. 00 10800 LUNG ACQUI SI TI ON		0	0	0	0	0 108. 00
109.00 10900 PANCREAS ACQUISITION		0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION		0	0	0	0	0 110. 00
111.00 11100 I SLET ACQUI SI TI ON		0	0	0	0	0 111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE		0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	21, 038, 14	1 8, 052, 1	02 858,	379 561,	214 2, 546,	405 118. 00
NONREI MBURSABLE COST CENTERS] ,
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	29, 32	7 99, 6	50 10,	626	0 32,	101 190. 00
191. 00 19100 RESEARCH		0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	9, 08	9 89, 2	55 9,	517 22,	530 28,	752 192. 00
193. 00 19300 NONPALD WORKERS		0	0	0	0	0 193. 00
194. 00 07950 CMH		0	0	0	0	0 194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	21, 076, 55	7 8, 241, 0	07 878,	522 583,	744 2, 607,	258 202. 00

ST ELIZABETH DEARBORN

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0086 Cost Center Description DI ETARY CAFETERI A

	'			OF PERSONNEL	ADMI NI STRATI			
		10.00	11. 00	12. 00	13. 00	SUPPLY 14.00		
	GENERAL SERVICE COST CENTERS		T					
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP							1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL							5. 00
6.00	00600 MAI NTENANCE & REPAIRS							6. 00
7.00	00700 OPERATION OF PLANT							7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG							8. 00 9. 00
10. 00	01000 DI ETARY	815, 068	3					10.00
11. 00	01100 CAFETERI A		1, 576, 4	39				11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL			0	0			12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON		39, 6	59	0 1, 87	7, 525	0	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY			0	0	0	0	
16. 00	01600 MEDICAL RECORDS & LIBRARY		19, 8	329	ol	Ö	0	16. 00
17. 00	01700 SOCIAL SERVICE		19, 8	1	0 3	9, 389	0	17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)			0	0	0	0	18. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS			0	0	0	0	19. 00
20. 00 21. 00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD					0	0	20.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		ól	Ö	ol	O	0	ł
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	(4, 9	57	O	0	_ 0	
	INPATIENT ROUTINE SERVICE COST CENTERS							1
30.00	03000 ADULTS & PEDIATRICS	360, 27:	1	1		3, 275	0	
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	36, 07	104, 1	04	0 230	5, 332	0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		ól	Ö	ő	Ö	0	1
34.00	03400 SURGICAL INTENSIVE CARE UNIT			О	О	0	0	34. 00
40.00	04000 SUBPROVI DER - I PF			0	0	0	0	
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY			0	0	0	0	
44. 00	04400 SKILLED NURSING FACILITY				0	0	0	
45. 00	04500 NURSING FACILITY			o	o	o	0	ŀ
46. 00	04600 OTHER LONG TERM CARE		ol .	О	О	0	_ 0	46. 00
F0 00	ANCI LLARY SERVI CE COST CENTERS	200.00		70	ما در	4.570		1 50 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	238, 08	317, 2	1/2	0 56. 0	4, 569	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	25, 61	84, 2	275		5, 943	0	ł
53.00	05300 ANESTHESI OLOGY			o	o	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	520	133, 8	849		3, 130	0	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		34, 7	01	ol	o	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		14, 8	l l	ō	Ö	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	220	1	1	0 20	5, 259	0	59. 00
60.00	06000 LABORATORY		123, 9	934	0	0	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1	7	٥	٩	U .	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			o	o	0	0	ŀ
63.00	06300 BLOOD STORING, PROCESSING & TRANS.			o	O	O	0	1
64. 00	06400 I NTRAVENOUS THERAPY			0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		54, 5	•	0	0	0	
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY		109, 0 14, 8	1		0	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	1	1	1	ol	O	0	ł
69.00	06900 ELECTROCARDI OLOGY		24, 7	1	0 3	9, 389	0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY			0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		64, 4	46		0	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS		04, 4	0		0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)			Ö	o	O	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON		9, 9	15	1	6, 259	0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	()	0	0	0	_ 0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		<u> </u>	ol	O	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				ol	o	0	
90.00	09000 CLINIC			o	o	Ö	0	
91. 00	09100 EMERGENCY	17, 15!	143, 7	63	•	1, 980	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						_	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS	1			O			04.00
94. 00 95. 00	09400 HOME PROGRAM DI ALYSIS 09500 AMBULANCE SERVICES			0	0	0	0	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		ól	o o	ŏ	ŏ	0	ŀ
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD			О	o	О	0	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS			0	O	0	0	
99. 00	09900 CMHC		O	0	0	0	0	99. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

					5/23/2023 8: 0	05 am
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
			OF PERSONNEL	ADMINISTRATIO		
				N	SUPPLY	
	10.00	11. 00	12. 00	13. 00	14. 00	
99. 10 09910 CORF	1	0	0	0	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	1	0	0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	1	0	0	0	0	0 101. 00
102.00 10200 OPIOID TREATMENT PROGRAM		0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS] ,
105. 00 10500 KI DNEY ACQUI SI TI ON	1	0	0	0	0	0 105. 00
106. 00 10600 HEART ACQUISITION	1	0	0	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION	1	0	0	0	0	0 107. 00
108. 00 10800 LUNG ACQUISITION	1	0	0	0	0	0 108. 00
109. 00 10900 PANCREAS ACQUI SI TI ON	1	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	1	0	0	0	0	0 110. 00
111.00 11100 I SLET ACQUISITION		0	0	0	0	0 111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE		0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	677, 96	3 1, 576, 4	439	0 1, 877,	525	0 118.00
NONREI MBURSABLE COST CENTERS] ,
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0	0	0	0	0 190. 00
191. 00 19100 RESEARCH	1	0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1	0	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	(0	0	0	0	0 193. 00
194. 00 07950 CMH	137, 10	5	0	0	0	0 194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	815, 06	8 1, 576, 4	439	0 1, 877,	525	0 202. 00

ST ELIZABETH DEARBORN

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0086

PARRIANY PARRIANY REPORT CAL SOCIAL SO					I	То		Date/Time Pre 5/23/2023 8:0		
SPENSIAL SERVICE DIST DENTERS										
		Cost Center Description	PHARMACY				(SPECIFY)			
1.00 CONTROL OF CONTROL OF A FIRST 1.00 CONTROL OF CONTROL OF A FIRST 1.00 CONTROL OF A FIRST 1.00			15 00	LI BRARY			19 00			
2.00			15.00	10.00	17.00		10.00	17.00		
4.00 October Description		l I								
0.00 0.0000 MAINTENANCE SEPARATES 0.00000 0.00000 0.00000 0.00000 0.00000000	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT								4. 00
7.00 000000		l I								
9.00 00000 000000										
10.00 1000 CAPTERIAL 10.00 1000 CAPTERIAL 10.00 1000 CAPTERIAL 10.00 1000 CAPTERIAL 10.00 1000 CAPTERIAL 10.00 1000 CAPTERIAL 10.00 1000 CAPTERIAL 10.00 1000 CAPTERIAL SERVICE SERVICE 10.00 10.00 CAPTERIAL SERVICE SERVICE RVICE SERVI		i i	-							
12.00		l I								
13.00		i i								
15.00 01500 PHARMACY		l I								
16.00 01500 MEDICAL RECORDS & LIBRARY 0 331,548 16.00 17.71,971 17.00 1		01400 CENTRAL SERVICES & SUPPLY								
17.00 01700 SOCIAL SERVICE 0 0 1.71, 971 17.00 18.00 19.00		l	1	-	48					
19.00 01990 NONDHYNST CIAN MARSTHETISTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00	01700 SOCIAL SERVICE			P	71, 971				17. 00
20,00 02000 MURSING PROGRAM 0 0 0 0 0 0 22,00		1			0	0		0	0	
22.00 02200 AR SERVIC CES-OTHER PROW OSTS APPRVD 0 0 0 0 0 22.00					0	0		0	U	
23.00 0.2300 PARAMED LD PROM. (SPECIFY)		l I			0	0		0		
IMPATIENT ROUTINE SERVICE COST CENTERS 0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 3			1		0	-				
31.00 (03100) (INTENSIVE CARE UNIT 0 20,745 75,486 0 0 3.30.00 3320.00		INPATIENT ROUTINE SERVICE COST CENTERS]	
32.00 03200 CORDINARY CARE UNIT			•	1	The second secon					
34.00		03200 CORONARY CARE UNIT		5	0	0, 400		-	-	
40.00 04000 SUBPROVIDER IPF 0 0 0 0 0 0 0 0 0		i i			0	0		0		
43.00		l I			0	0		0		
44. 00 04400 NISSING FACILITY		l I			0	0		0	-	
45.00 04500 NURSIN 6 FACILITY 0 0 0 0 0 0 0 0 0		l) 1, 3)				0		
AMCILLARY SERVICE COST CENTERS	45. 00	04500 NURSING FACILITY	l e	•	0	0		0	0	45. 00
50.00 05000 0FEATING ROOM	46. 00			0	0	0		0	0 	46. 00
52.00 05200 05200 05200 05200 05200 05200 05200 05200 05200 05300 05300 05300 05300 05300 05300 05300 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 0550		05000 OPERATING ROOM	1	1		2, 220				
53. 00 05300 ANESTHESI OLOGY 0 4, 325 15, 761 0 0 53. 00 54. 00 54. 00 65. 00 65. 00 65. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 057. 00 059.		l		-	٦	0 17 973		-	-	
55. 00 05500 RADI OLOGY-THERAPEUTI C	53.00	05300 ANESTHESI OLOGY		4, 3	25 1	15, 761		O		53. 00
56.00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 57.00				31, 0				0		
58. 00 05900 MAGNETIC RESONANCE I IMAGING (MRI) 0 3,859 14,102 0 0 58,00 05900 05900 05900 05900 04001 02011 02		l			0	0		o	0	
59, 00 05900 CARDIAC CATHETERI ZATION 0 4, 021 14, 655 0 0 59, 00 06000 06000 LABORATORY 0 0 8, 946 32, 489 0 0 0 00 00 00 00 00								0	-	
60. 00 06000 LABORATORY 0 8,946 32,489 0 0 60. 00								0	-	
61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRCM ONLY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l I			The second secon			0	-	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	0		O	0	
64.00 06400 NTRAVENOUS THERAPY 0 0 0 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 18,078 38,158 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 9,145 33,319 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 1,162 4,286 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 736 2,627 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 3,175 11,613 0 0 69.00 70.00 07000 ELECTROCARDI OLOGY 0 3,175 11,613 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 07200 MPLD DEV. CHARGED TO PATIENTS 0 23,249 84,611 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 23,249 84,611 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 76.07 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 77.00 07000 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 78.00 09000 OSSENVATI ON BEDS (NON-DISTINCT PART) 0 45,652 166,042 0 0 79.00 09500 DSSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 79.00 09500 DSSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 79.00 09500 DSSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 79.00 09500 DSSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 79.00 09500 DSSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 79.00 09500 DARBLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 79.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 79.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 79.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 79.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 79.00 09700 D	62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0	0		0		62. 00
65. 00 06500 RESPIRATORY THERAPY 0 18,078 38,158 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 9,145 33,319 0 0 66.00 0670 0CUPATI ONAL THERAPY 0 1,162 4,286 0 0 67.00 0670 0CUPATI ONAL THERAPY 0 1,162 4,286 0 0 67.00 06800 SPEECH PATHOLOGY 0 736 2,627 0 0 68.00 06900 ELECTROCARDI OLOGY 0 3,175 11,613 0 0 69.00 0 0 0 0 0 0 0 0 0					0	0		0	-	
67. 00 06700 0CCUPATI ONAL THERAPY 0 1, 162 4, 286 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 736 2, 627 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 3, 175 11, 613 0 0 69. 00 70. 00 07000 CLECTROCEPHALOGRAPHY 0 56 138 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 23, 249 84, 611 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 17, 476 63, 596 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 575 2, 074 0 0 76. 97 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 77. 00 09700 CLI NI C 0 0 0 0 0 89. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0 99. 00 09000 CLI NI C 0 0 0 0 0 91. 00 09100 EMERGENCY 0 45, 652 166, 042 0 0 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 09700 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 09700 0				18, 0	78 3	38, 158		Ö		
68. 00 06800 SPEECH PATHOLOGY 0 736 2,627 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 3,175 11,613 0 0 69. 00 70. 00 70000 ELECTROENCEPHALOGRAPHY 0 56 138 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 23,249 84,611 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 17,476 63,596 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATION 0 575 2,074 0 0 76. 97 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TION 0 0 0 0 0 89. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 89. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 90. 00 09000 CLINI C 0 0 0 0 0 91. 00 09000 EMERGENCY 0 45,652 166,042 0 0 91.00 92. 00 09200 DSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00		l I						0	•	
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73. 00 07300 DRUGS CHARGED TO PATIENTS 0 17, 476 63, 596 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 00 76. 97 07697 CARDIAC REHABILITATION 0 575 2, 074 0 0 76. 97 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 77. 00					0	138		0	-	
74. 00	72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS			P			0	-	72. 00
75. 00) 17, 4	.76 6 0	3, 596 0		0		
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON O O O O O O O O	75. 00	07500 ASC (NON-DISTINCT PART)			0	0		O	0	75. 00
SECTION SERVICE COST CENTERS SERVICE CO		l I	1	1					-	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 0 0 91. 00 09100 EMERGENCY 0 45, 652 166, 042 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 The reimbursable cost centers 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 95. 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 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 99. 00 09700 0 0 0 0 0 0 0 99. 00 09700 0 0 0 0 0 0 99. 00 09700 0 0 0 0 0 0 99. 00 0 0 0 0 0 99. 00 0 0 0 0 0 99. 00 0 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 99. 00 0 0 0 99. 00 0 0	77.00			4	- O ₁					. 77.00
90. 00 09000 CLINI C 0 0 0 0 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 OP400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 95. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 0 0					0	0		0	-	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00					0	0		0	-	
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 94. 00		09100 EMERGENCY		45, 6	52 16	6, 042		0	0	
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 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 97. 00]	92.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00	94.00	09400 HOME PROGRAM DIALYSIS			0	0		0	-	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00))	0	0		0	-	
98. 00 09850 01HER REIMBURSABLE COST CENTERS 0 0 0 0 98. 00	97. 00	09700 DURABLE MEDICAL EQUIP-SOLD			0	0		ō	0	97. 00
	98. 00	U985U UIHER REIMBURSABLE COST CENTERS	(Ŋ	0	0		0	0	<u>98</u> . 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST ELIZABETH DEARBORN

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: Provi der CCN: 15-0086

				To 12/31/2022	Date/Time Pre	
				OTHER GENERAL	5/23/2023 8: 0	5 am
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL	(SPECIFY)	NONPHYSI CI AN	
cost center bescription	PHARIMACT	RECORDS &	SERVICE	(SPECIFI)	ANESTHETI STS	
		LI BRARY	SERVICE		ANESTRETISTS	
	15. 00	16. 00	17. 00	18. 00	19. 00	
99. 00 09900 CMHC		0	0	0	0	0 99.00
99. 10 09910 CORF		o	O	o	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM		o	O	o	0	0 100.00
101.00 10100 HOME HEALTH AGENCY		o	O	o	0	0 101.00
102.00 10200 OPI OID TREATMENT PROGRAM		o	O	o	0	0 102. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION		0	0	0	0	0 105.00
106.00 10600 HEART ACQUISITION		0	0	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION		0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION		0	0	0	0	0 108. 00
109. 00 10900 PANCREAS ACQUI SI TI ON		0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION		o	O	o	0	0 110.00
111.00 11100 ISLET ACQUISITION		0	0	0	0	0 111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE		0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	(0 331, 5	1, 171	, 971	0	0 118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	0	0 190. 00
191. 00 19100 RESEARCH		0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES		0	0	0	0	0 192. 00
193.00 19300 NONPALD WORKERS		0	0	0	0	0 193. 00
194. 00 07950 CMH		0	0	0	0	0 194. 00
200.00 Cross Foot Adjustments						0 200. 00
201.00 Negative Cost Centers		0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)		0 331, 5	548 1, 171	, 971	0	0 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

						To 12/		Date/Time Pre 5/23/2023 8:0		
				INTERNS &	RESI DENTS					
		Cost Center Description	NURSI NG S	ERVI CES-SALA	SERVI CES-OT	HE PARAM	IED ED	Subtotal		
			PROGRAM F	RY & FRINGES	R PRGM COST	TS PR	RGM			
	GENER	RAL SERVICE COST CENTERS	20. 00	21. 00	22. 00	23.	. 00	24. 00		_
1.00	00100	CAP REL COSTS-BLDG & FIXT								1.00
2. 00 4. 00	•	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT								2. 00 4. 00
5.00		D ADMINISTRATIVE & GENERAL								5. 00
6.00		MAINTENANCE & REPAIRS								6. 00
7.00	1	OPERATION OF PLANT								7. 00
8. 00 9. 00	1	D LAUNDRY & LINEN SERVICE HOUSEKEEPING								8. 00 9. 00
10. 00	1	DI ETARY								10. 00
11.00	01100	CAFETERI A								11.00
12.00	1	MAINTENANCE OF PERSONNEL								12.00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY								13. 00 14. 00
15. 00		PHARMACY							1	15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY								16.00
17. 00 18. 00		SOCIAL SERVICE OTHER GENERAL SERVICE (SPECIFY)								17. 00 18. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS								19. 00
20. 00	02000	NURSING PROGRAM	c)					:	20. 00
21. 00	1	DI&R SERVICES-SALARY & FRINGES APPRVD			o					21. 00
22. 00 23. 00	1	1 &R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY)				0	118, 55	50		22. 00 23. 00
23.00		TENT ROUTINE SERVICE COST CENTERS					110, 50	JO	1	23.00
	03000	ADULTS & PEDIATRICS	C	1	0	0		0 12, 530,		30. 00
31.00		INTENSIVE CARE UNIT	C	2	0	0		0 5, 269, 2		31.00
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		1		Ol		0		32. 00 33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	i c	o d	ŏ	o		0		34. 00
40. 00	04000	SUBPROVI DER - I PF	C)	o	0		0		40.00
41. 00 43. 00		SUBPROVIDER - IRF		2	O O	0		0 672.8		41.00
43.00	1	NURSERY SKILLED NURSING FACILITY		<u>'</u>	0	ol		0 672, 8		43. 00 44. 00
45. 00		NURSING FACILITY	Č	1	Ö	Ö		Ö		45. 00
46. 00		OTHER LONG TERM CARE)	o	0		0	, 0	46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM		7	0	ol		0 17, 414, 0	กรลไ	50. 00
51. 00		RECOVERY ROOM		1	0	0		0 17, 414, 0		51. 00
52. 00	05200	DELIVERY ROOM & LABOR ROOM	(c)	o	О		0 3, 263, 2	253	52. 00
53.00	1	ANESTHESI OLOGY	C		O O	0		0 2,580,4		53.00
54. 00 55. 00	1	D RADI OLOGY-DI AGNOSTI C D RADI OLOGY-THERAPEUTI C)		0		0 5, 448, 6		54. 00 55. 00
56. 00		RADI OI SOTOPE	c		ŏ	ŏ		Ö		56. 00
57. 00		CT SCAN)	o	0		0 1, 403, 4		57. 00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION			0	0		0 595, 0 1, 210, 3		58.00
60.00		LABORATORY		j j	ol	ol		0 5,556,		60.00
60. 01	06001	BLOOD LABORATORY	(c		ŏ	Ō		0		60. 01
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY			_				1	61.00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.		2	O	0		0		62.00
63. 00 64. 00	1	INTRAVENOUS THERAPY		\(\frac{1}{3}\)		ol		0		63. 00 64. 00
65. 00		RESPIRATORY THERAPY	c		ŏ	Ö		0 2, 488,		65. 00
66. 00		PHYSI CAL THERAPY)	o	0		0 3, 844, 5		66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY		(O O	0		0 547, 2 0 321, 8		67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY		,)	ol	0		0 1,023,4		69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	c)	ō	0			753	70. 00
	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	C		o	0		0		71.00
		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		0	O O	118, 55	0 6, 981, 5 6, 179, 4		72. 00 73. 00
		RENAL DIALYSIS	i	j J	o	o	110,00	0 3, ,		74. 00
75. 00	07500	ASC (NON-DISTINCT PART)	(c)	o	О		0	0	75. 00
	1	7 CARDI AC REHABI LI TATI ON	C		o	0		0 325,		76. 97
//. 00		ALLOGENEIC STEM CELL ACQUISITION TIENT SERVICE COST CENTERS		η	0	U		0	0	77. 00
88. 00		RURAL HEALTH CLINIC	С		0	0		0	0 :	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	C)	o	0		0		89. 00
90.00		CLINIC DEMERCENCY		2	0	0		0 7 040 1		90.00
91. 00 92. 00	1	DEMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)		1	٩	۷		0 7,069,		91. 00 92. 00
72.00		R REIMBURSABLE COST CENTERS							i !	72.00
	1	HOME PROGRAM DIALYSIS	C)	0	0		0		94. 00
		DAMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED		2	ol	0		0		95. 00 96. 00
		DURABLE MEDICAL EQUIP-RENTED DURABLE MEDICAL EQUIP-SOLD		, ,	ol	ol		0		96. 00 97. 00
		OTHER REIMBURSABLE COST CENTERS)	o	o		o		98. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/23/2023 8:05 am

					5/23/2023 8: 0	05 am
		INTERNS &	RESI DENTS			
Cost Center Description	NURSI NG	SEDVICES SALA	SERVI CES-0THE	PARAMED ED	Subtotal	
cost center bescription	PROGRAM	RY & FRINGES		PRGM	Subtotal	
	20. 00	21. 00	22.00	23. 00	24. 00	
99. 00 09900 CMHC		0	0	0	0	0 99.00
99. 10 09910 CORF		О	o	O	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 OPIOID TREATMENT PROGRAM		0	0	0	0	0 102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION		0	0	0	0	0 105. 00
106.00 10600 HEART ACQUISITION		0	0	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION		0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION		0	0	0	0	0 108. 00
109. 00 10900 PANCREAS ACQUI SI TI ON		0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION		0	0	0	0	0 110. 00
111.00 11100 I SLET ACQUI SI TI ON		0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE		0			0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		0	0	0 118,	550 84, 738,	_918 118. 00
NONREI MBURSABLE COST CENTERS						」 ,
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	0 261,	100 190. 00
191. 00 19100 RESEARCH		0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES		0	0	0	0 186,	850 192. 00
193. 00 19300 NONPALD WORKERS		0	0	0	0	0 193. 00
194.00 07950 CMH		0	0	0	0 137,	105 194. 00
200.00 Cross Foot Adjustments		O	0	0	0	0 200. 00
201.00 Negative Cost Centers		O	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)		O	0	0 118,	550 85, 323,	973 202. 00

Health Financial Systems ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 od: Worksheet B 01/01/2022 Part I 12/31/2022 Date/Time Prepared: COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0086 Peri od: From 01/01/2022 5/23/2023 8:05 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 26.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2. 00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 |חחהחח| MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 01900 NONPHYSI CI AN ANESTHETI STS 19 00 19 00 02000 NURSING PROGRAM 20.00 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 12, 530, 795 30.00 03100 INTENSIVE CARE UNIT 5, 269, 248 31.00 31.00 32.00 03200 CORONARY CARE UNIT 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 34.00 04000 SUBPROVIDER - IPF 0 40.00 40.00 04100 SUBPROVIDER - IRF 0 41.00 0 41.00 04300 NURSERY 43 00 0 672,814 43.00 |04400|SKILLED NURSING FACILITY 0 44.00 0 44.00 45 00 04500 NURSING FACILITY 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 17, 414, 038 51.00 05100 RECOVERY ROOM o 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 3, 263, 253 52.00 0 53.00 05300 ANESTHESI OLOGY 2, 580, 467 53.00 05400 RADI OLOGY-DI AGNOSTI C 5, 448, 607 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 0 0 05600 RADI OI SOTOPE 56 00 56 00 0 57.00 57 00 05700 CT SCAN 1, 403, 434 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 595, 996 58.00 59.00 05900 CARDIAC CATHETERIZATION 1, 210, 339 59.00 60.00 06000 LABORATORY 5, 556, 903 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 65.00 2, 488, 405 65.00 06600 PHYSI CAL THERAPY 3, 844, 525 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 547, 270 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 321,873 06900 ELECTROCARDI OLOGY 69.00 69 00 1, 023, 456 0) 07000 ELECTROENCEPHALOGRAPHY 70.00 70 00 11, 753 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 981, 522 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 6, 179, 490 73.00 74.00 07400 RENAL DIALYSIS 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 75.00 07697 CARDIAC REHABILITATION 0 76. 97 325, 184 76. 97 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 88.00 0 o 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89 00 0 90.00 09000 CLINIC 90.00 0 09100 EMERGENCY 7, 069, 546 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00

o

0

0

97.00

98.00

09700 DURABLE MEDICAL EQUIP-SOLD

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Health Financ	cial Systems	ST ELIZABET	H DE	EARBORN		In Lieu	of Form CMS-2	2552-10
COST ALLOCAT	ION - GENERAL SERVICE COSTS				CCN: 15-0086	Peri od: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/23/2023 8:0	
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00		Total 26. 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
	HOME HEALTH AGENCY		0		0			101. 00
	OPIOID TREATMENT PROGRAM L PURPOSE COST CENTERS		0		0			102.00
	KIDNEY ACQUISITION		ol		0			l105.00
	HEART ACQUISITION		o		o			106. 00
107. 00 10700	LIVER ACQUISITION		O		o			107. 00
108. 00 10800	LUNG ACQUISITION		o		o			108. 00
109. 00 10900	PANCREAS ACQUISITION		o		o			109. 00
110.00 11000	INTESTINAL ACQUISITION		o		o			110.00
111. 00 11100	ISLET ACQUISITION		o		o			111. 00
113. 00 11300	INTEREST EXPENSE		- 1					113. 00
114. 00 11400	UTILIZATION REVIEW-SNF		- 1					114. 00
115. 00 11500	AMBULATORY SURGICAL CENTER (D. P.)		o		o			115. 00
116. 00 11600	HOSPI CE		O		o			116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)		0	84, 738,	918			118. 00
	MBURSABLE COST CENTERS]
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	261, 1	100			190. 00
191. 00 19100	RESEARCH		0		0			191. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES		0	186, 8	850			192. 00
	NONPALD WORKERS		0		0			193. 00
194. 00 07950			0	137, 1	105			194. 00
	Cross Foot Adjustments		0		0			200. 00
	Negative Cost Centers		0		0			201. 00
202. 00	TOTAL (sum lines 118 through 201)		0	85, 323, 9	973			202. 00

ST ELIZABETH DEARBORN

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

								0	12/31/2022	5/23/2023 8:		
				(CAPITAL REL	ATE	D COSTS					
		Cost Center Description	Di rectl y	BLI	DG & FIXT	MV	BLE EQUIP	1	Subtotal	EMPLOYEE		
			Assigned New Capital							BENEFITS DEPARTMENT		
			Related Costs							DEI ARTIMENT		
	CENED	AL SERVICE COST CENTERS	0		1. 00		2. 00		2A	4. 00		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT									<u> </u>	1. 00
2.00	00200	CAP REL COSTS-MVBLE EQUIP										2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT		0	200 5	0	227	0	E 4.7 . F	0	0	4.00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	9, 3	14	209, 5 404, 8		337, 652,		547, 5 1, 067, 0		0	5. 00 6. 00
7.00	00700	OPERATION OF PLANT		0	1	49		241	3	390	0	7. 00
8.00		LAUNDRY & LINEN SERVICE	12, 35		6, 6		10,		29, 6		0	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	8, 54	0	4, 8 16, 6		26,	884 769	21, 3 43, 3		0	9. 00 10. 00
11. 00	01100	CAFETERI A		0	11, 7		18,		30, 7		0	11. 00
12.00	1	MAINTENANCE OF PERSONNEL		0	0.5	0	15	0	24.6	0	0	12.00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY		0	9, 5	0	15,	339	24, 8	0	0	13. 00 14. 00
15. 00	01500	PHARMACY		0		0		0		0	0	15. 00
16.00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE		0	F 1	0	0	0	10.1	0	0	16.00
17. 00 18. 00		OTHER GENERAL SERVICE (SPECIFY)		0	5, 1	0	8,	258 0	13, 3	0	0	17. 00 18. 00
19. 00	01900	NONPHYSICIAN ANESTHETISTS		0		0		0		O	0	19. 00
20.00		NURSI NG PROGRAM		0		0		0		0	0	20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD		0		0		0		0	0	21. 00 22. 00
23. 00	02300	PARAMED ED PRGM-(SPECIFY)		0	1, 2	16	1,	961	3, 1	177	0	23. 00
30. 00		IENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	18, 7	1 4	145 2	E 4	244	442	450, 7	722] ol	20.00
31. 00		INTENSIVE CARE UNIT		42	165, 3 30, 7		266, 49,		450, <i>i</i> 80, 2		0	30. 00 31. 00
32. 00	03200	CORONARY CARE UNIT		0	, .	0	,	0		0	0	32. 00
33. 00		BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		0		0		0		0	0	33. 00
34. 00 40. 00		SUBPROVIDER - IPF		0		0		0		0	0	34. 00 40. 00
41. 00	1	SUBPROVI DER - I RF		0		0		0		O	0	41. 00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY		0	1, 6	60	2,	677	4, 3	337	0	43. 00 44. 00
45. 00		NURSING FACILITY		0		0		0		0	0	45. 00
46. 00	04600	OTHER LONG TERM CARE		0		0		0		0	၂ ၀	46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	33, 79	94	146, 1	21	235,	643	415, 5	558	ا م	50. 00
51. 00		RECOVERY ROOM	33, 7	0	140, 1	0	233,	0	410,	0	0	51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	4	42	39, 1	42	63,	122	102, 3	306	0	52. 00
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53, 76	0 65	60, 4	18	97,	0 434	211, 6	0 517	0	53. 00 54. 00
55. 00		RADI OLOGY-THERAPEUTI C	33, 70	0	00, 4	0	77,	0	211,0	0	0	55. 00
56. 00		RADI OI SOTOPE		0		0		0		0	0	56. 00
		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	3, 09	90	3, 3	32	5	374	3, 0 8, 7	090 706	0	57. 00 58. 00
59. 00		CARDI AC CATHETERI ZATI ON		0	4, 7			730	12, 5		0	59. 00
60.00		LABORATORY	71, 97	72	27, 8	87	44,	972	144, 8	1	0	60.00
60. 01 61. 00		BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY		O		U		U		0	0	60. 01 61. 00
62. 00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0		0		O	0	62. 00
63.00		BLOOD STORING, PROCESSING & TRANS.		0		0		0		0	0	63.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	12, 84	40	4, 8	30	7.	790	25, 4	0 460	0	64. 00 65. 00
66. 00	06600	PHYSI CAL THERAPY	47, 41		31, 3		50,		129, 4		0	66. 00
67.00		OCCUPATIONAL THERAPY		0	3, 2			314	8, 6		0	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY		0	1, 7 13, 5		2, 21,	838 824	4, 5 35, 3		0	68. 00 69. 00
70. 00		ELECTROENCEPHALOGRAPHY		0	,	0		0		0	0	70. 00
		MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0		0		0	0	71.00
		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	166, 51	13	6, 1	54	9.	اں 925	182, 5	592	0	72. 00 73. 00
74.00	07400	RENAL DIALYSIS	100,01	0	0,	0	* 1	0	.02,	0	ō	74. 00
		ASC (NON-DISTINCT PART)		0		0		0		0	0	75. 00
76. 97 77. 00	1	CARDIAC REHABILITATION ALLOGENEIC STEM CELL ACQUISITION		0		0		0		0	0	76. 97 77. 00
	OUTPA	TIENT SERVICE COST CENTERS		<u> </u>]	771.00
		RURAL HEALTH CLINIC		0		0		0		0	0	88. 00
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER CLINIC		0		0		0		0	0	89. 00 90. 00
91. 00	09100	EMERGENCY	33	39	40, 1	87	64,	808	105, 3	334	0	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)								0	,	92. 00
94. 00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS		0		0		ol		0] o	94. 00
95. 00	09500	AMBULANCE SERVICES		0		0		Ō		0	0	95. 00
		DURABLE MEDI CAL EQUI P-RENTED DURABLE MEDI CAL EQUI P-SOLD		0		0		0		0	0	96. 00 97. 00
71.00	107/00	DOMADLE WEDI ONE EQUIT-SULU		Ч		υĮ		U		O _I	U	<u></u>

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST ELIZABETH DEARBORN Provi der CCN: 15-0086

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part II

					12/31/2022	Date/Time Pre 5/23/2023 8:0	
		CAPITAL REL	ATED COSTS			3/23/2023 0.0	JS alli
		07.11.77.12.77.12.	2,1125 00010				
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	S	ubtotal	EMPLOYEE	
	Assigned New					BENEFITS	
	Capi tal					DEPARTMENT	
L. F.	Related Costs						
	0	1. 00	2. 00	Ш.	2A	4. 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 0PIOLD TREATMENT PROGRAM	0		0	0		0	0 102.00
SPECIAL PURPOSE COST CENTERS] ,
105. 00 10500 KI DNEY ACQUI SI TI ON	0		0	0		0	0 105. 00
106.00 10600 HEART ACQUISITION	0		0	O		0	0 106. 00
107.00 10700 LIVER ACQUISITION	0		0	O		0	0 107. 00
108.00 10800 LUNG ACQUISITION	0		0	O		0	0 108. 00
109. 00 10900 PANCREAS ACQUI SI TI ON	0		0	O		0	0 109. 00
110. 00 11000 INTESTINAL ACQUISITION	0		0	0		0	0 110. 00
111.00 11100 SLET ACQUISITION	0		0	O		0	0 111. 00
113. 00 11300 I NTEREST EXPENSE							113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	_			_			114. 00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0		0	0		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)	438, 736	1, 250, 8	73 2, 017	, 226	3, 706, 8	335	0 118.00
NONREI MBURSABLE COST CENTERS			7.1	700]
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		7, 8	12	, 702	20, 5	78	0 190. 00
191. 00 19100 RESEARCH	0		0	0		0	0 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		7, 0	11	, 377	18, 4	132	0 192.00
193. 00 19300 NONPALD WORKERS	0		0	O		0	0 193. 00
194. 00 07950 CMH			O	O		0	0 194. 00
200.00 Cross Foot Adjustments						U _I	200.00
201.00 Negative Cost Centers	400 70/	4 0/5 0	0	0	0.745.6	U	0 201.00
202.00 TOTAL (sum lines 118 through 201)	438, 736	1, 265, 8	04 2, 041	, 305	3, 745, 8	345	0 202. 00

Provider CCN: 15-0086

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/23/2023 8:05 am |

Cost Center Description	ADMI NI STRATI V MA			LAUNDRY & HO	23/2023 8: 05 a	am
	E & GENERAL 5.00	REPAIRS 6. 00	7. 00	NEN 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 EQUI P						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL	547, 574		+			4. 00 5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	52, 888	1, 119, 912	2			6. 00
7. 00 00700 OPERATION OF PLANT	5, 626	257	l l			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	3, 153	11, 359	9 64	44, 191		8. 00
9. 00 00900 HOUSEKEEPI NG	16, 293	8, 405	1	1	46, 062	ŀ
10. 00 01000 DI ETARY	3, 232	28, 540	l l		1, 195	1
11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE OF PERSONNEL	8, 751	20, 242	2 113 0 0		848	3 11. 00 12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	10, 690	16, 375	1		686	ı
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	(0,070	0 0			14.00
15. 00 01500 PHARMACY	O	(0 (c	0	(15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	2, 001	(0 (c		(16. 00
17. 00 01700 SOCI AL SERVI CE	6, 471	8, 804			369	1
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	(0	1		18.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 20. 00 02000 NURSI NG PROGRAM		(0		19.00
21. 00 02100 1 &R SERVICES-SALARY & FRINGES APPR		(0		21.00
22. 00 02200 Lar Services - Other Prom Costs Appr		(1		22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	588	2, 091	1 12	0	88	3 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	52, 806	284, 296			11, 905	
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	27, 020	52, 798	ŀ		2, 21	
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN I NTENSI VE CARE UNIT		(0 0	1		32.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT		(1		34.00
40. 00 04000 SUBPROVI DER - I PF	Ö	(1		40.00
41. 00 04100 SUBPROVI DER - RF	o	(0	0	(41.00
43. 00 04300 NURSERY	4, 086	2, 854	4 16	0	120	43.00
44.00 04400 SKILLED NURSING FACILITY	0	(0			44.00
45. 00 04500 NURSING FACILITY	0	(0			45. 00
46.00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	(0 0	0		46. 00
50. 00 05000 OPERATING ROOM	84, 335	251, 226	6 1, 408	9, 477	10, 52	1 50.00
51. 00 05100 RECOVERY ROOM	0	(0		·	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	14, 067	67, 296	6 377	2, 582	2, 818	52. 00
53. 00 05300 ANESTHESI OLOGY	16, 432	(0 (0			53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	25, 900	103, 877	1		4, 350	1
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	(0 0	1		55.00
57. 00 05700 CT SCAN	8, 341	(1		56.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 130	5, 729	-		240	ŀ
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 780	8, 241	l l		345	ł
60. 00 06000 LABORATORY	31, 366	47, 946	6 269	0	2, 008	
60. 01 06001 BLOOD LABORATORY	0	(0	0	(60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONL		,			,	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CEL 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	.L5 0	(0		62.00
64. 00 06400 I NTRAVENOUS THERAPY		(0		64.00
65. 00 06500 RESPIRATORY THERAPY	14, 699	8, 305	-	1	348	1
66. 00 06600 PHYSI CAL THERAPY	19, 855	53, 968	l l	2, 404	2, 260	ł
67. 00 06700 OCCUPATI ONAL THERAPY	2, 988	5, 665			237	1
68. 00 06800 SPEECH PATHOLOGY	1, 774	3, 025	l l		127	
69. 00 06900 ELECTROCARDI OLOGY	4, 482	23, 267	. 1	1	974	l .
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI EN	74 TS 0	(1		70.00
72. 00 07700 IMPL. DEV. CHARGED TO PATIENTS	44, 113	(-		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	37, 249	10, 581			443	1
74.00 07400 RENAL DIALYSIS	0	(0			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	(0 (C	0	(75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 838	(0			76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	(0 0	0	(77. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	1 0		0 (0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		(1		89.00
90. 00 09000 CLINIC	Ö	(Ö		90.00
91. 00 09100 EMERGENCY	35, 548	69, 094	4 387	9, 804	2, 894	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T)					92.00
OTHER REIMBURSABLE COST CENTERS						1
94. 00 09400 HOME PROGRAM DI ALYSI S	0	(0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	(0	0		95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		(96.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		(98.00
99. 00 09900 CMHC		(l ol		99.00
99. 10 09910 CORF		Ć	0			99. 10

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

				10 12/31/2022	5/23/2023 8: 0	
Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
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 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	0 106. 00
107. 00 10700 LI VER ACQUI SI TI ON		0	0	0	0	0 107. 00
108. 00 10800 LUNG ACQUI SI TI ON		0	0	0	0	0 108. 00
109.00 10900 PANCREAS ACQUISITION		0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION		0	0	0	0	0 110. 00
111.00 11100 I SLET ACQUI SI TI ON		0	0	0	0	0 111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE		0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	546, 57	6 1, 094, 2	41 6,	129 42,	485 44,	987 118. 00
NONREI MBURSABLE COST CENTERS] ,
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	76	2 13, 5	42	76	0	567 190. 00
191. 00 19100 RESEARCH		0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	23	6 12, 1	29	68 1,	706	508 192. 00
193. 00 19300 NONPALD WORKERS		0	0	0	0	0 193. 00
194. 00 07950 CMH		0	0	0	0	0 194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	547, 57	4 1, 119, 9	12 6,	273 44,	191 46,	062 202. 00

ST ELIZABETH DEARBORN

Provi der CCN: 15-0086 Peri od: In Lieu of Form CMS-2552-10
Worksheet B

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

1.00 0	Cost Center Description	DI ETARY				5/23/2023 8: 0	JU CIII	d
1.00 0			CAFETERI A	MAINTENANCE OF PERSONNEL	ADMINISTRATIO N	CENTRAL SERVI CES & SUPPLY		
1.00 0	CENTRAL CERVILOR COST CENTERS	10. 00	11. 00	12. 00	13. 00	14. 00		
	GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT	T	T			<u> </u>		1. 00
2.00 0	00200 CAP REL COSTS-BLDG & FIXT							2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT					1		4. 00
	00500 ADMINISTRATIVE & GENERAL							5. 00
	00600 MAINTENANCE & REPAIRS							6. 00
7.00 0	00700 OPERATION OF PLANT							7. 00
	00800 LAUNDRY & LINEN SERVICE							8. 00
	00900 HOUSEKEEPI NG							9. 00
	01000 DI ETARY	77, 359	1					10.00
	D1100 CAFETERIA	U C	60, 7					11.00
	D1200 MAINTENANCE OF PERSONNEL	0	1 1	0 527	0 54.	252		12.00
	D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY	۲) 1, 5)	0	0 54,	0	0	13. 00 14. 00
	01500 PHARMACY	7	1	ol		0	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	Č	-	764		o	0	16. 00
	01700 SOCIAL SERVICE	- (1	764	0 1,	138	0	17. 00
	01850 OTHER GENERAL SERVICE (SPECIFY)	1 ()	ol	ŏl .	ol	o	18. 00
	01900 NONPHYSICIAN ANESTHETISTS	c	ار	ol	ōl	ō	0	19. 00
	02000 NURSI NG PROGRAM	c	ار	o	o	O	0	20. 00
	D2100 I&R SERVICES-SALARY & FRINGES APPRVD	c	ار	o	o	o	0	21. 00
	D2200 I&R SERVICES-OTHER PRGM COSTS APPRVD	c	ار	o	0	0	0	22. 00
	D2300 PARAMED ED PRGM-(SPECIFY)		⁻	191	0	0	_ 0	23. 00
[1]	NPATIENT ROUTINE SERVICE COST CENTERS						1	
	D3000 ADULTS & PEDIATRICS	34, 193	1		0 12,		0	30. 00
	03100 INTENSIVE CARE UNIT	3, 424	4, (009		829	0	31. 00
	03200 CORONARY CARE UNIT	(C	ار ا	0	0	0	0	32. 00
	03300 BURN INTENSIVE CARE UNIT	C	기	0	0	0	0	33. 00
	03400 SURGI CAL INTENSI VE CARE UNIT	0	기	0	0	0	0	34.00
	04000 SUBPROVI DER - I PF	C	기	0	0	0	0	40.00
	04100 SUBPROVI DER – I RF	0	1	0	0	0	0	41.00
	04300 NURSERY	U	시	0	O	0	0	43.00
	04400 SKILLED NURSING FACILITY	U	1	0	0	0	0	44. 00
	04500 NURSING FACILITY	U	1	0	0	0	0	45. 00
_	04600 OTHER LONG TERM CARE	U	Л	0	0	0	7 0	46. 00
-	ANCILLARY SERVICE COST CENTERS	1 22 50-	1 12 1	240	0 14	244	ام	- FO OC
	05000 OPERATING ROOM	22, 597	7 12, 2	218	0 16,	314	0	50.00
t	D5100 RECOVERY ROOM D5200 DELIVERY ROOM & LABOR ROOM	2, 431	<u>.</u>	246	-1	691	0	51. 00 52. 00
	05300 ANESTHESI OLOGY	2, 70,	1	0	0	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	50	5, 1	155	ol	379	ŏ	54. 00
	05500 RADI OLOGY-THERAPEUTI C		,	0	ol	0	ő	55. 00
	05600 RADI OI SOTOPE	C		ől	ol	ő	o	56. 00
	05700 CT SCAN	1 (1, :	336	ōl	ol	o	57. 00
t	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	1	573	o	0	0	58. 00
	D5900 CARDI AC CATHETERI ZATI ON	21	1	764	o	759	0	59. 00
	D6000 LABORATORY	(773	o	0	0	60.00
60. 01 0	D6001 BLOOD LABORATORY	0)	o	o	0	0	60. 01
1	D6100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	(c)	0	0	0	0	62. 00
	D6300 BLOOD STORING, PROCESSING & TRANS.	C)	0	0	0	0	63. 00
	06400 INTRAVENOUS THERAPY	(C	ار ا	0	0	0	0	64. 00
	06500 RESPI RATORY THERAPY	0	1	100	0	0	0	65. 00
	06600 PHYSI CAL THERAPY	C	1	200	0	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	1	573	0	0	0	67. 00
t	06800 SPEECH PATHOLOGY	2	1	382	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	U	<u>۱</u>	955	0 1,	138	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	Ü	시	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	기	O	O	0	0	71.00
t	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	0	0	0	0	72.00
t	07300 DRUGS CHARGED TO PATIENTS	0	2, 4	482	O	0	0	73.00
t	07400 RENAL DIALYSIS		기	0	0	0	0	74.00
	07500 ASC (NON-DISTINCT PART)		1 .	0	0	0	0	75. 00
t t	07697 CARDI AC REHABI LI TATI ON		기 :	382		759	0	76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION		<u>/ </u>	0	0	0	기 이	77. 00
	DUTPATIENT SERVICE COST CENTERS	, ,	1	~I	al	_1	ا	22 00
	08800 RURAL HEALTH CLINIC	0	기	0	0	0	0	88. 00
1	08900 FEDERALLY QUALIFIED HEALTH CENTER		기	0	O	0	0	89.00
	09000 CLINIC	1 620	1	0	0	0	0	90.00
	09100 EMERGENCY	1, 628	5, 5	537	0 8,	726	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						_n 1	92. 00
	OTHER REIMBURSABLE COST CENTERS	, ,		.1	-1	.1	ا	- 4 00
	09400 HOME PROGRAM DIALYSIS	Ü	1	0	0	0	0	94.00
	09500 AMBULANCE SERVICES	Ü	시	0	O	0	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	U	시	이	이	0	U	96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	U	1	0	0	0	0	97. 00
	09850 OTHER REIMBURSABLE COST CENTERS	U	1	0	0	0	0	98.00
00 00 10	09900 CMHC	U	기	0	0	0	0	99. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

				0 12/01/2022	5/23/2023 8: 0	
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
			OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
				N	SUPPLY	
	10. 00	11. 00	12. 00	13. 00	14. 00	
99. 10 09910 CORF	C)	0	0	0	0 99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	C)	0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	C)	0	0	0	0 101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	C)	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS				- I]
105. 00 10500 KI DNEY ACQUI SI TI ON		2	0	0	0	0 105.00
106. 00 10600 HEART ACQUISITION		2	0	0	0	0 106. 00
107. 00 10700 LI VER ACQUI SI TI ON		2	0	0	0	0 107. 00
108. 00 10800 LUNG ACQUISITION		2	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		<u>'</u>	0	0	0	0 110.00
111. 00 11100 SLET ACQUISITION]	O	O	O	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 SURGI CAL CENTER (D. P.)		()	0	0	0	0 115. 00
116. 00 11600 HOSPI CE	(4.24)	/ / /	71.0	0	252	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	64, 346	60, 7	/ 13	0 54,	253	0 118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1	0	O.	0	0 190.00
191. 00 19100 RESEARCH			0		0	0 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		5	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS		5	0	0	0	0 193. 00
194. 00 07950 CMH	13, 013		o	o	0	0 194, 00
200.00 Cross Foot Adjustments	10,010	1				200. 00
201.00 Negative Cost Centers			o	o	o	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	77, 359	60, 7	713	0 54,	253	0 202. 00
, , ,	•	•	•			,

Heal th Financial Systems

ST ELIZABETH DEARBORN

In Lieu of Form CMS-2552-10

Provider CCN: 15-0086

Period:
From 01/01/2022
To 12/31/2022

To 12/31/2022

To 12/31/2022

Part II
Date/Time Prepared:
5/23/2023 8: 05 am

PHARMACY

MEDICAL
RECORDS & SERVICE
LI BRARY

15. 00 16. 00 17. 00 18. 00 19. 00

	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	SERVI CE (SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
		15. 00	16. 00	17. 00	18. 00	19. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100		1				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL				1		11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY		0				15. 00
16. 00 17. 00	O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE		0 2, 7	0 31,8	870		16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)		o o	0	0	О	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS		o	0	О	0	0 19.00
20.00	02000 NURSI NG PROGRAM		0	0	0	0	20. 00
21. 00 22. 00	02100 &R SERVI CES-SALARY & FRINGES APPRVD 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD		0	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		o o	o	Ö	Ö	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1	1		519 053	0	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT		0	0	0	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT		ō	O	o	Ö	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0	0	0	0	34. 00
40. 00 41. 00	04000 SUBPROVI DER - PF 04100 SUBPROVI DER - RF		0	0	0	0	40. 00 41. 00
43.00	04300 NURSERY		ol	11	132	o	43. 00
44. 00	04400 SKILLED NURSING FACILITY		ō	0	0	Ö	44. 00
45.00	04500 NURSING FACILITY	l .	0	0	0	0	45. 00
46. 00	O4600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS		0	0	0	0	46. 00
50. 00	05000 OPERATING ROOM		0 7	701 8, 2	216	0	50.00
51.00	05100 RECOVERY ROOM		o	0	o	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0	l l	489	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C		0 2	l l	429 072	0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		o -	0	0	Ö	55. 00
56. 00	05600 RADI OI SOTOPE		0	0	0	0	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)		0 1		241 383	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		ol		399	o	59.00
	06000 LABORATORY		ō		384	Ö	60. 00
60. 01	06001 BLOOD LABORATORY		o	0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS						61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		o o	0	0	Ö	63. 00
64. 00	06400 I NTRAVENOUS THERAPY		o	0	О	О	64. 00
65. 00	06500 RESPI RATORY THERAPY		0 1		038	0	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		0	1	906 117	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		o o	6	71	Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY		o	26	316	О	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY		0	0	4	0	70. 00
71.00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O7200 MPL. DEV. CHARGED TO PATIENTS		0 1	93 2, 3	301	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		1		729	Ö	73. 00
74. 00	07400 RENAL DIALYSIS		o	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0	0	0	0	75. 00
76. 97 77. 00	O7697 CARDIAC REHABILITATION O7700 ALLOGENEIC STEM CELL ACQUISITION		0	0	56	0	76. 97 77. 00
	OUTPATIENT SERVICE COST CENTERS		<u> </u>		-1	-]
88. 00	08800 RURAL HEALTH CLINIC		0	0	0	0	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0			0	89. 00 90. 00
91.00	09100 EMERGENCY		ŏ 3	880 4, 5	515	o	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
04.00	OTHER REIMBURSABLE COST CENTERS		ol		ol		04.00
94. 00 95. 00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES		0 0			0	94. 00 95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		o	0	O	O	96. 00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD		0	0	O O	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	1	υĮ	U	U	U	98. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

				10 12/31/2022	5/23/2023 8: 0	
				OTHER GENERAL		
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	(SPECIFY)	NONPHYSI CI AN	
		RECORDS &	SERVI CE		ANESTHETI STS	
-	15.00	LI BRARY	47.00	10.00	10.00	
22 22 2222 2440	15. 00	16. 00	17. 00	18. 00	19. 00	
99. 00 09900 CMHC			0	0	0	99. 00
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 10200 OPI OI D TREATMENT PROGRAM)	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS		SI.				405.00
105. 00 10500 KI DNEY ACQUI SI TI ON			0	0	0	105. 00
106. 00 10600 HEART ACQUISITION			0	0	0	106. 00
107. 00 10700 LIVER ACQUISITION			0	0	0	107. 00
108. 00 10800 LUNG ACQUI SI TI ON			0	0	0	108. 00
109. 00 10900 PANCREAS ACQUISITION			0	0	0	109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON			0	0	0	110.00
111. 00 11100 SLET ACQUISITION	()	0	O	0	111. 00
113. 00 11300 NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	,					114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)			0	0	0	115. 00
116. 00 11600 HOSPI CE			0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		2, 7	765 31	, 870	0	0 118.00
NONREI MBURSABLE COST CENTERS		N.				400.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			0	0	0	190. 00
191. 00 19100 RESEARCH	(0	0	0	191. 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES			0	0	0	192. 00
193. 00 19300 NONPALD WORKERS			0	0	0	193. 00
194. 00 07950 CMH			0	0	O	194. 00
200.00 Cross Foot Adjustments			_	_		0 200. 00
201.00 Negative Cost Centers	(]	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	(0 2, 7	⁷ 65 31	, 870	0	0 202. 00

Hea<u>lth Financial Systems</u> ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 Peri od: From 01/01/2022 Worksheet B

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0086

Part II
Date/Time Prepared: 12/31/2022 5/23/2023 8:05 am INTERNS & RESIDENTS PARAMED ED Cost Center Description NURSI NG SERVI CES-SALA SERVI CES-OTHE Subtotal PROGRAM RY & FRINGES R PRGM COSTS PRGM 20.00 21.00 22.00 23.00 24.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 16, 00 16, 00 17.00 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18, 00 19 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 20.00 02000 NURSING PROGRAM 20.00 21.00 02100 & SERVICES-SALARY & FRINGES APPRVD 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 6, 147 23.00 NPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 870, 134 30.00 31.00 03100 INTENSIVE CARE UNIT 181, 443 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34.00 04000 SUBPROVIDER - IPF 40 00 0 40 00 04100 SUBPROVIDER - IRF 41.00 0 41.00 43.00 04300 NURSERY 11,556 43.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 45.00 04500 NURSING FACILITY 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 832, 571 05100 RECOVERY ROOM 51.00 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 201, 344 52.00 05300 ANESTHESI OLOGY 16, 897 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 357, 455 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 0 05600 RADI OI SOTOPE 56.00 56, 00 0 14, 934 05700 CT SCAN 57 00 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 19, 971 58 00 58.00 05900 CARDIAC CATHETERIZATION 59.00 30.077 59.00 60.00 06000 LABORATORY 232, 151 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 52, 147 65.00 65.00 06600 PHYSI CAL THERAPY 213, 395 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 18.370 67.00 10, 031 68.00 06800 SPEECH PATHOLOGY 68.00 69 00 06900 ELECTROCARDI OLOGY 66, 753 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 78 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 46,607 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 235, 280 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 07697 CARDIAC REHABILITATION 76. 97 3,040 76. 97 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 09000 CLINIC 90 00 90 00 0 91 00 09100 EMERGENCY 243, 847 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 94.00 09500 AMBULANCE SERVICES 0 95.00 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

				1	0 12/31/2022	5/23/2023 8:0	
			I NITEDNIC 9.	RESI DENTS		3/23/2023 6.0	
			INILKINO &	KLSIDLNIS			
	Cost Center Description	NURSI NG	SEDVI CES-SALA	SERVI CES-OTHE	PARAMED ED	Subtotal	
	cost center bescription		RY & FRINGES		PRGM	Subtotal	
		20. 00	21. 00	22. 00	23. 00	24. 00	
99. 00 09900	CMHC	1	1				0 99.00
99. 10 09910	CORF						0 99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM						0 100. 00
101, 00 10100	HOME HEALTH AGENCY						0 101. 00
102.00 10200	OPIOID TREATMENT PROGRAM						0 102. 00
SPECI A	AL PURPOSE COST CENTERS	•	•	<u> </u>	<u> </u>	<u> </u>] '
105. 00 10500	KIDNEY ACQUISITION						0 105.00
106.00 10600	HEART ACQUISITION						0 106. 00
107. 00 10700	LIVER ACQUISITION						0 107. 00
108.00 10800	LUNG ACQUISITION						0 108. 00
109.00 10900	PANCREAS ACQUISITION						0 109. 00
110.00 11000	INTESTINAL ACQUISITION		İ				0 110.00
111.00 11100	ISLET ACQUISITION		İ				0 111.00
113.00 11300	INTEREST EXPENSE		İ				113. 00
114. 00 11400	UTILIZATION REVIEW-SNF		1				114. 00
115.00 11500	AMBULATORY SURGICAL CENTER (D. P.)						0 115. 00
116. 00 11600							0 116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)		o	O	o	0 3, 658,	081 118. 00
NONREI	MBURSABLE COST CENTERS]
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					35,	525 190. 00
191. 00 19100	RESEARCH						0 191. 00
192.00 19200	PHYSICIANS' PRIVATE OFFICES					33,	079 192. 00
193. 00 19300	NONPALD WORKERS		1				0 193. 00
194. 00 07950	СМН		1			13,	013 194. 00
200. 00	Cross Foot Adjustments		o	0	0 6,	147 6,	147 200. 00
201.00	Negative Cost Centers		o	0	0	0	0 201. 00
202.00	TOTAL (sum lines 118 through 201)		o	0	0 6,	147 3, 745,	845 202. 00

Hea<u>lth Financial Systems</u> In Lieu of Form CMS-2552-10 ST ELIZABETH DEARBORN d: Worksheet B 01/01/2022 Part II 12/31/2022 Date/Time Prepared: Provi der CCN: 15-0086 Peri od: From 01/01/2022 ALLOCATION OF CAPITAL RELATED COSTS 5/23/2023 8:05 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 26.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2. 00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 19 00 02000 NURSING PROGRAM 20.00 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 870, 134 30.00 03100 INTENSIVE CARE UNIT 31.00 181, 443 31.00 32.00 03200 CORONARY CARE UNIT 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 34.00 04000 SUBPROVIDER - IPF 0 40.00 40.00 04100 SUBPROVIDER - IRF 0 41.00 0 41.00 04300 NURSERY 43 00 11,556 43.00 |04400|SKILLED NURSING FACILITY 44.00 0 44.00 45 00 04500 NURSING FACILITY 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 832, 571 51.00 05100 RECOVERY ROOM o 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 201.344 52.00 0 53.00 05300 ANESTHESI OLOGY 16, 897 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 357, 455 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 0 05600 RADI OI SOTOPE 56 00 56 00 0 57.00 57 00 05700 CT SCAN 14.934 05800 MAGNETIC RESONANCE IMAGING (MRI) 19, 971 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 30, 077 59.00 60.00 06000 LABORATORY 232, 151 60.00 60.01 06001 BLOOD LABORATORY 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 0 06500 RESPIRATORY THERAPY 65.00 52, 147 65.00 06600 PHYSI CAL THERAPY 213, 395 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 18, 370 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 10.031 06900 ELECTROCARDI OLOGY 66, 753 69 00 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 70 00 78 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 O 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 46,607 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 235, 280 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) o 0 75.00 07697 CARDIAC REHABILITATION 0 76. 97 3, 040 76. 97 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 88.00 0 o 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89 00 0 90.00 09000 CLINIC 90.00 0 09100 EMERGENCY 243, 847 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00

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0

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97.00

98.00

09700 DURABLE MEDICAL EQUIP-SOLD

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	ST ELIZABETH	DEARBORN		In Lieu	of Form CMS-2552-10	
ALLOCATION OF CAPITAL RELATED COSTS			CCN: 15-0086	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/23/2023 8:05 am	
Cost Center Description	Intern & Residents	Total				
	Cost & Post					
	Stepdown					
	Adjustments					
	25. 00	26. 00				
99. 00 09900 CMHC		0	0		99. (
99. 10 09910 CORF 100. 00 10000 I&R SERVI CES-NOT APPRVD PRGM		2			99. 1	
101.00 10100 HOME HEALTH AGENCY			0		101. (
102. 00 10200 OPI OI D TREATMENT PROGRAM			Ö		102.0	-
SPECIAL PURPOSE COST CENTERS		91	<u> </u>		1.02.	, ,
105. 00 10500 KI DNEY ACQUI SI TI ON	()	0		105. (00
106.00 10600 HEART ACQUISITION		0	0		106. (
107.00 10700 LIVER ACQUISITION	(0	0		107. (
108. 00 10800 LUNG ACQUI SI TI ON	(0	0		108. (
109. 00 10900 PANCREAS ACQUISITION			0		109. (
110. 00 11000 NTESTI NAL ACQUI SI TI ON 111. 00 11100 SLET ACQUI SI TI ON		2			110. (111. (
113. 00 11300 NTEREST EXPENSE	'	٦	٥		113. (
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114. (
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	1 .		o		115. (
116. 00 11600 H0SPI CE	1 (o	0		116. (
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		3, 658,	081		118. (00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	35,	525		190. (
191. 00 19100 RESEARCH	1	0	0		191. (
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS		33,	079		192. (193. (
193.00 19300 NONPALD WORKERS 194.00 07950 CMH		12	013		194. (
200.00 Cross Foot Adjustments			147		200. (
201.00 Negative Cost Centers		ol o,	0		201. (
202.00 TOTAL (sum lines 118 through 201)		3, 745,	845		202. (00

	ancial Systems ATION - STATISTICAL BASIS	ST ELIZABETH	DEARBORN Provi der C	CN: 15-008	6 Per	In Lie iod: m 01/01/2022	wof Form CMS Worksheet E		2-10
					To	12/31/2022	Date/Time F 5/23/2023 8	repar 3: 05 a	red:
		CAPITAL REL	ATED COSTS						
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOY BENEFI DEPARTM (GROS SALARII	TS IENT IS	econciliatio n	ADMI NI STRATI E & GENERAI (ACCUM. COST	-	
		1. 00	2. 00	4. 00		5A	5. 00		
	RAL SERVICE COST CENTERS DO CAP REL COSTS-BLDG & FIXT	305, 02	2			T			1.00
2.00 0020	OO CAP REL COSTS-MVBLE EQUIP		305, 0						2. 00
	DO EMPLOYEE BENEFITS DEPARTMENT DO ADMINISTRATIVE & GENERAL	50, 50	0 4 50, 5		435, 75° 341, 21°	1	557 64, 24	7, 416	4. 00 5. 00
6.00 0060	DO MAINTENANCE & REPAIRS	97, 55	5 97, 5	555	927, 24	1	0 6, 20	5, 330	6. 00
	DO OPERATION OF PLANT DO LAUNDRY & LINEN SERVICE	1, 59	6 2 1, 5	36 192	518, 74 ¹ 104, 85	1		0, 088 9, 900	
9.00 0090	DO HOUSEKEEPI NG	1, 17	8 1, 1	78 1,	115, 64	2	0 1, 91	1, 682	9. 00
	DO DI ETARY DO CAFETERI A	4, 00 2, 83			360, 09 520, 04			9, 210 6, 784	
	OO MAINTENANCE OF PERSONNEL	2,03	0	0	320, 04	•	0 1,02	0, 704	1
	DO NURSING ADMINISTRATION DO CENTRAL SERVICES & SUPPLY	2, 29	5 2, 2	95	874, 10	7 0	0 1, 25	4, 249 0	
	DO PHARMACY		o o	0			0	0	
	MEDICAL RECORDS & LIBRARY	l .	0	0	164, 46			4, 719	1
18. 00 0185	DO SOCIAL SERVICE 50 OTHER GENERAL SERVICE (SPECIFY)	1, 23	4 1, 2 0	0	409, 96	0	0 75	9, 269 0	ł
	NONPHYSICIAN ANESTHETISTS		o	0	(o	0	0	
	DO NURSING PROGRAM DO I&R SERVICES-SALARY & FRINGES APPRVD		0	0			0	0	
22. 00 0220	00 I&R SERVICES-OTHER PRGM COSTS APPRVD	l .	O	0		D	0	0	22. 00
	DO PARAMED ED PRGM-(SPECIFY) TIENT ROUTINE SERVICE COST CENTERS	29	3 2	93	55, 32	2	0 6	8, 984	23. 00
30.00 0300	OO ADULTS & PEDIATRICS	39, 84			044, 00	1		 5, 724	
	DO INTENSIVE CARE UNIT DO CORONARY CARE UNIT	7, 40	0 7,4	00 2,	018, 05	1	0 3, 17	0, 265 0	ł
	DO BURN INTENSIVE CARE UNIT		ŏ	0		o o	Ö	0	
	DO SURGICAL INTENSIVE CARE UNIT DO SUBPROVIDER - IPF		0	0	(0	0	0	
	OU SUBPROVIDER - TPF		0	0		0	0	0	
43.00 0430	DO NURSERY	40	0 4	00	299, 31	1	1	9, 367	43. 00
	DO SKILLED NURSING FACILITY DO NURSING FACILITY		0	0		0	0	0	
46. 00 0460	OO OTHER LONG TERM CARE		ő	Ö		0	ő	_ 0	
	LLARY SERVICE COST CENTERS DO OPERATING ROOM	35, 21	1 35, 2	11 5	260, 050	n	0 9 80	 5 880	50.00
	00 RECOVERY ROOM		o	0		О	0	0, 000	1
	DO DELIVERY ROOM & LABOR ROOM DO ANESTHESIOLOGY	9, 43	2 9, 4	32 1,	044, 32 4, 71			0, 423 7, 921	1
	DO RADI OLOGY-DI AGNOSTI C	14, 55	9 14, 5	559 1,	896, 90	1		8, 812	1
	00 RADI OLOGY-THERAPEUTI C 00 RADI OI SOTOPE		0	0	(O O	0	0	
	DO CT SCAN		0	0	641, 57	-	0 97	8, 665	
	MAGNETIC RESONANCE IMAGING (MRI)	80	1	803	244, 97	1		7, 298	1
1	DO CARDIAC CATHETERIZATION DO LABORATORY	1, 15 6, 72		ı	362, 52 547, 44	1		5, 539 0, 154	
60. 01 0600	D1 BLOOD LABORATORY		o	0		D	0	0	60. 01
	DO PBP CLINICAL LAB SERVICES-PRGM ONLY DO WHOLE BLOOD & PACKED RED BLOOD CELLS			0			0	0	61. 00 62. 00
	DO BLOOD STORING, PROCESSING & TRANS.		ŏ	0	i	o o	Ö	0	63.00
	OO DESDURATORY THERAPY	1 1/	0	0	000 35	0	0 1.72	0	
	00 RESPI RATORY THERAPY 00 PHYSI CAL THERAPY	1, 16 7, 56			080, 350 655, 00	1		4, 571 9, 599	1
67. 00 0670	OO OCCUPATIONAL THERAPY	79	4	'94	261, 48	3	0 35	0, 550	67. 00
	DO SPEECH PATHOLOGY DO ELECTROCARDIOLOGY	3, 26	1	24 261	160, 42 349, 81	1		8, 113 5, 913	1
70.00 0700	DO ELECTROENCEPHALOGRAPHY		0	0	7, 08	3	0	8, 704	70.00
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS DO IMPL. DEV. CHARGED TO PATIENTS		0	0	(0	0 5.17	0 5 744	
	DO DRUGS CHARGED TO PATIENTS OF DRUGS CHARGED TO PATIENTS	1, 48	3 1, 4	83 1,	128, 06	1	-, -, -,	5, 744 0, 440	1
74.00 0740	DO RENAL DIALYSIS	1	o	o		0	0	0	74. 00
1	DO ASC (NON-DISTINCT PART) D7 CARDIAC REHABILITATION		0	0	139, 33	U 6	0 21	0 5, 625	
	,	1	-1	-1	, , 00	- 1	-1 -1	.,	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET) WVBLE EQUIP EMPLOYEE BENEFITS BENEFITS						To 1:	2/31/2022	Date/Time Pr			
SUBSTITUTE COST Center Description SUBSTITUTE COURT			CAPITAL RELA	TED COSTS				5/23/2023 8:	05 ai	111	
SQUARE FEET SQUARE FEET BENEFITS DEPARTMENT (GCUM. COST) PROPERTY CGROSS SALARI ES PROPERTY CGROSS SALARI ES PROPERTY CGROSS SALARI ES PROPERTY			ON TIME REE	TIED COSTS							
SQUARE FEET SQUARE FEET BENEFITS DEPARTMENT (GCUM. COST) PROPERTY CGROSS SALARI ES PROPERTY CGROSS SALARI ES PROPERTY CGROSS SALARI ES PROPERTY	Cos	ost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Recor	nciliatio	ADMI NI STRATI V	/		
DEPARTMENT (GROSS SALARI ES) SALARI ES) SALARI ES) SALARI ES) SALARI ES SALARI ES											
1.00 2.00 4.00 5A 5.00			`	,	DEPARTMEN	IT		(ACCUM. COST)			
1.00 2.00 4.00 5A 5.00					(GROSS			· ·			
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 97. 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 98. 0 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 0 0 99. 0 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0 0 0 0 99. 1 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 101. 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101. 0 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 0 102. 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 105. 0 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 0 0 106. 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 0 107. 0 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 0 109. 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 109. 0 110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 110. 0 111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 0 0 0 111. 0					SALARI ES)					
98. 00			1.00	2. 00	4. 00		5A				
99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99.0 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0 99.1 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 100.0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.0 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 0 102.0 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 0 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 0 105. 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 107. 0 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 107. 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 109.0 110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 110. 0 111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 0 0 0 111. 0					0	0		-	0		
99. 10					0	0		0	0		
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	0		0	0	99	. 00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 0 101. 00 102. 00 102.00 10200 OPI 01 D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0 102. 00 102.00 SPECI AL PURPOSE COST CENTERS					0	0		0	0	99	. 10
102. 00 10200 OPI 0I D TREATMENT PROGRAM O O O O O 102. 00 SPECIAL PURPOSE COST CENTERS O O O O O O 105. 00 105. 00 10500 KI DNEY ACQUI SI TI ON O O O O O O O O O O O O O O O O O O					0	0		0	0	100	. 00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105.00 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 106.00 106.00 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 109.00 110.00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 111.00 111.00 11100 ISLET ACQUI SI TI ON 0 0 0 0 0 111.00					0	0		0			
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 0 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 106. 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 0 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 108. 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 109. 0 110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 110. 0 111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 0 0 111. 0	102. 00 10200 OP	PIOID TREATMENT PROGRAM			0	0		0	_ 0	102	. 00
106. 00 10600 HEART ACQUISITION 0 0 0 0 106. 0 0 106. 0 0 0 106. 0 0 0 107. 0 0 0 0 0 0 0 107. 0 0 0 0 0 0 0 0 107. 0 0 0 0 0 0 0 0 0 108. 0 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>											
107. 00 10700 LIVER ACQUISITION 0 0 0 0 107. 0 0 0 0 107. 0 0 0 0 0 107. 0 0 0 0 0 0 0 0 108. 0 0 0 0 0 0 0 0 108. 0 0 0 0 0 0 0 0 109. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 110. 0 0					0	0		0			
108. 00 10800 LUNG ACQUISITION 0 0 0 0 108. 0 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 0 109. 0 0 0 0 0 0 0 0 110. 0 0	106. 00 10600 HE	EART ACQUISITION			0	0		0			
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 0 111. 00 0 <td>107. 00 10700 LI</td> <td>IVER ACQUISITION</td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>107</td> <td>. 00</td>	107. 00 10700 LI	IVER ACQUISITION			0	0		0	0	107	. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0 0 0 110. 0 111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 111. 0	108. 00 10800 LU	UNG ACQUISITION			0	0		0	0	108	. 00
111. 00 11100 I SLET ACQUISITION 0 0 0 1111. 0	109. 00 10900 PA	ANCREAS ACQUISITION			0	0		0	0	109	. 00
	110. 00 11000 I N	NTESTINAL ACQUISITION			0	0		0	0	110	. 00
113. 00 11300 I NTEREST EXPENSE	111. 00 11100 I S	SLET ACQUISITION			0	0		0	0	111	. 00
	113. 00 11300 I N	NTEREST EXPENSE								113	. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	114. 00 11400 UT	TILIZATION REVIEW-SNF								114	. 00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 115. 0	115. 00 11500 AM	MBULATORY SURGICAL CENTER (D.P.)			0	0		0	0	115	. 00
116. 00 11600 HOSPI CE 0 0 0 0 116. 0	116. 00 11600 HO	OSPI CE			0	0		0	0	116	. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 301, 424 301, 424 31, 415, 406 -21, 076, 557 64, 130, 313 118.00	118. 00 SU	JBTOTALS (SUM OF LINES 1 through 117)	301, 42	301, 4	124 31, 41	15, 406	-21, 076, 5	557 64, 130	<u>,</u> 313	118	. 00
NONREI MBURSABLE COST CENTERS											
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,898 1,898 20,345 0 89,396 190.0			1, 89	1, 8	398 2	20, 345		0 89			
191. 00 19100 RESEARCH 0 0 0 0 191. 0					0	0		-			
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 700 1, 700 0 0 27, 707 192. 0			1, 70	1, 7	700	0		0 27	, 707	192	. 00
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 0	193. 00 19300 NO	ONPALD WORKERS			0	0		0	0	193	. 00
194. 00 07950 CMH 0 0 0 0 194. 0					0	0		0	0		
200.00 Cross Foot Adjustments 200.00										200	. 00
201.00 Negative Cost Centers										201	. 00
202.00 Cost to be allocated (per Wkst. B, 1,265,804 2,041,305 1,263,630 21,076,557 202.0	202. 00 Co	ost to be allocated (per Wkst. B,	1, 265, 80	2, 041, 3	305 1, 26	53, 630		21, 076	, 557	202	. 00
Part I)											
203.00 Unit cost multiplier (Wkst. B, Part I) 4.149878 6.692321 0.040197 0.328053 203.0		,	4. 14987	6. 6923	321 0. (040197		0. 32	8053	203	. 00
204.00 Cost to be allocated (per Wkst. B, 0 547, 574 204.00						0		547	, 574	204	. 00
Part II)											
205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.008523 205.0					0.0	000000		0. 00	8523	205	. 00
206.00 NAHE adjustment amount to be allocated 206.0										206	. 00
(per Wkst. B-2)										L	
207.00 NAHE unit cost multiplier (Wkst. D, 207.00										207	. 00
Parts III and IV)	ј јРа	arts iii and iv)	1	I	I	I		I		l	

ST ELIZABETH DEARBORN

In Lieu of Form CMS-2552-10

Period: Worksheet B-1
From 01/01/2022
To 12/31/2022 Date/Time Prepared:
5/3/2023 8:05 am Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0086

		Cost Center Description	MAINTENANCE &	OPERATION OF	L	LAUNDRY & HO	DUSEKEEPI NG	5/23/2023 8:05 DIETARY	
		0001 00	REPAI RS	PLANT (SQUARE FEET)	LIN	NEN SERVICE (S		(MEALS SERVED)	
			6. 00	7. 00		LAUNDRY) 8. 00	9. 00	10.00	
1 00		AL SERVICE COST CENTERS	T	T					l 1 00
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP							1.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT							4. 00
5.00	1	ADMI NI STRATI VE & GENERAL							5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	156, 96		227				6. 00
7. 00 8. 00	1	LAUNDRY & LINEN SERVICE	1, 59	6 156, 9 2 1. 5	592	514, 781			7. 00 8. 00
9. 00	1	HOUSEKEEPI NG	1, 17	1	178	0	154, 1	57	9. 00
10.00	1	DIETARY	4, 00	1	000	10, 054	4, C	1	1
11. 00 12. 00	1	CAFETERIA MAINTENANCE OF PERSONNEL	2, 83	7 2, 8 0	337	0	2,8	337	0 11.00 0 12.00
13. 00	1	NURSI NG ADMI NI STRATI ON	2, 29	-	295	0	2, 2	-	0 13.00
14. 00	1	CENTRAL SERVICES & SUPPLY		o	0	0	ŕ	0	0 14.00
15.00	1	PHARMACY	1	0	0	0		0	0 15.00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	1, 23	0 1 1	234	0 10, 438	1, 2	0	0 16.00
18. 00	1	OTHER GENERAL SERVICE (SPECIFY)	1,23	0	0	0, 430	1, 2	0	0 18.00
19. 00	01900	NONPHYSICIAN ANESTHETISTS		o	0	0		0	0 19.00
20.00		NURSI NG PROGRAM		0	0	0		0	0 20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD			0	0		0	0 21.00 0 22.00
23. 00		PARAMED ED PRGM-(SPECIFY)	29	3 2	293	0	2	293	0 23.00
	I NPAT	ENT ROUTINE SERVICE COST CENTERS							'
30.00	1	ADULTS & PEDIATRICS	39, 84			110, 404	39, 8		1
31. 00 32. 00	1	INTENSIVE CARE UNIT CORONARY CARE UNIT	7, 40	0 7, 2	400 0	27, 447 0	7,4	100 2, 12	28 31.00 0 32.00
33. 00	1	BURN INTENSIVE CARE UNIT		o	0	0		0	0 33.00
34. 00	1	SURGICAL INTENSIVE CARE UNIT		o	0	0		0	0 34.00
40.00	1	SUBPROVIDER - IPF		0	0	0		0	0 40.00
41. 00 43. 00	1	SUBPROVIDER - IRF NURSERY	40	0	0 400	0	1	0	0 41.00 0 43.00
44. 00		SKILLED NURSING FACILITY	40	o	0	0	7	0	0 44.00
45. 00		NURSING FACILITY		o	0	0		0	0 45.00
46. 00		OTHER LONG TERM CARE		0	0	0		0	0 46.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	35, 21	1 35, 2	211	110, 399	35, 2	211 14, 04	15 50.00
51. 00		RECOVERY ROOM	33,2.	0	0	0	00,2	0	0 51.00
52. 00	1	DELIVERY ROOM & LABOR ROOM	9, 43	2 9, 4	432	30, 082	9, 4	1, 5	1
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	14, 55	0 9 14,5	0	0 25, 805	14, 5	0	0 53.00
55. 00		RADI OLOGY-THERAPEUTI C	14, 55	0 14, 3	0	25, 805	14, 5	0	0 55.00
56. 00	1	RADI OI SOTOPE		o	0	0		0	0 56.00
57. 00		CT SCAN		0	0	9, 578		0	0 57.00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	80 1, 15		303 155	13, 348 1, 936		803	0 58.00
60.00		LABORATORY	6, 72		720	1, 730	6, 7		0 60.00
60. 01	1	BLOOD LABORATORY		o	0	0	,	0	0 60.01
61.00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62. 00 63. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.		0	0	0		0	0 62.00
64. 00	1	INTRAVENOUS THERAPY		o	0	0		0	0 64.00
65. 00		RESPI RATORY THERAPY	1, 16	4 1, 1	164	0	1, 1	64	0 65.00
66.00		PHYSI CAL THERAPY	7, 56		564	28, 009	7, 5		0 66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	79	1	794 124	1, 623 341		794 124	0 67.00
69. 00	1	ELECTROCARDI OLOGY	3, 26	1	261	1, 262	3, 2		0 69.00
70. 00	1	ELECTROENCEPHALOGRAPHY		O	0	0		0	0 70.00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0		0	0 71.00
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	1, 48	0 3 1 /	0 483	0	1, 4	U 183	0 72.00 0 73.00
74. 00		RENAL DIALYSIS	1, 40	o	0	0	1,4	0	0 74.00
75. 00	07500	ASC (NON-DISTINCT PART)		O	0	0		0	0 75.00
76. 97	1	CARDIAC REHABILITATION		0	0	0		0	0 76. 97
77. 00		ALLOGENEIC STEM CELL ACQUISITION TIENT SERVICE COST CENTERS		UI	U	0		0	0 77.00
88. 00		RURAL HEALTH CLINIC		0	0	0		0	0 88.00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0		0	0 89.00
90.00	1	CLI NI C		0	0	114 107		0	0 90.00
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	9, 68	4 9, 6	584	114, 187	9, 6	1, 0	91. 00 92. 00
00		REIMBURSABLE COST CENTERS							, ,2.00
	09400	HOME PROGRAM DIALYSIS		0	0	0		0	0 94.00
		AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED		OJ	0	0		0	0 95.00
		DURABLE MEDICAL EQUIP-RENTED		ŏ	0	0		0	0 97.00
		OTHER REIMBURSABLE COST CENTERS		o o	0	0		o	0 98.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

Peri ot: Worksheet B-1
From 01/01/2022
To 12/31/2022 Date/Time Prepared:

			-	Γο 12/31/202	2 Date/Time Prep 5/23/2023 8:09	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		J alli
oost conten beschiptron	REPAI RS	PLANT		(SQUARE FEET		
	(SQUARE FEET)			(040/11/2 / 22/)	SERVED)	
	(SQUARE TEET)	(SQUINE TEET)	LAUNDRY)		J SERVED)	
	6. 00	7. 00	8. 00	9. 00	10.00	
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		o	0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY		o	0	0	0	0 101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM		o	0	0	0	0 102. 00
SPECIAL PURPOSE COST CENTERS						·
105. 00 10500 KIDNEY ACQUISITION		0	0	0	0	0 105. 00
106.00 10600 HEART ACQUISITION		0	0	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION		0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION		0	0	0	0	0 108. 00
109. 00 10900 PANCREAS ACQUISITION		0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION		0	0	0	0	0 110. 00
111.00 11100 ISLET ACQUISITION		o	0	0	0	0 111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		o	0	0	0	0 115. 00
116. 00 11600 HOSPI CE		o	O	o	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	153, 36	5 153, 3	329 494,	913 150	, 559 39, 9	994 118. 00
NONREI MBURSABLE COST CENTERS	_					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 89	8 1, 8	398	0 1	, 898	0 190. 00
191. 00 19100 RESEARCH		0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 70	0 1, 7	700 19,	868 1	, 700	0 192. 00
193.00 19300 NONPALD WORKERS		0	0	0	0	0 193. 00
194. 00 07950 CMH		0	0	0	0 8,0	088 194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	8, 241, 00	7 878, 5	522 583,	744 2, 607	, 258 815, 0	068 202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)		•		•		524 203. 00
204.00 Cost to be allocated (per Wkst. B,	1, 119, 91	2 6, 2	273 44,	191 46	, 062 77, 3	359 204. 00
Part II)	7 40407					
205.00 Unit cost multiplier (Wkst. B, Part	7. 13487	9 0. 0399	0. 085	844 0. 29	8/99 1. 6088	397 205. 00
206.00 NAHE adjustment amount to be allocated	4					206. 00
(per Wkst. B-2)	1					200.00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						207.00
1 1	1	1	1	'	1	1

Health Financial Systems ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086 Period: Worksheet B-1

	ALLOCATION - STATISTICAL BASIS	OT EETENBETH		CCN: 15-0086	Peri od:	Worksheet B-1		
					From 01/01/2022 To 12/31/2022	2 Date/Time Pre		
	Cost Center Description	CAFETERIA N	MAI NTENANCE	NURSI NG	CENTRAL	5/23/2023 8: 0 PHARMACY	<u>15 am</u>	n I
			F PERSONNEL (NUMBER	ADMINISTRATION		(COSTED REQUIS.)		
			HOUSED)	(NURSI NG	(COSTED	REQUIS.)		
		11. 00	12. 00	FTES) 13. 00	REQUIS.) 14.00	15. 00		
	GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	15.00		
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT							1.00
4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT							2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL							5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT							6. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE							8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY							9.00
10. 00 11. 00		318						10. 00 11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	ol		o				12. 00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	ଅ		0	143	0		13. 00 14. 00
15.00	01500 PHARMACY	ol		o	o o	ŏ	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	4		0	0	0	0	16.00
17. 00 18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0		0	0	0	0	17. 00 18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	ol		o	o	0	0	19. 00
	02000 NURSI NG PROGRAM 02100 L&R SERVI CES-SALARY & FRI NGES APPRVD	U U		0	0	0	0	20. 00 21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	ol	,	o	o	o	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	1]		0	0	0	ᅟ이	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	46		0	33	0] o	30.00
31. 00	03100 INTENSIVE CARE UNIT	21		0	18	0	0	31. 00
32. 00 33. 00	03200 CORONARY CARE UNIT	0		0	0	0	0	32. 00 33. 00
34. 00	ł l	ől	,	o	ŏ	o o	0	34.00
40.00	· · · · · · · · · · · · · · · · · · ·	O		0	o	0	0	40.00
41.00	04100 SUBPROVI DER - I RF 04300 NURSERY	o o		ol	ol	0	0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	ol		0	o	O	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0		0	0	0	0	
	ANCILLARY SERVICE COST CENTERS	-		-1]	1
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	64	1	0	43 0	0	0	
	05200 DELIVERY ROOM & LABOR ROOM	17	1	0	15	0	0	
53.00	05300 ANESTHESI OLOGY	0)	O	o	0	0	53. 00
54. 00 55. 00	l l	27		0	1 0	0	0	54. 00 55. 00
	05600 RADI OI SOTOPE	o		o	ŏ	ŏ	0	
57. 00 58. 00		7		0	o	0	0	57. 00 58. 00
58. 00 59. 00	` '	4		0	2	0	0	59.00
60.00	06000 LABORATORY	25	1	0	o	O	0	60.00
60. 01 61. 00	ł l	0		0	0	0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	ol		О	О	0	0	62. 00
63.00	t t	0		0	o	0	0	63.00
64. 00 65. 00	ł l	11		ol	ol	0	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	22		0	o	O	0	66. 00
67. 00 68. 00	ł l	3		0	0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	5		o	3	ŏ	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0		0	o	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		ol Ol		0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	13		O	o	o	0	73. 00
	07400 RENAL DI ALYSIS 07500 ASC (NON-DI STI NCT PART)	U		0	0	0	0	74. 00 75. 00
	07697 CARDI AC REHABI LI TATI ON	2		0	2	o	0	76. 97
77. 00		0		O	o	0	ᅟ이	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC	0		0	O	0	l ol	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	1	ō	Ö	Ö	0	89. 00
90.00	09000 CLI NI C 09100 EMERGENCY	0 29		0	0 23	0	0	90. 00 91. 00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	۷٦		9	23	U	ا	91.00
	OTHER REIMBURSABLE COST CENTERS		1]	
	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0		0	0	0	0	l.
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	ol		o o	ŏ	ŏ	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	0	97. 00 98. 00
98.00	09850 OTHER RETMBURSABLE COST CENTERS		-			U		<u>98</u> . 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

In Lieu of Form CMS-2552-10

Period: Worksheet B-1
From 01/01/2022
To 12/31/2022 Date/Time Prepared:

				-	To 12/31/202	2 Date/Time Pre 5/23/2023 8:0	
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	JS am
	cost center bescription	(FTES)	OF PERSONNEL	ADMI NI STRATI O		(COSTED	
		(FIES)	(NUMBER	N N	SUPPLY	REQUIS.)	
			HOUSED)	(NURSI NG	(COSTED	REQUIS.)	
			HOUSED)	FTES)	REQUIS.)		
	-	11. 00	12. 00	13. 00	14. 00	15. 00	
99. 00 09900	CWHC	11.00	0	0	0	0	0 99.00
99. 10 09910				0		0	0 99.10
	I &R SERVICES-NOT APPRVD PRGM			0		0	0 100, 00
	HOME HEALTH AGENCY			0		0	0 100.00
	OPIOID TREATMENT PROGRAM		0	0	0	0	0 101.00
	AL PURPOSE COST CENTERS	1	<u> </u>	<u> </u>	<u> </u>	<u> </u>	7
	KIDNEY ACQUISITION		ol	0	O	0	0 105.00
	HEART ACQUISITION		ol .	0	0	0	0 106. 00
	LIVER ACQUISITION			0		0	0 100.00
	LUNG ACQUISITION					0	0 107.00
	PANCREAS ACQUISITION			0		0	0 109. 00
	INTESTINAL ACQUISITION			0		0	0 110, 00
	ISLET ACQUISITION			0		0	0 111.00
	INTEREST EXPENSE			9	٩	o _l	113. 00
	UTILIZATION REVIEW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P.)			0		0	0 115. 00
116. 00 11600				0		0	0 116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	31	Q Q	0	143	Ö	0 118.00
	IMBURSABLE COST CENTERS		<u> </u>	0	140	<u> </u>	7
	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	0	0 190.00
191. 00 19100			o l	0	0	0	0 191. 00
ı	PHYSICIANS' PRIVATE OFFICES			0	0	0	0 192. 00
	NONPALD WORKERS			0	0	0	0 193. 00
194. 00 07950				0	0	0	0 194, 00
200.00	Cross Foot Adjustments		٦		٩	٩	200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	1, 576, 43	9	0 1, 877,	525	0	0 202. 00
202.00	Part I)	1,070,10	1	1,077,	020		0 202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	4, 957. 35534	6 0.0000	000 13, 129. 545	0.00	0000 0.000	0000 203. 00
204.00	Cost to be allocated (per Wkst. B,	60, 71			253	0	0 204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	190. 92138	4 0.0000	379. 391	608 0.00	0000 0.000	0000 205. 00
	[II)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)		1				

Health Financial Systems	ST ELIZABETH DEARBORN	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0086	Pariod: Workshoot R_1

From 01/01/2022 Date/Time Prepared: 12/31/2022 5/23/2023 8: 05 am OTHER GENERAL SERVI CE Cost Center Description MEDI CAL SOCI AL (SPECLFY) NONPHYSI CI AN NURSI NG RECORDS & SERVI CE PROGRAM (TIME SPENT) **ANESTHETISTS** LI BRARY (TIME SPENT) (ASSI GNED (ASSI GNED (ADJUSTED TIME) TIME) CHARGES) 19. 00 16.00 17.00 18. 00 20.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUI P 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5. 00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7 00 00700 OPERATION OF PLANT 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 229, 749, 559 16.00 16.00 01700 SOCIAL SERVICE 8.477 17.00 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18 00 18 00 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 19.00 0 20.00 02000 NURSING PROGRAM 0 0 O 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22 00 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 25, 877, 797 936 0 30.00 03100 INTENSIVE CARE UNIT 14, 375, 975 0 31.00 31.00 546 0 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 0 0 33.00 03300 BURN INTENSIVE CARE UNIT o 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 34.00 04000 SUBPROVIDER - IPF 0 40.00 0 0 40.00 0 04100 SUBPROVIDER - IRF 0 41 00 41.00 0 04300 NURSERY 0 43 00 932, 144 35 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 0 45.00 04500 NURSING FACILITY 0 0 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 57, 590, 806 2, 186 0 0 0 50.00 0 0 05100 RECOVERY ROOM 0 51.00 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 433, 245 130 52.00 53.00 05300 ANESTHESI OLOGY 2, 996, 889 114 00000000 0 0 0 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 21, 520, 510 817 54.00 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 0 05600 RADI OI SOTOPE 0 56.00 0 56.00 57.00 05700 CT SCAN 8, 682, 918 330 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 674, 524 0 58.00 58 00 102 2, 786, 309 59 00 05900 CARDIAC CATHETERIZATION 106 0 59.00 0 60.00 06000 LABORATORY 6, 199, 762 235 0 60.00 0 60.01 06001 BLOOD LABORATORY 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS 0 0 0 63.00 63.00 00000000000 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 12, 528, 247 276 0 0 0 0 65.00 06600 PHYSI CAL THERAPY 6, 337, 649 0 66.00 241 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 805, 328 31 0 68 00 06800 SPEECH PATHOLOGY 510 133 19 68 00 69.00 69.00 06900 ELECTROCARDI OLOGY 0 2, 200, 589 84 70.00 07000 ELECTROENCEPHALOGRAPHY 38,660 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 16, 111, 760 612 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 12, 110, 923 460 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75. 00 07697 CARDIAC REHABILITATION 398, 810 15 0 0 0 76. 97 76.97 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER o 0 0 0 0 89.00 89.00 0 0 90.00 logoool CLI NI C 0 0 90.00 0 1, 201 0 91 00 91 00 09100 EMERGENCY 31, 636, 581 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00

0

0

0

0 96.00

96.00

09600 DURABLE MEDICAL EQUIP-RENTED

Provi der CCN: 15-0086

			10		5/23/2023 8:05	
		OT	HER GENERAL		072072020 0.00	am
			SERVI CE			
Cost Center Description	MEDI CAL	SOCI AL	(SPECIFY) N	ONPHYSI CI AN	NURSI NG	
	RECORDS &	SERVICE (T	TIME SPENT) A	NESTHETI STS	PROGRAM	
	LI BRARY (TIME SPENT)		(ASSI GNED	(ASSI GNED	
	(ADJUSTED			TIME)	TIME)	
	CHARGES)					
	16. 00	17. 00	18. 00	19. 00	20. 00	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	1	-1	0 97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	1	-1	0 98.00
99. 00 09900 CMHC	0	0	C		~	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			0 100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	C			0 101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	C		0	0 102. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	C			0 105. 00
106.00 10600 HEART ACQUISITION	0	0	C		0	0 106. 00
107.00 10700 LIVER ACQUISITION	0	0	C		0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	0	C		0	0 108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	C			0 109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	C		0	0 110. 00
111.00 11100 ISLET ACQUISITION	o	0	C		0	0 111. 00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.))	o	C	ol	0	0 115.00
116. 00 11600 HOSPI CE	l ol	o	C	ol		0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through	h 117) 229, 749, 559	8, 477	C		0	0 118. 00
NONREI MBURSABLE COST CENTERS					•	'
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTI	EEN O	0	C		0	0 190. 00
191. 00 19100 RESEARCH	0	0	C		0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	O	0	C		0	0 192. 00
193.00 19300 NONPALD WORKERS	O	0	C		0	0 193. 00
194. 00 07950 CMH	O	0	C		0	0 194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. I	B, 331, 548	1, 171, 971	C		0	0 202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Pa	art I) 0.001443	138. 253038	0. 000000	0. 00000	0. 00000	0 203. 00
204.00 Cost to be allocated (per Wkst. I	B, 2, 765	31, 870	C		0	0 204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Pa	art 0.000012	3. 759585	0. 000000	0. 00000	0. 00000	0 205. 00
206.00 NAHE adjustment amount to be allo	ocated					0 206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst.	D,				0. 00000	0 207. 00
Parts III and IV)						

ST ELIZABETH DEARBORN

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

						T	Го	12/31/2022 Date/Time Pre 5/23/2023 8:0	
			INTERNS & RE	ESI DENTS					
		Cost Center Description	SERVI CES-SALA SE		P/	PARAMED ED			
			RY & FRINGES R (ASSIGNED	R PRGM COSTS (ASSIGNED	(PRGM (ASSI GNED			
			TIME)	TIME)		TIME)			
	GENER	RAL SERVICE COST CENTERS	21. 00	22. 00		23. 00			
1.00	1	CAP REL COSTS-BLDG & FIXT							1.00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	'					ı	2. 00 4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	'					ı	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	'					ı	6. 00 7. 00
8.00		LAUNDRY & LINEN SERVICE						i	8. 00
9.00	1	HOUSEKEEPI NG						ı	9. 00
10. 00 11. 00	1	D DI ETARY CAFETERI A						ı	10. 00 11. 00
12. 00	01200	MAINTENANCE OF PERSONNEL	'					ı	12. 00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	'					ı	13. 00 14. 00
15. 00		PHARMACY						ı	15. 00
16.00	1	MEDICAL RECORDS & LIBRARY						ı	16.00
17. 00 18. 00		SOCIAL SERVICE OTHER GENERAL SERVICE (SPECIFY)	'					ı	17. 00 18. 00
19. 00	01900	NONPHYSICIAN ANESTHETISTS	'					i	19. 00
20. 00 21. 00	1	NURSING PROGRAM I&R SERVICES-SALARY & FRINGES APPRVD	0					ı	20. 00
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	- 1		0			ı	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY) TENT ROUTINE SERVICE COST CENTERS				1	100		23. 00
30. 00	03000	ADULTS & PEDIATRICS	0	,	0		0		30.00
31. 00 32. 00	1	INTENSIVE CARE UNIT CORONARY CARE UNIT	0		0		0	ı	31. 00 32. 00
32.00	1	BURN INTENSIVE CARE UNIT	0	,	0		0	ı	32.00
34.00	1	SURGICAL INTENSIVE CARE UNIT	0		0		0	ı	34. 00
40. 00 41. 00	1	SUBPROVI DER - I PF SUBPROVI DER - I RF	0		0		0	ı	40. 00 41. 00
43. 00	04300	NURSERY	o	,	0		o	ı	43. 00
44. 00 45. 00		SKILLED NURSING FACILITY NURSING FACILITY	0		0		0	ı	44. 00 45. 00
46. 00	1	OTHER LONG TERM CARE	0		0		0		45.00
50. 00	_	LARY SERVICE COST CENTERS OPERATING ROOM			o		0		50.00
51.00	05100	RECOVERY ROOM	0		0		0	r	50.00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM	0		0		0	i	52.00
53. 00 54. 00		D ANESTHESI OLOGY D RADI OLOGY-DI AGNOSTI C	0	,	0		0	i	53. 00 54. 00
55.00		RADI OLOGY-THERAPEUTI C	0		0		0	ı	55. 00
56. 00 57. 00		RADI OI SOTOPE CT SCAN	0	,	0		0	ı	56. 00 57. 00
58. 00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0		0	ı	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	C		0		0	ı	59. 00 60. 00
60. 01	06001	BLOOD LABORATORY	O O		0		0	ı	60. 01
61. 00 62. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS			0		0	ı	61. 00 62. 00
63. 00	06300	BLOOD STORING, PROCESSING & TRANS.	o o	,	o		o	r	63. 00
64. 00 65. 00	1	INTRAVENOUS THERAPY	0		0		0	ı	64.00
65. 00 66. 00	1	RESPIRATORY THERAPY PHYSICAL THERAPY	0	,	0		0	ı	65. 00 66. 00
67. 00	06700	OCCUPATIONAL THERAPY	0		0		0	i	67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	C		0		0	ı	68. 00 69. 00
70. 00	07000	ELECTROENCEPHALOGRAPHY	o		0		0	ı	70. 00
		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0		0		0	ı	71. 00 72. 00
73. 00	07300	DRUGS CHARGED TO PATIENTS	ō	,	ŏ		100	ı	73. 00
	1	RENAL DIALYSIS ASC (NON-DISTINCT PART)	0'		0		0	ı	74. 00 75. 00
76. 97	07697	CARDIAC REHABILITATION	0	,	0		0	ı	76. 97
77. 00		ALLOGENEIC STEM CELL ACQUISITION	0		0		o		77. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	,	0		0		88. 00
		FEDERALLY QUALIFIED HEALTH CENTER	0		0		0	ı	89. 00
90. 00 91. 00		CLINIC EMERGENCY	0		0		0	ı	90. 00 91. 00
	09200	OBSERVATION BEDS (NON-DISTINCT PART)			\perp		\perp		92. 00
94. 00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS	0	ı	0		0		94. 00
		AMBULANCE SERVICES	0		0		0	i	95. 00
		D DURABLE MEDI CAL EQUI P-RENTED D DURABLE MEDI CAL EQUI P-SOLD	0)	0		0	ı	96. 00 97. 00
		-	_						

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

					То	12/31/2022	Date/Time 5/23/2023	
		INTERNS & F	RESI DENTS				3/23/2023	5. 05 am
	Cost Center Description	SERVI CES-SALA			RAMED ED			
			R PRGM COSTS		PRGM			
		(ASSI GNED	(ASSI GNED	1 `	SSI GNED			
		TIME)	TIME)		TIME)			
98. 00 09850	OTHER REIMBURSABLE COST CENTERS	21.00	22. 00	0 2	23. 00	ol		98. 00
99. 00 09900			ار ا	0		0		99.00
99. 10 09910			ဂါ	0	ì	0		99. 10
	I &R SERVICES-NOT APPRVD PRGM	\perp i	á	n	i	0		100.00
	HOME HEALTH AGENCY	\perp i	റി	ol	i	0		101.00
	OPI OI D TREATMENT PROGRAM	i	ol	o		ol		102. 00
	AL PURPOSE COST CENTERS		1			5		
	KIDNEY ACQUISITION	T (0	0	(0		105. 00
	HEART ACQUISITION	1	o	0	(o		106.00
107. 00 10700	LIVER ACQUISITION	(၁	O	(ol		107. 00
108. 00 10800	LUNG ACQUISITION	(၂	0	(ol		108. 00
109. 00 10900	PANCREAS ACQUISITION	(၂	0	(ol		109. 00
	INTESTINAL ACQUISITION)	0	(ol		110. 00
	ISLET ACQUISITION	(၁ 	0	(0		111. 00
	INTEREST EXPENSE							113. 00
	UTILIZATION REVIEW-SNF							114. 00
	AMBULATORY SURGICAL CENTER (D. P.)		0	0	(0		115. 00
116. 00 11600					(0		116. 00
	SUBTOTALS (SUM OF LINES 1 through 117)		0	0	100	0		118. 00
	MBURSABLE COST CENTERS		-1			_1		1200 00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	(0	0		0		190.00
191. 00 19100		1)	0		0		191. 00
	PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	,	ر ا	O O	(192. 00 193. 00
193.00 19300				0				193.00
200.00	Cross Foot Adjustments		7	۷	•	9		200. 00
	Negative Cost Centers			- 1				200.00
202.00	Cost to be allocated (per Wkst. B,	\perp	0	n	118, 550			201.00
202.00	Part I)	-	1	Ĭ	110,00	3		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 0000	000 1	1, 185. 50000	ol		203. 00
204. 00	Cost to be allocated (per Wkst. B,	l	0	0	6, 14	1		204. 00
	Part II)							
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 0000	000	61. 470000	ol		205. 00
	[11]							
206. 00	NAHE adjustment amount to be allocated	i			(0		206. 00
	(per Wkst. B-2)					_		
207. 00	NAHE unit cost multiplier (Wkst. D,				0. 000000	0		207. 00
	Parts III and IV)		I	1		I		1 1

COMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provi der CC	1	Period: From 01/01/2022 To 12/31/2022	5/23/2023 8:0	epared: 05 am
			Title	XVIII	Hospi tal Costs	PPS	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	erapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PATIENT ROUTINE SERVICE COST CENTERS BOOO ADULTS & PEDIATRICS	12, 530, 795		12, 530,	705	0 12, 530,] 795 30.
	B100 NTENSI VE CARE UNIT	5, 269, 248		5, 269,		0 12, 330, 0 5, 269,	
	3200 CORONARY CARE UNIT	0			0	0	0 32.
	3300 BURN INTENSIVE CARE UNIT 3400 SURGICAL INTENSIVE CARE UNIT	0			0	0	0 33.
	1000 SUBPROVI DER – I PF	0			o	o	0 40.
	1100 SUBPROVI DER – I RF	0			0	0	0 41.
	1300 NURSERY 1400 SKILLED NURSING FACILITY	672, 814		672,	814	0 672,	814 43. 0 44.
45. 00 04	1500 NURSING FACILITY	o o			ő	Ö	0 45.
	1600 OTHER LONG TERM CARE	0			0	0	0 46.
	5000 OPERATING ROOM	17, 414, 038		17, 414,	038	0 17, 414,	038 50.
	5100 RECOVERY ROOM	0		0.04-	0	0	0 51.
	5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY	3, 263, 253 2, 580, 467		3, 263, 2, 580,		0 3, 263, 0 2, 580,	
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	5, 448, 607		5, 448,	607	0 5, 448,	607 54.
	5500 RADI OLOGY-THERAPEUTI C 5600 RADI OI SOTOPE	0			0	0	0 55. 0 56.
	5700 CT SCAN	1, 403, 434		1, 403,	434	0 1, 403,	
	MAGNETIC RESONANCE IMAGING (MRI)	595, 996		595,		0 595,	
	5900 CARDI AC CATHETERI ZATI ON 5000 LABORATORY	1, 210, 339 5, 556, 903		1, 210, 5, 556,		0 1, 210, 0 5, 556,	
60. 01 06	6001 BLOOD LABORATORY	0		, , , , ,	0	0	0 60.
	5100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	0 61.
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 6300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	0 62. 0 63.
64.00 06	5400 INTRAVENOUS THERAPY	0			0	0	0 64.
	5500 RESPI RATORY THERAPY 5600 PHYSI CAL THERAPY	2, 488, 405 3, 844, 525		0 2, 488, 0 3, 844,		0 2, 488, 0 3, 844,	
	5700 OCCUPATIONAL THERAPY	547, 270		0 547,	•	0 547,	
	5800 SPEECH PATHOLOGY	321, 873		0 321,	•	0 321, 0 1,023.	
	5900 ELECTROCARDI OLOGY 7000 ELECTROENCEPHALOGRAPHY	1, 023, 456 11, 753		1, 023, 11,	753	-,,	456 69. 753 70.
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	0 71.
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	6, 981, 522 6, 179, 490		6, 981, 6, 179,		0 6, 981, 0 6, 179,	
74. 00 07	7400 RENAL DIALYSIS	0, 177, 170		0, 1, 7,	0	0	0 74.
	7500 ASC (NON-DISTINCT PART) 7697 CARDIAC REHABILITATION	0		225	0	0 325.	0 75. 184 76.
	7700 ALLOGENEIC STEM CELL ACQUISITION	325, 184 0		325,	0	0 325, 0	0 77.
	TPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC 8900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	0 88. 0 89.
90.00 09	POOO CLI NI C	0			0	0	0 90.
	0100 EMERGENCY 0200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 069, 546 1, 791, 878		7, 069, 1, 791,	•	0 7, 069, 1, 791,	
	HER REIMBURSABLE COST CENTERS	1,771,070		1,771,	070	1,,,,,,] ,
	0400 HOME PROGRAM DIALYSIS 0500 AMBULANCE SERVICES	0			0	0	0 94. 0 95.
	2600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	0 96.
	2700 DURABLE MEDI CAL EQUI P-SOLD	0			0	0	0 97.
98. 00 09 99. 00 09	P850 OTHER REIMBURSABLE COST CENTERS	0			0	0	0 98. 0 99.
99. 10 09	•	o o			ő		0 99.
	0000 I &R SERVI CES-NOT APPRVD PRGM	0			0		0 100.
	0100 HOME HEALTH AGENCY 0200 OPIOID TREATMENT PROGRAM	0			0		0 101. 0 102.
SP	ECIAL PURPOSE COST CENTERS						
	0500 KIDNEY ACQUISITION 0600 HEART ACQUISITION	0			0		0 105. 0 106.
107. 00 10	0700 LIVER ACQUISITION	0			O		0 107.
	0800 LUNG ACQUISITION 0900 PANCREAS ACQUISITION	0			0		0 108. 0 109.
107.0011	1000 INTESTINAL ACQUISITION				o		0 1109.
					0		0 111.
110. 00 11 111. 00 11	1100 SLET ACQUISITION	1					I a
110. 00 11 111. 00 11 113. 00 11	1300 I NTEREST EXPENSE						113. 114
110. 00 11 111. 00 11 113. 00 11 114. 00 11 115. 00 11	300 INTEREST EXPENSE 400 UTILIZATION REVIEW-SNF 500 AMBULATORY SURGICAL CENTER (D.P.)	o			O		114. 0 115.
110. 00 11 111. 00 11 113. 00 11 114. 00 11 115. 00 11 116. 00 11	300 INTEREST EXPENSE 400 UTI LI ZATI ON REVIEW-SNF 500 AMBULATORY SURGI CAL CENTER (D.P.) 600 HOSPI CE	0 0		0, 500	0 0 704	0 04 520	114. 0 115. 0 116.
110. 00 11 111. 00 11 113. 00 11 114. 00 11 115. 00 11	300 INTEREST EXPENSE 400 UTILIZATION REVIEW-SNF 500 AMBULATORY SURGICAL CENTER (D.P.)	0 0 86, 530, 796 1, 791, 878		0 86, 530, 1, 791,	•		114. 0 115.

Health Financial Systems ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 Worksheet C Part I Date/Time Prepared: 5/23/2023 8:05 am COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0086 Peri od: From 01/01/2022 To 12/31/2022 T<u>itle XVIII</u> PPS Hospi tal Charges Total (col. 6 Cost or Other + col. 7) Ratio Cost Center Description Inpati ent Outpati ent TEFRA Inpatient Ratio 6. 00 7. 00 8. 00 9. 00 10.00 | INPATIENT ROUTINE SERVICE COST CENTERS 30.00 | 03000 | ADULTS & PEDIATRICS 22, 964, 034 22, 964, 034 30.00 31.00 03100 INTENSIVE CARE UNIT 14, 375, 975 14, 375, 975 31. 00 32. 00 03200 CORONARY CARE UNIT 32.00 0 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 34.00 0 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 0 40.00 40.00 41.00 0 0 41.00 43.00 04300 NURSERY 932, 144 932, 144 43.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 0 04500 NURSING FACILITY 45.00 45.00 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS 46.00 46.00 50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 0. 302375 0.000000 50.00 18, 899, 887 38, 690, 919 57, 590, 806 0. 000000 0.000000 51.00

05100 RECOVERY ROOM	0	0	0	0. 000000	0. 000000) 51
05200 DELIVERY ROOM & LABOR ROOM	3, 186, 691	246, 554	3, 433, 245	0. 950486	0. 000000	52
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05700 CT SCAN	2, 135, 674	6, 547, 244	8, 682, 918	0. 161632	0. 000000) 57
05800 MAGNETIC RESONANCE IMAGING (MRI)	273, 790	2, 400, 734	2, 674, 524	0. 222842	0.000000) 58
05900 CARDI AC CATHETERI ZATI ON	960, 963	1, 825, 346	2, 786, 309	0. 434388	0. 000000	59
	1					
	0, 127, 722	0, 071, 010	0, 177, 702			
		0	0			
		U	0			
		0	0			
06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0. 000000	0. 000000	63
06400 I NTRAVENOUS THERAPY	O	0	0	0. 000000	0.000000	64
06500 RESPIRATORY THERAPY	10, 808, 720	1, 719, 527	12, 528, 247	0. 198624	0.000000	65
	1 ' '					
	1					
	1					
	1					
06900 ELECTROCARDI OLOGY	635, 161	1, 565, 428	2, 200, 589		0. 000000) 69
07000 ELECTROENCEPHALOGRAPHY	O	38, 660	38, 660	0. 304009	0.000000	70
07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l ol	0	0		0. 000000	71
	1	- 1	-1	1		
	1					
	1	0	O			
07500 ASC (NON-DISTINCT PART)	0	0	0	0. 000000	0. 000000	75
07697 CARDIAC REHABILITATION	418	398, 392	398, 810	0. 815386	0.000000	76
07700 ALLOGENEIC STEM CELL ACQUISITION		0	ol	0. 000000	0. 000000	77
		- 1	-1			1
		0	n			1 88
	1	-	-			
	1	- 1	0			89
	1	-1	O			
09100 EMERGENCY	8, 442, 938	23, 193, 643	31, 636, 581	0. 223461	0. 000000	91
09200 OBSERVATION BEDS (NON-DISTINCT PART)	387, 187	2, 526, 576	2, 913, 763	0. 614970	0.000000	92
OTHER REIMBURSABLE COST CENTERS						
09400 HOME PROGRAM DIALYSIS	0	0	0	0. 000000	0.000000	94
	1	- 1				
		- 1	0			
	1	<u> </u>	0			
		0				
	0	0	0	0. 000000	0. 000000	98
09900 CMHC	0	0	0			99
09910 CORF	o	0	0			99
10000 L&R SERVICES-NOT APPRVD PRGM		0	ol			100
	1	- 1	o o			101
	1	-				
	1 0	0	O			102
			-			
10500 KIDNEY ACQUISITION	0	0	0			105
10600 HEART ACQUISITION	0	0	0			106
	o	o	ol			107
		o o	ام	•		108
						100
	0	o	و			
	1	-	-1			110
11100 SLET ACQUISITION	0	0	0			111
11300 INTEREST EXPENSE						113
						114
		0	ام			115
	1		-			
	1	-1	۰			116
,	101, 584, 135	128, 165, 424	229, 749, 559			200
Less Observation Beds						201
Total (see instructions)	101, 584, 135	128, 165, 424	229, 749, 559			202
				Į.		
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 001TPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CIL NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 07HER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09500 OBSERVATI ON BEDS (NON-DI STI NCT PART) 07HER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 OBSERVATI ON BEDS (NON-DI STI NCT PART) 07HER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 OBSERVATI ON BEDS (NON-DI STI NCT PART) 07HER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09500 AMBULANCE SERVI CES 09500 CMIC 09910 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY 10200 OPI OD TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON 10700 LIVER ACQUI SI TI ON 10700 LIVER ACQUI SI TI ON 10800 LUNG ACQUI SI TI ON 10900 PANCREAS ACQUI SI TI ON 11000 INTESTI NAL ACQUI SI TI ON 11000 INTESTI NAL ACQUI SI TI ON 11000 INTESTI NAL ACQUI SI TI ON 11000 INTERSTI SEXPENSE 11400 UTI LI ZATI ON REVI EW-SNF 11500 AMBULATORY SURGI CAL CENTER (D. P.)	05300 ANESTHESI OLOGY 0642, 534 05500 RADI OLOGY-DI AGNOSTIC 05500 RADI OLOGY-THERAPEUTIC 0 0 05600 RADI OLOGY-THERAPEUTIC 0 0 05700 CT SCAN 2,135,674 05500 RADI OLOGY-THERAPEUTIC 0 0 0 05700 CT SCAN 2,135,674 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 273,790 05900 CARDI AC CATHETERI ZATI ON 960,963 0,960 0	05300 ANESTHESI OLOGY 662, 534 2, 334, 355 05400 ARDIOLOGY-J IAGNOSTIC 3, 912, 724 17, 607, 786 05500 RADI OLOGY-THERAPEUTI C 0 0 05500 RADI OLOGY-THERAPEUTI C 0 0 05700 CT SCAN 2, 135, 674 6, 547, 244 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 273, 790 2, 400, 734 05900 CARDI AC CATHETERI ZATI ON 960, 963 3, 127, 922 3, 071, 840 06001 BLOD LABORATORY 3, 127, 922 3, 071, 840 0 06010 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 06300 BLOOD STORI ING, PROCESSI NG & TRANS. 0 0 0 064001 INTRAVENOUS THERAPY 10, 808, 720 1, 719, 527 066000 PHYSI CAL THERAPY 687, 477 5, 650, 172 06600 SPEECH PATHOLOGY 169, 269 340, 864 06900 ELECTROCARDI OLOGY 169, 269 340, 864 06900 ELECTROCARDI OLOGY 635, 161 1, 565, 428 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS <td< td=""><td> 05300 AMESTHESI OLOGY</td><td> 0.8300 AMESTHESI OLLOGY</td><td> 0.5300 AMESTHESI OLOGY 0.625,34 2, 334,355 2, 996,889 0.61049 0.000000 0.5500 EARD I STOTPE 0 0 0.000000 0.000000 0.5500 CAT STOTPE 0 0 0 0.000000 0.000000 0.5700 CT SCAN 0.00000 0.000000 0.000000 0.5700 CT SCAN 0.00000 0.000000 0.000000 0.5700 CT SCAN 0.00000 0.000000 0.000000 0.5700 CT SCAN 0.00000 0.000000 0.000000 0.000000 0.5900 CARDIAC CATHERIN ZATION 90.0 963 1, 825, 346 2, 786, 309 0.43438 0.000000 0.5900 CARDIAC CATHERIN ZATION 90.0 963 1, 825, 346 2, 786, 309 0.43438 0.000000 0.6000 BLOOD LABORATORY 3, 127, 792 3, 071, 840 0.6199, 762 0.000000 0.000000 0.6000 BLOOD LABORATORY 0 0 0.000000 0.000000 0.6000 BLOOD LABORATORY 0 0 0.000000 0.000000 0.000000 0.6020 MINISTER STANDAR 0.0000000 0.0000000 0.0000000 0.00000000</td></td<>	05300 AMESTHESI OLOGY	0.8300 AMESTHESI OLLOGY	0.5300 AMESTHESI OLOGY 0.625,34 2, 334,355 2, 996,889 0.61049 0.000000 0.5500 EARD I STOTPE 0 0 0.000000 0.000000 0.5500 CAT STOTPE 0 0 0 0.000000 0.000000 0.5700 CT SCAN 0.00000 0.000000 0.000000 0.5700 CT SCAN 0.00000 0.000000 0.000000 0.5700 CT SCAN 0.00000 0.000000 0.000000 0.5700 CT SCAN 0.00000 0.000000 0.000000 0.000000 0.5900 CARDIAC CATHERIN ZATION 90.0 963 1, 825, 346 2, 786, 309 0.43438 0.000000 0.5900 CARDIAC CATHERIN ZATION 90.0 963 1, 825, 346 2, 786, 309 0.43438 0.000000 0.6000 BLOOD LABORATORY 3, 127, 792 3, 071, 840 0.6199, 762 0.000000 0.000000 0.6000 BLOOD LABORATORY 0 0 0.000000 0.000000 0.6000 BLOOD LABORATORY 0 0 0.000000 0.000000 0.000000 0.6020 MINISTER STANDAR 0.0000000 0.0000000 0.0000000 0.00000000

Health Financial Systems
COMPUTATION OF RATIO OF COSTS TO CHARGES ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 Provider CCN: 15-0086 Title XVIII Cost Center Description PPS Inpatient 00 00 00 00 00 00 00 00 00 00 00 00 00

	cost center bescription	Ratio		
		11. 00		
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30. 00	03000 ADULTS & PEDIATRICS			30.00
31. 00	03100 INTENSIVE CARE UNIT			31.00
32. 00	03200 CORONARY CARE UNIT			32.00
33. 00	03300 BURN INTENSIVE CARE UNIT			33. 00
34. 00	03400 SURGI CAL I NTENSI VE CARE UNI T			34.00
40. 00	04000 SUBPROVIDER - I PF			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	04500 NURSING FACILITY			45. 00
46. 00	04600 OTHER LONG TERM CARE			46. 00
40.00				40.00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0. 302375	-	50.00
51. 00	05100 RECOVERY ROOM	0. 000000		51. 00
52. 00	l l			
	05200 DELIVERY ROOM & LABOR ROOM	0. 950486		52. 00
53. 00	05300 ANESTHESI OLOGY	0. 861049		53. 00
54. 00	05400 RADI OLOGY THERAPEUTI C	0. 253182		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0.000000		55. 00
56.00	05600 RADI OI SOTOPE	0.000000		56.00
57. 00	05700 CT SCAN	0. 161632		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 222842		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 434388		59. 00
60.00	06000 LABORATORY	0. 896309		60.00
60. 01	06001 BLOOD LABORATORY	0.000000		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000		64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 198624		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 606617		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 679562		67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 630959		68. 00
69. 00	1	0. 465083		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 304009		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 433318	3	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 510241		73. 00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0.000000		75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 815386		76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000		77. 00
	OUTPATIENT SERVICE COST CENTERS			
88. 00	08800 RURAL HEALTH CLINIC			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89. 00
90.00	09000 CLI NI C	0.000000		90. 00
91.00	09100 EMERGENCY	0. 22346	1	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 614970		92. 00
	OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94. 00
95.00	1 1	0. 000000		95. 00
96.00	· · · · · · · · · · · · · · · · · · ·	0. 000000		96. 00
97. 00	· · · · · · · · · · · · · · · · · · ·	0. 000000		97. 00
98. 00	· ·	0.000000		98. 00
	09900 CMHC			99. 00
	09910 CORF			99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM			100. 00
	10100 HOME HEALTH AGENCY			101. 00
	10200 OPI OI D TREATMENT PROGRAM			102. 00
0	SPECIAL PURPOSE COST CENTERS			1
105 00	10500 KI DNEY ACQUI SI TI ON			105. 00
	10600 HEART ACQUISITION			106. 00
	10700 LIVER ACQUISITION			107. 00
	10800 LUNG ACQUISITION			107.00
	10900 PANCREAS ACQUISITION			109. 00
	11000 NTESTINAL ACQUISITION			110. 00
	11100 ISLET ACQUISITION			111.00
	11300 INTEREST EXPENSE			113. 00
	· ·			114. 00
	11400 UTI LI ZATI ON REVI EW-SNF			
	11500 AMBULATORY SURGI CAL CENTER (D. P.)			115. 00
	11600 HOSPI CE			116. 00
200.00	1 1			200. 00
201.00	•			201. 00
202.00	Total (see instructions)	I		202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES ST ELIZABETH DEARBORN Provi der CCN: 15-0086 Title XIX

Cost Center Description	Total Cost (from Wkst.	Therapy Limit	Total C		Costs RCE sallowance	Total	Costs		
	B, Part I, col. 26)								
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	2. 00	3. 00)	4. 00	5.	00		
30. 00 03000 ADULTS & PEDI ATRI CS	12, 530, 7	95	12	, 530, 795		0	12, 530,	795	30. 00
31.00 03100 INTENSIVE CARE UNIT	5, 269, 2	1		, 269, 248		0	5, 269, 3	248	31. 00
32.00 03200 CORONARY CARE UNIT		O		0		0			32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0		0		0 :	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0		0		0 :	34. 00
40. 00 04000 SUBPROVI DER - 1 PF		0		0		0			40. 00
41. 00 04100 SUBPROVI DER - I RF		0		0		0			41. 00
43. 00 04300 NURSERY	672, 8	14		672, 814		0	672,		43. 00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY		0		0		0			44.00
46.00 04600 OTHER LONG TERM CARE				0		0			45. 00 46. 00
ANCI LLARY SERVI CE COST CENTERS	1	<u> </u>		U		O		٠ ا ١	40.00
50. 00 05000 OPERATING ROOM	17, 414, 0	38	17	, 414, 038		0	17, 414, 0	038	50. 00
51.00 05100 RECOVERY ROOM	, , , , ,	0		0		0			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 263, 2	53	3	, 263, 253		0	3, 263, 3	253 !	52. 00
53. 00 05300 ANESTHESI OLOGY	2, 580, 4	67	2	, 580, 467		0	2, 580,		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 448, 6	07	5,	, 448, 607		0	5, 448,		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0		0		0			55. 00
56. 00 05600 RADI 01 SOTOPE	4 400 4	0		0		0	4 400		56. 00
57. 00 05700 CT SCAN	1, 403, 4 595, 9		1.	, 403, 434		0	1, 403, 4 595, 9		57.00
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 O5900 CARDIAC CATHETERIZATION	1, 210, 3	1	1	595, 996 , 210, 339		0	1, 210,		58. 00 59. 00
60. 00 06000 LABORATORY	5, 556, 9			, 556, 903		0	5, 556,		60.00
60. 01 06001 BLOOD LABORATORY	3, 330, 7	0	3	, 330, 703		0	5, 550,		60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		o		0		o			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		O		0		0			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0		0		0			63. 00
64.00 06400 INTRAVENOUS THERAPY		0		0		0		0 (64. 00
65. 00 06500 RESPI RATORY THERAPY	2, 488, 4	1		, 488, 405		0	2, 488,		65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 844, 5	1	0 3	, 844, 525		0	3, 844,		66. 00
67. 00 06700 OCCUPATIONAL THERAPY	547, 2	1	0	547, 270		0	547,		67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	321, 8	1	0	321, 873		0	321,		68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 023, 4 11, 7			, 023, 456 11, 753		0	1, 023, 4 11,		69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 7	0		11, 733		0	11,		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	6, 981, 5	22	6	, 981, 522		0	6, 981,		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 179, 4	1		, 179, 490		O	6, 179,		73. 00
74.00 07400 RENAL DIALYSIS		0		0		0			74. 00
75.00 07500 ASC (NON-DISTINCT PART)		0		0		0			75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	325, 1			325, 184		0	325,		76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0		0		0		0	77. 00
OUTPATIENT SERVICE COST CENTERS				٥				م ا ہ	00 00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0		0			88. 00 89. 00
90. 00 009000 FEDERALLY QUALIFIED HEALTH CENTER				0		0			90.00
91. 00 09100 EMERGENCY	7, 069, 5	٦	7	, 069, 546		o	7, 069,	- 1	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 791, 8			, 791, 878			1, 791,		
OTHER REIMBURSABLE COST CENTERS				, , , , , , ,					
94.00 09400 HOME PROGRAM DIALYSIS		0		0		0			94. 00
95. 00 09500 AMBULANCE SERVICES		0		0		0			95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		U		0		0			96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 98.00 09850 OTHER REIMBURSABLE COST CENTERS				0		0			97. 00 98. 00
98.00 09850 OTHER RETMBURSABLE COST CENTERS 99.00 09900 CMHC				0		U			98. 00 99. 00
99. 10 09910 CORF				0					99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM		o		0					00.00
101. 00 10100 HOME HEALTH AGENCY		o		o					01. 00
102.00 10200 OPIOLD TREATMENT PROGRAM		0		0					02. 00
SPECIAL PURPOSE COST CENTERS									
105. 00 10500 KI DNEY ACQUI SI TI ON		0		0					05. 00
106. 00 10600 HEART ACQUISITION		0		0					06. 00
107. 00 10700 LI VER ACQUI SI TI ON		0		0					07. 00
108. 00 10800 LUNG ACQUISITION 109. 00 10900 PANCREAS ACQUISITION				0					08. 00 09. 00
110. 00 11000 NTESTINAL ACQUISITION				ار					10. 00
111. 00 11100 I SLET ACQUISITION		ŏ		n					11. 00
113. 00 11300 INTEREST EXPENSE	1	-		J					13. 00
114. 00 11400 UTILIZATION REVIEW-SNF									14. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		O		О					15. 00
116. 00 11600 HOSPI CE		0		0					16. 00
200.00 Subtotal (see instructions)	86, 530, 7			, 530, 796		0	86, 530,		
201.00 Less Observation Beds	1, 791, 8	1		, 791, 878			1, 791, 8		
202.00 Total (see instructions)	84, 738, 9	ا۵	0 84	, 738, 918		0	84, 738,	918 20	u2. U0

MCRI F32 - 19. 1. 175. 2

Health Financial Systems In Lieu of Form CMS-2552-10 ST ELIZABETH DEARBORN COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: From 01/01/2022 Worksheet C Provi der CCN: 15-0086 Part I
Date/Time Prepared: 12/31/2022 5/23/2023 8:05 am Title XIX Hospi tal Cost Charges TEFRA Cost Center Description Inpatient Outpati ent Total (col. 6 Cost or Other Inpati ent + col . 7) Ratio Ratio 6. 00 7. 00 8. 00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 22, 964, 034 22, 964, 034 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 14, 375, 975 14, 375, 975 03200 CORONARY CARE UNIT 32 00 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 34 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 40.00 04000 SUBPROVIDER - IPF 0 0 41.00 04100 SUBPROVI DER - I RF 0 04300 NURSERY 43.00 932, 144 932, 144 44.00 04400 SKILLED NURSING FACILITY 0 0 04500 NURSING FACILITY 45 00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 18, 899, 887 38, 690, 919 57, 590, 806 0.302375 0.000000 05100 RECOVERY ROOM 0.000000 0.000000 51 00 05200 DELIVERY ROOM & LABOR ROOM 0.950486 0.000000 52.00 3, 186, 691 246, 554 3, 433, 245 2, 996, 889 53.00 05300 ANESTHESI OLOGY 662, 534 2. 334. 355 0.861049 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 912, 724 17, 607, 786 21, 520, 510 0. 253182 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 0 56.00 05600 RADI OI SOTOPE 0.000000 0.000000

30.00 31.00 32 00 33.00 34 00 40.00 41.00 43.00 44.00 45.00 46.00 50.00 51 00 52.00 53 00 54.00 55.00 56.00 57.00 05700 CT SCAN 2, 135, 674 6, 547, 244 8, 682, 918 0. 161632 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 273, 790 2, 400, 734 2, 674, 524 58.00 0. 222842 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 960, 963 1, 825, 346 59.00 2, 786, 309 0.434388 0.000000 59.00 60.00 06000 LABORATORY 3, 127, 922 3, 071, 840 6, 199, 762 0.896309 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0 0.000000 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0.000000 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0.000000 62.00 ol 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0.000000 0.000000 63.00 0 06400 INTRAVENOUS THERAPY 0.000000 64 00 0.000000 64 00 0 06500 RESPIRATORY THERAPY 10, 808, 720 1, 719, 527 12, 528, 247 0.000000 65.00 0.198624 65.00 06600 PHYSI CAL THERAPY 66.00 687, 477 5, 650, 172 6, 337, 649 0.606617 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 292, 713 512, 615 805, 328 0.679562 0.000000 67.00 06800 SPEECH PATHOLOGY 169, 269 340, 864 510, 133 0.630959 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 635, 161 1, 565, 428 2, 200, 589 0.465083 0.000000 69.00 70.00 07000 FLECTROENCEPHALOGRAPHY 38, 660 38,660 0.304009 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 183, 464 12, 928, 296 16, 111, 760 0.433318 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 544, 450 0.000000 73.00 73.00 6, 566, 473 12, 110, 923 0.510241 07400 RENAL DIALYSIS 74.00 0.000000 0.000000 74.00 0 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 0.000000 75.00 0 07697 CARDIAC REHABILITATION 398, 392 398, 810 0.000000 76.97 418 0.815386 76. 97 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 0.000000 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 0 0 0.000000 0.000000 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.000000 0.000000 89.00 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 8, 442, 938 23, 193, 643 31, 636, 581 0. 223461 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.614970 0. 000000 92.00 92.00 387, 187 2, 526, 576 2, 913, 763 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0. 0000000 94.00 0.000000 94.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0.000000 0.000000 95.00 0 0 09600 DURABLE MEDICAL EQUIP-RENTED o 0.000000 96.00 0.000000 96.00 09700 DURABLE MEDICAL EQUIP-SOLD o 0 0 97 00 0.000000 0.000000 97 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 0.000000 0.000000 98.00 99.00 09900 CMHC 99.00 0 0 99.10 09910 CORF 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0. 000000 105. 00 0.000000 106.00 10600 HEART ACQUISITION 0.000000 106.00 0 0 0 0.000000 o 0 0 107.00 10700 LIVER ACQUISITION 0.000000 0. 000000 107. 00 0 0 108. 00 10800 LUNG ACQUISITION 0 0.000000 0. 000000 108. 00 109. 00 10900 PANCREAS ACQUISITION o 0 0.000000 0.000000 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0. 000000 110. 00 0 0.000000 111.00 11100 ISLET ACQUISITION 0 0 0. 000000 111. 00 0 000000 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 115. 00 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 101, 584, 135 200.00 128, 165, 424 229, 749, 559 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 101, 584, 135 128, 165, 424 229, 749, 559 202.00

MCRI F32 - 19. 1. 175. 2

Health Financial Systems
COMPUTATION OF RATIO OF COSTS TO CHARGES ST ELIZABETH DEARBORN In Lieu of Form CMS-2552-10 Provi der CCN: 15-0086 Title XIX Cost Center Description PPS Inpatient 0. 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 3. 00

	Cost Center Description	PPS Inpatient	
		Ratio	
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00	
30. 00	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		30.00
31. 00	· ·		31.00
32. 00	ł		32. 00
33.00			33. 00
34.00			34. 00
40.00	· ·		40.00
41. 00	1		41.00
43. 00 44. 00	ł		43. 00 44. 00
44.00	1		45.00
46. 00	· · · · · · · · · · · · · · · · · · ·		46. 00
10. 50	ANCI LLARY SERVI CE COST CENTERS		10.00
50.00		0.000000	50.00
51.00		0. 000000	51. 00
52.00	1	0. 000000	52. 00
53. 00	1	0. 000000	53. 00
54.00	ł	0.000000	54.00
55. 00	· ·	0.000000	55. 00
56. 00 57. 00	· ·	0. 000000 0. 000000	56. 00 57. 00
58. 00		0.000000	58.00
59. 00		0.000000	59.00
60. 00	i i	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0.000000	60. 01
61. 00	ł	0. 000000	61. 00
62. 00			62. 00
63. 00	· · · · · · · · · · · · · · · · · · ·	0. 000000	63. 00
64.00	1	0.000000	64.00
65. 00	ł	0.000000	65. 00
66. 00		0.000000	66.00
67. 00 68. 00	· ·	0. 000000 0. 000000	67. 00 68. 00
69. 00	1	0.000000	69.00
70. 00	· · · · · · · · · · · · · · · · · · ·	0.000000	70.00
71. 00	1	0.000000	71.00
72. 00	· ·	0. 000000	72. 00
73. 00		0. 000000	73. 00
74. 00		0. 000000	74. 00
75. 00	1 1	0.000000	75. 00
76. 97	1	0.000000	76. 97
77. 00	07700 ALLOGENEI C STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0.000000	77. 00
88. 00		0.000000	88. 00
89. 00		0.000000	89. 00
90. 00		0.000000	90.00
91. 00	ł	0.000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS		
94. 00	i i	0.000000	94.00
95. 00	1	0.000000	95.00
96. 00 97. 00		0.000000	96.00
98.00		0.000000	97. 00 98. 00
99. 00		0.00000	99.00
	09910 CORF		99. 10
	0 10000 I &R SERVICES-NOT APPRVD PRGM		100.00
	0 10100 HOME HEALTH AGENCY		101. 00
102.00	O 10200 OPIOID TREATMENT PROGRAM		102. 00
	SPECIAL PURPOSE COST CENTERS		
	0 10500 KIDNEY ACQUISITION		105. 00
	0 10600 HEART ACQUISITION		106. 00
	0 10700 LIVER ACQUISITION 0 10800 LUNG ACQUISITION		107. 00 108. 00
	0 10900 PANCREAS ACQUISITION		108.00
	0 11000 INTESTINAL ACQUISITION		110.00
	0 11100 I SLET ACQUISITION		111. 00
	0 11300 I NTEREST EXPENSE	l l	113. 00
	0 11400 UTI LI ZATI ON REVI EW-SNF		114. 00
	0 11500 AMBULATORY SURGICAL CENTER (D. P.)		115. 00
	0 11600 H0SPI CE		116. 00
200.00			200. 00
201.00			201. 00
202.00	0 Total (see instructions)	[2	202. 00

MCRI F32 - 19. 1. 175. 2

Health Financial Systems	ST ELIZABETI	H DEARBORN		In Lie	u of Form CMS-2	2552-	10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS			Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 8:0		
			XVIII	Hospi tal	PPS		
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 /		
	(from Wkst.	Adj d3 tillott	Related Cost		col . 4)		
	B, Part II,		(col . 1 -		601. 1)		
	col. 26)		col. 2)				
	1. 00	2. 00	3. 00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	870, 1	34	0 870	, 134 12,	154 71	. 59	30.00
31.00 INTENSIVE CARE UNIT	181, 4	43	181	, 443 1,	820 99	. 69	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 SUBPROVI DER - I PF		0	0	0			40.00
41. 00 SUBPROVI DER – I RF	44.5	0	0	0			41.00
43.00 NURSERY 44.00 SKILLED NURSING FACILITY	11, 5	0	11			- 1	43. 00 44. 00
44.00 SKILLED NORSING FACILITY 45.00 NURSING FACILITY				0			45.00
200.00 Total (lines 30 through 199)	1, 063, 1	33	1, 063	, 133 14,			200.00
Cost Center Description	Inpati ent	Inpatient	1,003	, 155 14,	777	-	.00. 00
out contain baseli per an	Program days	Program					
		Capital Cost					
		(col. 5 x					
		col. 6)					
	6. 00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						١,	
30. 00 ADULTS & PEDIATRICS	4, 3						30.00
31. 00 INTENSIVE CARE UNIT	5'	98 59, <i>6</i>	l l				31.00
32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT		0	0				32. 00 33. 00
33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT		0					34. 00
40. 00 SUBPROVI DER - I PF							40. 00
41. 00 SUBPROVI DER – I RF		0	0				41. 00
43. 00 NURSERY		ō	o				43. 00
44.00 SKILLED NURSING FACILITY		o	О				44. 00
45.00 NURSING FACILITY		0	О				45.00

APP0RT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der	CCN	F	Period: From 0° To 12	1/01/2022 2/31/2022			od:
					'	10 12	2/31/2022	Date/Time P 5/23/2023 8	гераг : 05-а	ea: m
			Ti t	le X	(VIII	Hos	pi tal	PPS		····
	Cost Center Description	Capi tal	Total Charge	es Ra	atio of Cost	Inp	atient	Capital Cost	s	
		Related Cost	(from Wkst.		to Charges	Pr	ogram	(column 3 x	:	
		(from Wkst.	C, Part I,		(col. 1 ÷	Ch	arges	column 4)		
		B, Part II,	col. 8)		col. 2)					
		col . 26) 1.00	2. 00	+	3. 00		4. 00	5. 00	+	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00		3.00	1 .	+. 00	5.00		
50. 00	05000 OPERATING ROOM	832, 5	71 57, 590	. 806	0. 014	457	3, 153, 7	700 4	 5, 593	50.00
51. 00	05100 RECOVERY ROOM		0	0	l .		-, ,	0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	201, 3	44 3, 433	, 245	II.		380, 5	578 2	2, 319	52. 00
53.00	05300 ANESTHESI OLOGY	16, 8	97 2, 996	, 889	0.005	638	198, 1	193	1, 117	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	357, 4	55 21, 520	, 510	0. 016	610	1, 523, 4	484 2	5, 305	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C		0	0				0	0	
56. 00	05600 RADI OI SOTOPE		0	0				0	0	
57. 00	05700 CT SCAN	14, 9					677,		1, 165	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	19, 9					94,		708	
59.00	05900 CARDI AC CATHETERI ZATI ON	30, 0					416,		4, 499	
60. 00 60. 01	O6000 LABORATORY O6001 BLOOD LABORATORY	232, 1	51 6, 199 0	, 762 0			1, 705, 1	0	3, 848 0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		٩	U	0. 000	000		٥	U	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		o	0	0. 000	1000		o	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0	0	l .			0	0	
64. 00	06400 I NTRAVENOUS THERAPY		0	0	l .			0	0	
65. 00	06500 RESPI RATORY THERAPY	52, 1	47 12, 528	-	II.		3, 981, 1	139 1	6, 570	
66. 00	06600 PHYSI CAL THERAPY	213, 3					303,		0, 206	
67. 00	06700 OCCUPATI ONAL THERAPY	18, 3		, 328			123,		2, 826	
68. 00	06800 SPEECH PATHOLOGY	10, 0		, 133		663	77,	971	1, 533	68.00
69. 00	06900 ELECTROCARDI OLOGY	66, 7	53 2, 200	, 589	0. 030	334	218, 3	359	6, 624	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY		78 38	, 660	0. 002	018		0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0				0	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	46, 6					1, 293, 3		3, 742	
73. 00	07300 DRUGS CHARGED TO PATIENTS	235, 2	1				1, 836, 3		5, 675	
74.00	07400 RENAL DIALYSIS		0	0				0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	2.0	0	010				0	0	
76. 97 77. 00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	3, 0	40 398 0	, 810 0				0	0	
77.00	OUTPATIENT SERVICE COST CENTERS		Ч	- 0	<u>)</u> 0.000	000		U _I	¬ '	//. 00
88. 00	08800 RURAL HEALTH CLINIC		ol	0	0.000	nnnl		ol		88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		o	0				Ö	0	
90.00	09000 CLINIC		o	0	lt.			Ö	0	
91. 00	09100 EMERGENCY	243, 8	47 31, 636		I I		2, 327, 6	615 1	7, 941	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	124, 4					139, 3		5, 949	
	OTHER REIMBURSABLE COST CENTERS									
94. 00	09400 HOME PROGRAM DIALYSIS		0	0	0.000	000		0	0	
95. 00	09500 AMBULANCE SERVICES									95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0	0				0	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0	0				0	0	
98. 00	O9850 OTHER REIMBURSABLE COST CENTERS Total (lines 50 through 199)	2, 719, 3	0 76 191, 477	0		000	18, 450, 7	0	0	98. 00 200. 00
200.00										

Health Financial Systems	ST ELIZABETH	DEARBORN		In Lie	u of Form CMS-:	2552-1	0
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F			CCN: 15-0086	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part III	epared	
		Title	e XVIII	Hospi tal	PPS		_
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursi ng Program		h Allied Health n Cost	All Other Medical Education Cost		
	1A	1. 00	2A	2. 00	3. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							_
30. 00			0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 3 0 3 0 3 0 4 0 4	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00
200.00 Total (lines 30 through 199)		1	o	0	0		0.00
Cost Center Description	Swing-Bed Adjustment (Amount (see instructions)	Total Costs sum of cols. 1 through 3, ninus col. 4)	Total Patier Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	0 20	. 00
INDATI ENT DOUTING CEDIUSE COCT CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00		
INPATIENT ROUTINE SERVICE COST CENTERS	()		0 1 0 0 0 0 0 0 0 0	, 820 0 0 0 0 0 0 0 0 0 0 0 523 0 0 0	. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	598 3 0 3 0 3 0 4 0 4 0 4	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 44. 00 45. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00						
INPATIENT ROUTINE SERVICE COST CENTERS							-
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 33.00 03400 SURGI CAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVI DER - IPF 41.00 04100 SUBPROVI DER - IRF 43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY 200.00 Total (lines 30 through 199)						3 3 3 4 4 4 4 4	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 44. 00 45. 00 60. 00

Health Financial Systems	ST ELIZABETH D	EARBORN	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER	Provi der CCN: 15-0086	Peri od:	Worksheet D

From 01/01/2022 Part IV
To 12/31/2022 Date/Time Prepared:
5/23/2023 8:05 am PASS THROUGH COSTS

				10 127 017 2022	5/23/2023 8: 05			
			Titl€	e XVIII	Hospi tal	PPS		_
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health		
		Anesthetist	Program	Program	Post-Stepdown			4
		Cost	Post-Stepdown		Adjustments			
			Adjustments					
		1. 00	2A	2. 00	3A	3. 00		
	ANCILLARY SERVICE COST CENTERS	_	-1			_	اء	
50.00	05000 OPERATING ROOM		0	0	0	0	-	50.00
51. 00	05100 RECOVERY ROOM	l	0	0	0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	'	기	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	· '	기	0	0	0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	_	기	0	0	0	0	55. 00
56.00	05600 RADI 0I SOTOPE	·	၁	0	0	0	0	56. 00
57.00	05700 CT SCAN	-	ာ	0	0	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	- [၁	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1	ာ	0	0	0	0	59.00
60.00	06000 LABORATORY	,	ડ	o	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	1	၁ <mark> </mark>	o	o	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1	əl	o	o	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		ol	o	ol	O	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY		ol	ol	ol	Ö	0	64. 00
65. 00	06500 RESPIRATORY THERAPY		ól	ol	ōl	ol	ol	65. 00
66. 00	06600 PHYSI CAL THERAPY		ól	ol	ol	o	ō	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		ń	o	ol	0	ol	67. 00
68. 00	06800 SPEECH PATHOLOGY		ól	n n	ol .	o	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY		ó	0		0	ŏ	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	,				0	٥	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	,		0		0	0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	,				0	٧١	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	,	۵			0 118, 5		72.00
		,				0 118, 3		
74.00	07400 RENAL DIALYSIS	'	ر ا	0	OJ	-		74.00
75. 00	07500 ASC (NON-DISTINCT PART)	'	ي ا	٧	U O	0		75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON		0 0	0	0	0		76. 97
77. 00	O7700 ALLOGENEIC STEM CELL ACQUISITION)	0	0	0	0	77. 00
20.00	OUTPATIENT SERVICE COST CENTERS	_					ام	20 00
88. 00	08800 RURAL HEALTH CLINIC	1	0	0	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	- 1	89. 00
90.00	09000 CLI NI C		0	0	0	0		90.00
91. 00	09100 EMERGENCY		0	0	0	0		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0		0	92. 00
	OTHER REIMBURSABLE COST CENTERS						- 1	
94. 00	09400 HOME PROGRAM DI ALYSI S	-	0	0	0	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES							95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	'	기	0	0	0	0	96. 00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	-	기	0	0	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	-	기	0	0	0		98. 00
200.00	Total (lines 50 through 199)		0	0	0	0 118, 5	550 2	200. 00

Health Financial Systems	ST ELIZABETH D	EARBORN	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER	Provi der CCN: 15-0086	Peri od:	Worksheet D
PASS THROUGH COSTS			From 01/01/2022	Part IV

PASS I	HROUGH COSTS			Í				12/31/2022	2 Dat	te/Time Prepare	ed:
									5/2	23/2023 8:05 ar	<u>m</u>
			-		e XVII			ospi tal	<u> </u>	PPS	_
	Cost Center Description	All Other		otal Cost		Total		al Charges			
		Medi cal	1 `	um of cols.		tpati ent		rom Wkst.		Charges	
		Educati on	1,	2, 3, and		t (sum of		Part I,	١ ،	col . 5 ÷	
		Cost		4)		s. 2, 3,	(col. 8)	C	col . 7)	
					a	and 4)			ino	(see	
		4. 00		5. 00		6. 00	\vdash	7. 00	Inst	tructions) 8.00	
	ANCI LLARY SERVI CE COST CENTERS	4.00	Н	5.00	4	6.00	\vdash	7.00	4	8.00	
	05000 OPERATING ROOM	T	O		0		0	57, 590, 8	806	0. 000000	1 50 00
	05100 RECOVERY ROOM		0		0		ol	0,,0,0,	0	0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM		0		0		0	3, 433, 2	245	0. 000000	
53. 00	05300 ANESTHESI OLOGY		ol		o		ol	2, 996, 8		0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C		0		o		0	21, 520, !	1	0. 000000	
	05500 RADI OLOGY-THERAPEUTI C		0		o		0	2., 52.,	0	0. 000000	
	05600 RADI OI SOTOPE		0		o		0		0	0. 000000	
	05700 CT SCAN		ol		ol		ol	8, 682,		0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		ol		ol		ol	2, 674, !		0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		ol		0	2, 786, 3		0. 000000	
	06000 LABORATORY		0		0		0	6, 199,		0. 000000	
60. 01	06001 BL00D LABORATORY		ol		ő		ol	0, 1,,,	0	0. 000000	l I
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				Ĭ		Ĭ			0. 000000	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0		٥		0	0. 000000	l l
	06300 BLOOD STORING, PROCESSING & TRANS.		0		0		0		0	0. 000000	I I
64. 00	06400 I NTRAVENOUS THERAPY						0		0	0. 000000	•
	06500 RESPIRATORY THERAPY						0	12, 528, 2	247	0. 000000	
	06600 PHYSI CAL THERAPY		0		0		0	6, 337, 6		0. 000000	II.
67. 00	06700 OCCUPATI ONAL THERAPY						0	805,	1	0. 000000	
	06800 SPEECH PATHOLOGY		0		0		0	510, °	1	0. 000000	I I
	06900 ELECTROCARDI OLOGY							2, 200, !	1	0. 000000	II.
	07000 ELECTROCARDI OLOGI						0		660	0. 000000	I I
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0				0	30, 1	000	0. 000000	I I
	07200 I MPL. DEV. CHARGED TO PATIENTS		0				0	16, 111,	760	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS			118, 5	-50	118, 5	E 5 0	10, 111,	1	0. 000000	
	07400 RENAL DIALYSIS			110, 5	120	110, 3	220	12, 110,	923	0. 000000	
	i i						0		0	0. 000000	II.
	07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION		0					398, 8		0. 000000	l l
			0		0		0	370, 1			
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		<u>U</u>		U		U		0	0. 000000	17.00
99 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	1	ol		0		O			0. 000000	.1 00 00
	1						0		0		
	08900 FEDERALLY QUALIFIED HEALTH CENTER						0		0	0.000000	
	09000 CLINIC		U				0	21 424	L01	0. 000000	II.
	09100 EMERGENCY		U				U	31, 636, !		0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				0 _	2, 913,	763	0. 000000	92.00
24.00	OTHER REIMBURSABLE COST CENTERS	1								2 220000	1 24 00
	09400 HOME PROGRAM DIALYSIS		0		0		U		U	0. 000000	
	09500 AMBULANCE SERVICES									0.000000	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED		U		O		U		U	0.000000	l l
	09700 DURABLE MEDI CAL EQUI P-SOLD		0		0		0		Ü	0. 000000	1
	09850 OTHER REIMBURSABLE COST CENTERS		0		0		0	404 477	0	0. 000000	I I
200.00	Total (lines 50 through 199)		0	118, 5	[50د	118, 5	550	191, 477,	406	•	200. 00

Health Financial Systems	ST ELIZABETH	1 DEARBORN		In Lieu	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY PASS THROUGH COSTS	TENT/OUTPATIENT ANCILLARY SERVICE OTHER			Period: From 01/01/2022 To 12/31/2022		
	Title	: XVIII	Hospi tal	PPS		
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						

		Ratio of Cost	Program	Program	Program	Program		
		to Charges	Charges	Pass-Through	Charges	Pass-Through		
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	7	
		col. 7)		x col. 10)		x col. 12)		
		9. 00	10. 00	11. 00	12. 00	13. 00		
	ANCILLARY SERVICE COST CENTERS							
50. 00	05000 OPERATING ROOM	0. 000000		700	0 8, 149,	331	0	
51. 00	05100 RECOVERY ROOM	0. 000000		0	0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				062	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000		93	0 488,	773	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000		184	0 4, 389,	568	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000		0	0	0	0	55.00
56. 00	05600 RADI OI SOTOPE	0. 000000		0	0	0	0	56.00
57. 00	05700 CT SCAN	0. 000000	0 677, 1	01	0 1, 351,	284	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0 448,	044	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 511,	305	0	59. 00
60.00	06000 LABORATORY	0. 000000	0 1, 705, 1	10	0 640,	261	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	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. 000000	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	0 3, 981, 1	39	0 320,	338	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	0 303, 1	19		774	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0 123, 9	905	0 4,	238	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0 77, 9	771	0	730	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0 218, 3	359	0 332,	166	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0 6,	375	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	0	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			0 3, 532,		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 009789	9 1, 836, 3	360 17, 9	76 900,	632 8	3, 816	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0	0	0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	0	0	0	0	75.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0 153,	630	0	76. 97
77. 00		0. 000000	0	0	0	0	_ 0	77. 00
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC	0. 000000		0	0	0	0	00.00
89. 00	1	0. 000000		0	0	0	0	89. 00
90. 00	09000 CLI NI C	0. 000000		0	0	0	0	90.00
91. 00	09100 EMERGENCY	0. 000000			0 3, 088,		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0 139, 3	315	0 231,	512	_ 이	92.00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0	0	0	0	0	
95. 00								95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	1	0	0	0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	0	0	0	0	97. 00
98. 00		0. 000000	1	0	0	0	0	98. 00
200.00	Total (lines 50 through 199)		18, 450, 7	79 5 17, 9	76 24, 553,	923 8	ا 816,	200. 00

PPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	F Provider C	CN: 15-0086	Period: From 01/01/202 To 12/31/202	2 Pa 2 Da	orksheet D art V ate/Time Pre /23/2023 8:0	pare	ed:
			Title	: XVIII	Hospi tal		PPS		
				Charges			Costs		
	Cost Center Description	Cost to	PPS	Cost	Cost	PF	PS Services		
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(:	see inst.)		
		From	Services (see		Services Not				
		Worksheet C,	inst.)	Subject To	Subject To				
		Part I, col.			. Ded. & Coins.				
		9		(see inst.)	(see inst.)	-			
	ANOLILARY OFRIGE COOT OFFITERS	1. 00	2. 00	3. 00	4. 00		5. 00		
	ANCILLARY SERVICE COST CENTERS	1 00000	I 0 1 10 0] 1	l = a
	05000 OPERATI NG ROOM	0. 3023		l l	0	0			
	05100 RECOVERY ROOM	0. 0000	1	0	0	0	1	0	51.
	05200 DELIVERY ROOM & LABOR ROOM	0. 9504			0	0	1 .,	960	52.
	05300 ANESTHESI OLOGY	0. 8610			0	0			53.
	05400 RADI OLOGY - DI AGNOSTI C	0. 2531		l l	0	0	.,		54.
	05500 RADI OLOGY-THERAPEUTI C	0. 0000		0	0	0		0	55.
	05600 RADI OI SOTOPE	0.0000		0	0	0	1	0	56.
	05700 CT SCAN	0. 1616			1	0	218,		57.
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 2228		l l	0	0			58.
	05900 CARDI AC CATHETERI ZATI ON	0. 4343			0	0			59.
	06000 LABORATORY	0. 8963			0	0			60.
	06001 BLOOD LABORATORY	0. 0000		0	0	0	1	0	60.
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.0000	•		0	0			61.
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.0000		0	0	0	1	0	62.
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 00000		0	0	0		0	63.
	06400 I NTRAVENOUS THERAPY	0. 00000	•	0	0	0		0	64.
	06500 RESPI RATORY THERAPY	0. 1986:		1	0	0	63,	627	65.
	06600 PHYSI CAL THERAPY	0. 6066		ł	0	0	1 .,	683	66.
	06700 OCCUPATI ONAL THERAPY	0. 6795		1	0	0	2,	880	67.
	06800 SPEECH PATHOLOGY	0. 6309	59 7	'30	0	0		461	68.
	06900 ELECTROCARDI OLOGY	0. 4650		66	0	0	154,		69.
	07000 ELECTROENCEPHALOGRAPHY	0. 3040		375	0	0	1,	938	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.0000	00	0	0	0		0	71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 4333			0	0	1, 530,	795	72.
	07300 DRUGS CHARGED TO PATIENTS	0. 5102		32	0 3,	, 570	459,	539	73.
	07400 RENAL DIALYSIS	0. 00000	•	0	0	0		0	74.
	07500 ASC (NON-DISTINCT PART)	0. 00000	00	0	0	0		0	75.
	07697 CARDI AC REHABI LI TATI ON	0. 8153			0	0			76.
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 0000	00	0	0	0)	, 0	77.
	DUTPATIENT SERVICE COST CENTERS] ,	
	08800 RURAL HEALTH CLINIC								88.
	08900 FEDERALLY QUALIFIED HEALTH CENTER								89.
	09000 CLI NI C	0.0000		0	0	0		0	90.
	09100 EMERGENCY	0. 2234			0	0			91.
2. 00 📗	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 6149	70 231, 5	12	0	0	142,	373	92.
	OTHER REIMBURSABLE COST CENTERS]	
	09400 HOME PROGRAM DIALYSIS	0.0000			0	0			94.
	09500 AMBULANCE SERVICES	0.0000			0				95.
	09600 DURABLE MEDICAL EQUIP-RENTED	0.0000		0	0	0		0	96.
	09700 DURABLE MEDICAL EQUIP-SOLD	0.0000	00	0	0	0		0	97.
3. 00	09850 OTHER REIMBURSABLE COST CENTERS	0.0000	00	0	0	0		0	98
00.00	Subtotal (see instructions)		24, 553, 9	23	1 3	, 570	8, 285,	698	200
01. 00	Less PBP Clinic Lab. Services-Program				0	0			201.
	Only Charges								
2.00	Net Charges (line 200 - line 201)	1	24, 553, 9	23	1 3	, 570	8, 285,	698	202

PORTI ON	MENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/23/2023 8:0	
		0 1		XVIII	Hospi tal	PPS	
	Cook Cooks - Books - I - I	Costs					
	Cost Center Description	Services Se Subject To Solution Ded. & Coins. De	Cost Reimbursed Prvices Not Subject To d. & Coins. see inst.) 7.00				
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0		0			5
	100 RECOVERY ROOM	0		0			5
	200 DELIVERY ROOM & LABOR ROOM	0		0			5
	BOO ANESTHESI OLOGY	0		0			5
	400 RADI OLOGY - DI AGNOSTI C	0		0			5
	500 RADI OLOGY-THERAPEUTI C	0		0			5
	600 RADI 0I SOTOPE			0			5
	700 CT SCAN	0		0			5
	BOO MAGNETIC RESONANCE IMAGING (MRI)			0			5
	POO CARDI AC CATHETERI ZATI ON DOO LABORATORY	0		0			5
	001 BLOOD LABORATORY			0			6
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY			٩			ŀ
1	200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0			6
	300 BLOOD STORING, PROCESSING & TRANS.			0			6
	100 INTRAVENOUS THERAPY			0			6
	500 RESPI RATORY THERAPY			0			6
	500 PHYSI CAL THERAPY			0			1 6
	700 OCCUPATI ONAL THERAPY			0			6
	BOO SPEECH PATHOLOGY			0			6
	900 ELECTROCARDI OLOGY			o			6
	DOO ELECTROENCEPHALOGRAPHY			o			7
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS			o			7
	200 IMPL. DEV. CHARGED TO PATIENTS	0		o			7
	BOO DRUGS CHARGED TO PATIENTS	o	1, 8	22			7
	400 RENAL DIALYSIS		, -	0			7
	ASC (NON-DISTINCT PART)	o		0			7
	697 CARDI AC REHABI LI TATI ON	0		0			7
00 077	700 ALLOGENEIC STEM CELL ACQUISITION	0		0			_ 7
OUT	PATIENT SERVICE COST CENTERS						
	BOO RURAL HEALTH CLINIC						8 8
	900 FEDERALLY QUALIFIED HEALTH CENTER						8
	DOO CLI NI C	0		0			9
	100 EMERGENCY	0		0			9
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0			, 9
	IER REI MBURSABLE COST CENTERS			_			
	400 HOME PROGRAM DIALYSIS	0		0			9
	500 AMBULANCE SERVICES	0					9
	500 DURABLE MEDI CAL EQUI P-RENTED	0		0			9
	700 DURABLE MEDI CAL EQUI P-SOLD	0		0			9
	B50 OTHER REIMBURSABLE COST CENTERS	0		0			9
0.00	Subtotal (see instructions)	0	1, 8	22			20
1.00	Less PBP Clinic Lab. Services-Program	0					20
	Only Charges	1		1			

Health Financial Systems	ST ELIZA	ST ELIZABETH DEARBORN In Lie			
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE	COST Provi der CCN: 15-0086	From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared:	

				From 01/01/2022 To 12/31/2022	2 Date/Time Pre		
		Ti +I	le XIX	Hospi tal	5/23/2023 8: 0 Cost	<u>15 am</u>	<u>n</u> '
		11 11	Charges	Hospi tal	Costs		
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services		
Cost Center Description				1 1 1 1			
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed Services Not	(see inst.)		4
	From Worksheet C,	Services (see inst.)	Services Subject To				4
	· ·	Hist.)	1 -	Subject To			4
	Part I, col.		Ded. & Coins.				4
	1.00	2. 00	(see inst.) 3.00	(see inst.) 4.00	5. 00		4
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00		
50. 00 05000 OPERATING ROOM	0. 30237	75	0 203,	125	0	اه	50.00
51. 00 05100 RECOVERY ROOM	0. 00000		0 203,	0	o	0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 95048	•		, 003	0	0	
53. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 95048	1		, 003 , 529	0	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 25318	1	· ·	, 886	o	0	
55. 00 05500 RADI OLOGY - DI AGNOSTI C	0. 25318	1	0 99,	, 886	0	0	
56. 00 05600 RADI 01 SOTOPE	0.00000	1	0	0	0	0	
57. 00 05700 CT SCAN	0. 00000	1	-1	, 508	0	0	
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 16163		, , ,	, 508 , 370	0	0	
59. 00 05900 MAGNETTC RESUNANCE TMAGING (MRT) 59. 00 05900 CARDIAC CATHETERIZATION	0. 22282	1		, 370 , 916	0	0	
60. 00 06000 LABORATORY	•	1			0	0	
	0. 89630			, 420			
60. 01 06001 BLOOD LABORATORY	0.00000		0	0	0	0	60. 01
61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY	0.00000	1	_	0	0	١	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.00000	1	0	0	0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.00000		0	0	0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0.00000	1	0	0	0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 19862	1		, 630	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 60661	1		, 553	0	0	
67. 00 06700 OCCUPATIONAL THERAPY	0. 67956	•	· ·	, 131	0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 63095			, 541	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 46508	1		, 943	0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 30400	1	0	0	0	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENTS	0.00000	1	0	0	0	0	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 43331	1	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 51024		0 10,	, 285	0	0	
74. 00 07400 RENAL DI ALYSI S	0.00000	•	0	0	0	0	
75. 00 07500 ASC (NON-DISTINCT PART)	0.00000	•	0	0	0	0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 81538	1	0	0	0	0	
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0.00000)0	0	0	0	_ 이	77. 00
OUTPATIENT SERVICE COST CENTERS						1.	1 -2 20
88. 00 08800 RURAL HEALTH CLINIC						- 1	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	2 0000						89. 00
90. 00 09000 CLI NI C	0.00000		0	이	0	0	
91. 00 09100 EMERGENCY	0. 22346	1	0 662,	· I	0	0	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 61497	10	0	0	0	_ 이	92. 00
OTHER REIMBURSABLE COST CENTERS							
94.00 09400 HOME PROGRAM DIALYSIS	0. 00000			0	0	1	94. 00
95. 00 09500 AMBULANCE SERVICES	0. 00000	1	0	0		- 1	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 00000	•	0	0	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 00000	1	o	0	0	0	1 , , , , , ,
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0.00000	00	0	0	0	0	
200.00 Subtotal (see instructions)			0 1, 222,	527	0		200. 00
201.00 Less PBP Clinic Lab. Services-Program				0	0	ľ	201. 00
Only Charges						- 1	1
202.00 Net Charges (line 200 - line 201)			0 1, 222,	527	0	01	202. 00

Ith Financial Systems ORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	ST ELIZABETH D	Provi der CCN: 15-0086	Peri od:	of Form CMS-2552-1 Worksheet D
5 6	7.1.5 77.001.112 000.		From 01/01/2022	Part V Date/Time Prepared
		T: +I - VI V	11: +-1	5/23/2023 8: 05 am
	Costs	Title XIX	Hospi tal	Cost
Cost Center Description	Cost	Cost		
p		Rei mbursed		
	Servi ces Se	ervices Not		
		Subject To		
	Ded. & Coins. De			
	(see inst.) (6.00	see inst.) 7.00		
ANCILLARY SERVICE COST CENTERS	0.00	7.00		
00 05000 OPERATING ROOM	61, 423	0		
00 05100 RECOVERY ROOM	0	O		5
00 05200 DELIVERY ROOM & LABOR ROOM	1, 904	О		5
00 05300 ANESTHESI OLOGY	8, 205	O		5
00 05400 RADI OLOGY-DI AGNOSTI C	25, 289	0		5
00 05500 RADI OLOGY - THERAPEUTI C	0	0		5
00 05600 RADI 01 SOTOPE	0	0		5
00 05700 CT SCAN 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	11, 396	0		5
00 05800 MAGNETIC RESONANCE I MAGING (MRI) 00 05900 CARDIAC CATHETERIZATION	1, 420 11, 258	0		5
00 06000 LABORATORY	62, 222	0		
01 06001 BLOOD LABORATORY	02, 222	0		6
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		3		6
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	i o	O		6
00 06300 BLOOD STORING, PROCESSING & TRANS.	O	0		6
00 06400 I NTRAVENOUS THERAPY	0	О		6
00 06500 RESPI RATORY THERAPY	2, 111	0		6
00 06600 PHYSI CAL THERAPY	10, 648	0		6
00 06700 OCCUPATI ONAL THERAPY	6, 205	0		6
00 06800 SPEECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY	5, 389	0		6
00 06900 ELECTROCARDI OLOGY 00 07000 ELECTROENCEPHALOGRAPHY	7, 880	0		$\frac{\epsilon}{7}$
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0		7
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0		1 7
00 07300 DRUGS CHARGED TO PATIENTS	5, 248	O		+
00 07400 RENAL DIALYSIS	0	О		7
00 07500 ASC (NON-DISTINCT PART)	0	0		7
97 07697 CARDI AC REHABI LI TATI ON	0	0		7
00 07700 ALLOGENEI C STEM CELL ACQUISITION	0	0		7
OUTPATIENT SERVICE COST CENTERS				
00 08800 RURAL HEALTH CLINIC 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				8 8
00 09000 CLINIC		0		9
00 09100 EMERGENCY	148, 082	0		9
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	140, 002	0		ģ
OTHER REIMBURSABLE COST CENTERS				
00 09400 HOME PROGRAM DIALYSIS	0	0		
00 09500 AMBULANCE SERVICES	0			ç
00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		9
00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		9
00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		9
Subtotal (see instructions)	368, 680	0		20
.00 Less PBP Clinic Lab. Services-Progra	m O			20
Only Charges Net Charges (line 200 - line 201)	368, 680	O		20

	Financial Systems ST ELIZABETH [ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0086	Peri od:	of Form CMS-2552 Worksheet D-1	
			From 01/01/2022 To 12/31/2022	Date/Time Prepar	
		Title XVIII	Hospi tal	5/23/2023 8: 05 a	<u>am</u>
	Cost Center Description	THE ATTE	nospi tai		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
- 4	I NPATI ENT DAYS			10.454	
	Inpatient days (including private room days and swing-bed d Inpatient days (including private room days, excluding swin			12, 154 12, 154	
	Private room days (excluding swing-bed and observation bed			· ·	
,	do not complete this line.	aayey: yea nave en y	private reem day		`
	Semi-private room days (excluding swing-bed and observation			10, 416	
00	Total swing-bed SNF type inpatient days (including private reporting period	room days) through Dece	mber 31 of the co	st 0) !
00	Total swing-bed SNF type inpatient days (including private	room days) after Decemb	er 31 of the cost	0	, (
, ,	reporting period (if calendar year, enter 0 on this line)	. com dayo, a. to. booms	0. 0. 0. 1.0 0001		
00	Total swing-bed NF type inpatient days (including private r	room days) through Decem	ber 31 of the cos	t 0) 7
,	reporting period	seem days) often Decembe	r 21 of the cost	0	
00	Total swing-bed NF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	oom days) after becembe	i si di the cost	0) 8
00	Total inpatient days including private room days applicable	e to the Program (exclud	ing swing-bed and	4, 333	3 (
	newborn days) (see instructions)	-			
00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instr		e room days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII		e room days) afte	r 0	1
	December 31 of the cost reporting period (if calendar year,	enter 0 on this line)			
00	Swing-bed NF type inpatient days applicable to titles V or	XIX only (including pri	vate room days)	0	1:
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or	XIX only (including pri	vate room days)	0	1:
	after December 31 of the cost reporting period (if calendar				1 "
	Medically necessary private room days applicable to the Pro			0	
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0) 1
4	Medicare rate for swing-bed SNF services applicable to serv	vices through December 3	1 of the cost	0.00) 1
	reporting period	J			
00	Medicare rate for swing-bed SNF services applicable to serv	vices after December 31	of the cost	0.00) 1
00	reporting period Medicaid rate for swing-bed NF services applicable to servi	ces through December 31	of the cost	0.00) 10
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to servi	ces after December 31 o	f the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructi	ons)		12, 530, 795	5 2
	Swing-bed cost applicable to SNF type services through Dece	•	orting period (li		1
	5 x line 17)	·			
. 00	Swing-bed cost applicable to SNF type services after Decemb	per 31 of the cost repor	ting period (line	6 0	2
. 00	x line 18) Swing-bed cost applicable to NF type services through Decem	nher 31 of the cost rand	rting period (lin	e 0	2
	7 x line 19)	inoci or or the cost repo	ing periou (III		` ~
. 00	Swing-bed cost applicable to NF type services after Decembe	er 31 of the cost report	ing period (line	8 0	2!
00	X line 20)				, ,
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cos	st (line 21 minus line 2	6)	12, 530, 795	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(1.110 21 minus 11116 2	-,	12, 550, 175	1 -
00	General inpatient routine service charges (excluding swing-	-bed and observation bed	charges)	0	
	Pri vate room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2	27 - line 281		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00000	1
00	Average semi-private room per diem charge (line 30 ÷ line 4			0.00	3
	Average per diem private room charge differential (line 32		ructi ons)	0.00	1
	Average per diem private room cost differential (line 34 x Private room cost differential adjustment (line 3 x line 35			0.00	1
	General inpatient routine service cost net of swing-bed cos		differential (li		
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				•
4	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AI			4 004 33	م ا م
	Adjusted general inpatient routine service cost per diem (s Program general inpatient routine service cost (line 9 x li	•		1, 031. 00 4, 467, 323	1
	frogram general impatrent routine service cost (ille 9 x II	•	_	4,407,323	'l 3
	Medically necessary private room cost applicable to the Pro	ogram (line 14 x line 35)	0) 40

∐oal +b	Financial Systems	ST ELIZABETH D	E A DDODN		Inlio	u of Form CMS 1	0550	10
	Financial Systems ATION OF INPATIENT OPERATING COST	31 ELIZABETH D	Provi der CC	N: 15-0086	Peri od:	worksheet D-1		- 10
					From 01/01/2022 To 12/31/2022	2 2 Date/Time Pre	epare	ed:
			Title	XVIII	Hospi tal	5/23/2023 8: 0 PPS)5 an	<u>n</u>
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost		
		Inpatient Cost	Inpatient Days	Diem (col. + col. 2)	1	(col. 3 x col. 4)		
		1.00	2. 00	3. 00	4. 00	5. 00		
	NURSERY (title V & XIX only)	0		0	0. 00	0	0	42. 00
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	5, 269, 248	1, 82	20 2, 89	5. 19	598 1, 731,] 324	43. 00
	CORONARY CARE UNIT	0		l l	0. 00	0	0	44. 00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0		l l	0. 00	0	0	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description					1.00		
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)				400	48. 00
	Program inpatient cellular therapy acquisiti				10, column 1)	12 222	0	48. 01
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	I)(see Instru	uctions)		13, 223,	047]]	49. 00
4	Pass through costs applicable to Program inp	atient routine s	servi ces (fro	om Wkst. D,	sum of Parts I	and 369,	814	50. 00
51. 00	III) Pass through costs applicable to Program inc	atient ancillary	, services (1	from Wkst D	sum of Parts	11 283	596	51. 00
	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I and IV)							31.00
	Total Program excludable cost (sum of lines		atad non n	weisian and	cthotict and	653, 12, 569.		
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-pr	iysi ci an ane	strietist, and	12, 509,	03/	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION]	E4 00
	Program discharges Target amount per discharge					0		54. 00 55. 00
55. 01	Permanent adjustment amount per discharge					0	. 00	55. 01
	Adjustment amount per discharge (contractor					0	- 1	55. 02
	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		aet amount	(line 56 min	us line 53)		0	56. 00 57. 00
	Bonus payment (see instructions)	· ·	J.	•	•		0	58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	the cost rep	porting peri	od ending 1996,	0	. 00	59. 00
60. 00								60. 00
61. 00	market basket)	o E2 . lino E4 i	s loss than	the Lowest	of lines EE plu		0	41 00
61.00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les						١	61. 00
	53) are less than expected costs (lines 54 \times	60), or 1 % of	the target a	amount (line	56), otherwise			
62. 00	enter zero. (see instructions) Relief payment (see instructions)						0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instrud	ctions)				, 이	63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	mber 31 of th	ne cost repo	rting period (S	ee] Ol	64. 00
	instructions)(title XVIII only)	Ü		·				
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the	cost report	ing period (See		0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line	65)(title X	VIII only); for		0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost	renorting neri	od	0	67. 00
07.00	(line 12 x line 19)	c costs through	December 51	or the cost	reporting peri			07.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13×1 ine 20)	e costs after De	ecember 31 of	f the cost r	eporting period		0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + lir	ne 68)			0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU				27)		J ,	70.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				37)		ŀ	70. 00 71. 00
	Program routine service cost (line 9 x line			,				72. 00
	Medically necessary private room cost applic		•				ŀ	73. 00 74. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				, Part II, colu	mn		75. 00
7. 00	26, line 45)	0)						7, 66
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line							76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)						78. 00
	Aggregate charges to beneficiaries for exces			*.	minus lino 70)			79. 00 80. 00
	Total Program routine service costs for comp Inpatient routine service cost per diem limi		vət ilmitätli(אוווו) ווע	minus iine 79)			80.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)						82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				}	83. 00 84. 00
	Utilization review - physician compensation		ns)				ŀ	85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					,	86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					1] 738	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 031	. 00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 791,	ช78	89. 00

Health Financial Systems	ST ELI ZABETH	H DEARBORN		In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 01/01/2022			
				To 12/31/2022	Date/Time Pre 5/23/2023 8:0		
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	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	870, 13	12, 530, 7	95 0.06	9440 1, 791,	878 124,	428 90.00	
91.00 Nursing Program cost		0 12, 530, 7	95 0.00	0000 1, 791,	378	0 91.00	
92.00 Allied health cost		0 12, 530, 7	95 0.00	0000 1, 791,	378	0 92.00	
93.00 All other Medical Education		0 12, 530, 7	95 0.00	0000 1, 791,	378	0 93.00	

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0086	Peri	od:	worksheet D-3	
			From To	01/01/2022 12/31/2022	 Date/Time Pre	
					5/23/2023 8: 0	
	Title	XVIII		lospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	it I	npatient Program	Inpatient Program Costs	
		To charges		Charges	(col. 1 x	
					col . 2)	
		1. 00		2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS . 00 03000 ADULTS & PEDIATRICS				12 750 /	:0(]
.00 03000 ADULTS & PEDIATRICS .00 03100 INTENSIVE CARE UNIT				13, 759, 6 4, 817, 8		
. 00 03200 CORONARY CARE UNIT				4,017,0	0	
. 00 03300 BURN INTENSIVE CARE UNIT					0	
.00 03400 SURGICAL INTENSIVE CARE UNIT					0	
0.00 O4000 SUBPROVI DER - I PF					0	
. 00 04100 SUBPROVI DER - I RF					0	
3. 00 O4300 NURSERY						, ·
ANCILLARY SERVICE COST CENTERS . 00 05000 OPERATING ROOM		0. 30	2375	3, 153, 7	700 953,] 600 !
. 00 05100 RECOVERY ROOM		0.00		-, .55, ,	0	0
.00 05200 DELIVERY ROOM & LABOR ROOM		0. 95		380, 5	361,	734
. 00 05300 ANESTHESI OLOGY		0. 86		198, 1		
. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 25		1, 523, 4		
. 00 05500 RADI OLOGY-THERAPEUTI C		0.00			0	0
. 00 05600 RADI 01 SOTOPE . 00 05700 CT SCAN		0. 00 0. 16		677, 1	0 101 109,	0 ! 441 !
. 00 05700 CT SCAN . 00 05800 MAGNETI C RESONANCE MAGING (MRI)		0. 10		94, 7		115
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 43		416, 7		
0.00 06000 LABORATORY		0. 89		1, 705, 1		
0. 01 06001 BLOOD LABORATORY		0. 00	0000		0	0
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00			0	0
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00			0	0
1. 00 06300 BLOOD STORING, PROCESSING & TRANS. 1. 00 06400 INTRAVENOUS THERAPY		0. 00 0. 00			0	0
5. 00 06500 RESPIRATORY THERAPY		0. 19		3, 981, 1	139 790,	
. 00 06600 PHYSI CAL THERAPY		0. 60		303, 1		
. 00 06700 OCCUPATI ONAL THERAPY		0. 67		123, 9		201
8.00 06800 SPEECH PATHOLOGY		0. 63	0959	77, 9	971 49,	197
0.00 06900 ELECTROCARDI OLOGY		0. 46		218, 3		
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 30			0	0
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS .00 07200 MPL. DEV. CHARGED TO PATIENTS		0. 00 0. 43		1, 293, 3	329 560,	423
1. 00 07200 TMPL. DEV. CHARGED TO PATTENTS		0. 43		1, 293, 3		
00 07400 RENAL DIALYSIS		0.00		., 555, 6	0 750,	0
5. 00 07500 ASC (NON-DISTINCT PART)		0. 00			0	0
. 97 O7697 CARDI AC REHABI LI TATI ON		0. 81			0	0
. 00 O7700 ALLOGENEI C STEM CELL ACQUI SI TI ON		0.00	0000		0	0
OUTPATIENT SERVICE COST CENTERS . 00 08800 RURAL HEALTH CLINIC		0.00	0000] 0 :
B.OO O8800 RURAL HEALTH CLINIC B.OO O8900 FEDERALLY QUALIFIED HEALTH CENTER		0.00				0
09000 CLINIC		0.00			О	0
. 00 09100 EMERGENCY		0. 22	3461	2, 327, 6	515 520,	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 61	4970	139, 3	85,	675
OTHER REIMBURSABLE COST CENTERS			00]
. 00 09400 HOME PROGRAM DI ALYSI S		0. 00	0000		U	0
. 00 09500 AMBULANCE SERVICES . 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.00	امممما			0
. 00 09600 DURABLE MEDICAL EQUIP-RENTED . 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00			0	0
B. 00 09850 OTHER REI MBURSABLE COST CENTERS		0.00			ŏ	0
00.00 Total (sum of lines 50 through 94 and 96 through 98)				18, 450, 7	7, 024,	
11.00 Less PBP Clinic Laboratory Services-Program only charg	jes (line 61))	İ		0	20
Net charges (line 200 minus line 201)				18, 450, 7	795	20

NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	rovi der C	CN: 15-0086	Perio		Worksheet D-3	3	
				To	01/01/2022 12/31/2022	Date/Time Pre 5/23/2023 8:0		
		Ti tl	e XIX	, H	ospi tal	Cost		
	Cost Center Description		Ratio of Cos		npati ent	Inpatient		
			To Charges		-	Program Costs		
					Charges	(col . 1 x col . 2)		
			1. 00		2. 00	3. 00		
IN	PATIENT ROUTINE SERVICE COST CENTERS		1. 00		2.00	0.00		
	000 ADULTS & PEDIATRICS				431, 3	356		30.
1. 00 03	100 INTENSIVE CARE UNIT				567, 1	179		31.
	200 CORONARY CARE UNIT					0		32.
	300 BURN INTENSIVE CARE UNIT					0		33.
	400 SURGICAL INTENSIVE CARE UNIT					0		34.
	000 SUBPROVI DER - I PF					0		40.
	100 SUBPROVI DER – I RF			ŀ		0		41.
	300 NURSERY CILLARY SERVICE COST CENTERS					<u> </u>	1	43.
	000 OPERATING ROOM		0. 30	2375	247, 7	722 74	905	50.
	100 RECOVERY ROOM			00000	, .	0	0	51.
	200 DELIVERY ROOM & LABOR ROOM			0486	74, 2	268 70,	591	52.
	300 ANESTHESI OLOGY		0. 86	1049	6, 7		794	53.
4. 00 05	400 RADI OLOGY-DI AGNOSTI C		0. 25	3182	85, 1	153 21,	559	54.
	500 RADI OLOGY-THERAPEUTI C		t e	00000		0	0	55.
	600 RADI OI SOTOPE		i i	00000		0	0	56.
1	700 CT SCAN		l l	1632	41, 1		659	57.
	800 MAGNETIC RESONANCE IMAGING (MRI)		l l	22842	11, 9		655	58.
	900 CARDI AC CATHETERI ZATI ON 000 LABORATORY			34388	23, 0		032 555	59. 60.
	000 LABORATORY			00000	60, 8	0 54,	0	60.
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY			00000		0	0	61.
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS			00000		0	0	62
	300 BLOOD STORING, PROCESSING & TRANS.			00000		Ö	0	63.
	400 INTRAVENOUS THERAPY			00000		0	0	64.
5. 00 06	500 RESPI RATORY THERAPY		0. 19	8624	398, 1	132 79,	079	65.
6. 00 06	600 PHYSI CAL THERAPY		0. 60	06617	8, 3	336 5,	057	66.
1	700 OCCUPATI ONAL THERAPY			9562	1, 2		831	67
	800 SPEECH PATHOLOGY			30959	6, 3		019	68
	900 ELECTROCARDI OLOGY			5083	14, 1		603	69
	000 ELECTROENCEPHALOGRAPHY		t e	14009		0	0	70
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS		t e	3318		0	0	71
	300 DRUGS CHARGED TO PATIENTS		ł	0241	71, 1	9	285	72
	400 RENAL DIALYSIS		t e	00000	, , ,	0	0	74
	500 ASC (NON-DISTINCT PART)		t e	00000		o	0	75
	697 CARDI AC REHABI LI TATI ON		t e	5386		o	0	76
. 00 07	700 ALLOGENEIC STEM CELL ACQUISITION		0.00	00000		0	0	77
OU	TPATIENT SERVICE COST CENTERS]	
	800 RURAL HEALTH CLINIC			00000		0	0	1
	900 FEDERALLY QUALIFIED HEALTH CENTER			00000		0	0	89
	000 CLINIC			00000		0	0	90
	100 EMERGENCY			23461	213, 1		639	1
	200 OBSERVATION BEDS (NON-DISTINCT PART)		0.61	4970		0	0	92
	HER REIMBURSABLE COST CENTERS 400 HOME PROGRAM DIALYSIS		0.00	00000		0	0	94
	500 AMBULANCE SERVICES		0.00	,5550		٦	J	95
	600 DURABLE MEDI CAL EQUI P-RENTED		0.00	00000		0	0	96
	700 DURABLE MEDICAL EQUIP-SOLD			00000		ő	0	1
	850 OTHER REIMBURSABLE COST CENTERS			00000		o	0	1
0.00	Total (sum of lines 50 through 94 and 96 through 98)				1, 263, 4	426,		1
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61))		,,	0		201
2.00	Net charges (line 200 minus line 201)		1	- 1	1, 263, 4	107		202

Health Financial Systems	ST FLIZABETH DEARBORN	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0086	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre	narod:
	Title XVIII	Hospi tal	5/23/2023 8: 0 PPS	
	THE AVIT	1103pi tai	113	

	litle XVIII Hospital	PPS	
		1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1.00	_
	DRG Amounts Other than Outlier Payments		1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	7, 063, 587	
ļ	instructions)		
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	2, 679, 142	1. 02
- 00	instructions)		1 00
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octobe	er 0	1. 03
1 04	1 (see instructions)	0	1 04
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	U	1. 04
2. 00	Outlier payments for discharges. (see instructions)		2. 00
2. 00	Outlier reconciliation amount	0	1
2. 01	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	180, 192	
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	134, 129	
3. 00	Managed Care Simulated Payments	0	1
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)	56. 24	1
	Indirect Medical Education Adjustment		1
5. 00	FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending o	on 0.00	5.00
	or before 12/31/1996. (see instructions)		
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap fo		1
ļ	new programs in accordance with 42 CFR 413.79(e)		
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0.00	6. 26
	the CAA 2021 (see instructions)		
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	1
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0.00	7. 01
	cost report straddles July 1, 2011 then see instructions.		
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural	0.00	7. 02
ļ	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)		
· -	and 87 FR 49075 (August 10, 2022) (see instructions)		
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
İ	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,		
	1998), and 67 FR 50069 (August 1, 2002).	2.00	- 01
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cos	0. 00	8. 01
2.02	report straddles July 1, 2011, see instructions.	0.00	2 02
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02
2 21	under § 5506 of ACA. (see instructions)	0.00	0 21
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0.00	8. 21
9. 00	instructions) Sum of lines 5 and 5.01 plus line 6, plus lines 6.26 through 6.49 minus lines 7 and 7.01 plus or	0.00	
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
	FTE count for residents in dental and podiatric programs.		11.00
	Current year allowable FTE (see instructions)		12.00
	Total allowable FTE count for the prior year.		12.00
	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997		14.00
14.00	lotal allowable FIE count for the penultimate year if that year ended on or after September 30, 1997 otherwise enter zero.	, 0.00	14.00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.	0.00	15. 00
	Adjustment for residents in initial years of the program (see instructions)		16.00
			17.00
	Adjustment for residents displaced by program or hospital closure		
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).	0.00000	18.00
	, , , , , , , , , , , , , , , , , , , ,		1
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)	0. 000000 0. 000000	1
	Enter the lesser of lines 19 or 20 (see instructions)		l .
	IME payment adjustment (see instructions)		22.00
,	IME payment adjustment - Managed Care (see instructions)) 22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allocatic and estengathic LME_ETE_resident can slots under 42 CER 412 105	0 00	1 22 00
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
24. 00	<pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)</pre>	0.00	24.00
	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see		25.00
20.00	instructions)	0.00	20.00
26. 00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	26 00
	IME payments adjustment factor. (see instructions)	0. 000000	1
	IME payments adjustment ractor. (see instructions)	0.000000	1
	IME add-on adjustment amount - Managed Care (see instructions)	0	1
	Total IME payment (sum of lines 22 and 28)	0	1
	Total TME payment (Sum of Times 22 and 28) Total TME payment - Managed Care (sum of Lines 22.01 and 28.01)	0	1
ŕ	Disproportionate Share Adjustment		∠7. ∪.
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1, 73	30.00
	Percentage of Medicaid patient days (see instructions)	•	31.00
	Sum of lines 30 and 31	i i	32.00
	Allowable disproportionate share percentage (see instructions)		33.00
	Disproportionate share adjustment (see instructions)	130, 797	
51.00	prospropor tronate and eady estiment (see Their estrate)	100,	0 1. 00

Health Financial Systems ST ELIZABET	ΓΗ DEARBORN		In Lieu	of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15	From	01/01/2022 12/31/2022	Worksheet E Part A Date/Time Pr 5/23/2023 8:	
	Title XVII		Hospi tal	PPS	
		FFY (yyy	y)	Amount	
		0		1. 00	
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or plus 2.04 (see instructions) 91.00 Capital outlier from Wkst. L, Pt. I, line 2 92.00 Operating outlier reconciliation adjustment amount (see 93.00 Capital outlier reconciliation adjustment amount (see in The rate used to calculate the time value of money (see 95.00 Time value of money for operating expenses (see instruct	instructions) structions) instructions) ions)				0 90.00 0 91.00 0 92.00 0 93.00 0.00 94.00 0 95.00
96.00 Time value of money for capital related expenses (see in	structions)				0 96.00
		Pri		On/After 10/1	
			1. 00	2. 00	
HSP Bonus Payment Amount					」 ,
100.00 HSP bonus amount (see instructions)				0	_ 0 100.00
HVBP Adjustment for HSP Bonus Payment					J ,
101.00 HVBP adjustment factor (see instructions)			0. 00000000		0000 101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instru	ctions)			0	0 102.00
HRR Adjustment for HSP Bonus Payment					
103.00 HRR adjustment factor (see instructions)			0. 00		000 103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instruc				0	0 104. 00
Rural Community Hospital Demonstration Project (§410A Der					lago oo
200.00 Is this the first year of the current 5-year demonstrati Century Cures Act? Enter "Y" for yes or "N" for no.	on period under the	ZIST			200. 00
Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II	lino 40)				」 201. 00
202.00 Medicare discharges (see instructions)	, Title 49)				201.00
203.00 Case-mix adjustment factor (see instructions)					202.00
Computation of Demonstration Target Amount Limitation (N.	// in first year of	the current	5 year domo	netrati on	7 203.00
period) 204. 00 Medicare target amount	- The first year of	the current	3-year demoi	1311 411 011	
205.00 Case-mix adjusted target amount (line 203 times line 204)				204.00
205.00 Case-mix adjusted target amount (Trie 203 times Trie 204 206.00 Medicare inpatient routine cost cap (line 202 times line					205.00
Adjustment to Medicare Part A Inpatient Reimbursement	203)				7 200.00
207. 00 Program reimbursement under the §410A Demonstration (see	instructions)				l207. 00
208. 00 Medicare Part A inpatient service costs (from Wkst. E, P	,				208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)	,,				209. 00
210. 00 Reserved for future use					210. 00
211.00 Total adjustment to Medicare IPPS payments (see instruct	i ons)				211. 00
Comparision of PPS versus Cost Reimbursement				<u> </u>	7
212.00 Total adjustment to Medicare Part A IPPS payments (from	line 211)				212. 00
213.00 Low-volume adjustment (see instructions)	,				213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between	PPS and cost reimbu	rsement)			218. 00
(line 212 minus line 213) (see instructions)					

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2022 Part A Exhibit 4
To 12/31/2022 Date/Time Prepared: Provi der CCN: 15-0086

						То	12/31/2022	Date/Time 5/23/2023		
		W/S E Dort A	Amounts (from	Title Pre/Post	XVIII Period Pri		Hospi tal Peri od	PP Total (Col	S	
		W/S E, Part A line		Entitlement	to 10/01	וטו	On/After	through 4		
		0	1. 00	2. 00	3. 00		10/01 4.00	5. 00		
1.00	DRG amounts other than outlier		1.00		0			0	0	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	7, 063, 587		0 7, 06	3, 587	7	7, 0	063, 587	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 679, 142		0		2, 679, 1	2, 6	579, 142	1. 02
	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1.03	C		0	(0	1.03
1.04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	C		0			0	0	1.04
2.00	Outlier payments for	2. 00								2. 00
	discharges (see instructions) Outlier payments for	2. 02	0		0	(0	0	2.0
	discharges for Model 4 BPCI	2.02							_	
	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	180, 192		0 18	0, 192	2	1	80, 192	2. 02
	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	134, 129		0		134, 1	129 1	34, 129	2.03
3.00	Operating outlier	2. 01	0		0	(0	0	3.00
4.00	reconciliation Managed care simulated payments	3. 00	О		0	C		О	0	4.00
	ndirect Medical Education Adj	ustment								
	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 00000	0. 0	00000	0. 0000	000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	0		0	C		0	0	6.00
6. 01	IME payment adjustment for managed care (see	22. 01	C		0	C		0	0	6.0
	instructions) Indirect Medical Education Adj	ustment for th	e Add-on for Se	ection 422 of	the MMA					
7.00	IME payment adjustment factor	27. 00	0. 000000			00000	0.0000	000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0		О	C	D	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	C		0	()	0	0	8.0
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	О		О	C		0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	O		0	C)	0	0	9. 01
	8.01) Disproportionate Share Adjustm	 ent		l			1			l
	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0537	0. 053	57 C	. 0537	0. 05	537		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	130, 797			4, 829			30, 797	
	Uncompensated care payments Additional payment for high pe	36.00	740, 127		0 60	3, 803	3 136, 3	324 7	40, 127	11.0
12. 00	Total ESRD additional payment	46. 00	C	ur seriar ges	0	C		0		12.00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	10, 927, 974		0 7, 94	2, 411	2, 985, 5	563 10, 9	927, 974	
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	C		U	(J	U	0	14.00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	10, 927, 974		0 7, 94	2, 411	2, 985, 5	563 10, 9	927, 974	15.00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	729, 437		0 52	7, 852	201, 5	585 7	29, 437	16.00
17. 00	Special add-on payments for new technologies	54. 00	109, 416		0 6	4, 561	44, 8	355 1	09, 416	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0		0	(O	0	17. 0° 17. 0°

Heal th	Financial Systems		ST ELIZABETI	H DEARE	BORN				In Lie	u of	f Form CMS-2	552	-10	
	LUME CALCULATION EXHIBIT 4				ovi der C		<u> </u>	То	od: 01/01/2022 12/31/2022	Wo Pa Da	orksheet E art A Exhibi ate/Time Pre /23/2023 8:0	t 4 pare	ed:	
					Title				lospi tal	\perp	PPS			
		W/S E, Part A			/Post		eriod Prior		Peri od		tal (Col 2			
		line	E, Part A)	Entit	lement		to 10/01	'	On/After	t	hrough 4)			
		0	1.00		00		0.00	-	10/01	-	F 00			
10.00	C	0 93.00	1. 00		00	\perp	3. 00		4. 00		5. 00			00
18. 00	Capital outlier reconciliation adjustment amount (see	1 93.00		0		0		0		0	I	٥	18	. 00
	instructions)										I			
10 00	SUBTOTAL					o	8, 534,	024	3, 232,	003	11, 766,	027	10	00
19.00	JOBIOTAL	W/S L, line	(Amounts from			T	0, 554,	1	3, 232,	T 003	11, 700,	027	17	. 00
		W/3 L, TITIE	L)											
		0	1. 00	2.	00		3. 00		4. 00		5. 00			
20. 00	Capital DRG other than outlied		724, 39			0	525,	571	198,	819		390	20	. 00
20. 01	Model 4 BPCI Capital DRG other		1, -	0		0	,	0	,	0	I	0		. 01
	than outlier	1						- [I	٦		
21.00	Capital DRG outlier payments	2. 00	5, 0	47		0	2,	281	2,	766	5,	047	21	. 00
21. 01	Model 4 BPCI Capital DRG	2. 01		o		0		0		0	l	o	21	. 01
	outlier payments										I			
22.00	Indirect medical education	5. 00	0.000	00	0.00	000	0. 0	0000	0. 0	0000	İ	ĺ	22	. 00
	percentage (see instructions)										l			
23. 00	Indirect medical education	6. 00		0		0		0		0	I	0	23	. 00
	adjustment (see instructions)										İ	l		
24. 00	Allowable disproportionate	10. 00	0.000	00	0. 00	000	0. 0	0000	0. 0	0000	İ		24	. 00
	share percentage (see										İ			
05.00	instructions)	44.00									İ		٥.	00
25. 00	Disproportionate share adjustment (see instructions)	11. 00		0		0		0		0	İ	0	25	. 00
26. 00	Total prospective capital	12. 00	729, 43	27		0	527,	052	201,	505	729,	127	26	00
20.00	payments (see instructions)	12.00	127, 4.	37		۷	527,	032	201,	303	127,	437	20	. 00
		W/S E, Part A	(Amounts to											
		line	E, Part A)											
		0	1. 00	2.	00		3. 00		4. 00		5. 00			
27. 00	Low volume adjustment factor			1			0. 248	3106	0. 021	439			27	. 00
28.00	Low volume adjustment	70. 96					2, 117,	541			2, 117,	541	28	. 00
	(transfer amount to Wkst. E,										İ			
	Pt. A, line)										l			
29. 00	1	70. 97							69,	291	69,	291	29	. 00
	(transfer amount to Wkst. E,										1			
400	Pt. A, line)										1			
100.00			Y								1		100	. 00
	aαjustments to Wkst. Ε, Pt. A.	- [1			ļ					•	J		
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y								I		100	

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2022 Part A Exhibit 5
To 12/31/2022 Date/Time Prepared:

					То	12/31/2022		/Time Prepar /2023 8:05 a	
			Title	XVIII		Hospi tal	3/23	PPS	<u> </u>
		Wkst. E, Pt.	Amt. from	Period to		Period on		l (col s.	
		A, line V	Wkst. E, Pt. A)	10/01	а	fter 10/01	2 8	and 3)	
		0	1. 00	2. 00		3. 00		4. 00	
1.00	DRG amounts other than outlier payments	1.00			·	·		•	1.00
1. 01	DRG amounts other than outlier payments for	1. 01	7, 063, 58	7, 063	, 587			7, 063, 587	1. 01
1 00	discharges occurring prior to October 1	4 00	0 (70 4)			0 (70 4		0 (70 440	4 00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 679, 14	12		2, 679, 1	142	2, 679, 142	1. 02
1. 03	DRG for Federal specific operating payment	1. 03	•		0			C	1. 03
1.00	for Model 4 BPCI occurring prior to October	1.00		٦	Ü				1.00
	1								
1.04	DRG for Federal specific operating payment	1. 04		0			0	C	1. 04
	for Model 4 BPCI occurring on or after								
2. 00	October 1 Outlier payments for discharges (see	2. 00							2. 00
2.00	instructions)	2.00							2.00
2.01	Outlier payments for discharges for Model 4	2. 02		o	0		0	C	2. 01
	BPCI								
2.02	Outlier payments for discharges occurring	2. 03	180, 19	180	, 192			180, 192	2. 02
	prior to October 1 (see instructions)							404 400	
2. 03	Outlier payments for discharges occurring or	n 2. 04	134, 12	29		134, 1	129	134, 129	2. 03
3.00	or after October 1 (see instructions) Operating outlier reconciliation	2. 01	•	0	0		0	C	3.00
4. 00	Managed care simulated payments	3. 00		ol	0		0	C	1
	Indirect Medical Education Adjustment			-1					
5.00	Amount from Worksheet E, Part A, line 21	21.00	0.00000	0. 00	0000	0. 0000	000		5.00
	(see instructions)								
6.00	IME payment adjustment (see instructions)	22.00		0	0		0	C	
6. 01	IME payment adjustment for managed care (see instructions)	e 22. 01		o	0		O	C	6. 01
	Indirect Medical Education Adjustment for th	ne Add-on for Se	ection 422 of	the MMA		L			I
7. 00	IME payment adjustment factor (see	27. 00	0.00000		0000	0. 0000	000		7.00
	instructions)								
8.00	IME adjustment (see instructions)	28. 00		0	0		0	C	
8. 01	IME payment adjustment add on for managed	28. 01		0	0		0	C	8. 01
9. 00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29. 00			0		0	C	9.00
9. 01	Total IME payment for managed care (sum of	29. 01			0		0	0	
7.01	lines 6.01 and 8.01)	27.01		٦	Ü		Ĭ		7.01
	Di sproporti onate Share Adjustment								
10.00	Allowable disproportionate share percentage	33. 00	0. 053	0. (0537	0. 05	537		10.00
11 00	(see instructions)	24.00	120 70	.7	000	25.0	.,,	120 707	11 00
11. 00	Disproportionate share adjustment (see instructions)	34.00	130, 79	94	, 829	35, 9	768	130, 797	11. 00
11. 01	Uncompensated care payments	36.00	740, 12	603	, 803	136, 3	324	740, 127	11. 01
	Additional payment for high percentage of ES					,			
	Total ESRD additional payment (see	46.00		0	0		0	c	12. 00
	instructions)								
13.00	Subtotal (see instructions)	47. 00	10, 927, 97	7, 942	, 411	2, 985, 5	663	10, 927, 974	1
14.00	Hospital specific payments (completed by SCA and MDH, small rural hospitals only.) (see	48. 00		o	Ü		U	C	14. 00
	instructions)								
15. 00	Total payment for inpatient operating costs	49.00	10, 927, 97	7, 942	, 411	2, 985, 5	63	10, 927, 974	15. 00
	(see instructions)		' ' ' '	1					
16. 00	Payment for inpatient program capital (from	50.00	729, 43	527	, 852	201, 5	85	729, 437	16. 00
17.00	Wkst. L, Pt. I, if applicable)	-	400 :	,	F//			100 41	17.00
17.00	Special add-on payments for new technologies	54.00	109, 41	64	, 561	44, 8	355	109, 416	1
17. 01 17. 02	Net organ acquisition cost Credits received from manufacturers for	68. 00		0	0		0	C	17. 01 17. 02
17.02	replaced devices for applicable MS-DRGs	00.00		٦	U		٥	C	17.02
18. 00	Capital outlier reconciliation adjustment	93.00		o	0		0	C	18. 00
	amount (see instructions)				_			_	
19. 00	SUBTOTAL			8, 534	, 824	3, 232, 0	003	11, 766, 827	19. 00

Heal th	Financial Systems	ST ELIZABETH	I DEARBORN			In Lieu	of Form CMS-	2552	-10	
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT			То	od: 01/01/2022 12/31/2022	Worksheet E Part A Exhib Date/Time Pr 5/23/2023 8:	it 5 epare	ed:	
				XVIII	H	lospi tal	PPS			
	\	Wkst. L, line	(Amt. from							
	-	0	Wkst. L) 1.00	2, 00		3. 00	4. 00			
20. 00	Capital DRG other than outlier	1.00	724, 3		 5, 571	3.00 <u> </u> 198.8		, 390	20.	വ
20. 00	Model 4 BPCI Capital DRG other than outlier	1. 01	/21,0	0	3, 3, 1	170, 0	0 724	, 370	20.	
21. 00	Capital DRG outlier payments	2.00	5, 0	147	2, 281	2, 7	-	. 047	21.	
	Model 4 BPCI Capital DRG outlier payments	2. 01	-, -	0	0	-, .	0	0 17	21.	
22. 00	Indirect medical education percentage (see	5. 00	0.00	000	. 0000	0. 00	٩		22.	
	instructions)									-
23.00	Indirect medical education adjustment (see	6. 00		0	0		0	0	23.	00
	instructions)									
24. 00	Allowable disproportionate share percentage	10.00	0. 00	000	. 0000	0. 00	000		24.	00
	(see instructions)									
25. 00	Disproportionate share adjustment (see	11. 00		0	0		0	0	25.	00
37.00	instructions)	10.00	700							
26. 00	Total prospective capital payments (see instructions)	12.00	729, 4	137 52	7, 852	201, 5	85 729	, 437	26.	00
		Wkst. E, Pt.	(Amt. from							
		A, line	Wkst. E, Pt.							
		71, 11110	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	2, 117, 5		7, 541		2, 117		28.	
29. 00	Low volume adjustment on or after October 1	70. 97	69, 2	291		69, 2	291 69	, 291	29.	
30.00	HVBP payment adjustment (see instructions)	70. 93		0	0		0	0	30.	
30. 01	HVBP payment adjustment for HSP bonus	70. 90		0	0		0	0	30.	01
04.00	payment (see instructions)	70.04	00 -		. 700		200	700	0.4	~~
	HRR adjustment (see instructions)	70. 94	-38, 7	/82 -3:	2, 790	-5, 9		, 782		
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91		O	U		0	0	31.	υI
	Thistructions)						(Amt. to			
							Wkst. E, Pt.			
							A)			
		0	1. 00	2. 00		3. 00	4. 00			
32. 00	HAC Reduction Program adjustment (see	70. 99			0		0	0	32.	00
	instructions)									
100.00	Transfer HAC Reduction Program adjustment to		N						100.	00
	Wkst. E, Pt. A.	1			I					

ALCIII	Financial Systems ST ELIZABETH D			of Form CMS-2552	- 10
LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0086	Peri od: From 01/01/2022 To 12/31/2022	Date/Time Prepar	
		Title XVIII	Hospi tal	5/23/2023 8: 05 a PPS	<u>am</u>
		II (I & AVI I I	Πυοριταί		
	DART R MEDICAL AND OTHER HEALTH CERVICES			1. 00	
) 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			1, 822	2
00	Medical and other services reimbursed under OPPS (see instru	uctions)		8, 276, 882	2 2
00	OPPS payments			5, 793, 666	
00 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			62, 580 0	
00	Enter the hospital specific payment to cost ratio (see instr	ructions)		0.000	!
00	Line 2 times line 5			0 00	
00 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		8, 816	5
. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			1 922	
. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			1, 822	<u>/ </u>
	Reasonable charges				1 .
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	lino 60)		3, 571	
	Total reasonable charges (sum of lines 12 and 13)	11116 09)		3, 571	
	Customary charges				,
	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable f) 1) 1
. 00	had such payment been made in accordance with 42 CFR §413.13		s on a chargebasi	5	Ί΄
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	- 1
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete of	only if line 18 exceeds	line 11) (see	3, 571 1, 749	
. 00	instructions)	only it time to exceeds	11116 11) (366	1, 747	` '
. 00	Excess of reasonable cost over customary charges (complete of	only if line 11 exceeds	line 18) (see	0) 2
. 00	instructions) Lesser of cost or charges (see instructions)			1, 822	2 2
. 00	Interns and residents (see instructions)			0) 2
	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			5, 865, 062	- 1 -
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT)		3, 803, 002	- -
	Deductibles and coinsurance amounts (for CAH, see instruction				2
	Deductibles and Coinsurance amounts relating to amount on Ii Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			1, 047, 139 4, 819, 745	
	instructions)	•	22 and 20] (666	1,017,710	
	Direct graduate medical education payments (from Wkst. E-4,	•		0	- 1
. 00	ESRD direct medical education costs (from Wkst. E-4, line 36 Subtotal (sum of lines 27 through 29)	5)		4, 819, 745	
	Primary payer payments			465	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	/I CES)		4, 819, 280) 3
	Composite rate ESRD (from Wkst. I-5, line 11)	(TCL3)) 3
	Allowable bad debts (see instructions)			69, 157	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	structions)		44, 952 60, 471	1
	Subtotal (see instructions)	structions)		4, 864, 232	
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	3
	N95 respirator payment adjustment amount (see instructions)	5113)		0	
. 97	Demonstration payment adjustment amount before sequestration			0	- -
. 98 . 99	Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see inst	ructions)	0 0	- -
. 00	Subtotal (see instructions)			4, 864, 232	2 4
	Sequestration adjustment (see instructions)			61, 290	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs			0	4
. 00	Interim payments			4, 919, 669	
	Interim payments-PARHM or CHART				4
. 00 . 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM or CHART (for contractor use only)	v)		0	4
. 00	Balance due provider/program (see instructions)			-116, 727	7 4
3. 01	Balance due provider/program-PARHM (see instructions)	dance with CMS Dub 15	2 chanter 1	0	4
. 00	Protested amounts (nonallowable cost report items) in accord §115.2	uance writh GWS PUD. 15-	z, chapter I,		′ 4
	TO BE COMPLETED BY CONTRACTOR				D 9
.00	Original outlier amount (see instructions)			1 0	. 1

0 91.00 0.00 92.00 0 93.00 0 94.00

92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Total (sum of lines 91 and 93)

91.00 Outlier reconciliation adjustment amount (see instructions)

Health Financial Systems	ST ELIZABETH D	EARBORN	In Lieu	of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0086	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Pre 5/23/2023 8:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

	Financial Systems ST ELIZABETH SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der Co	CN: 15-0086	Peri od:	of Form CMS-2 Worksheet E-1		
ANALI	JOS OF TATMENTS TO THOUTDERS TON SERVICES RENDERED	Trovider of	ON. 13 0000	From 01/01/2022		pare	
		Title	XVIII	Hospi tal	PPS	o all	_
		Inpatien		Par			
		·					
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
	I 	1. 00	2. 00	3. 00	4. 00		
1.00	Total interim payments paid to provider		12, 34	· .	4, 919, 6		1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0		0	2. 00
	services rendered in the cost reporting period. If none,						
	write "NONE" or enter a zero						
3.00	List separately each retroactive lump sum adjustment					İ	3.00
	amount based on subsequent revision of the interim rate						
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					J	
3. 01	ADJUSTMENTS TO PROVIDER			0		ol	3. 01
3. 02	ADJUST MENTS TO TROVIDER			ol		0	3. 02
3. 03				Ö		ō	3. 03
3.04				o		0	3.04
3.05				0		0	3. 05
	Provider to Program					- 1	
3.50	ADJUSTMENTS TO PROGRAM			0		0	3. 50
3. 51 3. 52				0		0	3. 51 3. 52
3. 52				0		0	3. 52
3. 54				0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o		Ö	3. 99
	3. 50-3. 98)						
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		12, 34	7, 047	4, 919, 6	569	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as						
	appropriate) TO BE COMPLETED BY CONTRACTOR						
5. 00	List separately each tentative settlement payment after					1	5. 00
3.00	desk review. Also show date of each payment. If none,						3. 00
	write "NONE" or enter a zero. (1)						
	Program to Provider					·	
5. 01	TENTATI VE TO PROVI DER			0		0	5. 01
5. 02				0		0	5. 02
5. 03	Provider to Program			0		0	5. 03
5. 50	TENTATI VE TO PROGRAM			0		ol	5. 50
5. 51	TENTATI VE TO TROGRAM			o		ő	5. 51
5. 52				o		ō	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			o		0	5. 99
	5. 50-5. 98)						
6. 00	Determined net settlement amount (balance due) based on						6. 00
۷ 01	the cost report. (1)		24	0 111		0	6. 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		24	9, 111	116,	-	6. 01
7. 00	Total Medicare program Liability (see instructions)		12.59	- 1	4, 802, 9		7. 00

7. 00

8. 00

0 116, 727 4, 802, 942

NPR Date (Mo/Day/Yr) 2.00

Contractor Number 1.00

8.00 Name of Contractor

Total Medicare program liability (see instructions)

Heal th	Financial Systems ST ELIZABETH D	of Form CMS-2	2552-10			
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0086	Peri od:	Worksheet E-1		
			From 01/01/2022			
			To 12/31/2022			
		T		5/23/2023 8: 0	5 am	
		Title XVIII	Hospi tal	PPS		
				4.00		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				,	
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	t. S-3, Pt. I col. 15 li	ne 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 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6. 00	
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technolog	gy Wkst. S-2, Pt.	1	7. 00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				,	
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	31.00 Other Adjustment (specify)					
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructi	ons)		32. 00	

	n Financial Systems ST ELIZABETH D LATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0086	Peri			Form CMS-25 ksheet E-3	JJZ	
CALCO	ATTOM OF RETWINDORSEMENT SETTLEMENT	Trovider con. 13-0000	Fro	n 01/01/2022	Part	VII		
			То	12/31/2022		e/Time Prep 8/2023 8:05		
		Title XIX		Hospi tal	3/23	Cost) all	
		11 11 3 711 71		Inpatient	0ut	pati ent		
				1. 00		2. 00		
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	SERVICES FOR TITLES V OF	XIX	SERVI CES				
4 00	COMPUTATION OF NET COST OF COVERED SERVICES						1	4.0
1. 00 2. 00	Inpatient hospital/SNF/NF services Medical and other services				0	368, 6	00	1. 0 2. 0
3.00	Organ acquisition (certified transplant programs only)				0	308, 0	180	3. 0
4. 00	Subtotal (sum of lines 1, 2 and 3)				0	368, 6	.an	4. 0
5. 00	Inpatient primary payer payments				0	300, 0		5. 0
6.00	Outpatient primary payer payments						0	6. 0
7. 00	Subtotal (line 4 less sum of lines 5 and 6)				0	368, 6	- 1	7. 0
	COMPUTATION OF LESSER OF COST OR CHARGES						'	
	Reasonabl e Charges							
8.00	Routine service charges				0			8. 0
9. 00	Ancillary service charges			1, 263, 4		1, 222, 5	27	9. 0
10.00					0			10.0
11.00	i i			1 0/0	0			11.0
12. 00	1			1, 263, 4	197	1, 222, 5	2/	12. 0
13. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment 1	for coryllogs on a charge			0		ام	13. 0
13.00	basis	Tor services on a charge	=		U		٧	13.0
14. 00		for payment for services	s on		0		0	14. 0
00	a charge basis had such payment been made in accordance with						Ĭ	0
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	- ()		0. 0000	000	0. 0000	00	15.0
16.00	Total customary charges (see instructions)			1, 263,		1, 222, 5		16. 0
17. 00	Excess of customary charges over reasonable cost (complete of	only if line 16 exceeds		1, 263, 4	197	853, 8	47	17. 0
	line 4) (see instructions)							
18. 00		only if line 4 exceeds I	ıne		0		0	18. 0
19. 00	16) (see instructions) Interns and Residents (see instructions)				0		0	19. 0
20. 00	,	structions)			0		0	20. 0
21. 00		,			0	368, 6	- 1	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b		vi de	rs.			1	
22. 00	, , , , , , , , , , , , , , , , , , , ,	,			0		0	22. 0
23.00	Outlier payments				0		0	23. 0
24. 00					0			24. 0
25. 00					0			25. 0
26.00	,				0		0	26. 0
27. 00	, ,				0		0	27. 0
28. 00 29. 00	, , , , , , , , , , , , , , , , , , , ,)			0	368, 6	0	28. 0
∠9. UU	COMPUTATION OF REIMBURSEMENT SETTLEMENT				U	308, 0	000	29. U
30. 00					0		ol	30. 0
31. 00	,	6)			0	368, 6	- 1	31. 0
32. 00		•			Ö	2237 0	0	32. 0
33.00	i				0		0	33.0
34. 00	Allowable bad debts (see instructions)				0		0	34. 0
35. 00					0			35. 0
37 UU	Subtotal (cum of lines 21 24 and 25 minus cum of lines 22 a	and 331		1	\cap	240 4	COOL	

368, 680

368, 680

368, 680 40. 00 0 41. 00 368, 680 42. 00

0

36.00

37. 00

38. 00 39. 00

43.00

Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)

Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,

Subtotal (line 36 ± line 37)
Direct graduate medical education payments (from Wkst. E-4)
Total amount payable to the provider (sum of lines 38 and 39)

OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

Balance due provider/program (line 40 minus line 41)

36.00

37. 00

38. 00

39. 00

40. 00 41. 00

42.00

43.00

Interim payments

chapter 1, §115.2

Heal th	Financial Systems ST E	ELIZABETH DEARBORN	In Lieu	of Form CMS-	2552-	10
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provi der CCN: 15-0086	Peri od: From 01/01/2022	Worksheet E-	5	
				Date/Time Pro 5/23/2023 8:		
	PPS					
	1. 00					
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt. A, lin	e 2, or sum of 2.03 plus 2.04 (see	e instructions)		_ 0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00	Operating outlier reconciliation adjustment amoun	it (see instructions)			0	3.00
4.00	Capital outlier reconciliation adjustment amount	(see instructions)			0	4.00
5.00 The rate used to calculate the time value of money (see instructions)						5.00
6.00		o	6. 00			
7. 00	Time value of money for operating expenses (see i Time value of money for capital related expenses				0	7. 00

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

Health Financial Systems

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

Provider CCN: 15-0086 Period: From 01/0

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/23/2023 8:05 am

onl y)				10 12/31/202	5/23/2023 8:0		
		General Fund	Specific	Endowment d Fund	Plant Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00		
	CURRENT ASSETS	1			_1		
1. 00 2. 00	Cash on hand in banks	160, 754, 7	53	0	0	0	1. 00 2. 00
3. 00	Temporary investments Notes receivable			o	0	0	3.00
4. 00	Accounts receivable	10, 924, 3	58	ő	o	0	4. 00
5.00	Other recei vable	108, 2	l l	o	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable		0	0	0	0	6. 00
7.00	Inventory	2, 682, 7	98	0	0	0	7. 00
8.00	Prepaid expenses		0	0	0	0	8.00
9. 00 10. 00	Other current assets Due from other funds			0	0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	174, 470, 1	68	ő	Ö	0	
	FIXED ASSETS						
12. 00	Land	500, 0	l l	0	0	0	
13.00	Land improvements	18, 8	•	0	0	0	
14. 00 15. 00	Accumul ated depreciation Buildings	-10, 4 3, 151, 8	l l	0	0	0	14. 00 15. 00
16. 00	Accumulated depreciation	-918, 4	<u> </u>	o	0	0	16. 00
17. 00	Leasehold improvements	,10,1	0	ő	Ö	0	17. 00
18. 00	Accumul ated depreciation	-3, 3	36	О	0	0	18. 00
19. 00	Fixed equipment		0	0	0	0	19. 00
20.00	Accumulated depreciation	05.5	0	0	0	0	20.00
21. 00 22. 00	Automobiles and trucks	25, 5	30	0	0	0	21. 00 22. 00
23. 00	Accumulated depreciation Major movable equipment	5, 652, 9	55	ol	0	0	23. 00
24. 00	Accumulated depreciation	-2, 560, 8	l l	ő	o	0	24. 00
25. 00	Mi nor equi pment depreci abl e	188, 0	l l	o	0	0	25. 00
26. 00	Accumulated depreciation		0	0	0	0	26. 00
27. 00	HIT designated Assets	74, 6	91	0	0	0	
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable			0	0	0	
30. 00	Total fixed assets (sum of lines 12-29)	6, 118, 9	00	o	0	0	l .
00.00	OTHER ASSETS	9, 1.0, 7		<u> </u>	<u> </u>	1	, 00.00
31.00	Investments		0	0	0	0	31.00
32. 00	Deposits on Leases		0	0	0	0	
33. 00	Due from owners/officers	-171, 420, 4	1	0	0	0	
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	476, 6 -170, 943, 8	l l	0	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	9, 645, 2	•	o	o	0	l .
	CURRENT LIABILITIES	,					
37. 00	Accounts payable	1, 134, 9	1	0	0	0	
38. 00	Sal ari es, wages, and fees payable	2, 651, 6	01	0	0	0	
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)		0	0	0	0	
41. 00	Deferred income				0	0	41. 00
42. 00	Accel erated payments		o	Ĭ		Ū	42. 00
43.00	Due to other funds		0	О	0	0	43. 00
44. 00	Other current liabilities	5, 981, 6		0	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	9, 768, 1	36	0	0	7 0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	1		ol	0		46. 00
47. 00	Notes payable			o	0	0	
48. 00	Unsecured Loans		o	ō	O	0	
49.00	Other long term liabilities	224, 8	00	O	0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	224, 8		0	0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	9, 992, 9	36	0	0	7 0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	-347, 7	17				52. 00
53. 00	Specific purpose fund	347,7	'/	o			53. 00
54.00	Donor created - endowment fund balance - restricted				0		54.00
55.00	Donor created - endowment fund balance - unrestricted				0		55. 00
56.00	Governing body created - endowment fund balance				0		56. 00
57. 00	Plant fund balance - invested in plant					0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion					0	58. 00
59. 00	Tepracement, and expansion Total fund balances (sum of lines 52 thru 58)	-347,7	17	o	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	9, 645, 2	l l	o o	Ō	0	
	59)						

| Period: | Worksheet G-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES ST ELIZABETH DEARBORN

Provi der CCN: 15-0086

					lo 12/31/2022	2 Date/lime Pre 5/23/2023 8:0	
		General	Fund	Special Pu	urpose Fund	Endowment Fund	JS alli
	-	1 00	2.00	2 00	4.00	F 00	
1. 00	Fund balances at beginning of period	1.00	2. 00 8, 106, 2	3. 00	4. 00	5. 00	1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) HOMER OFFICE ALLOCATION ROUNDING	15, 400, 602 4 0 0 0	-7, 294, 1 812, 0	49	0 0 0 0	0	2. 00 3. 00 0 4. 00 0 5. 00 0 6. 00 0 7. 00 0 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions	16, 560, 401 0 0 0	15, 400, 6 16, 212, 6	•	0 0 0 0 0	0	0 9.00 10.00 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		16, 560, 4 -347, 7			0	18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		Tunu			-		
		6. 00	7. 00	8. 00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) HOMER OFFICE ALLOCATION ROUNDING	0		0 0 0 0 0	0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0		0 0 0 0 0	0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
17.00	sheet (line 11 minus line 18)				١		17.00

Health Financial Systems STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES ST ELIZABETH DEARBORN
Provi der CCN: 15-0086

				10	12/31/2022	5/23/2023 8:		
	Cost Center Description		Inpatient	0ι	utpati ent	Total	<u> </u>	
			1. 00		2. 00	3. 00		
	PART I - PATIENT REVENUES							
	General Inpatient Routine Services							
1.00	Hospi tal		23, 896,	, 178		23, 896,	178	1.00
2.00	SUBPROVI DER - I PF			0			0	2. 00
3.00	SUBPROVI DER - I RF			0			0	3. 00
4.00	SUBPROVI DER							4. 00
5.00	Swing bed - SNF			0			0	5. 00
6.00	Swing bed - NF			0			0	6. 00
7.00	SKILLED NURSING FACILITY			0			0	
8.00	NURSING FACILITY			0			0	
9. 00	OTHER LONG TERM CARE			o			0	9. 00
	Total general inpatient care services (sum of lines 1-9)		23, 896,	178		23, 896,	178	1
	Intensive Care Type Inpatient Hospital Services]	
11.00	INTENSIVE CARE UNIT		14, 375,	975		14, 375,	975	11. 00
12. 00	CORONARY CARE UNIT		1	o			0	12. 00
	BURN INTENSIVE CARE UNIT			o			0	13. 00
	SURGI CAL INTENSI VE CARE UNI T			o			0	14. 00
	OTHER SPECIAL CARE (SPECIFY)			1			-	15. 00
	Total intensive care type inpatient hospital services (sum o	flines	14, 375,	975		14, 375,	975	
	11-15)					,		
17. 00	Total inpatient routine care services (sum of lines 10 and 1	6)	38, 272,	153		38, 272,	153	17. 00
	Ancillary services	5)	54, 481,		102, 445, 2			
	Outpatient services		8, 830,		25, 720, 2			1
	RURAL HEALTH CLINIC		=,=	ol	20,	0	0	20. 00
	FEDERALLY QUALIFIED HEALTH CENTER			ol		o	0	21. 00
	HOME HEALTH AGENCY			Ĭ		o	0	22. 00
	AMBULANCE SERVICES			ol		ol	0	
24. 00				آ		0	0	24. 00
	CORF			o		ol	0	24. 10
	AMBULATORY SURGICAL CENTER (D. P.)			ol		ol	0	25. 00
	HOSPI CE			ol		0	0	26. 00
	PHYS REV, A&G, OP ROUTINE, ETC		5, 021,	283	1, 725, (011 6, 746,	294	27. 00
	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst	106, 605,		129, 890, 4			
20.00	G-3, line 1)	J to wist.	100, 000,	, 4,10	127,070,	200, 170,	000	20.00
	PART II - OPERATING EXPENSES						7 '	P
29. 00	Operating expenses (per Wkst. A, column 3, line 200)				71, 758, 8	388	_	29. 00
	HOME OFFICE		15, 400,	602	, , , , , , , , ,			30.00
31. 00	THOME OFFICE		10, .00,	002				31. 00
32. 00				ol				32. 00
33. 00				ol				33. 00
34. 00				ام				34. 00
35. 00				0				35. 00
36. 00	Total additions (sum of lines 30-35)		1	٦	15, 400, 6	602		36.00
37. 00	DEDUCT (SPECIFY)		1		13, 400, 0	302		37. 00
38. 00	DEDUCT (SPECIFI)		}	٥				38.00
39. 00			}	0				39.00
40. 00				0				40.00
41. 00				0				41.00
	Total deductions (sum of lines 27 41)			Ч		0		
42.00	Total deductions (sum of lines 37-41)	42) (+ranaf	.		07 150	400		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line to Wkst. G-3, line 4)	42) (transfer	1		87, 159, 4	+70		43. 00
	(10 WKSt. G-3, Time 4)		I	ı				

Heal th	Financial Systems ST ELIZABETH D	FARRORN	In lieu	of Form CMS-2552	2_10	
	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0086 Period:					
317(1 EIII	ENT OF REVENUES 71110 ENTENUES	11001461 3011.13 3000	From 01/01/2022	Worksheet G-3		
			To 12/31/2022	Date/Time Prepar		
				5/23/2023 8: 05 a	am	
			-	1 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	no 20)		1. 00 236, 495, 853	1.00	
2. 00	Less contractual allowances and discounts on patients' accou			158, 145, 002		
3. 00	Net patient revenues (line 1 minus line 2)	unts		78, 350, 851		
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	. 42)		87, 159, 490		
5. 00	Net income from service to patients (line 3 minus line 4)	e 43)		-8, 808, 639		
	OTHER INCOME			-0, 000, 039	7 5.00	
6. 00	Contributions, donations, bequests, etc				6. 00	
7. 00	Income from investments					
8. 00	Revenues from telephone and other miscellaneous communication	on services				
9. 00	Revenue from television and radio service	511 361 11 663				
	Purchase di scounts					
	Rebates and refunds of expenses					
	Parking lot receipts			i c	1	
	Revenue from Laundry and Linen service				1	
	Revenue from meals sold to employees and guests			266, 303	14.00	
	Revenue from rental of living quarters			C	1	
	Revenue from sale of medical and surgical supplies to other	than patients		C	1	
	Revenue from sale of drugs to other than patients	•		533, 228	17. 00	
18.00	Revenue from sale of medical records and abstracts			161	18. 00	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			C	19. 00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			135, 030	20.00	
21.00	Rental of vending machines			9, 337	21. 00	
22.00	Rental of hospital space			35, 422	22. 00	
23.00	Governmental appropriations			C	23. 00	
24.00	GRANTS			535, 009	24.00	
24.50	COVI D-19 PHE Fundi ng			C	24. 50	
25.00	Total other income (sum of lines 6-24)			1, 514, 490	25. 00	
26.00	Total (line 5 plus line 25)			-7, 294, 149	26. 00	
	OTHER EXPENSES (SPECIFY)			C		
	Total other expenses (sum of line 27 and subscripts)			C	20.00	
29. 00	Net income (or loss) for the period (line 26 minus line 28)			-7, 294, 149	29. 00	

Heal th	Financial Systems ST ELIZABETH D	DEARBORN	In Lieu	ı of Form CMS-255	2-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0086	Peri od: From 01/01/2022 To 12/31/2022	Date/Time Prepa	
		Title XVIII	Hospi tal	5/23/2023 8: 05 PPS	am
		Title XVIII	nospi tai	113	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				1
1. 00	Capital DRG other than outlier			724, 39	
1. 01	Model 4 BPCI Capital DRG other than outlier				0 1.01
2.00	Capital DRG outlier payments			5, 04	i .
2. 01 3. 00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost of	reporting period (coe i	notrusti ono)	35. 20	o
4. 00	Number of interns & residents (see instructions)	reporting period (see i	nstructions)	0.00	1
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the	he sum of lines 1 and 1	01 columns 1 an		0 6.00
0.00	1.01) (see instructions)	The Sam of Times I and I	. OT, COTAINIS T OF		0.00
7.00	Percentage of SSI recipient patient days to Medicare Part A	patient days (Workshee	t E, part A line	0.00	0 7.00
	30) (see instructions)		·		
8.00	Percentage of Medicaid patient days to total days (see inst	ructi ons)		0. 00	
9.00	Sum of lines 7 and 8			0.00	
10. 00	Allowable disproportionate share percentage (see instruction	ns)		0.00	
	Disproportionate share adjustment (see instructions)		0 11.00		
12. 00	Total prospective capital payments (see instructions)			729, 43	7 12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)				0 1.00
2.00	Program inpatient ancillary capital cost (see instructions)				0 2.00
3. 00	Total inpatient program capital cost (line 1 plus line 2)				0 3.00
4.00	Capital cost payment factor (see instructions)				0 4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)				0 5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
1.00	Program inpatient capital costs (see instructions)				0 1.00
2.00	Program inpatient capital costs for extraordinary circumstan	nces (see instructions)			0 2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)				0 3.00
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)				0 5.00
6. 00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00	
7. 00	Adjustment to capital minimum payment level for extraordinal	ry circumstances (line	2 x line 6)		0 7.00
8.00	Capital minimum payment level (line 5 plus line 7)				8.00
9.00	Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)				9.00
10. 00 11. 00	Carryover of accumulated capital minimum payment level over				0 10.00
11.00	Worksheet L, Part III, Line 14)	Capital payment (110m	prior year	· ·	11.00
12.00					0 12.00
13.00					0 13. 00
14.00	Carryover of accumulated capital minimum payment level over	capital payment for th	e following peric	od (0 14.00
45.00	(if line 12 is negative, enter the amount on this line)				45.60
15.00	Current year allowable operating and capital payment (see in		0 15.00		
16. 00 17. 00	Current year operating and capital costs (see instructions) Current year exception offset amount (see instructions)				0 16.00
17.00	Journal year exception oriset amount (see instructions)			· '	0 17.00