Heal th Financia	al Systems	HOLY FAMILY MEDICAL	_ CENTER	In Lie	u of Form CMS-2552-10
This report is	required by law (42 USC 1395g since the beginning of the cos				FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX CO SUMMARY	OST REPORT CERTIFICATION	Provider CCN: 1420	Peri od: From 01/01/2014 To 12/31/2014	
PART I - COST	REPORT STATUS				
Provi der use only	1. [X] Electronically filed of 2. [] Manually submitted costs. 3. [0] If this is an amended 4. [F] Medicare Utilization.	st report report enter the number of	f times the provide for low.	Date: 5/19/20 er resubmitted this c	
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened	7. Contractor No.	this Provider CCN		

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY 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 the Balance Sheet and Statement of Revenue and Expenses prepared by HOLY FAMILY MEDICAL CENTER (142011) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 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.

(Si gned)			
	Officer o	r Administrator	of Provider(s)
			• •
Title			
11 11 0			
Date			

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	512, 928	82, 612	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	512, 928	82, 612	0	0	200. 00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	acca in the pire cost repetring period. In column .	-, 0	101 100 0		.0.			
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24. 00	If this provider is an IPPS hospital, enter the	0	0	0	0	0	0	24. 00
	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.							
25.00	If this provider is an IRF, enter the in-state	0	о	О (О (О (25. 00
	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.							
	, . ,	1		1	'	1	1	1

HUSPI 1	_		DICAL CENTER	2011 4 40211		n Lie	u of For		
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΙA	Provi der (Fi	eriod: com 01/01/		Worksho Part I		
				To	12/31	/2014	Date/Ti 5/19/20		
			'	<u>'</u>	Urban/Rui		Date of	Geogr	
26. 00	Enter your standard geographic classification (not wa	ge) sta	atus at the beg	inning of the	1. 00	1	2. ()()	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa			of the cost		1			27. 00
27.00	reporting period. Enter in column 1, "1" for urban or					·			27.00
35. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the			H status in		0			35. 00
	effect in the cost reporting period.	Tiullibei	or perrous sci	III Status III					33.00
					Begi nni 1. 00		Endi 2. (_
36. 00	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number	1.00		2. (30	36.00
37. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		umber of period:	s MDH status		0			37.00
	in effect in the cost reporting period.		·						
38. 00	Enter applicable beginning and ending dates of MDH st of periods in excess of one and enter subsequent date		Subscript line	38 for number					38.00
					Y/N		Υ/		
39. 00	Does this facility qualify for the inpatient hospital	pavmer	nt adiustment f	or low volume	1. 00 N)	2. (39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Ente	er in column 1	"Y" for yes					
	or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes								
40. 00	Is this hospital subject to the HAC program reduction	,		,	N		N		40.00
	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.			es or N Tor					
						1. 00	XVIII 2. 00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45. 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for o	di sproporti onat	e share in acc	ordance	N	N	N	45. 00
46. 00	Is this facility eligible for additional payment exce	ption 1	for extraordi na	ry circumstanc	es	N	N	N	46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	. L, P	t. III and Wkst	. L-1, Pt. I t	hrough				
47. 00	Is this a new hospital under 42 CFR §412.300 PPS capi	tal? I	Enter "Y for ye:	s or "N" for n	10.	N	N	N	47. 00
48. 00	Is the facility electing full federal capital payment Teaching Hospitals	? Ente	er "Y" for yes	or "N" for no.		N	N	N	48.00
56.00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" f	or yes	Υ			56.00
57. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p	eriod (durina which re	sidents in ann	roved	N			57.00
	GME programs trained at this facility? Enter "Y" for	yes o	r "N" for no in	column 1. If	column 1				
	is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y								
E0 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb			no! com d coo c					F0 00
58. 00	defined in CMS Pub. 15-1, § 2148? If yes, complete Wk	st. D-	5.		15	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health	, compl	lete Wkst. D-2,	Pt. I.		N N			59. 00 60. 00
	provider-operated criteria under §413.85? Enter "Y"				tions)	l IN			00.00
		Y/N	IME	Direct GME	IME		Di rec	t GME	
		1. 00	2. 00	3. 00	4.00		5. (
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N				0. 00		0.00	61.00
	column 1. (see instructions)								
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0.00	0. 00					61. 01
	ending and submitted before March 23, 2010. (see								
	li netrueti one)								
61. 02	instructions) Enter the current year total unweighted primary care		0.00	0.00	}				61. 02
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0.00	0.00					61. 02
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.00					61. 02
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care		0.00	0. 00					
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for								
61. 03	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0. 00					61. 03
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see								61. 03
61. 03 61. 04	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0. 00	0. 00					61. 03
61. 03 61. 04	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0. 00					61. 03
61. 03 61. 04	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0. 00	0. 00					61. 03 61. 04 61. 05
61. 03 61. 04	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being		0. 00	0. 00					61. 03
61. 03 61. 04 61. 05	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0. 00 0. 00 0. 00	0. 00 0. 00 0. 00					61. 03 61. 04 61. 05

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMP		MILY MEDICAL ATA			eriod: rom 01/01/2014		pared:
		Progran	n Name	Program Code	Unweighted IME FTE Count		
		1. (00	2. 00	3.00	4. 00	
61.10 Of the FTEs in line 61.05, speci specialty, if any, and the number for each new program. (see instruction of the program code, enter in column 3, unweighted count and enter in compart of the FTEs unweighted count. 61.20 Of the FTEs in line 61.05, speci program specialty, if any, and the program specialty, if any, and the program special transfer in column 1, enter in column 2, the program of the IME FTE unweighted count 1, direct GME FTE unweighted count 1, direct GME FTE unweighted count 1.	er of FTE residents ructions) Enter in er in column 2, the the IME FTE olumn 4, direct GME fy each expanded the number of FTE gram. (see the program name, code, enter in column and enter in column				0. 00		61. 20
4, direct ome the diwerghted coc	anc.						
				(11004)		1.00	
ACA Provisions Affecting the Head 62.00 Enter the number of FTE resident					od for which	0.00	62. 00
your hospital received HRSA PCRE	funding (see instru	ctions)					
62.01 Enter the number of FTE resident during in this cost reporting pe					your hospital	0.00	62. 01
Teaching Hospitals that Claim Re			IISTI UCTI OI	15)			
63.00 Has your facility trained reside	ents in nonprovider se	ettings duri			eriod? Enter	N	63. 00
"Y" for yes or "N" for no in col	umn 1. If yes, comple	ete lines 64	-67. (see	instructions) Unweighted	Unwei ghted	Ratio (col. 1/	
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
				1. 00	2. 00	3.00	
Section 5504 of the ACA Base Year period that begins on or after a				This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column)	s yes, or your facilitaber of unweighted nor tations occurring in a number of unweighted bur hospital. Enter in 1 + column 2)). (see	ty trained r n-primary ca all nonprov d non-primar n column 3 t instruction	esidents ire ider y care he ratio	0. 00			64. 00
	Program Name	Progran	n Code	Unwei ghted	Unweighted FTEs in	Ratio (col. 3/	
				FTEs Nonprovi der Si te	Hospi tal	(col. 3 + col. 4))	
(F 00 F 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1. 00	2. (00	3. 00	4.00	5.00	45.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00	0.00	0.000000	33.00

Health Financial Systems HOLY FAMILY MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 142011 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/19/2015 5:43 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs 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 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 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 Unwei ghted Unwei ghted Ratio (col. 3/ Program Code FTEs FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) 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 4)) (see instructions) 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. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 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 program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	1	Period: From 01/01/2		Worksheet Part I	
			Γο 12/31/2	2014	Date/Time 5/19/2015	
	'	1	V		XI X	
Title V and XIX Services			1.00		2. 00	
.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	services? E	nter "Y" for	N		Υ	90.
.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			N		N	91.
.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica		ion)? (see			N	92.
.00 Does this facility operate an ICF/MR facility for purposes o "Y" for yes or "N" for no in the applicable column.			N		N	93.
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.			N		N	94.
.00 If line 94 is "Y", enter the reduction percentage in the app .00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N	0. 00	N	0. 00 95. 96.
.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	icable column	n.		0. 00	ı	0. 00 97.
5.00 Does this hospital qualify as a Critical Access Hospital (CA 6.00 of this facility qualifies as a CAH, has it elected the all-for outpatient services? (see instructions)		hod of payment	N			105 106
7.00 Column 1: If this facility qualifies as a CAH, is it eligib for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on Wk the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I&Rs in an approved medical educa CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "	in column 1. st. B, Pt. I, D-2, Pt. II. (tion program	(see col. 25 and Column 2: If train in the				107
instructions) 8.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N			108
	Physi cal	Occupati onal	Speech	ı	Respi rato	ory
9.00 f this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2.00	3.00		4. 00	109
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	IN .					109.
therapy services provided by outside supplier? Enter "Y"	Demonstrati	on project (41	OA Demo)for		1.00 N	1109.
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"	Demonstrati	on project (41	OA Demo)for	1. 00	N	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information	Demonstration for no. "N" for no in the column 2 in the for long tenth the column 2 in the co	n column 1. If is "E", enter rm care (inclu	column 1 in column des		N 2. 00 3	110
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208. 1. 6.00 Is this facility classified as a referral center? Enter "Y" 7.00 Is this facility legally-required to carry malpractice insur	Demonstration for no. "N" for no in the second of the sec	n column 1. If is "E", enter rm care (inclu he definition " for no.	column 1 in column des in CMS	1. 00	N 2. 00 3	110 00 0 115
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, \$2208. 1. 6.00 Is this facility classified as a referral center? Enter "Y" 7.00 Is this facility legally-required to carry malpractice insur no.	"N" for no in If column 2 it for long tens) based on the for yes or "N" ance? Enter ""	n column 1. If is "E", enter rm care (inclu he definition " for no. Y" for yes or	column 1 in column des in CMS	1. 00 N	N 2. 00 3	110 .00 0 115
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therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1. 6.00 Is this facility classified as a referral center? Enter "Y" for olls this facility legally-required to carry malpractice insur no. 8.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 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 que Hold Harmless provision in ACA §3121 and applicable amendmene Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for	"N" for no in If column 2 it for long tenses) based on the solumn 2 it for yes or "N" ance? Enter "" icy? Enter 1 it column 1, "Y' alifies for the solumn 1,	n column 1. If is "E", enter rm care (inclu he definition " for no. Y" for yes or if the policy Premiums 1.00 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to	Cool umn 1 in col umn des in CMS "N" for is Losses 2.00 N	1.00 N N N N 2	1 nsurance 3.00	110 .00 0 115 116 117 118 .ee
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Health Financial Systems		MEDICAL CENTER				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 142011	Period:	1/01/2014	Worksheet S- Part I	-2
					2/31/2014	Date/Time Pr	
						5/19/2015 5:	43 pm
					1. 00	2.00	
128.00 If this is a Medicare certified li			cation date				128. 00
in column 1 and termination date, 129.00 If this is a Medicare certified It	ing transplant center, e	nter the certific	cation date i	n			129. 00
column 1 and termination date, if 130.00 If this is a Medicare certified pa			ification				130. 00
date in column 1 and termination of 131.00 If this is a Medicare certified in			erti fi cati on				131. 00
date in column 1 and termination of 132.00 If this is a Medicare certified is			cation date				132. 00
in column 1 and termination date, if applicable, in column 2. 33.00 f this is a Medicare certified other transplant center, enter the certification date							133. 00
in column 1 and termination date, 134.00 If this is an organ procurement or			n column 1				134. 00
and termination date, if applicabl		The or o ridinger i	TI COI GIIII I				134.00
All Providers 140.00 Are there any related organization chapter 10? Enter "Y" for yes or '				6	Υ	14H082	140. 00
are claimed, enter in column 2 the		er. (see instruct !.00	i ons)		3. 00		
If this facility is part of a chai	n organization, enter o	n lines 141 thro		name and		of the	
home office and enter the home offi 141.00 Name: PRESENCE HEALTH	Contractor name and Contractor's Name:			tor's Nur	mber: 0013	R1	141. 00
142.00 Street: 200 S. WACKER DRIVE	PO Box:	1100	Joantraet	.01 3 1101	ilber. oore	, ,	142. 00
143. 00 Ci ty: CHI CAGO	State:	I L	Zi p Code	e:	6060)6 	143. 00
						1.00	
144.00 Are provider based physicians' cos						Υ	144. 00
145.00 If costs for renal services are cl only? Enter "Y" for yes or "N" for		ine 74, are the c	costs for inp	oati ent	servi ces	Y	145. 00
					1. 00	2.00	
146.00 Has the cost allocation methodolog					N N	2.00	146. 00
Enter "Y" for yes or "N" for no in		. 15-2, § 4020) I	f yes, enter	r			
the approval date (mm/dd/yyyy) in 147.00 Was there a change in the statisti		r ves or "N" for	no.		N		147. 00
148.00 Was there a change in the order of	allocation? Enter "Y"	for yes or "N" fo	or no.		N		148. 00
149.00 Was there a change to the simplifino.	ed cost finding method?	Enter "Y" for ye	es or "N" for	r	N		149. 00
IIIO.		Part A	Part B		tle V	Title XIX	
Does this facility contain a provi	der that qualifies for	1.00	2.00		3.00	4.00	
or charges? Enter "Y" for yes or '						3. 13)	
155. 00 Hospi tal		N	N N		N	N	155. 00
156. 00 Subprovi der - IPF 157. 00 Subprovi der - IRF		N N	l N N		N N	N N	156. 00 157. 00
158. 00 SUBPROVI DER		14	"		14		158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	l N		N	N	160.00
161. 00 CMHC			N N		N	N	161. 00
						1.00	
Multicampus 165.00 s this hospital part of a Multica	ampus hospital that has	one or more campu	uses in diffe	erent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	· · · · · · · · · · · · · · · · · · ·	<u> </u>					1
	Name O	County 1.00	State Zi	p Code 3.00	4. 00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each campus enter the name in column		11 00	2.00	0.00	11.00		00 166. 00
0, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
						1.00	
Health Information Technology (HI) incentive in the Amer	ican Recovery and	d Reinvestme	nt Act		1.50	
167.00 Is this provider a meaningful user	under Section §1886(n)	? Enter "Y" for	yes or "N" f	for no.		N	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			e 167 is "Y")), enter	the		0168.00
169.00 If this provider is a meaningful u			(line 105 is	"N"), e	nter the	0.	00169.00
transition factor. (see instruction				,, -			

Health Financial Systems	7					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	ND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 142011 Period: W					
			To 12/31/2014	Date/Time Pre 5/19/2015 5:4		
			Begi nni ng	Endi ng		
			1. 00	2. 00		
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)		170. 00				
				1. 00		
171.00 If line 167 is "Y", does this provider Medicare cost plans reported on Wkst. S (see instructions)	N	171. 00				

		HOLY FAMILY MEDICA				eu of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE:	STI ONNAI RE	Provi der	F	Period: From 01/01/2014 To 12/31/2014	Date/Time Pro	epared:
					Y/N	5/19/2015 5: Date	43 pm
					1. 00	2. 00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	onses. Enter N for	all NO re	esponses. Enter	all dates in	the	
1. 00	Provider Organization and Operation Has the provider changed ownership immediatel	v prior to the bea	i nni na of	the cost	N		1.00
	reporting period? If yes, enter the date of t						
				Y/N 1,00	Date	V/I 3. 00	
2.00	Has the provider terminated participation in	the Medicare Progr	am? If	1.00 N	2. 00	3.00	2. 00
	yes, enter in column 2 the date of termination						
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g.			N			3.00
	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 relationships? (see instructions)						
	Teratronships: (see Fristructions)			Y/N	Type	Date	
				1.00	2. 00	3.00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared Accountant? Column 2: If yes, enter "A" for			Y	А		4. 00
	or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	enter date availab					
5.00	Are the cost report total expenses and total			Υ			5. 00
	those on the filed financial statements? If y	yes, subiiii t reconci	11 att on.		Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities		! - 41		NI NI		
6. 00	Column 1: Are costs claimed for nursing schothe legal operator of the program?	DOI? COLUMN 2: IT	yes, is ti	ne provider is	N		6.00
7. 00	Are costs claimed for Allied Health Programs?	Plf"Y" see instru	ıcti ons.		N		7. 00
8.00	Were nursing school and/or allied health programs reporting period? If we are instruction		or renewed	d during the	N		8. 00
9. 00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		urrent cos	st report? If	Υ		9. 00
	yes, see instructions.			•			
10. 00	Was an Intern-Resident program been initiated period? If yes, see instructions.	or renewed in the	current o	cost reporting	N		10.00
11. 00	Are GME cost directly assigned to cost center		in an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see	instructions.				Y/N	
	Bad Debts					1.00	
12. 00	Is the provider seeking reimbursement for bac	debts? If yes, se	e instruc	tions.		Υ	12.00
13. 00	If line 12 is yes, did the provider's bad deb	ot collection polic	y change o	during this cos	st reporting	N	13.00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments	wai ved? I	f yes, see inst	ructions.	N	14. 00
15. 00	Did total beds available change from the price	or cost reporting p	eriod? If	yes, see instr	ructions.	N	15. 00
		· · ·		Par	rt A	Part B	
		Descriptio 0	on	Y/N 1.00	2. 00	Y/N 3.00	
	PS&R Data	0		1.00	2.00	3.00	
16. 00	Was the cost report prepared using the PS&R Report only? 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			Y	04/17/2015	Y	16.00
17. 00	instructions) Was the cost report prepared using the PS&R			N		N	17. 00
	Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)						
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file			N		N	18.00
19. 00	this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see			N		N	19. 00
20. 00	instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N		N	20.00

	Financial Systems	HOLY FAMILY MEDICAL			In Lie	u of Form CM	IS-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 142011	Peri od: From 01/01/2014 To 12/31/2014		Prepared:
	·			Р	art A	Part B	
		Descriptio	n	Y/N	Date	Y/N	
		0		1.00	2. 00	3.00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00
						1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCEPT CH	HILDRENS H	OSPI TALS)			
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purpose	es? If yes, see ins	tructions				22. 00
23. 00	Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.	ation expense due	to apprais	als made duri	ng the cost		23. 00
24. 00	Were new leases and/or amendments to existing lf yes, see instructions	g leases entered in	to during	this cost rep	porting period?		24. 00
25. 00	Have there been new capitalized leases entere instructions.	ed into during the	cost repor	ting period?	If yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	uired during the co	st reporti	ng period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy charcopy.	nged during the cos	t reportin	g period? If	yes, submit		27. 00
	Interest Expense						
28. 00	Were new Loans, mortgage agreements or Letter period? If yes, see instructions.	rs of credit entere	d into dur	ing the cost	reporting		28. 00
29. 00	Did the provider have a funded depreciation attreated as a funded depreciation account? If			bt Service Re	eserve Fund)		29. 00
30. 00	Has existing debt been replaced prior to its instructions.			debt? If yes,	see		30. 00
31. 00	Has debt been recalled before scheduled matur	rity without issuan	ce of new	debt? If yes,	see		31.00
	instructions.						
32. 00	Purchased Services Have changes or new agreements occurred in pa	ationt care comples	- Euroi obo	d through on	atmostusi		32, 00
32.00	arrangements with suppliers of services? If			a through cor	iti actuai		32.00
33. 00	If line 32 is yes, were the requirements of 3 no, see instructions.			g to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili	ty under an arrang	ement with	provi der-bas	sed physi ci ans?		34.00
	If yes, see instructions.						
35. 00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			ts with the p	orovi der-based		35. 00
	physicians during the cost reporting period:	ii yes, see ilistiu	ZTI OHS.		Y/N	Date	
					1. 00	2. 00	
	Home Office Costs						
36. 00	Were home office costs claimed on the cost re	•					36. 00
37. 00	If line 36 is yes, has a home office cost stall f yes, see instructions.	atement been prepar	ed by the	home office?			37. 00
38. 00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the						38. 00
20 00	If Line 24 is yes, did the provider render of						20.00

37.00	If yes, see instructions.							
20.00	1 3 1	Si		20.00				
38.00	If line 36 is yes, was the fiscal year end of the home off			38. 00				
20.00	the provider? If yes, enter in column 2 the fiscal year end			39. 00				
39.00								
	see instructions.							
40. 00								
	i nstructi ons.							
		1.00	2.00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	SANDI	COSLER	41. 00				
	held by the cost report preparer in columns 1, 2, and 3,							
	respectively.							
42.00	Enter the employer/company name of the cost report	PRESENCE HEALTH		42.00				
	preparer.							
43.00	Enter the telephone number and email address of the cost	8158062327	SANDRA. COSLER@PRESENCEHEALTH	43.00				
	report preparer in columns 1 and 2, respectively.		. ORG					
	1 - F - F - F - F - F - F - F - F - F -	T .	1					

						From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Part B Date 4.00					<u>5/19/2015</u> 5: 4	3 piii
	PS&R Data	4.00						
16. 00	Was the cost report prepared using the PS&R Report only? 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)	04/17/2015						16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)							17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.							18. 00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.							19. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:							20. 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.							21. 00
				3. 00				
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns are respectively.		SYSTEM	DIR OF REIMBUR	RSEMENT			41. 00
42. 00	Enter the employer/company name of the cost r	report						42. 00
43. 00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respective							43. 00

 Heal th Financial
 Systems
 HOLY FAM

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 142011

					10) 12/31/2014	5/19/2015 5: 4	
							I/P Days / 0/P	J piii
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		120	43, 800	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and				·			
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			120	43, 800	0.00	0	
7.00	beds) (see instructions)			.20	10,000	0.00	Ŭ	7.00
8.00	INTENSIVE CARE UNIT	31. 00		8	2, 920	0.00	0	8. 00
9.00	CORONARY CARE UNIT				,			9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14. 00	Total (see instructions)			128	46, 720	0.00	0	
15. 00	CAH visits			120	40, 720	0.00	0	15. 00
16. 00	SUBPROVI DER - I PF						0	16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19.00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY							22.00
	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			128				27. 00
28. 00	Observation Bed Days			120			0	28. 00
29. 00	Ambul ance Tri ps						0	29.00
30.00	Employee discount days (see instruction)							30.00
	Employee discount days (see Fristruction)							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 00	Total ancillary labor & delivery room			٩	U			32.00
32.01	outpatient days (see instructions)							32.01
33 00	LTCH non-covered days			ł				33. 00
33.00	Lion non covered days	I	l	I			l	1 33.00

						5/19/2015 5:4	3 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	18, 512	1, 698	33, 424			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds) HMO and other (see instructions)	30	0				2 00
2. 00 3. 00	HMO IPF Subprovider	0	0				2. 00 3. 00
4. 00	HMO IRF Subprovider		0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF		0	(5.00
6.00	Hospital Adults & Peds. Swing Bed NF	U	0				6.00
7. 00	Total Adults and Peds. (exclude observation	18, 512	1, 698	33, 424			7.00
7.00	beds) (see instructions)	10, 512	1, 070	33, 424			7.00
8. 00	INTENSIVE CARE UNIT	1, 032	91	2, 220)		8. 00
9. 00	CORONARY CARE UNIT	1,002	, ,	2,220			9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13.00
14.00	Total (see instructions)	19, 544	1, 789	35, 644	0.09	556. 40	14.00
15.00	CAH visits	o	0	C)		15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	C			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0. 09	556. 40	1
28. 00	Observation Bed Days		0	C			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF		0	C			31.00
32. 00	Labor & delivery days (see instructions)	0	0	C			32.00
32. 01	Total ancillary labor & delivery room				'		32. 01
33 00	outpatient days (see instructions) LTCH non-covered days	o					33.00
33.00	TETOTI HOTI COVETEU days	ı Y	ı	l	1	I	1 33.00

				To	12/31/2014	Date/Time Prep 5/19/2015 5:4:	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
1.00		11. 00	12.00	13.00	14.00	15.00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		C	583	49	1, 481	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1	0		2. 00
3.00	HMO IPF Subprovider						3. 00
4. 00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						6. 00 7. 00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		_				13. 00
14.00	Total (see instructions)	0. 00	C	583	49	1, 481	14. 00
15. 00 16. 00	CAH visits SUBPROVIDER - IPF						15. 00 16. 00
17. 00	SUBPROVIDER - IPF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00 24. 10	HOSPICE						24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room						32. 00 32. 01
32.01	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33. 00

Heal th	n Financial Systems	HOLY FAMILY MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der		Peri od:	Worksheet A	
					rom 01/01/2014	D 1 /T' D	
					o 12/31/2014	Date/Time Prep 5/19/2015 5:4:	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	3 PIII
	oost center bescription	Sararres	Other	+ col . 2)	ons (See A-6)	Tri al Balance	
				+ (01. 2)	0113 (See A-0)	(col . 3 +-	
						col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT		4, 508, 025	4, 508, 025	-2, 875, 194	1, 632, 831	1. 00
2.00	00200 CAP REL COSTS-BEDG & TTXT		4, 500, 025	4, 500, 023		4, 847, 505	2.00
3. 00	00300 OTHER CAP REL COSTS		0		4, 647, 303		
	00400 EMPLOYEE BENEFITS DEPARTMENT	121 440	-8. 904	140 25		140.353	3.00
4.00		-131, 449				-140, 353	4. 00
5. 01	00540 NONPATI ENT TELEPHONES	0	201, 423	201, 423		201, 423	5. 01
5. 02	00550 DATA PROCESSING	0	40 570	40 576	11 400	0	5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	0	49, 578	49, 578	-11, 499	38, 079	5. 03
5. 04	00570 ADMITTING	1/1/00	75 (54	007.04	0 010	0	5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	161, 692	75, 654			229, 133	5. 05
5.06	00590 ADMI NI STRATI VE & GENERAL	4, 098, 637	12, 439, 478				5. 06
6. 00	00600 MAINTENANCE & REPAIRS	444, 240	371, 001			815, 036	6. 00
7. 00	00700 OPERATION OF PLANT	375, 200	2, 990, 922			3, 361, 512	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	286, 152			286, 044	8. 00
9.00	00900 HOUSEKEEPI NG	927, 337	674, 978			1, 583, 825	9. 00
10.00	01000 DI ETARY	643, 972	1, 385, 462	2, 029, 434		1, 219, 240	10. 00
11. 00		0	0	(798, 846	798, 846	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	(0	0	12.00
13.00	01300 NURSING ADMINISTRATION	622, 148	128, 005	750, 153	-869	749, 284	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	92, 276	344, 485	436, 761	-414, 568	22, 193	14. 00
15. 00	01500 PHARMACY	1, 046, 323	3, 722, 659	4, 768, 982	-3, 487, 569	1, 281, 413	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	355, 914	222, 429			571, 141	16. 00
17. 00		0	. 0	(0	0	17. 00
21. 00		0	0		2, 298	2, 298	21. 00
22. 00		l o	0) 2,2,0	0	22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS				,	<u> </u>	22.00
30. 00		11, 989, 464	5, 203, 855	17, 193, 319	-2, 797, 599	14, 395, 720	30. 00
31. 00		1, 601, 844	532, 314			1, 945, 904	31. 00
01.00	ANCI LLARY SERVICE COST CENTERS	1,001,011	002,011	2, 101, 100	100, 201	1, 710, 701	01.00
50. 00		1, 110, 779	1, 339, 896	2, 450, 675	-1, 032, 265	1, 418, 410	50. 00
53. 00	1	1,110,777	326, 281				
54. 00	1	482, 420	230, 877			609, 225	54. 00
56. 00	1	37, 847	29, 758			53, 786	56. 00
57. 00	1	138, 306	65, 247			185, 019	57. 00
57. 00	1	166, 526	46, 692	1		206, 736	57. 00
58. 00							
	1 1	39, 217	12, 512			50, 755	
60.00	1	1	2, 286, 198			2, 286, 480	60.00
65. 00	1	3, 064, 197	1, 086, 317			3, 833, 512	65. 00
66. 00		2, 401, 014	572, 970			2, 941, 199	66.00
69. 00		65, 198	22, 895			80, 700	69.00
70.00		225, 649	91, 596	1			70.00
71. 00		0	0	(_,,	2, 824, 001	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(579, 808		
73. 00		0	0	(3, 669, 660	
74. 00		602, 140	254, 206			781, 020	74. 00
76. 00		125, 258	39, 177	164, 435	967, 166	1, 131, 601	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	756, 289	857, 719	1, 614, 008	-536, 181	1, 077, 827	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00		66, 657	-13, 283	53, 374	-6, 340	47, 034	90.00
90. 02	1	189, 640	63, 428			· ·	
92. 00	1						92.00
	SPECIAL PURPOSE COST CENTERS						
113. 0	0 11300 I NTEREST EXPENSE		848, 907	848, 907	-848, 907	Ω	113. 00
118. 0	1	31, 698, 735	41, 288, 909			72, 987, 644	
	NONREI MBURSABLE COST CENTERS	2., 3,0,,00	, _55, 707	. =, , 5., 61		. =, , , , , , , ,	1
200. 0		31, 698, 735	41, 288, 909	72, 987, 644	0	72, 987, 644	200. 00
					-1		

Health FinancialSystemsHOLY FAMILRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

				5/19/2015 5:	43 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
. 00	00100 CAP REL COSTS-BLDG & FLXT	104, 698	1, 737, 529		1.
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	384, 701		•	2.
. 00	00300 OTHER CAP REL COSTS	001,701	1		3.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	240, 528		1	4.
. 01	00540 NONPATI ENT TELEPHONES	2 10, 020	201, 423	•	5.
. 02	00550 DATA PROCESSING	1, 249, 892		•	5.
. 03	00560 PURCHASING RECEIVING AND STORES	474, 447		•	5.
. 04	00570 ADMITTING	.,,,,,,	0.2,020	1	5.
. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 627, 424	1, 856, 557		5.
. 06	00590 ADMINISTRATIVE & GENERAL	-4, 554, 392			5.
. 00	00600 MAINTENANCE & REPAIRS			1	6.
. 00	00700 OPERATION OF PLANT		3, 361, 512		7.
. 00	00800 LAUNDRY & LINEN SERVICE	C	286, 044	1	8.
. 00	00900 HOUSEKEEPI NG	C	1	•	9.
0. 00	01000 DI ETARY	-15, 924			10.
1.00	01100 CAFETERI A	-332, 617			11.
2.00	01200 MAINTENANCE OF PERSONNEL	C		1	12.
3.00	01300 NURSING ADMINISTRATION	C	749, 284		13.
4.00	01400 CENTRAL SERVICES & SUPPLY	82, 740	104, 933		14.
5.00	01500 PHARMACY	C	1, 281, 413		15.
6.00	01600 MEDICAL RECORDS & LIBRARY	-780	570, 361		16.
7.00	01700 SOCIAL SERVICE	C	0		17.
1. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	C	2, 298		21.
2. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	C	0		22.
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS	-27, 347	14, 368, 373		30.
1. 00	03100 INTENSIVE CARE UNIT	185, 137	2, 131, 041		31.
	ANCILLARY SERVICE COST CENTERS	Т .		T	٠
0.00	05000 OPERATI NG ROOM	000 (4)	1 .,	•	50.
3.00	05300 ANESTHESI OLOGY	-306, 646			53.
4.00	05400 RADI OLOGY-DI AGNOSTI C		609, 225	•	54.
6.00	05600 RADI OI SOTOPE		53, 786	•	56.
7.00	05700 CT SCAN		185, 019	•	57.
7. 01 8. 00	03630 ULTRA SOUND		206, 736	•	57. 58.
0.00	06000 LABORATORY	144 E40	50, 755	•	60.
5. 00	06500 RESPIRATORY THERAPY	-164, 568			65.
6. 00	06600 PHYSI CAL THERAPY	-796		1	66.
9. 00	06900 ELECTROCARDI OLOGY	-770	80, 700	•	69.
0.00			304, 257	•	70.
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		2, 824, 001		71.
2. 00			579, 808		72.
3. 00	07300 DRUGS CHARGED TO PATIENTS				73.
	07400 RENAL DIALYSIS		781, 020		74.
6. 00			1, 131, 601	1	76.
6. 97	07697 CARDI AC REHABI LI TATI ON		0	1	76.
	07698 HYPERBARI C OXYGEN THERAPY				76.
	07699 LI THOTRI PSY	C			76.
0. //	OUTPATIENT SERVICE COST CENTERS		,, ,	1	┤ ′ °.
0. 00	09000 CLINIC	С	47, 034		90.
	09001 WOMENS DIAGNOSTIC CENTER				90.
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		275, 700		92.
2.00	SPECIAL PURPOSE COST CENTERS				⊢ ′².
13 00	11300 INTEREST EXPENSE	T c	0		113.
18. 00		-1, 053, 503			118.
		., 000, 000	., ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	1.15.
	NONREI MBURSABLE COST CENTERS				

Health Financial Systems RECLASSIFICATIONS Provider CCN: 142011

11.00 12.00 13.00 10.00						5/19/2015 5: 43	
A - BECLASS NOV ENUMERT DEPTR EXPENSE CORP OF COSTS - WORD FOOL P 2,00 0 2,975,194			Increases				
A. SECLASS SWIP CONTS MULL POWER DEPOSES							
DAP INCL COSTS-TOWNEL EQUIP 2.00				4. 00	5. 00		
IDIALS							
B - SECLASS INTEREST EXPENSE	1. 00						1. 00
CAP BELL COSTS MAINE FOULP 2.00				0	2, 875, 194		
TOTALS CAT I TIEZA CAT I TIEZA 1.00 CHECLASS DIETAMY COSTS 1.00 PATENT NEL CALS SUPPLY COSTS 1.00 PATENT INIT. BEV CHARGED TO PATENT INIT. BEV CHARGED TO PATENT INIT. BEV CHARGED TO ROO 0 0.00							
Company Comp	1. 00						1. 00
1.00 CAPTERN A 11.00 293.487 545.359				0	848, 907		
TOTAL S							
D	1.00		11.00	+			1. 00
DO PATE SCHARGED TO PA				253, 487	545, 359		
PATLENT	4 00		74 00		0.004.004		4 00
MPL DEV. CHARGE TO	1.00		/1.00	O	2, 824, 001		1. 00
ATTENTS SERVICES & SUPPLY 14.00	2 00	1	72.00		F70, 000		2 00
3.00 CENTRAL SERVICES & SUPPLY 14.00 0 219,499 40.00 0 264 40.00 60.00 0 0 0 0 0 0 0 0 0	2.00		72.00	٩	379, 000		2. 00
4. 00 7. 00 8. 00 7. 00 9. 00	3 00		14 00		210 400		3. 00
6.00 8.00 10.0			· •	- 1			4. 00
7.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		LABORATORT		- 1			6. 00
0.00			·	-			7. 00
10.00							
11.00 12.00 13.00 10.00				- 1			8.00
12.00 14.00 15.00 16.00 16.00 16.00 16.00 16.00 10.00				-1			10.00
13.00							11.00
14. 00 0. 00 0. 00 0 0 0 0 0				-1			12.00
15. 00			· · · · · · · · · · · · · · · · · · ·				13.00
16. 00 18. 00 19. 00 19. 00 21. 00 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20			· · · · · · · · · · · · · · · · · · ·	-			14. 00
17. 00 18. 00 19. 00 19. 00 20							15. 00
18. 00 21. 00 21. 00 21. 00 22. 00 23. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 20			· · · · · · · · · · · · · · · · · · ·				16. 00
19,00			· · · · · · · · · · · · · · · · · · ·	0			17. 00
21 00	18.00		0.00	0	0		18.00
22 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19.00		0.00	0	0		19.00
23 00	21.00		0.00	O	0		21.00
24.00 0.00 0 0 0 0 0 0 0				o			22. 00
24.00 0.00 0 0 0 0 0 0 0			•	0	0		23. 00
25. 00 0.00 0.00 0 0 0 0 0				- 1			24. 00
26. 00 0.00 0 0 0 0 0 0 0				0			25. 00
27. 00							26. 00
TOTALS			· · · · · · · · · · · · · · · · · · ·				27. 00
TOTALS				- 1	0		28. 00
E - RECLASS DRUG COSTS 1. 00 DRUGS CHARGED TO PATIENTS 73 00 0 0 29, 197 3. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 29, 197 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00	TOTALS — — — — —			3 623 592		20.00
1. 0.0 DRUGS CHARGED TO PATIENTS 73. 00 0 3, 669, 660 2. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 29, 197 3. 00 4. 00 0 0 0 0 4. 00 0 0 0 0 5. 00 0 0 0 0 6. 00 0 0 0 0 7. 00 0 0 0 8. 00 0 0 0 9. 00 0 0 0 11. 00 0 0 0 113. 00 0 0 0 114. 00 0 0 0 115. 00 0 0 0 115. 00 0 0 0 116. 00 0 0 0 117. 00 0 0 0 118. 00 0 0 0 119. 00 0 0 0 119. 00 0 0 0 110. 00				<u> </u>	0,020,072		
2. 00 CENTRAL SERVI CES & SUPPLY	1 00		73 00	0	3 669 660		1. 00
3.00 4.00 5.00 0.00 0.00 0.00 0.00 0.00 0		1	•	•			2. 00
4. 00				•			3. 00
5.00			·	o			4. 00
6. 00 7. 00 8. 00 9. 00 10. 00 9. 00 10. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10. 00							5. 00
7. 00 8. 00 9. 00 10. 00 10. 00 112. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10.				- 1			6. 00
8. 00 9. 00 10. 00 0. 00 0. 00 0. 00 0. 00 0. 00 12. 00 13. 00 14. 00 0.				-1			7. 00
9. 00 10. 00 10. 00 11. 00 12. 00 0.				-			8. 00
10. 00 12. 00 12. 00 13. 00 0. 00 0. 00 0. 00 0. 00 0. 00 14. 00 15. 00 16. 00 0. 00							9. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 17. 00 18. 00 17. 00 18. 00 19. 00 20. 00 19. 00 20. 00 10			· · · · · · · · · · · · · · · · · · ·				
13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 19. 00 20. 00 17. 00 18. 00 19. 00 20. 00 10 10 10 10 10 10 10 10 10 10 10 10 1			· · · · · · · · · · · · · · · · · · ·				10.00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 10 10 10 10 10 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 10				•			12.00
15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 TOTALS F - RECLASS RESI DENCY COSTS 1. 00 18 R SERVI CES-SALARY & 21. 00 2, 298 0 FRI NGES APPRV				0			13.00
16. 00 17. 00 18. 00 19. 00 0.				0			14.00
17. 00 18. 00 19. 00 20. 00 10. 00 20. 00 10. 00 20. 00 10. 00 20. 00 10. 00 20. 00 10. 00 20. 00 10. 00 20. 00 10. 00 20. 00 10. 00 20. 00 10. 00 20. 00 10. 00 20. 00 10. 00 20. 0			· · · · · · · · · · · · · · · · · · ·	0	0		15.00
18. 00 19. 00 20. 00 TOTALS F - RECLASS RESIDENCY COSTS I &R SERVI CES-SALARY & 21. 00 2, 298 0 G - RECLASS RENTAL COSTS 1. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 3. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9.				0	0		16.00
19.00 20.00 TOTALS F - RECLASS RESIDENCY COSTS I &R SERVI CES-SALARY & 21.00 2, 298 0 FRI NGES APPRV 70TALS CAP REL COSTS-MVBLE EQUI P 2.00 0 1, 123, 404 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.00 0.00 0.00 0.00 0				0	0		17. 00
20. 00				0	0		18. 00
TOTALS F - RECLASS RESIDENCY COSTS 1.00 I &R SERVI CES-SALARY & 21.00 2, 298 0 FRI NGES APPRV 2, 298 0 G - RECLASS RENTAL COSTS 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 1, 123, 404 2.00 3.00 4.00 5.00 6.00 7.00 0.00				0			19. 00
F - RECLASS RESIDENCY COSTS I &R SERVICES-SALARY & 21.00 2,298 0 TOTALS 2,298 0 G - RECLASS RENTAL COSTS CAP REL COSTS-MVBLE EQUIP 2.00 0 1,123,404 2.00 0 0 0 0 3.00 0 0 0 4.00 0 0 0 5.00 0 0 0 6.00 0 0 0 7.00 0 0 0 8.00 0 0 0 9.00 0 0 0 9.00 0 0 0 0 0 0	20.00		0.00	0_			20. 00
1. 00				0	3, 698, 857		
FRI NGES APPRV							
TOTALS G - RECLASS RENTAL COSTS 1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	1.00		21. 00	2, 298	0		1. 00
G - RECLASS RENTAL COSTS 1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9			L _ L				
G - RECLASS RENTAL COSTS 1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9				2, 298	0		
2. 00 0. 00 0 0 3. 00 0. 00 0 0 4. 00 0. 00 0 0 5. 00 0. 00 0 0 6. 00 0. 00 0 0 7. 00 0. 00 0 0 8. 00 0. 00 0 0 9. 00 0. 00 0 0		G - RECLASS RENTAL COSTS					
2. 00 0. 00 0 0 3. 00 0. 00 0 0 4. 00 0. 00 0 0 5. 00 0. 00 0 0 6. 00 0. 00 0 0 7. 00 0. 00 0 0 8. 00 0. 00 0 0 9. 00 0. 00 0 0	1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 123, 404		1.00
3.00 4.00 5.00 6.00 7.00 8.00 9.00				ol	_		2. 00
4.00 0.00 0 0 5.00 0.00 0 0 6.00 0.00 0 0 7.00 0.00 0 0 8.00 0.00 0 0 9.00 0.00 0 0				- 1			3. 00
5. 00 0.00 0 0 6. 00 0.00 0 0 7. 00 0.00 0 0 8. 00 0.00 0 0 9. 00 0.00 0 0			· · · · · · · · · · · · · · · · · · ·	-1	-		4. 00
6.00				-	-		5. 00
7. 00				0	0		
8. 00 9. 00 0. 00 0 0				O C	0		6.00
9.00 0.00 0				-			7. 00
				-			8.00
10.00 L O OOL OL O				1			9.00
	10. 00	<u> </u>	0.00	0	0		10. 00

Health Financial Systems RECLASSIFICATIONS HOLY FAMILY MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 142011

Period: Worksheet A-0
From 01/01/2014
To 12/31/2014 Date/Time Prepared: 5/19/2015 5:43 pm

					37 197 2013 3: 43 pili	_
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 00		
11.00		0.00	0	0	11.00	Ю
12.00		0.00	0	0	12.00	Ю
13.00		0.00	0	0	13.00	Ю
14.00		0.00	0	0	14.00	Ю
15.00		0.00	0	0	15. 00	Ю
16.00		0.00	0	0	16. 00	Ю
17.00		0.00	0	0	17. 00	Ю
18.00		0.00	0	0	18.00	Ю
20.00		0.00	0	0	20.00	Ю
21.00		0.00	0	0	21.00	Ю
22.00		0.00	0	0	22. 00	Ю
23.00		0.00	0	0	23. 00	Ю
24.00		0.00	0	0	24. 00	Ю
25.00		0.00	0	0	25. 00	Ю
26.00		0.00	0	0	26. 00	Ю
27.00		0.00	0	0	27. 00	Ю
	TOTALS — — — — —		₀	1, 123, 404		
	H - RECLASS SUBSTANCE ABUSE					
1.00	SUBSTANCE ABUSE	76.00	693, 351	273, 815	1. 00	00
	TOTALS		693, 351	273, 815		
500.00	Grand Total: Increases		949, 136	12, 989, 128	500. 00	Ю

						5/19/2015 5:	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	A - RECLASS MOV EQUIPMENT DEF						
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	•	<u>2, 875, 1</u> 94			1. 00
	TOTALS		0	2, 875, 194			
	B - RECLASS INTEREST EXPENSE	,			,		
1. 00	INTEREST EXPENSE	113.00	•	84 <u>8, 9</u> 07			1. 00
	TOTALS		0	848, 907			
	C - RECLASS DIETARY COSTS						
1.00	DI ETARY	10.00	<u>253, 4</u> 87	54 <u>5, 3</u> 59			1. 00
	TOTALS		253, 487	545, 359			
	D - RECLASS SUPPLY COSTS						
1.00	PURCHASING RECEIVING AND	5. 03	0	8	0		1. 00
	STORES						
2.00	CASHI ERI NG/ACCOUNTS	5. 05	0	4, 527	0		2. 00
	RECEI VABLE						
3.00	ADMINISTRATIVE & GENERAL	5. 06	0	328	0		3. 00
4.00	MAINTENANCE & REPAIRS	6.00	0	8	0		4. 00
6.00	HOUSEKEEPI NG	9.00	0	18, 408	0		6. 00
7.00	DI ETARY	10.00	0	468	0		7. 00
8.00	NURSING ADMINISTRATION	13.00	0	130	0		8. 00
10.00	PHARMACY	15.00	0	14, 955	0		10.00
11. 00	ADULTS & PEDIATRICS	30.00	0	1, 649, 462	0		11. 00
12.00	INTENSIVE CARE UNIT	31.00	0	171, 182	0		12. 00
13.00	OPERATING ROOM	50.00	0	999, 715			13. 00
14. 00	ANESTHESI OLOGY	53. 00	o	15, 557			14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	96, 457			15. 00
16. 00	RADI OI SOTOPE	56.00	0	11, 090			16. 00
17. 00	CT SCAN	57. 00	o	14, 227	- 1		17. 00
18. 00	ULTRA SOUND	57. 01	o	6, 482			18. 00
19. 00	MRI	58.00	Ö	965			19. 00
21. 00	RESPIRATORY THERAPY	65.00	0	302, 003			21. 00
22. 00	PHYSICAL THERAPY	66.00	0	18, 662			22. 00
23. 00	ELECTROCARDI OLOGY	69.00	0	772			23. 00
	•	1	0				1
24. 00	ELECTROENCEPHALOGRAPHY	70.00	ı,	9, 130			24. 00
25. 00	RENAL DIALYSIS	74.00	0	73, 681			25. 00
26.00	HYPERBARIC OXYGEN THERAPY	76. 98	0	204, 893			26. 00
27. 00	CLINIC	90.00	0	3, 536			27. 00
28. 00	WOMENS DIAGNOSTIC CENTER	90.02	•	<u>6, 946</u>			28. 00
	TOTALS		0	3, 623, 592			_
1 00	E - RECLASS DRUG COSTS	10.00	٥	100			1 00
1.00	DI ETARY	10.00	0	102			1.00
2.00	DUA DIMA OV	0.00	0	0	-		2. 00
3.00	PHARMACY	15.00	0	3, 469, 635			3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	155, 858			4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	16, 525			5. 00
6. 00	OPERATING ROOM	50.00	0	18, 854			6. 00
7. 00	ANESTHESI OLOGY	53.00	0	819			7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 732			8. 00
9. 00	RADI OI SOTOPE	56.00	0	57			9. 00
10. 00	CT SCAN	57.00	0	4, 248			10. 00
12. 00	MRI	58.00	0	9	-		12. 00
13.00	LABORATORY	60.00	0	2	0		13. 00
14. 00	RESPIRATORY THERAPY	65.00	0	11, 339	0		14. 00
15.00	PHYSI CAL THERAPY	66.00	0	508			15. 00
16.00	ELECTROCARDI OLOGY	69.00	0	416	0		16. 00
17. 00	RENAL DIALYSIS	74.00	0	1, 628	0		17. 00
18.00	HYPERBARIC OXYGEN THERAPY	76. 98	o	15, 515	0		18. 00
19.00	CLINIC	90.00	0	591			19. 00
20.00	WOMENS DIAGNOSTIC CENTER	90. 02	O	19	0		20.00
	TOTALS			3, 698, 857			İ
	F - RECLASS RESIDENCY COSTS	1	1		'		
1.00	ADMINISTRATIVE & GENERAL	5. 06	2, 298	0	0		1.00
	TOTALS		2, 298	₀			
	G - RECLASS RENTAL COSTS		-, 0				
1.00	PURCHASI NG RECEI VI NG AND	5. 03	0	11, 491	10		1.00
00	STORES	0.00	Ĭ	,			
2.00	CASHI ERI NG/ACCOUNTS	5. 05	0	3, 686	o		2. 00
2.00	RECEI VABLE	3.03	9	3, 000	١		2.00
3. 00	ADMINISTRATIVE & GENERAL	5. 06	o	23, 814	o		3. 00
4. 00	MAINTENANCE & REPAIRS	6.00	0	197			4. 00
5. 00	OPERATION OF PLANT	7.00	0	4, 610			5. 00
6. 00	LAUNDRY & LINEN SERVICE	8.00	0	108			6. 00
		9.00	0				7. 00
7.00	HOUSEKEEPI NG			82 10. 779			
8.00	DI ETARY	10.00	0	10, 778			8.00
9. 00	NURSING ADMINISTRATION	13. 00	0	739	0		9. 00

Health Financial Systems RECLASSIFICATIONS HOLY FAMILY MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 142011

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

							5/19/2015 5:43 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
10.00	CENTRAL SERVICES & SUPPLY	14. 00	0	663, 264	(0	10.00
11. 00	PHARMACY	15. 00	0	2, 979	(0	11.00
12.00	MEDICAL RECORDS & LIBRARY	16. 00	0	7, 202	(0	12. 00
13.00	ADULTS & PEDIATRICS	30.00	0	25, 113	(0	13. 00
14.00	INTENSIVE CARE UNIT	31.00	0	547	(0	14. 00
15.00	OPERATING ROOM	50.00	0	13, 696	(0	15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	4, 883	(0	16. 00
17.00	RADI OI SOTOPE	56.00	0	2, 672	(0	17. 00
18.00	CT SCAN	57. 00	0	59	(18. 00
20.00	RESPIRATORY THERAPY	65. 00	0	3, 660	(20. 00
21.00	PHYSI CAL THERAPY	66. 00	0	13, 615	(21. 00
22.00	ELECTROCARDI OLOGY	69. 00	0	6, 205	(0	22. 00
23.00	ELECTROENCEPHALOGRAPHY	70. 00	0	3, 858	(23. 00
24.00	RENAL DIALYSIS	74. 00	0	17	(24. 00
25.00	HYPERBARIC OXYGEN THERAPY	76. 98	0	315, 773	(25. 00
26.00	CLINIC	90.00	0	2, 213	(26. 00
27.00	WOMENS DIAGNOSTIC CENTER	90. 02	0	2, 143		o l	27. 00
	TOTALS		0	1, 123, 404			
	H - RECLASS SUBSTANCE ABUSE						
1.00	ADULTS & PEDIATRICS	30.00	693, 351	273, 815	()	1. 00
	TOTALS		693, 351	273, 815			
500.00	Grand Total: Decreases		949, 136	12, 989, 128			500.00

					From 01/01/2014 To 12/31/2014	Date/Time Pre	
				A : -: +:		5/19/2015 5: 4	3 pm
		Dogi nai ng	Purchases	Acquisitions Donation	Total	Di anggal a and	
		Begi nni ng Bal ances	Pur chases	Donation	Total	Disposals and Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	3.00	4.00	3.00	
1.00	Land	342,000	0		0 0	0	1.00
2.00	Land Improvements	4, 077, 827	0		0	0	2.00
3.00	Buildings and Fixtures	84, 740, 088	817, 597		0 817, 597	0	3. 00
4.00	Building Improvements	0	0		0 0	0	4. 00
5.00	Fi xed Equi pment	2, 119, 028	0		o o	0	5. 00
6.00	Movable Equipment	34, 685, 987	1, 285, 484		0 1, 285, 484	0	6. 00
7.00	HIT designated Assets	0	0		0 0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	125, 964, 930	2, 103, 081		0 2, 103, 081	0	8. 00
9.00	Reconciling Items	0	0		0 0	0	9. 00
10.00	Total (line 8 minus line 9)	125, 964, 930	2, 103, 081		0 2, 103, 081	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	342, 000	0				1. 00
2.00	Land Improvements	4, 077, 827	0				2. 00
3.00	Buildings and Fixtures	85, 557, 685	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	2, 119, 028	0				5. 00
6.00	Movable Equipment	35, 971, 471	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	128, 068, 011	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	128, 068, 011	0				10. 00

Health Financial Systems HO	OLY FAMILY MED	DICAL CENTER		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 142011	Peri od:	Worksheet A-7		
				From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	narod:	
				10 12/31/2014	5/19/2015 5: 4	pareu. 3 pm	
		Sl	JMMARY OF CAP	I TAL			
Cost Center Description De	epreciation	Lease	Interest	Insurance (see	•		
				instructions)			
	9. 00	10. 00	11. 00	12.00	13. 00		
PART II - RECONCILIATION OF AMOUNTS FROM WORKSH	<u>IEET A, COLUM</u>	N 2, LINES 1 a	nd 2				
1.00 CAP REL COSTS-BLDG & FLXT	4, 508, 025	0		0	0	1. 00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00	
3.00 Total (sum of lines 1-2)	4, 508, 025	0		0 0	0	3. 00	
	SUMMARY OF	CAPI TAL					
Cost Center Description	0ther	Total (1) (sum					
Car	pi tal -Rel ate	of cols. 9					
d	Costs (see	through 14)					
i n	nstructions)						
	14. 00	15. 00					
PART II - RECONCILIATION OF AMOUNTS FROM WORKSH	HEET A, COLUMN	N 2, LINES 1 a	nd 2				
1.00 CAP REL COSTS-BLDG & FLXT	0	4, 508, 025				1. 00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	0				2. 00	
3.00 Total (sum of lines 1-2)	o	4, 508, 025				3. 00	

Health Financial Systems	HOLY FAMILY ME	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014		pared:
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col	instructions)		
			2)			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 CAP REL COSTS-BLDG & FLXT	92, 096, 540					1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	35, 971, 471		, ,			2. 00
3.00 Total (sum of lines 1-2)	128, 068, 011		128, 068, 01			3. 00
	ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
DART 111 DECONOLITATION OF CARLEY COOPE	6.00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT			ı	0 1 707 500	1 0	1 00
	0	0		0 1, 737, 529		1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 3, 259, 895 0 4, 997, 424		2. 00 3. 00
3.00 Total (Suill Of Titles 1-2)	0	<u> </u>	'I JMMARY OF CAPI		1, 123, 404	3.00
		30	DIVINIART OF CAPT	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
DART III DECONOLILIATION OF CARLTAL COSTS O	11. 00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT	1		ı		1 727 520	1 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	848, 907	_	1	0 0	1, 737, 529	1. 00 2. 00
3.00 Total (sum of lines 1-2)	848, 907	l .		0 0	-,,	
3. 00 Total (Suill Of TITIES 1-2)	040, 907	1	"	0	0, 909, 733	J 3.00

| Peri od: | Worksheet A-8 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provider CCN: 142011

Expense Classification on Non-Charles A Fig.						o 12/31/2014	Date/Time Prep 5/19/2015 5:43	
Cast Center Rescription Resist/Code (2) Amount Cost Center Line # Most. A.7 Buf.					Expense Classification on	Worksheet A	37 177 2013 3. 4.	5 piii
1.00 Investment Income					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income								
1.00 Investment Income								
1.00 Investment Income								
Treasplant Income - CAP REL OCAP REL OSTS-BLDG & FIXT 1.00 0 1.00		Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
Continue			1.00					
1.00 1.00	1. 00	II.		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
CRISTS-WHILE FLOUR P (chapter 2)	2 00			0	CAP REL COSTS-MVBLE FOLLP	2 00	0	2 00
Chapter 2) Chapter 2) Chapter 2) Chapter 3) Chapter 4) Chapter 3) Chapter 3) Chapter 3) Chapter 3) Chapter 3) Chapter 4) Chapter 2) Chapter 3) Chapter 2) Chapter 2) Chapter 3) Chapter 4) Chapter 2) Chapter 3) Chapter 3) Chapter 3) Chapter 3) Chapter 3) Chapter 4) Chapter 2) Chapter 3) Chapter 4) Chapter 5) Chapter 3) Chapter 4) Chapter 6) Chapter 6) Chapter 6) Chapter 6) Chapter 6) Chapter 6) Chapter 7) Chapter 6) Chapter 7) Chapter 8) Chapter 6) Chapter 6) Chapter 7) Chapter 6) Chapter 6) Chapter 7) Chapter 6) Chapter 7) Chapter 7) Chapter 7) Chapter 8) Chapter 8) Chapter 8) Chapter 8) Chapter 8) Chapter 9) Chapter 6) Chapter 1) Chapter 6) Chapter 7) Chapter 8) Chapter 8) Chapter 8) Chapter 8) Chapter 9) Chapter 9) Chapter 1) Chapter 1) Chapter 1) Chapter 1) Chapter 1) Chapter 2) Chapter 2) Chapter 2) Chapter 1) Chapte	2.00			O	NEE SOSTS WIVELE EQUIT	2.00	Ĭ	2.00
Trade, quantity, and time	3.00	Investment income - other		0		0.00	0	3.00
1 1 2 2 2 2 2 2 2 2								
Refunds and rebates of comparison (hoper 9) 0 0 0 0 0 0 0 0 0	4.00			0		0.00	0	4. 00
expenses (chapter 8)	5. 00			0		0.00	0	5. 00
Suppliers (chapter 8)								
Telephone services (pay stations excluded) (chapter 21) Services excluded) (chapter 22) Services excluded) (chapter 23) Services excluded) (chapter 24) Services exclu	6.00			0		0.00	0	6. 00
Stations excluded) (Chépter 27)	7.00			0		0.00		7.00
17	7.00			U		0.00	U	7.00
1.00 0.00								
Parking 10t (chapter 21) A-8-2 -869,227 0.00 0	8.00	Television and radio service		0		0.00	0	8.00
10.00 Provider-based physician all street all str								
adjustment			A 0 2	040 227		0.00	1	
11.00 Saile of scrap, waste, etc. (chapter 23) 12.00 Rel ated organization (chapter 10) 13.00 Laundry and I linen service 0 0 0.00 0.13.00 15.00 Rental of quarter's to employee and guests B -332_c17CAFETERIA 11.00 0.14.00 16.00 Gofferia-employees and guests B -332_c17CAFETERIA 11.00 0.14.00 16.00 Saile of desired and surgical supplies to other than patients 17.00 Saile of drugs to other than patients 18.00 Saile of drugs to other than patients 18.00 Saile of modical records and abstracts 19.00 Nursing school (full tion, fees, books, etc.) 19.00 Nursing school (full tion, fees, books, etc.) 20.00 Vending machines B -780MEDICAL RECORDS & LIBRARY 16.00 0.19.00 books, etc.) 20.00 Vending machines B -780MEDICAL RECORDS & LIBRARY 16.00 0.19.00 books, etc.) 20.00 Vending machines B -780MEDICAL RECORDS & LIBRARY 16.00 0.19.00 books, etc.) 20.00 Vending machines B -780MEDICAL RECORDS & LIBRARY 16.00 0.20.00 contract sexpense on Medicare overpayments and borrowings to repay costs in excess of Illmitation (chapter 14) 24.00 Adjustment for respiratory therapy costs in excess of Illmitation (chapter 14) 25.00 Utilization review - Chapter 14) 26.00 Depreciation - CAP REL COSTS-BUDG & FIXT 1.00 0.20.00 costs-Budge & Oxford Rel Costs-WRIE Foulp 2.00 costs-Budge & Oxford Rel Costs-Budge & Fixt 2.00 costs-Budge & Oxford Rel Costs-Budge & Oxford Rel Costs-Budge & Oxford Rel Costs-WRIE Foulp 2.00 costs-Budge & Oxford Rel Costs-Budge & Oxf	10.00		A-8-2	-809, 227			U	10.00
Chapter 23)	11. 00			0		0.00	0	11. 00
transactions (chapter 10) 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 16.00 17.00 17.00 17.00 17.00 17.00 18.0		(chapter 23)						
13.00 Laundry and I inen service 0 0 0 13.00 15.00 1	12. 00		A-8-1	253, 850			0	12. 00
14.00 Caffeteria-employees and guests B -332,617CAFETERIA 11.00 0 14.00	12 00			0		0.00		12 00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 0 17.00 0 0 17.00 0 0 17.00 0 0 17.00 0 0 17.00 0 0 0 17.00 0 0 18.00 0 0 0 0 18.00 0 0 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0			B	-332 617	CAFETERIA			
and others				0 0	OALETERIA			
Supplies to other than Datients		and others						
patients	16. 00			0		0.00	0	16. 00
17. 00 Sale of drugs to other than patients 0 0.00								
patients	17. 00			0		0.00	0	17. 00
abstracts				· ·		0.00		
19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines B	18. 00		В	-780	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
Books. fet.)	10.00	1		0		0.00		10.00
20. 00 Vending machines Canada	19.00			U		0.00	U	19.00
21.00 Income from imposition of interest, finance or penal ty charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medic	20. 00		В	-15, 924	DI ETARY	10.00	0	20. 00
Charges (Chapter 21) Charges (Chapter 14) Chapter 14) Chapter 14) Chapter 14) Chapter 14) Chapter 21)	21. 00			0				21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay medicare overpayments and borrowings to repay Medicare overpayments A-8-3 ORESPIRATORY THERAPY 65.00 23.00								
Overpayments and borrowings to repay Medicare overpayments A-8-3 ORESPIRATORY THERAPY 65.00 23.00	22.00			0		0.00		22.00
Page Medicare overpayments Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00	22.00			U		0.00	U	22.00
23.00 Adj ustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG & FIXT 1.00 0 27.00 0 27.00 0 27.00 COSTS-BLDG & FIXT 1.00 0 27.00 0 27.00 0 27.00 0 27.00 COSTS-BLDG & FIXT 1.00 0 27.00 0			1					
I mi tation (chapter 14)	23. 00		A-8-3	0	RESPIRATORY THERAPY	65. 00		23.00
24.00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 0 0 0 0 0 0 0 0 0								
therapy costs in excess of	24 00		1 0 2	0	DUVSICAL THEDADV	66 00		24 00
1 imitation (chapter 14)	24.00		A-0-3	0	FITTSTCAL THERAFT	00.00		24.00
physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 0 26.00 27.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 0 26.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 28.00 0 29.0								
Cchapter 21)	25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 27.00 28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29. 00 Physicians' assistant 0 *** Cost Center Deleted *** 19.00 29.00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 *** Cost Center Deleted *** 67.00 30.00 30. 99 Hospice (non-distinct) (see instructions) 0 ADULTS & PEDIATRICS 30.00 30.99 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 *** Cost Center Deleted *** 68.00 31.00 32. 00 CAH HIT Adjustment for Depreciation and Interest Depreciatio								
COSTS-BLDG & FIXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 O 27.00	26 00		-	0	CAD DEL COSTS_BLDG & FLYT	1 00	١	26 00
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 2.00 0 27. 00 28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19. 00 28. 00 29. 00 Physicians' assistant 0 0.00 0 29. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 **** Cost Center Deleted *** 67. 00 30. 00 30. 99 Hospice (non-distinct) (see instructions) 0 ADULTS & PEDIATRICS 30. 00 30. 99 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 **** Cost Center Deleted *** 68. 00 31. 00 32. 00 CAH HIT Adjustment for Depreciation and Interest 0 0.00	20.00			0	CAL REE COSTS-BEDG & TTAT	1.00		20.00
28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 *** Cost Center Deleted *** 67.00 30.00 30.99 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 0 FFSET SUBSTANCE ABUSE REVENUE B -755 ADULTS & PEDIATRICS 30.00 0 33.00 33.00 0 33.00 3	27. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 OFFSET SUBSTANCE ABUSE REVENUE Depreciation and Interest 33.00 OFFSET SUBSTANCE ABUSE REVENUE Depreciation and Interest O ADDULTS & PEDIATRICS 30.00 OF*** Cost Center Deleted *** O ADDULTS & PEDIATRICS 30.00 OF*** Cost Center Deleted *** O O O O O O O O O O O O O O O O O								
30.00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adj ustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adj ustment for Depreciation and Interest 33.00 OFFSET SUBSTANCE ABUSE REVENUE 30.00 **** Cost Center Deleted **** 4.8-3 O **** Cost Center Deleted *** 5.8-0 O **** Cost Center Deleted *** 5.8-0 O O O O O O O O O O O O O O O O O O O				0	*** Cost Center Deleted ***			
therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest 33. 00 OFFSET SUBSTANCE ABUSE REVENUE B -755 ADULTS & PEDIATRICS 30. 00 ADULTS & PEDIATRICS 30. 00 30. 00 30. 99 0 ADULTS & PEDIATRICS 30. 00 30. 00 31. 00		1 3	1 0 2	0	*** Cost Contor Doloted ***			
I imitation (chapter 14)	50.00		N-0-2	0	Cost center bereted """	67.00		30.00
instructions) Adjustment for speech A-8-3 0*** Cost Center Deleted *** 68.00 31.00 pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest 0FFSET SUBSTANCE ABUSE REVENUE B -755 ADULTS & PEDIATRICS 30.00 0 33.00		limitation (chapter 14)						
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 OFFSET SUBSTANCE ABUSE REVENUE B -755 ADULTS & PEDIATRICS 30.00 0 33.00	30. 99			0	ADULTS & PEDIATRICS	30.00		30. 99
pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 OFFSET SUBSTANCE ABUSE REVENUE B -755 ADULTS & PEDIATRICS 30.00 0 33.00	21 00		1 400	^	*** Coct Conton Deleted ***	(0.00		21 00
I i mi tation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 OFFSET SUBSTANCE ABUSE REVENUE B -755 ADULTS & PEDIATRICS 30.00 0 33.00	S1.00		A-8-3	0	Cost center beleted ^^^	68.00		S1.00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest 33.00 OFFSET SUBSTANCE ABUSE REVENUE B -755 ADULTS & PEDIATRICS 30.00 0 33.00								
33.00 OFFSET SUBSTANCE ABUSE REVENUE B -755 ADULTS & PEDIATRICS 30.00 0 33.00	32. 00	CAH HIT Adjustment for		0		0.00	o	32.00
	20.00			 -	ADJULTO A DEDLATOLOG	20.55		22.62
05.01 mil 00 / mil mil 1 mounts 0 -104, 104 mulli mil 3 mail vie & Genterale 3.00 0 33.01								
		IN 30 ADMIN THOUME	ا ہ	104, 104	PROMINITIVE & OUNCIAL	3.00	١	

						5/19/2015 5: 43	3 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					· ·		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
33. 02	OFFSET INCOME TAX	A	-4, 700	ADMINISTRATIVE & GENERAL	5. 06	9	33. 02
33. 03			0		0.00	0	33. 03
34.00	OFFSET FINANCE INTEREST INCOME	В	-13, 621	ADMINISTRATIVE & GENERAL	5.06	0	34.00
35.00	OFFSET LAB INCOME	В	-17, 030	LABORATORY	60.00	0	35. 00
36.00	OFFSET PATIENT TRANSPORT	В	-11, 295	ADMINISTRATIVE & GENERAL	5. 06	O	36. 00
	INCOME						
37.00	OFFSET PT INCOME	В	-796	PHYSI CAL THERAPY	66.00	0	37. 00
38.00	OFFSET CHILDCARE INCOME	В	-26, 856	ADMINISTRATIVE & GENERAL	5. 06	0	38. 00
39.00	CY PORTION OF 1995 LOSS	A	10, 120	CAP REL COSTS-MVBLE EQUIP	2.00	9	39. 00
39. 01	CURRENT YEAR PORTION OF 1996	A I	4, 680	CAP REL COSTS-MVBLE EQUIP	2. 00	9	39. 01
	LO						
39. 02	1977 & 1983 EXCESS INTEREST	A	43, 296	CAP REL COSTS-MVBLE EQUIP	2.00	9	39. 02
39. 03	DEMOLITION ADD BACK	A	32, 256	CAP REL COSTS-MVBLE EQUIP	2.00	9	39. 03
50.00	TOTAL (sum of lines 1 thru 49)		-1, 053, 503				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 142011 Peri od: Worksheet A-8-1 From 01/01/2014 | Date/Time Prepared: OFFICE COSTS

					5/19/2015 5: 4	3 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	RGANI ZATI ONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL	104, 698	0	1. 00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	294, 349	0	2.00
3.00	5. 06	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	3, 282, 792	7, 176, 619	3.00
3.01	4. 00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	240, 528	0	3. 01
3.02	5. 02	DATA PROCESSING	DATA PROCESSING	1, 249, 892	0	3. 02
3.03	5. 03	PURCHASING RECEIVING AND STO	PURCHASI NG	474, 447	0	3. 03
3.04	5. 05	CASHIERING/ACCOUNTS RECEIVAB	PATIENT ACCTS	1, 627, 424	0	3.04
3.05	31.00	INTENSIVE CARE UNIT	ELECTRONIC ICU	185, 137	0	3. 05
3.06	14. 00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	82, 740	0	3.06
3.07	60.00	LABORATORY	ALVERNO LAB	1, 888, 842	2, 000, 380	3. 07
4.00	0.00			0	o	4.00
5.00	TOTALS (sum of lines 1-4).			9, 430, 849	9, 176, 999	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
, ,		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
 B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	RESURRECTION HEALTH CARE	100.00	0.00	6. 00
7.00	С	ALVERNO LAB	66.00	0. 00	7.00
8.00			0.00	0. 00	8.00
9.00			0.00	0. 00	9.00
10.00			0.00	0. 00	10.00
100.00	G. 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

In Lieu of Form CMS-2552-10
: Worksheet A-8-1
1/01/2014
2/31/2014 Date/Time Prepared: 5/19/2015 5:43 pm
37 197 2013 3. 43 piii
ATIONS OR CLAIMED
THE SHE SK SELLIMED
1.00
2. 00
3.00
3. 01
3. 02
3. 03
3. 04
3. 05
3. 06
3. 07
4.00

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

5.00

Related Organization(s) and/or Home Office		
and/or nome office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00		6. 00
7. 00		7.00
8. 00		8.00
9. 00		9.00
10.00		10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	10	100.00

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

5.00

253, 850

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 142011

					1	Го 12/31/2014	Date/Time Pre 5/19/2015 5:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
					'		Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	53. 00	ANESTHESI OLOGY	306, 646	306, 646	0	0	0	1. 00
2.00	60.00	LABORATORY	36, 000	36, 000	0	0	o	2. 00
3.00	5. 06	ADMINISTRATIVE & GENERAL	419, 716	419, 716	0	0	O	3. 00
4.00	30.00	ADULTS & PEDIATRICS	83, 500	0	83, 500	177, 200	668	4. 00
5.00	5. 06	ADMINISTRATIVE & GENERAL	252, 106	0	252, 106	177, 200	2, 017	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	О	7. 00
8.00	0.00		0	0	0	0	О	8. 00
9.00	0.00		0	0	0	0	o	9. 00
10.00	0.00		0	0	0	0	o	10.00
200.00			1, 097, 968	762, 362	335, 606		2, 685	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8.00	9. 00	12. 00	13. 00	14. 00	
1.00	•	ANESTHESI OLOGY	0	0		0	0	
2.00	•	LABORATORY	0	0	0	0	0	2. 00
3.00	5. 06	ADMINISTRATIVE & GENERAL	0	0	0	0	0	3. 00
4.00	•	ADULTS & PEDIATRICS	56, 908			0	0	4. 00
5.00	•	ADMINISTRATIVE & GENERAL	171, 833	8, 592	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10. 00
200.00			228, 741	11, 437		0	0	200.00
	Wkst. A Line #	,	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14	16. 00	17. 00	18. 00		
1 00		2. 00 ANESTHESI OLOGY	15. 00	16.00				1 00
1. 00 2. 00		LABORATORY		0	0	306, 646 36, 000		1. 00 2. 00
				0	0			
3.00		ADMINISTRATIVE & GENERAL	0	F / 000	2/ 502	419, 716		3. 00
4. 00 E. 00	1	ADULTS & PEDIATRICS		56, 908	·	26, 592		4.00
5.00	1	ADMINISTRATIVE & GENERAL		171, 833	80, 273	80, 273		5. 00
6.00	0.00				0	0		6. 00
7.00	0.00				0			7. 00
8.00	0.00	1			0			8. 00
9.00	0.00	1			0			9.00
10.00	0.00			220 741	104.045	040 227		10.00
200.00	I		0	228, 741	106, 865	869, 227		200. 00

Health Financial Systems HOLY FAMILY MEDICAL CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 142011 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/19/2015 5:43 pm CAPITAL RELATED COSTS NONPATI ENT Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** for Cost **BENEFITS TELEPHONES** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1, 737, 529 1 00 1, 737, 529 2.00 00200 CAP REL COSTS-MVBLE EQUIP 5, 232, 206 5, 232, 206 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 100, 175 2, 119 6, 382 108, 676 4.00 00540 NONPATI ENT TELEPHONES 13, 835 5 01 201 423 41, 660 256, 918 5 01 5.02 00550 DATA PROCESSING 1, 249, 892 C 0 17, 469 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 512, 526 37, 447 112, 762 0 5, 823 5.03 5.04 00570 ADMITTING 0 5.04 0 0 0 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 1, 856, 557 13, 044 552 5 05 5 05 0 00590 ADMINISTRATIVE & GENERAL 5.06 11, 957, 283 438, 367 1, 320, 057 13, 985 45, 421 5.06 00600 MAINTENANCE & REPAIRS 815, 036 199, 697 1, 517 6.00 66, 316 3, 494 6.00 00700 OPERATION OF PLANT 3, 361, 512 252, 319 759, 807 1, 281 4, 891 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 29, 455 8.00 8.00 286.044 88, 697 0 9.00 00900 HOUSEKEEPI NG 1, 583, 825 20, 843 62, 763 3, 166 1,863 9.00 01000 DI ETARY 1, 333 10.00 1, 203, 316 85, 584 257, 718 1,630 10.00 2, 329 01100 CAFETERI A 466, 229 C 0 865 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 C 0 0 Ω 12 00 01300 NURSING ADMINISTRATION 749, 284 2, 124 466 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 104, 933 41, 486 124, 927 315 2, 329 14.00 01500 PHARMACY 15.00 1, 281, 413 34.203 102.995 15.00 3.572 5. 124 01600 MEDICAL RECORDS & LIBRARY 16.00 570, 361 22, 201 66, 854 1, 215 17,004 16.00 01700 SOCIAL SERVICE 17.00 17.00 0 0 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 2, 298 0 8 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV C 0 22.00 22.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 14, 368, 373 198, 872 598, 861 38, 572 64, 056 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 131, 041 22,810 68, 687 <u>1, 1</u>65 31.00 5.469 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 1, 418, 410 20, 498 50.00 166, 267 500, 679 3.792 50.00 53.00 05300 ANESTHESI OLOGY 3, 259 656 1, 975 1,630 53.00 05400 RADI OLOGY-DI AGNOSTI C 609. 225 44. 338 133, 513 19, 799 54 00 1,647 54 00 56.00 05600 RADI OI SOTOPE 53, 786 7, 699 23, 184 129 0 56.00 05700 CT SCAN 185, 019 472 57.00 3, 033 9, 132 0 57.00 03630 ULTRA SOUND 206, 736 57.01 57.01 12,606 569 4, 186 0 50, 755 05800 MRI 58.00 C 134 466 58.00 60.00 06000 LABORATORY 2, 121, 912 38, 214 115,072 0 13,743 60.00 65.00 06500 RESPIRATORY THERAPY 3, 833, 512 3, 115 9, 379 10, 461 5, 590 65.00 66 00 06600 PHYSI CAL THERAPY 199, 838 5, 124 2 940 403 66.363 8 197 66 00 06900 ELECTROCARDI OLOGY 69.00 80,700 10, 533 31, 717 223 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 304, 257 17, 915 53, 948 770 2, 795 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 2, 824, 001 C 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 579 808 72 00 0 72 00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 3,669,660 0 0 73.00 07400 RENAL DIALYSIS 781,020 1, 914 5, 765 2,056 233 74.00 74.00 76.00 03950 SUBSTANCE ABUSE 1, 131, 601 52, 511 158, 125 2, 795 0 76.00 07697 CARDIAC REHABILITATION 76.97 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1,077,827 17, 675 53, 225 2, 582 466 76.98 07699 LI THOTRI PSY 76.99 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 47 034 20, 567 90.00 09000 CLI NI C 61.935 228 0 90.02 09001 WOMENS DIAGNOSTIC CENTER 243, 960 50, 246 466 90.02 16,686 647 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 71, 934, 141 1, 737, 529 5, 232, 206 108, 676 256, 918 118. 00 118.00 NONREI MBURSABLE COST CENTERS 200.00 200 00 Cross Foot Adjustments

71, 934, 141

1, 737, 529

5, 232, 206

108 676

0 201.00 256, 918 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

			1	To 12/31/2014	Date/Time Pre 5/19/2015 5:4	
Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	J pili
0001 001101 20001 1 211011	PROCESSI NG	RECEIVING AND	7.5	OUNTS	oub to tu.	
		STORES		RECEI VABLE		
	5. 02	5. 03	5. 04	5. 05	5A. 05	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00540 NONPATI ENT TELEPHONES						5. 01
5. 02 00550 DATA PROCESSING	1, 267, 361					5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES	26, 077	694, 635				5. 03
5. 04 00570 ADMI TTI NG	C	1	(5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	114, 741		(1, 986, 231		5. 05
5.06 00590 ADMINISTRATIVE & GENERAL	385, 950	1	(이	14, 190, 167	5. 06
6.00 00600 MAINTENANCE & REPAIRS	15, 646		(이	1, 112, 508	6. 00
7.00 O0700 OPERATION OF PLANT	5, 215		(-	4, 393, 353	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	5, 215			1 1	448, 990	8. 00
9. 00 00900 HOUSEKEEPI NG	5, 215		(-	1, 693, 191	9. 00
10. 00 01000 DI ETARY	5, 215			-	1, 620, 634	10. 00
11. 00 01100 CAFETERI A	5, 215	1	(-	474, 638	11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	C		(0	0	12. 00
13. 00 01300 NURSING ADMINISTRATION	C	231	(이	752, 105	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	5, 215		(0	281, 703	14. 00
15. 00 01500 PHARMACY	26, 077		(0	1, 453, 384	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	114, 741	1	(0	792, 376	16. 00
17. 00 01700 SOCI AL SERVI CE	C	_	(0	0	17. 00
21.00 02100 I &R SERVI CES-SALARY & FRINGES APPRV	C		(-	2, 306	21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	C	0	[(0	0	22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	70.047	0.4.000		504 000	45 047 000	00.00
30. 00 03000 ADULTS & PEDI ATRI CS	73, 017		(15, 947, 893	30.00
31. 00 03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	C	1, 917		48, 537	2, 279, 626	31. 00
50. 00 05000 OPERATING ROOM	67, 801	2, 605		105, 951	2, 286, 003	50. 00
53. 00 05300 ANESTHESI OLOGY	07,001	1			32, 957	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	172, 111	_		· ·	1, 008, 854	54. 00
56. 00 05600 RADI 0I SOTOPE	172, 111	68			87, 483	56.00
57. 00 05700 CT SCAN		1			227, 917	57. 00
57. 01 03630 ULTRA SOUND		37			240, 994	57. 01
58. 00 05800 MRI	5, 215				64, 562	58. 00
60. 00 06000 LABORATORY	135, 602				2, 633, 632	60.00
65. 00 06500 RESPIRATORY THERAPY	26, 077				4, 175, 695	65. 00
66. 00 06600 PHYSI CAL THERAPY	52, 155	1			3, 340, 427	66. 00
69. 00 06900 ELECTROCARDI OLOGY	02,100	1			133, 914	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	15, 646				411, 790	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				3, 320, 730	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS					668, 953	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0			4, 029, 774	73. 00
74.00 07400 RENAL DIALYSIS		122			816, 032	74. 00
76. 00 03950 SUBSTANCE ABUSE		397		28, 456	1, 373, 885	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		1		· ·	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	C	5, 258		20, 999	1, 178, 032	76. 98
76. 99 07699 LI THOTRI PSY	C			ol	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	C	325	(4, 533	134, 622	90. 00
90.02 09001 WOMENS DIAGNOSTIC CENTER	5, 215	1, 164	(6, 627	325, 011	90. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 267, 361	694, 635	(1, 986, 231	71, 934, 141	118. 00
NONREI MBURSABLE COST CENTERS						
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	0	(0	201. 00
202.00 TOTAL (sum lines 118-201)	1, 267, 361	694, 635	(1, 986, 231	71, 934, 141	202. 00

				T	o 12/31/2014	Date/Time Pre 5/19/2015 5:4	
	Cost Center Description	ADMI NI STRATI VE I	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	3 PIII
	cost center bescription	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOUSEKEELLING	
		5. 06	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	1 0.00			0.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 04	00570 ADMITTING						5. 03
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
	1	14 100 147					
5.06	00590 ADMINISTRATIVE & GENERAL	14, 190, 167	1, 385, 899				5. 06
6.00	00600 MAINTENANCE & REPAIRS	273, 391		F 7/0 474			6. 00
7.00	00700 OPERATION OF PLANT	1, 079, 636	296, 485	5, 769, 474			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	110, 336	34, 611	183, 297	777, 234	0.040.475	8. 00
9.00	00900 HOUSEKEEPI NG	416, 090	24, 491	129, 703		2, 263, 475	9. 00
10.00	01000 DI ETARY	398, 259	100, 565	532, 586	0	220, 929	10. 00
11. 00	01100 CAFETERI A	116, 639	0	0	0	0	11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13. 00	01300 NURSING ADMINISTRATION	184, 825	0	0	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	69, 227	48, 748	258, 168	0	107, 094	14. 00
15. 00	01500 PHARMACY	357, 159	40, 190	212, 845	0	88, 293	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	194, 721	26, 087	138, 156	0	57, 310	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	567	0	0	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 919, 070	233, 683	1, 237, 575	577, 635	513, 376	30.00
31.00	03100 INTENSIVE CARE UNIT	560, 202	26, 803	141, 945	55, 661	58, 882	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	561, 769	195, 371	1, 034, 677	80, 353	429, 209	50.00
53.00	05300 ANESTHESI OLOGY	8, 099	771	4, 081	0	1, 693	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	247, 919	52, 099	275, 911	9, 363	114, 455	54.00
56.00	05600 RADI OI SOTOPE	21, 498	9, 047	47, 910	0	19, 874	56. 00
57.00	05700 CT SCAN	56, 009	3, 564	18, 873	5, 519	7, 829	57.00
57. 01	03630 ULTRA SOUND	59, 223	4, 919	26, 050	6, 400	10, 806	57. 01
58.00	05800 MRI	15, 866	0	0	163	0	58. 00
60.00	06000 LABORATORY	647, 197	44, 903	237, 802	0	98, 646	60.00
65.00	06500 RESPI RATORY THERAPY	1, 026, 148	3, 660	19, 383	677	8, 040	65. 00
66. 00	06600 PHYSI CAL THERAPY	820, 887	77, 979	412, 974	18, 890	171, 312	66. 00
69. 00	06900 ELECTROCARDI OLOGY	32, 908	12, 376	65, 544		27, 189	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	101, 195	21, 051	111, 487	918	46, 247	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	816, 046	0.700	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	164, 391	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	990, 289	0	0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	200, 534	2, 250	11, 914	0	4, 942	74. 00
76. 00	03950 SUBSTANCE ABUSE	337, 623	61, 702	326, 773	0	135, 553	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	337,023	01, 702	320, 773 0	0	133, 333	76. 97
76. 98		289, 493	20, 769	109, 993	17, 487	45, 628	76. 98
		207, 473	20, 709	107, 773	17, 467	45, 028	76. 9 8
70. 99	07699 LI THOTRI PSY	l d	U	U	U	U	70. 99
00.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	33, 082	24, 168	127, 991	200	F2 004	00 00
90.00					298	53, 094	90.00
90. 02	09001 WOMENS DIAGNOSTIC CENTER	79, 869	19, 607	103, 836	3, 163	43, 074	90. 02
92. 00							92. 00
440 0	SPECIAL PURPOSE COST CENTERS						110 00
	11300 INTEREST EXPENSE	14 400 417	1 005 000	F 7/0 /7:	777 004	0.040.435	113.00
118. 00		14, 190, 167	1, 385, 899	5, 769, 474	777, 234	2, 263, 475	118.00
202 21	NONREI MBURSABLE COST CENTERS						200 22
200.00			_	_			200. 00
201.00		0	1 225 222	0	0	0 0/0 475	201. 00
202.00	TOTAL (sum lines 118-201)	14, 190, 167	1, 385, 899	5, 769, 474	777, 234	2, 263, 475	202.00

				10 12/31/2014	5/19/2015 5:4	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O	NURSI NG	CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
OFFICE AND ASSOCIATION	10. 00	11. 00	12. 00	13.00	14. 00	
GENERAL SERVICE COST CENTERS						1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00540 NONPATI ENT TELEPHONES						5. 01
5. 02 00550 DATA PROCESSING						5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04 00570 ADMI TTI NG						5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 00590 ADMI NI STRATI VE & GENERAL						5. 06
6. 00 00600 MAI NTENANCE & REPAI RS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG	0 070 070					9. 00
10. 00 01000 DI ETARY	2, 872, 973	F04 077				10.00
11. 00 01100 CAFETERIA	0	591, 277				11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	0 70/		0		12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	U	9, 726		946, 656	7/0 544	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	4, 604			769, 544	14.00
15. 00 01500 PHARMACY	0	17, 661			0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	11, 742			0	16.00
17. 00 01700 SOCIAL SERVICE	0	0			0	17. 00
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0			0	21. 00
22.00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U ₁	U	')	U	22. 00
30. 00 03000 ADULTS & PEDIATRICS	2, 780, 629	310, 499	· ·	717, 038	0	30. 00
31. 00 03100 NTENSI VE CARE UNIT	92, 344	29, 753		68, 708	0	31. 00
ANCI LLARY SERVI CE COST CENTERS	72, 344	27, 733	<u> </u>	00, 700		31.00
50. 00 05000 OPERATING ROOM	0	25, 316		58, 463	0	50. 00
53. 00 05300 ANESTHESI OLOGY	o	20, 010		0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	Ö	9, 111			0	54. 00
56. 00 05600 RADI OI SOTOPE	Ö	700			0	56. 00
57. 00 05700 CT SCAN	0	1, 917			0	57. 00
57. 01 03630 ULTRA SOUND	0	3, 569			0	57. 01
58. 00 05800 MRI	0	728			0	58. 00
60. 00 06000 LABORATORY	0	0			0	60. 00
65. 00 06500 RESPIRATORY THERAPY	o	72, 633			0	65. 00
66. 00 06600 PHYSI CAL THERAPY	o	48, 954		ol ol	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	O	1, 427		3, 296	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	6, 046		13, 961	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			638, 459	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o o	131, 085	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		o	0	73.00
74.00 07400 RENAL DIALYSIS	0	11, 238		25, 951	0	74.00
76. 00 03950 SUBSTANCE ABUSE	0	3, 779		8, 726	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	17, 018		39, 299	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	1, 455		3, 361	0	90.00
90. 02 09001 WOMENS DIAGNOSTIC CENTER	0	3, 401		7, 853	0	90. 02
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS			ı			
113. 00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	2, 872, 973	591, 277		946, 656	769, 544	118. 00
NONREI MBURSABLE COST CENTERS						000 00
200.00 Cross Foot Adjustments	_	=		_		200.00
201.00 Negative Cost Centers	0 070 070	0		0		201. 00
202.00 TOTAL (sum lines 118-201)	2, 872, 973	591, 277	1	946, 656	769, 544	202.00

| Period: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/19/2015 5:43 pm

							5/19/2015 5: 4	3 pm
						INTERNS &	RESI DENTS	
		Cost Contan Decement on	DUADMACY	MEDICAL	COCLAL CEDVICE	CEDVI CEC CALAD	CEDVI CEC OTHER	
		Cost Center Description	PHARMACY	MEDICAL RECORDS &	SUCTAL SERVICE	Y & FRINGES	SERVICES-OTHER PRGM COSTS	
				LI BRARY		APPRV	APPRV	
			15. 00	16. 00	17. 00	21. 00	22. 00	
	GENER	AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	1	NONPATI ENT TELEPHONES						5. 01
5. 02 5. 03		DATA PROCESSING PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 04		ADMITTING						5. 03
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06		ADMINISTRATIVE & GENERAL						5. 06
6.00		MAINTENANCE & REPAIRS						6. 00
7.00	00700	OPERATION OF PLANT						7. 00
8.00	00800	LAUNDRY & LINEN SERVICE						8. 00
9. 00		HOUSEKEEPI NG						9. 00
10. 00		DI ETARY						10. 00
11.00		CAFETERI A						11.00
12.00		MAINTENANCE OF PERSONNEL						12.00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00		PHARMACY	2, 169, 532					15. 00
16. 00		MEDICAL RECORDS & LIBRARY	2, 107, 552	1, 220, 392				16. 00
17. 00		SOCIAL SERVICE	l o	1, 220, 0,2	1			17. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRV	O	C	1			21. 00
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	o	C	0	0	0	22. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDI ATRI CS	0	357, 542			0	
31. 00		INTENSIVE CARE UNIT LARY SERVICE COST CENTERS	0	29, 822	2 0	0	0	31.00
50. 00		OPERATING ROOM	٥	65, 099	0	0	0	50.00
53. 00		ANESTHESI OLOGY		15, 627	•		ĺ	1
54. 00		RADI OLOGY-DI AGNOSTI C	o	16, 041	1		Ö	1
56.00		RADI OI SOTOPE	О	1, 608		0	0	56. 00
57. 00	05700	CT SCAN	0	17, 950	0	0	0	57. 00
57. 01		ULTRA SOUND	0	10, 359	1		0	1
58. 00	05800	l .	0	4, 639			0	58. 00
60.00		LABORATORY	0	111, 465	1		0	60.00
65.00	1	RESPIRATORY THERAPY	0	171, 135	1		0	65.00
66. 00 69. 00	1	PHYSI CAL THERAPY ELECTROCARDI OLOGY	0	41, 674 6, 585			0	66. 00 69. 00
70. 00	1	ELECTROCARDI OLOGI	0	9, 504				1
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	82, 040			l ő	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	o	5, 480	1		Ö	
73.00		DRUGS CHARGED TO PATIENTS	2, 169, 532	221, 265		0	0	73. 00
74.00	07400	RENAL DIALYSIS	o	15, 313	0	0	0	74. 00
76.00	1	SUBSTANCE ABUSE	0	17, 484	1 0	0		1
76. 97		CARDI AC REHABI LI TATI ON	0	C	0		0	
76. 98		HYPERBARI C OXYGEN THERAPY	0	12, 903			l e	
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS	0) 0	0	0	76. 99
90. 00		CLINIC	ol	2, 785	i 0	O	0	90.00
90. 02		WOMENS DIAGNOSTIC CENTER	l ol	4, 072	1		Ö	
92.00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE					l	113. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2, 169, 532	1, 220, 392	2 0	2, 873	0	118. 00
200.00		IMBURSABLE COST CENTERS Cross Foot Adjustments			I		0	200. 00
200.00		Negative Cost Centers	n	C	0	0		200.00
202.00		TOTAL (sum lines 118-201)	2, 169, 532	1, 220, 392	•			202. 00
	•	•	· '		•			

Health Financial Systems HOLY FAMILY MEDICAL CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 142011 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/19/2015 5:43 pm Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 24.00 25.00 26.00 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 00540 NONPATIENT TELEPHONES 5.01 5. 01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00590 ADMINISTRATIVE & GENERAL 5.06 5 06 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 MAI NTENANCE 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 16.00 16 00 17.00 01700 SOCIAL SERVICE 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 26, 597, 813 -2, 873 26, 594, 940 30.00 03100 INTENSIVE CARE UNIT 3, 343, 746 31.00 3, 343, 746 31.00 ANCILLARY SERVICE COST CENTERS 4, 736, 260 50.00 05000 OPERATING ROOM 50.00 4, 736, 260 53.00 05300 ANESTHESI OLOGY 63, 228 0 63, 228 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 733, 753 1, 733, 753 54.00 54.00 56, 00 05600 RADI OI SOTOPE 188, 120 0 188, 120 56, 00 05700 CT SCAN 57 00 339, 578 0 339, 578 57 00 362, 320 57.01 03630 ULTRA SOUND 362, 320 57.01 58.00 05800 MRI 85, 958 85, 958 58.00 06000 LABORATORY 3, 773, 645 60.00 3, 773, 645 60.00 06500 RESPIRATORY THERAPY 5, 477, 371 65.00 5, 477, 371 65.00 66,00 06600 PHYSI CAL THERAPY 4, 933, 097 4, 933, 097 66.00 06900 ELECTROCARDI OLOGY 283, 946 283, 946 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 722, 199 722, 199 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4, 857, 275 4, 857, 275 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 969, 909 969, 909 72.00 07300 DRUGS CHARGED TO PATIENTS 7, 410, 860 7, 410, 860 73.00 73.00 74.00 07400 RENAL DIALYSIS 1,088,174 0 1,088,174 74.00 76.00 03950 SUBSTANCE ABUSE 2, 265, 525 2, 265, 525 76, 00 0 76. 97 07697 CARDIAC REHABILITATION 76. 97 C 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76.98 1, 730, 622 1, 730, 622 76.99 07699 LI THOTRI PSY 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 380, 856 380.856 90.02 09001 WOMENS DIAGNOSTIC CENTER 589, 886 C 589, 886 90.02 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 INTEREST EXPENSE 113 00

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SUBTOTALS (SUM OF LINES 1-117)

NONREI MBURSABLE COST CENTERS Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

Health Financial Systems HOLY FAMILY MEDICAL CENTER In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 142011 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/19/2015 5:43 pm CAPITAL RELATED COSTS Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal **EMPLOYEE** Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 119 6, 382 8, 501 8, 501 4.00 5.01 00540 NONPATIENT TELEPHONES 0 0 0 13, 835 41,660 55, 495 5.01 0 00550 DATA PROCESSING 5 02 5 02 C 0 5.03 00560 PURCHASING RECEIVING AND STORES 37, 447 112, 762 150, 209 0 5.03 5.04 00570 ADMITTING 0 5.04 5.05 00580 CASHI ERING/ACCOUNTS RECEIVABLE 000000000000000 5.05 43 00590 ADMINISTRATIVE & GENERAL 5.06 438, 367 1, 320, 057 1, 758, 424 1,094 5.06 6.00 00600 MAINTENANCE & REPAIRS 66, 316 199, 697 266, 013 119 6.00 00700 OPERATION OF PLANT 7.00 252, 319 759, 807 1, 012, 126 100 7.00 00800 LAUNDRY & LINEN SERVICE 29 455 8 00 88. 697 118 152 8 00 0 00900 HOUSEKEEPI NG 9.00 20,843 62, 763 83, 606 248 9.00 01000 DI ETARY 85, 584 257, 718 343, 302 104 10.00 10.00 01100 CAFETERI A 11.00 68 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12 00 C 0 0 0 13.00 01300 NURSING ADMINISTRATION 0 0 166 13.00 01400 CENTRAL SERVICES & SUPPLY 124, 927 14.00 41, 486 166, 413 25 14.00 01500 PHARMACY 34, 203 102, 995 137, 198 279 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 89, 055 16 00 22, 201 66, 854 95 16.00 17.00 01700 SOCIAL SERVICE C 0 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 0 22.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 198, 872 598, 861 3, 017 30.00 797, 733 03100 INTENSIVE CARE UNIT 0 31.00 22, 810 68, 687 91, 497 428 31.00 ANCILLARY SERVICE COST CENTERS 297 50.00 05000 OPERATING ROOM 0 166, 267 500, 679 666, 946 50.00 1, 975 05300 ANESTHESI OLOGY 0 2,631 53.00 656 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 44, 338 133, 513 177, 851 129 54.00 05600 RADI OI SOTOPE 7, 699 30.883 56,00 23. 184 10 56,00 57.00 05700 CT SCAN 3,033 9, 132 12, 165 37 57.00 03630 ULTRA SOUND 57.01 000000000000000 4, 186 12,606 16, 792 44 57.01 05800 MRI 58.00 10 58.00 C 06000 LABORATORY 60.00 38, 214 115,072 153, 286 Ω 60.00 65.00 06500 RESPIRATORY THERAPY 3, 115 9, 379 12, 494 818 65.00 06600 PHYSI CAL THERAPY 66, 363 199, 838 266, 201 66.00 641 66.00 06900 ELECTROCARDI OLOGY 10, 533 31, 717 42, 250 69 00 17 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 17, 915 53, 948 71, 863 60 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT C 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 \cap 0 Ω 73.00 74.00 07400 RENAL DIALYSIS 1, 914 5, 765 7, 679 161 74.00 03950 SUBSTANCE ABUSE 76.00 52, 511 158, 125 210, 636 219 76.00 76 97 07697 CARDIAC REHABILITATION 76 97 0 07698 HYPERBARI C OXYGEN THERAPY 76.98 17, 675 53, 225 70,900 202 76.98 76. 99 07699 LI THOTRI PSY 0 76.99

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OUTPATIENT SERVICE COST CENTERS

09001 WOMENS DIAGNOSTIC CENTER

SPECIAL PURPOSE COST CENTERS

NONREI MBURSABLE COST CENTERS Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

09200 OBSERVATION BEDS (NON-DISTINCT PART

SUBTOTALS (SUM OF LINES 1-117)

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113. 00 11300 I NTEREST EXPENSE

| Period: | Worksheet B | From 01/01/2014 | Part II | Date/Time Prepared: | 5/19/2015 5: 43 pm

						5/19/2015 5: 4	3 pm
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMITTING	CASHI ERI NG/ACC	
	·	TELEPHONES	PROCESSI NG	RECEIVING AND		OUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATI ENT TELEPHONES	55, 495					5. 01
5. 02	00550 DATA PROCESSING	3, 773	3, 773				5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	1, 258	78	1			5. 03
5. 04	00570 ADMITTING	0	0		0		5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 818	342		0	3, 495	1
5. 06	00590 ADMINISTRATIVE & GENERAL	9, 811	1, 143	1	0	0, 170	1
6. 00	00600 MAINTENANCE & REPAIRS	755	47	1	0	Ö	
7. 00	00700 OPERATION OF PLANT	1, 057	16	1	0	ĺ	1
8. 00	00800 LAUNDRY & LINEN SERVICE	1,037	16		0		
9. 00	00900 HOUSEKEEPING	403	16	1	0	0	9. 00
10. 00	01000 DI ETARY	352	16		0		10.00
	1	1			-		1
11.00	01100 CAFETERIA	503	16	1	0	1	11.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	1	0	0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	101	0		0	1	
14. 00	01400 CENTRAL SERVICES & SUPPLY	503	16		0	0	
15. 00	01500 PHARMACY	1, 107	78		0	0	
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 673	342	0	0	0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	13, 832	217	5, 285	0	1, 031	30.00
31.00	03100 INTENSIVE CARE UNIT	252	0	418	0	85	31.00
	ANCILLARY SERVICE COST CENTERS	·		•			1
50.00	05000 OPERATI NG ROOM	4, 428	202	568	0	186	50.00
53.00	05300 ANESTHESI OLOGY	352	0	1	0	45	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 277	512	461	0	l .	1
56. 00	05600 RADI OI SOTOPE	., _,	0.2	1	0	5	56.00
57. 00	05700 CT SCAN		0		0	51	57. 00
57. 01	03630 ULTRA SOUND		0		0	l .	1
58. 00	05800 MRI	101	16		0	13	1
60. 00	06000 LABORATORY	2, 968	404		0	318	1
65. 00	06500 RESPIRATORY THERAPY	1	78		0	l .	1
		1, 208					1
66.00	06600 PHYSI CAL THERAPY	1, 107	155	1	0		
69.00	06900 ELECTROCARDI OLOGY	0	0		0	19	1
70.00	07000 ELECTROENCEPHALOGRAPHY	604	47		0	27	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	,	0		1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	17, 503	0	16	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		1
74. 00	07400 RENAL DI ALYSI S	50	0	27	0	44	1
76. 00	03950 SUBSTANCE ABUSE	0	0	87	0	50	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	101	0	1, 147	0	37	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	71	0	8	90. 00
90. 02	09001 WOMENS DIAGNOSTIC CENTER	101	16	254	0	12	90. 02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 INTEREST EXPENSE						113. 00
118.00	1	55, 495	3, 773	151, 545	0	3 495	118. 00
	NONREI MBURSABLE COST CENTERS	33, 473	5,775	151, 545	0	3, 473	1.10.00
200.00							200. 00
201.00	1 1		0	o	0	n	201. 00
202.00		55, 495	3, 773		0		202. 00
202.00	/ TOTAL (Sum TITIES TID-201)] 33, 473	5, 775	151,545	Ü	J, 470	1202.00

| Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 142011

				11	0 12/31/2014	5/19/2015 5: 4	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE	0.00	
	GENERAL SERVICE COST CENTERS	5. 06	6. 00	7.00	8. 00	9. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		•				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATIENT TELEPHONES						5. 01
5.02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04	00570 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	4 77/ 000					5. 05
5.06	00590 ADMINISTRATIVE & GENERAL	1, 776, 822					5.06
6.00	00600 MAINTENANCE & REPAIRS	34, 233					6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	135, 188	64, 933 7, 580				7. 00 8. 00
9. 00	00900 HOUSEKEEPING	13, 816 52, 101	5, 364			172, 443	9.00
10. 00	01000 DI ETARY	49, 869	22, 025				1
11. 00	01100 CAFETERI A	14, 605	22, 020			0	11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	Ö			0	12. 00
13.00	01300 NURSING ADMINISTRATION	23, 143	0	0	0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 668	10, 676	54, 379	0	8, 159	14.00
15. 00	01500 PHARMACY	44, 722	8, 802	44, 832	0	6, 727	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	24, 382	5, 713			4, 366	1
17. 00	01700 SOCIAL SERVICE	_0	0			0	17. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	71	0	_		0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
30. 00	O3000 ADULTS & PEDIATRICS	490, 717	51, 179	260, 673	138, 833	39, 112	30.00
31. 00	03100 NTENSI VE CARE UNI T	70, 146					31.00
01.00	ANCI LLARY SERVI CE COST CENTERS	70, 110	0,070	27,070	10,070	1, 100	01.00
50.00	05000 OPERATI NG ROOM	70, 343	42, 788	217, 936	19, 313	32, 699	50.00
53.00	05300 ANESTHESI OLOGY	1, 014	169	859	0	129	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	31, 043	11, 410	58, 116	2, 250	8, 720	54.00
56. 00	05600 RADI 0I SOTOPE	2, 692	1, 981		0	1, 514	1
57. 00	05700 CT SCAN	7, 013	780			596	1
57. 01	03630 ULTRA SOUND	7, 416	1, 077		1, 538		57. 01
58. 00	05800 MRI	1, 987	0 024	_			58.00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	81, 039	9, 834 802				ı
66. 00	06600 PHYSI CAL THERAPY	128, 490 102, 788	17, 078				66.00
69. 00	06900 ELECTROCARDI OLOGY	4, 121	2, 711				69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	12, 671	4, 610			3, 523	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	102, 182	0			0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	20, 584	0	o	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	124, 000	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	25, 110	493	2, 509	0	377	74. 00
76. 00	03950 SUBSTANCE ABUSE	42, 276	13, 513	68, 829	0	10, 327	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	_		0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	36, 249	4, 549				76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	4, 142	5, 293	26, 959	72	4, 045	90.00
90.00	09001 WOMENS DI AGNOSTI C CENTER	10, 001	4, 294				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10,001	4, 2,4	21,071	700	3, 202	92. 00
,2. 00	SPECIAL PURPOSE COST CENTERS						1 .2. 00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		1, 776, 822	303, 524	1, 215, 237	186, 807	172, 443	
	NONREI MBURSABLE COST CENTERS						
200.00							200. 00
201.00		0	0				201. 00
202.00	TOTAL (sum lines 118-201)	1, 776, 822	303, 524	1, 215, 237	186, 807	172, 443	J202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 142011

| Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared:

				Т	o 12/31/2014	Date/Time Pre 5/19/2015 5:4	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	SERVICES &	
		10.00	11. 00	12.00	13. 00	SUPPLY 14. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
1	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
1	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	DO540 NONPATIENT TELEPHONES DO550 DATA PROCESSING						5. 01 5. 02
1	DOSSO DATA PROCESSING			•			5. 02
4	00570 ADMI TTI NG						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
1	00590 ADMINISTRATIVE & GENERAL						5. 06
1	00600 MAI NTENANCE & REPAI RS						6.00
1	DO700 OPERATION OF PLANT DO800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
1	00900 HOUSEKEEPI NG						9.00
1	D1000 DI ETARY	559, 044					10.00
1	D1100 CAFETERI A	0	15, 192				11. 00
1	01200 MAI NTENANCE OF PERSONNEL	0	0	1			12.00
1	D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY	0	250 118	1	- '	249, 502	13. 00 14. 00
	01500 PHARMACY		454	l .	0	249, 502	15. 00
	01600 MEDICAL RECORDS & LIBRARY	o	302	1	o	0	16. 00
4	01700 SOCIAL SERVICE	O	0	l .	o	0	17. 00
1	D2100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21. 00
-	D2200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	541, 075	7, 979	0	17, 958	0	30. 00
	D3100 INTENSIVE CARE UNIT	17, 969	7, 373	1		0	31.00
_	ANCILLARY SERVICE COST CENTERS	, -			,		
1	05000 OPERATING ROOM	0	650	1		0	50. 00
1	D5300 ANESTHESI OLOGY	0	0			0	53.00
1	D5400 RADI OLOGY-DI AGNOSTI C D5600 RADI OI SOTOPE	0	234 18	1	_	0	54. 00 56. 00
4	05700 CT SCAN		49	1	_	0	57.00
1	D3630 ULTRA SOUND	o	92	1	_	0	57. 01
58. 00	05800 MRI	o	19	0	o	0	58. 00
1	06000 LABORATORY	0	0	_	_	0	60.00
1	06500 RESPI RATORY THERAPY	0	1, 866	1		0	65.00
1	D6600 PHYSI CAL THERAPY D6900 ELECTROCARDI OLOGY	0	1, 258 37	1		0	66. 00 69. 00
1	07000 ELECTROCARD GEOGRAPHY	0	155		l .	0	70.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	0			207, 001	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	o	42, 501	72. 00
	D7300 DRUGS CHARGED TO PATIENTS	0	0	1	_	0	73. 00
	07400 RENAL DIALYSIS 03950 SUBSTANCE ABUSE	0	289 97	1	650 219	0	74. 00 76. 00
	07697 CARDI AC REHABI LI TATI ON		97			0	1
	07698 HYPERBARI C OXYGEN THERAPY	o	437	l .		0	1
76. 99	D7699 LI THOTRI PSY	0	0			0	
-	OUTPATIENT SERVICE COST CENTERS			_			
	D9000 CLINIC D9001 WOMENS DIAGNOSTIC CENTER	0	37 87			0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	١	07		197	U	90.02
	SPECIAL PURPOSE COST CENTERS						/2.00
-	11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	559, 044	15, 192	0	23, 710	249, 502	118. 00
	NONREI MBURSABLE COST CENTERS						200 00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		0	o	0	0	200. 00 201. 00
201.00	TOTAL (sum lines 118-201)	559, 044	15, 192				
		,,	, . , -	'	_ ==,	, 502	

Provider CCN: 142011

						LATERNO	5/19/2015 5: 43	3 pm
						INTERNS &	RESI DENTS	
		Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	
		oost conten beschiptron	111111111111111111	RECORDS &	SOUTHE SERVICE	Y & FRINGES	PRGM COSTS	
				LI BRARY		APPRV	APPRV	
			15.00	16. 00	17.00	21. 00	22. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		NONPATI ENT TELEPHONES						5. 01
5. 02		DATA PROCESSING						5. 02
5. 03 5. 04	1	PURCHASING RECEIVING AND STORES						5. 03 5. 04
5. 05		ADMITTING CASHIERING/ACCOUNTS RECEIVABLE						5. 05
5. 06	1	ADMINISTRATIVE & GENERAL						5. 06
6. 00		MAINTENANCE & REPAIRS						6. 00
7. 00		OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8. 00
9.00	1	HOUSEKEEPI NG						9. 00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERI A						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00		NURSING ADMINISTRATION						13.00
14. 00	1	CENTRAL SERVICES & SUPPLY						14.00
15. 00	1	PHARMACY	244, 199					15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	157, 028	1			16. 00
17. 00		SOCIAL SERVICE	0	0	1			17. 00
21. 00	1	I &R SERVI CES-SALARY & FRI NGES APPRV	0	0				21. 00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRV I ENT ROUTINE SERVICE COST CENTERS	U_		0		0	22. 00
30. 00		ADULTS & PEDIATRICS	O	45, 884	. 0			30. 00
31. 00	1	INTENSIVE CARE UNIT		3, 841				31. 00
31.00		LARY SERVICE COST CENTERS	<u> </u>	3, 041				31.00
50.00		OPERATI NG ROOM	0	8, 386	0			50.00
53.00	05300	ANESTHESI OLOGY	o	2, 013	1			53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	O	2, 066	0			54.00
56.00	05600	RADI OI SOTOPE	O	207	0			56.00
57.00		CT SCAN	0	2, 312	2 0			57.00
57. 01	1	ULTRA SOUND	0	1, 334				57. 01
58. 00	05800		0	598				58. 00
60.00	1	LABORATORY	0	14, 358				60.00
65. 00		RESPI RATORY THERAPY	0	22, 044				65. 00
66. 00 69. 00		PHYSI CAL THERAPY ELECTROCARDI OLOGY	0	5, 368				66. 00
70.00		ELECTROCARDI OLOGI ELECTROENCEPHALOGRAPHY	0	848 1, 224				69. 00 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT		10, 568				71. 00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	706				72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	244, 199	28, 501				73. 00
74.00	1	RENAL DIALYSIS	0	1, 972	1			74.00
76.00		SUBSTANCE ABUSE	O	2, 252	1			76.00
76. 97	07697	CARDIAC REHABILITATION	0	0	0			76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	0	1, 662				76. 98
76. 99		LI THOTRI PSY	0	0	0			76. 99
		TIENT SERVICE COST CENTERS				T		
90.00		CLINIC	0	359				90.00
90. 02		WOMENS DIAGNOSTIC CENTER	0	525	0			90. 02
92. 00	-	OBSERVATION BEDS (NON-DISTINCT PART AL PURPOSE COST CENTERS						92. 00
113 00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	244, 199	157, 028	0	0		118. 00
		IMBURSABLE COST CENTERS	277, 177	137, 020	·, 0			. 10. 00
200.00		Cross Foot Adjustments				72	0	200. 00
201.00	1	Negative Cost Centers	o	0	0	0		201. 00
202.00		TOTAL (sum lines 118-201)	244, 199	157, 028			0	202. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 142011

				'	0 12/31/2014	5/19/2015 5:43 pm
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost			
			& Post			
			Stepdown			
		24.00	Adjustments 25.00	26. 00	_	
	GENERAL SERVICE COST CENTERS	24.00	25.00	20.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	00540 NONPATI ENT TELEPHONES					5. 01
5. 02	00550 DATA PROCESSING					5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING					5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 05
5. 06	00590 ADMINISTRATIVE & GENERAL					5. 06
6.00	00600 MAINTENANCE & REPAIRS					6. 00
7.00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL					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					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV					21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV					22. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 414, 525	0	2, 414, 525	:	30.00
31. 00	03100 I NTENSI VE CARE UNI T	240, 753	1	240, 753		31.00
	ANCILLARY SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·			
50.00	05000 OPERATING ROOM	1, 066, 206	1	1, 066, 206		50. 00
53.00	05300 ANESTHESI OLOGY	7, 213	1	7, 213		53.00
54. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C	297, 115	0	297, 115		54. 00 56. 00
57. 00	05600	47, 416 28, 533	0	47, 41 <i>6</i> 28, 533		57. 00
57. 01	03630 ULTRA SOUND	34, 641		34, 641		57. 01
58. 00	05800 MRI	2, 880	o	2, 880		58. 00
60.00	06000 LABORATORY	325, 849	O	325, 849		60.00
65. 00	06500 RESPI RATORY THERAPY	175, 118	l I	175, 118		65. 00
66.00	06600 PHYSI CAL THERAPY	499, 406	l I	499, 406		66.00
69. 00	06900 ELECTROCARDI OLOGY	66, 138	l I	66, 138		69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	119, 054 399, 221	0	119, 054 399, 221		70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	81, 310	-1	81, 310		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	397, 331		397, 331		73.00
	07400 RENAL DIALYSIS	39, 361	o	39, 361		74. 00
76.00	03950 SUBSTANCE ABUSE	348, 505	O	348, 505	j i	76. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	C		76. 97
	07698 HYPERBARI C OXYGEN THERAPY	147, 115	1	147, 115		76. 98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	C	<u> </u>	76. 99
90. 00	09000 CLINIC	123, 590	O	123, 590)	90.00
90. 02	09001 WOMENS DIAGNOSTIC CENTER	108, 383	1	108, 383		90. 02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92. 00
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE					113.00
118.00		6, 969, 663	0	6, 969, 663	<u> </u>	118. 00
200.00	NONREI MBURSABLE COST CENTERS Cross Foot Adjustments	72	O	72	o	200. 00
200.00		0	l I	/ 2 C		200.00
202.00		6, 969, 735	1	6, 969, 735		202. 00
		·	·			

	h Financial Systems	HOLY FAMILY ME		0011 440044 B		u of Form CMS-	
COST	ALLOCATION - STATISTICAL BASIS		Provi der	Fi	eriod: com 01/01/2014	Worksheet B-1	
				To	12/31/2014	Date/Time Pre 5/19/2015 5:4	pared: 3 pm
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	DATA	
	, , , , , , , , , , , , , , , , , , ,	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	TELEPHONES	PROCESSI NG	
				DEPARTMENT	(NUMBER OF	(NUMBER OF	
				(GROSS SALARI ES)	LINES)	I NSTRUMENT)	
		1.00	2.00	4. 00	5. 01	5. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	296, 776					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	362	296, 776 362	31, 830, 184			2. 00 4. 00
5. 01	00540 NONPATIENT TELEPHONES	2, 363		31, 630, 164	1, 103		5. 01
5. 02	00550 DATA PROCESSI NG	0	0	O	75	243	1
5. 03	00560 PURCHASING RECEIVING AND STORES	6, 396		0	25	5	
5. 04 5. 05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0 161, 692	0 56	0 22	5. 04 5. 05
5.05	00590 ADMI NI STRATI VE & GENERAL	74, 875	74, 875	· ·	50 195	74	
6. 00	00600 MAI NTENANCE & REPAI RS	11, 327		444, 240	15	3	
7.00	00700 OPERATION OF PLANT	43, 097	43, 097	375, 200	21	1	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	5, 031		0	0	1	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 560 14, 618		927, 337 390, 485	8	1	9.00
11. 00	01100 CAFETERI A	14,616	14, 010	253, 487	10	1	11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	Ö	0	0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	0	0	622, 148	2	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	7, 086		92, 276	10	1	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	5, 842 3, 792		1, 046, 323 355, 914	22 73	5 22	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	3, 792		355, 914	73	0	1
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0		2, 298	Ö	0	1
22. 00		0	0	0	0	0	22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	22.0/0	22.0/0	11 207 112	275	1.4	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	33, 968 3, 896			275 5	14 0	1
000	ANCI LLARY SERVI CE COST CENTERS	0,070	0,070	1,001,011	<u> </u>		1
50.00	05000 OPERATING ROOM	28, 399		1, 110, 779	88	13	
53.00	05300 ANESTHESI OLOGY	112		0	7	0	
54. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	7, 573 1, 315			85 0	33	1
57. 00	05700 CT SCAN	518			0	0	1
57. 01	03630 ULTRA SOUND	715		166, 526	0	0	57. 01
58. 00	05800 MRI	0	0	39, 217	2	1	58. 00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	6, 527		0 3, 064, 197	59 24	26 5	1
66. 00	06600 PHYSI CAL THERAPY	532 11, 335			24 22	10	
69. 00	06900 ELECTROCARDI OLOGY	1, 799			0	0	1
	07000 ELECTROENCEPHALOGRAPHY	3, 060			12	3	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	
	07400 RENAL DIALYSIS	327	-	602, 140	1	0	1
76. 00	1	8, 969	8, 969	818, 609	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	1
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	3, 019	3, 019	756, 289 0	2	0	
70. 77	OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	<u> </u>	0	70. 99
90.00	09000 CLI NI C	3, 513	3, 513	66, 657	0	0	
90. 02		2, 850	2, 850	189, 640	2	1	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118. 00		296, 776	296, 776	31, 830, 184	1, 103	243	118. 00
	NONREI MBURSABLE COST CENTERS						
200.00							200.00
201. 00 202. 00		1 727 520	5 222 206	100 676	256 019	1, 267, 361	201. 00
∠∪∠. ∪(Part I)	1, 737, 529	5, 232, 206	108, 676	256, 918	1, 207, 301	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5. 854682	17. 630152	0. 003414	232. 926564	5, 215. 477366	203. 00
204.00	1 1			8, 501	55, 495	3, 773	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	1		0. 000267	50. 312783	15. 526749	205 00
200.00				0.000207	50. 512765	13. 320749	200.00
				·	·		

| Peri od: | Worksheet B-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 142011

				0 12/31/2014	Date/Time Pre 5/19/2015 5:4	
Cost Center Description	PURCHASI NG	ADMI TTI NG		Reconciliation	ADMI NI STRATI VE	
	RECEIVING AND STORES	(I NPATI ENT REVENUE)	OUNTS RECEI VABLE		& GENERAL (ACCUM COST)	
	(COST OF RE	KEVENOL)	(GROSS		(ACCOM COST)	
	QUI STI ONS)		REVENUE)			
GENERAL SERVICE COST CENTERS	5. 03	5. 04	5. 05	5A. 06	5. 06	
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATIENT TELEPHONES						4.00
5. 01 00540 NONPATI ENT TELEPHONES 5. 02 00550 DATA PROCESSI NG						5. 01 5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES	5, 020, 257					5. 03
5. 04 00570 ADMI TTI NG	0	C				5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06 00590 ADMI NI STRATI VE & GENERAL	9, 660 210, 344	C	347, 776, 055	-14, 190, 167	57, 743, 974	5. 05 5. 06
6. 00 00600 MAI NTENANCE & REPAI RS	78, 069	C	1	-14, 190, 107	1, 112, 508	1
7.00 00700 OPERATION OF PLANT	60, 186	C	0	0	4, 393, 353	1
8. 00 00800 LAUNDRY & LINEN SERVICE	286, 044	C	1	0	448, 990	
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	112, 138 475, 826	C	1	0	1, 693, 191 1, 620, 634	
11. 00 01100 CAFETERI A	473,020	C		-	474, 638	1
12. 00 01200 MAINTENANCE OF PERSONNEL	0	C	o o	0	0	
13.00 01300 NURSING ADMINISTRATION	1, 670	C	0	0	752, 105	
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	18, 054	C		0	281, 703 1, 453, 384	
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	C		0	792, 376	
17. 00 01700 SOCIAL SERVICE	0	C	0	0	0	1
21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRV	0	C	ή		2, 306	
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	0	C) 0	0	0	22. 00
30. 00 03000 ADULTS & PEDI ATRI CS	175, 059	C	101, 880, 021	0	15, 947, 893	30.00
31.00 03100 INTENSIVE CARE UNIT	13, 853	C	8, 498, 812	0		
ANCILLARY SERVICE COST CENTERS	10.007		10 550 005		2 207 202	T FO OO
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	18, 827 22	C			2, 286, 003 32, 957	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	15, 278	C	1			
56. 00 05600 RADI 0I SOTOPE	494	C	458, 285		87, 483	
57. 00 05700 CT SCAN 57. 01 03630 ULTRA SOUND	7, 569 264	C	5, 115, 364 2, 952, 242	0	227, 917 240, 994	
58. 00 05800 MRI	3, 197	C	1, 321, 942	0	64, 562	1
60. 00 06000 LABORATORY	200, 017	C	1	0	2, 633, 632	1
65. 00 06500 RESPIRATORY THERAPY	65, 292	C	48, 770, 340		4, 175, 695	
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	3, 772 174	C	11, 876, 182 1, 876, 495		3, 340, 427 133, 914	
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	7, 169	C	1		411, 790	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 624, 968	C	23, 379, 797	0	3, 320, 730	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	579, 808	C	1, 561, 716		668, 953	
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0 879	C	63, 056, 286 4, 363, 877		4, 029, 774 816, 032	
76. 00 03950 SUBSTANCE ABUSE	2, 866	C	1	1		1
76. 97 07697 CARDIAC REHABILITATION	O	C	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	37, 998	C				
76. 99 O7699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	C) 0	0	0	76. 99
90. 00 09000 CLI NI C	2, 348	C	793, 773	0	134, 622	90.00
90. 02 09001 WOMENS DIAGNOSTIC CENTER	8, 412	C	1, 160, 420	0	325, 011	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 020, 257	C	347, 776, 055	-14, 190, 167	57, 743, 974	
NONREI MBURSABLE COST CENTERS						200 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers						200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B,	694, 635	C	1, 986, 231		14, 190, 167	
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 138366	0. 000000	1		0. 245743	
204.00 Cost to be allocated (per Wkst. B, Part II)	151, 545	C	3, 495		1, 776, 822	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 030187	0. 000000	0. 000010		0. 030771	205. 00
11)	1		I			I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

				17	0 12/31/2014	Date/Time Pre 5/19/2015 5:4	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5 piii
		REPAIRS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)			
		6.00	7. 00	8.00	9. 00	10.00	
1 00	GENERAL SERVI CE COST CENTERS						1 00
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATIENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03 5. 04	OO560 PURCHASING RECEIVING AND STORES OO570 ADMITTING						5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 ADMINISTRATIVE & GENERAL						5. 06
6.00	00600 MAI NTENANCE & REPAI RS	201, 453	i e				6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	43, 097 5, 031	158, 356 5, 031				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	3, 560			149, 765		9.00
10. 00	01000 DI ETARY	14, 618	l		14, 618	i e	10.00
11. 00	01100 CAFETERI A	0	0		0	0	11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	_	0	0	12.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	7, 086	7, 086	0	7, 086	0	13. 00 14. 00
15. 00	01500 PHARMACY	5, 842	l		5, 842	l e	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 792	l		3, 792	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	_	0	0	17. 00
21. 00 22. 00	02100 1 & R SERVI CES-SALARY & FRINGES APPRV 02200 1 & R SERVI CES-OTHER PRGM COSTS APPRV	0	0	_	0	0	21. 00 22. 00
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0		22.00
30.00	03000 ADULTS & PEDIATRICS	33, 968	33, 968	401, 266	33, 968	100, 272	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 896	3, 896	38, 666	3, 896	3, 330	31. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	28, 399	28, 399	55, 819	28, 399	0	50. 00
53. 00	05300 ANESTHESI OLOGY	20, 399	20, 399				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 573	ł		7, 573		54.00
56. 00	05600 RADI OI SOTOPE	1, 315	l		1, 315	0	56. 00
57. 00	05700 CT SCAN	518	l	·		l	57.00
57. 01 58. 00	03630 ULTRA SOUND	715	715 0	·		0	57. 01 58. 00
60.00	06000 LABORATORY	6, 527	6, 527			Ö	60.00
65. 00	06500 RESPI RATORY THERAPY	532	532			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	11, 335	l		11, 335		66.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 799 3, 060	1, 799 3, 060		1, 799 3, 060		69. 00 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0,000	0,000		0,000	Ö	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03950 SUBSTANCE ABUSE	327 8, 969	327 8, 969	0 0	327 8, 969	0	74. 00 76. 00
76. 97	07697 CARDIAC REHABILITATION	0, 707	· ·			1	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	3, 019	3, 019	12, 148	3, 019	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	3, 513	3, 513	207	3, 513	0	90. 00
90.00	09001 WOMENS DIAGNOSTIC CENTER	2, 850	l			l	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,000	2,000	2, . , ,	2,000		92.00
	SPECIAL PURPOSE COST CENTERS						
113. 00 118. 00	11300 I NTEREST EXPENSE	201 452	150 25/	F20 024	140 7/5	102 (02	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	201, 453	158, 356	539, 921	149, 765	103, 602] 118.00]
200.00							200. 00
201.00	1 9						201. 00
202.00		1, 385, 899	5, 769, 474	777, 234	2, 263, 475	2, 872, 973	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	6. 879515	36. 433567	1. 439533	15. 113511	27. 730864	203 00
204.00	1 1	303, 524	l		172, 443	l	1
	Part II)						
205.00		1. 506674	7. 674082	0. 345990	1. 151424	5. 396073	205. 00
	1)	T .	l	I		l	I

Health Fina	ncial Systems	HOLY FAMILY ME	EDI CAL	CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCA	NTION - STATISTICAL BASIS			Provi der		eri od:	Worksheet B-1	
					To	rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
							5/19/2015 5: 4	
	Cost Center Description	CAFETERI A		ENANCE OF		CENTRAL	PHARMACY	
		(FTES)			ADMI NI STRATI ON		(COSTED	
				UMBER USED)	(DIRECT NRSING	SUPPLY (COSTED	REQUIS.)	
			"	USLD)	HRS)	REQUIS.)		
		11.00	1	2. 00	13. 00	14. 00	15.00	
	RAL SERVICE COST CENTERS							
i i	O CAP REL COSTS-BLDG & FIXT							1.00
	O CAP REL COSTS-MVBLE EQUIP							2.00
	O EMPLOYEE BENEFITS DEPARTMENT O NONPATIENT TELEPHONES							4. 00 5. 01
	D DATA PROCESSING							5. 02
	O PURCHASING RECEIVING AND STORES							5. 03
	O ADMITTING							5. 04
	CASHI ERI NG/ACCOUNTS RECEI VABLE							5. 05
	O ADMINISTRATIVE & GENERAL							5. 06
	O MAINTENANCE & REPAIRS							6. 00
	O OPERATION OF PLANT							7. 00
	O LAUNDRY & LINEN SERVICE							8. 00
	O HOUSEKEEPI NG							9.00
	O DI ETARY	42.250						10.00
	O CAFETERIA O MAINTENANCE OF PERSONNEL	42, 250		0				11. 00 12. 00
	O NURSING ADMINISTRATION	695		0	29, 292			13. 00
	O CENTRAL SERVICES & SUPPLY	329		0	27, 272	3, 403, 809		14. 00
1	O PHARMACY	1, 262	1	0	o o	0, 100, 007	3, 669, 660	1
	O MEDICAL RECORDS & LIBRARY	839		0	ő	Ö	0	1
	SOCIAL SERVICE	C		0	0	0	0	1
21. 00 0210	O I&R SERVICES-SALARY & FRINGES APPRV	C		0	0	0	0	21. 00
	O I&R SERVICES-OTHER PRGM COSTS APPRV	C)	0	0	0	0	22. 00
	TIENT ROUTINE SERVICE COST CENTERS							
	O ADULTS & PEDI ATRI CS	22, 187		0		0	0	
	O INTENSIVE CARE UNIT LLARY SERVICE COST CENTERS	2, 126	이	0	2, 126	0	0	31.00
	O OPERATING ROOM	1, 809	9	0	1, 809	0	0	50.00
	O ANESTHESI OLOGY	, , , , , , , , , , , , , , , , , , ,	1	0		O	0	
54. 00 0540	O RADI OLOGY-DI AGNOSTI C	651	1	0	0	0	0	54.00
56.00 0560	O RADI OI SOTOPE	50		0	0	0	0	56. 00
	OCT SCAN	137		0	0	0	0	
	O ULTRA SOUND	255		0	0	0	0	
58. 00 0580	I and the second	52		0	0	0	0	
	O LABORATORY O RESPI RATORY THERAPY	5, 190	1	0	0	0	0	
	O PHYSI CAL THERAPY	3, 498		0	0	0	0	1
	O ELECTROCARDI OLOGY	102		0	102	0	0	1
	O ELECTROENCEPHALOGRAPHY	432		0	432	Ö	0	1
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	C	1	0	0	2, 824, 001	0	1
	O IMPL. DEV. CHARGED TO PATIENTS	C		0	0	579, 808	0	72. 00
	DRUGS CHARGED TO PATIENTS	C		0	0	0	3, 669, 660	73. 00
	O RENAL DIALYSIS	803		0	803	0	0	74. 00
	O SUBSTANCE ABUSE	270		0	270	0	0	
	7 CARDI AC REHABI LI TATI ON	C		0	0	0	0	
	8 HYPERBARI C OXYGEN THERAPY	1, 216		0		0	0	
	9 LITHOTRIPSY ATIENT SERVICE COST CENTERS		ا		0	0	0	76. 99
	O CLINIC	104	1	0	104	0	0	90.00
	1 WOMENS DIAGNOSTIC CENTER	243		0			0	
i i	O OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECI	IAL PURPOSE COST CENTERS	_						
	O I NTEREST EXPENSE							113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	42, 250)	0	29, 292	3, 403, 809	3, 669, 660	118. 00
	EI MBURSABLE COST CENTERS		Т					200 00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers							200. 00
202. 00	Cost to be allocated (per Wkst. B,	591, 277	7	0	946, 656	769, 544	2, 169, 532	
202.00	Part I)	371, 277		U	740, 030	707, 344	2, 107, 332	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	13. 994722	2	0. 000000	32. 317902	0. 226083	0. 591208	
204. 00	Cost to be allocated (per Wkst. B,	15, 192		0	23, 710		244, 199	
	Part II)							
205. 00	Unit cost multiplier (Wkst. B, Part	0. 359574	4	0. 000000	0. 809436	0. 073301	0. 066545	205. 00
I	11)	1	I		l l	l		I

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 142011 Peri od: Worksheet B-1 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/19/2015 5:43 pm INTERNS & RESIDENTS Cost Center Description MEDI CAL SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER Y & FRINGES RECORDS & PRGM COSTS LI BRARY (TIME SPENT) **APPRV APPRV** (GROSS (ASSI GNED (ASSI GNED REVENUE) TIME) TIME) 17. 00 16.00 21.00 22.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATI ENT TELEPHONES 5 01 5 01 5.02 00550 DATA PROCESSING 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 05 5 05 5.06 00590 ADMINISTRATIVE & GENERAL 5.06 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 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 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 347, 776, 055 16.00 01700 SOCIAL SERVICE 17.00 17.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 100 21.00 0 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 101, 880, 021 30.00 100 30.00 8, 498, 812 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 0 ANCILLARY SERVICE COST CENTERS 18, 552, 095 05000 OPERATING ROOM 50.00 50.00 0 0 53.00 05300 ANESTHESI OLOGY 4, 453, 547 0 0 53.00 4, 571, 372 0 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 0 54 00 0 56.00 05600 RADI OI SOTOPE 458, 285 0 56.00 05700 CT SCAN 0 57.00 5, 115, 364 0 0 0 57.00 03630 ULTRA SOUND 2, 952, 242 0 0 57.01 57.01 0 05800 MRI 1, 321, 942 0 58.00 58.00 0 60.00 06000 LABORATORY 31, 765, 501 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 48, 770, 340 0 0 0 65.00 66 00 06600 PHYSI CAL THERAPY 11, 876, 182 0 0 66 00 0 69.00 06900 ELECTROCARDI OLOGY 1, 876, 495 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 708, 325 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 23, 379, 797 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 1, 561, 716 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 63, 056, 286 0 73.00 07400 RENAL DIALYSIS 4, 363, 877 0 0 0 74.00 74.00 0 76.00 03950 SUBSTANCE ABUSE 4. 982. 666 0 0 76, 00 0 76.97 07697 CARDIAC REHABILITATION 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 3, 676, 997 C 0 0 76.98 07699 LI THOTRI PSY 76.99 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 793 773 09000 CLI NI C Ω 0 0 90.00 90.02 09001 WOMENS DIAGNOSTIC CENTER 1, 160, 420 C 0 0 90.02 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 92 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 347, 776, 055 100 118.00 0 0 118.00 NONREI MBURSABLE COST CENTERS 200.00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 220, 392 2,873 O 202.00 Part I) 203.00 0.003509 0.000000 28.730000 Unit cost multiplier (Wkst. B, Part I) 0.000000 203 00 204.00 Cost to be allocated (per Wkst. B, 157, 028 204. 00 72 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000452 0.000000 0.720000 0.000000 205.00 II)

Heal th	Financial Systems	HOLY FAMILY ME	DI CAL	CENTER		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES			Provi der		Period: From 01/01/2014 To 12/31/2014		
				Titl	e XVIII	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		apy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00		2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	26, 594, 940			26, 594, 94	0 26, 592	26, 621, 532	30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 343, 746			3, 343, 74	6 0	3, 343, 746	31. 00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	4, 736, 260			4, 736, 26	0	4, 736, 260	50. 00
53.00	05300 ANESTHESI OLOGY	63, 228			63, 22	8 0	63, 228	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 733, 753			1, 733, 75	3 0	1, 733, 753	54.00
56. 00	05600 RADI 0I SOTOPE	188, 120			188, 12	0 0	188, 120	56. 00
57. 00	05700 CT SCAN	339, 578			339, 57	8 0	339, 578	57. 00
57. 01	03630 ULTRA SOUND	362, 320			362, 32	0 0	362, 320	57. 01
58.00	05800 MRI	85, 958			85, 95	8 0	85, 958	58. 00
60.00	06000 LABORATORY	3, 773, 645			3, 773, 64	5 0	3, 773, 645	60.00
65.00	06500 RESPI RATORY THERAPY	5, 477, 371		0	5, 477, 37	1 0	5, 477, 371	65.00

4, 933, 097

4, 857, 275

7, 410, 860

1, 088, 174

2, 265, 525

1, 730, 622

380, 856

589, 886

71, 931, 268

71, 931, 268

283, 946

722, 199

969, 909

4, 933, 097

4, 857, 275

7, 410, 860

1, 088, 174

2, 265, 525

1, 730, 622

380, 856

589, 886

71, 931, 268

71, 931, 268

283, 946

722, 199

969, 909

4, 933, 097

4, 857, 275

7, 410, 860

1, 088, 174

2, 265, 525

1, 730, 622

380, 856

589, 886

71, 957, 860 200. 00

71, 957, 860 202. 00

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283, 946

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0 201. 00

0

26, 592

26, 592

66. 00 06600 PHYSI CAL THERAPY

69. 00 70. 00

71.00

72.00

73.00

74.00

76.00

76. 97

76. 98

76.99

90.00

90. 02

92.00

200.00

201.00

202.00

06900 ELECTROCARDI OLOGY

07400 RENAL DIALYSIS

03950 SUBSTANCE ABUSE

07699 LI THOTRI PSY

113. 00 11300 | INTEREST EXPENSE

09000 CLI NI C

07000 ELECTROENCEPHALOGRAPHY

07697 CARDIAC REHABILITATION

07300 DRUGS CHARGED TO PATIENTS

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

09001 WOMENS DIAGNOSTIC CENTER

SPECIAL PURPOSE COST CENTERS

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

07200 IMPL. DEV. CHARGED TO PATIENTS

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	HOLY FAMILY MED			In Lie Period: From 01/01/2014	u of Form CMS-2 Worksheet C Part I	
				Го 12/31/2014	Date/Time Pre 5/19/2015 5:4	pared: 3 pm
	_		e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
	(00	7.00	0.00	0.00	Ratio	
INDATIENT DOUTINE CEDALCE COCT CENTEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 O3000 ADULTS & PEDI ATRI CS	101 000 001		101 000 00	,1		20.00
	101, 880, 021		101, 880, 02			30.00
31. 00 03100 I NTENSI VE CARE UNI T	8, 498, 812		8, 498, 812	<u> </u>		31. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	1, 752, 724	1/ 700 271	18, 552, 09!	0. 255295	0. 000000	50.00
53. 00 05300 ANESTHESI OLOGY	445, 710	16, 799, 371 4, 007, 837			0.000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 194, 892	1, 376, 480			0.000000	54.00
56. 00 05600 RADI 0LOGY - DI AGNOSTI C	3, 194, 892 68, 548	389, 737			0. 000000	56.00
57. 00 05700 CT SCAN	3, 567, 066	1, 548, 298			0.000000	57. 00
57. 00 03700 CT SCAN 57. 01 03630 ULTRA SOUND	838, 493	2, 113, 749			0.000000	57. 00
58. 00 05800 MRI	945	1, 320, 997			0.000000	58. 00
60. 00 06000 LABORATORY	25, 437, 390	6, 328, 111	31, 765, 50		0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	48, 730, 254	40, 086	48, 770, 340		0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	9, 299, 018	2, 577, 164			0. 000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	986, 737	889, 758			0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	139, 358	2, 568, 967			0. 000000	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 733, 040	1, 646, 757			0. 000000	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	219, 946	1, 341, 770			0. 000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	58, 712, 075	4, 344, 211	63, 056, 286		0. 000000	73.00
74. 00 07400 RENAL DI ALYSI S	4, 363, 877	0	4, 363, 87		0. 000000	74.00
76. 00 03950 SUBSTANCE ABUSE	ol	4, 982, 666			0. 000000	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0. 000000	0. 000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	169, 660	3, 507, 337	3, 676, 99		0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0. 000000	0.000000	76. 99

12, 527

290, 051, 093

290, 051, 093

781, 246

1, 160, 420

57, 724, 962

57, 724, 962

793, 773

1, 160, 420

347, 776, 055

347, 776, 055

0. 479805

0.508338

0. 000000

0.000000

0.000000

0.000000

90.00

90. 02

92.00

113. 00 200. 00 201. 00 202. 00

OUTPATIENT SERVICE COST CENTERS

09001 WOMENS DIAGNOSTIC CENTER

Less Observation Beds

Total (see instructions)

SPECIAL PURPOSE COST CENTERS

113.00 11300 INTEREST EXPENSE
200.00 Subtotal (see instructions)

09200 OBSERVATION BEDS (NON-DISTINCT PART

90.00

90.02

92.00

200. 00 201. 00

202.00

09000 CLI NI C

Health Financial Systems	HOLY FAMILY MEDICAL CENTER		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der	r CCN: 142011	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/19/2015 5:43 pm

			12, 31, 2011	5/19/2015 5: 43 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNIT				31. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 255295			50.00
53. 00 05300 ANESTHESI OLOGY	0. 014197			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 379263			54. 00
56. 00 05600 RADI 0I SOTOPE	0. 410487			56. 00
57. 00 05700 CT SCAN	0. 066384			57. 00
57. 01 03630 ULTRA SOUND	0. 122727			57. 01
58. 00 05800 MRI	0. 065024			58. 00
60. 00 06000 LABORATORY	0. 118797			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 112309			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 415377			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 151317			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 266659			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 207755			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 621053			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 117528			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 249359			74. 00
76. 00 03950 SUBSTANCE ABUSE	0. 454681			76. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 470662			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 479805			90. 00
90.02 09001 WOMENS DIAGNOSTIC CENTER	0. 508338			90. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems		HOLY FAMILY ME	DICAL CENTER		In lie	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COS	TS TO CHARGES	TIOLI TAMILLI ME	Provi der	<u> </u>	Period: From 01/01/2014 Fo 12/31/2014	Worksheet C Part I Date/Time Pre 5/19/2015 5:4	
			Ti1	le XIX	Hospi tal	PPS	
					Costs		
Cost Center Des	cription	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SER	VI CE COST CENTEDS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI AT		26, 594, 940		26, 594, 940	26, 592	26, 621, 532	30.00
31. 00 03100 NTENSI VE CARE		3, 343, 746		3, 343, 74			
ANCI LLARY SERVI CE COS		0,010,710		0,010,71	21 9	0,010,710	01.00
50. 00 05000 OPERATI NG ROOM	T. GENTENO	4, 736, 260		4, 736, 260	0	4, 736, 260	50.00
53. 00 05300 ANESTHESI OLOGY		63, 228		63, 22		63, 228	
54. 00 05400 RADI OLOGY-DI AGN	OSTI C	1, 733, 753	l	1, 733, 75		1, 733, 753	
56. 00 05600 RADI 0I SOTOPE		188, 120	l	188, 120		188, 120	
57. 00 05700 CT SCAN		339, 578		339, 57		339, 578	1
57. 01 03630 ULTRA SOUND		362, 320	.	362, 320		362, 320	
58. 00 05800 MRI		85, 958		85, 95		85, 958	
60. 00 06000 LABORATORY		3, 773, 645		3, 773, 64	5 ol	3, 773, 645	60.00
65. 00 06500 RESPI RATORY THE	RAPY	5, 477, 371		1		5, 477, 371	
66. 00 06600 PHYSI CAL THERAP	Υ	4, 933, 097		4, 933, 09		4, 933, 097	66. 00
69. 00 06900 ELECTROCARDI OLO	GY	283, 946		283, 94		283, 946	69. 00
70. 00 07000 ELECTROENCEPHAL	OGRAPHY	722, 199		722, 19	e o	722, 199	70. 00
71.00 07100 MEDICAL SUPPLIE	S CHARGED TO PATIENT	4, 857, 275		4, 857, 27	5 0	4, 857, 275	71. 00
72.00 07200 IMPL. DEV. CHAR	GED TO PATIENTS	969, 909		969, 90	e o	969, 909	72. 00
73.00 07300 DRUGS CHARGED T	O PATIENTS	7, 410, 860		7, 410, 860	ol ol	7, 410, 860	73. 00
74.00 07400 RENAL DIALYSIS		1, 088, 174		1, 088, 17	4 o	1, 088, 174	74. 00
76.00 03950 SUBSTANCE ABUSE		2, 265, 525		2, 265, 52	5 o	2, 265, 525	76. 00
76. 97 07697 CARDI AC REHABI L	I TATI ON	0			ol ol	0	76. 97
76. 98 07698 HYPERBARI C 0XYG	EN THERAPY	1, 730, 622		1, 730, 62	<u>2</u> 0	1, 730, 622	76. 98
76. 99 07699 LI THOTRI PSY		0			ol ol	0	76. 99
OUTPATIENT SERVICE CO	ST CENTERS	.		•			
00 00 00000 CLINIC		200 05/		200 05		200 05/	1 00 00

380, 856 589, 886

71, 931, 268

71, 931, 268

380, 856 589, 886

71, 931, 268

71, 931, 268

380, 856

589, 886

26, 592

26, 592

71, 957, 860 200. 00

71, 957, 860 202. 00

90.00

90. 02

92.00

113. 00

0 201. 00

09000 CLINIC 09001 WOMENS DIAGNOSTIC CENTER 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

SPECIAL PURPOSE COST CENTERS

113. 00 11300 | INTEREST EXPENSE

90.00

90. 02

92.00

200.00

201.00

202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	HOLY FAMILY MED			In Lie Period: From 01/01/2014 To 12/31/2014	u of Form CMS-2 Worksheet C Part I Date/Time Pre 5/19/2015 5:4	
	_	Ti t	le XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	101, 880, 021		101, 880, 02			30. 00
31.00 03100 INTENSIVE CARE UNIT	8, 498, 812		8, 498, 81	2		31. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 752, 724	16, 799, 371	18, 552, 09		0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	445, 710	4, 007, 837	4, 453, 54		0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 194, 892	1, 376, 480			0.000000	54.00
56. 00 05600 RADI OI SOTOPE	68, 548	389, 737			0.000000	56.00
57. 00 05700 CT SCAN	3, 567, 066	1, 548, 298			0.000000	57.00
57. 01 03630 ULTRA SOUND	838, 493	2, 113, 749			0.000000	57. 01
58. 00 05800 MRI	945	1, 320, 997			0.000000	58. 00
60. 00 06000 LABORATORY	25, 437, 390	6, 328, 111	31, 765, 50		0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	48, 730, 254	40, 086			0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	9, 299, 018	2, 577, 164			0.000000	66. 00
69. 00 06900 ELECTROCARDI OLOGY	986, 737	889, 758			0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	139, 358	2, 568, 967			0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 733, 040	1, 646, 757	23, 379, 79	7 0. 207755	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	219, 946	1, 341, 770	1, 561, 71	6 0. 621053	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 712, 075	4, 344, 211	63, 056, 28	6 0. 117528	0.000000	73.00
74.00 07400 RENAL DIALYSIS	4, 363, 877	0	4, 363, 87	7 0. 249359	0.000000	74.00
76. 00 03950 SUBSTANCE ABUSE	O	4, 982, 666	4, 982, 66	6 0. 454681	0.000000	76.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0. 000000	0.000000	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	169, 660	3, 507, 337	3, 676, 99	7 0. 470662	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0. 000000	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						

12, 527

290, 051, 093

290, 051, 093

781, 246

1, 160, 420

57, 724, 962

57, 724, 962

793, 773

1, 160, 420

347, 776, 055

347, 776, 055

0. 479805

0.508338

0.000000

0.000000

0.000000

0.000000

90.00

90. 02

92.00

113. 00 200. 00 201. 00 202. 00

90. 00 09000 CLI NI C

90.02

92.00

200. 00 201. 00

202.00

09001 WOMENS DIAGNOSTIC CENTER
09200 OBSERVATION BEDS (NON-DISTINCT PART
SPECIAL PURPOSE COST CENTERS

113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	HOLY FAMILY MEDICAL CENTER		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der	r CCN: 142011	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/19/2015 5:43 pm

			10 12/01/2011	5/19/2015 5: 43 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 255295			50.00
53. 00 05300 ANESTHESI OLOGY	0. 014197			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 379263			54.00
56. 00 05600 RADI 0I SOTOPE	0. 410487			56.00
57. 00 05700 CT SCAN	0. 066384			57. 00
57.01 03630 ULTRA SOUND	0. 122727			57. 01
58. 00 05800 MRI	0. 065024			58. 00
60. 00 06000 LABORATORY	0. 118797			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 112309			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 415377			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 151317			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 266659			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 207755			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 621053			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 117528			73. 00
74.00 07400 RENAL DIALYSIS	0. 249359			74.00
76.00 03950 SUBSTANCE ABUSE	0. 454681			76. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 470662			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 479805			90.00
90. 02 09001 WOMENS DIAGNOSTIC CENTER	0. 508338			90. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Finar	cial Systems		HOLY	FAMIL	LY MEDICAL	CENTER			In Lie	u of Form CMS-2552-10
	OF OUTPATIENT SERVICE (OR MEDICALD ONLY	COST TO CHARGI	RATI OS	NET O	F	Provi der	CCN:	142011	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Prepared:

Title XIX					11	0 12/31/2014	5/19/2015 5: 4	pared: 3 nm
Wisst				Ti t	le XIX	Hospi tal		<u> </u>
1, col. 26 11 col. 26 cost (col. 1 - col. 2)		Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00			(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
NO 2.00 3.00 4.00 5.00			I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
ANCILLARY SERVICE COST CENTERS								
50. 00 05000 OPERATI NG ROOM 4,736, 260 1,066, 206 3,670, 054 0 0 50. 00 53. 00 05300 AMESTHESI OLOGY 63,228 7,213 56,015 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1,733,753 297,115 1,436,638 0 0 54. 00 55. 00 05600 RADI OLOGY-DI AGNOSTI C 1,733,753 297,115 1,436,638 0 0 54. 00 05600 RADI OLOGY-DI AGNOSTI C 1,733,753 297,115 1,436,638 0 0 54. 00 057. 00 05800 MR 85,958 2,880 83,078 0 0 58. 00 06. 00 06000 LABORATORY 3,773,645 325,849 3,447,796 0 0 06. 00 06500 RESPIRATORY THERAPY 5,477,371 175,118 5,302,253 0 0 065.00 06500 PINSI CAL THERAPY 4,933,097 499,406 4,433,691 0 0 06. 00 06000 LECTROCARDI OLOGY 283,946 66,138 217,808 0 069,00 06900 ELECTROCARDI OLOGY 283,946 66,138 217,808 0 069,00 070. 00 07000 ELECTROENCEPHALOGRAPHY 722,199 119,054 603,145 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 722,199 119,054 603,145 0 0 70. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 969,909 81,310 888,599 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 969,909 81,310 888,599 0 0 0 0 0 0 0 0 0			1.00	2. 00	3. 00	4. 00	5. 00	
53. 00 05300 AMESTHESI OLOGY 6.3, 22.8 7, 213 56, 015 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 733, 753 297, 115 1, 436, 638 0 0 54. 00 57. 00 05600 RADI OLOGY-DI AGNOSTI C 1, 733, 753 297, 115 1, 436, 638 0 0 54. 00 57. 00 05700 CT SCAN 339, 578 28, 533 311, 045 0 0 57. 00 58. 00 05800 MRI 86, 2320 34, 641 327, 679 0 0 57. 00 58. 00 05800 MRI 85, 958 2, 880 83, 078 0 0 58. 00 60. 00 06000 LABORATORY 1, 733, 743, 645 325, 849 3, 447, 796 0 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 5, 477, 371 175, 118 5, 302, 253 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 4, 933, 097 499, 406 4, 433, 691 0 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 283, 946 66, 138 217, 808 0 0 69. 00 71. 00 071000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 4, 857, 275 399, 221 4, 458, 054 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 969, 909 81, 310 888, 599 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 7, 410, 860 397, 331 7, 013, 529 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 1, 088, 174 39, 361 1, 048, 813 0 74. 00 76. 97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 0 76. 98 07699 LI HOTRI PSY 0 0 0 0 00 09000 DESERVATI ON BEDS (MON-DI STI NCT PART 589, 886 108, 383 481, 503 0 0 0 0 00 09000 OSBERVATI ON BEDS (MON-DI STI NCT PART 589, 886 108, 383 481, 503 0 0 0 0 00 00 00 0 0								
54. 00						0	0	
56.00 05600 RADI OI SOTOPE 188, 120 47, 416 140, 704 0 0 56.00						0	0	
57. 00 05700 CT SCAN 339, 578 28, 533 311, 045 0 0 57. 00 57. 01 03630 ULTRA SOUND 362, 320 34, 641 327, 679 0 0 57. 01 58. 00 05800 MRI 85, 958 2, 880 83, 078 0 0 58. 00 60. 00 06000 LABORATORY 3, 773, 645 325, 849 3, 447, 796 0 0 60. 00 65. 00 06500 RESPIRATORY THERAPY 5, 477, 371 175, 118 5, 302, 253 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 4, 933, 907 499, 406 4, 433, 691 0 0 66. 00 69. 00 06600 ELECTROCARDI OLOGY 283, 946 66, 138 217, 808 0 0 69. 00 70. 00 07000 ELECTROCARDI OLOGY 283, 946 66, 138 217, 808 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 4, 857, 275 399, 221 4, 458, 054 0 0 71. 00 72. 00 07200 IMPL DEV CHARGED TO PATI ENTS 969, 909 81, 310 888, 599 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 7, 410, 860 397, 331 7, 013, 529 0 0 74. 00 76. 00 07400 REMAL DI ALYSI S 1, 088, 174 39, 361 1, 048, 813 0 0 74. 00 76. 97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 0 76. 97 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 76. 99 000 09000 CLI NI C 380, 856 123, 590 257, 266 0 0 90. 00 00 09000 DSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 00 00 00						0	0	
57. 01 03630 ULTRA SOUND 362, 320 34, 641 327, 679 0 0 57. 01 58. 00 05800 MRI 85, 958 2, 880 83, 078 0 0 58. 00 60. 00 06000 LABORATORY 3, 773, 645 325, 849 3, 447, 796 0 0 65. 00 65. 00 06500 RESPIRATORY THERAPY 5, 477, 371 175, 118 5, 302, 253 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 4, 933, 097 499, 406 4, 433, 691 0 0 66. 00 670. 00 06900 ELECTROCARDI OLOGY 283, 946 66, 138 217, 808 0 0 69. 00 670. 00 07000 ELECTROENCEPHALOGRAPHY 722, 199 119, 054 603, 145 0 0 70. 00 671. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 4, 857, 275 399, 221 4, 458, 054 0 0 71. 00 672. 00 07300 DRUGS CHARGED TO PATI ENTS 969, 909 81, 310 888, 599 0 0 72. 00 673. 00 07300 DRUGS CHARGED TO PATI ENTS 7, 410, 860 397, 331 7, 013, 529 0 0 73. 00 674. 00 07400 RENAL DI ALYSI S 1, 088, 174 39, 361 1, 048, 813 0 0 74. 00 676. 90 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76. 97 676. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 730, 622 147, 115 1, 583, 507 0 0 76. 99 676. 90 07699 ULTHOTRI PSY 0 0 0 0 0 0 76. 99 676. 90 07000 CLI NI C 380, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 380, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 380, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 580, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 580, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 580, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 580, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 680, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 680, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 680, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 680, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 680, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 680, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 680, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 680, 856 123, 590 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 680, 856 123, 850 257, 266 0 0 90. 00 679. 00 09000 CLI NI C 680, 856 250 250 250 250 250 250 250 250 250 25						0	0	
S8.00 05800 MRI						0	0	
60.00 06000 LABORATORY 3,773,645 325,849 3,447,796 0 0 60.00 65.00 65.00 RESPI RATORY THERAPY 5,477,371 175,118 5,302,253 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 4,933,097 499,406 4,433,691 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 283,946 66,138 217,808 0 0 69.00 07000 ELECTROCARDI OLOGY 722,199 119,054 603,145 0 0 70.00 71.00 70.100 MEDI CAL SUPPLIES CHARGED TO PATIENT 4,857,275 399,221 4,458,054 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 969,909 81,310 888,599 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 7,410,860 397,331 7,013,529 0 0 73.00 74.00 RENAL DI ALYSIS 1,088,174 39,361 1,048,813 0 0 74.00 76.00 0 3950 SUBSTANCE ABUSE 2,265,525 348,505 1,917,020 0 0 0 0 76.97 76.98 07699 HYPERBARI C OXYGEN THERAPY 1,730,622 147,115 1,583,507 0 0 76.98 76.99 LITHOTRI PSY 0 0 0 0 0 0 76.99 0 0 0 0 0 0 0 0 0						0	0	
65. 00						0	0	
66. 00						0	0	1
69. 00						0	0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY 722, 199 119, 054 603, 145 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 4, 857, 275 399, 221 4, 458, 054 0 0 71. 00 72. 00 072. 00 072. 00 072. 00 072. 00 07300 DRUGS CHARGED TO PATI ENTS 969, 909 81, 310 888, 599 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 7, 410, 860 397, 331 7, 013, 529 0 0 73. 00 73. 00 07400 RENAL DI ALYSI S 1, 088, 174 39, 361 1, 048, 813 0 0 74. 00 76. 00 03950 SUBSTANCE ABUSE 2, 265, 525 348, 505 1, 917, 020 0 0 76. 00 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 1, 730, 622 147, 115 1, 583, 507 0 0 76. 98 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0	0	1
71. 00				66, 138	217, 808	0	0	69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 969, 909 81, 310 888, 599 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 7, 410, 860 397, 331 7, 013, 529 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 1, 088, 174 39, 361 1, 048, 813 0 0 74. 00 76. 00 03950 SUBSTANCE ABUSE 2, 265, 525 348, 505 1, 917, 020 0 0 76. 00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 1, 730, 622 147, 115 1, 583, 507 0 0 76. 99 00 07699 LITHOTRIPSY 0 0 0 0 0 0 76. 99 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 7, 410, 860 397, 331 7, 013, 529 0 0 73. 00 74. 00 7	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 857, 275	399, 221	4, 458, 054	0	0	71. 00
74. 00 07400 RENAL DI ALYSI S 1,088,174 39,361 1,048,813 0 0 74. 00 76. 00 03950 SUBSTANCE ABUSE 2,265,525 348,505 1,917,020 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1,730,622 147,115 1,583,507 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 76. 99 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 380,856 123,590 257,266 0 0 90. 00 90. 02 09001 WOMENS DI AGNOSTI C CENTER 589,886 108,383 481,503 0 0 90. 02 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	969, 909	81, 310	888, 599	0	0	72. 00
76. 00 03950 SUBSTANCE ABUSE 2, 265, 525 348, 505 1, 917, 020 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 730, 622 147, 115 1, 583, 507 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76. 99 00 0 0 0 0 0 0 0 0 76. 99 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73. 00	07300 DRUGS CHARGED TO PATIENTS	7, 410, 860	397, 331	7, 013, 529	0	0	73. 00
76. 97	74. 00	07400 RENAL DIALYSIS	1, 088, 174	39, 361	1, 048, 813	0	0	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY 1,730,622 147,115 1,583,507 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0 0	76. 00	03950 SUBSTANCE ABUSE	2, 265, 525	348, 505	1, 917, 020	0	0	76. 00
76. 99 07699 LITHOTRI PSY 0 0 0 0 0 0 0 0 76. 99 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLINI C 380, 856 123, 590 257, 266 0 0 90. 00	76. 97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 380,856 123,590 257,266 0 0 90.00 90. 02 09001 WOMENS DIAGNOSTIC CENTER 589,886 108,383 481,503 0 0 0 90.02 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 113.00 INTEREST EXPENSE 200.00 Subtotal (sum of lines 50 thru 199) 41,992,582 4,314,385 37,678,197 0 0 200.00 201.00 Less Observation Beds 0 0 0 0 0 201.00	76. 98	07698 HYPERBARIC OXYGEN THERAPY	1, 730, 622	147, 115	1, 583, 507	0	0	76. 98
90. 00 09000 CLINIC 380, 856 123, 590 257, 266 0 0 90. 00	76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
90. 02 09001 WOMENS DI AGNOSTIC CENTER 589,886 108,383 481,503 0 0 90.02 92.00								
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 92. 00	90.00	09000 CLI NI C	380, 856	123, 590	257, 266	0	0	90. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (sum of lines 50 thru 199) 41,992,582 4,314,385 37,678,197 0 0 200.00 201.00 Less Observation Beds 0 0 0 0 0 201.00	90. 02	09001 WOMENS DIAGNOSTIC CENTER	589, 886	108, 383	481, 503	0	0	90. 02
113.00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92. 00
200.00 Subtotal (sum of lines 50 thru 199) 41,992,582 4,314,385 37,678,197 0 0 200.00 201.00 Less Observation Beds 0 0 0 0 201.00								
201.00 Less Observation Beds 0 0 0 0 0 201.00	113.00							
			41, 992, 582	4, 314, 385	37, 678, 197	0		
202.00 Total (line 200 minus line 201) 41,992,582 4,314,385 37,678,197 0 0 202.00		•	0	•	1	0		
	202.00	Total (line 200 minus line 201)	41, 992, 582	4, 314, 385	37, 678, 197	0) O	202. 00

Hea	Ith Financial Systems	HOLY FA	AMILY MEDICAL	CENTER		In Lieu	u of Form CMS-2552-10
	CULATION OF OUTPATIENT SERVICE COS UCTIONS FOR MEDICAID ONLY	T TO CHARGE RATIOS NE	ET OF	Provi der C	CN: 142011	From 01/01/2014	Worksheet C Part II Date/Time Prepared:

					5/19/2015 5:	43 pm
			le XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and		Cost to Charge			
		Part I, column				
	Reduction	8)	/ col . 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 736, 260	18, 552, 095	0. 255295	5		50.00
53. 00 05300 ANESTHESI OLOGY	63, 228	4, 453, 547	0. 014197	,		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 733, 753	4, 571, 372	0. 379263	3		54.00
56. 00 05600 RADI 0I SOTOPE	188, 120	458, 285	0. 410487	,		56. 00
57.00 05700 CT SCAN	339, 578	5, 115, 364	0. 066384			57. 00
57.01 03630 ULTRA SOUND	362, 320	2, 952, 242	0. 122727	,		57. 01
58. 00 05800 MRI	85, 958	1, 321, 942	0. 065024			58. 00
60. 00 06000 LABORATORY	3, 773, 645	31, 765, 501	0. 118797	,		60.00
65. 00 06500 RESPIRATORY THERAPY	5, 477, 371	48, 770, 340	0. 112309			65. 00
66. 00 06600 PHYSI CAL THERAPY	4, 933, 097	11, 876, 182	0. 415377	,		66. 00
69. 00 06900 ELECTROCARDI OLOGY	283, 946	1, 876, 495	0. 151317	,		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	722, 199	2, 708, 325	0. 266659			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	IT 4, 857, 275	23, 379, 797	0. 207755	5		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	969, 909	1, 561, 716	0. 621053	3		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 410, 860	63, 056, 286	0. 117528	3		73. 00
74.00 07400 RENAL DIALYSIS	1, 088, 174	4, 363, 877	0. 249359			74. 00
76. 00 03950 SUBSTANCE ABUSE	2, 265, 525	4, 982, 666	0. 454681			76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 730, 622	3, 676, 997	0. 470662	2		76. 98
76. 99 07699 LI THOTRI PSY	0					76. 99
OUTPATIENT SERVICE COST CENTERS			•	•		
90. 00 09000 CLI NI C	380, 856	793, 773	0. 479805	5		90.00
90. 02 09001 WOMENS DIAGNOSTIC CENTER	589, 886					90. 02
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAI		1	1			92. 00
SPECIAL PURPOSE COST CENTERS				•		
113. 00 11300 NTEREST EXPENSE						113. 00
200.00 Subtotal (sum of lines 50 thru 199	9) 41, 992, 582	237, 397, 222				200. 00
201.00 Less Observation Beds	0	1				201. 00
202.00 Total (line 200 minus line 201)	41, 992, 582	237, 397, 222				202. 00
			1	1		

Health Financial Systems	HOLY FAMILY ME	DICAL CENTER		In Lieu of Form CMS-255		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi de	r CCN: 142011	Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/19/2015 5:4	
		Ti ·	tle XVIII	Hospi tal	PPS	<u> Бин</u>
Cost Center Description	Capi tal	Swi ng Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cos	t	,	
	Part II, col.		(col. 1 - co	l.		
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	<u>.</u>		
30. 00 ADULTS & PEDI ATRI CS	2, 414, 525		0 2, 414, 5	25 33, 424	72. 24	30. 00
31.00 INTENSIVE CARE UNIT	240, 753		240, 7	53 2, 220	108. 45	31.00
200.00 Total (lines 30-199)	2, 655, 278		2, 655, 2	78 35, 644		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost	:			
		(col. 5 x col				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	18, 512	1, 337, 30)7			30. 00
31.00 INTENSIVE CARE UNIT	1, 032	111, 92	20			31.00
200.00 Total (lines 30-199)	19, 544	1, 449, 22	27			200. 00

Hoal th	Financial Systems	HOLY FAMILY ME	DICAL CENTED		In Lie	eu of Form CMS-2	2552 10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II	pared:
				le XVIII	Hospi tal	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	(from Wkst. C	Ratio of Cos to Charges (col. 1 ÷ col 2)	Program	Capital Costs (column 3 x column 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>		·	-	•	
50.00	05000 OPERATI NG ROOM	1, 066, 206	18, 552, 09	5 0.05747	71 989, 309	56, 857	50.00
53.00	05300 ANESTHESI OLOGY	7, 213	4, 453, 54	7 0. 00162	259, 849	421	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	297, 115	4, 571, 37	2 0. 06499	95 1, 817, 152	118, 106	54.00
56.00	05600 RADI 0I SOTOPE	47, 416		5 0. 10346	31, 826	3, 293	56. 00
57.00	05700 CT SCAN	28, 533	5, 115, 36			10, 554	57. 00
57. 01	03630 ULTRA SOUND	34, 641	2, 952, 24	2 0. 01173	486, 702	5, 711	57. 01
58.00	05800 MRI	2, 880	1, 321, 94	2 0. 00217	79 0	0	58. 00
60.00	06000 LABORATORY	325, 849	31, 765, 50	1 0. 0102	14, 427, 612		60.00
65.00	06500 RESPI RATORY THERAPY	175, 118	48, 770, 34	0. 00359	28, 746, 035	103, 227	65. 00
66.00	06600 PHYSI CAL THERAPY	499, 406					
69. 00	06900 ELECTROCARDI OLOGY	66, 138					1
70.00	07000 ELECTROENCEPHALOGRAPHY	119, 054					1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	399, 221	23, 379, 79			211, 709	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	81, 310		6 0. 0520	55 112, 458	5, 855	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	397, 331					1
74.00	07400 RENAL DIALYSIS	39, 361	4, 363, 87	7 0. 00902	20 2, 539, 551	22, 907	74. 00
76.00	03950 SUBSTANCE ABUSE	348, 505	4, 982, 66			0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		0. 00000		0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	147, 115	3, 676, 99	•	•	l .	
76. 99	07699 LITHOTRI PSY	0		0. 00000	00 0	0	76. 99

123, 590

108, 383

4, 314, 385

793, 773

1, 160, 420

237, 397, 222

0. 155699

0. 093400 0. 000000

7, 866

102, 919, 309

1, 225

0 0

1, 151, 576 200. 00

90.00

90. 02 92. 00

OUTPATIENT SERVICE COST CENTERS

90. 00 | 09000| CLI NI C | 90. 02 | 09001| WOMENS DI AGNOSTI C CENTER | 92. 00 | 09200| OBSERVATI ON BEDS (NON-DI STI NCT PART 200. 00 | Total (lines 50-199)

Health Financial Systems	HOLY FAMILY ME	EDI CAL	CENTER		In Li∈	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS	TS	Provi der	CCN: 142011	Peri od:	Worksheet D	
					From 01/01/2014		narad.
					To 12/31/2014	Date/Time Pre 5/19/2015 5:4	pareu: 3 nm
			Ti tl	e XVIII	Hospi tal	PPS	o piii
Cost Center Description	Nursing School	Alli	ed Health	All Other	Swi ng-Bed	Total Costs	
			Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	st Amount (see	1 through 3,	
					instructions)	minus col. 4)	
	1.00		2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	C		C		0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	C		C		0	0	31. 00
200.00 Total (lines 30-199)	C		C)	0	0	200. 00
Cost Center Description	Total Patient	Per [Diem (col.	I npati ent	I npati ent		
	Days	5 ÷	col . 6)	Program Days			
					Pass-Through		
					Cost (col. 7 x		
					col . 8)		
	6. 00		7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS					_		
30. 00 03000 ADULTS & PEDI ATRI CS	33, 424		0.00				30. 00
31.00 03100 INTENSIVE CARE UNIT	2, 220		0.00	1			31.00
200.00 Total (lines 30-199)	35, 644	·		19, 54	14 0		200. 00

Heal th Financial Systems	HOLY FAMILY ME		CON 142011		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE UTHER PAS	5 Provider		Peri od: From 01/01/2014 To 12/31/2014		
		Ti tI	e XVIII	Hospi tal	PPS	о р
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	()	0	0	
53. 00 05300 ANESTHESI OLOGY	0	()	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	()	0	0	54.00
56. 00 05600 RADI OI SOTOPE	0	()	0	0	56. 00
57. 00 05700 CT SCAN	0	()	0	0	57. 00
57. 01 03630 ULTRA SOUND	0	()	0	0	57. 01
58. 00 05800 MRI	0	()	0	0	58. 00
60. 00 06000 LABORATORY	0	()	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	()	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	()	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	()	0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	()	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	()	0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	()	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0	0	
74. 00 07400 RENAL DI ALYSI S	0	()	0	0	74. 00
76. 00 03950 SUBSTANCE ABUSE	0	()	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	()	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	()	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0)	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	()	0	0	
90. 02 09001 WOMENS DIAGNOSTIC CENTER	0	()	0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	()	0	0	
200.00 Total (lines 50-199)	0	1	NI	ol o	Ι	200.00

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	HOLY FAMILY ME VICE OTHER PASS		r CCN: 142011	Peri od:	eu of Form CMS-: Worksheet D	
THROUG	H COSTS				From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/19/2015 5:4	
			Ti -	le XVIII	Hospi tal	PPS	о рііі
	Cost Center Description	Total	Total Charge	s Ratio of Cos		Inpatient	
	·	Outpati ent	(from Wkst. (to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ co	I. to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	_		_			
50.00	05000 OPERATING ROOM	0	18, 552, 09				
53.00	05300 ANESTHESI OLOGY	0	4, 453, 54				
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 571, 37	•			
56. 00	05600 RADI OI SOTOPE	0	458, 28			•	
57. 00	05700 CT SCAN	0	5, 115, 36				
57. 01	03630 ULTRA SOUND	0	2, 952, 24				57. 01
58. 00	05800 MRI	0	1, 321, 94				58. 00
60.00	06000 LABORATORY	0	31, 765, 50				60.00
65.00	06500 RESPI RATORY THERAPY	0	48, 770, 34				
66. 00	06600 PHYSI CAL THERAPY	0	11, 876, 18				
69. 00	06900 ELECTROCARDI OLOGY	0	1, 876, 49				
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	2, 708, 32				
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	23, 379, 79			1 ' '	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 561, 7°	6 0.0000	0. 000000	112, 458	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	63, 056, 28				
74.00	07400 RENAL DIALYSIS	0	4, 363, 87				74.00
76.00	03950 SUBSTANCE ABUSE	0	4, 982, 66	0.0000	0. 000000	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	0		0.0000	0. 000000		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	3, 676, 99	0. 0000			76. 98
76. 99	07699 LI THOTRI PSY	0		0.0000	0. 000000	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	OOOOO CLINIC		702 7	12 0 0000	0 000000	7 0//	

0.000000

0. 000000 0. 000000

0.000000

0. 000000 0. 000000

90. 00 0 90. 02 0 92. 00

7, 866

102, 919, 309 200. 00

793, 773 1, 160, 420 0

237, 397, 222

90. 00 | 09000 CLI NI C | 90. 02 | 09001 | WOMENS DI AGNOSTI C CENTER | 92. 00 | 09200 | 0BSERVATI ON BEDS (NON-DI STI NCT PART 200. 00 | Total (lines 50-199)

Health Finan	cial Systems		HOLY	FAMILY M	IEDI CAL	CENTER			In Lieu	u of Form C	MS-2552-10
APPORTI ONMEN	IT OF INPATIENT/OUTPATIENT S	ANCILLARY SE	ERVICE (OTHER PAS	SS	Provi der	CCN:	142011	od: 01/01/2014 12/31/2014		Prepared:

			11	5 12/31/2014	5/19/2015 5:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS	,					
50.00 05000 OPERATING ROOM	0	4, 530, 750				50.00
53. 00 05300 ANESTHESI OLOGY	0	1, 006, 828	•			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	438, 259	1			54. 00
56. 00 05600 RADI 0I SOTOPE	0	146, 690	•			56. 00
57. 00 05700 CT SCAN	0	724, 216				57. 00
57. 01 03630 ULTRA SOUND	0	454, 848	1			57. 01
58. 00 05800 MRI	0	312, 363				58. 00
60. 00 06000 LABORATORY	0	829, 210				60. 00
65. 00 06500 RESPI RATORY THERAPY	0	34, 777				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 135				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	266, 905				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	564, 369				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 501, 314				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	27, 289				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 437, 410	0			73. 00
74. 00 07400 RENAL DI ALYSI S	0	C	0			74. 00
76. 00 03950 SUBSTANCE ABUSE	0	18	8 0			76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C	0			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	1, 430, 876	0			76. 98
76. 99 07699 LI THOTRI PSY	0	C	0			76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	211, 064	· 0			90.00
90. 02 09001 WOMENS DIAGNOSTIC CENTER	0	134, 401	0			90. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C	0			92.00
200.00 Total (lines 50-199)	0	15, 052, 722	2 0			200. 00

Health Financial Systems	HOLY FAMILY MEDICA	L CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 142011	Period: From 01/01/2014	Worksheet D

12/31/2014 Date/Time Prepared: 5/19/2015 5:43 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 255295 4, 530, 750 1, 156, 678 50.00 53.00 05300 ANESTHESI OLOGY 0.014197 1,006,828 0 0 14, 294 53.00 05400 RADI OLOGY-DI AGNOSTI C 0. 379263 438, 259 0 54 00 166, 215 54 00 0 56.00 05600 RADI OI SOTOPE 0.410487 146, 690 60, 214 56.00 57.00 05700 CT SCAN 0.066384 724, 216 48, 076 57.00 454, 848 0 57. 01 03630 ULTRA SOUND 0.122727 0 55.822 57.01 0 05800 MRI 58.00 0.065024 312, 363 20, 311 58.00 60.00 06000 LABORATORY 0.118797 829, 210 98, 508 60.00 06500 RESPIRATORY THERAPY 0 65.00 0.112309 34, 777 0 3, 906 65.00 0 06600 PHYSI CAL THERAPY 66 00 0 415377 1, 135 471 66 00 69.00 06900 ELECTROCARDI OLOGY 0.151317 266, 905 40, 387 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 266659 564, 369 0 150, 494 70.00 1, 501, 314 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 207755 1, 915 311, 905 71.00 0 16, 948 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0.621053 27, 289 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.117528 2, 437, 410 0 14, 364 286, 464 73.00 74.00 07400 RENAL DIALYSIS 0. 249359 74.00 76. 00 03950 SUBSTANCE ABUSE 0. 454681 18 0 0 76.00 8 0 76. 97 07697 CARDIAC REHABILITATION 0.000000 C 0 0 76.97 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 470662 1, 430, 876 0 673, 459 76.98 07699 LI THOTRI PSY 0.000000 0 76. 99 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 0 479805 211, 064 0 101, 270 90.02 09001 WOMENS DIAGNOSTIC CENTER 0.508338 134, 401 0 0 68, 321 90.02 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0.000000 0 92.00 0 16, 279 200.00 200.00 Subtotal (see instructions) 15, 052, 722 3, 273, 751 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 15, 052, 722 0 3, 273, 751 202. 00 16, 279

Health Financial Systems		HOLY FAMILY MEDICAL	CENTER	In Lie	u of Form CMS-2552-1
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	VACCINE COST	Provi der CCN: 142011	From 01/01/2014	Worksheet D Part V Date/Time Prepared: 5/19/2015 5:43 pm
			Title XVIII	Hospi tal	PPS

Cost Center Description					To 12/31/2014	Date/lime Pre 5/19/2015 5:4	epared: 13 pm
Cost Center Description			Ti tl	e XVIII	Hospi tal		
Reimbursed Servi ces Not Subject To Ded. & Coins. (See inst.) Ded. & Coins. (See inst.)		Cost	ts				
ANCI LLARY SERVICE COST CENTERS	Cost Center Description	Cost	Cost				
Subject To Ded. & Coins Coins (see inst.) Ded. & Coins (see inst.)							
Ded. & Coi ns. (See inst.) Ded. & Coi ns. (See inst.)							
See inst. See							
ANCI LLARY SERVI CE COST CENTERS							
ANCILLARY SERVICE COST CENTERS							
50.00 5000 DERATING ROOM 50 0 0 0 0 0 0 0 0	ANOTHER OF THE CONTROL OF THE CONTRO	6.00	7. 00				
53. 00 05300 AMESTHESI OLOGY 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 00 56. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 55. 00 57. 01 05700 CT SCAN 0 0 0 57. 00 57. 01 03630 ULTRA SOUND 0 0 0 57. 01 58. 00 05800 MRI 0 0 0 0 65. 00 60. 00 06600 LABORATORY 0 0 0 65. 00 66. 00 65. 00 06600 PHYSI CAL THERAPY 0 0 0 65. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 66. 00 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70. 00 71. 00 07000 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 73. 00 76. 97 07300 PRUGS CHARGED TO PATI ENTS							
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0		1	-				
56. 00 05600 RADIOISOTOPE 0 0 0 0 0 05700 CT SCAN 0 0 0 0 05700 CT SCAN 0 0 0 0 0 05700 CT SCAN 0 0 0 0 0 05700 CT SCAN 0 0 0 0 0 0 0570.01 05800 MRI 0 0 0 0 0 0 05800 MRI 0 0 0 0 0 05900 CESTRICATION 0 0 0 0 0 05900 CESTRICATION 0 0 0 0 0 0 0 0 0 0		0	0				
57. 00 05700 CT SCAN 0 0 0 0 57. 00 57. 01 03630 ULTRA SOUND 0 0 0 57. 01 58. 00 05800 MRI 0 0 0 0 60. 00 06500 LABORATORY 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 66. 00 06500 RESPI RATORY THERAPY 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 67. 00 06900 ELECTROCARDI OLOGY 0 0 0 68. 00 06900 ELECTROCARDI OLOGY 0 0 0 69. 00 07000 ELECTROCEPHALOGRAPHY 0 0 0 70. 00 07000 ELECTROECEPHALOGRAPHY 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 1,688 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 76. 00 03950 SUBSTANCE ABUSE 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 99 07699 LTHOTRI PSY 0 0 0 76. 99 07699 LTHOTRI PSY 0 0 76. 99 07699 LTHOTRI PSY 0 0 76. 90 079000 CLI NI C 0 0 90. 02 90001 WOMENS DI AGNOSTI C CENTER 0 0 90. 02 90001 WOMENS DI AGNOSTI C CENTER 0 0 90. 02 90001 SUBSTANTO BEDS (NON-DISTINCT PART 0 0 90. 02 90001 SUBSTANTO BEDS (NON-DISTINCT PART 0 0 90. 01 Subtotal (see instructions) 0 2,086 201. 00 Only Charges 0		0	0				
57. 01 03630 ULTRA SOUND		0	0				
58. 00		0	0				
60. 00		0	0				
65. 00		0	0				
66. 00			0				
69. 00			0				
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0			0				
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 398 71. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 1, 688 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 76. 97 76. 98 76. 97 CARDI AC REHABI LITATI ON 0 0 0 76. 97 76. 98 76. 99 76. 99 07699 LITHOTRI PSY 0 0 0 0 76. 99 07699 LITHOTRI PSY 0 0 0 0 0 0 0 0 0			-				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			-				
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 1,688 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 90			370				
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 76. 00 76. 00 76. 00 76. 00 76. 00 76. 97 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 0			1 600				
76. 00	· · · · · · · · · · · · · · · · · · ·			1			
76. 97 76. 98 76. 99 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 07000 CLI NI C 0 090. 02 09001 WOMENS DI AGNOSTI C CENTER 092. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0				
76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 00 00 00 00 00 00 00 00 00 00 00		0	0				
76. 99 07699 LITHOTRIPSY 0 0 0 0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 90. 02 09001 WOMENS DIAGNOSTIC CENTER 0 0 0 92. 00 09200 DISERVATION BEDS (NON-DISTINCT PART 0 0 0 200. 00 Subtotal (see instructions) 0 2,086 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 0 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·	0	0				
OUTPATIENT SERVICE COST CENTERS		1		1			
90. 00 09000 CLINIC 0 0 0 90. 0		· · · · · · · · · · · · · · · · · · ·		'			
92. 00 09200 085ERVATION BEDS (NON-DISTINCT PART 0 0 200. 00 201. 00 085ERVATION BEDS (NON-DISTINCT PART 0 0 200. 00 200. 00 201. 00 085ERVATION BEDS (NON-DISTINCT PART 0 0 200. 00 2		0	0)			90.00
200.00 Subtotal (see instructions) 0 2,086 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0nly Charges 0 0 0 0 0 0 0 0 0	90. 02 09001 WOMENS DIAGNOSTIC CENTER	O	0				90. 02
200.00 Subtotal (see instructions) 0 2,086 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 0nly Charges 200.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	O	0)			92.00
Only Charges		0	2, 086	,			200.00
	201.00 Less PBP Clinic Lab. Services-Program	0					201.00
202.00 Net Charges (line 200 +/- line 201) 0 2,086 202.00							
	202.00 Net Charges (line 200 +/- line 201)	0	2, 086				202. 00

Health Financial Systems	HOLY FAMILY ME	DICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014		nanad.
				10 12/31/2014	Date/Time Pre 5/19/2015 5:4	pareu: 3 pm
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 414, 525	(2, 414, 52	33, 424	72. 24	30. 00
31.00 INTENSIVE CARE UNIT	240, 753		240, 75	2, 220	108. 45	31. 00
200.00 Total (lines 30-199)	2, 655, 278		2, 655, 27	35, 644		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 698	122, 664	ļ			30. 00
31.00 INTENSIVE CARE UNIT	91	9, 869				31. 00
200.00 Total (lines 30-199)	1, 789	132, 533	В			200. 00

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	ITAL COSTS		Provi der		Peri od: From 01/01/2014	Worksheet D Part II	
						Date/Time Prep 5/19/2015 5:43	pared: 3 pm
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26) 1.00	(from Part	n Wkst. C,	Ratio of Cos to Charges (col. 1 ÷ col 2)	Program	Capital Costs (column 3 x column 4)	
ANCILLARY SERVICE COST CENTERS	•	•					

	Cost Center Description	Capi tal		Ratio of Cost	Inpatient	Capital Costs	
	·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
		Part II, col.	8)	2)	_		
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 066, 206	18, 552, 095	0. 057471	56, 263	3, 233	50.00
53.00	05300 ANESTHESI OLOGY	7, 213	4, 453, 547	0. 001620	16, 484	27	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	297, 115	4, 571, 372	0. 064995	153, 926	10, 004	54.00
56.00	05600 RADI OI SOTOPE	47, 416	458, 285	0. 103464	6, 846	708	56. 00
57.00	05700 CT SCAN	28, 533	5, 115, 364	0. 005578	161, 114	899	57. 00
57. 01	03630 ULTRA SOUND	34, 641	2, 952, 242	0. 011734	45, 517	534	57. 01
58. 00	05800 MRI	2, 880	1, 321, 942	0. 002179	0	0	58. 00
60.00	06000 LABORATORY	325, 849	31, 765, 501	0. 010258	994, 331	10, 200	60.00
65.00	06500 RESPI RATORY THERAPY	175, 118	48, 770, 340	0. 003591	2, 705, 446	9, 715	65. 00
66.00	06600 PHYSI CAL THERAPY	499, 406	11, 876, 182	0. 042051	417, 286	17, 547	66. 00
69.00	06900 ELECTROCARDI OLOGY	66, 138	1, 876, 495	0. 035245	41, 306	1, 456	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	119, 054	2, 708, 325	0. 043959	10, 700	470	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	399, 221	23, 379, 797	0. 017075	732, 946	12, 515	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	81, 310	1, 561, 716	0. 052065	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	397, 331	63, 056, 286	0. 006301	2, 699, 544	17, 010	73. 00
74.00	07400 RENAL DIALYSIS	39, 361	4, 363, 877	0.009020	0	0	74. 00
76.00	03950 SUBSTANCE ABUSE	348, 505	4, 982, 666	0.069943	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0.000000	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	147, 115	3, 676, 997	0. 040010	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	•	<u> </u>				
90.00	09000 CLI NI C	123, 590	793, 773	0. 155699	0	0	90. 00
90. 02	09001 WOMENS DIAGNOSTIC CENTER	108, 383	1, 160, 420	0. 093400	0	0	90. 02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92. 00
200.00		4, 314, 385	237, 397, 222		8, 041, 709	84, 318	200. 00

Health Financial Systems	HOLY FAMILY ME	EDICAL CENTER		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/19/2015 5:4	
		Ti t	le XIX	Hospi tal	PPS	<u> Бин</u>
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	C	0)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	C	0)	0	0	31.00
200.00 Total (lines 30-199)	C	0		0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	33, 424	•	1			30. 00
31.00 03100 INTENSIVE CARE UNIT	2, 220		1			31. 00
200.00 Total (lines 30-199)	35, 644	.[1, 78	9 0		200. 00

Health Financial Systems	HOLY FAMILY ME		CCN: 142011		eu of Form CMS-2	<u> 2552 - 10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	SERVICE UTHER PAS	5 Provider		Peri od: From 01/01/2014 To 12/31/2014		
		Ti t	Te XIX	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	9	
					4)	
ANOLILARY OFFICE COOT OFFITTED	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			.1			
50. 00 05000 OPERATING ROOM	0			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0			0	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0			0	0	
56. 00 05600 RADI 01 SOTOPE	0			0	0	
57. 00 05700 CT SCAN	0			0	0	
57. 01 03630 ULTRA SOUND 58. 00 05800 MRI	0			0	0	
60. 00 06000 LABORATORY	0			0	0	
65. 00 06500 RESPI RATORY THERAPY	0			0	0	
66. 00 06600 PHYSI CAL THERAPY	0			0	0	
69. 00 06900 ELECTROCARDI OLOGY						
70. 00 07000 ELECTROENCEPHALOGRAPHY						1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				٥	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				Ö	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0					1
74. 00 07400 RENAL DI ALYSI S	0	1		0 0	0	
76. 00 03950 SUBSTANCE ABUSE	0	1		0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1		0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	1		0 0	Ö	
76. 99 07699 LI THOTRI PSY	0			0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLI NI C	0	C		0 0	0	90.00
90. 02 09001 WOMENS DIAGNOSTIC CENTER	0		ol	0 0	0	90. 02
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 0	0	1
200.00 Total (lines 50-199)	0	1	J	0 0	1	200. 00

Heal th	Financial Systems	HOLY FAMILY ME	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORT	TOMMENT OF INPATIENT/OUTPATIENT ANCILLARY SER CH COSTS				Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV	pared:
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
	T	6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	1 .0,002,070	1		56, 263	
53.00	05300 ANESTHESI OLOGY	0	4, 453, 547	1			
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 571, 372	1			
56. 00	05600 RADI 0I SOTOPE	0	458, 285				
57. 00	05700 CT SCAN	0	5, 115, 364			161, 114	
57. 01	03630 ULTRA SOUND	0	2, 952, 242				
58. 00	05800 MRI	0	1, 321, 942			0	
60.00	06000 LABORATORY	0	31, 765, 501	1		994, 331	60.00
65.00	06500 RESPI RATORY THERAPY	0	48, 770, 340			2, 705, 446	
66. 00	06600 PHYSI CAL THERAPY	0	11, 876, 182			417, 286	
69. 00	06900 ELECTROCARDI OLOGY	0	1, 876, 495			41, 306	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2, 708, 325			10, 700	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	23, 379, 797		0.000000	732, 946	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 561, 716	0.00000	0.000000	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	63, 056, 286	0.00000	0.000000	2, 699, 544	73. 00
74.00	07400 RENAL DIALYSIS	0	4, 363, 877	0.00000	0.000000	0	74. 00
76.00	03950 SUBSTANCE ABUSE	0	4, 982, 666	0.00000	0. 000000	0	76. 00
76. 97	07697 CARDI AC REHABILITATION	0	C	0.00000	0. 000000	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	3, 676, 997	0.00000	0. 000000	0	76. 98
76. 99	07699 LI THOTRI PSY	0	C	0.00000	0. 000000	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
00 00	00000 CLINIC		702 772	0 00000	0 000000		00 00

0.000000

0. 000000 0. 000000

793, 773 1, 160, 420 0

237, 397, 222

0.000000

0. 000000 0. 000000

0 90.00 0 90.02 0 92.00

8, 041, 709 200. 00

90. 00 | 09000 CLI NI C | 90. 02 | 09001 | WOMENS DI AGNOSTI C CENTER | 92. 00 | 09200 | 0BSERVATI ON BEDS (NON-DI STI NCT PART 200. 00 | Total (lines 50-199)

Health Fina	ncial Systems	HOLY	FAMILY MEDICAL	L CENTER		In Lie	u of Form CMS-2552-10
APPORTI ONM THROUGH CO:	ENT OF INPATIENT/OUTPATIENT STS	ANCILLARY SERVICE	OTHER PASS	Provider CCN:	142011	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared:

					То	12/31/2014	Date/Time Pr 5/19/2015 5:	
			Ti t	le XIX		Hospi tal	PPS	то р
Cost Center Description	Inpatient	Out	pati ent	Outpati ent		<u> </u>		
	Program	Pr	ogram	Program				
	Pass-Through	Ch	narges	Pass-Through	h			
	Costs (col. 8			Costs (col.	9			
	x col. 10)			x col. 12)				
	11.00	1	12.00	13. 00				
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0		0)	0			50. 00
53. 00 05300 ANESTHESI OLOGY	0		0)	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		0)	0			54. 00
56. 00 05600 RADI 0I SOTOPE	0		0)	0			56. 00
57. 00 05700 CT SCAN	0		0	1	0			57. 00
57. 01 03630 ULTRA SOUND	0		0	1	0			57. 01
58. 00 05800 MRI	0		0		0			58. 00
60. 00 06000 LABORATORY	0		0)	0			60. 00
65. 00 06500 RESPIRATORY THERAPY	0		0)	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0		0)	0			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0)	0			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0)	0			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0)	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0)	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0)	0			73. 00
74.00 07400 RENAL DIALYSIS	0		0)	0			74. 00
76.00 03950 SUBSTANCE ABUSE	0		0)	0			76. 00
76. 97 07697 CARDIAC REHABILITATION	O		0)	0			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0	1	0			76. 98
76. 99 07699 LI THOTRI PSY	O		0)	0			76. 99
OUTPATIENT SERVICE COST CENTERS					•			
90. 00 09000 CLI NI C	0		0)	0			90. 00
90.02 09001 WOMENS DIAGNOSTIC CENTER	0		0)	0			90. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o		0)	0			92. 00
200.00 Total (lines 50-199)	0		0	1	0			200. 00

Heal th	Financial Systems	HOLY FAMILY MEDICAL	L CENTER	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 142011	Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/19/2015 5:4	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS					
1.00	Inpatient days (including private room days	and swing-bed days,	excluding newborn)		33, 424	1. 00
2.00	Inpatient days (including private room days	, excluding swing-be	d and newborn days)		33, 424	2. 00
3. 00	Private room days (excluding swing-bed and do not complete this line.	observation bed days). If you have only pr	ivate room days,	0	3. 00

	Cost Center Description		
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	33, 424	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	33, 424	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4 00	do not complete this line.	22 424	4 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	33, 424	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	-	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period	ا	
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	18, 512	9. 00
7. 00	newborn days)	10, 012	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)	_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Ĭ	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00
16.00	SWING BED ADJUSTMENT	0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
40.00	reporting period	0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medical d rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	26, 621, 532	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)	0	23. 00
23.00	x line 18)	٥	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
24 00	X line 20)		24 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 26, 621, 532	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	20, 021, 332	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32. 00 33. 00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	26, 621, 532	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	796. 48	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	14, 744, 438	1
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	14, 744, 438	

19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	26, 621, 532	21. 00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)	_	
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
25.00	Ix line 20)	١	25.00
26. 00	Total swing-bed cost (see instructions)	o	26. 00
27. 00	· · · · · · · · · · · · · · · · · · ·	26, 621, 532	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00		0	30. 00
31. 00		0. 000000	
32. 00		0.00	
33. 00		0. 00	
34. 00		0. 00	
35. 00		0.00	
36. 00		0	36. 00
37. 00	, , , , , , , , , , , , , , , , , , , ,	26, 621, 532	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00		796. 48	38 00
	Program general inpatient routine service cost (line 9 x line 38)	14, 744, 438	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00		14, 744, 438	41. 00

Heal th	Financial Systems	HOLY FAMILY ME	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Prep	pared:
				20.011		5/19/2015 5: 43	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	oost center bescriptron		Inpatient Days			(col. 3 x col.	
				col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	.					42.00
43.00	INTENSIVE CARE UNIT	3, 343, 746	2, 220	1, 506. 1	9 1, 032	1, 554, 388	43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (W	est D-3 col 3	R line 200)			1. 00 15, 662, 712	48. 00
	Total Program inpatient costs (sum of lines			ons)		31, 961, 538	
	PASS THROUGH COST ADJUSTMENTS	<u>.</u>					
50. 00	Pass through costs applicable to Program inp	patient routine	services (from	n Wkst. D, sum	of Parts I and	1, 449, 227	50. 00
51. 00	Pass through costs applicable to Program inp	oatient ancillar	y services (fr	om Wkst. D, s	um of Parts II	1, 151, 576	51. 00
	and IV)		,				
52. 00	Total Program excludable cost (sum of lines			! .!	4:-44	2, 600, 803	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-pny	sician anestn	etist, and	29, 360, 735	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	/					
	Program di scharges					0	54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	,	ting cost and ta	arget amount (I	ine 56 minus	ine 53)	Ö	57. 00
58. 00	Bonus payment (see instructions)	-				0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	endi ng 1996, u	ipdated and coi	mpounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	narket basket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	Tristructions)				o	62. 00
63. 00	Allowable Inpatient cost plus incentive payr	ment (see instru	ıcti ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Doos	mbor 21 of the	cost reporti	ag pariod (Saa	0	64. 00
04.00	instructions)(title XVIII only)	sts till ough bece	mber 31 of the	cost reporti	ig period (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus line 6	5)(+i+l_ Y\/II	only) For	o	66. 00
00.00	CAH (see instructions)	THE COSTS (TITHE	04 prus rine o	55)(title XVII	only). To		00.00
67. 00	j ,	ne costs through	December 31 o	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost reno	rting period	0	68. 00
00.00	(line 13 x line 20)	ic costs arter b	recember of or	the cost repo	tring period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service of	-					71. 00
72. 00	Program routine service cost (line 9 x line			05)			72. 00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine serv						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•			art II, column		75. 00
7. 00	26, line 45)	0)					7. 00
76. 00 77. 00	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						78. 00
79. 00	Aggregate charges to beneficiaries for excess	, ,		· .			79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitation	ı (Iıne 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem from)				82. 00
83. 00	Reasonable inpatient routine service costs	(see instruction	* .				83. 00
84.00	Program inpatient ancillary services (see in		nne)				84. 00 85. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sur						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	J/				
87.00	Total observation bed days (see instructions	*	Line 2)			0 00	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	,				88. 00 89. 00
	(30)					١	

Health Financial Systems	HOLY FAMILY ME	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 414, 525	26, 621, 532	0. 09069	8 0	0	90.00
91.00 Nursing School cost	0	26, 621, 532	0.00000	0	0	91.00
92.00 Allied health cost	0	26, 621, 532	0.00000	0	0	92. 00
93.00 All other Medical Education	0	26, 621, 532	0.00000	0	0	93.00

Heal th	Financial Systems	HOLY FAMILY MEDICAL	_ CENTER	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 142011	Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		
			Title XIX	Hospi tal	5/19/2015 5: 4 PPS	3 pm
	Cost Center Description		II tie xix	поѕрітаі	PF3	
	cost center bescription				1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS					
1.00	Inpatient days (including private room days				33, 424	1.00
2.00	Inpatient days (including private room days				33, 424	2. 00
3.00	Private room days (excluding swing-bed and	observation bed days). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.					
4. 00	Semi-private room days (excluding swing-bed				33, 424	4. 00
5.00	Total swing-bed SNF type inpatient days (in	ncluding private room	days) through Decembe	r 31 of the cost	0	5. 00
	reporting period			04 6 11		, ,,
6. 00	Total swing-bed SNF type inpatient days (in reporting period (if calendar year, enter (days) after December	31 OF the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (inc		days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	cruding private room o	uays) through becember	31 OF THE COST	U	7.00
8.00	Total swing-bed NF type inpatient days (inc	cluding private room (davs) after December 3	1 of the cost	0	8.00
0.00	reporting period (if calendar year, enter (days) arter becomber o	i or the cost	· ·	0.00
9. 00	Total inpatient days including private room		the Program (excluding	swing-bed and	1, 698	9. 00
	newborn days)	3 11	3 \	3	•	
10.00	Swing-bed SNF type inpatient days applicable	e to title XVIII only	y (including private r	oom days)	0	10. 00
	through December 31 of the cost reporting			-		
11. 00	Swing-bed SNF type inpatient days applicable			oom days) after	0	11. 00
	December 31 of the cost reporting period (i				_	
12. 00	Swing-bed NF type inpatient days applicable		only (including privat	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting partial Swing-bed NF type inpatient days applicable		anly (including asiyat	a maam daysa)	0	13. 00
13.00	after December 31 of the cost reporting per				U	13.00
14. 00	Medically necessary private room days appli				0	14. 00
15. 00	Total nursery days (title V or XIX only)	cable to the riegiam	(exer daring swring bed	uuys)	0	15.00
16. 00	Nursery days (title V or XIX only)				0	16.00
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services as	oplicable to services	through December 31 o	f the cost	0.00	17. 00
	reporting period	•	<u> </u>			
18. 00	Medicare rate for swing-bed SNF services approximately	oplicable to services	after December 31 of	the cost	0.00	18. 00
	reporting period					
19. 00	Medicaid rate for swing-bed NF services app	olicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period					
20. 00	Medicaid rate for swing-bed NF services app	oficable to services a	after December 31 of t	he cost	0. 00	20. 00
21 00	reporting period	at (ass impatruations)			27 721 522	21 00
21. 00	Total general inpatient routine service cos		21 of the cost report	ing ported (line	26, 621, 532 0	•
22. 00	Swing-bed cost applicable to SNF type servi 5 x line 17)	ces through becember	31 of the cost report	ing period (iine	U	22. 00
23. 00	Swing-bed cost applicable to SNF type servi	ces after December 3	1 of the cost reportin	a neriod (line 6	0	23. 00
23.00	x line 18)	ces arter becember 3	Tot the cost reportin	g period (Title o	O	23.00
24. 00	Swing-bed cost applicable to NF type service	ces through December :	31 of the cost reporti	na period (line	0	24. 00
2 50	7 x line 19)	: oag booombor .	2. 2. 1 3331 . 3601 1.		Ŭ	
25.00	Swing-bed cost applicable to NF type service	ces after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)					
26.00	Total swing-bed cost (see instructions)				0	26. 00

		1. 00	
	PART I - ALL PROVIDER COMPONENTS		
4 00	INPATIENT DAYS	22 424	4 00
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	33, 424	1. 00 2. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	33, 424 0	3.00
3.00	do not complete this line.	O ₁	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	33, 424	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	O ₁	8.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 698	9. 00
7.00	newborn days)	1,070	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥١	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15.00	Total nursery days (title V or XIX only)	0	•
16.00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
40.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	report in a peri od	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period	ļ	
21. 00	Total general inpatient routine service cost (see instructions)	26, 621, 532	•
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
21.00	7 x line 19)	١	21.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	ļ	
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	26, 621, 532	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		00 00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	
30. 00	Semi - pri vate room charges (excluding swing-bed charges)	0	1
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	ı
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	26, 621, 532	•
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	70/ :=	00.00
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	796. 48	1
39.00	Program general inpatient routine service cost (line 9 x line 38)	1, 352, 423	ı
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 1 352 <i>4</i> 23	40.00

0 66, 016 55, 502 32, 533 84, 318 16, 851	42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00
15 5: 43 PPS Cost x col . 0 0 37, 063 0 0 66, 016 55, 502 32, 533 84, 318 16, 851	42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00
PPS Cost x col. 0 0 0 666, 016 555, 502 32, 533 84, 318 16, 851	42. 00 43. 00 44. 00 45. 00 47. 00 48. 00 49. 00 50. 00
x col . 0 0 37, 063 0 0 666, 016 55, 502 32, 533 84, 318 16, 851	43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00
0 37, 063 0 66, 016 55, 502 32, 533 84, 318 16, 851	43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00
0 666, 016 555, 502 32, 533 84, 318 16, 851	43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00
0 66, 016 55, 502 32, 533 84, 318 16, 851	44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00
0 66, 016 55, 502 32, 533 84, 318 16, 851	44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00
66, 016 55, 502 32, 533 84, 318 16, 851	45. 00 46. 00 47. 00 48. 00 49. 00 50. 00
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66, 016 55, 502 32, 533 84, 318 16, 851	48. 00 49. 00 50. 00
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32, 533 84, 318 16, 851	49. 00 50. 00
32, 533 84, 318 16, 851	50. 00
84, 318 16, 851	
16, 851	51. 00
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	82. 00 83. 00
	84.00
	85. 00 86. 00
	ou. uu
	87. 00 88. 00

Health Financial Systems	HOLY FAMILY ME	EDICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 414, 525	26, 621, 532	0. 09069	8 0	0	90. 00
91.00 Nursing School cost	0	26, 621, 532	0.00000	0	0	91.00
92.00 Allied health cost	0	26, 621, 532	0. 00000	0 0	0	92.00
93.00 All other Medical Education		26, 621, 532	0. 00000	0 0	0	93. 00

Heal th Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 142011 Date/Time 5/19/2015 Title XVIII Hospital Program Cost Center Description Ratio of Cost Inpatient Program Cost Charges Charges 1	7-3 Prepared: : 43 pm 7-5 1. 30.00 31.00
To 12/31/2014 Date/Time 5/19/2015 Title XVIII	30. 00 31. 00
Cost Center Description	30. 00 31. 00
To Charges Program Program Cost Charges Charges Charges Charges Col. 1 x co. 2)	30.00
INPATIENT ROUTINE SERVICE COST CENTERS	31.00
30. 00 03000 ADULTS & PEDIATRICS 57, 618, 272 31. 00 03100 INTENSIVE CARE UNIT 4, 025, 880	31.00
31.00 03100 I NTENSI VE CARE UNI T 4, 025, 880	31.00
ANCI LLARY SERVI CE COST CENTERS	_
50. 00 05000 OPERATI NG ROOM 0. 255295 989, 309 252,	66 50.00
53. 00 05300 ANESTHESI OLOGY 0. 014197 259, 849 3,	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 379263 1, 817, 152 689,	79 54.00
56. 00 05600 RADI OI SOTOPE 0. 410487 31, 826 13, 6	64 56.00
57. 00 05700 CT SCAN 0. 066384 1, 892, 070 125, 1	
57. 01 03630 ULTRA SOUND 0. 122727 486, 702 59, 1	
58. 00 05800 MRI 0. 065024 0	0 58.00
60. 00 06000 LABORATORY 0. 118797 14, 427, 612 1, 713, '	
65. 00 06500 RESPI RATORY THERAPY 0. 112309 28, 746, 035 3, 228,	
66. 00 06600 PHYSI CAL THERAPY	•
69. 00 06900 ELECTROCARDI OLOGY	•
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 266659 74, 626 19, 10 10 10 10 10 10 10 10 10 10 10 10 10	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 207755 12, 398, 789 2, 575, 172. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 621053 112, 458 69, 18	•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 621053 112, 458 69, 773. 00 07300 DRUGS CHARGED TO PATIENTS 0. 117528 33, 039, 778 3, 883, 778 33, 883, 778 33, 883, 778 33, 883, 778 33, 883, 778 33, 883, 783, 7	
73. 00 07300 DR0GS CHARGED TO PATTENTS	
74. 00 07400 REINAE DI RETSIS	0 76.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 0	0 76.97
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0. 470662 126, 586 59, 1	-
76. 99 07699 LLI THOTRI PSY 0. 000000 0	0 76.99
OUTPATIENT SERVICE COST CENTERS	J 70. 77
90. 00 09000 CLI NI C 0. 479805 7, 866 3,	74 90.00
90. 02 09001 WOMENS DI AGNOSTI C CENTER	0 90.02
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0	0 92.00
	12 200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)	201. 00
202.00 Net Charges (line 200 minus line 201) 102,919,309	202. 00

66. 00 06600 PHYSI CAL THERAPY 0. 415377 417, 286 173, 331 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 151317 41, 306 6, 250 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 266659 10, 700 2, 853 70. 00 71. 00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 207755 732, 946 152, 273 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 621053 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 117528 2, 699, 544 317, 272 73. 00 74. 00 07400 RENAL DI ALYSI S 0. 249359 0 0 74. 00 76. 90 03950 SUBSTANCE ABUSE 0. 454681 0 0 76. 90 76. 98 07699 HYPERBARI C OXYGEN THERAPY 0. 470662 0 0 76. 98 76. 99 017PATI ENT SERVI CE COST CENTERS 0 0. 479805 0 0 90. 00 90. 00 09001 WOMENS DI AGNOSTI C CENTER 0. 508338 0								
Title XIX Hospital PPS Title XIX Hospital PPS			HOLY FAMILY MEDICAL			In Li€		
To 12/31/2016 Date/Time Prepared: To Date/Time Prepared: To Date/Time Prepared: To Date/Time Prepared: To Date/Time Prepared: Date	INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 142011		Worksheet D-3	
NPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00							Doto/Time Dro	nonod.
NAME						10 12/31/2014		
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.				Ti t	le XIX	Hospi tal		э рііі
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.		Cost Center Description						
NAME		3031 3011101 20301 Pt. 311						
NPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00								
INPAT ENT ROUTI NE SERVI CE COST CENTERS 4, 450, 425 30, 00 31, 00 31, 00 310 01 384, 735 31, 00 310 01 384, 735 31, 00 310 01 384, 735 31, 00 310 01 384, 735 31, 00 310 01 384, 735 31, 00 310 01 384, 735 31, 00						3.1		
30. 00 03000 ADULTS & PEDIATRICS 384,735 31. 00 03100 INTENSIVE CARE UNIT 384,735 31. 00 034,000 INTENSIVE CARE UNIT 384,735 31. 00 036,700 INTENSIVE CARE UNIT 384,735 384,400 3					1.00	2. 00		
31.00		INPATIENT ROUTINE SERVICE COST CENTERS			•			
ANCI LLARY SERVI CE COST CENTERS	30.00	03000 ADULTS & PEDIATRICS				4, 450, 425		30.00
50. 00 05000 OPERATI NG ROOM 0.255295 56, 263 14, 364 53. 00 50. 00 53. 00 0.5300 ANESTHESI OLOGY 0.014197 16, 484 234 53. 00 53. 00 53. 00 0.0414197 16, 484 234 53. 00 56. 00 0.379263 153, 926 58, 378 54. 00 56. 00 0.06600 RADI OLOGY-DI AGNOSTI C 0.0414087 6, 846 2. 810 56. 00 56. 00 56. 00 0.066384 161, 114 10, 695 57. 00 57. 00 57. 00 57. 00 0.065024 0 0 0 0 0 58. 70 0 57. 01 0.065024 0 0 0 0 0 58. 70 0 58. 70 0 58. 00 57. 01 0.065024 0 0 0 0 0 58. 00 57. 01 0.065024 0 0 0 0 0 58. 00 57. 01 0.065024 0 0 0 0 0 58. 00 58. 00 0 0 0 58. 00 0 0 58. 00 0 0 0 58. 00 0 0 0 0 0 0 58. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00	03100 INTENSIVE CARE UNIT				384, 735		31.00
53. 00 05300 ANESTHESI OLOGY 0.014197 16, 484 234 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.379263 153, 926 58, 378 54. 00 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0.410487 6, 846 2, 810 56. 00 57. 01 05700 CT SCAN 0.066384 161, 114 10, 695 57. 00 57. 01 03630 ULTRA SOUND 0.122727 45, 517 5, 586 57. 01 58. 00 05800 MRI 0.065024 0 0 0 58. 00 65. 00 06000 LABORATORY 0.118797 994, 331 118, 124 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.112309 2, 705, 446 303, 846 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.117377 417, 286 173, 331 66. 00 69. 00 ELECTROCARDI OLOGY 0.151377 417, 306 6. 250 69. 00 70. 00 O7000 E		ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.379263 153, 926 58, 378 54.00 56.00 05600 RADI OI SOTOPE 0.410487 6, 846 2, 810 56.00 57.01 05700 CT SCAN 0.066384 161, 114 10, 695 57.01 57.01 03630 ULTRA SOUND 0.122727 45, 517 5, 586 57.01 58.00 05800 MRI 0.065024 0 0 0.58.00 60.00 06500 LABORATORY 0.118797 994, 331 118, 124 60.00 66.00 06500 RESPI RATORY THERAPY 0.112309 2, 705, 446 303, 846 65.00 66.00 06600 PHYSI CAL THERAPY 0.415377 417, 286 173, 331 66.00 69.00 06900 ELECTROCARDI OLOGY 0.151317 41, 306 6, 250 69.00 71.00 70.00 7000 ELECTROCARDI OLOGY 0.151317 41, 306 6, 250 69.00 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.26659 10, 700 2, 853 70.00	50.00	05000 OPERATING ROOM			0. 2552	95 56, 263	14, 364	50.00
56. 00 05600 RADI OI SOTOPE 0.410487 6,846 2,810 56. 00 57. 00 07500 CT SCAN 0.066384 161,114 10,695 57. 00 57. 01 03630 ULTRA SOUND 0.122727 45,517 5,586 57. 01 58. 00 05800 MRI 0.065024 0 0 0.58.00 60. 00 06500 LABORATORY 0.118797 994,331 118,124 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.112309 2,705,446 303,846 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.415377 417,286 173,331 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0.151317 41,306 6,250 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0.151317 41,306 6,250 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.207555 732,946 152,273 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.61053 0.621053 0 0 72. 00	53.00	05300 ANESTHESI OLOGY			0. 01419	97 16, 484	234	53. 00
57. 00 05700 CT SCAN 0.066384 161, 114 10, 695 57. 00 57. 01 03630 ULTRA SOUND 0.122727 45, 517 5, 586 57. 01 58. 00 05800 MRI 0.065024 0 0 58. 00 60. 00 06000 LABORATORY 0.118397 994, 331 118, 124 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.112309 2, 705, 446 303, 846 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.415377 417, 286 173, 331 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0.151317 41, 306 6, 250 69. 00 70. 00 O7000 ELECTROENCEPHALOGRAPHY 0.266659 10, 700 2, 853 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.207755 732, 946 152, 273 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.621053 0 0 72. 00 73. 00 <	54.00	05400 RADI OLOGY-DI AGNOSTI C			0. 3792	53 153, 926	58, 378	54.00
57. 01 03630 ULTRA SOUND 0.122727 45, 517 5, 586 57. 01 58. 00 05800 MRI 0.065024 0 0 58. 00 60. 00 06000 LABORATORY 0.118797 994, 331 118, 124 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.112309 2, 705, 446 303, 846 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.415377 417, 286 173, 331 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0.151317 41, 306 6, 250 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.266659 10, 700 2, 853 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.207755 732, 946 152, 273 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.20153 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.117528 2, 699, 544 317, 272 73. 00 74. 00 07400 RENAL DI ALYSI S 0.249359 0 0 74. 00	56.00	05600 RADI OI SOTOPE			0. 41048	6, 846	2, 810	56. 00
58. 00 05800 MRI 0.065024 0 0 58. 00 60. 00 06000 LABORATORY 0.118797 994, 331 118, 124 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.112309 2, 705, 446 303, 846 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.415377 417, 286 173, 331 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0.151317 41, 306 6. 250 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0.266659 10, 700 2, 853 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.207755 732, 946 152, 273 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.621053 0 0 72. 00 73. 00 07400 RENAL DI ALYSI S 0.249359 0 0 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.249359 0 0 76. 90 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.470662 0 0 76. 99 00. 00	57.00	05700 CT SCAN			0. 06638	34 161, 114	10, 695	57.00
60. 00 06000 LABORATORY 0. 118797 994, 331 118, 124 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 112309 2, 705, 446 303, 846 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 415377 417, 286 173, 331 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 151317 41, 306 6, 250 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 266659 10, 700 2, 853 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 207755 732, 946 152, 273 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 621053 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 117528 2, 699, 544 317, 272 73. 00 74. 00 07400 RENAL DI ALYSI S 0. 249359 0 0 0 74. 00 76. 90 07697 CARDI AC REHABI LI TATI ON 0. 000000 0 0 0 0 0 76. 90 76. 90 07699 LI THOTRI PSY 0. 470662 0 0 0 76. 90 00 TOPATI ENT SERVI CE COST CENTERS 0. 479805 0 0 0 90. 00 09000 CLINI C 0. 479805 0 0 0 90. 00 09000 WMENS DI AGNOSTI C CENTERS 0. 508338 0 0 0 90. 00	57. 01	03630 ULTRA SOUND			0. 1227:	27 45, 517	5, 586	57. 01
65. 00 06500 RESPIRATORY THERAPY 0. 112309 2, 705, 446 303, 846 65. 00 66. 00	58.00	05800 MRI			0. 06502	24 0	0	58. 00
66. 00 06600 PHYSI CAL THERAPY 0. 415377 417, 286 173, 331 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 151317 41, 306 6, 250 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 266659 10, 700 2, 853 70. 00 71. 00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 207755 732, 946 152, 273 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 621053 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 117528 2, 699, 544 317, 272 73. 00 74. 00 07400 RENAL DI ALYSI S 0. 249359 0 0 74. 00 76. 90 O3950 SUBSTANCE ABUSE 0. 454681 0 0 76. 90 76. 98 O7699 HYPERBARI C OXYGEN THERAPY 0. 470662 0 0 76. 98 76. 99 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 76. 99 00 000 O9001 WOMENS DI AGNOSTI C CENTER 0 0 0 90. 00 <td></td> <td>06000 LABORATORY</td> <td></td> <td></td> <td>0. 11879</td> <td>97 994, 331</td> <td>118, 124</td> <td>60.00</td>		06000 LABORATORY			0. 11879	97 994, 331	118, 124	60.00
69. 00 06900 CLECTROCARDI OLOGY 0. 151317 41, 306 6, 250 69. 00 69.	65.00	06500 RESPI RATORY THERAPY			0. 11230	09 2, 705, 446	303, 846	65. 00
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92 00 1092001 ORSERVATION REDS (NON-DISTINCT PART 0 0000001 01 01 92 00								
	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0.0000		0	
200.00 Total (sum of lines 50-94 and 96-98) 8,041,709 1,166,016 200.00						8, 041, 709	1, 166, 016	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00				line 61)		0		1
202.00 Net Charges (line 200 minus line 201) 8,041,709 202.00	202. 00	Net Charges (line 200 minus line 201)			I	8, 041, 709	l	202.00

Health Financial Systems	HOLY FAMILY MEDICAL CENTER		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 142011		Worksheet E Part B Date/Time Prepared: 5/19/2015 5:43 pm
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PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00				10 12/31/2014	5/19/2015 5:4	
DOI: 10.00000000000000000000000000000000000			Title XVIII	Hospi tal		э рш
Note			,	1100pt tui	110	
Medical and other services (see instructions) 2,086 12, 227, 375 2,0					1. 00	
Medical and other services 'reinhoursed under OPPS (see instructions) 3, 273, 751 2, 2, 2018, 183, 184, 186, 186, 187, 187, 187, 187, 187, 187, 187, 187		PART B - MEDICAL AND OTHER HEALTH SERVICES				
2.00 Rose 3.00 PS payments 2.206, RSB 8.1		· · · · · · · · · · · · · · · · · · ·				1. 00
0.001 fire payment (see instructions) 0.000 5.6		· · · · · · · · · · · · · · · · · · ·				
Inter the fixes pital specific payment to cost ratio (see instructions)		1 ' 3				3. 00
Line 2 times line 5 0.0						
2.00 2.00 3.00			i ons)			
Transitional corridor payment (see instructions)						
Ancillary service other pass through costs from Wist. D, Pt. IV. col. 13, line 200 0 0.						
10.00 Organ acquisitions 0 10.0						
Total cost (sum of lines 1 and 10) (see instructions) 2.086 11.6			, col. 13, line 200			
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges 12.00 Ancil larry service charges (from Wist. D-4, Pt. 111, line 69, col. 4) 16, 279 14. 0 13. 0 Organ acquisit from charges (from Wist. D-4, Pt. 111, line 69, col. 4) 16, 279 14. 0 15. 0 15. 0 16, 279 14. 0 16, 279 1					1	
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13.00 Organ acquistion charges (from West. D-4, Pt. III., line 69, col. 4) 16.279 14.00 Total reasonable charges (sum of lines 12 and 13) 16.279 14.00 Total reasonable charges (sum of lines 12 and 13) 16.279 14.00 Total reasonable charges (sum of lines 12 and 13) 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 Amounts that would have been rade in accordance with 42 CFR \$43.13(e) 0 17.00	12 00				14 270	12 00
14.00 Total reasonable charges (sum of lines 12 and 13) 16.279 14.00			.1 4			
Country charges			11. 4)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.0	14.00				10, 279	14.00
16.00 Amounts that would have been realized from patients iable for payment for services on a chargebasis nad such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.0	15 00		yment for services on	a charge hasis	0	15 00
had such payment been made in accordance with 42 CFR §413.13(e)						
17.00	10.00			ii a chargebasis	ĺ	10.00
18.00 Total customary charges (see instructions) 16,279 18.0 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 14,193 19.00 19.	17 00				0 000000	17. 00
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 14,193 19.00		· · · · · · · · · · · · · · · · · · ·				
instructions			if line 18 exceeds li	ne 11) (see		
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00				, (222		
Instructions 2,086 21.00 1.00	20.00	· ·	if line 11 exceeds li	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.0 23.00				, ,		
23.00 Cost of physicians' services in a teaching hospital (see instructions) 2.3.0 2.227,703 24.00 Total prospective payment (sum of lines 3, 4, 8 and 9) 2.227,703 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 25.00 Deductible is and coinsurance (for CAH, see instructions) 513,267 26.00 Deductible sand Coinsurance relating to amount on line 24 (for CAH, see instructions) 513,267 26.00 27.00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 20.00 20.0	21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		2, 086	21.00
Total prospective payment (sum of lines 3, 4, 8 and 9) 2, 227, 703 24.0	22.00	Interns and residents (see instructions)			0	22. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions) 0 25.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 531, 267 26.00 26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 1, 698, 522 27.00 CAH, see instructions) 26.00 25.00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 202 28.00 Direct graduate medical education payments (from Wkst. E-4, line 36) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 1, 698, 724 30.00 30.00 20.00	23.00	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)		0	23.00
25.00 Deductibles and coinsurance (For CAH, see instructions) Deductibles and coinsurance relating to amount on line 24 (For CAH, see instructions) S31, 267 26.00 Deductibles and Coinsurance relating to amount on line 24 (For CAH, see instructions) 1,698, 522 27.00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 202 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 202 28.00 ESRD direct medical education costs (From Wkst. E-4, line 36) 0.00 29.0	24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			2, 227, 703	24.00
26. 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 531, 267 26. CAH, see instructions) 27. 00 Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions) 1, 698, 522 27. CAH, see instructions) 28. 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 202 28. CAH, see instructions 28. CAH, see instructions 29. CAH, see instructions 29. CAH, see instructions 20. 29. CAH, see instructions 30. CAH, see instruction						
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31.00 Primary payer payments					-	
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40.00 Subtotal (see instructions) 1,781,624 40.00 40.01 Sequestration adjustment (see instructions) 35,632 40.00 41.00 Interim payments 1,663,380 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 42.00 8al ance due provider/program (see instructions) 82,612 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Si15.2 10 10 10 10 10 10 10 1		· ·	d devices (see ilistruc	(10115)	_	
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41.00 Interim payments Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 1,663,380 41.0 42.00 42.00 43.00 44.00 90.00 90.00 90.00 90.00 91.00 92.00 93.00 1 ime Value of Money (see instructions) 0 90.00 93.00		· · · · · · · · · · · · · · · · · · ·				
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions)						
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 73.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)		· · · · · · · · · · · · · · · · · · ·				
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00 Outlier reconciliation adjustment amount (see instructions) 0 93.00 Outlier reconciliation adjustment amount (see instructions) 0 93.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 93.00 Outlier reconciliation adjustment amount (see instructions) 0 93.00 Outlier reconciliation adjustment amount (see instructions)			- with CMC Dub 15 2			1
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	44.00		e with CMS Pub. 15-2,	cnapter I,	ĺ	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 90.00 91.00 92.00 93.00 Time Value of Money (see instructions) 90.00 90.00 91.00 92.00 93.00 Time Value of Money (see instructions)					l	
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.0 92.00 92.0 93.00 Time Value of Money (see instructions)	00.00					00.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.0		, ,				
93.00 Time Value of Money (see instructions) 0 93.0		, , , , , , , , , , , , , , , , , , , ,				
94. 00 10 tai (suii 01 11 nes 91 and 93)		The state of the s				
	94.00	Liorai (2000 OI IIII62 AI 900 A2)			0	J 94. U

| Peri od: | Worksheet E-1 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 142011

					10 12/31/2014	5/19/2015 5: 43	
			Ti tl	e XVIII	Hospi tal	PPS	•
		Inp	oati en	t Part A	Pai	rt B	
		mm/dd/y	/۷۷۷	Amount	mm/dd/yyyy	Amount	
		1.00		2.00	3. 00	4.00	
1.00	Total interim payments paid to provider			29, 528, 10	01	1, 663, 380	1. 00
2.00	Interim payments payable on individual bills, either				0	0	2.00
	submitted or to be submitted to the contractor for						
	services rendered in the cost reporting period. If none,						
	write "NONE" or enter a zero						
3.00	List separately each retroactive lump sum adjustment						3. 00
	amount based on subsequent revision of the interim rate						
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
3. 01	ADJUSTMENTS TO PROVIDER				0	0	3. 01
3. 02					0	0	3. 02
3. 03					0	0	3. 03
3. 04					0	0	3. 04
3.05					0	0	3. 05
2 50	Provider to Program					0	2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM				0		3. 50 3. 51
3. 52		ŀ					3. 51
3. 53		ŀ					3. 52
3. 54		ŀ					3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines	1			0		3. 99
3. 77	3. 50-3. 98)				O .		3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			29, 528, 10	01	1, 663, 380	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					1, 222, 223	
	appropri ate)						
	TO BE COMPLETED BY CONTRACTOR				<u> </u>		
5.00	List separately each tentative settlement payment after						5. 00
	desk review. Also show date of each payment. If none,						
	write "NONE" or enter a zero. (1)						
	Program to Provider						
5. 01	TENTATI VE TO PROVI DER				0	0	5. 01
5.02					0	0	5. 02
5.03					0	0	5. 03
F F0	Provi der to Program						F F0
5. 50	TENTATI VE TO PROGRAM				0	0	5. 50
5. 51					0	0	5. 51
5. 52	Cultural (0	0	5. 52 5. 99
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				U	١	5. 99
6. 00	Determined net settlement amount (balance due) based on	1					6. 00
0.00	the cost report. (1)						0.00
6. 01	SETTLEMENT TO PROVIDER			512, 92	28	82, 612	6. 01
6. 02	SETTLEMENT TO PROGRAM			512, 72	0	02, 012	6. 02
7. 00	Total Medicare program liability (see instructions)			30, 041, 02	29	1, 745, 992	7. 00
	Trotal mode ode o program trability (ode thotal detroils)			30, 611, 02	Contractor	NPR Date	,. 50
					Number	(Mo/Day/Yr)	
			C)	1. 00	2.00	
8.00	Name of Contractor						8. 00

Heal th	Financial Systems HOLY FAMILY MEDICA	L CENTER	In Lie	u of Form CMS-2	2552-10		
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 142011 Period: From 01/01/2014 Part II						
	To 12/31/2014 Date/Time Prepare						
		Title XVIII	Hospi tal	PPS			
				1. 00			
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S	5-3, Pt. I col. 15 line	14	1, 481	1. 00		
2.00	.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 19,544						
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		35, 644	4. 00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			347, 776, 055	5. 00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir	ne 20		0	6. 00		
7. 00	CAH only - The reasonable cost incurred for the purchase of cer line 168	tified HIT technology	Wkst. S-2, Pt. I	0	7. 00		
8. 00	Calculation of the HIT incentive payment (see instructions)			0	8. 00		
9. 00	Sequestration adjustment amount (see instructions)			0	9. 00		
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		0	10.00		
	I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH	,					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00		
	Other Adjustment (specify)			0	31. 00		
	Balance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	s)	0	1		

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

0 30.00 0 31.00 0 32.00

Health Financial Systems	HOLY FAMILY MEDICAL	L CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142011	From 01/01/2014	Worksheet E-3 Part IV Date/Time Prepared: 5/19/2015 5:43 pm
		Title XVIII	Hospi tal	PPS

				5/19/2015 5: 4	3 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	00 Net Federal PPS Payments (see instructions)				1. 00
2.00	Outlier Payments			6, 082, 613	
3.00	Total PPS Payments (sum of lines 1 and 2)			33, 014, 674	
4.00	Nursing and Allied Health Managed Care payments (see instructio	ns)		0	4. 00
5.00	Organ acquisition (DO NOT USE THIS LINE)				5. 00
6.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	6. 00
7.00	Subtotal (see instructions)			33, 014, 674	7. 00
8.00	Primary payer payments			0	8. 00
9.00	Subtotal (line 7 less line 8).			33, 014, 674	9. 00
10.00	Deducti bl es			47, 424	10. 00
11. 00	Subtotal (line 9 minus line 10)			32, 967, 250	11. 00
12.00	Coinsurance			2, 836, 488	12. 00
13.00	Subtotal (line 11 minus line 12)			30, 130, 762	13. 00
14.00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		802, 127	14. 00
15. 00	Adjusted reimbursable bad debts (see instructions)			521, 383	15. 00
16.00					16. 00
17. 00	Subtotal (sum of lines 13 and 15)			30, 652, 145	17. 00
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		1, 966	18. 00
19. 00	Other pass through costs (see instructions)			0	19. 00
20.00	Outlier payments reconciliation			0	20. 00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	21. 00
21. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	21. 50
21. 99	Recovery of Accelerated Depreciation			0	21. 99
22.00	Total amount payable to the provider (see instructions)			30, 654, 111	22. 00
22. 01	Sequestration adjustment (see instructions)			613, 082	22. 01
23.00	Interim payments			29, 528, 101	23. 00
24.00	Tentative settlement (for contractor use only)			0	24. 00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and	24)		512, 928	25. 00
26.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	26. 00
	§115. 2		•		
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see inst	ructions)		0	50. 00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52.00	The rate used to calculate the Time Value of Money (see instruc	ti ons)		0.00	52. 00
53.00	Time Value of Money (see instructions)			0	53. 00
				•	•

Health Financial Systems	HOLY FAMILY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14201	From 01/01/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/19/2015 5:43 pm

			lo 12/31/2014	Date/lime Pre 5/19/2015 5:4	
		Title XIX	Hospi tal	PPS	<u> </u>
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		4, 835, 160		8. 00
9.00	Ancillary service charges		8, 041, 709	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		12, 876, 869	0	12. 00
12.00	CUSTOMARY CHARGES				12 00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis Amounts that would have been realized from patients liable for	normant for carriage on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42		U	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 9413. 13(e)	0.000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		12, 876, 869	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	12, 876, 869	0	17. 00
	line 4) (see instructions)		12/0/0/00/	Ü	.,,,,,,
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	23. 00
	1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30. 00 31. 00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	30. 00 31. 00
31.00	Deductibles		0	0	31.00
33. 00	Coinsurance		0	0	33. 00
34. 00			0	0	34. 00
	·		0	O	35. 00
36. 00	Utilization review O Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36. 00
	O Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) O OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
	0 Subtotal (line 36 ± line 37)		0	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	Ü	39. 00
	O Total amount payable to the provider (sum of lines 38 and 39)		0	0	40. 00
41. 00	Interim payments		0	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2	·			
			·		

Heal th	Financial Systems HOLY FAMILY MEDICA	L CENTER		In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prep 5/19/2015 5:43	
		Ti tl	e XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic prending on or before December 31, 1996.	· ·			2. 57	1. 00
2. 00 3. 00	Unweighted FTE resident cap add-on for new programs per 42 CFR Amount of reduction to Direct GME cap under section 422 of MMA	413. 79(e)(1) (see instr	ucti ons)	0. 00 0. 00	2. 00 3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance winstructions for cost reporting periods straddling 7/1/2011)	vith 42 CFR	§413.79 (m).	(see	1. 19	3. 01
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and os GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	steopathi c	programs due	to a Medicare	-1. 00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instrustraddling 7/1/2011)	uctions for	cost reporti	ng peri ods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	(see inst	ructions for	cost reporting	0. 00	4. 02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus 4.02 plus applicable subscripts	or minus	line 4 plus l	ines 4.01 and	0. 38	5. 00
6.00	Unweighted resident FTE count for allopathic and osteopathic pr records (see instructions)	ograms for	the current	year from your	0. 09	6. 00
7. 00	Enter the lesser of line 5 or line 6				0. 09	7. 00
			Primary Care		Total	
8. 00	Weighted FTE count for physicians in an allopathic and osteopat	·hi c	1. 00 0. 0	2.00	3. 00 0. 08	8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwis		0.0		0.08	9. 00
9.00	multiply line 8 times the result of line 5 divided by the amount		0.0	0.00	0.08	9.00
10. 00 11. 00	Weighted dental and podiatric resident FTE count for the currer Total weighted FTE count	nt year	0.0	0. 00 0. 00		10. 00 11. 00
12. 00	Total weighted resident FTE count for the prior cost reporting instructions)	year (see	0.0	0.00		12. 00
13. 00	Total weighted resident FTE count for the penultimate cost repoyear (see instructions)	orting	0.0	0.00		13. 00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided b	oy 3).	O. C			14. 00
15. 00	Adjustment for residents in initial years of new programs		0.0			15. 00
16.00	Adjustment for residents displaced by program or hospital closu	ıre	0.0			16.00
17. 00 18. 00	Adjusted rolling average FTE count Per resident amount		98, 702. 0			17. 00 18. 00
19. 00	Approved amount for resident costs		3, 94		3 948	19. 00
17.00	The first of the first delite costs		0, 71	0	0, 710	17.00
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4)	resident	cap slots rec	eived under 42	0. 00	20. 00
21. 00	Direct GME FTE unweighted resident count over cap (see instruct				0.00	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see instruc				0. 00	
23. 00	Enter the locally adjustment national average per resident amou	ınt (see in	structions)			23.00
	Multiply line 22 time line 23				0	
25. 00	Total direct GME amount (sum of lines 19 and 24)		l	.t Manager 1	3, 948	25. 00
			Inpatient Par A	t Managed care		
			1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26. 00	Inpatient Days (see instructions)		19, 54			26. 00
27. 00	Total Inpatient Days (see instructions)		35, 64			27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 54831			28. 00
29. 00	Program direct GME amount		2, 16			29. 00
30.00	Reduction for direct GME payments for Medicare Advantage			0	2 4 4 2	30.00
31.00	Net Program direct GME amount		I		2, 168	31. 00

Heal th	Financial Systems HOLY FAMILY MEDICA	AL CENTER	In Lie	u of Form CMS-2	2552-10	
	DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 142011 Period:					
MEDI CA	MEDICAL EDUCATION COSTS From 01/01/2014 To 12/31/2014					
	PPS					
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL		
32.00	, , , , , , , , , , , , , , , , , , , ,	t. I, sum of col. 20 an	d 23, lines 74	0	32. 00	
	and 94)					
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I,		74 and 94)	4, 363, 877		
34. 00	Ratio of direct medical education costs to total charges (line	32 ÷ line 33)		0. 000000		
	Medicare outpatient ESRD charges (see instructions)				35. 00	
36. 00	Medicare outpatient ESRD direct medical education costs (line 3			0	36. 00	
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	DNLY				
	Part A Reasonable Cost			31, 961, 538		
37. 00						
38. 00					38. 00	
	Cost of physicians' services in a teaching hospital (see instructions)			0	39. 00	
40. 00				0	40. 00	
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus	31, 961, 538	41.00			
	Part B Reasonable Cost			3, 275, 837		
	Reasonable cost (see instructions)					
	Primary payer payments (see instructions)				43.00	
44. 00					44. 00	
45. 00					45. 00 46. 00	
46. 00						
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 0.092					
49 00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 3.00 Total program GME payment (line 31) 2,168					
	' ' '	(soo instructions)			49. 00	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)				50.00	
30.00	0.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)					

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

Peri od: From 01/01/2014 To 12/31/2014

Date/Time Prepared: 5/19/2015 5:43 pm

					5/19/2015 5: 4	3 pm
		General Fund		Endowment Fund	Plant Fund	
			Purpose Fund			
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS	1				
1.00	Cash on hand in banks	8, 087	1	0	_	1. 00
2.00	Temporary investments	0	0	-		2. 00
3.00	Notes recei vabl e	0) 0	0	0	3. 00
4.00	Accounts receivable	21, 781, 974	0	0	0	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	41, 142	2 0	0	0	6. 00
7.00	Inventory	1, 013, 107		0	0	7. 00
8. 00	Prepai d expenses	1) 0	0	0	8. 00
9. 00	Other current assets	36, 240	0	0	l o	9. 00
10. 00	Due from other funds	428, 106		0	Ö	10. 00
				0	•	11. 00
11. 00	Total current assets (sum of lines 1-10)	23, 308, 656	0	U	0	11.00
12.00	FI XED ASSETS	242.000	J 0	0		10.00
12.00	Land	342, 000		0	_	12.00
13. 00	Land improvements	4, 077, 827	1	0		13. 00
14. 00	Accumulated depreciation	-4, 009, 038	1	0	_	14. 00
15. 00	Bui I di ngs	85, 557, 685	0	0	1	15. 00
16. 00	Accumulated depreciation	-70, 667, 875	0	0	0	16. 00
17.00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumul ated depreciation		o	0	0	18. 00
19.00	Fi xed equipment	2, 119, 028	o o	0	0	19. 00
20. 00	Accumul ated depreciation	-2, 013, 891		0	0	20. 00
21. 00	Automobiles and trucks	2,0.0,0,1	0	0	Ö	21. 00
22. 00	Accumulated depreciation			0	Ö	22. 00
23. 00	Major movable equipment	35, 971, 471	1	0	0	23. 00
	, ,	1		0	0	
24. 00	Accumulated depreciation	-29, 549, 481	1	0		24. 00
25. 00	Mi nor equi pment depreci abl e		0	0	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0) 0	0	0	27. 00
28. 00	Accumulated depreciation	0) 0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	21, 827, 726	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	C	0	0	0	31. 00
32.00	Deposits on Leases		0	0	0	32. 00
33. 00	Due from owners/officers		0	0	0	33. 00
34. 00	Other assets	293, 000	1	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	293, 000		0		35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)			0	1	36.00
30.00		45, 429, 382		U	0	30.00
07.00	CURRENT LI ABI LI TI ES	104 005		0		07.00
37. 00	Accounts payable	-191, 225	1	0		37. 00
38. 00	Salaries, wages, and fees payable	0	0	0	_	38. 00
39. 00	Payroll taxes payable	0) 0	0	0	39. 00
40.00	Notes and Loans payable (short term)	0) 0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	47, 417, 789	0	0	0	43.00
44.00	Other current liabilities	10, 254, 755		0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	57, 481, 319	1	0		45. 00
.0.00	LONG TERM LIABILITIES	0,7,10,70,7	·	<u> </u>		10.00
46. 00	Mortgage payable		0	0	0	46. 00
47. 00	Notes payable		0	0	1	47. 00
	1			_		
48. 00	Unsecured Loans	0	0	-		48. 00
49. 00	Other long term liabilities	3, 169, 000		0		49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	3, 169, 000) 0	0		50.00
51. 00	Total liabilites (sum of lines 45 and 50)	60, 650, 319	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	-15, 220, 937	'			52.00
53.00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted		1	n		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
				0	_	
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	-15, 220, 937		0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	45, 429, 382	2 0	0	0	60. 00
	[59]					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der CCN: 142011

| Peri od: | Worksheet G-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: | Date/Control | Prepared: | Pr

					То	12/31/2014	Date/Time Prep 5/19/2015 5:43	
		Genera	Fund	Speci al	Pur	pose Fund	Endowment Fund	Э рііі
				·		•		
	I 	1. 00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		-18, 268, 120			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3, 047, 180			0		2.00
3.00	Total (sum of line 1 and line 2) RECONCILING ITEM	2	-15, 220, 940		0	U	0	3. 00 4. 00
4. 00 5. 00	RECONCILING FIEM	3			0		0	4. 00 5. 00
6.00		0			0		0	6. 00
7. 00					0		0	7. 00
8. 00					0		Ö	8. 00
9. 00					0		0	9. 00
10. 00	Total additions (sum of line 4-9)		3			0	, and the second	10. 00
11. 00	Subtotal (line 3 plus line 10)		-15, 220, 937			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	o	,,		0		0	
13. 00	, , , , , , , , , , , , , , , , , , ,	o			0		0	13. 00
14.00		o			0		0	14.00
15.00		o			0		0	15.00
16.00		0			0		0	16.00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		-15, 220, 937			0		19. 00
	sheet (line 11 minus line 18)							
	Janeer (Trile Trillinias Trile To)	Endowmont Fund	DLant	Fund				
	The Training Trie 10)	Endowment Fund	PI ant	Fund				
	Janeet (Title TT MITMES TITLE TO)	Endowment Fund 6.00	7. 00	Fund 8. 00				
1.00	Fund balances at beginning of period				0			1. 00
2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	6. 00			0			2. 00
2. 00 3. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6. 00			0			
2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	6. 00						2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6. 00						2. 00 3. 00 4. 00 5. 00
2.00 3.00 4.00 5.00 6.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6. 00						2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6. 00						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6. 00						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 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) RECONCILING ITEM	6. 00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM Total additions (sum of line 4-9)	6. 00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6. 00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM Total additions (sum of line 4-9)	6. 00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6. 00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6. 00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6. 00			0			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
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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6. 00			0			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
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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6. 00			0			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
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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	6. 00			0 0 0			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 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	6. 00			0 0 0			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

Health Financial Systems H
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Peri od: | Worksheet G-2 | From 01/01/2014 | Parts | & | I | | To | 12/31/2014 | Date/Time | Prepared: Provider CCN: 142011

			To 12/31/2014	Date/Time Prep 5/19/2015 5:43			
	Cost Center Description	Inpati ent	Outpati ent	Total	Б		
		1.00	2. 00	3. 00			
	PART I - PATIENT REVENUES	·					
	General Inpatient Routine Services						
1.00	Hospi tal	109, 031, 09	0	109, 031, 090	1. 00		
2.00	SUBPROVI DER - I PF				2. 00		
3.00	SUBPROVI DER - I RF				3. 00		
4.00	SUBPROVI DER				4. 00		
5.00	Swing bed - SNF		0	0	5. 00		
6.00	Swing bed - NF		0	0	6. 00		
7.00	SKILLED NURSING FACILITY				7. 00		
8.00	NURSI NG FACILITY				8. 00		
9.00	OTHER LONG TERM CARE			400 004 000	9. 00		
10. 00	Total general inpatient care services (sum of lines 1-9)	109, 031, 09	0	109, 031, 090	10. 00		
11 00	Intensive Care Type Inpatient Hospital Services	0.527.70	1	0 524 701	11 00		
11. 00 12. 00	INTENSIVE CARE UNIT	9, 536, 79	1	9, 536, 791	11. 00 12. 00		
13. 00	BURN INTENSIVE CARE UNIT	ł			13. 00		
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00		
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00		
16. 00	Total intensive care type inpatient hospital services (sum of li	nes 9, 536, 79	1	9, 536, 791			
10.00	11-15)	7, 550, 77	'	7, 550, 771	10.00		
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	118, 567, 88	1	118, 567, 881	17. 00		
18. 00	Ancillary services	171, 467, 92		226, 988, 429	18. 00		
19. 00	Outpatient services	111, 121, 12	0 2, 202, 939	2, 202, 939			
20. 00	RURAL HEALTH CLINIC		o o	0	20. 00		
21.00	FEDERALLY QUALIFIED HEALTH CENTER		o o	0	21. 00		
22. 00	HOME HEALTH AGENCY				22. 00		
23.00	AMBULANCE SERVICES				23. 00		
24.00	CMHC				24. 00		
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00		
26. 00	HOSPI CE				26. 00		
27. 00	CLINIC OP REVENUE		0 16, 804	16, 804	27. 00		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to) Wkst. 290,035,80	4 57, 740, 249	347, 776, 053	28. 00		
	G-3, line 1)						
00.00	PART II - OPERATING EXPENSES		70 007 (44		00.00		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		72, 987, 644		29. 00		
30. 00 31. 00	ADD (SPECIFY)		0		30. 00 31. 00		
31.00		+	0		31.00		
33. 00		ł	0		33. 00		
34. 00			0		34. 00		
35. 00			0		35. 00		
36. 00	Total additions (sum of lines 30-35)		ا ا		36. 00		
37. 00	DEDUCT (SPECIFY)		o		37. 00		
38. 00	DEDUCT (GLEGITT)		o I		38. 00		
39. 00			ol I		39. 00		
40. 00			o I		40. 00		
41. 00			o		41. 00		
42.00	Total deductions (sum of lines 37-41)		o		42.00		
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)((transfer	72, 987, 644		43.00		
	to Wkst. G-3, line 4)						

Health Financial Systems HOLY FAMILY MEDICAL CENTER In Lieu	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 142011 Period:	Worksheet G-3	
From 01/01/2014 To 12/31/2014	Date/Time Prep 5/19/2015 5:43	
	1.00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1. 00 347, 776, 053	1, 00
2.00 Less contractual allowances and discounts on patients' accounts	273, 126, 579	2. 00
3.00 Net patient revenues (line 1 minus line 2)	74, 649, 474	3. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	72, 987, 644	
5.00 Net income from service to patients (line 3 minus line 4)	1, 661, 830	
OTHER I NCOME	170017000	0.00
6.00 Contributions, donations, bequests, etc	2, 422	6. 00
7.00 Income from investments	13, 621	7. 00
8.00 Revenues from telephone and other miscellaneous communication services	0	8. 00
9.00 Revenue from television and radio service	0	9. 00
10.00 Purchase discounts	0	10.00
11.00 Rebates and refunds of expenses	0	11. 00
12.00 Parking Lot receipts	0	12.00
13.00 Revenue from Laundry and Linen service	0	13.00
14.00 Revenue from meals sold to employees and guests	348, 541	14.00
15.00 Revenue from rental of living quarters	0	15.00
16.00 Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00 Revenue from sale of drugs to other than patients	0	17.00
18.00 Revenue from sale of medical records and abstracts	780	18. 00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0	20. 00
21.00 Rental of vending machines	0	
22.00 Rental of hospital space	0	22. 00
23.00 Governmental appropriations	0	
24.00 INTERCOMPANY RENTAL	858, 156	
24.01 NET ASSETS RELEASED	725	
24. 02 OTHER REVENUE	161, 105	
25.00 Total other income (sum of lines 6-24)	1, 385, 350	
26.00 Total (line 5 plus line 25)	3, 047, 180	
27. 00 OTHER EXPENSES (SPECIFY)	0	
28.00 Total other expenses (sum of line 27 and subscripts)	0	28. 00
29.00 Net income (or loss) for the period (line 26 minus line 28)	3, 047, 180	29. 00